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Evaluation of Models of Health Care Delivery in Inuit Regions

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Table of Contents

List of Tables and Charts

1. INTRODUCTION

The health care system in most of the Inuit north is barely 50 years old. Despite progress in the delivery of health services to Inuit during this period, further advances are required to bring these services up to the level enjoyed by other Canadians. Today, Inuit have the highest suicide rate, the lowest life expectancy and the highest birth rate of all Aboriginal peoples in Canada—and Aboriginal health status falls far below national standards. Recognizing the need for information on the effectiveness of the health care delivery systems that operate in Inuit regions, the Inuit Tapirisat of Canada (ITC) developed an evaluation project to document and assess these models. The goal is "to generate information that can lead to improved health care in Inuit communities through a comparative analysis of the existing models of health care administration, services and delivery mechanisms in the Inuit regions of Canada." The project was funded under the Health Transition Fund (HTF), a joint initiative involving the federal, provincial and territorial governments to support innovations leading to a more integrated health system.

The project was undertaken by the Inuit Tapirisat of Canada, a non-profit organization dedicated to the needs and aspirations of Canada's Inuit. The members of ITC are the land claim settlement organizations: Inuvialuit Regional Corporation (IRC), Nunavut Tunngavik Incorporated, Makivik Corporation and Labrador Inuit Association. The Board of Directors includes the presidents of each of these organizations, an elected president, the vice-president (who is president of the Inuit Circumpolar Conference—Canada), and, as ex-officio members, the presidents of Pauktuutit and the National Inuit Youth Council.

1.1 Project Overview

Information was gathered on the models of health care delivery in the six Inuit regions of Canada—Labrador, Nunavik (Quebec), Qikiqtani, Kivalliq, Kitikmeot (Nunavut) and Inuvialuit (Northwest Territories).[1] Because these regions fall under four provincial and territorial jurisdictions, it is extremely difficult to make comparisons across the regions. The project attempted to fill this information gap. In some cases, we have been successful; in others the success has been in more clearly identifying continuing information needs. There are, for example, substantial gaps in health indicator data for Inuit, both nationally and regionally.

The project objectives are outlined below.

[1] When this project was being developed, the three regions within Nunavut all had separate regional boards of health and social services. The Nunavut government dissolved regional health boards on April 1, 2000. Thus, Nunavut could be viewed as a single region; however, since the changes took place during the course of this project and health and social services are administered through regional offices of the Nunavut government, this report distinguishes between the three regions within Nunavut.

1. Gather information for a descriptive analysis of the health care services, administration and service delivery systems that exist in each Inuit region of Canada.

2. Undertake a comparative analysis of these existing models. This includes identifying best practices and mechanisms that support quality health care and identifying obstacles to the effective delivery of health services.

3. Publish the results of the evaluation in a report and disseminate it throughout the north and to relevant governments, organizations and individuals in the health care field in southern Canada.

A population health approach guided the research design as well as the organization of this report. The Federal, Provincial and Territorial Advisory Committee on Population Health (1999: 7), uses the following definition.

> Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, person health practices, individual capacity and coping skills, human biology, early childhood development, and health services.
>
> As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to development and implement policies and actions to improve the health and well-being of those populations.

The Government of the Northwest Territories (GNWT) (1999: 11) uses this approach in its collection and reporting of information on health status.

> The population health framework recognizes that environmental issues, social problems, economic factors, and personal habits and behaviours are all important determinants of the health and well being of the population. Addressing these issues are as important for population health as are good medical care, primary prevention, health promotion and sound public policy initiatives.

The Nunavik Regional Board of Health and Social Services (NRBHSS) used a similar approach in its 1997 publication on health and what affects it in Nunavik (Hodgins 1997). Information was presented on the population of the region and its age structure, birth and death rates, the ecosystem, transportation, housing, environmental contaminants, the influence of history, education, public policy, family, community and social supports, lifestyle issues (e.g., smoking, diet, physical activity, sexual behaviour and alcohol and drug use), income, poverty and employment, and access to health services. A review followed that looked at the health status of Nunavik residents, including rates of infant mortality, suicide, cancer, sexually transmitted diseases and so on (Hodgins 1997).

This approach is gaining acceptance nationally and at the provincial, territorial and regional levels. While the term “population health” may be new to Inuit, the concept is certainly familiar, and it is consistent with the holistic approach to health traditionally practised by Inuit.

Section 2 of this report outlines the project methodology and activities, as well as some of the problems with available health indicator data. Section 3 provides a context for understanding the health systems and how Inuit fit in, nationally and regionally. This, along with the review of non-medical determinants of health (section 4.2), allows for an analysis that incorporates the social, economic and political environments and their impact on health.

The fourth part of the report is divided into three subsections. The first reviews indicators of Inuit health status, such as life expectancy and suicide rates. As noted above, the second contains an overview of various non-medical determinants of health. Subsection 4.3 describes and assesses health services in the six Inuit regions. These regions have similar populations and geographic conditions, and the comparative analysis provides important insights into practices that work well, as well as obstacles to the delivery of quality health care. Conclusions are set out in section 5.

It is hoped the results of the evaluation will inform future decisions on service delivery options and models. This, in turn, may contribute to more effective service delivery, administration and, ultimately, improved Inuit health status. Consequently, the results of the evaluation may be of interest to Inuit organizations and health boards, provincial and territorial governments, the Government of Canada, and health researchers, medical professionals and policy analysts interested in the provision of health care in northern and remote regions.

2. Methodology

The methods used in this evaluation project include document review, observation of meetings and conferences, and key informant interviews. Interviews were conducted in person and by telephone. The draft project report was distributed to everyone interviewed and to those who provided documents for the review. Comments have been incorporated into the final report.

As noted, the project objectives included gathering information on health care services, delivery systems and administration in the six Inuit regions of Canada, including best practices and obstacles to the delivery of quality health care. In gathering this information, an attempt was made to include data on the health status of Inuit in the regions, services available, including fly-in and fly-out specialists, waiting times, and the provision of culturally and linguistically sensitive services.

While the focus was on health care services, five of the six Inuit regions operate under integrated health and social service boards or, in the case of Nunavut, a government department. Even in Labrador, where mandates focus on health, programs offered by the Labrador Inuit Health Commission (LIHC) encompass an expanded, holistic view of health. For example, LIHC runs child-care, family violence and addictions treatment programs.

The integration of health and social services at the administrative level is consistent with the population health approach guiding the analysis. Health status cannot be understood in isolation of social environments and living conditions. That being said, the services reviewed in section 4.3 of this report are primarily health services, a necessary limitation given the time and resources allotted to this project.

2.1 Project Activities

Informing Organizations, Governments and the Inuit Public about the Evaluation

In September 1999, the Inuit Tapirisat of Canada sent a letter to 50 organizations and individuals involved in the Inuit health field as well as to the 53 municipal offices in the Inuit regions. The letter provided information about the project and included a request for documents, such as annual reports, research and evaluation studies, and statistical information relevant to the study. The purpose of the letter was threefold: inform people that the study was taking place, provide background information on the project and request materials relevant to the project.

Document Review

Documents reviewed in the course of the project are included in the bibliography. This material was used in developing an analytical framework and in the analysis contained in this report. This included annual reports of regional health boards and commissions,

hospitals and other service providers; government documents (including studies, reports and main estimates); independent research reports and studies; briefs presented to governments, commissions and other bodies; evaluation reports; statistical information; and studies undertaken by Inuit organizations and others that address Inuit health issues.

Inuit Women's Health

As part of this evaluation project, Pauktuutit developed a paper, *Inuit Women's Health Overview and Policy Issues*. The paper provides an overview of Inuit women's perspectives on health and it includes a number of recommendations. Issues raised in the paper have been incorporated into this report.[2]

Observation of Meetings and Conferences

In October 1999, one of the researchers observed the Labrador Inuit Health Commission's (LIHC) Annual General Meeting and Health Fair held in the community of Rigolet. This meeting provided an excellent overview of LIHC's activities and the issues of importance to the population. It also provided a solid foundation for identifying issues to be covered in the interviews that took place later in the project.

In February 2000, the Inuit Tapirisat of Canada and Health Canada jointly sponsored the first Inuit Health Policy Forum ever to take place in Canada. Presentations by representatives of the six regional Inuit organizations, youth, women and the Nunavut Council for People with Disabilities addressed the services available and priority health issues in each region. Health Canada also made numerous presentations, and Inuit and government representatives met in discussion groups. The conference culminated in an Inuit caucus—attended by approximately 40 people chosen by the regional Inuit associations, ITC and Pauktuutit—where a listing of priority health issues was developed. This report includes material presented at the Forum as well as references to the outcomes of discussions.

Interviews

In January 2000, a number of informal interviews took place in Iqaluit. This was prior to the development of a formal interview schedule. These interviews, along with observations of the meeting in Labrador and the Inuit Health Policy Forum, contributed to the development of the interview schedule.

The interview schedule was pre-tested in Ottawa during April and May 2000. It was distributed to ITC's Health Committee for comments, revised and then translated into Inuktitut. Questions addressed the comprehensiveness of health care services, strengths and obstacles, traditional medicine, childbirth, telemedicine, non-insured health benefits (NIHB) and recommendations for improving service delivery and health status (See Appendix I).

[2] Copies of this paper are available by contacting Pauktuutit at (613) 238-3977.

Key informant interviews took place in Kuujjuaq and Puvirnituq in the Nunavik region, Iqaluit in the Qikiqtani region, Rankin Inlet in Kivalliq region and at the University of Manitoba's Northern Medical Unit in Winnipeg, Cambridge Bay in Kitikmeot and Inuvik in the Inuvialuit region. As travel funds had already been used to observe the health conference in Labrador, interviews there were by telephone. In total, 41 people participated in interviews.

When signing consent forms, interviewees could choose between full disclosure and anonymity. People were split almost evenly between the two choices so a decision was made to acknowledge everyone who contributed to the project, whether it be through participating in an interview, setting up interviews in their region, submitting documents and reports, or providing feedback on the draft interview schedule. Thus, individuals who participated in interviews are not specifically identified in the text but their input is nevertheless appreciated. Based on the pre-test, it was estimated that interviews would take approximately 30 minutes. In reality, they took much longer, in large part due to the high quality and volume of information offered and the seriousness with which this project was received.

Most key informants worked within the health and social services sector. This is consistent with the project's focus on models of health care delivery. It is also a necessary limitation given the project's short time frame, limited budget and the geographical scope of the Inuit world, which encompasses 53 communities from the Labrador coast in eastern Canada to Tuktoyaktuk, in the far northwestern corner of the country. While the views of users of health and social services are not directly represented here, the views of regional Inuit associations are represented in a number of ways:

- presentations at the Inuit health policy forum;
- the Inuit Health Committee reviewing the draft interview schedule and assisting in setting up interviews in each region; and
- outcomes of the Inuit Health Policy forum, including identification of priority health issues.

Finally, the goal of conducting key informant interviews was to gather information on the range of health care services available in each region. In some cases, individuals did not respond to the entire set of questions but focussed on their particular area of expertise, such as telemedicine.

2.2 Health Indicator Data and Its Limitations

It is well recognized that information gaps have hindered Inuit and government efforts to engage in effective policy analysis and policy and program development. An ITC discussion paper (2000a: 6) on health data states:

> Access to useful, relevant data is essential for effective policy and program development. This is as true for Inuit as it is for federal and provincial/territorial governments. It is equally true that planning and

> policy development are hindered by gaps in data, and currently there are large gaps with respect to the national Inuit population.

Section 4.1 includes data on the indicators of health. Selected non-medical indicators are included in section 4.2. The proposal recognized that not all the information sought would be available. However, a serious attempt was made to gather as much as possible. Data on Inuit health status were mined from published documents as well as from a search of data available electronically.[3]

The compilation of the data presented some challenges and difficult choices. The indicators used were defined during the May 1999 National Consensus Conference on Population Health Indicators. The conference was organized by the Canadian Institute of Health Information in co-operation with the Federal, Provincial and Territorial Advisory Committee on Population Health, Health Canada and Statistics Canada. No effort was made to define or redefine the health status indicators that would be specific to this project. Similarly, no effort was made to go to the raw census data to filter and calculate the health indicators. Only existing published sources of data were reviewed.

After an initial survey of data sources and a preliminary compilation of data, the final list of indicators was reduced to a more manageable number. Those indicators, where no relevant data had been found, or were expected to be found, were eliminated. At this time, three additional indicators were added: birth rate, mortality rate and disability. Ideally, data for a given indicator should have been broken down in terms of age groups and gender, but it was generally found that such data are not readily available in published form and would require accessing the original source data.

Even with predefined indicators, the task of collecting data proved difficult. The definition for a given indicator is often very narrow. For example, the definition for high school graduation is the proportion of the population age 25 to 29 with a graduation certificate. Most data sources are far less specific and list the proportion of individuals age 15 and over with a certificate. As a rule, these latter data were listed with an accompanying note detailing the exception to the definition. It was better to have some data rather than none at all. Nonetheless, large gaps remain in the data. On the negative side, comparing data based on differing definitions reduces the overall utility of the data set and the meaningful comparison of data among jurisdictions.

Different data sources often provided conflicting values for a given indicator and region. Either the age groups differed, the year data were collected or published differed, or the nature of the value differed in terms of an actual count, as a proportion of the population, or as a rate per 1,000, 10,000 or 100,000. When two different sources offered a value for a single regional indicator a choice had to be made. Generally, the value that was most consistent with those listed in the other jurisdictions or regions was selected. Usually, a

[3] The Nunavut government's statistical Web site went off-line during the final month of preparing this report. We understand that the government is preparing to release health indicator data in the near future, and speculate that this may be the reason older data were no longer available.

reference to the alternate value is made in the comment field or in the notes. A source that provided data for a number of regions was favoured over a source listing data for one indicator in one region. (For example, see tuberculosis values for the regions in Nunavut.) Unfortunately, across the six Inuit regions, there is very little consistent reporting of indicators.

The tables that summarize the health status indicators must be viewed with caution. As noted, the data sources are highly variable as are the indicator definitions used by any given source or region. It is therefore advisable to use caution when interpreting and using the information contained in the data set. Geographical variations and differences among sub-populations limit the comparison of regional data. Data between jurisdictions may be from different years, or age groups are compressed and do not match or are not standardized, or the definition of indicators may vary, and these can make the data less comparable. Wherever possible, these differences have been noted.

The creation of Nunavut confuses the data set for the Northwest Territories. Some older data include Nunavut, and the newer data do not. Much of the data are qualified, either in the comment field associated with each data entry, or in the accompanying notes.

The information presented here summarizes the range of data available and, more important, where data are lacking. Published data often were presented in summary graph form that lacked precise figures or in the form of reported cases but without a population base or denominator for calculating a rate. Similarly, census data are often randomly rounded up or down to a multiple of 5, or offered as a percentage rate of the whole population rather than as a rate per 1,000 or 100,000 population. The rounding up or down of data is significant where communities are small. Occasionally, minor recalculations were performed to have indicators match the definitions used here, but this can potentially be problematic. Many northern communities have small populations and to calculate the rate of an indicator in terms of cases per 1,000 or 100,000 is to extrapolate low numbers into terms and proportions that exceed the actual population of the community or region. If extensive recalculations were required, data were omitted or listed as published.

In summary, this report presents health indicator data, where available, for the Inuit regions of the north. Despite large gaps in the data and the questionable reliability of what is presented, the exercise was worthwhile. It clearly highlights the need for Inuit health data that are reliable and can be used to make comparisons across regions.

3. Context

A report (Brown 2000: 2) prepared for Health Canada's Working Group on the North and Accountability states that the delivery of health services in the north has been shaped by a number of geographical, historical, political and legal factors.

- Population in the north tends to be sparse and widely dispersed with the result that there is no health infrastructure comparable to southern areas of Canada.

- Aboriginal people comprise a high percentage of the residents in the north; however, unlike southern areas, there is no history of Indian reserves in the north.

- Historically, territorial governments did not have the capacity to provide health care services to their residents.

- In many areas, health care, including primary health care services, was introduced and provided, until recently, by Medical Services Branch of Health Canada.

- The desire of territorial governments for more autonomy has led to the gradual devolution of services from the federal to the territorial level.

- Comprehensive land claim agreements and self-government agreements have been negotiated and concluded in several regions of the north.

A basic knowledge of Inuit settlement regions is critical to understanding how Inuit have organized themselves politically, while completed land claim agreements contain provisions affecting health programs and service delivery. For example, the *James Bay and Northern Quebec Agreement* (JBNQA) led to the creation of a health board in the Nunavik region and the transfer of administrative responsibilities from federal and provincial governments to that board. The *Nunavut Land Claim Agreement* (NLCA) led directly to the creation of the Nunavut Territory. The Inuvialuit in the western Arctic region of the Northwest Territories signed a land claim agreement in 1984 and are now working with Gwich'in in the region to establish regional self-government. Labrador's land claim is at the agreement-in-principle stage. Land claim agreements are constitutionally protected under section 35 of the Canadian Constitution.

Another factor that affects Inuit health programs and services is the federal government's responsibility for Inuit health by virtue of section 91(24) of the *Constitution Act, 1867*. Federal programs and policies are concentrated in the First Nations and Inuit Health Branch of Health Canada (formerly Medical Services Branch).

Through provincial and territorial departments of health, there is a level of responsibility for the delivery of health services to Inuit as residents of that province or territory. The role of provinces and territories differs in each jurisdiction. For example, the Nunavik Regional Board of Health and Social Services administers federal and provincial

programs in that region, an arrangement originally established through the land claim agreement. While territorial governments perform similar roles through transfer and contribution agreements with the federal government, these agreements were negotiated between governments without the involvement of Inuit. The situation is still different in Labrador. The province provides basic health services to all residents, while the Labrador Inuit Health Commission administers an increasing number of federal programs, such as non-insured health benefits, to the region's Inuit population.

3.1 The Organization of Health Services in Each Jurisdiction

Labrador

The Labrador Inuit Health Commission was formed in 1985 by the Labrador Inuit Association (LIA) to address health care issues for its 5,000 members. LIHC reports directly to the LIA board of directors, specifically to the Health Committee. Funding for LIHC is provided through a transfer agreement with the federal government and through contribution agreements for specific projects.

Today, the Labrador Inuit Health Commission provides a wide range of programs and services to LIA's membership, including non-insured health benefits as noted above. In addition, Health Labrador Corporation (HLC) provides provincial health services to all residents of the province. In communities along the north coast, nurses working in health clinics (informally referred to as "clinic" or "treatment" nurses) are employees of the HLC. Public health nurses in the same communities are employed by LIHC.

Nunavik

The *James Bay and Northern Quebec Agreement*, signed in 1975, radically changed the way health and social services were administered and delivered in the Nunavik region. Prior to the Agreement, Medical Services Branch operated health stations and medical centres in Nunavik. The transfer took place within five years of signing the Agreement, transferring responsibility from Health Canada to Quebec, then to Nunavik. Services were to be available to all temporary and permanent residents of the region. Under section 15.0.19 of the Agreement, funding for health services includes federal health programs provided to "Native" people.

Nunavut

In 1988, the federal government devolved responsibility for the administration of health to the Government of the Northwest Territories, and the Nunavut government has inherited this agreement. Since that time, Medical Services Branch has provided funds for Inuit and First Nations programs, such as non-insured health benefits, to the territorial governments through a contribution agreement.

On April 1, 2000, the Nunavut government phased out the public health boards created by the GNWT during the 1980s. Board employees were incorporated into the Nunavut

Department of Health and Social Services. Local health committees are expected to take on added responsibilities, including setting priorities and goals for service delivery.

Nunavut Tunngavik Incorporated (NTI) is the organization mandated with implementing the *Nunavut Land Claim Agreement.* The presidents of the three regional Inuit associations—Qikiqtani Inuit Association, Kivalliq Inuit Association and Kitikmeot Inuit Association—sit on the NTI Board. In recent years, the regional associations have been increasingly involved in health issues and in advocating for Inuit involvement in the design, delivery and administration of federal programs that target Inuit. An additional player in the Inuit health field is the Nunavut Social Development Council (NSDC), which was created under Article 32 of the Agreement.

Section 32.3.3 sets out the NSDC mandate.

> The Council shall assist Inuit to define and promote their social and cultural development goals and objectives and shall encourage Government to design and implement social and cultural development policies and programs appropriate to Inuit.

Specific activities listed in the provision include conducting research and publishing and distributing information on social and cultural issues; consulting with community, regional, territorial, federal and other bodies; advising Inuit and governments on social and cultural policies, programs and services; and undertaking other activities relating to social and cultural issues. The NSDC has a nine-member board, with three members appointed from each region.

Inuvialuit

The *Inuvialuit Final Agreement* was signed in 1984 and the Inuvialuit Regional Corporation is negotiating a self-government agreement with the Government of the Northwest Territories. In 1988, the federal government devolved administrative responsibility for health to the Government of the Northwest Territories. Health care programs and services are provided by the GNWT through the Inuvik Board of Health and Social Services. The IRC is increasingly becoming involved in decisions regarding the delivery of programs and services designed specifically to benefit Inuvialuit (as opposed to all residents of the region) and supports delivery mechanisms whereby program funding will go directly to regional Inuit organizations, with the organizations determining who delivers the programs.

3.2 Characteristics Common to Inuit Regions of the North

As noted above, the population in the north tends to be sparse and widely dispersed. As a result, there is no health infrastructure comparable to southern areas of Canada. Moreover, there are few roads and no rail links to the Inuit north, resulting in high transportation costs. While 30 percent of the total Aboriginal population lives in major urban areas, only six percent of Inuit live in southern Canada. Most Inuit communities

have populations of less than 1,000. They are accessible year round by air and, during the summer months, by sea.

The cost of living is high, as are costs associated with providing health services and the infrastructure to support these services. Isolation limits access to many services at the community and regional levels. For example, emergency medical evacuations to southern hospitals are standard in all regions. Isolation also affects recruitment of southern medical professionals.

There are no universities in the north and Inuit must travel to southern Canada to attend university. There are few Inuit health professionals; thus, people from outside the north fill the majority of professional and medical positions.

The Inuit population is young compared to the rest of Canada, with as much as 60 percent of the population in some regions under the age of 30 years. Projected population growth is 48 percent between 1996 and 2016 (ITC 1999b: 17). The problems of overcrowded housing and youth unemployment can be expected to grow dramatically over the next 20 years, if no remedial action is taken.

The Inuit language and culture are essential components of the northern social environment. An ITC report (1999b: 17) notes both the strength of the Inuit language and the regional variations in language use.

> Inuktitut (which consists of several different dialects) is one of the healthiest Aboriginal languages in Canada. However, there are significant differences among regions in terms of the knowledge and use of Inuktitut. According to the Census data, Inuktitut is strongest in the Baffin [Qikiqtani] and Nunavik regions. It is weaker in the Keewatin [Kivalliq] and Kitikmeot and it appears to be seriously threatened in the Inuvialuit and Labrador regions.

A joint backgrounder, released by Health Canada and the ITC (2000b), at the first national Inuit Health Policy Forum provides additional information on Inuit health and living conditions in the north.

- The high cost of store-bought foods and their availability is a major problem in the North with 12.7 percent of Inuit people over the age of 15 reporting food availability problems, compared to 7.5 percent of the Canadian population. A recent study on living conditions in Nunavik rates the cost of living in Kuujjuaq as 50 to 55 percent higher than Montréal and Salluit as 60 to 70 percent higher.

- While the traditional Inuit diet of caribou, seal, whale, char, goose and ptarmigan is still a significant part of the diet, the high cost of hunting equipment and changing northern economies have led to traditional foods being less available than in the past.

- Crowded and inadequate housing contribute to a range of social and health problems,

such as the high incidence of respiratory disease among Inuit children.

- Although some Inuit communities have chosen to become "dry," alcohol, substance and solvent abuse remain major problems. Smoking rates among Inuit are over twice the Canadian average with 69 percent of Inuit youth smoking by the time they are teenagers.

- A study in the early 1990s found that only 18.8 percent of Northwest Territories Inuit men between the ages of 13 and 39 and 11.6 percent of women between the ages of 13 and 29 were physically active. Traditional economic activities, such as hunting, fishing and picking berries, and the traditional Inuit diet are considered vital components of an effective health promotion strategy.

- Diabetes among Inuit has not reached the epidemic levels experienced by many First Nations communities, and heart disease is less common among Inuit than non-Inuit. On one hand, changes from the traditional way of life tend to increase the likelihood of Inuit developing the risk factors associated with heart disease and diabetes. On the other, research suggests that the traditional Inuit diet may provide important nutrients known to protect against respiratory infections and heart disease, and may also lessen risk factors associated with diabetes. Culturally appropriate health promotion and prevention programs can have a significant influence on the future incidence of heart disease and diabetes among Inuit.

4. Overview of the Findings

One purpose of this project was to address the lack of information about Inuit health status and services. As noted in the methodology section, gaps remain in the health status data; however, progress was made in documenting regional health services. In light of the shared language and culture, and commonalties with respect to geography, community size, education, employment rates and social conditions, access to reliable data would facilitate the ability of regions to assess their situation compared to other regions. In combination with information about differences in programs, service levels, funding and administrative practices, the potential of engaging in rational, evidence-based planning is greatly enhanced.

Findings are presented in the three subsections that follow. Sections 4.1 and 4.2 provide an overview of available health indicator data and the non-medical determinants of health for Canada, the six Inuit regions of Canada and Inuit within those regions. Summary tables are contained at the end of each section. Notes on sources and the indicator definitions used are included as Appendix II. As noted, gaps in the data are significant.

Section 4.3 provides a descriptive analysis of health services in the six regions. Material used here was gathered from interviews, documents and the proceedings of the Inuit Health Policy Forum. Charts presented at the end of this section indicate the number of health care providers in each region and the specialized medical services available. This information was derived primarily from the interviews.

4.1 Health Status

The most obvious conclusion a review of health status indicators reveals is that significant information gaps exist at the regional level and for Inuit populations within regions. The second gap is as important as the first. Health indicators at the regional level are necessary in order to assess the impact of programs and services on populations over time. However, we also know that significant differences between Inuit and non-Inuit populations within regions and communities exist. Education, income and employment levels, where data exist, support this conclusion (see section 4.2).

Also missing from many of the health indicator data are gender breakdowns—a significant gap in light of the recognized impact of non-medical determinants on health. Gender has been shown to influence employment and income opportunities, which influence overall health and well-being. Suicide is another area where the impact of gender is well recognized, along with age. Young Inuit men kill themselves at higher rates than Inuit women and older men. However, while data are not available on attempted suicides, it appears that women may match or surpass men in this area. This is the kind of information needed to develop holistic prevention programs that meet the needs of all groups within the population.

Suicide was mentioned as a serious problem by every region in presentations to the Inuit Health Policy Forum. Inuit delegates identified suicide prevention and mental health as

their number one priority. In the months following the Forum, the number of suicides appears to have increased dramatically. In bad weeks, there have been one or two suicides in a single region. Statistics cannot possibly capture the creeping devastation that follows each report of a suicide. There is the immediate impact on family and extended family and then the news spreads into the community, the region and quickly on to other communities, other regions and Inuit living outside the north. No suicide is a nameless, faceless statistic. Within the small Inuit population, every suicide strikes home. Modern telecommunications have played an important role in uniting the Inuit world; as the suicide crisis grows, telecommunications make it possible for Inuit across the north to be brutally aware of every untimely death, often within hours of it occurring. No matter how the numbers are calculated—at the community, regional or national level—they will never truly reflect the terrible impact of hearing about yet another death by suicide.

Table 2 shows the suicide rate for Canada is 13 per 100,000. Comparable rates for the Inuit regions are as follows: Nunavik 82, Nunavut 77.4, and NWT 18. The Qikiqtani region of Nunavut has a rate of 94. As noted throughout this report, suicide is a priority health issue for Inuit.

An examination of various other indicators for Canada and the Inuit regions is equally revealing. It suggests that the overall health status of Inuit falls far below other Canadians. Examples include the following:

Comparison of Life Expectancy and Mortality Rates

	Rates per 100,000	
	Canada	Inuit Regions
Life Expectancy (Male)	75.7	Nunavik: 63.7 Nunavut Inuit: 66
Life Expectancy (Female)	81.4	Nunavik: 65.1 Nunavut Inuit: 71
Infant Mortality	5.5	Nunavik: 25.5 Nunavut: 24 NWT: 5
Unintentional Injury Death	43	Nunavik: 102 NWT: 128
Food/Water-Borne Diseases	97.8	Kivalliq: 408 Nunavut: 291

The earlier discussion regarding the lack of, or limitations of, available data may suggest that we do not know, with any certainty, the state of Inuit health. It would be closer to the truth, however, to state that we know that Inuit health is poorer than that of other Canadians, and we particularly know this with respect to life expectancy and suicide

rates. What are needed are more data and more details, so improvements and the impact of intervention strategies can be tracked over time. The Nunavut government (1999: 3) has published its vision of Nunavut in the year 2020. It states that Nunavut will be a place where “health and social conditions and indicators are at or better than the Canadian average.” Good health indicator data will be required to assess the government’s progress toward this vision. In addition, there is a need for Inuit-specific data across the Inuit regions as well as at the national level.

4.2 Non-Medical Determinants of Health

Adequate housing, education and employment opportunities, social supports (including safe and supportive family environments) and a variety of personal behaviours (e.g., alcohol, drug and tobacco use) all influence the physical and mental health of individuals. Collectively, they create a social and economic environment that can affect the health of groups or populations of people. In the north, the cultural environment is equally influential. Social, economic and cultural conditions are nothing like what existed in the 1950s, before the widespread move from traditional camps to permanent settlements. Fifty years later, Inuit society is still adjusting to, and coping with, the effects of these changes. Governments are increasingly aware that improving social and economic conditions can have a positive impact on physical and mental health. This section of the report deals with these conditions, referred to as non-medical determinants of health.

The report of the Federal, Provincial and Territorial Advisory Committee on Population Health (1999: ix) addresses the impact of non-medical determinants on health. This report explains how social and economic inequalities can influence the overall health of a population. For example, in Canada, life expectancy improves with every increase in income bracket. Studies suggest that "[l]arge gaps in income distribution among a population increases social problems and poorer health among the population as a whole."

This way of understanding the effects of income on health looks at the entire population, rather than individuals. While it is recognized that the health and well-being of individuals contribute to the well-being of the collective, the population health approach is consistent with the collective values of Inuit society. Also, it affirms the value of collecting data on population groups within a region, including Inuit and non-Inuit, and men and women. Where such employment and income data have been collected, the results are revealing. In Nunavik, for example, "[n]on-Inuit, who are not permanent residents of the region, hold over one third of the full-time jobs. These individuals make up 10% of the population" (NRBHSS 1998: 6).

A comparison of average employment incomes in Nunavik and Quebec is presented below.[4]

[4] Schnarch (1999: 16). Based on 1996 Census data for employed persons, 15 years of age and older. With respect to Inuit incomes, the author points out: "The exclusion of non-monetary production ignores significant contributions from hunting, fishing, child care, domestic chores, etc."

Average Employment Incomes

	Quebec $	Nunavik $	Inuit $	Non-Inuit $
Employment Income	25,116	20,771	16,122	36,574
Men Only	29,824	23,217	17,426	41,997
Women Only	19,472	17,773	14,562	29,326

Note: This chart affirms the importance of including a gender breakdown in all data sets. Unfortunately, much of the data in this report do not include gender. The ITC recognizes the importance of differentiating on the basis of sex in order to enhance the understanding of the data.

These data reveal differences in income levels, not only between Inuit and non-Inuit within the region, but also between men and women of both groups and between Nunavik and the Province of Quebec.

The Federal, Provincial and Territorial Advisory Committee on Population Health report also examines how the social environment affects health. For example, it recognizes that family violence has a "devastating effect on the health of women and children." In addition to family violence, the social environment includes education and literacy and its relationship to employment, income and health; the physical environment, including housing, homelessness and environmental contaminants; and personal health practices such as tobacco use, unsafe sexual practices and alcohol and drugs.

The Federal, Provincial and Territorial Advisory Committee on Population Health (1999: 178) identified three population groups as being especially vulnerable to poorer health.

> The evidence in this report suggests that three population groups are particularly vulnerable at this time to poor health outcomes. These three groups are children, youth (and by extension families with children and youth) and Aboriginal people.

Recommendations are presented in three categories: investing in early childhood, working with young people to improve their health and improving the health of Aboriginal people. Inuit, with children and youth representing such a high percentage of the population, could benefit from action (and resources) in each area.

An analysis of 1996 Census data undertaken by the Inuit Tapirisat of Canada (1999b: 15-17) reveals that Inuit fall behind non-Aboriginal people and other Aboriginal people on a variety of non-medical indicators of health. Examples of the data presented in this analysis include the following.

- In the Qikiqtani region, the average individual income for the total population was $26,329; for non-Aboriginal people it was $49,455 and for Inuit it was $16,831.

- In 1996, the proportion of the Inuit population employed (employment to population ratio) for the six Inuit regions was as follows: Labrador 42.6, Nunavik 50.9, Qikiqtani

46.3, Kivalliq 46.1, Kitikmeot 45.4 and Inuvialuit settlement region, 45.9. For Canada as a whole, it was 58.9.

- The 1996 Census showed that the educational attainment of the Inuit population was significantly lower than other Aboriginal and non-Aboriginal populations.

- Inuit tend to have smaller dwellings and more people per household than non-Aboriginal or other Aboriginal people in the same region. One half of Inuit houses were in need of repairs compared to one third of Canadian homes.

Table 3 summarizes available data on selected non-medical indicators of health for Canada and the Inuit regions. The same limitations that were outlined with respect to Table 2 apply to Table 3. Where data are available, differences between Canada as a whole and Inuit are evident. For example, smoking rates among Inuit in Nunavut, Labrador, Nunavik and the NWT are almost 2.5 times greater than for Canadians as a whole. Youth smoking rates are more than double the national rate. The incidence of heavy drinking is also higher.

While high school graduation rates are low in all Inuit regions, a comparison between Inuit regions and Canada cannot be made because of the way data are presented. As noted in Section 2, the Canadian rate is based on the definition developed at the Consensus Conference on Population Health Indicators, and it includes only people between the ages of 25 and 29. In contrast, data on the Inuit regions are for the entire population over the age of 15, including elders who never attended school. Thus, it cannot be used as a measure of recent high school graduation rates, while the Canadian indicator can. In fact, it would be very useful to have this kind of information available for Inuit populations.

Unemployment, long-term unemployment and youth unemployment rates, where available, all reflect the limited economic opportunities in Arctic communities. Interestingly, the one area where Inuit surpass Canadian norms is in social support (96 percent compared to 78 percent for Canada). This reflects the strong family and community ties that connect and support Inuit wherever they live in Canada.

While very little data are presented on housing affordability, Nunavut and NWT rates show this is less of a problem than in southern Canada. This finding is more a reflection of the housing system in the north than actual housing costs. Most northerners live in houses subsidized by governments (including public housing corporations and staff housing) or by the employer. The high cost of owning and operating houses in the north results in low levels of home ownership. The private rental market is similarly affected. The number of people per house provides a better indication of the housing situation.

A report (Hodgins 1997: 31) issued in the Nunavik region recalls the early one-room “matchbox houses” provided by the federal government in the 1960s and 1970s. It compares crowding in Nunavik at the time of the 1991 Census with Quebec.

> Although housing conditions were much improved and crowding reduced, at the time of the 1991 census *forty* percent of Nunavik households had six or more persons (versus two percent for Quebec). The average number per household was five (vs. 2.5 for Quebec.)

Housing shortages mean that two or three generations sometimes share a single dwelling. A later publication (Schnarch 1999: 21) uses 1996 Census data to compare household and family size in Nunavik and Quebec.

> Families in Nunavik are, in general, larger (4.6 persons on average in husband-wife and common-law families vs. 3.1 for Quebec). Additionally, household size is smaller in Nunavik with an average of 5.7 rooms vs. 7.4 for Quebec…. Both of these elements suggest that a multiple-family household in Nunavik may be, on average, more crowded that a multi-family household in the province as a whole.
>
> This notion is further supported by a comparison of the size of households with five or more people in them. In Nunavik, 51% of households with five or more persons have five or few rooms. In Quebec as a whole, 17% of five-plus person households have five or few rooms.
>
> As noted, the Inuit-only situation seems to be more crowded still and there has been an increase in crowding sine 1996 due to a lack of construction.

Pauktuutit (2000: 36) addresses the impact of overcrowded homes on home care workers. "Overcrowding in households raises serious questions about worker safety and about health risks to workers." In light of the federal government's new Home and Community Care program, the number of home care workers is expected to increase. This is a welcome development, but one that also highlights the inadequacy of those homes workers will be visiting. Also significant is the impact of crowded homes on family violence. Pauktuutit stresses the need for prevention programs, such as public education, on the causes and effects of violence. However, it cautions that prevention "also means addressing socio-economic conditions that lead or contribute to violence, including the pressing issue of housing."

The Nunavut government's vision statement and action plan, *The Bathurst Mandate* (1999), commits the government to achieving a range of affordable housing options by 2020. Over the next five years, the goal is to meet the following objective.

> Open and maintain a public dialogue on housing issues, while developing and implementing immediate and long-term plans to respond to housing shortfalls as one of the two primary commitments of this government's mandate.

In spite of this commitment to action in Nunavut, inadequate and overcrowded housing remains a major problem in all Inuit regions. Inuit delegates to the Inuit Health Policy

Forum recommended action on housing as one means of improving health status. Federal, provincial and territorial governments each have a role in solving this problem.

In addition to housing, an examination of the physical environment includes the land and waters, and in the north—where a large portion of the diet consists of country food—contaminants in that food. A forthcoming report analyzes the nutrient and contaminant contents of a wide variety of traditional Inuit foods (Kuhnlein et al. forthcoming). It has long been recognized that the traditional Inuit diet is a nutritious one. Caribou, muktuk, char, seal, walrus and whale provide important nutrients. Marine mammals, in particular, are rich in a type of fatty acid thought to protect against heart disease. A 1999 report on diabetes prepared by the Inuit Tapirisat (1999a: 5) states: "Recently, non-traditional foods have become a larger part of the Inuit diet. The addition of foods that are higher in sugars, fats, and carbohydrates has resulted in a loss of overall nutrition." There are concerns that in the absence of a serious prevention program, diabetes rates among Inuit may climb to the epidemic levels seen in some First Nations communities.

As noted earlier, governments now recognize the crucial role of addressing the non-medical determinants of health in efforts to improve overall health status. Based on the key informant interviews conducted as part of this study, health care workers and managers are equally aware of this link. In fact, those on the front lines of health care delivery are probably most acutely aware of the limitations of putting band-aids on problems that have deep, historical and systemic roots. Following are a few of the many comments on this issue by people interviewed in the course of this study.

> *Poverty impacts greatly—infectious disease rates, high birth rates, nutrition, young parents, the level of education, the need for good water and sewage in some communities. Third world conditions in health status impacts on health. You could start with any problem and move outward in analysis.*
>
> *Ninety percent of funding is devoted to treatment; the base level of funding must increase if prevention is to be incorporated.*
>
> *The health system is dealing with the crisis all the time. It is not equipped to deal with prevention, so the crisis will be repeated…. The physical health problems are addressed, but no social factors are addressed.*
>
> *For anyone, living north or south, the system is treatment driven, disease driven. This is a worldwide problem. The idea of prevention and promotion still needs to be worked on by health care providers.*
>
> *Provide people with proper housing, water, sewage, jobs and the means to provide adequate food and the health status would improve. Suicide is a major problem, in part, related to the high levels of unemployment. We need to intervene before people attempt suicide and to work on prevention.*

The next section focusses on the health care system—the services in place, the strengths and the barriers to providing quality health care. It highlights common issues and major differences. Charts outlining the health care providers and specialist services in each region are included at the end of the section. While the material presented forms the main body of this research project, it cannot be understood in isolation of the impact of non-medical determinants on the health of Inuit.

4.3 Health Services

Following a review of the models of health care delivery in the six regions and an overview of the major issues uncovered in this study, three areas of service delivery are addressed in greater – childbirth, non-insured health benefits and telemedicine. Childbirth is addressed as a bellwether issue—pregnancy and childbirth are among the most common reasons for contact with medical staff and for medical travel. The midwifery project in Puvirnituq and the Birthing Centre in Rankin Inlet are reviewed. The non-insured health benefits program is addressed because it is a major federal health program that targets Inuit, as opposed to all residents of a region. It is an administratively complex program and it raises issues for Inuit around communications, control and service delivery. Telemedicine is included because of its newness and its potential for improving health care delivery in remote areas.

All regions, except Labrador, have integrated health and social services into single departments or boards. In Nunavik and the Inuvialuit region, regional health and social service boards administer the delivery of services, while in Nunavut it is regional offices of the territorial government's Department of Health and Social Services. Labrador is the only region where an Inuit body delivers health programs and services to Inuit; the Province of Newfoundland and Labrador provides medical services to all residents of the region through the Health Labrador Corporation.

A brief description of the health care delivery models in the six regions follows.

Labrador: Before Confederation, and for years afterward, the Grenfell Mission, an international charity, provided health services to the Labrador Inuit. Since Newfoundland joined Canada in 1949, jurisdictional problems have been a fact of life. "The terms of union between Newfoundland and Canada made no reference to Indians and Inuit, resulting in the rather difficult and vexatious debate over just who is legally and financially responsible for native people in Labrador" (Baikie nd: 2) The eventual negotiation of the *Canada/Newfoundland/Native Peoples Health Agreement* provided a way for federal funds to be directed to Labrador Inuit—at first through the province and, now, through direct contribution agreements with the Labrador Inuit Association and its health arm, the Labrador Inuit Health Commission. For example, the non-insured health benefit and public health nurse programs in north coast communities are run directly by LIHC with federal funds. In fact, LIHC was one of the first Aboriginal groups to take on the administration of the NIHB program in 1989, and it now runs the program as a pilot transfer agreement.

The Labrador Inuit Health Commission was formed in 1985 by the Labrador Inuit Association to address health care issues for its 5,000 members. LIHC reports directly to the LIA board of directors. The organization provides a wide range of programs and services to the LIA membership under a transfer agreement with Health Canada and non-transferable program contribution agreements. Programs include environmental health, community health and communicable disease control, mental health, addictions

prevention, treatment and aftercare, public health nursing, child care and child development, home support services and non-insured health benefits.

The Province of Newfoundland and Labrador, through the Health Labrador Corporation, delivers physician care, treatment nursing and specialist services to all residents of the region.

Nunavik: The *James Bay and Northern Quebec Agreement*,[5] signed on November 11, 1975, radically changed the way health and social services were administered and delivered in the Nunavik region. Prior to the Agreement, Health Canada's Medical Services Branch operated nursing services in Nunavik. The Agreement divided Nunavik into two administrative sections—Hudson Bay and Ungava Bay—with two administrative and operational structures. Overall administration fell to the Kativik Health and Social Services Council which was composed of the same elected representatives as the Kativik Regional Government (Brown 2000).

In the early 1990s, the Government of Quebec initiated province-wide reforms in the health sector. The goal was to decentralize health and social services to 17 boards across the province. The *James Bay and Northern Quebec Agreement* protected the existing structures in Nunavik but following consultations, Makivik and the Kativik Regional Government decided to participate in the restructuring process. The feeling at the time was that decentralization, while not self-government, promoted independence at the regional level and opened the door to greater administrative powers. It also allowed for the creation of a board of directors independent from the Kativik Regional Government whose focus, quite naturally, was on a full range of municipal issues rather than solely health and social services.

Today, the Nunavik Regional Board of Health and Social Services administers health services and programs for all residents of the region. The Nunavik region, which includes 14 communities, is served by two hospitals as well as health centres in each community. Services are delivered through two establishments: the Inuulitsivik Health Centre on the Hudson Coast and the Ungava Tulattavik Health Centre on the Ungava Coast.

Nunavut: In April 2000, one year into its mandate, the Nunavut government dissolved the three regional health boards established by the Government of the Northwest Territories during the 1980s. Board employees became part of the Nunavut Department of Health and Social Services. This research project took place during the transition year. (It began before and continued some months after the boards were phased out.) It is far too early to comment on the impact of this change.

Health and social services in the three regions of Nunavut—Qikiqtani, Kivalliq and Kitikmeot—are provided to all residents of the territory. The Qikiqtani or Baffin region is

[5] *James Bay and Northern Quebec Agreement and Complementary Agreements*, 1997 Edition, Les Publications du Québec, Sainte-Foy. The JBNQA is a negotiated agreement between the Inuit and Crees of Northern Quebec and the governments of Canada and Quebec. It is protected under section 35 of the Constitution. See, in particular, section 15, Health and Social Services (Inuit).

the largest with 12 communities. Five communities make up the Kitikmeot region and Kivalliq (formerly Keewatin) includes seven communities. Sanikiluaq in the Belcher Islands falls under the Kivalliq region for the purposes of health care delivery.

There are some differences in service delivery within these regions. The Qikiqtani region, for example, has a hospital in Iqaluit, while residents of the other regions must travel outside their region for hospital care. In Kivalliq, the Rankin Inlet Birthing Centre (the only birthing centre in Nunavut) recently had its mandate expanded from serving only the community to the entire region.

Inuvialuit: Health care programs and services are provided through the Inuvik Regional Health and Social Services Board (IRHSSB), which serves 13 communities in the northern portion of the Northwest Territories. The Inuvik region has a diverse population of Inuvialuit, Gwich'in, Sahtu Dene and non-Aboriginal people. The Inuvialuit Regional Corporation (IRC) represents approximately 5,000 Inuvialuit beneficiaries of the 1984 land claim agreement. Many of these beneficiaries reside in the six western Arctic communities of Aklavik, Holman, Inuvik, Paulatuk, Sachs Harbour and Tuktoyaktuk. The health and social services board consists of six members, including the chair. Representation is drawn from the Gwich'in Tribal Council, the Sahtu Secretariat, the Inuvialuit Regional Council and the communities of Norman Wells and Inuvik.

Inuvik is a large regional centre with a mixed population of 3,296 at the time of the 1996 Census. The other Inuvialuit communities are much smaller, ranging from 135 in Sachs Harbour to 727 in Aklavik. The regional hospital is located in Inuvik.

Overview of the Issues

There are services, programs and approaches in each Inuit region that work well. Many of the problems and obstacles to the delivery of quality health care, however, are prevalent throughout the north. Following is a review of the major issues that emerged in the course of this study. As noted in the methodology section, this research project did not include an examination of client satisfaction with health services. Therefore, no conclusions are made regarding the level of satisfaction with health care services in Inuit communities and regions.

Nursing Services: Nurses are the first point of contact for people in need of medical care in Inuit communities. The exception to this is at the Tulattavik Centre in Kuujjuaq, where doctors are available by appointment and at a walk-in clinic.

There is a critical shortage of nurses throughout the north. In the Inuvik region, shortages have reached the point where two health centres may be closed. Part of the problem is high turnover rates among nurses, most of whom make their permanent homes in the south. Burnout is also a contributing factor, as overworked nurses in understaffed health centres tend to burn out more quickly than if centres were fully staffed. Recruiting new nurses is increasingly difficult with the nursing shortage in southern Canada. One person involved in recruitment lamented:

> *We try so hard to get good people to work in our communities. It is most difficult to recruit nurses and keep them long enough so they can get to know Inuit.*

Another person stated:

> *Turnover is very high. Burnout is a major problem among the staff. The nurses are on 24-hour call, they feel isolated, homesick, lonely, and have no social life and no time for themselves. They don't have supplies they need in nursing stations.*

In some cases, salaries, benefits and incentives help with recruiting nurses; in other cases they are not high enough or comprehensive enough to make a difference. The *James Bay and Northern Quebec Agreement* explicitly recognizes the difficulties in recruiting and retaining medical staff. In implementing the Agreement, Quebec is required to "recognize and allow to the maximum extent possible for the unique difficulties of operating facilities and services in the North."[6] Factors to consider include attractive working conditions and benefits, providing education, employment and advancement opportunities for Native people, and budgeting for the high costs of developing and operating health and social services in the north. The collective agreement for nurses in Quebec includes a provision that allows nurses to take a one-year leave to work in the north, with a second year optional, without losing seniority. There is also a premium for working in the north. Unfortunately, the nursing shortage in the rest of the province has led some hospitals to institute a moratorium on these leaves.

There are far too few Inuit nurses. Labrador has a handful of trained Inuit nurses and Nunavik has a few but, overall, nursing care is provided by non-Inuit. Arctic College in Iqaluit recently began a nursing program in partnership with Dalhousie University, a major new development that should increase the number of Inuit entering the nursing profession. Nurses truly are the backbone of the northern health care system, and, over the long term, nursing shortages are best addressed through the education and training of Inuit nurses. A recent evaluation of a program to encourage Aboriginal people to pursue health careers states:

> [I]n order to attain parity with the non-Native population by 2001, it will be necessary to train more than 800 Native nurses and to increase nearly tenfold (more than 200) the current number of Inuit health professionals (Kishk Anaquot 1999: 51).

On a more positive note, northern practice provides experience that allows nurses to develop a broad range of skills. Often, they are doing work doctors would normally perform in the south. In Nunavik, one respondent described the work of nurses and doctors in the following way.

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6 *James Bay and Northern Quebec Agreement and Complementary Agreements*, 1997 Edition, Les Publications du Quebec, Sainte-Foy, section 15.0.21.

Nurses and GPs [general practitioners] do much more than they would in the south. Here, it is more like the old kind of country doctor. The team spirit is good; doctors provide support to nurses in the communities by telephone and they regularly travel to the communities.

Community nursing is recognized as a specialized field, and most northern nurses are highly skilled, whether developed through on-the-job experience or specialized training. One person interviewed for this study said:

A nurse up north can represent 50 percent of the total nursing staff as most communities have only two nurses. The experience they gain is invaluable.

As noted, nurses are the backbone of the health care system and, in the smaller communities, a fully staffed health centre may have only two nurses. Nurses can facilitate or deny access to a doctor or specialist and, often, there is no avenue for a second opinion. This means community members depend on the skills, and often the personality, of a few individuals. In most cases, northern nurses are dedicated, knowledgeable and skilled. Many make long-term commitments to the north. Too often, they are overworked. If they are new to the north, they may be feeling isolated, homesick and culture shocked. Apparently, in one of the nursing stations, there was a picture of a house the nurse wanted to buy, and that is why that individual was working in the north.

As soon as their dream home is paid for, they will leave the north. This attitude disturbed some of the patients.

The nursing shortage in the north keeps the system operating in crisis mode. Numerous people mentioned they would like to see more health promotion, education and prevention programs operating in their regions, but staff shortages keep everyone focussed on immediate care and treatment.

Doctors: Few Inuit communities have resident doctors. In general, doctors can be found in the larger communities and where there are regional hospitals: Inuvik, Cambridge Bay (currently vacant), Rankin Inlet, Iqaluit, Pond Inlet and Goose Bay. In Nunavik, there are resident doctors in Kuujjuaq, Puvirnituq, Inukjuak and Salluit.[7]

As noted in the interviews, there are problems even when a doctor is resident in the community.

Different doctors and medical staff come with different priorities. Priorities change as the people change.

[7] A doctor in a nearby Cree community provides services to the residents of Kuujjuaraapik.

Turnover of personnel is a big, big problem. People don't want to come to a new doctor; they will wait for months to see if that doctor stays in the north, sometimes wait two years.

It was noted that a family doctor in the south will know a person's medical, personal and family history. With staff changes in the north, this history and continuity is lost.

You cannot write everything into the charts.

There are differences in the way regions provide physician services. The University of Manitoba's Northern Medical Unit provides services to the seven Kivalliq communities and Sanikiluaq. Four physicians are based in Rankin Inlet; one remains there while the other three travel to the surrounding communities. (Sanikiluaq is served by doctors who travel from Winnipeg on a regular basis.) Doctors based in Rankin stay for one to two months at a time (referred to as locums), then return south to be replaced by other physicians. Most of the doctors are experienced, with well-established practices they can leave for this period of time. The philosophy guiding this approach is that physicians should not have to practise in isolation of other physicians. Physician services are, therefore, organized to avoid a lone doctor being posted full time to a community.

In contrast, the Nunavik Board of Health and Social Services has made a concerted effort to station doctors in the region. There are seven positions in Kuujjuaq, five in Puvirnituq, two in Inukjuak and one in Salluit. Here, the doctors tend to be younger men and women just beginning their medical careers. The problems associated with recruiting and training nurses also apply to doctors. One person working in Nunavik said:

Now it is more difficult to recruit doctors. Even with good salaries and working conditions, it is problematic to recruit. It is generally young doctors who are new graduates who are interested in coming north; it is rare to get one with experience. We need to promote the north in medical schools—bring doctors here while they are students, have them come for training—that is the best recruitment method.

In Labrador, doctors are available in Goose Bay. They travel to the communities every four to six weeks, and more often to Nain. The limited access to doctors in the communities and the constantly changing face of the physicians is viewed as a problem.

It seems you just get used to a doctor and they're gone.

The Qikiqtani region has 11 doctors (general practitioners or GPs), 10 in Iqaluit and one in Pond Inlet. One surgeon is stationed at the Baffin Regional Hospital. Physicians in Iqaluit and Pond Inlet visit every community on a regular basis.

The doctor situation in Kitikmeot is problematic at the moment as the one position in Cambridge Bay in now vacant. Doctors and specialists in Yellowknife travel to communities, and people in need of immediate care travel to Yellowknife.

There are seven doctors and a regional hospital in Inuvik to serve the region. Where services cannot be provided in the region, patients are sent to Yellowknife or Edmonton.

Specialist Services: A growing number of services are provided by specialists travelling to northern communities as opposed to patients being evacuated to southern centres. However, the degree to which this happens varies from region to region and from community to community. Generally, the larger the community, the more likely it is that a specialist will visit.

All regions have a relationship with a hospital, university or health services network outside of the north. The Inuvik and Kitikmeot regions deal with Edmonton, Kivalliq with Winnipeg, Qikiqtani with Ottawa, Nunavik with Montréal and Labrador with St. John's.

In Nunavik, there has been a serious effort to "patriate" specialist services. The NRBHSS (1999: 18) uses the term "patriation" to describe moving the specialized medical procedures that are currently performed in the south to the north.

> The objectives of patriation are to increase the region's autonomy, develop the health centres, bring the services closer to the users and reduce transfers to Montreal; finally, it involves using the available funds for providing services and not for related expenses (transportation, lodging, escorts).

One study suggested that transfers to Montréal for ears, nose and throat problems and for gynecology could be reduced by 65 percent "if the system operated at full capacity and if the obstacles to patriation were removed," resulting in savings of $375,000 (NRBHSS 1998: 66). In July and August 2000, a mammography unit travelled up the coast by boat, stopping in five communities. Normally, women over 50 are given mammograms when they are sent to Montréal for other medical diagnosis or treatment, and they are even arranged for women travelling south on vacations.

Services in Kivalliq are planned around need. If the need for a particular specialty reaches a certain level, then efforts are made to send the doctor in rather than the patients out.

The need to travel outside the community for emergency care, diagnosis, treatment or to give birth is an additional strain on everyone living in a remote northern community. On the positive side, all regions, except Labrador, reported minimal waiting time for patients sent to the south. In fact, most reported that patients are served more quickly than if they lived in the south. One reason for this is that out-of-province services bring additional money into the system.

Other Health and Social Service Professions: The evaluation of the Indian and Inuit Health Careers Program mentioned above states that more than 40 percent of health

professionals of Indian and Inuit origin fall into the category of social work and related fields. Further, it projects a growing need for the services of psychologists and social workers. Many careers are available in the health and social service field, and not all require extensive university educations. A report prepared for the Royal Commission on Aboriginal Peoples on the Inuulitsivik midwifery project recommends:

> Paramedical health careers should be encouraged for young Aboriginal people as a way of maintaining and strengthening the cultural and social links while earning a living in a position of respect within their communities. Significant efforts have been made over the years to encourage Aboriginal youth toward professional health careers, with varying success. More emphasis on paramedical careers would encourage the development of a medically astute cadre from which doctors and nurses would emerge (Fletcher and O'Neil 1994).

Even a partial list of medical, technical and social service careers is lengthy: community health workers, mental health counsellors, nursing assistants, midwives, laboratory technicians, X-ray technicians, child protection workers, alcohol and drug counsellors, pharmacy assistants, dental therapists, medical equipment and prosthetics technicians, dietitians, speech therapists, health care administrators and support workers, health educators, rehabilitation therapists and medical librarians. Key informants interviewed in this study had a great deal to say on this subject.

> *The more you de-professionalize health providers, the more you meet the needs of people with the involvement of people without the educational requirements. We tend to over-rate requirements for involvement in the health care system.*

> *Human resources are pretty skeleton, hard to get—CHRs [community health representatives], nurses, physicians. The CHR program [in Nunavut] has not been taught for six to eight years, but the program is under revision and may be offered soon as modules that provide enhancement for new CHRs as well as training. People working in these positions without training get frustrated; without the proper background, we set people up to be unhappy in their work if they do not have the tools.*

> *Train people from the area; get lots more local input. Training must be appropriate (i.e., Arctic College to run degree programs). Do a lot of health care courses, including medical, nursing, midwifery, occupational and physiotherapy, laboratory and X-ray technicians. Also, have incentives to keep existing staff (not necessarily monetary, but rents, education, day care). Expand facilities in each region. Why can Rankin not do what Churchill does?*

> *Focus on primary health care, an interdisciplinary approach. Nurses are better than doctors at this. Use resources in the community by building the*

para-medical professions such as CHRs, dental therapists, maternity workers, administrative assistants, mental health workers, hygiene workers (i.e., improving ear hygiene), home care. Nurses and doctors can work as team leaders. Professionals learn about holistic health from listening to their Inuit patients.

Inuit Culture: The interview schedule used in this study asked people if they knew of any example where traditional Inuit knowledge is integrated into health research or service delivery. The only clear and concrete example provided is the midwifery centre in Puvirnituq. This program is discussed in detail later in this section.

Most responses to this question identified a gap in health research and service delivery due to the absence of Inuit in the system as well as the absence of traditional Inuit knowledge.

Professional services are provided by outsiders, leaving a gap between the providers and the population. Language and cultural differences exist, meaning that Inuit behaviour is hard to understand (without judgment) by outside professionals.

Inuit workers are missing in the system, Inuit workers who know their culture, families and communities.

There should be a priority on mental health programs with a budget attached to it. There should be a structure to mental health programs, with a manager, staff—trained Inuit staff. Inuit would be fully qualified and able to be in charge of their mental health programs.

Stop hiring southern mental health workers. The goals should be to replace them with Inuit. This idea should be a vision.

There should be addiction treatment that fits with Inuit culture and Inuit needs. Also, treatment geared to adolescents and residential treatment for substance abuse.

As long as the system depends on outside professionals, there will be a need for cultural orientation. Some have suggested that communities take on this role but, given the high turnover rates, volunteers may soon tire of the job. Another suggestion was to hire local people to provide cultural orientation to all new staff shortly after they arrive in the community. The program could include time on the land, meeting elders and various members of the Inuit community, and an introduction to Inuit culture, values and traditions. Cultural orientation packages could also be developed and shared among communities and regions.

For some people, language is an accessibility issue. One person noted that being cared for in your own language is a kind of medicine. Another suggested that having to use a

medical interpreter for a sensitive medical problem means speaking about that problem with two people rather than one.

The Labrador Inuit Health Commission's Regional Heath Survey (1999 Vol.1, No.1: 3) reports the following.

> 86% of adults think that a return to traditional ways is a good idea for promoting community wellness. They are particularly keen on traditional approaches to healing, revival of traditional roles for men and women, renewal of native spiritually and traditional ceremonial activity. 54% of adults indicated that they are familiar with plants or methods traditionally used to prevent or cure sickness.

While the health survey indicated people see progress being made in cultural awareness in schools, the use of Inuit language and renewed relationships with the land, few examples of traditional knowledge being incorporated into health service delivery were offered by interviewees in this project (except, perhaps, the inclusion of local foods on the Canada Food Guide). However, the Regional Health Survey itself is a culturally sensitive instrument; it collects culturally relevant and useful information, and the research process adhered to strict ethical guidelines that included community ownership of the research data. While LIHC's research guidelines and approval processes may slow down approval of projects initiated by outside researchers,[8] they have resulted in greater community involvement and participation in projects that do go ahead.

With respect to social services, the gap between Inuit and Qallunaat (White) approaches to social problems is a recurring theme. Elders have a very different perspective on problems and solutions than health and social service professionals, as well as many younger Inuit. In June 2000, the Nunavik Regional Board of Health and Social Services held an emergency meeting in Kuujjuaq to develop a suicide prevention action plan. The meeting was called following the suicides of two young people the previous week, and it brought together NRBHSS board members from each community, elders and youth. In the introductory session, elders spoke about how difficult it is to work with the people and organizations in their communities because government laws and regulations, especially once the courts are involved, get in the way of traditional interventions. Assumptions underlying the discussion were that many youth at risk of suicide also had other problems, including problems with the law or at home. Some of the comments included the following.

> *It is hard to work with people in the Inuit way.*
>
> *We live in a fast-paced world run by documents.*
>
> *Regulations and laws have buried our lifestyle.*

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[8] Concerns that the lengthy approval process inhibits the initiation of evidence-based planning were expressed.

One person's response to the question about traditional Inuit medicine captures very well the different cultural perspectives and the way Inuit ways have been overtaken.

> *We (as social services workers) do not follow the Inuit traditional ways of doing things on social issues. We only apply our new methods due to the change from traditional ways. The life of Inuit is different from the past and we have to upgrade our way of working in helping Inuit in social problems. …the real Inuit traditional ways of dealing with social problems are forgotten. The way of being advised and listening to the parents is no longer practised. The social problems that Inuit had then were not as complicated as we have today.… When the alcohol became available it created more problems for Inuit because their lives changed.*
>
> *The social system among Inuit has changed since we no longer have our lives controlled by Inuit. The young people in the past had to follow what their parents want them to be, for example the parents arranged the marriages. The young couples had to be monitored by both parents (woman's parents and man's parents) to support them or guide the young couples to have their marriages work. It was the parents' responsibilities to make sure that the marriage was stable.*
>
> *In modern society…the parents do not have any say when their children get married. The parents are not involved and cannot say anything to their children when they have troubles with their marriages because their children had their own choice to marry their spouses. This is why there are so many problems with young people today, because they are not connected with their parents. It is known that if the children made their own choices of their spouses, it is up to the children to deal with problems.*

Whatever one's views on arranged marriage, this response highlights a number of very important points. The role of parents and elders in Inuit society has diminished over time, and this is perceived as contributing to social problems. The comment about parents not having a say in their children's choice of spouse and, therefore, not intervening when there are problems is reminiscent of the many other ways parents have lost control and feel out of control—with the school system, for example, or dealing with doctors and nurses when a child is ill. Until Inuit values, approaches and perspectives are incorporated into health and social services, it is difficult to imagine the system enhancing the mental health and well-being of Inuit individuals and communities.

Social Problems:

> *Psychologists are overwhelmed because their clientele face so many social problems.*

> *Nursing stations and hospitals see the worst effects of alcohol and violence. This is hard on workers, nurses and doctors. Local turnover rates are also high, for example, interpreters.*
>
> *Doctors and nurses experience the worst of society—accidents due to alcohol, rape, beatings—this impacts on retention and recruitment. This is also a problem for community members who take front-line jobs. It is like working in an underdeveloped country, but underdeveloped with money.*

As the above quotes demonstrate, social problems impact on the health care system and workers within that system. However, dealing with these problems was also mentioned time and again when people were asked for recommendations on improving health status and heath care delivery in their regions. Mental health and suicide prevention programs were seen as key to improving both health status and delivery. People also spoke about addressing underlying problems, such as unemployment and the absence of a sustainable economy. Overall, the focus was twofold—improving living conditions and improving mental health services. High suicide rates are leaving both service providers and community members overwhelmed.

In a presentation to the Inuit Health Policy Forum, Pat Lyall spoke about the relationship between suicide and other social problems.

> Overall, the mental health of Kitikmeot residents impacts on the number of other illnesses, accidents, and attempted and completed suicides. Suicide is one of the most pressing issues that Kitikmeot residents are faced with regularly. One of the contributing factors to the high suicide rate in Nunavut is the impact "social issues" have on the mental health of the residents. Community mental health worker positions have been developed for three of the five communities in the region to assist individuals, families and groups in developing community-based action plans to help promote a community awareness of mental health issues. It is also evident that more communication between the KHSSB and various hamlets needs to occur to enable more effective services to be provided to each community.

Youth representative, Roy Wilson, also addressed the Policy Forum: "At the regional level, youth have identified the issue of suicide as one of the top priorities that needs to be dealt with being that the suicide rate is many times higher than the national average."

Donat Milortok, Vice-president of the Kivalliq Inuit Association and mayor of Repulse Bay, had a clear message for delegates about suicide.

> Our contact with the communities of the Kivalliq Region tells us that the number one concern is in the area of mental health and social issues. In the spring of 1999, Coral Harbour experienced 10 attempted suicides among its youth, one of them successful. This kind of crisis has occurred in many

> other communities in Nunavut. Rankin Inlet had a similar crisis in 1997. Coral Harbour and Rankin Inlet have attempted to respond to this crisis differently. Hamlet council and community helpers consulted and decided to reach out for support.
>
> …The community development and capacity building process used in Coral Harbour recognizes that the community needs to be engaged in solving their own problems. The community must be in the driver's seat in determining what is helpful and what they need to assist them with their healing process. If real change is to occur in any one person's life, they need to participate meaningfully in making that change, choosing what help they need and changing patterns which have contributed to the problem. The same is true of communities. Communities need to actively participate in their own healing process.

In the Kivalliq region, the Nunavut Department of Health and Social Services is also attempting to address this problem. A new program aims at filling the gap between the medical personnel and social services by hiring psychiatric nurses. On the social services side, communities have varying services, including alcohol and drug workers, family counselling, foster care, child protection, homemakers and youth workers, while the medical nurses address physical health. It was noted that the problems being presented at nursing stations may be physical, but often the underlying complaint is psychological—and nurses are not trained to deal with this. At the same time, social service staff find much of their time taken up with mandated services, such as corrections and child protection, so their ability to provide individual counselling and support is limited. The new mental health workers/psychiatric nurses are being hired to fill this gap.

The program gives mental health a category of its own on the service continuum: there are health services, social services and mental health. The new mental health services will, however, have a psychiatric focus, with the nurses being able to provide medication as well as counselling. This model is already in place in Sanikiluaq and reports are that it is working well. However, a formal evaluation, involving individuals using the service, their families, community agencies, nurses and social workers would be helpful in assessing its success.

Diagnosis and Treatment:

> *Access to the health services in Inuvik region is good. Nobody has to wait to access health services like they would if they were in the south. The medivac service is good.*
>
> *Access to immediate on-site services is quick; there are nurses in every community and at the Baffin hospital 24-hours a day. Primary care services are there—often faster than in most southern communities. Access to referral services in the south is also fast.… One of the great values of our system is that it is a nurse-mandated primary care system; therefore, it*

> *is more holistic and teaching-focussed. Health promotion is integrated as it is a part of nurse training and the nurse role provides more comprehensive care.*
>
> *The transfer from small communities to the hospital centres and from there to the south is done quickly and efficiently. We have become experts in medical transfers (Nunavik).*

Johnny Nuktialuk, a member of the Nunavik Regional Board, describes the medical transfer process in a presentation to the Inuit Health Policy Forum held in Ottawa in February 2000.

> When a trauma situation or any serious medical condition occurs in a village other than Puvirnituq or Kuujjuaq, the doctors or nurses communicate with the health centres regarding the patient and the decision is made for transport via medical evacuations. At the health centre the patient is evaluated and stabilized. When the problem is serious, the patient is flown from Puvirnituq (1,625 km) or Kuujjuaq (1,437 km) by medical evacuations to Montréal.

Similar processes take place in all regions and medical evacuations, for the most part, are quickly and efficiently addressed. With respect to referrals, the situation as described by an interviewee in the Kivalliq region is fairly standard: the local nurse determines the need for a medical opinion after assessing the client. If it is urgent, a physician is reached by telephone and a decision is made. If it is not urgent or elective, then an appointment is made for the next time a physician visits the community. Specialists travel to the communities (this is not true for all regions). Regardless, people are often sent south for diagnosis and testing. Nurses schedule all appointments with doctors, and there is no process for second opinions. There have been various proposals for setting up a formal process for appeals, conflict resolution and to deal with complaints about medical services.

In Labrador, clinic nurses are the first point of contact in the curative system. If further examination or testing is required, but not urgently, an appointment is made to see a doctor, either during the next community visit or in Goose Bay. Regular medical planes travel from Goose Bay to the communities on Monday, Wednesday and Friday (referred to as sched-evacs or mission planes from the time when the Grenfell Mission ran the health service). Medical travel on Tuesday and Thursday is on regular Labrador Air flights. If, after seeing a doctor, further tests are required, the patient is sent to St. John's. Emergency medical evacuations take place as required; however, it is not uncommon for bad weather to cause delays. In Nain, where there are no runway lights, planes can only land in daylight—in the height of winter, the sun sets at 3:30, which can lead to long nights for the nurse on duty and the family of a patient in need of serious medical help.

Diagnosis and treatment services are almost exclusively available in English or French. Medical interpreters play an important role in the process, especially at southern hospitals

and medical boarding homes. In the south, interpreters do much more than translate from one language to another; they explain the medical system to patients and the cultural context of particular statements or behaviours to doctors and nurses (Kaufert and Putsch 1997). In the interviews, one person spoke about the challenges faced by interpreters in having their cultural interventions understood.

> *Some patients go crazy with the full moon and traditionally these people who have psychologically mild problems are well understood by Inuit. They are not severe and are able to function normally, but they get anxious or behave crazier when it is a full moon. The problem is that the Kabloona doctors or nurses don't understand it when we, as interpreters say, "she or he has this problem because of full moon." As an interpreter, it is a challenge to explain these connections and get in the middle of two different people who are not understanding each other at all.*

Childbirth in the North

In the mid-1980s, a group of determined Inuit women in the northern Quebec village of Puvirnituq worked with supportive doctors and other health providers to establish a birthing centre and midwifery project. The Inuulitsivik Maternity, which opened in 1986, is now held as a shining example of how traditional Inuit approaches to health can be integrated into the medical system. Since its opening, four Inuit midwives have completed training.

Until well into the second half of the 20th century, births took place on the land. Later, women gave birth in newly established nursing stations with the assistance of foreign-trained nurse-midwives and, often, Inuit midwives as well. In the early 1970s, the federal government established a policy whereby all births were to take place in a hospital.[9] This policy changed far more than the location of births: it left few opportunities for Inuit midwives to practise and pass on their skills, and it meant long periods away from home for pregnant women.

In a report on Inuit women's health, Pauktuutit (2000: 3) describes the role of traditional midwives in Inuit society.

> While practices varied in each community, in general Inuit midwives were expected to know a woman's reproductive system, how to guide a woman through the different stages of labour, to massage the womb to achieve quick deliveries, to cut the umbilical cord and handle complications. Midwives knew how to massage and turn babies in the womb in case of breached births, or how to clean and dress a newborn and to ensure that

[9] There were some regional differences in the way this policy was implemented. In the Kivalliq region, for example, first births and from fifth births on took place in hospital, while the remaining births, if low risk, could take place at the nursing station. Pat Kaufert reports that 45 percent of babies were born in nursing stations in 1970. By the early 1980s, the policy changed to evacuating all women, regardless of risk. See Kaufert (1990: 5).

> the placenta was completely removed to avoid infections. They also knew the properties of plants and which ones to use to stanch excessive bleeding or treat other ailments.

Since it became policy for women to give birth in hospitals, Puvirnituq was, for many years, the only northern community where women could go through the birthing process assisted by Inuit midwives. A birthing centre recently opened in Inukjuak with the Puvirnituq midwives and other medical staff providing training and support (there is a resident doctor in Inukjuak). In 1993, the Rankin Inlet Birthing Centre opened its doors to pregnant women in that community, and in May 2000, it became a regional birthing centre. While there are not yet any Inuit midwives working in Rankin, there are plans to train the two maternity workers presently at the Centre.

In most other cases, women continue to give birth in hospital settings—in Inuvik, Yellowknife, Edmonton, Churchill, Winnipeg, Iqaluit, Ottawa, Kuujjuaq, Montréal, Goose Bay, or St. John's, depending on where they live and the nature of the risks associated with their pregnancy.

The Labrador Inuit Health Commission reports that only accidental births take place in the north coast communities. A pregnant woman is sent to Goose Bay for an ultrasound[10] at 28 weeks, then she goes back again to give birth, either at 36 weeks, or 38 weeks if there is a nurse-midwife in the community. There are no funds for subsidized travel for the father and other children to accompany her to Goose Bay. This means leaving the family at home for two to four weeks.[11] Numerous studies have reported the negative impacts of obstetric evacuations on the pregnant woman, her family and the community.[12] The Regional Health Survey conducted in Labrador found that 84 percent of women found it stressful to leave home to have babies, and 54 percent reported that children left at home had problems during their absence (LIHC 1999: 4).

While women on the Hudson Coast outside of Puvirnituq—and now Inukjuak—still leave their communities to give birth, the circumstances differ greatly from those in other regions. Babies are delivered at the maternity ward. Husbands and boyfriends accompany women from outlying communities, and half of their airfare is covered by the health centre. This encourages families to be together at the time of the birth.

The following account is based on interviews conducted in the Nunavik region during the course of this project.

> *At the Maternity, women give birth in a natural way. The midwives practise their traditional methods and the technology, such as ultrasounds, is a last resort. If there is a concern about the pregnancy, a*

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[10] Plans are under way to have a portable ultrasound available for use in the communities.

[11] LIHC (1999: Vol. 1, No. 2: 3) reports that from 1987 to 1992, women were away from home an average of 17 days awaiting delivery.

[12] See O'Neil and Kaufert et al. (1988). While this study was done in the Kivalliq region, the problems it raises are the same. See also Pauktuutit (2000).

medical doctor is consulted and then ultrasound is used, but for medical reasons only. Pregnant women are not allowed to use the ultrasound to find out about the gender: in the Inuit traditional way, they are not supposed to find out if it will be a girl or a boy. It is the Inuit way to accept the baby whether it is a girl or a boy. The Inuit midwives follow traditional methods as much as possible; they use their hands for examinations and then follow with technology if necessary. They have found that most of the time, the results of the examination are correct.

The midwives teach the women about good nutrition, parenting after giving a birth and breast-feeding. In many cases, they successfully encourage women to breast-feed even if their newborn babies are going to be adopted. When women learn the critical role of breast-feeding in developing the immune system, they are happy to breast-feed the babies for a few days before leaving the health centre.

Family planning information is provided, but the midwives do not encourage or influence women about matters related to their personal lives. Instead, they teach about healthy lifestyles, healthy diets and dangers to their health, such as smoking during the pregnancy, sexually transmitted diseases, alcohol during pregnancy, and HIV and AIDS.

The midwives monitor pregnant women very closely to make sure they do not have high blood pressure, which can lead to serious complications. Births only take place at the Maternity if the woman is healthy during her pregnancy. If the pregnancy is at risk, they are sent out to Montréal to deliver their babies in the hospital. For example, if a woman had a Cesarean section on her first pregnancy, on the second pregnancy she would be sent out to the south with a plan to have a natural birth if it is possible. Then, if this birth was normal and the third pregnancy is normal, the midwives would deliver the third baby in Puvirnituq.

The Inuit midwives are trying not to be too influenced by the southern midwives and doctors in the way they deal with pregnancy, as the Inuit traditional midwifery practice is to be preserved. The Inuit midwives constantly discuss their concerns among themselves to keep in mind to continue the Inuit traditional practice in delivering the babies.

An extensive research paper (Fletcher and O'Neil 1994) on the Innuulitsivik Maternity was prepared for the Royal Commission on Aboriginal Peoples. It provides solid evidence of the benefits of returning childbirth to the community and of incorporating traditional Inuit approaches into health care delivery. Among the 15 recommendations, are three that address issues related to culturally relevant health services, Inuit control and the need to develop and support Inuit health care workers. Other recommendations are equally relevant: incorporating culturally specific health knowledge and beliefs into health services; planning for the long term; and allowing for opportunities for

advancement for non-professional and para-professional personnel as one way of encouraging effective Inuit participation in health care delivery.

In 1992-93, Pauktuutit carried out a research project on traditional Inuit midwifery that included 77 interviews with Inuit elders in 10 Arctic communities. Elders were asked detailed questions about their own births and about those where they acted as midwife or helper. The interviews provided information on where births took place (on the land, in a nursing station or hospital), who assisted, the birthing position and props used, and details about labour and the birthing process.

Pauktuutit's research uncovered a number of interesting facts that could be incorporated into health promotion strategies. For example, while few prohibitions against eating specific foods during pregnancy were revealed, some women were advised "not to eat too many berries, because berries picked in a following spring will have fermented, and never to eat aged food" (Archibald et al. 1996: 429). This suggests awareness in traditional Inuit society of the effects of alcohol on the fetus. The study concluded with a call to use research material like this to develop culturally appropriate educational resources and strategies. "Working within cultural norms and practices may substantially increase levels of personal and community responsibility for health and well-being, and, thus, reverse the growing dependency on external health professionals and technologies" (Archibald et al. 1996: 432-33).

The midwifery project in Puvirnituq was well under way at the time of this study. The success of the project supports Pauktuutit's prediction of increased levels of individual and community responsibility for health and well-being. In a presentation to the Society of Obstetricians and Gynecologists of Canada in 1996, midwives Nellie Tookalak and Leah Qinuajuaq exhibited pride in their profession, their skills and their community while addressing issues of how the Maternity has improved the health of mothers and children.

> In the beginning, our women used to ask their questions to the Qalunaats [White people], not to us. Now women ask *us* the questions, and they trust us. It means our self-esteem, not only personal, but as a community, is coming back. We are trusting our own people again. We are providing great care to our women and their families, in our own cultural way, *and* within a provincial health care system.
>
> ...There have been over 1,000 births in our Maternity since its opening. The statistics gathered have proven we are providing care that has not only improved our cultural and personal lives but also improved our perinatal mortality and morbidity rates.

Risk Assessment and Childbirth

In general, Inuit women have low intervention rates for babies born in hospitals. Yet, first births are often considered high risk for the simple fact that the medical profession has not been able to assess how this particular woman gives birth. In interviews in one of the

regions without a birthing centre, the researchers were told that the risk issue is the biggest obstacle to professional support for midwifery.

The Rankin Inlet Birthing Centre is now moving away from the standardized pregnancy risk evaluation form developed for use in southern hospitals. An evaluation of the Rankin Inlet Birthing Centre published in 1996 found it to be safe for low risk births. It also noted that the standardized risk assessment tool led to greatly reduced numbers of women being assessed as low risk: "The use of the present risk score substantially reduces the number of women who would be eligible to give birth in their Birthing Centre" (Chamberlain 1996: vii).

The Rankin Inlet Birthing Centre recently developed draft guidelines based on those used by midwives in Ontario. They specify the appropriate care provider to consult in specific situations. For example, a midwife handles the consultation if a woman has had a previous postpartum hemorrhage, while a physician or specialist is consulted when there is a history of spontaneous abortions.[13] The draft guidelines note that these criteria are not necessarily considered risk factors but require discussion to determine the appropriate plan of care.

This moves the risk assessment process in Rankin a step closer to the holistic approach used at the Inuulitsivik Maternity. The following description (Fletcher and O'Neil 1994: 25) of the Perinatal Committee is lengthy but informative.

> The perinatal committee of the Innuulitsivik health centre meets weekly to assess the pregnancies of women between 31 and 34 weeks' gestation. The committee is composed of midwives, doctors, and nurses and is charged with evaluating the pregnant woman's health and risks to it. This committee reviewed each woman's file from a variety of perspectives to gain an overall view of her condition. The committee makes the decision when necessary to send a woman out of the community for specialized testing and treatment as well as for delivery. A perinatal committee meeting was observed during the course of this study.... Present at the meeting were three midwives in training, three midwives, two physicians (one part-time, one full-time), two nurses, and two medical students. Five pregnancies were discussed; four of the women were residents of Povungnituk, and the fifth was from Ivujivik. This meeting was different from many in that there was no telephone conference with the nursing station to assess the pregnancies of women from other villages. In each case the woman's social status (marital, number of previous children, age, job, support network) history (abuse, adoptions, previous problems) and problems, if any, were discussed. Her situation on arrival for [the] first pregnancy test was brought up if relevant, as well as her apparent mood and disposition toward being pregnant. The various laboratory results were related and missing information queried. Medical problems, current and

[13] The draft guidelines contain detailed listings of indications based on initial history and physical exam, prenatal care, during labour and birth, and postpartum (maternal and baby).

> past, were discussed and management methods discussed. The presence of toxoplasmosis antibodies and nutritional status were particularly important factors, as were estimated dates of conception and delivery.

The report goes on to mention that Inuit personnel presented all files, but one. The authors state: “What was particularly striking about this meeting was the input of social information that could come only from living in the community with the individual in question” (p. 26).

As noted earlier, the Inuulitsivik Maternity is a wonderful example of melding traditional Inuit and Western approaches to health care delivery. The Rankin Inlet Birthing Centre offers women in Kivalliq an alternative to travelling outside of their region to give birth. In time, it is expected to have trained Inuit midwives on staff and to incorporate more of the traditional approaches used in Puvirnituq. From time to time, proposals are made to establish birthing centres in other communities: Pond Inlet, Taloyoak, Nain, Kuujjuaq and Salluit, to name a few. Birthing centres not only reduce the need for medical travel, they offer comprehensive, holistic pre- and post-natal care, and the opportunity for much more Inuit involvement in the delivery of health services. In the absence of a birthing centre in the Qikiqtani region, one person suggested setting up a separate boarding home for pregnant women, “with midwives there for support, and older women familiar with the Inuit way of giving birth to help the younger women and act as coaches.” Similar suggestions have been made for medical boarding homes in Winnipeg, Ottawa, Edmonton and Montréal.

Non-Insured Health Benefits

The federal Non-Insured Health Benefits program is for all registered First Nations people and Inuit. It provides health benefits not covered by provincial or territorial health care programs, such as prescription drugs, medical equipment (e.g., wheelchairs and hearing aids), eye glasses, dental services, some of the costs associated with medical travel and, in First Nations regions, mental health services.

In the territories, the NIHB program is administered by the NWT and Nunavut governments. The program was not included in the 1988 health transfer agreement, in which the federal government unconditionally transferred the responsibility for the delivery of health services. However, it is included in contribution agreements with the governments of Nunavut and the NWT—the territorial governments administer and deliver the program according to requirements established by Health Canada

In Labrador, the Non-Insured Health Benefits program is run directly by LIHC with federal funds. In fact, LIHC was one of the first Aboriginal groups to take on the administration of the NIHB program in 1989, and it is now running the program as a pilot transfer agreement.

In Nunavik, the NIHB program no longer exists. Under the *James Bay and Northern Quebec Agreement*, funding is transferred from the federal government to the

Government of Quebec through the Department of Finance (i.e., it is no longer any part of Health Canada). The Nunavik Board runs its own program and determines benefits and payments—not based on NIHB directives but on the needs and circumstances of the region. Whether or not the level of federal funding is sufficient is unclear—no one in Health Canada could respond to requests for information in this regard, possibly because it is part of a transfer to the province that includes other items as well.

The NIHB program has been at the forefront of government–First Nations relations for some time.[14] In 1993, Health Canada established the Joint Task Force on Future Management Options for the Non-Insured Health Benefits program. The Task Force was composed of five First Nations chiefs and five senior managers from Medical Services Branch. The two-member consultation team included one person each from MSB and the Assembly of First Nations (AFN).

Initially, this review applied only to First Nations south of the 60th parallel of latitude. The AFN lobbied to have Inuit and First Nations in the Northwest Territories included in the consultations process, and in June 1995, the MSB extended the review to include the NWT. Consultations took place between August 1995 and June 1996. In February 1996, while the NWT consultations were still taking place, the final report and recommendations of the Task Force were completed.

In April 1997, Cabinet approved the NIHB mandate renewal and, in July, the report, "Recommendations from the Inuit and First Nations on the Future of the NIHB Program in the NWT" was released. The Task Force had been disbanded by the time the recommendations were released.

The report on the NIHB program (Health Canada 1997:11) in the NWT acknowledges the inadequacies of the consultation process for Inuit.

> The Inuit organizations stated that their participation was an afterthought, that they had not been initially included in the JTF [Joint Task Force] process, that there was no Inuit representation on either the JTF or the Consultation Team. Recognizing the importance of participating in the Consultation Process and of expressing the unique concerns and challenges faced in the North, the Inuit Organizations agreed to participate.

Issues of Inuit involvement in the NIHB program continue to be raised in Nunavut and the Northwest Territories. In a presentation to the Inuit Health Policy Forum, Donat Milortok of the Kivalliq regions said:

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[14] In addition to government concerns about escalating costs, in 1993, the Auditor General reported that there was no federal mandate for the program and its program definitions, principles and benefits were ill defined. First Nations have sought and achieved greater control over the program. At the national level, the MSB and AFN participate in a joint management committee (with some Inuit participation on this First Nations committee.

> We need to be given the power to manage our own affairs such as Non-Insured Health Benefits and other related programs. Many of our people have a very limited understanding of what benefits and services are available to them through these programs. The language and cultural differences often contribute to confusion. We sometimes find that our elders and other Inuit end up paying for things that are actually covered under the program. Managing these programs by Inuit for Inuit would eliminate these problems. We Inuit have the skills to manage many of these programs for our own people. It is time to start handing some of these things back to us.

The following comments were excerpted from interviews in the Inuvialuit region.

> *For Non-Insured Health Benefits, we do not have any idea how much of the money is spent on Inuit. The public government manages the NIHB program and how they apply it to Inuit, they would not tell us. The specific programs for Inuit are folded into overall core funding and it is hard to find out how they are spent.*

> *The Non-Insured Health Benefits program for Inuit is a real concern. We are not properly represented and people from the south are making decisions for us and they don't even know who we are. ITC has to make sure that we in the Inuvialuit region are represented. If Health Canada wants Inuit to be truly represented, each Inuit region should be represented at the national level. If there was an invitation to sit on the national committee on NIHB, I would like to be invited. I have real concerns about the NIHB because we don't have information on what is rightfully Inuit's.*

> *There has to be a better way to keep track of NIHB programs. This program is for Inuit. There should be NIHB information materials written in languages so Inuit are aware of their eligibility on the program…. The public has a right to know what services are available under the NIHB. There has to be a communication strategy for the Inuit public.*

The following is a summary of the administration of non-insured health benefits in Nunavut. Similar processes are likely in place in the NWT.

Administration of NIHB in Nunavut: One or two people in the Rankin Inlet office of the Nunavut Department of Health and Social Services handle NIHB claims for the entire territory. Also, the registration list is kept in Rankin. A person is registered for NIHB in Nunavut, if he/she is a beneficiary under the Nunavut Land Claim Agreement (i.e., on the Nunavut Tunngavik Incorporated beneficiary list). If a baby is born in the north and the mother is Inuk, then registration is automatic. If only the father is Inuk, then the name is checked with NTI to ensure NTI enrollment. If the mother lives in southern Canada, the baby must be registered through an NIHB office in the south.

The agreement between the MSB and Nunavut commits Health Canada to provide a specific amount of money for NIHB and specifies how it can be spent. The Nunavut government sends monthly invoices to Ottawa for reimbursement. Nunavut pays the invoices to ensure medical practitioners, specialists, airlines and medical suppliers are paid in a timely manner and is then reimbursed by Health Canada.

Health Canada controls the approval process for claims. For example, someone sent to Ottawa to be fit for an artificial limb may have to make a second trip to pick up the limb because the approval process is slow. Attempts are being made to start the approval process with the decision to send the person south (at the same time travel arrangements and medical appointments are made) in order to speed up the process and reduce the number of southern trips the patient is required to make.

Dental services in Nunavut are handled differently in Kivalliq than the other two Nunavut regions. In Qikiqtani and Kitikmeot, a fee-for-service arrangement is in place. If dental work is required in excess of $600, Health Canada agrees to pay for services, travel and accommodations only after a work plan is approved. (In the Inuvialuit region, dentists are frustrated by the paperwork and the waiting time for the approval for work over $600. Approval comes from the predetermination unit in Ottawa. X-rays must be sent by mail to Ottawa, and if there is a complex case, Ottawa usually requests more information before making a decision.)

In Kivalliq, the former Board of Health and Social Services entered into an agreement with Health Canada to block fund dental care (an amount was agreed upon, but it is not paid up front). Dentists are subcontracted through the Northern Medical Unit of the University of Manitoba with the region covering the cost of travel and accommodations, supplies and equipment. Costs are rolled up and submitted monthly to Health Canada for reimbursement. Cash flow difficulties could arise from the need to pay up front when the reimbursement process tends to be slow.

People working within the Nunavut government are as adamant as Inuit organizations about the need for good public information on the NIHB program. The appeals process is especially complicated, and it takes a long time even for those working within the system. Usually, appeals are around big-ticket items, such as a wheelchair, and the patient may be an elder or a unilingual person who needs both an interpreter and an advocate to help them through the process. In contrast, the appeal process in Labrador has been greatly simplified. In Nunavik, where the regional board is responsible for the entire program including defining eligible services, this does not seem to be a problem.

Telemedicine

Delegates to the Inuit Health Policy Forum recommended that telemedicine be explored for its potential for improving health care in the north. People at the regional and community levels wanted to be involved in informed discussions of both the potential

and the problems associated with this new technology. For example, tele-medicine has the potential of filling gaps in specialist services, especially with respect to diagnosis. However, it should not take the place of hands-on medical care. Smaller communities need all sorts of equipment—basic medical equipment as well as new technologies for tele-medicine. Along with new technologies is the need for trained technicians, and it was noted that training should be provided for Inuit in their own communities.

A pilot project in Nain links the community by video-conference to Goose Bay and St. John's. It has been used primarily for mental health assessments, particularly in cases involving the RCMP where an assessment is needed within 24 hours of an arrest. It has also been used for live conferencing and for follow-up in tuberculosis therapy. One of the problems with the system is that the clinic nurses are expected to run it, without having been trained. Back-up and instructions are only at the tele-centre in St. John's, available by telephone.

The Nunavik region is linked to a health and social services telecommunications network used throughout Quebec. It is part of a secure system that links 600 institutions (more than 2,000 physical sites) with the 18 regional health and social service boards and the Quebec ministry. Implementation in the province began in 1997, and Nunavik came on stream in September 1998 with e-mail for the regional board. This alone reduced costs immediately, since documents could be exchanged free of charge (no long distance fax or shipping disks by air). This network is completely free to regional health boards in Quebec until March 31, 2001 (Ministère de la Santé et Services sociaux pays). E-mail has already reduced the isolation of medical professionals working in Nunavik as they can contact experts all over the world and access information via the Internet. On March 31, 2000 the Internet links were completely implemented. This alone took one and a half years to do.

Both hospital centres in the region have a machine with a mobile camera and speakers attached to a computer; it can also be hooked up to other equipment, such as an X-ray decoder. Video-conferencing was used recently to conduct job interviews, saving the board the costs associated with the hiring committee travelling south. The Université de Montréal health centre has an internal video-conferencing facility where job applicants were interviewed by a team in Kuujjuaq.

In Puvirnituq, a psychiatrist in Montréal was linked by video-conference with a doctor and patients in Puvirnituq for psychiatric assessment. Equipment has also been linked to an electroencephalogram (EEG) machine and the results were transferred immediately to Montréal. Video-conferencing can also be used for distance education and training, saving the travel costs associated with bringing people into one community or to the south.

The *Nunatsiaq News* reported on May 5, 2000 that Nunavut's health minister had signed two memoranda of understanding on telehealth using satellite technology to transmit medical images and information between remote communities and medical experts in

larger centres—one with the Province of Newfoundland and Labrador, and the other with the Queensland Telemedicine Network in Australia.

Nunavut's telemedicine project, Ikajuruti Inungnik Ungasikumi, links Pond Inlet and Cape Dorset to Baffin Regional Hospital in Iqaluit. It is being expanded to include Cambridge Bay and Gjoa Haven and plans exist to expand to Arctic Bay, Igloolik and Pangnirtung in October and more sites in Kivalliq in 2001-02. The *Nunatsiaq News* story (2000: 14) reports:

> Picco said a pilot Prenatal Visitation Program uses teleconferencing to let expectant mothers in Iqaluit see and speak to their families every week. Over the next year Picco said patients will also receive consultations in dermatology, internal medicine, orthopedics, cardiology, counselling and psychiatry." This report shows its potential not only with respect to medicine but with the emotional support lost to patients who must travel outside of their communities for medical care, including childbirth, where women often must leave their home and family for weeks at a time.

The Sustainable Development Working Group of the Arctic Council had a special report prepared on telemedicine (Hild 2000). The report notes the potential of telemedicine in addressing the challenges to providing health care across the circumpolar world—vast distances to travel, limited staff including few or no doctors in many communities, limited equipment, maintaining qualified staff with current skills and limited access to medical specialists.

The Arctic Council report (Hild 2000) reviews telemedicine projects in Canada, Alaska, Greenland, Norway, Russia and Sweden. Among its recommendations are the following.

- If telecommunications systems are in place, affordable and reliable, they will be used for health care delivery.

- Health professionals working in the Arctic need to be trained to utilize fully the telemedicine tools.

- New endeavours should place a priority on the "front end" users in the most remote and underserved communities. (That is, begin with the most remote, isolated communities. This includes both the technology and the staff training necessary to assure these sites are maintained and supported so the telemedicine system is complete and operational at all levels.)

- Efforts to inform the Arctic public on telemedicine programs and services should be initiated. (Include discussions of what tools will best address community health needs, assessments of current work loads and practices, community comfort with new technologies, potential for accessing professionals outside of nation-states and innovative programs using customary and traditional practices shared.)

5. Conclusions

This study began as an examination of models of health care delivery in the six Inuit regions of Canada, and slowly expanded—with each document reviewed and interview conducted—to encompass the social, economic and political spheres of life in Inuit communities. The examination of services that address the physical needs of individuals grew to include mental health, which leads to discussions of living conditions in families and communities, economic security and the participation of Inuit in the design and delivery of these services. As such, it reinforces the usefulness of a holistic approach (a population health approach) in understanding and analyzing health systems. But much more work is required. This study is a beginning, and as such, it lays the foundation for a comparative analysis of the models of health care delivery in the Inuit north. Much more research is required. For example, until reliable health indicator data are available for Inuit at the regional level a complete analysis of the impact of regional service delivery models on the health status of Inuit will not be possible. However, some initial conclusions can be reached.

With respect to access to health services, all communities have basic, front-line nursing services, although the nursing shortage is putting services in some of the smaller communities in jeopardy. In general, a wider range of health and social services is available in the larger communities. Regional differences are more evident with respect to the provision of physician care but, again, shortages are having an impact. For example, the Kitikmeot region has a position for a doctor in Cambridge Bay, but the position is not filled at present. Physicians are most likely to be stationed in larger communities and where there are hospital services—Inuvik, Iqaluit, Kuujjuaq, Puvirnituq and Goose Bay. Physician care is organized differently in the Kivalliq region, where travelling doctors visit all communities on a regular basis—approximately one week each month—rather than being permanently stationed in a particular community. In Nunavik, efforts to “patriate” specialist services are a priority and more and more specialists are visiting the region as opposed to sending patients south for consultations. There is evidence that patriation results in significantly reduced costs. In contrast, people living on the north coast of Labrador are required to travel for even basic physician care. Emergency medical evacuations appear to be handled quickly and efficiently throughout the north, with Labrador, again, being a possible exception: the absence of runway lights in Nain limits flights to daylight hours, and inclement weather is an obstacle to the small planes that fly the north coast.

While this study did not solicit the views of users of health services on issues of quality of care, a number of issues were brought forward. First, almost every person interviewed remarked on the need for a greater emphasis on prevention, education and health promotion activities. It appears that the majority of human and fiscal resources continue to be devoted to treatment, and chronic staff shortages reinforce this pattern. Simply stated, immediate treatment needs are met first and other activities are undertaken on an ad-hoc basis. Another issue related to the quality of care revolves around the lack of Inuit

involvement at all levels of the health care system and the failure to integrate Inuit knowledge, values and culture into health and social services.

Some programs and services work well in the north, most notably the Inuulitsivik Maternity in Puvirnituq. This program is successful on a number of levels: it allows for on-the-job training of Inuit professionals, incorporates Inuit and Western approaches to medical care with positive impacts on the health of Inuit families and provides a needed medical service within a region.

Not surprisingly, the study uncovered recurring themes or issues. These are outlined below.

Addressing mental health issues and the painfully high number of suicides in the north are top priorities across all regions.
Mental health was the number one priority health issue identified by Inuit delegates to a health policy forum held in February 2000. The impact of suicide in small, closely knit communities, with extended family ties that reach across the north, is felt by every member of the Inuit world. Within the broad category of mental health, the following issues were mentioned: suicide prevention, addictions, the need for crisis intervention services in communities, the need for holistic programs, including prevention and after-care, and the need for programs that go beyond the crisis to address underlying issues and problems. Interviews conducted in the course of this study confirmed the view that suicide is the most pressing health issue facing Inuit society today.

Primary health care services are generally adequate.
Primary health care services (sometimes referred to as the "curative" side of health care) are adequate in most of the regions, *or would be* if not for the chronic shortages of nurses and doctors in the north. Although this varies somewhat among regions (Labrador services were more often referred to as "basic"), primary health care services are available, either in the community, at a regional centre or in the south. Efforts are being made, especially in Nunavik and Kivalliq, to bring more specialists in to the region.

Staff shortages are straining the system.
Common to all regions is the difficulty in recruiting and retaining staff. With respect to doctors and nurses, the difficulty is intensified with the current shortages in southern Canada. Until Inuit doctors and nurses are trained in large enough numbers to meet northern needs, dependence on the vagaries of what is happening in the south is likely to continue. The long-term solution, then, is to focus on creating an education system that produces young people with an interest in pursuing medical careers and with the academic background to do so. The new nursing program at Arctic College in Iqaluit should make a welcome contribution for it allows training to take place in the north and, presumably, subject matter is relevant to the north.

Recruiting and retaining local people for social work, counselling and community health worker positions continues to be a problem. These positions require less specialized training than doctors and nurses, yet recruitment and retention problems persist. The lack

of training programs is one aspect of this problem. Even if local people are hired, one person noted that the lack of training sets them up for frustration, as they often do not have the tools to carry out the job effectively. On-the-job training is more difficult when existing staff members are already overburdened and energy is focussed on meeting immediate client and patient needs. Burnout is a continuous problem since front-line health and social service workers see the worst effects of social problems, such as alcohol and violence. This affects southern professionals working in the north as well as people hired from within the community.

There are far too few Inuit working in the health and social services, at all levels. Unfortunately, there are still too few opportunities for people to pursue educational opportunities in the health and social service fields without leaving the north and, especially, without leaving their community. This impacts on the number of Inuit who are able to pursue education and training opportunities and secure positions in their home communities.

Perhaps the very real problems associated with recruitment and retention of medical personnel provide an opportunity to do things differently, to build health and social service networks based on hiring local people, training them on the job or through education leave. The goal would be to build a pyramid with community people forming the mass at the bottom, supported by relevant training in the north (on the job, in modules, educational leave), plus instituting training programs through existing institutions like Arctic College in Nunavut and the NWT, the College of the North Atlantic in Goose Bay, and the Kativik School Board and its affiliates. Programs could include nursing, community health representative training, social work, midwifery, health administration, and training of laboratory and X-ray technicians. At the top of the pyramid would be the health and social service professionals. At the moment these are almost entirely from outside the north, but eventually, with concerted efforts by governments and the education system, more and more would be from the north.

Increasing Inuit and community participation in decision making is a priority. Decisions about budgets are of primary importance. Decision making can be difficult when acute care services, which are considered mandatory throughout Canada, are seen as competing with prevention programs. One crisis caused by a lack of immediate care can have huge political implications and generate public outrage. For this reason, decision making must be participatory, the public engaged in an informed debate and involved in the decision-making processes of their communities and regions. The chronic understaffing of doctors and nurses, exacerbated by shortages in southern Canada, can skew the debate, make it more short sighted, focussed on short-term needs rather than long-term goals. In high-cost regions like the north, where everything from salaries to the cost of transporting people and supplies puts unusual pressure on budgets, the benefits of investing in prevention, education and capacity building are realized over a much longer period of time. Savings may accrue over 10, 20 or 30 years, but not in a two- or three-year period. It is here that a clear vision and community involvement in the decision-making process can perhaps assist.

Full Inuit involvement and participation in decision making is required at the national level as well. The federal government plays a significant policy role in the Inuit health field. Also, Health Canada has recently developed a number of new programs that target Inuit and First Nations peoples, such as Home and Community Care and the Aboriginal Diabetes Initiative. At the February 2000 Inuit Health Policy Forum, Inuit argued that involvement must occur much earlier in the policy development process—not after new program and policy decisions have been made and priorities have been determined.

Solving the acute problem of staff shortages will not radically alter the health status of Inuit.

Medical services in the north are suffering from physician and nurse shortages across the six Inuit regions. Shortages in southern Canada have only exacerbated an already challenging situation in the north. However, this problem is only the tip of the iceberg. If solved, it will maintain and enhance the delivery of care and treatment in Inuit communities. It will allow the health care systems in place to function at maximum efficiency. It may even provide time for medical professionals—especially nurses, who are providing the front-line care in understaffed clinics and health centres across the north—to devote time to prevention, education and health promotion programs. Prevention and promotion were mentioned as goals in interviews with those involved in the delivery and management of health services. They are articulated in mandates and vision statements guiding governments and health boards.

Underlying social and economic problems (including disparities and inequalities in comparison to non-Inuit populations) will continue to impact negatively on health. Until housing shortages are gone, until there is an economy that can support the growing number of young people reaching working age, until the education system can produce more high school graduates, and until a wide range of post-secondary opportunities are available in the north, the situation is unlikely to change. The alternative is to continue to rely on southern-trained doctors, nurses, social workers and managers.

This is not a new analysis. Variations on this theme have been included as recommendations in reports from national, provincial, territorial, regional and community governments and organizations, health boards, Inuit organizations, in evaluations of specific programs and services, and in the Report of the Royal Commission on Aboriginal Peoples. There is a growing consensus in Canada and in the Inuit regions that the system must shift toward primary prevention, population health and a holistic approach to health. These are different words for the same approach, which is to address the underlying living conditions and then health will improve. This approach views medical services and treatment as an essential part of the solution, but so are other elements, such as good, safe living conditions, enough food, something valuable to do, the ability to learn and work in one’s own language, and not to be limited in possibilities because of gender or language or physical ability. These types of changes can take a long time, especially given the number of players and jurisdictions involved in the health field, but the high rates at which Inuit youth are killing themselves, and attempting to kill themselves, and the social problems confronting Inuit society bring an added urgency to the debate.

However, there is one caution. An evaluation of the Indian and Inuit Health Careers Program (Kishk Anaquot 1999: 58) notes that while Canadian decision makers are beginning to accept that other policy areas, such as employment, nutrition, genetics and education, have a contribution to make:

> [t]his argument makes sense in the Canadian urban scenario where people have enjoyed enough access to health care services. However, it has serious implications for those communities in isolated and rural areas where they have not yet had quite enough health services to achieve the health status of the Canadian "plateau"…. In other words, let's not forget those communities where adequate access has NEVER been a reality and can still make a real difference.

Health Canada (1999: 30-31) recognizes many of the issues raised in this report. One recent report concludes:

> Despite improvements in many areas, First Nations and Inuit people continue to have a poorer health status than the general population. This discrepancy in health is, in part, due to the widespread inequities the Aboriginal population faces in the opportunities for health, notably in socio-economic conditions. Any efforts to improve the situation of the Native people need to respect and take into account its cultural beliefs and values and traditional views of the world and offer flexibility in the design and development of programs and services. First Nations and Inuit communities need to be empowered to identify and address their own needs through such means as capacity building, training, and technical and funding support. Although health promotion and disease prevention programs can help some First Nations and Inuit individuals achieve better health, healthy public policies from various sectors need to be developed with the input of Aboriginal communities.

This conclusion was reached by Health Canada based primarily on data collected by the federal government. While one of the weaknesses in the report is the limited amount of Inuit data used,[15] its conclusions are nevertheless apt. In fact, they are absolutely consistent with those reached in this report. One wonders why, if the solutions are so clear, changes in policy are so slow to follow.

[15]Health Canada has recently entered into a contract with the Inuit Tapirisat of Canada to fund a meeting of Inuit regional representatives, federal government departments and relevant provincial and territorial governments to discuss data collection needs.

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NOTE: The Tables contained in this report are summary tables only. The full tables include 36 pages of data with detailed notes and sources for each entry. Copies of the complete set of tables can be obtained by contacting Linda Archibald.