GOVERNMENT OF NUNAVUT

APPLICATION TO HEALTH CANADA'S PRIMARY HEALTH CARE TRANSITION FUND

DECEMBER 2002

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EXECUTIVE SUMMARY

Primary Health Care is the level of care that meets most of the every day health care needs of the population. Primary health care encompasses all first level care and includes acute care, home care, mental health, public health, promotion and palliative care.

From an individual patient's perspective, it is the first contact point with the health care system and the place where basic services are provided. However, primary health care's strength is that it has a much wider focus than just individual level care, for primary health care is also designed to address the health needs of identified populations.

Primary health care is delivered by a variety of providers working collaboratively with clients, their families, and their communities to maintain health and treat illness. To be effective, primary health care requires the full participation of citizens and communities.

Nunavummiut are a young and growing people. Eighty-five percent of the 26,745 people of Nunavut are Inuit. Approximately one half of the people are under the age of 20 years. Population growth was 8.1% between 1996 and 2001, one of the highest rates in the country and the highest in the northern territories. The population distribution of Nunavut, with its small communities and vast distances, offers particular challenges for the delivery of primary health care.

Health Canada and Statistics Canada indicators reveal a huge burden of preventable illness and premature death in Nunavut.

- Life Expectancy at birth is ten years less than that of the average Canadian
- Infant mortality is twice the national average
- Very high rates of infectious diseases, particularly sexually transmitted diseases (approximately 15 times the national rate) and tuberculosis (eight times the national rate)

Compared to the national average, Nunavut's health status indicators, show that Nunavut has:

- 6 times the suicide rate
- 3 times the teenage pregnancy rate
- 7 times the sexual assault rate.

These striking statistics emphasize the critical need for a population health approach. Renewed Primary Health Care, that incorporates community development and empowerment with integrated service delivery, is imperative if Nunavut is to break the ongoing cycle of preventable suffering.

This review of primary health care in Nunavut has highlighted a number of recurrent themes and shortfalls that if addressed could accelerate the primary health care renewal process. To ensure Nunavut's primary health care system is sustainable, effective and

accountable, the Department of Health and Social Services proposes to use its Primary Health Care Transition Fund allocation to undertake a series of staged transitional initiatives that will lead to structural change. These transitional initiatives will consist of a change management process and an information management strategy. A primary health care transition office will support these two initiatives.

Nunavummiut must continue to maintain their unique identity while simultaneously developing the infrastructure, resources and health care capacity to fulfill the vision of Nunavut's founders. The ultimate purpose of this funding application is to enable Nunavut's primary health care system to have the capacity to take the right steps at the right time and in a direction that is right for Nunavummiut.

PART A

SETTING THE STAGE

There is almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to the health care system. The majority of policy experts and health care professionals consider primary health care to be an absolute priority.[i]

The main benefits of primary health care are:

- *More coordinated care – access to a team or network of providers working together to coordinate care across different aspects of the health care system.*
- *Better quality of care – more effective care can be provided at the front lines where people first come in contact with the system. Comprehensive information can assist providers continuously monitor people's health, track their progress and take a broader approach to helping them stay healthy.*
- *Better use of resources – with effective primary health care, people are less likely to rely on emergency departments, should get assistance to help them stay healthy and have coordinated care if they have a chronic disease.* [ii]

WHAT IS PRIMARY HEALTH CARE?

Primary Health Care is the level of care that meets most of the every day health care needs of the population. Primary health care encompasses all first level care and includes acute care, home care, mental health, public health, promotion and palliative care.

From an individual patient's perspective, it is the first contact point with the health care system and the place where basic services are provided. However, primary health care's strength is that it has a much wider focus than just individual level care, for primary health care is also designed to address the health needs of identified populations.

Primary health care is delivered by a variety of providers working collaboratively with clients, their families, and their communities to maintain health and treat illness. To be effective, primary health care requires the full participation of citizens and communities.

EMERGING TRENDS IN PRIMARY HEALTH CARE

The basic principles, rationale and general structure of desired Primary Health Care systems are much as they have been described for many years. Recent reviews of Health Care in Canada[iii] continue to press for action in primary health care, echoing findings of the many commissions and reports preceding them.

There are however, recent refinements and expansions in concepts and approaches that include:

- Increasing recognition that efficient and effective primary health care is the key to financial and organizational sustainability of the health care system overall. This includes increasing understanding that a population health approach is a 'business case' approach.[1]
- Evidence-based interventions at the earliest points in the pathway to ill health, not only result in better health outcomes, but also decrease cost pressures on the system.
- Information, in its broadest sense, plays a pivotal role in the planning, delivery and evaluation of primary health care initiatives.
- There is increasing prevalence of chronic health conditions that require community based prevention approaches as well as coordinated and continuous management of care. Success in these areas requires informed and active consumers.
- The need to examine a range of innovative and flexible models and approaches that are sensitive the needs of diverse communities.
- The utility of technological supports such as telehealth to support high quality local care, particularly in isolated communities.

All of these resonate in Nunavut. The challenges of providing high quality, culturally appropriate care to people in small isolated communities add compelling impetus to the need for primary health care renewal.

PURPOSE OF THIS FUNDING APPLICATION

This application to Health Canada is to access funding from the Primary Health Care Transition Fund to assist Nunavut in accelerating primary health care renewal by supporting transitional programs that will have long term systemic benefits.

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[1] A **population health approach** 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 is as important for the health of a population as are good medical care, primary prevention, health promotion and sound public policy initiatives. [Government of Northwest Territories definition quoted in The Inuit Tapirisat of Canada submission to the Health Transition Fund – *Evaluation of Models of Health Care Delivery in Inuit Regions*; September 8, 2000.]

WHAT MAKES NUNAVUT UNIQUE?

With its distinctive people, geography, economy and government, Nunavut differs fundamentally from other Canadian provinces and territories.[iv]

VAST DISTANCES AND SMALL, ISOLATED COMMUNITIES

At more than 2.1 million square kilometers, Nunavut encompasses 23 per cent of Canada's land mass. The new territory is substantially larger than Quebec (Canada's largest province), three times the size of Texas, ten times larger than Britain, and roughly the size of continental Europe. It is so large that, if independent, it would rank as the world's twelfth largest country.[v]

Nunavut means 'Our Land' in Inuktitut, the language of the Inuit. Within Nunavut, the distances between communities are considerable and the distance to other areas of Canada even greater. There are no roads to connect the communities. Although all the communities, with the exception of Baker Lake, are located by the ocean, shipping is restricted to the summer 'sea lift'. For most of the year the only link between communities is via air. The flight distance between Iqaluit and Ottawa is approximately 2,100 kilometers; Iqaluit to Pond Inlet is some 1,065 kilometers; and, Iqaluit to Kugluktuk is about 2,600 kilometers. Yellowknife, Northwest Territories (NWT) is as far from Iqaluit as Vancouver, British Columbia is from Thunder Bay, Ontario.

Nunavut straddles four time zones - Atlantic, Eastern, Central and Mountain, but only the latter three are used by Nunavut's 25 communities. Parts of eastern Baffin Island, including the hamlet of Pangnirtung, actually fall inside the Atlantic time zone, but the community operates on Eastern time.

Costs of Isolation

As air is the only mode of transportation available year round, the cost of living in Nunavut is high. Similarly, the cost of providing services and their associated infrastructure is high. Isolation limits access to many services at the community and regional levels. Residents of Nunavut need to travel outside their communities for emergency medical care, diagnosis, treatment and to give birth (with the exception of Rankin Inlet and Iqaluit). Emergency medical evacuations to southern hospitals are standard in all regions. Isolation also greatly impedes the recruitment and retention of health care professionals.[vi] There are few Inuit health professionals and most positions requiring professional qualifications are filled by 'outsiders' from southern Canada or other countries.

APPROXIMATE DISTANCES IN NUNAVUT [vii]

Population Size

The population of Nunavut is spread over a vast area and the size of its communities is relatively small. Most communities have a population of 1,000 or less. However, the population growth rate is twice that of the rest of Canada. The table below highlights these unique features of Nunavut's population.

NUNAVUT POPULATION AND PRIVATE DWELLING COUNTS

Place	2001 Population	1996 Population	% Change	Total Private Dwellings in 2001
Canada	**30,007,094**	**28,846,761**	**4.0**	12,548,588
Nunavut	**26,745**	**24,730**	**8.1**	8,177
Arctic Bay	646	639	1.1	**170**
Arviat	1,899	1,559	21.8	**456**
Baffin, Unorganized	75	270	-72.2	**0**
Baker Lake	1,507	1,385	8.8	**464**
Bathurst Inlet	5	18	-72.2	**20**
Cambridge Bay	1,309	1,351	-3.1	**457**
Cape Dorset	1,148	1,118	2.7	**333**
Chesterfield Inlet	345	337	2.4	**103**
Clyde River	785	708	10.9	**160**
Coral Harbour	712	669	6.4	**194**
Gjoa Haven	960	879	9.2	**249**
Grise Fiord	163	148	10.1	**49**
Hall Beach	609	543	12.2	**134**
Igloolik	1,286	1,174	9.5	**324**
Iqaluit	5,236	4,220	24.1	**2,105**
Keewatin, Unorganized	0	0		**0**
Kimmirut	433	397	9.1	**108**
Kitikmeot, Unorganized	0	0		**0**
Kugaaruk	605	496	22.0	**120**
Kugluktuk	1,212	1,201	0.9	**392**
Nanisivik	77	287	-73.2	**75**
Pangnirtung	1,276	1,243	2.7	**403**
Pond Inlet	1,220	1,154	5.7	**308**
Qikiqtarjuaq	519	488	6.4	**150**
Rankin Inlet	2,177	2,058	5.8	**744**

Place	2001 Population	1996 Population	% Change	Total Private Dwellings in 2001
Repulse Bay	612	559	9.5	130
Resolute	215	198	8.6	85
Sanikiluaq	684	631	8.4	156
Taloyoak	720	648	11.1	192
Uningmaktok	5	51	-90.2	5
Whale Cove	305	301	1.3	91

Source: Statistics Canada – 2001 Census

DECENTRALIZATION OF THE TERRITORY

Regional Divisions

Before Nunavut split from the NWT, on April 1, 1999, the government of the NWT was divided into administrative regions. Nunavut opted to retain these regional divisions. The regions are:

- Qikiqtani (or Baffin) Region in eastern and northern Nunavut
- Kivalliq (or Keewatin) Region in the south and central portions of Nunavut near Hudson Bay and north of Manitoba
- Kitikmeot Region in central and western Nunavut and north of Yellowknife.

Most transportation connections, for medical referral, are along a north-south axis, which means that each region has developed its own referral patterns for providing care to residents for services that are not available locally. The Baffin refers to Ottawa or Montreal, the Kivalliq to Churchill or Winnipeg in Manitoba, and the Kitikmeot to Yellowknife in the NWT.

Decentralized Government Structure

From its inception, the Government of Nunavut opted to create a decentralized government. While the core machinery of government (such as the Department of Executive and Intergovernmental Affairs, Department of Finance, Department of Justice and the Legislative Assembly) are located in capital of Iqaluit, a number of headquarters' functions are based in 10 other communities. These communities are: Igloolik, Rankin Inlet, Cambridge Bay, Cape Dorset, Arviat, Gjoa Haven, Kugluktuk, Pangnirtung, Baker Lake and Pond Inlet. Decentralization was intended to extend new employment opportunities to as many communities as possible without compromising the government's effectiveness and to enhance the possibility of participation in the shaping of government across Nunavut's communities.

As was the case when Nunavut was still a part of NWT, Rankin Inlet and Cambridge Bay continue to function as the regional government centres in the Kivalliq and Kitikmeot

respectively. However, as part of the decision to make Iqaluit the capital of the new Territory, the Baffin regional management positions have been relocated to a variety of Baffin communities. For example, the regional office for Health and Social Services is Pangnirtung, while its regional financial and human resources supports are in Igloolik. The regional centre for schools is in Pond Inlet, while the regional centre for Community Government is in Cape Dorset. Sanikiluaq, in the Belcher Islands, is part of the Kivalliq region for health and social services but for all other purposes it is part of the Qikiqtani or Baffin region.

PARTNERS AND STAKEHOLDERS

The Hamlets

Locally elected Hamlet Governments are acknowledged as having a social mandate to provide leadership in all social programs, except education. In 2000, the territorial government dissolved the Regional Health and Social Services Boards, established under the NWT system. At the invitation of the Minister, Hamlets subsequently established Health Committees as vehicles for citizen participation in system governance. Although each Hamlet has committed funding and appointed representatives to these committees, to date they have had little direct role in local health program planning and delivery. Over $3 million of mostly federal funding is provided through the Department of Health and Social Services to Hamlets for wellness programs that are focused on healthy child programs (e.g., Brighter Futures), nutrition, addictions and mental health crisis services.

Nunavut Inuit Organizations

Nunavut Tunngavik Incorporated (NTI) – This birthright organization is the instrument that oversees the management of benefits flowing to Nunavut's Inuit through the *Nunavut Land Claims Act*. It deals with a large network of organizations across Nunavut, most of which flow from the provision of the Act. NTI has a very broad mandate, ensuring that the parties to the *Nunavut Land Claims Act* meet their obligations. It also provides a range of specific benefits to individuals such as: a pension for elders, a program to support Inuit hunters, scholarships and a fund to promote the development of Inuit-owned businesses. NTI's predecessor, Tungavik Federation of Nunavut, signed the historic 1993 Agreement with the Governments of Canada and the NWT. The *Clyde River Protocol* governs the working relations between the Government of Nunavut and NTI.

Regional Inuit Associations (RIAs) – NTI represents all Inuit of Nunavut and partners with three regional associations (Kitikmeot Inuit Association, Kivalliq Inuit Association and the Qikiqtani Inuit Association in the Baffin) to safeguard and advance the rights and benefits of Inuit in their regions. However, the RIAs' mandates go beyond land management and claims implementation. They promote social and business development in their regions and are a potential focal point of regional political activity, especially in health, education and economic development.

Nunavut Implementation Training Committee (NITC) – NITC was created to ensure that Inuit are trained to take positions in the government and in Designated Inuit Organizations (DIOs). NITC provides training funds to DIOs, offers an Inuit scholarship

and supports special, fast-track training for Inuit managers and executives. [NITC was set-up in recognition of the experience of Alaska and other claims regions where, without adequate training, most of the DIO and government jobs, especially the best ones, were awarded to outsiders.]

National Inuit Organizations

Inuit Tapiriit Kanatami (ITK) – ITK represents Canada's 41,000 Inuit and is dedicated to preserving the Inuit identity, culture and way of life. Board members include representatives from NTI, Paukuutit and the National Inuit Youth Council.

Pauktuutit – Pauktuutit is the national Inuit Women's Association and represents all Inuit women in Canada. It works to raise awareness of the social, cultural and economic needs of Inuit women and to encourage their participation in community, regional and national concerns. Pauktuutit is recognized for its work on culturally sensitive issues such as substance abuse, smoking, midwifery, family violence, youth suicide, justice, housing and the threat of HIV/AIDS among Inuit.

Inuit Circumpolar Conference (ICC) – The ICC is a non-government organization that represents the 135,000 Inuit of Chukotka (Russia), Alaska, Canada and Greenland in the international arena of environmental and social initiatives

PROVISIONS TO REFLECT THE POPULATION PROFILE IN EMPLOYMENT

The territory of Nunavut was established under the statutes of Canada *Nunavut Act* on June 10, 1993. The *Nunavut Land Claims Agreement Act* came into law at the same time as the *Nunavut Act*.

Among other provisions relating to land use and royalties, the *Nunavut Land Claims Agreement Act*, asserts that Inuit be trained to take key roles in employment and contracting. In the context of health and social services, the provisions which have greatest significance are Articles 23 and 24. They specify the following:

- Inuit employment in the government will eventually be proportional to the number of Inuit in Nunavut's population - 85 per cent.
- Policies ensuring that federal and territorial government contracts awarded for Nunavut-destined projects see increased participation of Inuit firms.
- Training and education provided where needed, and labor force hirings within contracted firms to reflect proportion of Inuit in Nunavut.[viii ix]

The key objective of these provisions is to encourage self-reliance and the cultural and social well-being of Inuit. That these ideals are fulfilled is critical to the core vision of Nunavut; that they are not currently being adequately fulfilled in the delivery of health care is problematic. Currently, professional health care providers are mostly non-Inuit and mostly trained outside the territory.

THE ECONOMIC REALITY

Nunavut is the most fiscally-dependent jurisdiction in Canada as measured by reliance on federal funding. Ninety-four percent of the Government of Nunavut's revenue comes from the federal government, whereas in the NWT it is 81 per cent and the Yukon 71 per cent.[x] The Conference Board of Canada has recently prepared a report for the Nunavut Economic Development Strategy.[xi] The main findings include:

- Back-to-back increases in real GDP (4.5% in 2000 and 3.7% in 2001)
- Improved economic opportunities in fishing, sealing, food processing, tourism, and mining. This is based on the work of government, Inuit organizations, non-government agencies and business action groups
- Nunavut continues to lag behind the NWT and the rest of Canada in terms of health status and education
- Crime overall and family violence in particular, continue to be significant social problems.
- Continued high demand for social housing, particularly in light of the growing population and the absence of significant federal contribution to new social housing
- Lack of high speed internet hampers connectivity
- Educational attainment is an area that requires great attention. There are few comparable indicators of educational achievement available, but high school completion rates and post secondary attendance rates are much lower than elsewhere in Canada
- Health sector infrastructure is lacking
- There are gaps in health human resources
- There is a need for ongoing workforce development overall
- Ongoing need for common vision and a united strategy to enable horizontal integration and cooperation of programs, strategies and organizations.

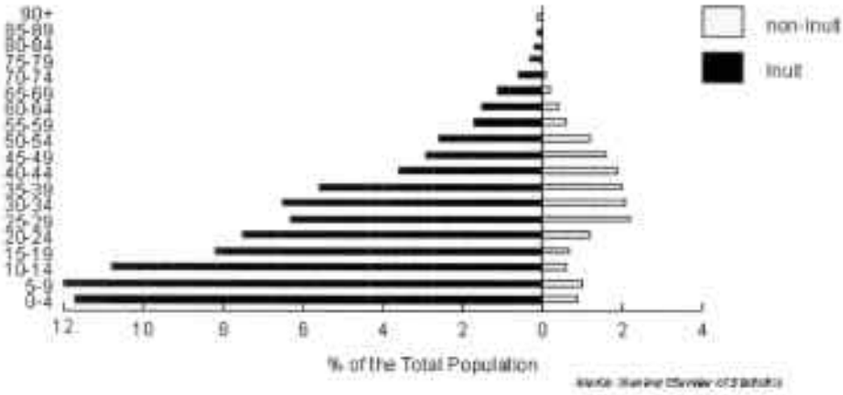
THE HEALTH OF THE PEOPLE OF NUNAVUT

Despite improvements in many areas, First Nations and Inuit people continue to have a poorer health status than the general Canadian population. This discrepancy in health is, in part, due to the widespread inequities the Aboriginal population faces in the opportunities for health, notably in socioeconomic conditions.[xii]

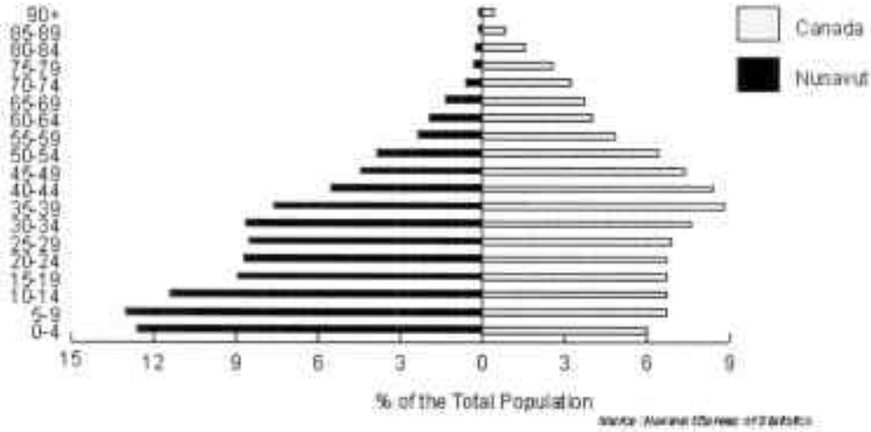
Studies show that young Aboriginals are more often exposed to problems such as alcohol abuse and drug addiction than other Canadians of the same age. Combined with pervasive poverty, persistent racism, and a legacy of colonialism, Aboriginal peoples have been caught in a cycle that has been perpetuated across generations.[xiii]

Nunavummiut are a young and growing people. Eighty-five percent of the 26,745 people of Nunavut are Inuit. Approximately one half of the people are under the age of 20 years. Population growth was 8.1% between 1996 and 2001, one of the highest rates in the country and the highest in the northern territories.[xiv]

Population Pyramid, Nunavut, by Ethnicity, 2000



Population Pyramid, Nunavut and Canada, 2000



The primary health care needs of such a young population are different from the typical profile in North America. Perinatal health is a major issue. The development of innovative approaches to the delivery of high quality maternity care is a priority for the health system. Focus on child and adolescent issues has the greatest potential to improve community health.

Nunavut continues to lag behind the NWT and the rest of Canada in terms of health status and education. Crime overall and family violence in particular, continue to be significant social problems.[xv]

In September 2002, the Government of Nunavut, Department of Health and Social Services, released the *Report on Comparable Indicators for Nunavut and Canada.*[xvi] The extensive work that was necessary to prepare this report highlights the significant challenges in information availability. There is a lack of consistency in the collection of information about care services at the delivery level. Paper records of varying formats and coding accuracy are submitted for data entry centrally. This makes representation of the utilization of these services, in the context of health status, particularly problematic.[xvii] Health Canada and Statistics Canada have embarked on a national initiative to examine the burden of disease and risk factors, considering not just mortality information but also years lost to disability. If Nunavut is to take advantage of evolving planning tools such as these it is critical that the data elements be available and reliable.

Review of Nunavut's 2001 indicators reveals a huge burden of preventable illness and premature death.

- Life Expectancy at birth is ten years less than that of the average Canadian
- Infant mortality is three times the national average
- Very high rates of infectious diseases, particularly sexually transmitted diseases (approximately 17 times the national rate) and tuberculosis (17 times the national rate)

Compared to the national average, Nunavut's health status indicators, show that Nunavut has:

- 6 times the suicide rate
- 6 times the teenage pregnancy rate
- 7 times the sexual assault rate.

These striking statistics emphasize the critical need for a population health approach. Renewed Primary Health Care, that incorporates community development and empowerment with integrated service delivery, is imperative if Nunavut is to break the ongoing cycle of preventable suffering.

> *Statistics cannot possibly capture the creeping devastation that follows each report of 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….No matter how the numbers are calculated – at the community, regional and national level – they will never truly reflect the terrible impact of hearing about yet another death by suicide.[xviii]

CURRENT ORGANIZATIONAL PROFILE OF PRIMARY HEALTH CARE IN NUNAVUT

STRUCTURE OF HEALTH AND SOCIAL SERVICES

In April 2000, one year into its mandate, the Government of Nunavut dissolved the three regional health boards established under the Government of the NWT in the 1980s. The Department of Health and Social Services now directly manages these regional health services and the health board staff became departmental employees.

PRIMARY HEALTH CARE PROFILE

General Profile

The population distribution of Nunavut offers particular challenges for the delivery of health care. A large number of very small communities means that some of the services typically considered part of the primary health care team, such as physiotherapy, occupational therapy, pharmacy, and specialized disease management providers, cannot feasibly be incorporated into the delivery systems of most communities. Practitioners must be prepared to be generalists and seek support for specialized services from afar. With Nunavut's young population, child health is a priority issue, yet there are very few rehabilitation services for children in Nunavut. The core primary health care service of care planning for children with special needs is not currently supported by paediatric rehabilitation consultation.

With the exception of Iqaluit, Community Health Centres (CHCs) are located in the other 24 population centers in the three regions of Nunavut. CHCs serve as a local hub for providing primary health care services. Iqaluit is served by the Baffin Regional Hospital, while public health services operate at a separate location. Typically, CHCs are staffed by registered nurses who provide acute care, on call services with 24/7 coverage and public health nursing services. CHCs have Inuit clerk-interpreters who are a vital cultural link with the community and an essential element of all services delivered in Nunavut. Most CHCs also have a Community Health Representative (CHR), a position intended to provide community development and assist with implementing population health promotion and prevention activities. However, not all of the CHR positions are filled.

In most communities, clinic nurses also fill a public health role, delivering maternal and child health, immunization, adult and chronic care programs, as well as tuberculosis and other communicable disease control programs. The immediate demands of acute care often take precedence over non-emergency clients, especially when staffing is low, consequently community nurses have difficulty delivering some of the public health programs, such as Well Woman or Well Man clinics.

Physicians fly into all of Nunavut's communities except for Iqaluit, Rankin Inlet and Pond Inlet. There are 10 physician FTE's in the Baffin region, 7 family practitioners and 3 specialists, who are reimbursed through service contracts. There is one fee-for-service

general practitioner in Iqaluit. Physician services (both primary care and specialist), rehabilitation services, speech language pathology, audiology and other consultants (e.g., psychiatry) are provided for the Kivalliq Region through a longstanding contract with the Northern Medical Unit, University of Manitoba, Winnipeg. The contract provides tertiary treatment, education and research. The Department has liaison nurses in both Churchill and Winnipeg to ensure communication with nurses and families in home communities and provide discharge planning. The Kitikmeot has two unfilled physician positions, allocated for Cambridge Bay and Kugluktuk. The total physician to population ratio for Nunavut (with all available contract positions filled) is 14.5 doctors/29,000 people (1 physician /2000 people) compared to the national figure of 1 physician/524 people.[xix] The majority of specialist services are provided outside of Nunavut with an annual budgeted medical travel amount of approximately $30 million in 2002/03 (this does not include the reciprocal billing). A comprehensive examination of physician services within and outside the territory has not been undertaken and physician service profiles are not routinely reported.

Primary health care services in Iqaluit are provided through a physician staffed outpatient clinic located at the hospital. Public health, mental health and social services are all provided at separate sites in the community.

In the other communities, Chronic Disease Clinics (CDC) are scheduled on days when physicians visit CHCs. Nurses develop a roster of patients to be seen and physicians act as medical consultants to the nurses for patients with complex care needs. In some communities, social workers and registered psychiatric nurses are part of the CDC team providing case management for people with chronic mental health problems. Should residents of Nunavut require emergency or tertiary treatment services, each region has its own north-south referral arrangement with Baffin referring to Ottawa and Montreal, Kivalliq to Winnipeg or Churchill, and Kitikmeot to Yellowknife

Birthing Services
Rankin Inlet in the Kivalliq Region is the only Nunavut community, at this time, to offer midwifery services. Qualified midwives provide antepartum, interpartum and postpartum care for women assessed as low risk. In other communities of the Kivalliq and Kitikmeot regions, pregnant women leave their families and go to referral centers two or more weeks before their delivery date (the timing depends on the risk status of the woman). In the Baffin Region, women are transferred to the Baffin Regional Hospital in Iqaluit.

Social Services
Social workers, like nurses, have a broad range of responsibilities and significant autonomy in their practice. They provide generic services for children and families as well as adult counseling services, mental health services and, in a few communities, probationary services. In some communities, there is liaison and case management integration with mental health and nurses at community health clinics. In other communities, social workers and community social services workers tend to function independently as child protection investigators, apprehending children at risk, under the provisions of the *Child and Family Services Act*.[xx]

Mental Health and Addictions
It is important to note that Nunavut's Addiction and Mental Health Strategy, March 2002, has based its operational principles on a primary health care model that stresses health enhancement, illness prevention and community participation – priorities that are very close in spirit to the Bathurst Mandate.[xxi] Nunavut communities have had mental health and addictions services at the forefront of their attention because of suicides and chronic addiction and mental health problems.

In many communities, former hamlet addiction workers have been brought into the Health and Social Services department as 'Wellness Counselors'. Wellness Counselors have been the front-line mental health staff in the Baffin Region, they are trained to do assessments, counseling, marital support, abuse and addictions counseling. They have a working relationship with nurses, CHRs and social workers. In the Kivalliq and Kitikmeot regions, hamlets continue to operate Alcohol and Drug Addictions programs, funded by Health and Social Service contributions. Referrals to facility-based care are initiated by either wellness counselors or hamlet alcohol and drug employees, and are approved by designated Health and Social Services regional coordinators. One of the Kivalliq's five Registered Psychiatric Nurses (RPNs) functions as the Director of Mental Health Services for both the Kivalliq and the Kitikmeot. The Kivalliq has RPNs in five out of eight communities. The Kitikmeot has three RPNs and a regional Mental Health/Drug and Alcohol Manager. In some communities, there may be no mental health worker. Baffin has, in addition to a director of Mental Health and Wellness Services, 5 RPN positions, 8 wellness counselors and a regional psychologist. There are 5 child and youth outreach workers across Nunavut.

A transitional facility for people with moderate and severe mental illness has recently opened in Iqaluit. This facility provides residential care to help clients reintegrate into the community.

Both the University of Toronto and the Northern Medical Unit provide psychiatric outreach visits to Baffin and Kivalliq respectively. Selkirk Mental Health Center in Manitoba provides in-patient care, education and clinical supervision for the whole of Nunavut.

Home and Community Care Services
The First Nations and Inuit Health Branch of Health Canada introduced Home and Community Care services in 1999. Prior to starting up these Home and Community Care Services, communities held focus groups to identify needs of seniors and chronically ill residents in the community. In the Kitikmeot and Kivalliq regions, most communities have been allocated funds for a Home and Community Care (HCC) nurse. Most of the nurses work out of the Health Centers, but in Baker Lake, the Hospice Society operates the service. Baffin Region has four communities with home care nurse positions and three are working out of the health centers.

Members of the public or health workers can refer clients to the HCC Program. Once a client is referred, the HCC nurse will do an assessment and develop a care plan. Progress report forms are completed and fixed to the client's record in the Health Center chart. The Health Clinic Nurse will follow up if further assessment or chronic disease management is required. All regions have held orientation sessions for home support workers. The Health and Social Services Department has just signed an agreement to fund orientation sessions through the QIA. This funding recognizes the commitment home support workers make in providing a service that meets program standards.

Under supervision from the HCC nurses, support workers provide personal care and will do dressings and administer IVs. Some workers administer directly observed therapy for tuberculosis. In most regions, HCC is moving into health promotion and prevention for seniors. In Pond Inlet, for example, an elders group has been formed for health promotion and there is some interest in a diabetes support group for Pangnirtung when they hire their HCC nurse. There are opportunities for integrated care as those receiving home care services are also seen by nurses and physicians in Chronic Disease Clinics at the Health Centers.

Other Services

There are a number of regional facilities that provide critical back-up for the community management of persons with mental health and addictions. In the Baffin Region, the Baffin Hospital has the capacity to treat emergency mentally ill or suicidal clients. There is also the Agvvik Society Shelter for battered women and children and a seniors facility. Iqaluit also has a homeless shelter and in Cape Dorset and Pangnirtung, there are women's shelters. Kivalliq has a family violence shelter and home for handicapped adults in Rankin Inlet, and a territorial long term care facility in Chesterfield Inlet. Kitikmeot has two short-term violence shelters and a group home in Cambridge Bay.

Under the auspices of the Department of Health and Social Services, the Government of Nunavut provides a Dental Program, primarily to children in school based clinics. Seventeen of Nunavut's 26 communities have positions for resident dental therapists who have been trained at the Saskatchewan Indian Federated College's National School of Dental Therapy in Prince Albert. There is a shortage of Dental Therapists; currently, there are less than 10 in the Territory. Where they do exist, Dental Therapists provide outreach services to neighbouring communities. The Non-Insured Health Benefits Program provides funding for a broad range of adult clinical dental care and dental services, including orthodontics, dental surgery and denturist services. In the Baffin and Kivalliq regions, the region administers dental services. They are provided by visiting dental practitioners in the health units. In the Kitikmeot region, a contractor has private clinics in three communities, which provide both contracted and fee for service dental services.[xxii]

The Department of Health and Social Services has a Health Promotion section which is currently involved in a number of activities including tobacco reduction, nutrition, fetal alcohol syndrome and diabetes. The Department works with Hamlets and community

groups to provide health promotion programs such as Brighter Futures, Head Start and Prenatal Nutrition Programs.

INFORMATION SYSTEMS

- ✓ How well is the primary health care system meeting the needs of the people?
- ✓ How effectively is the health system delivering service?
- ✓ How efficient is the health care system?

Routinely collected health information should provide the evidence base for answers to these questions and provide the platform for decision making in health care planning, funding, delivery and evaluation. The key for turning program data into useful information is the ability to link data across program areas and to analyze and review from a number of perspectives.

Nunavut's decentralized government structure and its numerous small communities spread across almost two million square kilometers, demand a communication and information infrastructure that will connect and inform its citizens, providers and planners.

Patient information is relayed from the field to headquarters through a variety of paper-based documentations. In an effort to have useful information for local service delivery, many of the communities have developed their own data and reporting systems, some using Access database or others simple spreadsheets. Many nursing stations have developed paper systems to recall patients for immunizations and chronic care follow up.

The Information Technology (IT) Section of the Department of Health and Social Services has yet to formally articulate a strategic plan for information systems development. The stated primary long-term goal within the IT Section is to have all of the essential systems for Nunavut's primary health care and the related administration integrated. Several newly developed systems have been designed for use as separate modules within one overall, integrated system, using the Nunavut Health Care Number as the key identifier.

Presently there are a number of independently operating data-bases that collect information and in some cases analyze it and routinely report. There are concerns about data quality in many of these systems as data entry is occurring distantly from site of service and completeness is an on-going challenge. Much of the data is collected and not reported back to the service providers, recipients or public, thereby eroding the motivation of staff on the front lines who, in turn, need to ensure that the information is correct and complete

The Community Health Reporting System (CHRS), for example, receives boxes of paper documents (30,000 pieces of paper per month) with encounter records from the CHCs which include type of visit and diagnosis. There are ongoing issues with record completion and coding accuracy. These records are then entered into a data base and

reported on a monthly basis. However, it is very difficult to pull simple statistics, such as immunization rates, from this information system.

A range of information services are managed through the Health Insurance section in Rankin Inlet. This office is responsible for the management of Vital Statistics, Health Care Plan Number assignment (through NWT at present), physician services, hospital services, reciprocal billing, Non-Insured Health Benefits, Extended Health Benefits. A data warehouse for this information is maintained but a description of its contents and capabilities is not available. Reporting and analysis from these systems is undertaken on an ad hoc basis. Vital Statistics for births and deaths that occur within Nunavut are reported monthly. There are no other routinely generated public reports or administrative reports produced from these systems.

The myriad of systems and reporting forms for clinical care and for administration are frustrating and problematic for staff at every level of the system. With such little reliable and reproducible data it is a significant challenge to develop useful planning or evaluation information for the functioning of the system at any level. Opportunities for the linkage of data are impeded by the administrative structure and the lack of compatibility of data systems (many still paper based). All of these factors, combined with the ongoing difficulty in the recruitment and retention of staff trained in data analysis hamper efforts to provide a comprehensive picture of the health of the people of Nunavut, the health services that they receive and the outcomes of those services.

The diagram below demonstrates the myriad of data collections points that have been developed just for health care in Nunavut

THE SEPARATE COLLECTIONS OF HEALTH RELATED DATA IN NUNAVUT

Data about Health Status

- Communicable Disease Data Base
- Tuberculosis information
- Cancer Registry
- Cervical Screening Registry
- Nunavut Household Survey
- Canadian Community Health Survey
- Vital Statistics
- Suicide Data base
- National Diabetes Surveillance System

Data about Health Services

- Community Health Reporting System
- Individual Health Centre immunization and chronic disease management tracking systems
- Environmental Health (water quality database)
- Physician services within Nunavut ('Shadow billing')
- Fee for service physician services out of territory
- Medical Travel Data base
- Hospital Data – Health Records Abstraction (Iqaluit)
- Hospital Data out of territory
- Hospital Pharmacy Data
- Laboratory Data (different systems in each region)
- Home care database
- Adoption Database
- Children in care
- Adults in care

29,000 Residents of Nunavut

Data for Administration

- Registration and designation of unique identifier
- Non-insured Health Benefits Claims
- Extended Health Benefits Claims
- Physician and hospital services (inside and outside the Nunavut) claims processing/ reciprocal billing
- HR data (paper only)
- Payroll (Government of Nunavut-wide)
- Finance system (Government of Nunavut-wide)

TELEHEALTH

In 1999, the Government of the NWT initiated a 'Telehealth' pilot project by placing Telehealth communications equipment in six communities, three of which were located in what is now Nunavut. These communities were Pond Inlet, Cape Dorset and Iqaluit. In 2000, two additional communities were added to the network at Gjoa Haven and Cambridge Bay. The program was never fully implemented, primarily due to lack of properly trained and supported staff as well as technical issues.[xxiii]

In recognition of the uniqueness of the Territory of Nunavut, a large land mass with small isolated communities, and the corresponding potential benefits Telehealth could add to healthcare delivery in Nunavut, the *Ikajuruti Inungnik Ungasiktumi* Telehealth Network Project was subsequently initiated and funding was secured from Health Canada in March of 2001. The project was targeted to run from April 1, 2001 through March 31 2003.

The current status on the Telehealth project is that installation and training is underway in 15 sites in: Iqaluit, Pond Inlet, Cape Dorset, Arctic Bay, Pangnirtung, Iglulik, Grise Fiord, Rankin Inlet, Arviat, Baker Lake, Chesterfield Inlet, Sanikiluaq, Cambridge Bay, Gjoa Haven and Kugluktuk. The training team spends five days in each site training staff. Training materials include a quick reference guide, a training manual and one-on-one instruction.

The Honourable Edward Picco, Nunavut's Minister of Health and Social Services, has claimed that telehealth has the potential to be a lifesaver in Nunavut, as it can provide access to health care in a region where people live in communities some 2,000 km apart.[xxiv] Recognizing these potential benefits, the Government of Nunavut has signed agreements with the governments of Australia and Newfoundland and Labrador to share information and new developments in telehealth. Nunavut expects that increased use of telehealth technology will result in both cost savings and in improved health for its residents.[xxv]

The IIU Telehealth Network concept document puts the utility of telehealth into perspective:

> *Telehealth programming does present major opportunities but it is not a panacea and should not be regarded as a single solution or even the most important solution in resolving the challenges of healthcare delivery to the residents of Nunavut. In the final analysis it will be the activities of clinicians and residents that will maximize the benefits of telehealth by appropriate use of telehealth programs and technology.*[xxvi]

INFORMAL PROVIDERS

Social support is a key determinant of health. The value of extended families and the ethic of sharing are both central to Inuit culture. Additionally, there is an informal

network of 'wise people' and 'healers' in the community. These providers are often not 'visible' but the recognition of this self-care network and enabling it to flourish is critical to the successful evolution of primary health care in Nunavut.

FACILITIES AND EQUIPMENT

The Government of Nunavut annual budget allocates about $75 million to capital projects to provide for communities' needs for new buildings, renovations and new or replacement equipment. This is considered insufficient to keep up with effective capital planning. Many community health centres are older than 15 years and are neither functional nor adequate. [For example, the Iqaluit hospital was built 40 years ago, the Cambridge Bay Health Centre 44 years ago, Pangnirtung Health Centre and Igloolik Health Centre 26 years ago, and Rankin Inlet Health Centre 32 years ago.] Furthermore, as the capital budgets are already stretched, the regions do not adequately budget for renovations or the replacement of medical equipment and biomedical maintenance.

> *Planning design and construction schedules* are *linked at the hip to sealift barge re-supply dates. You get these dates and then work your schedule backwards to allow for tendering and awarding of contracts by the GN [Government of Nunavut] and ordering of materials by construction contractors and delivery on whatever is the first re-supply date. Some communities only have one re-supply barge or ship. Some re-supply is as early as July and others are not until September due to the presence of ice.*[xxvii]

Space for meetings, group sessions and the like is limited, as even though most health centres started out with some such space, it has been quickly converted to accommodate new programs and/or staff. For example, the Public Health Centre opened in Rankin Inlet just three years ago with a teaching room. However, as no plans had been made for the establishment of physiotherapy or occupational therapy positions, the teaching space has been re-allocated to office space for these providers.

Input into the Planning of Health Facilities

Planning is frequently not informed by utilization statistics as collection of these statistics is sporadic and not standardized.

> *Without utilization data, it is impossible to accurately project for future health services utilization. Social Services has never had an overall data base for utilization and ...we usually ask the social worker to describe a typical day, week and construct utilization information from there.*[xxviii]

Staff turnover, the newness of the Government, limited needs assessments and lack of a shared strategic vision were all citied as contributing to the challenges with capital planning.

> *The last thing they think of is where is the activity going to take place and what do the caregivers require in that space. With all the new initiatives ....all health centres are maxed out. Just in the last month a dental contract was changed in the Kitikmeot and now the dentists will be working out of public health rooms or other space in Health Centres.*[xxix]

Nunavut seeks community input into the planning of its new health facilities. The issues are explained on local radio call-in programs and residents phone in to chat about their ideas and needs.

NUNAVUT'S VISION

THE BATHURST MANDATE

The Bathurst Mandate - *Pinasuaqtavut* is a detailed plan that addresses the expectations and needs of the people of Nunavut. This compelling agreement was made by the government of Nunavut, with the help and inspiration of many people and organizations across the Territory.

It is extremely relevant that the priorities expressed in the Bathurst Mandate, for the next five years, are: Healthy Communities, Simplicity and Unity, Self-reliance and Continuing Learning. The Bathurst Mandate, therefore, underpins the objectives of primary health care. Extracts from the Bathurst Mandate are provided below:

The Bathurst Mandate - Pinasuaqtavut[xxx]
That which we set out to do - Our hopes and plans for Nunavut

1 Healthy Communities

We believe that:

The health of Nunavut depends on the health of each of its physical, social, economic and cultural communities, and the ability of those communities to serve Nunavummiut in the spirit of *Inuuqatigiittiarniq*; the healthy inter-connection of mind, body, spirit and environment.

Principles that will guide us are:

- People come first;
- People are responsible and accountable for their own well being;
- Nunavut needs to provide options and opportunities which build the strengths of individuals, families and communities;
- We acknowledge and will respond to the challenges of substance abuse, violence and loss as individuals, families and communities;
- Building the capacity of communities will strengthen Nunavut;
- All levels of government working together will strengthen Nunavut.

2 Simplicity and Unity

We believe that:

Simplicity in the processes of government encourages access by all; makes the tasks more focused and more achievable; and invites participation.

Principles that will guide us are:

- Inuit Qaujimajatuqangit will provide the context in which we develop an open, responsive and accountable government;
- By developing programs and services which are fair, understandable and easy to access we will encourage public participation and create accountability;
- Every activity and expense must have a productive purpose;

- Simplicity does not mean uniformity - diversity in approach can build on unique strengths, resources and ways of doing things;
- MLA's will be respected as important sources of community opinion;
- Cooperation will be the operating standard at every level.

3 Self Reliance

We believe that:

As individuals we are each responsible for our own lives and responsible through our own efforts and activities to provide for the needs of our families and communities;

As communities and as a government we are connected to and reliant on each other to care for those in need, to establish common goals, and to secure the resources required to achieve those goals;

As Nunavummiut we look to support ourselves and contribute to Canada through the potential of our land, the responsible development of our resources and the contributions of our peoples and our cultures.

Principles that will guide us are:

- We will work within our means;
- We will incorporate traditional activities and values into new strategies to participate actively in the development of our economic resources;
- We will build on our strengths, respecting and highlighting the unique elements of our residents, communities, and the environment and economy in Nunavut;
- Nunavut residents should receive every opportunity to benefit from public dollars spent in and by Nunavut;
- Full and willing commitment to the Nunavut land Claims Agreement will be the standard;
- Nunavut can and will contribute to our country, as a committed and active participant in the life of Canada, and to the circumpolar world as an active Arctic neighbour.

4 Continuing Learning

We believe that:

To achieve the dreams of Nunavut we all need to listen closely and learn well in order to acquire the skills we need to increase our independence and prosperity.

Principles that will guide us are:

- The value of teaching and learning shall be acknowledged at all levels and from sources inside and outside of our communities;
- Learning is a lifelong process;
- Equal opportunity and equal access across Nunavut is fundamental to our success;
- It is important to recognize all of the potential teachers in our communities, beginning with elders and in families;
- Land and language skills and respectful pride in our cultures and languages are fundamental for adults and children;
- Our education system needs to be built within the context of Inuit Qaujimajatuqangit;
- Respect for individuals is the basis of effective learning and a healthy workplace.

INUIT QAUJIMAJATUQANGIT POLICY

Inuit Qaujimajatuqangit – literally 'that which are long known by Inuit'. The guiding principles of *Inuit Qaujimajatuqangit* for the Department of Health and Social Services are *Innuqatigiittiarasukniq* (work to stay as acquaintances) and *Piliriqatigiittiarasukniq* (work to stay working together). The Department looks to the Elders to preserve and to maintain *Inuit Qaujimajatuqangit*.

The Department of Health and Social Services recognizes that the Inuit of Nunavut have vast knowledge in *Inuit Qaujimajatuqangit* through living in close harmony with the land from the past and that this knowledge continues to apply today. The Department will continue the use of and the support of *Inuit Qaujimajatuqangit* in its practical application.

The Department of Health and Social Services has committed to recognize that *Inuit Qaujimajatuqangit* is a valid and essential source of knowledge about the natural environment, about the use of natural resources, and about the relationship of people to the land. *Inuit Qaujimajatuqangit* is also a valid and essential source of knowledge about peoples' relationships with each other and the formation of healthy communities. *Inuit Qaujimajatuqangit* provides guiding principles for governance.

VISION AND GOALS OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Mission

To promote, protect and provide for the health and well being of Nunavut residents in support of leading self-reliant and productive lives.

Founding Principles

- ***People oriented*** - All activities of our system will support an approach that places people first
- ***Culturally sensitive programs and services*** represent the values, knowledge, beliefs and cultural distinctiveness of Nunavut
- ***Continuum of care*** - Activities of our system will support the full continuum of care: prevention, promotion, treatment, continuing care and rehabilitation
- ***Seamlessness*** - Programs and services will fit together and be integrated with other government and non-government services
- ***Sustainability*** - Our system will operate in a way that is accountable, sustainable and responsive to the needs of its people
- ***Responsibility*** - Individuals, families and communities have responsibility in achieving health, well-being and self-reliance

Goals

- Improve the health status of Nunavummiut
- Provide supportive environments for individuals, families and communities in making decisions that affect their health, well-being and independence
- Deliver integrated and coordinated health and social services to individuals, families and communities
- Develop healthy public policy
- Be a Department that is accountable and responsive to the people of Nunavut; that delivers flexible and excellent programming; and, that is able to demonstrate effective use of public resources.

THE KEY FEATURES OF PRIMARY HEALTH CARE

- Care is focused on the **client's needs**
- Services are designed to address the health needs of an **entire population** or catchment area
- Care is easy to **access** because it is provided as close as possible to where people work and live and is available at appropriate times
- Care is **coordinated** and linked within primary health care as well as with other levels of care. As the first point of contact with the system, clients are screened to ensure appropriate and effective use of the health care system
- Care is **responsive** to the needs of the local community. There are mechanisms in place to involve the community and/or special populations.
- There is an **ongoing** or continuous relationship between consumers of care and providers
- There is a **comprehensive** range of services to address the health needs of individuals and the population/community, e.g., episodic, diagnostic, educative, preventative, rehabilitative and palliative
- Care is delivered by **interdisciplinary** teams of providers, e.g., cultural interpreters, doctors, nurses, dentists, pharmacists, home care, mental health, physical therapists, etc. Care is delivered by the most appropriate provider in the most appropriate setting.
- There is **consistent quality** of care and mechanisms to ensure efficient management of resources, accountability and appropriate outcomes.

THE SYSTEM IN NUNAVUT AS MEASURED BY ITS OWN VISION AND THE OBJECTIVES OF THE PHCTF

> *More often than anything else, people expressed a desire to receive information from government. Whether youth were consulted or health care professionals, carvers, workers, or community members, there was a near-universal demand for*

> *information. This so frequently expressed desire indicates a strong need of Nunavummiut to know what government is doing about issues that affect their lives. The other point that was expressed nearly as frequently was a wish for government departments to coordinate their efforts....One more common thread runs through virtually all consultations: the dual need for training and for meaningful employment opportunities.*[xxxi]
>
> *Geography is, in fact, a determinant of health.*[xxxii]

Nunavut's vision of the future, as expressed in the Bathurst Mandate, the *Inuit Qaujimajatuqangit* and other polices that support the maintenance of traditional Inuit values; as well as in the very statutes that brought about the creation of the Territory, all support, reinforce and are congruent with the principles and objectives of renewed primary health and a population health approach.

Being mindful of the Health Canada's objective and incorporating the vision, insights and needs of the people of Nunavut, as expressed in this and numerous consultations, Nunavut's objective for this application to Health Canada's Primary Health Care Transition Fund has been to identify and move to implement improvements which will, over the course of approximately three and a half years, have the greatest impact in assisting Nunavut's formal and informal health care system to provide effective and sustainable primary health care services. The criteria that will guide this process are identified below:

- ✓ ***Accessible*** – supporting temporal (24 hours a day, seven days per week), geographic, financial, physical (e.g., location and access for individuals with physical challenges) and culturally accessibility.
- ✓ ***Technologically appropriate*** – the most appropriate technologies are used in planning for the use of new technologies incorporates appropriate preparations (for providers, clients and administration).
- ✓ ***Preventative*** – the system provides information and services which effectively promote well-being, prevent disease and injury and reduce harm.
- ✓ ***Engaging*** – establishing priorities and operationalizing the primary health care system to directly engage the patient and the population being served, meaningfully and continuously.
- ✓ ***Intersectoral and interdisciplinary*** – respecting the privacy of individuals and confidentiality of client information, services focus on client populations (as opposed to provider of system needs), engaging other sectors and disciplines in an uncomplicated and habitual manner.

How Nunavut's Current Primary Health Care System stacks up against its Vision for an Effective, Sustainable System

I won't go to the health center anymore – they don't know me. Every time it's a different nurse I have to tell the same story. They try to give me pills and they don't even know what is wrong. I don't know about the doctor I just don't know him or anything about him, he doesn't know me. My family has a doctor in Winnipeg if we are sick we call him and he can get us into a specialist or for in for tests. I try to keep myself healthy I eat good foods and I don't drink anymore. When I was a teenager I used to drink a lot and I got depressed. I thought about suicide and went to the health center they sent me to a social worker and the social worker sent me to Yellowknife. It was horrible, I needed to be with my family to get better and I was far away from them. Finally I just asked myself about what I was doing and used my strength inside to get better.[xxiii]

Criteria	Current Strengths	Current Challenges
Accessibility	• Long tradition of informal system of care providers • Emergency care is available 24 X 7 at nursing stations in all communities • Clerk interpreters in health centres • Community health representatives position in many communities • Birthing centre in Rankin Inlet • Medical transportation system for emergencies and higher level care • Strong and formalized links with southern medical centres	• Provider teams not co-located in communities • Isolated communities and large distances • Nunavut ranks lowest in Canada on most health indicators • Lack of Inuit care providers • Few providers speak Inuktituk and lack of health information in Inuktituk • Limited primary health services to address children's needs. • Recruitment and retention of full complement of staff • Lack of a comprehensive range of services (e.g., rehabilitation, palliative care) • Lack of adequate information for the monitoring and improvement of quality • Low physician to population ratio. • Heavy dependence on itinerant and distant medical services • Secondary services all outside communities • Narrow range of primary health care providers

Criteria	Current Strengths	Current Challenges
		• Aging infrastructure and lack of physical accessibility in some communities
Technologically appropriate	• Telehealth installations in 10 communities • Paper records and some data entry procedures established in all sites	• Internet connections depend on satellite links • Many health centres are not connected to government intranet • Digital radiography not available • Clinical records are in paper format • Lack of accessibility to information of all kinds
Preventative	• Targeted initiatives with dedicated funding (e.g., Healthy Futures, HeadStart) • Wellness Workers/Addiction Counselors funded in most communities • Tobacco reduction strategy in place • Often medical care and public health services are provided by same provider at same location	• Nunavut ranks lowest in Canada on most health indicators • High rates of TB, STDs and other preventable illnesses and injuries • High rates of suicide, family violence and crime • Programmatic and administrative separation of public health and care services • Significant acute care demands on health centre staff erodes time available for prevention
Engaging	• Vision, values and formalized policy statements, e.g., *Inuit Qaujimajaatuqangit* Policy are clearly defined • Health Committees of Hamlets are established to facilitate community input • Nunavut Household Survey and Canadian Community Health Survey collect information directly from consumers and could have utility for planning and evaluation	• No systematic cross-orientation of community culture and providers to support respect and understanding • Lack of patient engagement in care • Lack of patient and family education in support of self-care • Underutilization of traditional health practices and informal providers • Program supports for Health

Criteria	Current Strengths	Current Challenges
		Committees not yet in place • Limited understanding of the potential of population health approach amongst providers and communities
Intersectoral and Interdisciplinary	• Health and Social Services in one department • Small communities with opportunities for providers to work in small, integrated teams • In many communities, social workers and police are 'informally linked' with patient care	• Lack of interdisciplinary team approach • Limited intersectoral linkages • Staff turnover/retention issues challenge relationship development in teams and hinder longitudinal care • Resource pool for staff is limited and competitive • Limited use of traditional/informal system • Providers are trained in many different jurisdictions • Limited orientation to work in isolated and culturally unique environment

HEALTH HUMAN RESOURCE ISSUES IN NUNAVUT

Although the *Nunavut Land Claims Agreement* asserts that Inuit be trained to take key roles in employment and contracting and that Inuit employment in the government will eventually be proportional to the number of Inuit in Nunavut's population (85 per cent), the reality is that majority of health care providers are neither Inuit nor are they from the Territory. For example, it is only now in 2002, that there are four Inuit students enrolled in the nursing program at Arctic College. During the years it will take to fully implement this vision of Inuit in key positions; it is essential that the health workforce is fully equipped with as much cultural and local understanding as possible.

The providers in Nunavut come from all over the world attracted by the visions of the new territory and eagerness to be involved in the provision of care in this land. They bring different jurisdictional perspectives and different expectations based on values and training. Immediately upon arrival, they are often faced with community crisis and overwhelming work demands. Although there is a requirement for every new employee to take part in a three week Inuktitut language program, this can rarely be accommodated due to immediate demands for service. Consequently, the responsibility for cultural orientation and translation frequently falls to the local Clerk Interpreters and Community Health Representatives. This puts heavy demands on these workers.

Otherwise, human resource issues in Nunavut are similar to those experienced elsewhere in Canada, but accentuated by distances, remoteness, isolation and Nunavut's decentralized administration. They include challenges in recruitment, retention, and the lack of orientation for new staff, continuing education, supervision and professional support. When providers talk about their work, many cite the stress of the job, professional and social isolation and administrative complexity as factors contributing to burn out and short tenure.

The Calgary Health Region estimates that roughly 30% of nursing time is spent managing paper records. (A 5% reduction in the time nurses in that region spend doing charts could free up the equivalent 90 nursing positions and generate $5 million a year in savings.)[xxxiv] In Nunavut there are approximately 160 nurses; and a similar, modest reduction in nurses' time spent on attending to paper records and administrative matters, like travel arrangements, could considerably optimize time spent on core activities.

Obstacles to effective Primary Health Care

Romanow's recent report identifies six obstacles to effective primary health care. These obstacles are reflected in the challenges noted above and include:

- *The central and predominant focus on hospital and medical care*
- *Increasing professional specialization and protection – the development of primary health care demands flexible working arrangements and shared responsibilities among health providers*
- *Fragmented health care delivery – instead of fragmented silos of care providers are encouraged to integrated services from the first contact with the system*
- *Lack of health information – comprehensive, timely and accurate information is lacking and is not used effectively to guide decisions*
- *Limited control by patients over their own care – currently patients have only a passive role in decisions about their own care. Primary health care focuses on patients and gives them a dominant role in decision making*
- *Marginal prevention and promotion – primary health care puts a major emphasis on prevention and promotion activities.*[xxxv]

PART B

INITIATIVE TO ACCELERATE PRIMARY HEALTH CARE RENEWAL

> *Primary health care is about fundamental change across the entire health care system. It is about transforming the way the health care system works today – taking away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care providers and putting the focus on consistent efforts to prevent illness and injury, and improve health. In fact, no other initiative holds as much potential for improving health and sustaining our health care system.*[xxvi]
>
> *The desire for perfection is also an obstacle to change.*[xxvii]

This review of primary health care in Nunavut, as outlined in Part A, has highlighted a number of recurrent themes and shortfalls, that if addressed could accelerate the primary health care renewal process. These themes and shortfalls are:

- Population-based initiatives should be initiated and rooted in communities
- With the rapid turnover of staff and immediate needs for services, not all providers have an opportunity to learn about the Inuit culture.
- Current primary health care services are delivered by a variety of providers who see opportunities to create effective team-based care to address community health issues.
- Nunavut's population is young; their population health problems are problems of youth. The young need to be targeted with early interventions and appropriate supports to improve overall health outcomes
- Increasingly, front line community primary care providers are faced with managing complex addiction and mental health problems
- Nunavut needs better data about health status, health services and health service administration

The themes and shortfalls lead to two compelling foci for action, which are:

- Change management activities, focusing on community involvement and provider support, leading to integrated, coordinated primary health care.
- The provision of clear, useful information to support quality primary health care.

To ensure Nunavut's primary health care system is sustainable, effective and accountable, the Department of Health and Social Services proposes to use its Primary

Health Care Transition Fund allocation to undertake a series of staged transitional initiatives that will lead to structural change. These transitional initiatives will consist of a change management process and an information management strategy. The two initiatives will be supported by a primary health care transition office.

PRIMARY HEALTH CARE TRANSITION OFFICE

The Primary Health Care Transition office will act as the key management and coordinating body for all of the PHC transition initiatives in Nunavut. Experience, for example with the telehealth project, has shown that a dedicated locus of responsibility is necessary for successful implementation of complex projects.

The team will consist of a Primary Health Care Transition Coordinator who will serve as the mentor for a co-leader who will be Inuit. (This person may also be a student of a health, social science or other human service program.) Other members of the team will include: a Research Officer; administrative staff; and, a senior staff member of the department who will be responsible for the information projects.

Budget provision has been made for an evaluation component for each activity and product development (as defined below). It will be the responsibility of this office to establish an overall evaluation framework that meets the requirements of the PHCTF.

PROCESS 1 – CHANGE MANAGEMENT

> *Focusing on the person's abilities and capacities can result in enhanced strength, resilience, and self-confidence.*[xxxviii]
>
> *Public participation in the health system is primarily concerned with:*
>
> - *Improving the quality of information regarding the population's needs and preferences*
> - *Encouraging public debate over the fundamental direction of the health system*
> - *Ensuring public accountability for the processes within and outcomes of the system*
> - *Protecting the public interest.*[xxxix]

Community Engagement

Meaningful community engagement evolves over time as communities and providers learn more about each other and grow in respect and understanding. The PHCTF offers an opportunity to structure a process to support the development of these relationships.

This component of the change management process is a series of stepwise initiatives for community engagement. The overall process will be hosted by local Health Committees and facilitated and resourced by Primary Health Care Transition Office staff. The transition staff will develop and publish the supporting materials in the form of modules which will become legacy products for communities and education programs e.g., the

Community Health Representative and Social Services Worker programs at Arctic College. The intention of these structured interactions is to start a process which will have immediate day-to-day implications for the provision and reception of services. [Note: Arctic College has the capacity to assist communities to design and implement activities to address their own health issues.]

A series of community engagements would occur over the three and half year duration of the Primary Health Care Transition project. In the first year, this would involve six communities - the three regional centres and three smaller communities.

Program Outline

Participants will include:

- The Health Committee members and staff
- The public
- Partner organizations
- Health and Social Services, Education, police, clergy, etc

Some suggested modules are outlined below:

Community Engagement Module 1

- What do we know about our community?
- Looking at health information together.

Community Engagement Module 2

- How do we convert identified needs into plans for service?
- Talking about what has worked elsewhere and what might work here.

Community Engagement Module 3

- Who needs to help?
- Defining teams for community action.

Community Engagement Module 4

- How do we know we are making a difference?
- Learning from experience.

Supporting Providers

> *Overall, what is needed is 'a fundamentally new approach to the people side of the health care system – treating employees as assets that need to be nurtured rather than costs that need to be controlled'.*[xi]

The two priority initiatives for human resource development are cultural orientation and team building.

Cultural Orientation

> *The importance of accessibility to primary care cannot be overstated in Aboriginal health systems. Aboriginal people require multiple entry points into the system, such as CHRs, traditional healers, nurses, nurse practitioners and physicians. Accessibility is a perception as well as a reality, for example, community members may not feel comfortable approaching a health clinic to see a visiting physician.*[xli]
> *For some people, language is an accessibility issue...being care for in your own language is a kind of medicine.*[xlii]
>
> *Traditional health practitioners are a valuable and sustainable resource that already exists in most communities. The training and utilization of these practitioners in primary health care, working in close collaboration with conventional health staff, can be expected to contribute, in many countries substantially, to obtaining more practical, effective, and culturally acceptable health systems for communities.*[xliii]

Cultural Orientation Module - An Introduction to Nunavut for Primary Health Care Providers

The course should include modules on history, language, holistic health beliefs, family structures and healing. This will be based on IQ policy developed in partnership with, Departments of Culture, Language, Elders and Youth; Education and Justice; as well as, Arctic College; elders; community members; and NTI.

This initial formal orientation will be followed by ongoing learning in the community. Providers will be linked with community members who will help them further develop an understanding of Inuit culture.

Team Building

> *Current initiatives in primary health care highlight the need for providers to work together in integrated teams and networks focused on meeting patients' needs....the education and training of providers is falling short of meeting Canadians' health care needs.*[xliv]
>
> *We have largely been training our health care professionals in silos. Then when they graduate, we call on them to work together.*[xlv]

Team Building Module - A case based approach

Some suggested modules are:

- An identified community health issue will be the focus of a facilitated team based problem solving exercise.
- Discussion of concepts of team building including the challenges and practical approaches. The session will produce a local plan for the ongoing support of the team.

Expanding the Range of Primary Health Care Services

> *Children are our future, yet we have no services for them.*[xlvi]

A child health initiative will facilitate early diagnosis and intervention and lead to improve health outcomes. Child health, for those with special needs in particular, requires comprehensive care planning and on-going, family centred care. Innovative approaches must be developed to provide supported 'at a distance' care in small communities. Although there are rehabilitation providers in Nunavut, they are not functioning as part of the primary health care team. They are situated in a few larger communities; therefore, many places have no rehabilitation services, necessitating travel to larger centres.

It is suggested that one of the Primary Health Care Centres in Nunavut could serve as the site for the development of child health resources. Dissemination of materials would be accomplished through telehealth, outreach services, etc.

Mental Health Education Program

> *In extensive consultations, community members, Inuit organizations and front-line workers have expressed a strong desire for improved and better-integrated addictions and mental health services that are locally practical and informed by proven and effective methods.*[xlvii]

> *Training primary care and general health care staff in the detection and treatment of common mental and behavioural disorders is an important public health measure.*[xlviii]

Primary Health Care providers need the tools to provide high quality mental health care. The World Health Organization (WHO) has prepared an education package for primary health care providers to increase their mental health care knowledge, skills and behaviours. The WHO package facilitates early diagnosis, early intervention and treatment of common mental disorders. It also helps patients and families develop insight into the disorder; and, it teaches patients how to monitor symptoms and handle difficult situations.

This program will be disseminated for training purposes by using WHO educational materials in workshops. Approximately 100 primary health care providers will be given the opportunity to participate in these workshops. The program has its own in-built evaluation component.

PROCESS 2 – CLEAR AND USEFUL INFORMATION TO SUPPORT QUALITY PRIMARY HEALTH CARE

Information is critical to primary health care because:

- *It helps patients make informed choices on available services as well as on diagnostic, therapeutic and preventive options*
- *It gives health care providers the information they need about their patients and their care so that they can provide continuity of care, monitor their health and provide appropriate prevention programs where necessary*
- *It allows health care professionals to keep up with the immense amount of knowledge necessary for good practice and to apply this knowledge to their patients' specific circumstances*
- *It gives health care administrators the information they need to ensure that communities' need are addressed and that resources are allocated to priority needs*
- *It provides in-depth knowledge of the health needs and expectations of the population and, at the same time, allow policymakers to assess the impact of different approaches on improving the quality of primary health care services.*[xlv]

In the absence of a system, everybody creates their own system.[1]

Quality information is the hub of a coordinated, integrated, interdisciplinary and intersectoral health delivery system. Information is a key component in the planning, measurement and evaluation of primary health care. Not only must information be comprehensive, timely and accurate information but it must be readily available and it must be used effectively.[li]

There is no other way to 'operationalize' a patient focused, community involved primary health care system than to give the patients, communities, planners and providers the tools to make informed choices about their care and needs. Information is how patients, communities, providers and planners are *enabled* to sing from the same song sheet.

Information has always been power. It is the force that pulls the systems together. Information can also help facilitate the key values of Nunavut's empowering Bathurst Mandate:

- Healthy Communities
- Simplicity and Unity
- Self Reliance
- Continuing Learning

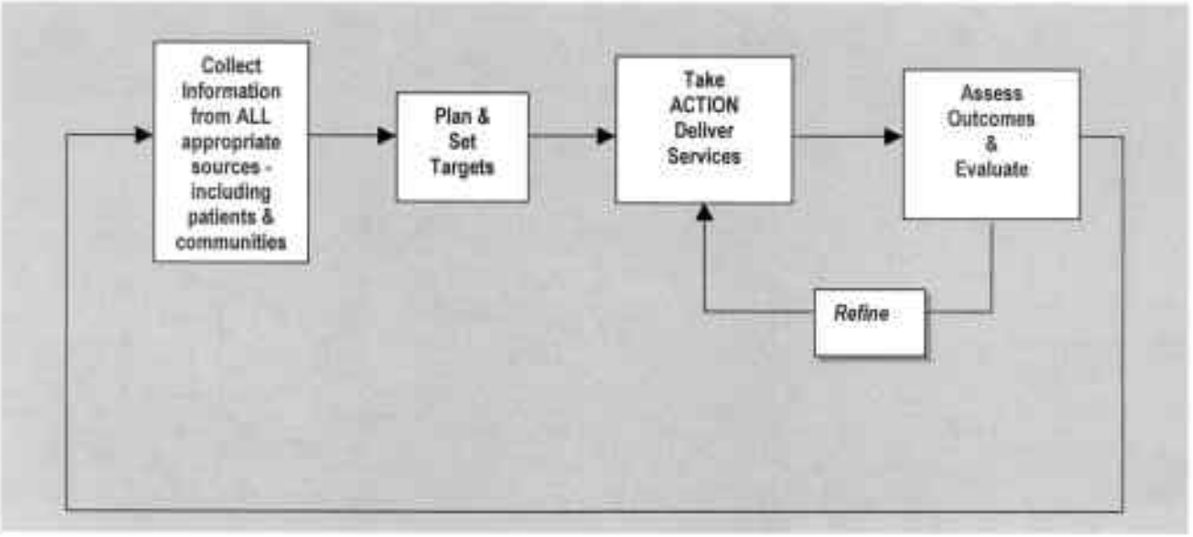
The Advisory Committee on Health Info-structure also echoes these sentiments and claims there are three strategic thrusts of health information. They are:

- *Empowering the public – The information system should provide public access to the information needed to make health decisions and provide a single window of timely and credible information*

- *Strengthen and integrate health care services – A client based system where the collection and management of clinical data and health services are organized and linked to meet patient needs, privacy safeguards and administrative objectives in a seamless system*
- *Creating information sources for accountability – An info-structure which will contribute to achieving accountability within the health care sector by gathering, analyzing and disseminating new information.*[iii]

Information is a mission critical component of an integrated primary health care system for Nunavut. Simple, concise and easily understandable information is essential to the process of change management. A basic diagram to demonstrate the utility and flow of information is outlined below.

PLANNING CYCLE DRIVEN BY INFORMATION



Defining Core Information Elements

The following activities could be directed by the Manager of Information and Research in the Department of Health and Social Services.

Standardization of collection and use of information is required to effectively plan, administer and evaluate the primary health care system. Before any further technological investment is considered it is crucial to:

- Define legislative requirements for the reporting of health information and financial data
- Define elements for payments and administrative requirements
- Undertake a work-flow analysis to support the definition of core information requirements

- Define indicators at the community level to meet community expectation for health information
- Define elements required for health status reporting, including obligations to national data bases, etc.

These elements must be the foundation of a comprehensive department information technology strategy. It is imperative that all efforts are undertaken as part of a comprehensive plan for information services.

PROJECT GOALS, OBJECTIVES AND STRATEGIES

Process 1 - Effective Change Management leading to a culture that supports primary health care and population health

Objective 1	***Objective 2***	***Objective 3***	***Objective 4***	*Objective 5*
Empowered and engaged consumers and communities who are active in shaping the design and delivery of renewed primary health care	**Planning at the territorial, community, and service delivery levels is based on a population health approach and the vision and principles of the Bathurst Mandate (e.g., understanding the importance of prevention and self-efficacy in diminishing the burden of disease)**	**Multidisciplinary teams of primary health care providers who deliver client-focused, integrated care**	**A care system that is respectful of all patients and providers and that resonates with Inuit culture**	Primary health care delivery that is informed by evidence and best practices

Strategies

1. Appointment of a PHC Transition Coordinator to oversee a PHC Co-ordinating office (similar to the successful Telehealth Coordinating team) and to spearhead initiatives and be accountable for Nunavut's allocation of the primary health care transition fund. [Objectives 1 – 5]
2. Establish a mentorship program to train local Inuit to take leadership roles in primary health care planning and delivery. [Objectives 1, 2, 4]
3. Communications Tools to develop community and provider understanding of the determinants of health and how they can be targeted in the community/across Nunavut. [Objectives 1 - 5]
4. Determine the most appropriate structure to ensure citizen and key stakeholder participation in PHC planning, delivery and evaluation (e.g., supported Community Health Committees). [Objectives 1, 2, 4, 5]
5. Incremental staging of initiatives by building on existing community strengths. Select communities to become initial sites for primary health care planning and delivery. Recommended approach is for the 3 regional centers (Cambridge Bay, Rankin Inlet and Iqaluit) plus 2 small communities in each region for an initial total of 9. The rationale being that it is possible to move quickly in the small communities and necessary to move in the regional centers. [Objective 5]
6. Systematically remove structural barriers to the delivery of integrated, coordinated care [Objectives 3, 5]
7. Develop an inclusive, team-focused process for sharing best practices and 'exporting' showpiece initiatives as well as 'importing' non-showpiece successes, e.g., televised case conferences and articles in monthly newsletter. [Objective 5]
8. Formalize orientation and on-going education programs that are specifically tailored for service planning, delivery and evaluation/accountability in Nunavut. [Objectives 1, 2, 4, 5]

Process 1 - Effective Change Management leading to a culture that supports primary health care and population health
9. Specific staff training for priority initiatives, such as mental health and child health. [Objectives 3, 4, 5] 10. Develop education modules for all health and social services staff that address cultural issues and needs. [Objectives 3, 4, 5] 11. Develop a best-practices tool kit that supports primary health care delivery in Nunavut. [Objective 5] 12. Enhance, value and respect the role Inuit health care workers/Community Health Representatives. [Objectives 1 – 5] 13. Allocation of needs-based funds for the local development of innovative and targeted initiatives (e.g., drop-in centre for youth, elders-youth network). [Objectives 1, 2, 4, 5] 14. Child health resource development. [Objectives 3, 4, 5]
Performance Measures Patient satisfaction The number of communities engaged in integrated primary health care Number of Inuit care providers Range of disciplines involved in teams Quality outcomes are identified and measured Communications materials and strategy -- Web site; Written materials; Focus Groups Case conferences via telehealth to inform and educate providers The presence of coordination and linking mechanisms to link with other sectors Provider satisfaction Turnover rates of staff

Process 2 – Provision of clear, useable information to support high quality primary health care

Objective 1	***Objective 2***	*Objective 3*
High quality, simple, functional information system	**Information that supports planning and evaluation of integrated PHC**	Info systems that are compatible with and serve as the foundation for strategic territorial and national initiatives, e.g., electronic patient record

Strategies

1. Ascertain basic/foundational information needs and requirements to support the delivery of care and the management and administrative processes necessary for the planning, delivery and evaluation of services. [Objectives 1 – 3]
2. Develop data collection and information management tools and templates that can 'easily' be implemented and accessed (across the territory and across sectors). [Objectives 1 – 3]
3. Review systems and requirements for the reporting of patient based information external to Nunavut that need to articulate with any data collection and reporting undertaken in the territory. This must include consideration of the ongoing commitment to participation in the development and reporting of comparable health indicators at the national level. [Objective3]
4. Engage all staff in this process in order to: (i) refine data collection and use; (ii) aid effective planning; (iii) develop the basic 'infrastructure' or 'tools' for staff to function as an integrated team; (iv) help patients, families and communities make informed choices; and (v) assists with evaluation of outcomes. [Objectives 1 – 3]
5. Ensure that the work undertaken forms the foundation of planned initiatives such as the electronic patient record. [Objective 3]
6. Participate in Community based indicator development with Government of Nunavut's Department of Evaluation and Statistics. [Objectives 1 – 3]

Performance Measures

Comprehensive information plan to support PHC

Data use is routine at all levels of the system

The presence of coordination and linking mechanisms to connect with other sectors

Indicators are developed that meet community, provider and system needs

Routine, reliable reports on useful and relevant information for planning and evaluation are prepared and distributed to all stakeholders

'User-friendly' information system for financial and administrative support

STRENGTHS AND RISKS OF THIS PROPOSAL

The strengths and risks of this proposal are:

Strengths

- Builds on the overall vision for Nunavut and helps 'operationalize' the Bathurst Mandate
- Builds on strengths, as Nunavut has a better opportunity than many other jurisdictions to use its untapped network of informal care providers
- Builds on long tradition of dedicated health care providers in small isolated communities
- Framework within which other initiatives can fit, e.g., the Aboriginal component of the PHCTF proposal submitted by the Government of Nunavut (which will focus on suicide prevention); the multi-jurisdictional proposal to develop a 24/7 nurse triage call-line; and, the national proposal on the Role of the Nurse Practitioner in Primary Health Care
- Establishes clear responsibility for the stewardship of the funding allocation and outcomes of the initiatives
- Evaluation component built in from the inception
- Builds on and supports the work of local education institutions, e.g., Arctic College
- Provides opportunities for meaningful partnerships
- Provides opportunities for developing leadership in the local community
- Initially, staff turnover can be used as an opportunity to promote the culture of change by ensuring that all new providers receive high quality, culturally sensitive orientation
- Consistent change management and team building processes for providers promotes retention and community stability

Risks

- Physical infrastructure maybe a limiting factor for team-based care in some communities
- Physical infrastructure is aging
- Long tradition of stand-alone providers
- Human Resource issues, e.g., housing
- Community capacity – the start-up of the new territory has placed enormous demands on community leaders
- Long-term change initiatives may be less of a priority when dealing with overwhelming and immediate acute care needs.

TRANSITION PROJECT BUDGET

ESTIMATED FOUR YEAR BUDGET (2002/03 TO 2005/06)

Initiatives	Year 1 02/03 $	Year 2 03/04 $	Year 3 04/05 $	Year 4 05/06 $
Primary Health Care Transition Office				
Salary and Benefits				
* Coordinator	35,000	120,000	120,000	120,000
* Co-leader/Mentorship		75,000	75,000	75,000
* Research Officer		82,000	82,000	82,000
* Administration Support	10,000	48,000	48,000	48,000
Equipment	20,000	26,000	26,000	26,000
Office Space	10,000	40,000	40,000	40,000
Travel/Accommodation	32,000	120,000	120,000	90,000
Recruitment/Relocation	50,000	54,000		
Housing Allowances		20,000	20,000	20,000
Change Management				
Community Development Modules				
* Core Curriculum		25,000	25,000	
* Testing/Focus Group		25,000	25,000	
* Final Presentation (including translation)		12,000	12,000	
* Community Participation & Implementation		80,000	100,000	130,000
Cultural Orientation & Team Building Modules				
* Core Curriculum		35,000		
* Testing/Focus Groups		18,000		
* Final Presentation		12,000		
Evaluation of Training Modules				100,000

Initiatives	Year 1 02/03 $	Year 2 03/04 $	Year 3 04/05 $	Year 4 05/06 $
Child Health Outreach resource infrastructure				
* Development Plan		120,000		
* Equipment and building renovation			500,000	
Mental Health Component				
* WHO Modules		135,000		
* Implementation		100,000		
Community Initiatives as identified in planning cycle			300,000	
Information Process				
Define legislative & admin requirements		30,000		
Work flow analysis	30,000	90,000		
Health status reporting elements		60,000	60,000	60,000
Participation in GN community level indicator project		30,000		
Primary health care information technology plan and vendor review		80,000		
Initiatives to ensure information project meets needs of PHC and emerging national initiatives		60,000	68,000	300,000
Yearly Totals	***187,000***	***1,497,000***	***1,621,000***	***1,091,000***
Project Total - $ 4,396,000				

ESTIMATED QUARTERLY BUDGET – LAST QUARTER 2002/03 TO LAST QUARTER 2003/04 (INCLUSIVE)

Initiatives	Q1 Jan/Mar 2003 $	Q2 Apr/Jun 2003 $	Q3 Jul/Sep 2003 $	Q4 Oct/Dec 2003 $	Q5 Jan/Mar 2004 $	Total Fiscal 2003/04 $
Primary Health Care Transition Office						
Salary and Benefits						
* Coordinator	35,000	30,000	30,000	30,000	30,000	120,000
* Co-leader/ Mentorship		18,750	18,750	18,750	18,750	75,000
* Research Officer		20,500	20,500	20,500	20,500	82,000
* Administration Support	10,000	12,000	12,000	12,000	12,000	48,000
Equipment	20,000	6,500	6,500	6,500	6,500	26,000
Office Space	10,000	10,000	10,000	10,000	10,000	40,000
Travel/Accommodation	32,000	30,000	30,000	30,000	30,000	120,000
Recruitment/Relocation	50,000	13,500	13,500	13,500	13,500	54,000
Housing Allowances		5,000	5,000	5,000	5,000	20,000
Change Management Initiatives						
Community Development Modules						
* Core Curriculum		25,000				25,000
* Testing/Focus Group			25,000			25,000
* Final Presentation (including translation)					12,000	12,000
* Community Participation & Implementation		20,000	20,000	20,000	20,000	80,000
Cultural Orientation & Team Building Modules						
* Core Curriculum			35,000			35,000
* Testing/Focus Groups				18,000		18,000
* Final Presentation					12,000	12,000
Evaluation of Training Modules						

Initiatives	Q1 Jan/Mar 2003 $	Q2 Apr/Jun 2003 $	Q3 Jul/Sep 2003 $	Q4 Oct/Dec 2003 $	Q5 Jan/Mar 2004 $	Total Fiscal 2003/04 $
Child Health Outreach resource infrastructure						
* Development Plan				60,000	60,000	120,000
* Equipment and building renovation						
Mental Health Component						
* WHO Modules		135,000				135,000
* Implementation			100,000			100,000
Community Initiatives as identified in planning cycle						
		Information Process				
Define legislative & admin requirements			15,000	15,000		30,000
Work flow analysis	30,000		45,000	45,000		90,000
Health status reporting elements		30,000		30,000		60,000
Participation in GN community level indicator project		30,000				30,000
Primary health care information technology plan and vendor review		20,000	20,000	20,000	20,000	80,000
Initiatives to ensure information project meets needs of PHC and emerging national initiatives				30,000	30,000	60,000
Total	***187,000***	***406,250***	***406,250***	***384,250***	***300,250***	***1,497,000***

CONTINUING TO TAKE THE RIGHT STEPS

This project is specifically designed to bring about structural change through an ongoing series of transition initiatives that will renew Nunavut's primary health care system.

Primary Health Care in Nunavut must continue to be responsive to the local issues, as well as be shaped by advances at the national and international level. The Romanow Commission on the Future of Health Care in Canada has not only foreshadowed the future of health care but also recommended how the Canadian health care system can prepare itself for inevitable pressures and rapid advances in technology.

With respect to the focus of this Funding Application, the Change Management initiative is entirely congruent with Romanow's assertion that an effective primary health care system is essential to meet the needs of today's citizens and to ensure that the entire health care system is sustainable.

Romanow also made several recommendations regarding the future of health care information management, those that will have particular impact in Nunavut are:

- Standardized electronic health record
- Protocols for sharing of clinical information
- The establishment of a national immunization registry to aid in the harmonization of immunization schedules, identification of national standards, vaccine safety monitoring, procurement and evaluation and information and awareness campaigns.[liii]

The Information Process, as outline in this application, will help ensure that Nunavut is well positioned to address health care needs through quality information systems.

The goal of Nunavut's primary health care transition, therefore, is not to arrive at some set renewal point but to set in place a quality process for on-going renewal and to continually be guided by the value that in health care 'people come first'.[liv] Nunavummiut must continue to maintain their unique identity while simultaneously developing the infrastructure, resources and health care capacity to fulfill the vision of Nunavut's founders.

The ultimate purpose of this funding application is to enable Nunavut's primary health care system to have the capacity to take the right steps at the right time and in a direction that is right for Nunavummiut.

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