Nunavut

Realizing the Dream

Final Report:

Caring for Health in the Territory of Nunavut

Prepared for the

Department of Health and Social Services

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Acronyms

BRH – Baffin Regional Hospital

CAHR – Centre for Aboriginal Health Research

CIHR – Canadian Institute of Health Research

CPD – Continuing Professional Development

DHSS – Department of Health and Social Services

HCC – Health Care Commission

HCP – Health Care Professional

HCS – Health Care System

IQ – Inuit Qaujimajatukangit

NMU – Northern Medical Unit

OHSNI – Ottawa Health Services Network Incorporated

PC – Public Consultation

QWL – Quality of Working Life

RCMP – Royal Canadian Mounted Police

RFP – Request for Proposal

SSP – Social Services Professional

Introduction

The privilege of engaging in the planning related to health and the health care system in Nunavut had its genesis during the Health Care Commission (HCC) and its Public Consultation held in Iqaluit. The Public Consultation, chaired by Commissioner Romanow, was held Monday April 8, 2002. However, the Health Care Commission had arrived on April 6th and gave us the opportunity of meeting Minister Edward Picco and his senior officials. We toured Iqaluit, Baffin Regional Hospital (BRH) as well as Pangnirtung and its Community Health Centre.

It was during that time that the Minister indicated his interest in a return trip. The purpose would be to provide some advice and assistance to the Department of Health and Social Services (DHSS) after the expiration of the HCC.

An agreement with Acting Deputy Minister Keith Best was reached in December 2002 and a contract executed. My charge was to "make recommendations pursuant to a review of the services by the Baffin Regional Hospital in relation to services provided to communities in the Baffin Region". Over the next several weeks following conversations with Acting Deputy Minister Keith Best, Mr. Don Ellis and others, a wider context emerged. It was agreed that the inclusion of Kivalliq and Kitikmeot as well as relevant southern partners was essential in the review process.

Before embarking on any travel or work it was necessary to do considerable background research. This was conducted throughout December and early January and a synthesis of this work is attached in Appendix I. (The full collection of materials is available upon request.)

In all of the many meetings and engagements, numbering close to one hundred individual encounters, the experience has almost always been the same. Openness and freedom of communication have been the rule. Commitment and professionalism have constantly been encountered. The task at hand was identified as the need to plan for the

preferred future of the health care system for Nunavut and Nunavummiut and the essential role for the DHSS.

The challenges were and are acknowledged as being enormous, echoing the presentations heard on April 8, 2002 at the Public Consultation in Iqaluit. The disease burden borne by the people of Nunavut (reference DHSS publication "Comparable Health Indicators for Nunavut and Canada" 2002), the challenge of delivering care over vast distances (east-west dimension of Nunavut is the same distance as Montreal to Saskatoon). For example, Nunavut consists of 1,994,000 square kilometers or about 20% of Canada's land mass. The population density is one person per 100 square kilometers versus 29 for Canada as a whole. The Inuit have the greatest disease burden of any group in Canada with almost 3 times the perinatal mortality rate, shorter life expectancy (by about 9 years), and higher suicide rates (7 times that of Canada) among other challenges.

Nonetheless there is not only a belief among the many people I met in the possibility of solutions, but also clear evidence of some existing practices that are succeeding. These success stories form the basis of defining priorities and identifying the requisite changes for the short and long term.

Chronology – Rationale

The real beginning of the chronology occurred with the visit of the Health Care Commission to Iqaluit and Pangnirtung on April 6-8, 2002.

Following the contractural agreement, the initial trip to Iqaluit was January 21-23. This was followed by another trip from March 30 to April 5 to the regions of Kivalliq and Kitikmeot, as well as their southern partners in Winnipeg and Yellowknife respectively (Appendix II). The trip of mid May (the 14-16) was initiated by a morning (May 14) spent with the Ottawa Health Services Network Incorporated (OHSNI). The following day there was a meeting with all senior staff of the DHSS, the Interim Deputy Minister Ms. Anne Crawford and the Deputy Minister Designate Mr. Bernard Blais. Finally, on the 16th there was another visit to BRH. At the latter meeting it was again possible to interact with health care professionals. The fifth trip was to Pond Inlet and Iqaluit (Appendix III) in the first week of June (2-5). A third stop scheduled for Kimmurut had to be cancelled due to airline problems.

This sequence of events, trips and engagements leading to the writing of the Final Report was intended to enhance the understanding of Baffin Regional Hospital and its role in the Territory. In particular, the report was to further understanding of the role of BRH not only in Iqaluit but also for all communities in Qikiqtani, Kitikmeot and Kivalliq. In addition, the relationships of BRH and DHSS with the southern partners in Winnipeg, Ottawa and Yellowknife were seen as part of the context of the enquiry. The questions suggested by research and conversations with senior officials were:

- What is the role of BRH at present?
- What is the context of its role and its relationship to communities in each region?
- How do the communities see BRH?
- How is the institutional performance of BRH in relationship to this role?
- What strengths and weaknesses are there? (quality and accountability)
- What should be BRH's role in the future?
- How should the DHSS build on the successes and address the weaknesses?

- What changes should be made to ensure BRH's success in the long-term?

In regards to the southern partners the following questions were raised:

- How effectively is medical travel to and from each of the 3 regions managed?
- How well are each of the southern partners achieving functionality and quality of services?
- What is their perspective of the DHSS and BRH?

And for all contacts these questions were raised:

- What are the best practices you support?
- What is needed to achieve a better future?

The feedback and responses (recorded in the appendices) were extraordinarily helpful and reassuring. The perspectives provided a convergent validity and a constancy of messaging that proved very illuminating.

Perhaps one of the most interesting suggestions was to change the name "Baffin Regional Hospital" to something very different. The new name would be an opportunity to capture the emerging role which would reflect a changing reality. One suggestion that serves to illustrate the point is the "Nunavut Territorial Health Organization". Another idea was to use the name of an important historical Inuit figure. While the proposal is certainly a valid one and merits consideration, the current name of Baffin Regional Hospital (BRH) will be used for the purposes of this report.

Background Research

The beginning point for research had been the on site experience afforded by the trip with the HCC and the subsequent Public Consultation (PC). Meeting Minister Edward Picco and touring the BRH as well as the very impressive Pangnirtung Community Health Centre were crucial for setting the stage for the PC. At the event, presentations were heard from the following organizations:

- Government of Nunavut – Honourable Edward Picco, Minister of Health and Social Services
- Nunavut Tunngavik Incorporated
- Pauktuutit – Inuit Women's Association of Canada
- Qikiqtani Inuit Association

There were also written submissions relating to the presentations that were part of the record. These formed a basis to pursue further research. It proved to be a very important starting point for December 2002.

Once discussions began and the probability of creating a relationship with the Government of Nunavut emerged, a literature search was undertaken. The fruits of that activity are summarized in Appendix I. What must be emphasized, however, is the rich resource that is provided by the University of Manitoba and its Centre for Aboriginal Health Research (CAHR). Accessible on the web www.umanitoba.ca, full papers are freely available and highly recommended. Other important sources included the First Nations and Inuit Health Branch and the new Canadian Institutes of Health Research (CIHR) Institute for Aboriginal People's Health. The CAHR has well established linkages with the latter 2 organizations and there is evidence of a good working relationship among them.

Clearly it was necessary to have as much background information as possible before the assignment was begun. However, what has also occurred is the discovery of many other rich sources of information and corresponding insight. Among the best of these was a book entitled "Nunavut – Inuit Regain Control of Their Lands and Their Lives"

that was published in 2000. Jack Hicks, Director of Evaluation and Statistics, Executive and Intergovernmental Affairs, is one of the 3 co-authors. Other important publications and documents were either acquired through the generosity of those with whom I visited, (especially in the Northern Medical Unit of the University of Manitoba) or discovered in the course of continuing research.

The process of learning has been deeply rewarding and while much has been learned, the journey continues.

The challenges are enormous and varied but solutions are at hand. There is ample evidence of innovative and excellent models of practice. It is through building on these best practices and taking a renewed approach in the administration and delivery of health care that success will follow.

The following 8 principles which build on these practices, are presented as essential for achieving effective and sustainable change.

Principles for Change

1) Values

This point was made to the HCC by all presenters. Any recommended change must respect the 4 pillars of the Bathurst Mandate be guided by Inuit Qaujimajatukangit (IQ) and be congruent with both the Nunavut Land Claims Agreement and the Nunavut Act.

The principles of the Bathurst Mandate (Appendix I, page 5) are:

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

These principles are fundamentally sound and they strike me as being both profound and eloquent.

Inuit Qaujimajatuqangit/IQ (Appendix I, page 4) has 6 components:

- Pijitsirniq – being useful in service to others
- Aajiiqatigiingniq – dialogue and communication
- Pilimaksarniq – learning by observation, experience and practice
- Piliriqatigiingniq – teamwork and collaborative relationships
- Qanuqtuurunnarniq/Iqqakaukirinniq – creative problem solving
- Avatik Kamattiarniq – environmental stewardship

Comment: This report endeavours to be guided throughout by the principles of the Bathurst Mandate and IQ.

Recommendation #1: That the commitment to the values of the Bathurst Mandate and Inuit Qaujimajatuqangit be continued and, where appropriate, enhanced in all planning for health and health care in Nunavut. The Bathurst Mandate and the 6 components of Inuit Qaujimajatuqangit should be posted widely and publicly in

health centres, be part of the orientation of non-Inuit staff and referenced in decision–making fora.

2) Quality of Working Life (QWL) of Health Care Professionals (HCPs) and Social Services Professionals (SSPs) – Pijitsirniq

At every stop and in virtually all discussions this issue was raised as a serious problem. While something of this issue exists in all jurisdictions, it is as troubling or even more so, in Nunavut than in any other province or territory. The problem of QWL in Nunavut has many dimensions including those found in the rest of Canada but in addition the following concerns were raised:

- Inadequate support for Continuing Professional Development (CPD). Annual study leave and protected development time in the work week are widely seen as lacking despite being considered essential by educators, businesses and accrediting bodies.
- Isolation – most notably professional, but personal as well. There is a lack of east-west connectivity among the Territory's professionals which results in an inability to discuss best practices, case management and quality assurance.
- Inefficient financial systems – for example, the erratic payments of medical specialists experienced by visiting specialists from Ottawa.
- Insufficient infrastructure support resulting in nurses and doctors often expending precious time doing clerical or similar work not requiring their expertise. This is both inefficient and costly.
- Retention. There is a lot of work related stress and uncertainty. Turnover is a constant reality and universally seen as a concern. The turnover results in shortages of staff coverage and/or inexperienced HCPs or locums. This exacerbates the situation and contributes to burn-out which was cited as being common. For example, it was claimed to me that in the 10 years the Rankin Inlet Program has been running, there have been 40 mid-wives for the 3 positions.
- SSPs feel as if they are not treated equitably compared to HCPs
- Inadequate orientation of newly arriving HCPs. The immediacy of clinical needs generally trumps orientation processes.

Comment: While there are many concerns and indeed angst aired by HCPs and SSPs, it must be emphasized that nearly all felt their work is fascinating, rewarding and important. Recruitment is much less of an issue than retention. The focus is not an issue of remuneration but rather one of respect, being listened to and heard regularly and being able to pursue their occupation in a supportive/learning environment. They wish to be more engaged by the DHSS in those decisions that most affect their working life. Greater adherence to the principles of both the Bathurst Mandate and IQ would help to improve the situation. For example, simplicity and unity, continuing learning as well as dialogue and communication (Aajiiqatigiiniq) are less than what is required. If these principles were addressed and the short-falls remedied, the QWL and morale could be improved significantly.

This is as true for Community Health Centres as it is for the Baffin Regional Hospital.

There are currently very few Inuit health care professionals. The interest of the youth of Nunavut in a health professional career path would be much enhanced if retention and QWL were effectively addressed. At present administrative roles stimulate more interest among young Inuit as there are more attractive working conditions.

Recommendation #2: The issue of Quality of Working Life of professionals working for DHSS be urgently addressed. The scope of the enquiry should include, but not be limited to:

- **infrastructure and clerical support for health care professionals**
- **communications among professions and to professions by the DHSS**
- **continuing professional development**
- **engagement in decision-making processes**

(The Primary Health Care Transition Fund may offer an opportunity to support Recommendation #2.)

3) Community Capacity Building and Integration – "Healthy Communities"

The Bathurst Mandate speaks first to "Healthy Communities". The belief is that individuals, families and communities must all be addressed. Putting people first is an underlying value. It is this that leads to "... a healthy connection of mind, body, spirit and environment" (Appendix I, page 5).

Unfortunately at one hamlet, a spokesperson for the Community Wellness Council stated that "we are not a well community". There is no reason to believe it is confined to this one community, but rather, it is they who articulated it most clearly.

It has been stated that it takes a village to raise a child. The environment or neighbourhood where children are brought up is an important determinant of health in both the short and long term. The community is also crucial for the well-being of all and certainly for elders and new mothers. In all communities it was possible to witness short-falls in community infrastructure (e.g. sports facilities, community centres). Youths are provided few life options and are said to be disrespectful of elders; it is thought that this is contributing to and is a risk factor for truancy from school, substance abuse, teen pregnancies and suicide. There is a strong sense that the youth one encounters (Appendix III) are in a world apart, caught in the mid-point between the traditional Inuit culture and the images and messages from the south. Their experience of the latter is constant through television, consumer goods and exposure to *qallunaaq* (white people), especially tourists. As all teenagers do, they are struggling to find themselves and their identity, but unlike their peers elsewhere they must deal with the incursion of a culture from other peoples and lands. This incursion appears to have an overwhelming impact. In short, they are vulnerable to forces of assimilation and they are correspondingly placed at risk.

While it is very important that these subjective observations be addressed and subject to research evaluation, unfortunately the problem is a current reality and delay in acting is unacceptable. This has been made clear in presentations to the HCC and most

recently by the Government of Nunavut who have identified strategies to prevent suicide as their first priority. It will be crucial that evaluation be part of any such strategy.

The concept of ***ilagitsiarniq*** (healthy community connections) was identified as an important strategy in a recent conference in suicide prevention. It merits attention and further support.

The DHSS cannot address the problem as a single department but it can make an important difference. All existing and proposed initiatives should be seen as an opportunity to integrate services to become sustaining ventures for the community. Their functional plans must reflect a focus on at-risk youth and mental health issues. The new health care facilities that are being planned in all 3 regions are a good example. It was heartening to witness this approach of integration of services being pursued in Pond Inlet and Cambridge Bay. Health care, social services and public health are to be brought under one roof. Additionally, in Pond Inlet, the Nurse in Charge is personally accomplishing active and effective community relations. She is also acutely aware of the challenges facing youth and of substance abuse among youth and the adult population (with a prevalence approaching 90% according to the HCPs in Pond Inlet and the RCMP). She has a good working relationship with the RCMP and Hamlet Council. In short, her performance is exemplary. Nor is she alone as many of her colleagues in other hamlets are endeavouring to accomplish similar goals.

What was less apparent was a system-level (territorial/regional) support for integration and in particular, interdepartmental initiatives. Rather the impression was that disintegration and fragmentation were the predominant phenomena. There are exceptions to this observation as noted above, but these appear to be related to the individual efforts of highly motivated staff as opposed to the management systems in place.

Unless all departments, regions and the hamlet governments work together to create healthy communities and to develop effective **healthy** public policy, the goal is less likely to be realized. There are many areas where this cooperation is needed such as

Early Childhood Development and the integration of services for management of substance abuse. For example, it has been suggested that the RCMP should be enabled to make referrals to alcohol and drug treatment programs, an idea that may have merit.

Comment: The foregoing is applicable to communities that have been visited including Iqaluit. In Iqaluit and Pond Inlet, there is deeply concerning and recurring evidence of disaffected youth openly participating in risk-taking behaviour (smoking, gambling, drug abuse, participating in the sex trade). Conversely, it has been reported to me that there is variation and some communities are coping better. Unfortunately, it has not been possible to uncover information on risk-taking behaviours on a community by community basis.

Recommendation #3:

a) That integration of services provided by DHSS be mandated for all emerging projects and fostered in existing programs.

b) That priority be given to mental health issues for all and to preventing youth suicide in particular.

c) That further mandating of inter-departmental (inter-sectoral) committees at the territorial and community levels is required.

d) That an interdepartmental body be constituted for the purpose of addressing healthy public policy and community capacity building. (A precedent of this concept did exist in Ontario – the Premier's Council on Health.)

4) Quality and Accountability – Kamattiarniq

Certainly the Health Care Commission heard about the deficiencies in quality and accountability in every forum it organized across Canada. So fundamental was the issue that it was seen as indicative of a "crisis in leadership" and/or a "crisis in democracy" in our governments.

In Nunavut, comparable, though less vitriolic, sentiments were expressed. Concerns were heard about BRH, "administration" (intending to convey weakness of systems in place or simply the "way things are running"), medical travel and the DHSS.

Baffin Regional Hospital is situated at the centre of a rapidly growing population (doubling 1979 to 1999) and also has a higher proportion of southerners (qallunaaq) with urban/southern expectations; perhaps because of this, it is perceived as having quality issues and a reputation that is more negative than it deserves. However, concerns regarding quality of care and patient safety have been raised at the most senior and other levels.

Whatever the reality may be, the situation must be addressed. Furthermore, any attempt to improve the situation must be value-based and constructive. Specifically there is no evidence from my findings that the problem is one of "bad apples". On the contrary BRH generally has a committed and caring staff. (Some exceptions have been brought to my attention but they are just that – exceptions.) What is clear is that there are serious problems with the system of administering the hospital and that, while change is needed, it must be understood that it is instability at the leadership level of administration that has contributed to the problem (see Appendix III, page 8)

The QWL (Recommendation #2) issue also has relevance here. With the current infrastructure support for doctors and nurses in Iqaluit, any system of Quality Assurance will be seen as a non-sustainable add-on. It is imperative that consideration of this variable be at the forefront of planning, or recruitment is apt to lead to a continuance of short-term appointments and high turnover. The creation of a Community Advisory or Executive Council of BRH is also a part of the puzzle. Specifically, one task as intermediaries would be to bring the community perspective to BRH. Equally important, they would also provide the community with a perspective on the realities of health care delivery in BRH.

Another issue, and one unique to Nunavut, is that of medical travel. On average there are about five times as many "boardings" of airplanes per unit of population than the rest of Canada. This is necessitated by the vastness of Nunavut and the absence of any alternative form of travel. These distances have very important implications for medical travel for both elective and urgent transfers. It is difficult and expensive and consumes almost 20% of the budget of the DHSS.

There is a necessity to establish the following:

- Transfer guidelines, i.e. the decision
- Transfer protocol, i.e. the requisite personnel, equipment and communications
- Monitoring post-event, regarding utility and necessity of transfers
- Feedback loop to adjust practice and/or service as needed e.g. conferences at the regional and territorial level
- Engagement of southern partners in the process
- Territorial-wide information systems regarding the above with linkages to southern partners

This concept was raised at many sites and supported. Air ambulance will be a continuing reality for the foreseeable future. Nunavut should strive to create a model system.

Finally, in terms of the department, it must be said that its very existence and the degree of functionality it has are remarkable achievements. The territory has only been an independent jurisdiction for 4 years and yet the Health Care System is certainly running well in many ways. I witnessed many success stories and met excellent professionals and staff.

There are however problems that are pressing. There are three areas that command attention:

- Financial systems require a more efficient and systematic approach. Accounts payable are often delayed and this in turn has harmed relations with health professionals.
- The DHSS is seen as remote and less communicative than it could be. Communities in Nunavut are widely dispersed and there is a tendency for communications to be only north-south. The problem was particularly apparent in Kivalliq and Kitikmeot. To many working in these regions, Iqaluit seems "as far away as Iceland".
- Integration is a key responsibility of DHSS. The department must show leadership in linking communities with one another across the territory as well as within regions. It could be accomplished through many means including CPD, best practices seminars and cooperative problem solving.

Comment: Quality and accountability, which are concerns throughout Canada, are certainly issues in Nunavut. These concerns also represent a unique opportunity because relatively simple interventions, such as enhanced communications efforts (as outlined subsequently), have the potential to make a great deal of difference. The need to address quality and accountability will always command attention. Success is often a journey more than a destination. Accordingly, the following recommendation is presented.

Recommendation #4:

That quality and accountability relating to the following 5 areas be addressed as priorities:

- **BRH and patient safety (and related infrastructure support)**
- **Public/community communications**
- **Creation of a Community Advisory Council for BRH**
- **Review all elements of medical travel to ensure that it meets the needs of the patient/clients in need of care and of clinical care-givers in the most efficient and effective way possible**
- **Administrative systems in the DHSS**

5) Communications and Linkages – Aajiiqatigiingniq

The challenge of communications and linkages confront all governments and organizations. However in Nunavut, because of its vast land mass, highly dispersed population and relative lack of infrastructure, the challenge is the most substantial of any in Canada. There is no other jurisdiction that stands to benefit more from the existence of a superior information and communications system. Telehealth and telemedicine are an integral part of the future success of Nunavut in health care; it is the linkage that can knit together the territory and address the enormous challenges of access to care. Telehealth and telemedicine are at least as significant as air and medical travel – neither will succeed without the other. Both are essential to "shrink" the distances that are part of the daily challenge that exists for the health care system (HCS).

For the purposes of this report the focus will be on communications and linkages between Nunavut and external partners and within Nunavut.

Nunavut and External Partners

The history of Nunavut to this time has been one of connection and referrals on a north-south axis. Kitikmeot shares health care responsibility with Yellowknife and Edmonton (Stanton Regional Hospital and the Capital Health Region, respectively). Kivalliq has a long history of relating to the Northern Medical Unit at the University of Manitoba in Winnipeg. Finally, the former Baffin Region (Qikiqtani) relates to Ottawa and the Ottawa Health Services Network Incorporated over the past 4 years and to Montreal prior to 1999.

Each relationship is unique (further details are contained in Appendix II). What is shared among the three is that they coordinate the provision of most secondary and all tertiary care needs for Nunavut. They do so with the use of medical/air travel or medical evacuation in emergencies.

It is only in Iqaluit and BRH that some secondary care is provided in Nunavut.

Of the 3 relationships, the most outstanding is that with the Northern Medical Unit (NMU). It is an exemplar. There is not only engagement from the health and health care perspective, but also a sophisticated and highly appropriate research and education resource provided to Kivalliq. The other two partners/linkages are focused on the provision of health care.

The NMU has a long history with the former Keewatin District (Kivalliq) extending back over 35 years (although there was an 18 month hiatus in the late nineties). The degree of understanding of the health and health care challenges confronted by the Inuit is well understood. Of equal importance however, is the culture of the NMU that emphasizes the broad perspective of health and practices it. Furthermore, they are highly efficient in their administration and are seen as such at the community level in Rankin Inlet. They appear to make the best use of the technologies of communications and air travel. Virtually all health care professionals that I encountered in Nunavut spoke highly of the work of the NMU. As an example, those in Rankin Inlet who are not part of the NMU program made it clear that they would like to be. In addition, the prevailing evidence suggests that the tracking of medical travel and patients/clients is managed most effectively by NMU. (best practices)

Rather than dwell on the relative merits of the 3 relationships, the most useful thing that can be said is that this is a success story of NMU that should be built upon (see Recommendation # 5a). It is also a relationship that would help build bridges to national organizations such as First Nations and Inuit Health Branch of Health Canada and the Canadian Institutes of Health Research as the Centre for Aboriginal Health Research at the University of Manitoba is already doing.

Q Is NMU willing? probably. Surely we don't want to Ottawa rather than Winnipeg?

(Note: The recruitment of full-time family physicians to Nunavut varies by region. The NMU manages it for Kivalliq while the Director of Medical Affairs Dr. W. MacDonald manages it for Qikiqtani. He feels that recruitment for all regions would be best accomplished in Iqaluit. This strategy must be carefully considered but is at variance with the view of NMU. In general, the physicians working in Kivalliq were more

satisfied with the administrative supports than those working in Iqaluit. Visiting specialists are coordinated by OHSNI for the Qikiqtani Region and by NMU for Kivalliq). what about Kitikmeot?

Communications and Linkages within Nunavut

While mentioned earlier this element merits particular emphasis. For the future of Nunavut and fulfillment of its promise, a sense of the identity and culture of the Territory must be strengthened. Building the communications and related networking is a keystone activity. There is not only a necessity to increase the connectivity within Nunavut, but it is also an opportunity to create a core building block for managing new directions and building consensus for planning and implementation. It will not only help enhance the QWL of HCPs, SSPs and others but will also address issues of accountability, system functionality and team-building. It requires infrastructure, much of which exists or is becoming available, commitment and a culture shift. There are obstacles but fewer than might be anticipated as the receptivity to this direction was enthusiastically embraced in every community visited. The HCPs and SSPs are eager to be in regular communication with the DHSS and each other. - how can we do this? - is it a function for HSA or for EDO's to address?

BRH has a very important role to play in providing health care advice to all communities and should be supported in upgrading this role. Southern partners should also be included as appropriate from the care perspective but also for education and research (knowledge sharing, transfer and dissemination).

what is that "manner" - can it be duplicated without the rich historical connection? - can we achieve this in an RFP?

Recommendation #5a

That the NMU model be reproduced through a Request for Proposal (RFP) process so that all southern partners function in a comparable manner. The NMU could assist in development and adjudication of the RFP with the DHSS, or if they are interested in extending their activity, becoming a bidder themselves instead.

again, why not medivac to Winnipeg?

Recommendation #5b

- # of airline services for scheduled medical travel?
- medivac flight distances?
- is Winnipeg equipped for all of Nunavut?

That the communications within Nunavut be actively pursued, enhanced and consider the following as essential elements:

- **Frequent, scheduled and sustainable activity**
- **All 3 regions and 25 communities networked in appropriate combinations**
- **Between and within disciplines**
- **Include the DHSS at a senior level**
- **Congruent with a consensual strategy**

(Substantive progress should be possible in 6 months.)

6) The Health Continuum – "Unity"

The greatest challenge that has beset governments both within Canada and internationally has been the challenge of balancing health care and health. During the HCC, this matter was raised in all parts of the country and is readily apparent in Nunavut. The acute care sector has always commanded the greatest attention and resources. It is a sector that has become highly politicized over the past 20-25 years. Perceived short-comings rapidly attract media attention and perhaps this helps explain the continuance of health care as a top-of-the-mind issue in opinion polls. The reality is that elected representatives ignore the issue of perceived short-comings in the HCS at their peril.

In implementing change, the acute care system must not be sacrificed but rather strengthened. Similarly, efforts in disease prevention and health promotion cannot be neglected as they have been in the past. Neglect, as we have learned in recent years, has tragic consequences. A continued focus solely on the acute care sector at the expense of other equally important upstream considerations is a non-sustainable policy. One could argue that in the long term, upstream (prevention, promotion) solutions are of the highest importance.

It is ironic that in truth the publicly-funded health care system is not as threatened by the usual cost-drivers that preoccupy some opinion-leaders in the south, such as emerging technologies and the aging of the population. It is much more imperiled by the

failure to move upstream in our planning and priorities and actually embrace disease prevention and health promotion. A poignant example is the Potential Years of Life Lost due to suicide which is reported to be 24 times that of the rest of Canada (Report on Comparable Health Indicators for Nunavut and Canada, September 2002). There must be recognition of public health threats and the threat that cultural assimilation represents for all Inuit, especially the young. In order for health promotion to succeed in Nunavut, these realities must be confronted together with education, health literacy, and social cohesion, among others. → yes, being done in various suicide prevention initiatives

In each of the Health Accords signed at the First Ministers' Meetings on September 11, 2000 and February 5, 2003 commitments were made to prevention and promotion but the fulfillment of the undertaking has proven elusive. The notion of assimilation versus integration and the threat it represents for First Nation and Inuit peoples in Canada, received less attention than it should have. Yet for Nunavut, the only Federal/Provincial/Territorial jurisdiction in Canada with a majority (85%) of aboriginal people, assimilation is a pervasive reality. (The Northwest Territories have a majority of 52% non-aboriginal people; Canadian Geographic, January/February 1999).

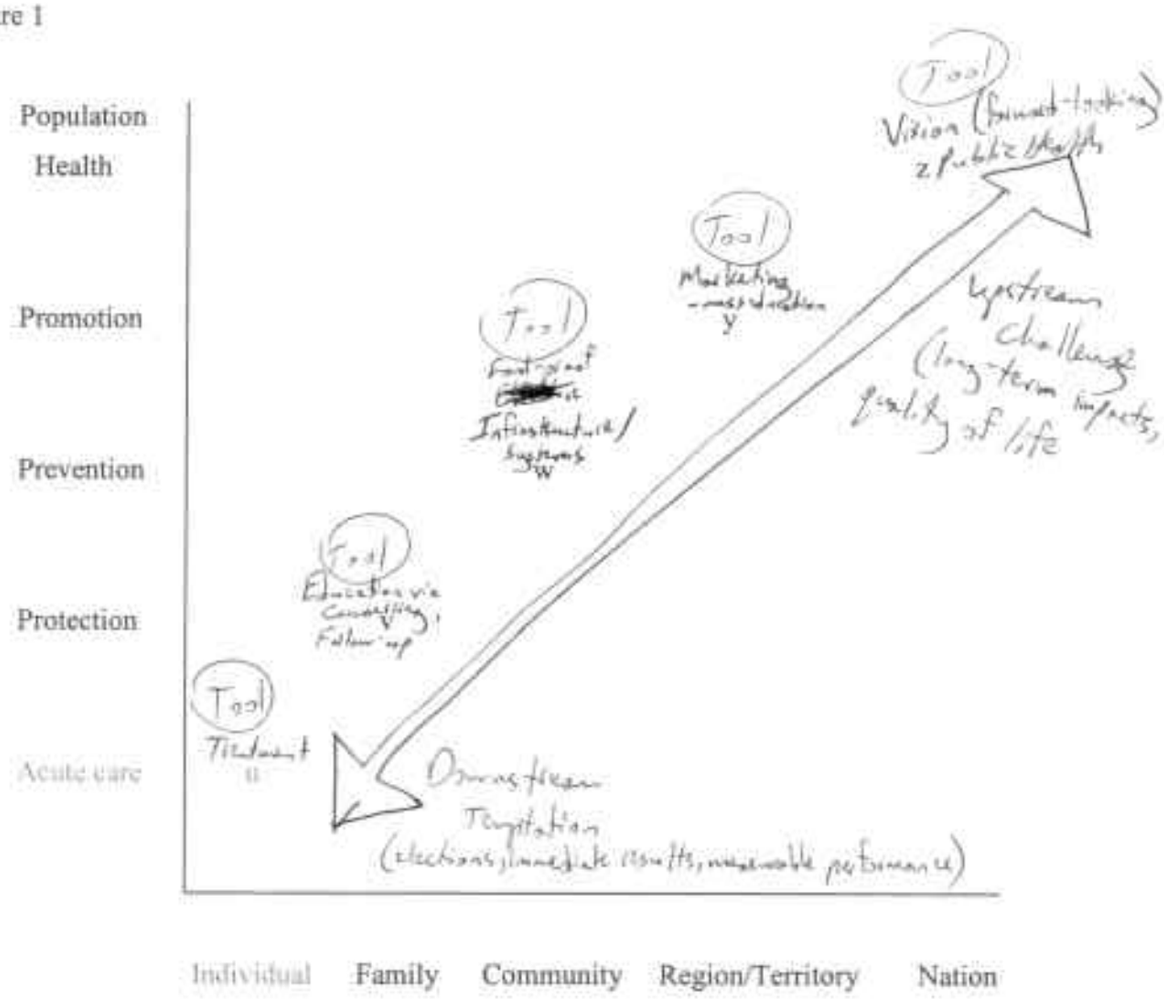
Nunavut is different and can succeed. It is a new Territory guided by ancient wisdom (IQ) that can find a different way. It has a different demographic (younger), a rapidly growing population, more disease burden and a unique (if threatened) culture. Thus, there are many compelling reasons that Nunavut can and should take another path.

Framework for Consideration

Bearing in mind the foregoing, a conceptual framework originally developed at the Population and Public Health Branch of Health Canada (RYM) is presented. It was part of an initiative identified as the "Wellness Agenda" in 2001-02. This was presented informally to the Deputy-Minister (then Designate) Bernard Blais and he suggested its inclusion in this report.

The purpose of the framework is to present all the elements (generically) that need to be considered in developing health and health care policy. (Figure 1)

Figure 1



Legend – to illustrate 5 of the 25 intersections

u – e.g. treatment of pneumonia, depression or substance abuse

v – e.g. well-baby care, child rearing, family violence

w – e.g. safe water, food, air, immunization

y – e.g. health literacy, tobacco strategy, social capital

z – e.g. healthy policy (not health policy) that is culturally appropriate

Comment: The above scheme assumes an understanding of the determinants of health. For example, on the individual basis the determinants include biology, behaviour, education and genetic endowment, as well as factors extrinsic to the individual including the social, cultural, physical and economic environment. To date, in most jurisdictions the vast majority of investment is directed toward the one-by-one health care system leading to the relative neglect of serious issues such as mental health, public and population health.

Recommendation #6: That strategic planning or policy development in Nunavut always reference Inuit Qaujimajatuqangit and the continuum that makes up health. Budget planning must factor in investment for disease prevention and health promotion which should be seen as imperative for the future health and well-being of Nunavummiut, as well as for the sustainability of the health care system.

7) Synergy and Cooperation – Piliriqatigiingniq

The aspiration of synergy and cooperation is a value that is widely shared. While it is a worthy goal, only concerted effort brings it to fruition. Nunavut could be a model of best practice in this regard because it is a young jurisdiction and correspondingly less encumbered by precedent. The first principle of the Bathurst Mandate ("Simplicity and Unity") speaks to it just as *Piliriqatigiingniq* or "teamwork and collaborative relations" does. It is, in short, a valued quality in the cultural tradition of the Inuit people.

There are four specific strategies (some of which were witnessed during the consultation visits) that offer the possibility of realizing the goal:

- Co-locating all DHSS services in each community. This is being done in Cambridge Bay under the leadership of the Nurse in Charge. It is part of the functional planning of the new health care facility. In other communities this approach is lacking and there are problems that are consequent to it. Health care, public health and social services should be linked physically and functionally.

- Information Systems and Information Technology is being managed separately among departments and various public services. It is neither affordable nor efficient.
- Intersectoral Committees (along similar lines as the Regional Intersectoral Committees in Saskatchewan) exist but require an enhanced focus and mandate. Examples have been cited earlier of informal engagements across departments and services such as education, the Pond Inlet Hamlet Council and the RCMP. This kind of initiative should be supported especially at the regional level.
- Cooperative research and education across regions and with southern partner(s) should be pursued. An example of success in this regard is seen between NMU and Kivalliq to the benefit of both.

Other possibilities exist. For example, creating educational and employment opportunities for Inuit community members in health care services has many benefits. For example:

- Nunavut Lands Claim Agreement (Article 23) with respect to 85% Inuit employment
- community capacity building
- economic development
- health care services delivery

Such opportunities include Rehabilitation Assistants, Community Health Representatives and Home Care Workers (up to 9 categories, reference Appendices Rankin Inlet, Pond Inlet).

The important caveat is to ensure coordination among the various initiatives (see Appendix II, page 9) that are becoming more numerous in order to avoid overlap and confusion. Some variance in approaches was found among regions. Accordingly territorial planning that continues to encourage these developments while coordinating them is necessary. Among the goals of coordination is the need to ensure career paths for these workers leading to the health profession.

Comment: There are many activities in Nunavut that represent essential building blocks for the realization of synergy and cooperation. With further encouragement and coordination, meaningful progress is likely.

Recommendation # 7a: That steps be taken to support and build upon specific initiatives in community health centres such as co-location and inter-sectoral collaboration and that it be a condition of budget support.

Recommendation # 7b: That the many programs for establishing health care assistants/aides be reviewed and rationalized. The creation of a registry of these activities should be considered in cooperation with Arctic College. Furthermore, mechanisms should be put in place to ensure the support of career paths leading to higher qualification for each category of health (care) aide.

8) "Sophisticated" Primary Health Care

For more than 3 decades Primary Care and Primary Health Care Reform have been identified as essential strategies to advance system-wide reform in health care. Both refer to the first contact of patients/clients with the health care system and the care that is immediately accessible as a consequence of that contact.

However, the former term (Primary Care) is used to indicate a narrower scope than the latter term (Primary *Health* Care) and is generally accepted to refer to the physician delivered service only. The latter is a term intended to indicate first contact care that is delivered by the most appropriate health care professional or team of professionals which may or may not include a physician.

Representation to the HCC suggested that the latter term is preferred by most people engaged in the HCS. Although for some it is seen as contentious, it reflects the language of the Health Care Accords of 2000 and 2003. *Primary Health Care* will be used for the purposes of this report.

Components of Primary Health Care

In its final report "Building on Values" (pp. 117-8), the Commission on the Future of Health Care in Canada identified 6 components as follows:
(Note: Direct quotes will be indicated by quotation marks, otherwise the wording in the report will be paraphrased for brevity)

- "high quality comprehensive medical, nursing and other health care services with disease prevention and health education programs"
- services are provided to individuals and communities as a whole, including public health programs (disease prevention and health promotion)
- services are provided to groups on the basis of their culture, geographical location and particular needs
- "Teamwork and interdisciplinary collaboration are expected from health care providers..."
- "Services are available 24 hours a day, 7 days a week"
- "Decision making is decentralized to community-based organizations to ensure that services are adapted to the needs and characteristics of the population served." The intent is to enable community mobilization around health issues most relevant to their needs.

The benefits claimed for this approach are increased coordination, better quality of care and more appropriate use of resources.

These 6 components are relevant to the Territory of Nunavut, especially the requirement to adapt to local needs. Among those needs one must confront the realities of vast distances that challenge access, the greater burden of disease, the higher incidence of suicide, a younger population and the unique culture of the Inuit.

The opportunity is one of creating a model which fulfills the above criteria and is appropriate for Nunavut. Perhaps this could be an exemplar for circumpolar people and other populations that exist in comparable circumstances.

The concept of sophisticated primary health care is based on the foregoing, but also seeks to maximize the possibilities presented by provider substitution. The notion of provider substitution is a complex one, but in its simplest iteration achieves an appropriate match between the provider of services and the needs of the patient/client. At present the HCS, as often as not, deploys professionals whose degree of expertise is not necessary for a positive outcome. Indeed, it has been demonstrated (McMaster Study) that well-baby care is better delivered by nurse-practitioners than by family physicians. The latter in turn delivered superior well-baby care compared with pediatricians.

Applying this to Nunavut suggests that there is wisdom to the history (partly based on necessity) of nurses providing more advanced care than their southern peers. It has been demanded by the remoteness and isolation of the communities they serve. This should not be discouraged but rather built upon. The key to success is to ensure adequate training in the first instance followed by continuing professional development throughout their practice career. It also requires excellent communications and transport systems in support of their practices (see Recommendations #2, 4 and 5b). In addition, they should also be relieved of the burden of work not requiring their expertise.

The same reasoning should be applied to physicians, but a few questions arise. Can family physicians deliver virtually all the primary and secondary care that is essential for Nunavut? Can specialty care be provided on an itinerant basis as it has in Kivalliq for over 30 years? Can physicians be relieved of the hours of time they expend daily, coping with administrative challenges and clerical work?

The hypothesis presented here is that a sophisticated primary health care system could work as suggested above but the following elements are essential for success:

- physicians and nurses must all be trained in life support skills (i.e. Advanced Cardiac Life Support, Advanced Trauma life Support, Pediatrics Advanced Life Support etc.)

- provision must be made to ensure continuing competence in advanced life support skills
- additional training be provided to deal with further needs identified as necessary by HCPs; these must also be evidence-based
- cooperation/support be sought from the relevant licensing bodies, colleges, professional societies and/or academic health centres (Note: Preliminary discussions with these bodies have uncovered a strong interest in committing to, engaging with and being helpful to Nunavut, if asked.)

yes. Let them use us for positive PR and feel-good stories. We'll use them for practical help.

Priorities

There are emerging realities that underline the need for clarity of direction. Pressures on the existing health care system will demand action. It is important that directions that are set in taking such decisions are not prejudicial to the preferred future.

Near Term Actions: 1-12 months

- The first step would be to enhance communications and focus on building an overall territorial identity and reinforcing values. The retreat is a good beginning.
- Another early intervention is the introduction of new systems of management for medical travel, finances and quality assurance in the DHSS.
- A third is to initiate discussions with HCPs and SSPs as to strategies to enhance their QWL and the infrastructure support. The need to ensure that these professionals are able to focus on work requiring their expertise versus struggling with the system could have an important impact on health human resource planning.
- The fourth element is to pursue an information system and technology platform that takes advantage of developments already in place in DHSS and other departments.
- Initiatives to reduce "stove-piping" while buttressing cooperation as part of the functional planning of the health facilities under construction can be accomplished.
- Discussion of the role of BRH in the long-term should occur. The model of a sophisticated primary health care centre (Principle 8) that delivers health care, but also reinforces disease prevention and health promotion, is an option. In this model, BRH would serve the communities of Nunavut and be a key liaison with all the southern partners. It is an approach that appears preferable but requires some breaking of new ground. An option of being more in the mold of an institution in southern Canada with specialty care and related technology is closer

to the current practice and must also be put on the table. The 2 models (or others) require identification, discussion and a clear decision as to the preferred direction.

- Commence discussions to develop a strategy to repatriate obstetrics (e.g. mid-wives in all larger communities) so that Inuit women do not have to go south to have their babies.

Middle Term Actions: 6-24 months

- Address the governance at BRH with a mandate to stabilize administration
- Write an RFP for southern partners that builds upon the NMU experience and other best practices and complete the evaluation and choice congruent with contract cycle
- Implement new protocols and systems for Medical Travel
- Implement programs for Continuing Professional Development for HCPs and SSPs
- Implement the DHSS Communications Strategy
- Implement the registry for health assistants and health care aides and commence work on career path development

Longer Term Actions: 12 months +

- Revisit strategic plan, evaluate progress and modify as appropriate
- Build external relations with national organizations cooperatively with southern partner(s) and create a plan for research and education priorities
- Enhance circum-polar relationships
- Construct a long-term recruitment and retention plan built upon the success of QWL, CPD initiatives and the unique practice environment of Nunavut
- Hold meetings, conferences and lead in inter-sectoral activities in Nunavut and beyond
- Create a long-term strategy for community capacity building

Summary and Conclusions

As the newest and most unique territory in Canada, Nunavut faces daunting challenges but can do so with confidence. The more than one thousand year history of the Thule culture in the world's most forbidding climate not only sustained the Inuit in the past, but the inherited values are a beacon for the future.

Canada is at a watershed in its history as Canadians have once again affirmed their commitment to the publicly-funded health care system (HCS). Unfortunately progress is slow so the concern for the sustainability of the HCS remains. There are numerous issues that underpin the current challenges and Nunavut shares many of them with their partners in Confederation. Other issues are unique, such as accessibility to health care services. In Nunavut this is much more difficult and costly by an order of magnitude than the rest of Canada.

Can Nunavut succeed? Beyond any doubt. Success will most likely be achieved not by being imitative but by a willingness to learn from the best practices elsewhere while simultaneously being willing to dare, to be different and to be better.

In the foregoing report the 8 **Principles for Change** and a set of **Priorities** are presented in the hope of assisting the process.

It will be neither simple nor easy but it is possible. Who better to re-define the possible than the resourceful and exceptional people who live in the vast land that is Nunavut.

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Brief History of Nunavut Area

The story begins with the migration of the ancestors of the Palaeo-Eskimo from Asia to Alaska. This history is exceptionally explained in the book Nunavut: Inuit Regain Control of Their Lands and Their Lives and will not be attempted here.[1]

The Traditional Inuit Way of Life

"We are nomads. We chase opportunity in order to survive."[2]

The traditional Inuit lifestyle involves a subsistence economy of traveling and hunting animals such as seal, caribou, fish, birds and whales. Inuit clothing and many tools were traditionally made using the hunted animal – skin boots, fur or skin clothing.

The Europeans taught that the Arctic Lands were not discovered until they themselves explored them, thus ignoring the 4500 years that the Inuit and their ancestors had inhabited the area.[3] "Nevertheless with each trip (i.e. by a European explorer) the map of the Arctic became more European and then our land itself started to be claimed by outsiders."[4] The Europeans introduced the Inuit to new technology, materials and values, as well as diseases. These new things were not free and furthermore usurped Inuit traditions – the European contact was taking away both traditions and lives. In order to survive in a time when European whalers and trappers were swarming the area, the Inuit were required to further abandon their traditions in order to be successful hunters. The Europeans traded with the Inuit – guns for fox pelts etc. – but this created a power imbalance and a dependency.[4]

One can describe the transformation of the Inuit way of life since European contact as mobile meat eaters becoming sedentary sugar consumers. The results of this transformation are well depicted in this description of post-European contact by Ann Meekitjuk Hanson:

> "From that time on, we, without knowing it, were in mourning for the loss of language, culture, skills and spirituality that is connected to nature. We turned to alcohol, drugs, substance abuse and self-destruction."[2]

The Creation of Nunavut

In Inuktitut, the language of the Inuit, Nunavut means "our land" and what an appropriate name it is. Nunavut comprises one-fifth the area of Canada with a 1996 population of 24, 730 of whom 20,480 are Inuit.[5]

The Inuit Circumpolar Conference (ICC) is an organization representing and exploring environmental and social issues for all the Inuit (135,000) of Canada, Greenland, Alaska and Chukotka (Russia).[6] In 1971 the Inuit Tapirisat of Canada (ITC, more recently known as Inuit Tapiriit Kanatami, ITK) was formed to represent the

interests of Inuit people across Canada.[7] In 1973, three important court decisions supporting aboriginal rights were made.[5] Three years later in 1976, the ITC appealed to the federal government of Canada for an Inuit land claim as well as the creation of Nunavut, however the latter request was not accepted.[8] In 1982, the Northwest Territories voted to create a new territory and the boundaries of this new territory were decided in 1992.[7] The boundaries of Nunavut essentially split the former Northwest Territories along a line dividing the ethnically diverse west (consisting of Metis, Inuit, Dene and non-aboriginal peoples) that also includes the greater number of trees, from the east that is above the tree-line and has a population of 85% Inuit.[8] This split was not arbitrary: a map of Canada depicting Native Land use between 1891-1910 and 1950-1955 shows the clear land separation between the Dene and the Inuit.[9] The Inuit inhabited the north and east area of what was then the NWT.[9] A diagonal line running northwest to southeast could be drawn just north of Great Bear and Great Slave Lakes as the dividing line between settlements of Dene (to the south and west) and Inuit peoples.[9] If one looks at a map showing the areas of Nunavut and the NWT today, the former is comprised of where the Inuit traditionally settled.[9] However, there does appear to be a slight area north of the Yukon and the northwest top of the NWT where the Inuit also dwell/dwelt that is not included in Nunavut.[9]

November of 1982 saw 84.7% of voters supporting the agreement that had been reached with the federal government. Officially, the Nunavut Act was passed in 1993 and on February 15, 1999 the first Nunavut election was held.[7] Finally, on April 1, 1999 Nunavut officially became part of the federation of Canada.[5] In terms of both land acquisition and financial reparation, the Nunavut Land Claims Agreement (NLCA) is the largest claims settlement in Canadian history.[8] This settlement involves a land and water area of 1.9 to 2.1 million square kilometres (depending on which source is consulted), mineral rights to 35, 257 square kilometers and compensation of 1.1 billion dollars to be paid between 1993 and 2007.[8]

When the area of Nunavut was part of the Northwest Territories (NWT), it was divided into three administrative regions that Nunavut has retained. The central and western region that also encompasses the area north of Yellowknife is the *Kitikmeot* region, while *Kivalliq* (formerly Keewatin) comprises the south and central Hudson's Bay and north of Manitoba areas. The third region, *Qikiqtani* (formerly Baffin), makes up the eastern and northern part of Nunavut. The capital was decided through a referendum with Iqaluit (1996 population 4,220) being preferred over Rankin Inlet.[5] Iqaluit also had the highest population growth of all Nunavut's communities between 1996 and 2001, with an increase of 24.1%.[6] The Community Population Projections predict that in 2020 Iqaluit will remain the largest community with 8,394 people followed by Rankin Inlet with 3,633 people and Arviat with 2,855.[10] The total estimated population for Nunavut in 2020 is 43,824 people.[10]

The governmental structure of Nunavut is not strictly a territorial government (versus provincial) because the NLCA secured power over some areas that would normally be federal jurisdiction.[11] The government of Nunavut's (GN) structure has also been designed to maintain the tradition of leadership by consensus, including as such an absence of political parties at the territorial level.[11] The legislative assembly of Nunavut is comprised of 19 members and the assembly elects the speaker, premier (currently Paul Okalik) and executive.[11] At the federal level, Nunavut is represented by one senator

(Willie Adams) and one Member of Parliament (Nancy Karetak-Lindell).[11] There are ten departments in the GN as follows: Executive and Intergovernmental Affairs; Finance and Administration; Human Resources; Justice; Public Works, Telecommunications and Technical Services; Sustainable Development; Health and Social Services (HSS); Education; Culture, Language, Elders and Youth; and Community Government, Housing and Transportation.[12] Nine of the departments are similar to ones found in other jurisdictions, while the department of Culture, Language, Elders and Youth is unique and reflects a desire to maintain traditional Inuit culture and values.

The Tungavik Federation of Nunavut (the predecessor of Nunavut Tunngavik Incorporated - NTI) signed the Clyde River Protocol. This protocol directs the working relations between the GN and NTI.[6] The purpose of NTI is to oversee for the Inuit of Nunavut, the application of the NLCA.[13] Under the Nunavut Act, five Institutions of Public Government were created as follows: Nunavut Planning Commission (NPC), Nunavut Water Board (NWB), Nunavut Wildlife Management Board (NWMB), Nunavut Impact Review Board (NIRB) and Nunavut Surface Rights Tribunal (NSRT).[14] All five of these boards have Inuit and federal members; NTI oversees the former group's regional nomination.[14] There are also three Regional Inuit Associations (RIAs), which correspond to the three regions of Nunavut (Kivalliq, Kitikmeot and Qikiqtani) and oversee the application of the NLCA to their respective area.[14]

There are 25 communities in Nunavut, excluding several tiny encampments lacking community services.[34] There are no roads between communities and although all the communities are on the land area near the ocean, shipping can only occur during the summer sea lift.[6] This combination renders flying the most frequent way of travel, which in turn makes the cost of living high and providing services very expensive, not to mention difficult.[6] In Nunavut the cost of food is multiples of what it would be in Toronto. For example: two litres of 2% milk cost $5.71 in Nunavut versus $2.79 in Toronto and a loaf of white bread is $2.59 compared to $0.89.[13] A lack of high speed Internet also impedes communication between communities.[6] The development of a GN Wide Area Network is the responsibility of the department of Public Works and Services.[15] According to the Report on Decentralization, the "GN Wide Area Network is not living up to its potential".[16, p. 4]

The decentralization of the GN has created 700 positions among the communities of Iqaluit, Igloolik, Rankin Inlet, Cambridge Bay, Cape Dorset, Arviat, Gjoa Haven, Kugluktuk, Pangnirtung, Baker Lake and Pond Inlet with the "core machinery functions situated in Iqaluit".[11] The decentralization also provides more power to each of the three administrative regions. The regional governmental centres are Rankin Inlet for the Kivalliq region and Cambridge Bay for the Kitikmeot region.[6] Decentralization was recommended by the Nunavut Implementation Commission (NIC) in two reports: 'Footprints in New Snow' and 'Footprints 2'.[16] The Government of Canada nominated the nine members of the NIC which ran from 1993-1999.[30] Six of the nine members had to be residents of Nunavut. "The Commission advised all parties on the funding and design of training plans, the timetable for transferring service, and the process for holding the first election for the Government of Nunavut, in February 1999.[30] By December 2001, 340 positions were decentralized with 131 positions remaining vacant.[16] Inuit fill 59% of community jobs versus 42% public service as a whole and only 28% in Iqaluit.[16] The decentralized staff for the department of HSS in Kugluktuk has only managed to fill

three of 14 positions with one permanent position filled by an Inuk.[16] These numbers support the call for increased Inuit participation in health and social services education. In contrast, Nunavut Power has fared much better at Baker Lake by filling all but two of 18 positions, with 14 of them occupied by Inuit.[16] Decentralization appears to be more successful if jobs are only decentralized in a way that fits with the local skill base.[16] While the NIC called for a decentralized governmental model in order to spread out the economic benefits, Nunavummiut (residents of Nunavut) do not tend to hold the so-called professional level jobs.[13] There is also a dearth of social housing and educational completion of both high school and post secondary school.[6] The Nunavut Implementation Training Committee (NITC) was developed so that Inuit of Nunavut become trained to fill the positions in the GN and Designated Inuit Associations (DIOs), so there is less reliance on outsiders to occupy these jobs.[6] The Report on Decentralization noted the serious communication problems existing between headquarters and the communities.[16] There is also a tendency for decentralized workers to have low morale due to isolation and a lack of orientation to their job.[16]

Currently, the government of Canada supplies the vast majority (94%) of the GN's revenue.[6]

Although the Kivalliq and Kitikmeot regions have regional government centres, in Qikiqtani, due to Iqaluit being the capital, governmental management positions have been spread across the region.[9] The regional office of the Qikiqtani region for the department of Health and Social Services is in Pangnirtung while Igloolik contains its regional financial and human resource supports. Within Iqaluit public health, mental health and social services are not at the hospital location but are instead spread throughout the community.[6]

Nunavut has three official languages: Inuktitut, English and French of which the first is to be the working language of the government.[17] The language requirement is noble but poses a problem because initially the specialized posts will have to be filled with southerners until the educational system has prepared Nunavummiut to fill the positions. The idea is that the government should be working toward a work force ethnically representative of Nunavut - 85% Inuit.[13] Inuit Qaujimajatuqangit (I.Q.) means Inuit traditional knowledge and a goal is incorporation of this concept into the government.[18] I.Q. is made up of six concepts as follows:[4]

- Pijitsirniq – being useful in service to others
- Aajiiqatigiingniq – dialogue and communication
- Pilimaksarniq – learning by observation, experience and practice
- Piliriqatigiingniq – teamwork and collaborative relationships
- Qanuqtuurunnarniq / Iqqakaukiringniq – creative problem solving
- Avatik Kamattiarniq – environmental stewardship

One can see the economic transformation of this society by noting that only 60% of Inuit adults are considered part of the wage economy, in contrast to 91% of the non-adult Inuit.[13] Approximately 39% of the jobs are governmental in nature, followed by mining (held by mostly non-residents), construction, tourism, the fur industry and arts and crafts.[19] The population distribution of Nunavut is also skewed: in 1996, 56% of the population was under age 25.[20] Furthermore, in 1996 almost one third of the people over 15 years possessed an education level of less than grade nine[20] This population distribution combined with the lack of congruence between skill sets and employment

opportunities in Nunavut causes a high rate of unemployment.[13] The emphasis on wage jobs is antithetic to the traditional subsistence economy and thus poses a problem for preserving the traditional Inuit culture.

The Bathurst Mandate

The Bathurst Mandate was created to guide and provide the context of the development of Nunavut.[21] This important document emphasizes inuuqatigiittiarniq, or "the healthy interconnection of mind, body, spirit and environment." Four guiding principles are detailed in the mandate: Healthy Communities, Simplicity and Unity, Self Reliance, and Continuing Learning.

The principle of *Healthy Communities* involves putting people first and promoting development at three levels: individual, familial and community. Learning from the wisdom of Elders, communicating with the south, improving social and health conditions are all goals of Healthy Communities. A more specific objective is to possess a full complement of Health and Social Services staff who are properly trained and can be retained.

Simplicity and Unity incorporates the concept of I.Q. and its context for the government. There is an emphasis on co-operation, governmental openness to the public and equal employment opportunities. A specific goal within this area is to have Nunavut adopt a single time zone – currently the Nunavut landmass incorporates four time zones although only three (Eastern, Central and Mountain) are actually used by communities.[6]

The *Self Reliance* principle is concerned with the self-support of Nunavut as well as a contribution to the rest of Canada. The idea is to utilize traditional Inuit values and respect the uniqueness of Nunavummiut while also promoting personal growth within the communities. Evaluations of the GN and its systems, as well as increased access to programs, are also discussed.

The value of teaching and learning from both within Nunavut and without are highlighted in the principle of *Continuing Learning*. The goals for the educational system include a revamping of kindergarten to grade 12, with an integration of traditional Inuit knowledge. An overall increase in the number of people attending high school and higher education along with a higher number of Inuit professionals is an aim of the principle of Continuing Learning. The title of this principle explains its stress on lifelong learning.

Health Status for Nunavummiut

Note: Unless otherwise referenced, Information for this section is credited to the Application to Health Canada's Primary Health Care Transition Fund, which provided an outstanding review of the health status of Nunavummiut.[6]

As explained in the Application to Health Canada's Primary Health Care Transition Fund (PHCTF), the population of Nunavut does not reflect the average health of Canadians.[6] This health profile includes an at-birth life expectancy that is ten years less and an infant mortality rate of two times the national average. Nunavummiut also have much higher rates of infectious diseases such as tuberculosis (eight times the national rate) and sexually transmitted diseases in particular (fifteen times the Canadian

rate). Furthermore, the teenage pregnancy and sexual assault rates are three and seven times higher than the national average respectively. Mental health is a serious concern reflected in a suicide rate that is six times higher than the Canadian average. The population growth in Nunavut is also among the highest in Canada with a growth rate of 8.1% between 1996 and 2001.

In April 2000, the three former regional health boards were dismantled in favor of a single department of Health and Social Services (HSS).The Minister, Edward Picco, has been the same minister since the creation of Nunavut although there have been four Deputy Ministers.

The department of Health and Social Services considers the concepts of Inuuqatigiittiarasukniq (work to stay as acquaintances) and Piliriqatigiittiarasukniq (work to stay working together) to be its guiding principles. The mission of the department is "to promote, protect and provide for the health and well being of Nunavut residents in support of leading self-reliant and productive lives."[6, p. 27]

The PHCTF report emphasizes the important role of primary health care and population health for Nunavut. In support, the report provides details that the Romanow Commission found regarding the benefits of primary health care including: more coordinated care, better quality of care and better use of resources. In the report it is stated that 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."[6, p. 4] Through these perspectives, one can examine the health needs of an entire population, which would suit the situation in Nunavut very well. The purpose of this report was to apply for funding from the Primary Health Care Transition Fund and it concluded that a primary health care transition office should be created to oversee initiatives leading to structural change.

There is only one hospital in Nunavut – the Baffin Regional Hospital in Iqaluit.[22] According to Health Canada this hospital, "is the only acute care facility in Nunavut providing a range of in-patient and out-patient hospital services, as defined by the Canada Health Act."[15] There are Community Health Centres (CHCs) in 24 other communities across Nunavut. These CHCs provide public health, emergency room service and some overnight service (observation).[15] The CHCs are staffed with Registered Nurses who provide twenty-four hour, seven day per week on-call coverage. There are also Inuit clerk interpreters to help with language incompatibilities. Most CHCs have a Community Health Representative (CHR) who is a generalist providing preventative education and promoting health as well as community development. Due to staff shortages and high service demand, activities promoting prevention and education often get put on the back burner when acute care needs arise. Most CHCs have one or more social workers and approximately half have Registered Psychiatric Nurses (RPNs). The RPNs work with people who are moderately and seriously mentally ill, and connect to both community networks and consulting specialists.[31] Health Committees were also set up by the Hamlet governments to allow citizen participation in health matters but as yet they have had little direct influence on community health decisions and policy despite funding and designated representatives.

In Nunavut, there are the full-time equivalents of approximately 16 physicians with the majority (seven) being general practitioners.[31] "Practitioners must be prepared to be generalists and seek support for specialized services from afar."[6, p.15] Specialist

services are usually provided outside of Nunavut resulting in an extremely high annual travel budget - $30 million for 2002/03. Medical transportation to the south has a north-south axis for each of the three regions: Qikiqtani flies to Ottawa or Montreal, Kivalliq transports to Churchill or Winnipeg and Kitikmeot to Yellowknife. Chronic Disease Clinics outside of Iqaluit (i.e. at the CHCs) occur when physicians fly into the particular community. There are issues with the recruitment, retention and orientation of new staff. For example, all new employees are supposed to take part in a three-week course in Inuktitut but this rarely ever happens because of the urgency to fill positions. The PHCTF report highlights the problem that the majority of professional health care providers are non-Inuit (that is, not representative of Nunavut's 85% Inuit population) and are not trained within the territory. Further problems in staffing can be seen through such examples as Kitikmeot's unfilled physician positions for Cambridge Bay and Kugluktuk. According to the Canadian Institute for Health Information (2002), Nunavut has less than one-seventh of the physicians than the national average – that is, 25 versus 187 MDs per 100,000 people.[32]

Patient's records are transferred from each community to headquarters on paper and in various formats. The differing formats arose to make documentation useful and specific to each community, however they have also caused numerous problems. The department of Health and Social Services has an Information Technology section that has not yet been able to design and implement an integrated patient record system. According to the PHCTF report, IT has developed separate systems for integration into one with the Nunavut Health Care Number as the identifier. The Community Health Reporting System (CHRS) receives a plethora of inconsistent, paper-based information each month from which it has been difficult to gain useful statistics. However, this may be changing as of recently.[31] There are problems with the registries - the data are there, but reports are not being generated. The Report on Comparable Indicators for Nunavut and Canada (produced by GN, department of Health and Social Services as quoted in the PCHTF report) noted that there are significant problems with health related data collection. For example, there is no single format for health care records between communities and the coding accuracy is often in question. However, issues such as these are not location-specific, as they are experienced in most other jurisdictions.[31] There is an issue here in that there is no system that appropriately links information users, IT and information planning. Therefore, the planning for health services is not statistically informed since usage statistics and treatment profiles are not standardized as well as infrequent. Furthermore, there are still administrative remnants of Nunavut's connection with the Northwest Territories such as the fact that the Health Care Plan Number assignment is done through the NWT. Although according to Don Ellis (Acting Director of Programs, Health and Social Services), the NWT will no longer be responsible for this as of April 1, 2003).[31]

The unique distribution of Nunavut's population compared to the rest of Canada results in different primary health care needs with a focus required on perinatal, child and adolescent health. Women even have to leave their communities to give birth and the only midwifery services exist in Rankin Inlet in the Kivalliq region.

Health Care Programs

There seem to be inconsistencies between the three regions in terms of health care workers and programs as detailed in the PHCTF report. For example, the Qikiqtani region has Wellness Counselors who work with addictions among other issues, whereas the other two regions have Alcohol and Drug Addictions programs. The Kivalliq and Kitikmeot regions share a Director of Mental Health Services who is one of Kivalliq's five Registered Psychiatric Nurses. There is only one psychologist in all of Nunavut.[6]

There is only one mental health facility in Nunavut – a 10 bed transitional facility for the moderately and seriously mentally ill, in Iqaluit. There are no addictions facilities.[31] In the Qikiqtani region there is the Baffin Hospital, the Agvvik Society Shelter for battered women and children as well as a homeless shelter. In the Kivalliq region, a family violence shelter and home for handicapped adults exist in Rankin Inlet and Chesterfield Inlet has a long-term care facility. Finally, two short-term violence shelters and a group home in Cambridge Bay serve the Kitikmeot region.[6] University of Toronto and the Northern Medical Unit do psychiatric outreach visits to the Qikiqtani and Kivalliq/Kitikmeot regions respectively.[6]

In terms of dental care, the GN, through the HSS department, offers a dental program that is primarily for children.[6] Seventeen communities have resident dental therapist positions but currently only ten of them are filled. The training for this is received at the Saskatchewan Indian Federated College's National School of Dental Therapy in Prince Albert. Adults can receive dental care under the Non-Insured Health Benefits program and regional dental services exist in Qikiqtani and Kivalliq with practitioners who go out and visit the CHCs. In contrast, the Kitikmeot region has a private contractor who services three communities.[6]

The Ikajuruti Inungnik Ungasiktumi (in Inuktitut: a tool to help someone who is far away) Telehealth Project emerged from a 1999 NWT telehealth project.[6] The project is funded by Health Canada and as of November 2002 there were fifteen sites throughout Nunavut in which training and installation were occurring. The "bandwidth from the Anik-F1 satellite will be used to support the expansion of telemedicine applications to Nunavut communities."[23]

According to the PHCTF report, there is not enough money budgeted for new buildings, renovation and new or replacement equipment for health centres. The current budget for this is $75 million (an element of the overall sense that Nunavut may not be adequately resourced overall) and compounding the money issue is the dependency on the sea lift to receive construction materials.

Statistics Canada began the Canadian Community Health Survey (CCHS) to provide a consistent measure of health determinants, health status and health care system use by communities across Canada.[24] The survey divided the country into 136 health regions of which Nunavut is considered one health region. The anticipated sample size for Nunavut is 800 people with optional content investigation into: dental visits, depression, flu shots, home care, self-esteem, sexual behaviours, social support, spirituality, and suicidal thoughts and attempts. This survey will ideally provide some answers to questions regarding health care in Nunavut; however the results will only start to be available in summer 2003.[24] Furthermore, there is concern that work is required on the cultural meaning of certain areas of enquiry in the survey, rendering results seriously

misleading, at least in some areas. For example, in a jurisdiction with excessively high suicide rates, coherence scores are above average, depression scores below average.[31]

The following programs are funded by Health Canada, with total contributions of $5,630,000 in 2001-02: Brighter Futures, Building Healthy Communities: Mental Health Crisis Management, Solvent Abuse Program and Home Nursing, Canada Prenatal Nutrition Program and the National Native Alcohol and Drug Addiction Program (NNADAP).[25] They fund but deliver none of these. Health Canada, at the request of the three territories reorganized itself to provide a single window for wellness and health promotion programs, as well as NIHB. Northern Secretariat, which liaises with Ottawa, is evolving into that mechanism and handles programs and funding streams from several Health Canada branches. The Secretariat generally enjoys a good relationship with Nunavut partners.[31]

Brighter Futures is a community level, intervention program that enables communities to define and directly deliver appropriate interventions for local improvement.[27] Brighter Futures is therefore culturally sensitive, being built on Inuit values. Approximately half of the projects are concerned with community mental health, followed by child development.[27] In the Qikiqtani region alone, projects range from music education and practice to funding library book purchases to teaching traditional hunting skills. The Mental Health and Addictions division is in charge of the NNADAP that has been in existence for fifteen years.[28] The NNADAP is designed for implementation at the community level and addresses prevention, treatment and rehabilitation of alcohol and drug addictions. Many of the initiatives provide further education for counselors, including information on gambling addictions.[28] There is also an Aboriginal Diabetes Initiative (ADI) with activity in Nunavut, which is coordinated by Chronic Disease Prevention.[26] In 1999, the FNIHB (then the Medical Services Branch) started the Home and Community Care Services program ($4.817M in 2002/03).[6] In many communities, the Home and Community Care Nurse works out of the CHC. A lesson in consistency can be learned from the home support workers whose orientation sessions have standardized their practice.[9]

There is also a Non-Insured Health Benefits Directorate that "provides medically necessary health-related goods and services, not covered by other federal, provincial, territorial or third party health insurance plans, to about 706,000 eligible registered Indians and recognized Inuit and Innu".[26]

Review of the Department of Health and Social Services

Marcia Thomson, the Assistant Deputy Minister of Health for the province of Manitoba, performed an external review of Nunavut's department of Health and Social Services, based on a short visit to Nunavut and review of secondary materials.[29] This review was useful but, as the DM states, limited in a couple of ways, namely that the reviewer did not have the chance to visit any CHCs (only the hospital in Iqaluit) and the "quality of the services wasn't to be commented on."[29, p.2] While many aspects of the department impressed Thomson, she also pointed out that stability in management would help with momentum of the department and maintenance of focus.[29] Similarly, the Conference Board of Canada's report for the Nunavut Economic Development Strategy identified the "ongoing need for common vision and a united strategy to enable horizontal integration and cooperation of programs, strategies and organizations."[6, p.11]

Thomson also indicated that the roles and responsibilities between the departments of HSS, Finance and Human Resource need clarification. Furthermore, the review recommended a greater connection of headquarters staff with each other as well as to the regional operations and local community service. Thomson mentions that ideals of professionalism and Inuit employment goals may be at odds with each other – that is, perhaps less professionally qualified Inuit staff with supports would be advantageous at present, rather than strict educational prerequisites that the Inuit people probably have not had the chance to fulfill. The department's activities suggest that it is determined to maximize the role of specially trained Inuit workers (e.g., maternity care workers, mental health CHRs, CHRs with supplementary oral health or rehabilitation skills, home care workers with specialized training in care of diabetics, and so on). An interesting suggestion that Thomson made was to use outside consultations with reinterpretations made from the I.Q. perspective. As in the PHCTF report, she also advocates a population health approach as very compatible with Nunavut. In the review, it was also suggested that community-level education regarding the reasonable expectations of community health services would be valuable.[29]

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Appendix II

Trip of March 30 to April 5, 2003

Preamble: As part of the continuing exercise to further planning for the DHSS, a fact-finding trip was arranged over 7 days. DE communicated with key individuals at all sites indicated below explaining the purpose of the trip. Follow-up was undertaken by RYM and most contacts were contacted prior to March 30. The sole exception was Mr. Al Woods who was reached 2 days before the visit at Stanton Regional Hospital.

Itinerary: The following centres and communities were visited:

- Winnipeg and the Northern Medical Unit (NMU) - March 30-31
- Churchill March 31 overnight, owing to weather, and an unplanned connection with Dr Steve Langley who was about to commence a one month locum at Rankin Inlet
- Rankin Inlet - April 1-2 (5 health services)- region of Kivalliq
- Yellowknife and the Stanton Regional Hospital- April 2-3
- Cambridge Bay-region of Kitikmeot- April 3-4

Findings by site:

Winnipeg: Excellent itinerary arranged by Dr Bruce Martin. In addition, upon arrival at the Radisson Airport Hotel there were 7 documents awaiting me all of which were reviewed before the meeting. About 3 hours were available so the review was cursory but nonetheless very helpful and informative. They proved highly relevant to the events of the following week. It was possible to review the documents in more detail as the week wore on owing to the many flights.

Meeting #1 Dean Brian Hennen at his home.
He indicated support of and confidence in the Northern Medical Program. He is well aware of the work being undertaken and from his perspective there is an excellent working relationship between the University and NMU on one hand and the Government of Nunavut and the region of Kivalliq on the other. He expressed a high level of confidence in Dr Bruce Martin the Director of the NMU. He looks forward to continuing collaboration and should prove an important contact for future activities.

Meeting #2 Dinner meeting in a private dining room at Assiniboine Park 1730-2130
Attending were a total of 10 people indicated in Appendix 1. After introductions and a restatement of the purpose of the visit an animated and enduring discussion ensued in which everyone present took part and contributed meaningfully. It was a very successful evening from my perspective. Among the many "learnings" were;

- the long history of the NMU and Kivalliq and the strong sense of ownership (in the best sense) felt by the NMU
- the commitment to upstream care and approaches
- the collegiality among the professional groups ie medical specialists, family physicians, rehabilitation scientists etc

- the importance attached to mental health under the leadership of Dr Clark Wilkie
- the existence of a feasibility study for rehabilitation assistants and hearing/speech workers. This has been developed "Through its agreement with the Department of Health and Social Services in the Kivalliq Region,.."
- An unequivocal commitment to quality of service and team play by all HCPs
- The existence of a robust research capacity (e.g. Dr Alec Macaulay's master's thesis)
- The popularity of the Kivalliq region as a site for learners especially medical students and residents (post-grad students) **always** under supervision

In short the meeting left me with the impression of an excellent and perhaps exemplary working relationship. The meetings to follow shed more light on this impression.

Monday March 31st

Tour of the Kivalliq Inuit Centre
This was also highly informative and a pleasant surprise. A crowded and aging building (its replacement is to opened within the month) was filled with a buzz of happy people, purposeful activity and a functional medical record system that would compete with those I've seen in any jurisdiction. It is remarkable how under the leadership of Sharon Hunting (SH) a full up-to-date set of files exists for all patients/clients who have engaged the system in Kivalliq. What is more there is a duplicate copy with the same information in the relevant community-based health centre. It was interesting to hear SH's claim that the true original is in fact in the community and the copy is in Winnipeg. It speaks volumes about the mind-set of the people in the NMU and in particular their strong sense of mission and service to the people of Kivalliq.

I also had the opportunity to tour the soon-to-be-opened new building and it looked splendid and well-designed for the needs it will be required to meet.

Meeting #3
Following the tour described above a meeting was organized with the back-bone administrative staff. Once more the sense of collegiality and mutual respect pervaded the meeting. All voices mattered and were respected and certainly had a lot to offer.
Some highlights were:

- About 20% of the activity of the NMU is focused on the Kivalliq Region. The rest of their activity relates to northern Manitoba aboriginal people
- Aboriginal Library Director Janice Linton delivers an outstanding service for a remarkably low cost i.e. 0.14 FTE. For this inservices have been conducted on literature searches as an example. The apparent outcome was an increase of searches from 20 to 50 per year. For a total budget of

$18k annually acquisitions, delivery of documents and remaining "totally up to date" in their information base is delivered.

- Specialty services coordinator Lori Thiessen coordinates specialty clinics which are now up to 358 days per year. All are itinerant visits BUT by specialists who have been returning for decades. The principle services that are required are pediatrics, psychiatry, obstetrics, ENT, ophthalmology and internal medicine. The decisions for clinics and the choice of services is carried out on a needs-based approach. It appears to be a model worthy of emulation.
- Retention of Family physicians is also a challenge for the NMU. However the average term, including part-time MDs is 14-16 months.
- Recruitment, orientation and screening before and after placement are done and taken very seriously. Negative, legitimate feed-back is respected whether from nurses, translators or others and if confirmed it is then acted upon. This was a finding confirmed by all. In short quality assurance is pursued vigorously in this and all their endeavours. It is clear that the leadership is crucial for this and that all disciplines are very proud of NMU for this among other practices.
- Finance and administration is also very strong. Jenni Morris settles all invoices (travel and professional fees) within 3 weeks, stays within budget, works well with her counter-part in the DHSS and is appreciated by all. There is no contention about finances and related matters. This is not a common finding.
- Other findings include an initiative to create a web-site refreshed at regular intervals and a newsletter for staying in touch with all communities, very strong specialty-family physician relationships, and anecdotes about qualified/needed HCPs (not) landing jobs in the Baffin Region. They were simply turned away. VERY CONFIDENTIALLY: BRH is seen as being "not in control, technology-driven and hospital-centred".

Meeting #4

The final meeting was with medical staff and included 2 former directors of NMU. The key message was the striking reality of continuity, shared values enduring over decades and a strong corporate memory and pride. Another finding which was to be repeated in my meeting with Dr Steve Langley and others in Rankin Inlet and Cambridge Bay, is that of convergent validity. The reality of a high quality delivery of service with a strong, appropriate academic support system was confirmed and reconfirmed. At least 2 of the former directors who have taken on other very senior positions continue to return to "their communities" and speak proudly of knowing 3-4 generations of some families. It is no doubt a unit that has its imperfections but for me it is the best I have seen. The Government of Nunavut must not lose the opportunity to take advantage of this strength.

Flight to Rankin Inlet

The afternoon flight was not able to land in Rankin Inlet so all passengers spent an overnight in Churchill. As fate would have it I met a Dr Steve Langley who was on the same flight and on his way to Rankin to do a one month locum. It was his second such locum. We agreed to have dinner and he graciously accepted enquiries about his experiences and in particular with the NMU.
Dr Langley is an experienced physician who has practiced in various settings, both rural and remote in Alberta and Saskatchewan. He was very clear about the effective way the NMU was managed and how it stood out as a well-run program. He cited for example that payment was prompt, fair and timing is simply not an issue. (Note the timeliness of payment is in contrast to problems experienced by physicians in the Baffin Region.) He also noted that the staff at NMU were very pleasant and effective in all respects including communications and travel arrangements.

April 1 Rankin Inlet
The following morning we were able to fly into Rankin. I was met at the airport by Ms Patricia "Tish' Wilson. She and Wendy Dolan share the Executive Director role and both hold other jobs as well (at the Director level). Perhaps because of their excellent working relationship, the arrangement works very well. Certainly it was very effective from my perspective and the itinerary was full and deeply informative. It included meetings with all services (5) except Dental.

Meeting #5
Tish Wilson and Wendy Dolan-luncheon meeting
Of interest neither have been to Iqaluit. Tish is from North Bay and we had interacted in previous times relating to trauma care of patients and their referral to Sunnybrook in Toronto. I mention it as she viewed it as a good model of care. Both she and Wendy confirmed all the positive impressions that had been evolving since encountering the NMU – nothing but praise. They also identified what they feel is a communication shortfall between Iqaluit (HQ) and Kivalliq. Finally we spoke about the adequacy of nursing staffing levels in the region and Rankin and the difficulties they are experiencing e.g. "never fully staffed".

Meeting #6
Karen Taylor, Acting Nurse-in-Charge (NIC) Rankin Inlet
Like many professionals I have met both within Nunavut and elsewhere Karen is very dedicated and upon first meeting appears to be very capable and dedicated and yet is exhibiting frustration. Nursing in Rankin is professionally challenging and rewarding but the problems weigh heavily upon her and other nurses. At the core of her concerns is the issue of instability of staffing and lack of retention. She referred to transience and inconsistency and "too many people, too many changes". The loss of corporate memory is a real problem that she and others mentioned. Furthermore the perceived lack of commitment to Continuing Professional Development was identified again and again. There is a need for better screening, a well organized orientation and most of all an investment in the continuing education for nurses. It was mentioned that individual

nurses have to make their own arrangements to attend relevant educational events/courses and largely at their own expense and initiative (had to take holiday time)
To emphasize the consequent problems Ms Taylor noted that "a lot of the time we're scared". Their need for more training/education is strongly felt. She stated that "it seems as if we are in a constant crisis management mode". She also feels the situation is exacerbated by inadequate clerical staff both quantitatively and qualitatively.
Finally the role of contract nurses in this scenario is particularly concerning as most have little background to cope with the realities of nursing practice in the north. Karen feels that a system like the NMU manages for physicians and rehabilitation professionals would be very helpful to nursing.

{Of interest I was unable to find any explanation for why the NMU does not include nursing services. Perhaps it is due to the fact that they are part of a separate faculty in the University of Manitoba whereas the School of Rehabilitation Sciences is part of the Faculty of Medicine.}

Meeting #7
Birthing Centre
I was able to meet with all 3 mid-wives for 90 minutes. It is the only such unit in Nunavut. All agreed that birthing units should also exist in the other 2 regions. The Rankin Inlet Unit has been open for 10 years and does about 100 deliveries in Rankin and 100 others are managed in the local communities. They spoke eloquently about the centre as being a realization of the vision of the Inuit women of Kivalliq.
Once more I was impressed by the professionalism and dedication of the mid-wives. However many concerns reflected messages that were resonant with those I had heard previously. For brevity I will list them in point form;

- There is a major concern about receiving a written reassurance regarding malpractice insurance. This has been communicated to KB and DE.
- Instability of staffing is a major problem. There have been 40 mid-wives (MWs) in the history of the program according to Wendy Baker
- CPD is a serious issue for MWs as well ("work, work, work and we are not nurtured")
- Identified the need for a maternity-care worker to enhance their support and as an important step to ensure eventual succession by Inuit mid-wives
- Supported the management processes and approaches of the NMU. Indicated that they would prefer to work on contract with them.
- Other concerns related to housing and family life in Rankin.

April 2 Rankin Inlet
Meeting #8
Social Services- 3 SWs (Candace Ingles, Michelle and Margaret)
This is a group that is feeling the most disadvantaged of those I have encountered. They too feel the effects of instability but also are convinced that they are disadvantaged compared to health care workers, "not respected". There is little evidence of a

cooperative working relationship between health and social services. Although they are in a separate building the 2 edifices are sufficiently proximate to enable more cooperation than exists presently. For example, separate files are kept on the same clients (and remain separate or unlinked). Furthermore there is a lack of clarity on the relative roles of each and how they might work together.
As a consequence the SWs are certain (with good reason it appears) that there are significant gaps in service that would not exist if there was a more functional working relationship. It is not my attention to assign blame in any direction but it is essential that a more functional and thus sustainable working arrangement be created. Another important problem of morale that is unique to this group is that they feel very negatively perceived by the community. According to their own testimony they are seen as "baby-snatchers" and "family breakers" in league with the RCMP when they pursue their child-protection responsibilities. Local people are afraid to be seen with them or visiting their offices. There are more details but suffice it to say this service requires some attention and assistance urgently. There may be relative simple measures that could make a difference.

Meeting #9
Jennifer Berry Home and Community Services
This is a new program that is funded by Health Canada/FNIHB through the Government of Nunavut corporately. It appears to be off to a very promising start. It began last October (2002) and has a complement of 5.5 FTE nurses, 1 local coordinator and covers 8 communities. There are 16 Inuit Home Care Workers now trained and about 40 home-makers who existed prior to this program. It is very interesting to witness how Jennifer and her counter-part in Kitikmeot, Gogi Greeley, have created the program essentially from scratch. It is running, 2 education modules have been created and delivered. The first focused on professionalism, hygiene and personal care. Eighty individuals completed the course. The second module related to disease specific needs in the context of diabetes, chronic obstructive pulmonary disease, medication management and medial equipment. Sixty individuals took the second course. Five out of eight communities have the capacity to run telehealth programs and connect to the internet.
Of particular interest CPD and inservice activities occur at least every 2 weeks. There is an identified goal of one conference per person per year with all expenses paid.
In short in a short time remarkable progress has been made.
Jennifer's closing messages were;

- Health promotion and education are #1
- Community engagement is fundamental
- Coming together with public health is important and remains a need
- Building a team is a must

Well said!

Meeting #10
Medical Travel and Medical Evacuation (Medivac)

Three participants including the supervisor and the communications person (Lucie and Pauline) as well as the financial director (Claude) were at the meeting. We were joined by Tish Wilson in progress.
The activity of the program was stated to be about 30 trips per week of medical travel and 5-6 medical evacuations (urgent/emergent air transport) per week. All transfers are north-south. The decision -maker is virtually always the NIC in each community for Kivalliq-originated flights. There is daily communication among the directors and managers about the activities but there is no process of quality evaluation. Considerable discussion on this point ensued. There are no clear protocols or guidelines regarding medivacs and transfers. Most important there is not a process of review of transfers regarding either their necessity or indications or whether or not the transfer may have made a difference. Thus any lessons learned about best practices are not garnered.
The response to this , led by Tish Wilson was that it could and should change. Not only did she support a local process but also welcomed the notion of a process across the territory. Furthermore she felt there are unrealized opportunities to retain people more often in the region rather than sending them south for evaluations such as ultra-sound and stress-testing. Her points are certainly valid.

Given both the importance and the cost of medical transport this is certainly an item that merits close consideration. (See meeting with Donna Flood regarding the same issue).

Meeting#11
Public Health
Public Health Nurse (PHN) and Assistant
(Loretta and Fred)
This too is a unit that akin to Social Services feels peripheralized. The claim of undue focus on health care as opposed to health was made. Lack of resources was identified as a major issue with access to a car being at the top of the list. In their view this lack compromises community outreach. In addition they are very concerned about the immunization program and the current coverage rate of about 60-65%.
Dr Geraldine Osborne is appreciated for her leadership from Iqaluit. However there was frustration expressed about the absence of regional leadership since the PHNs role is purportedly limited to Rankin Inlet. Loretta often finds herself having to cover both regional and local responsibilities.
On the co-location question, strong support was voiced for the new building to include plans that will enhance cooperative working relations among HCPs and Social Services. Concern was expressed that no mention of this priority has yet surfaced in the planning of the new facility. Concern was also expressed about the need for a nutritionist and a health promotion worker. Finally in answer to the question about the status of surveillance of health events and health trends, it was stated that "too little is being done". An organized system is said not to be in place.

April 3 Yellowknife
Meeting #12
Mr. Al Woods, CEO of Stanton Regional Hospital (SRH)

The Northwest Territories has a population of 48 thousand according to Mr. Woods and Yellowknife a population of about 18 thousand. The Region of Kitikmeot has 6000 citizens for whom SRH provides secondary and some tertiary services. More complex tertiary services and quaternary services are provided in Edmonton and represent a small subset estimated at less than 5% of all cases. Generally speaking the clients require care from a neurosciences unit. He also noted that there are very strong links with Alberta Cancer Care.

SRH is entering the second year of a three year contract with the Government of Nunavut.

Stanton has a long-serving cadre of family physicians but also experiences some difficulties in retaining specialty physicians. In general however they are regularly able to provide care by core specialties. They have an ICU of 4 beds which is temporarily closed owing to a shortage of ICU nurses. They also have a dialysis unit.

Mr. Woods emphasized the very strong commitment SRH has to the health care of the Inuit of Kitikmeot. SRH wishes to maintain the relationship in the long term and stands ready to make any appropriate changes that would facilitate the goal. It includes, he stated, working on upstream issues that would support health literacy and education among the Inuit as he sees their health threats as growing especially in the area of chronic diseases such as diabetes.

Meeting #13
Steve Jackson
Tour of SRH
The hospital is a very attractive facility. It is very well maintained, bright and cheerful. Mr. Jackson identified design short-falls (e.g. lack of ambulatory care space, the need to redesign the labour, delivery and obstetrical unit) but they are remediable. My tour included the O.R.s, the wards, out-patients, obstetrical unit, the ICU, the dialysis unit and the emergency department. I would place the quality of the physical plant of SRH as in the top 5% of hospitals I have visited. I also found the staff to be generally very pleasant and genuinely interested in Kitikmeot and the Inuit people.

April 3-4
Cambridge Bay
Meetings (3) #15a,b,c
Donna Flood (DF)

Unlike the itinerary in Rankin I was only able to meet with the Director of Health Programs, Donna Flood. The interaction was very valuable and certainly highly informative. I can also state that DFs vision for an integrated health unit is inspiring. The limitation of the format however is my inability to corroborate the findings with other workers.
DF is determined to co-locate and integrate health care, public health, community and home care, social services and when the time comes the birthing centre. In Cambridge Bay a new community health centre is also being built and the plan is to ensure integration of the services physically (co-location) as well as functionally. Clearly these are laudable goals and a potential model for the territory.

Our discussions were rich and wide-ranging and for me highly instructive. I will endeavor to summarize it in the following 9 sections:

1. There are about 9 categories of health care worker at the assistant or aide level existing, emerging or contemplated in Nunavut. They include home care worker (also called community services worker), rehabilitation assistants, hearing/speech workers, community health representatives, social work assistants, nursing aides, alcohol and drug workers, homemakers and mid-wife assistants.
   A comprehensive plan relating to these workers may exist but to date no one I have spoken to can identify it. This is an understandable approach and offers many solutions. But it must be rationalized so there an appropriate mix and career laddering is assured (among other issues.)
2. Medical Travel and medical evacuations are much as described in Kivalliq but there is an added challenge of trips being organized at the SRH end without the coordination that exists with the NMU in Kivalliq. Once again there is a need for rationalization of the
   program with the development of protocols to assist NICs, review of flights as noted earlier and more coordination with the Yellowknife end.
3. "NMU is wonderful" and is a model to be repeated throughout the territories. There is a need for a Sharon Hunting for all regions. (one example only)
4. Territorial-wide initiatives are to be fostered to address common issues and certainly would have DFs support
5. The Baffin Regional Hospital is characterized by a southern perspective in DFs view. This echoes testimony of the Directors in Rankin Inlet.
6. Pharmacy issues exist that are soluble. If nurses could have the delegated right to prescribe a limited number of drugs according to a protocol, efficiencies could be gained both in patient care and cost control. According to DF this is a substantial issue that must be addressed and from what I can discern I would support her position. Certainly there is precedent in other jurisdictions.
7. There is a need for review of the staffing mix which according to DF has not been carried out since 1982.
8. Opportunities to do more testing and imaging in the regions should be explored. This point was raised by the Rankin Inlet Directors.
9. Supports the notion of an RFP to extend the NMU model.

Summary and Conclusions

The trip exceeded expectations. Not only was it an extraordinarily instructive fact-finding venture but it also gave me the opportunity to meet some wonderful, committed people who are dealing with exceptional challenges. There is little doubt that the challenges that do exist are substantial but as I went from place to place it became increasingly apparent that solutions not only exist but are becoming implemented piece by piece. What is needed to to create a cross-territorial culture that takes up the solutions and realizes the possible.

I will make no explicit recommendations (but many implicit suggestions are apparent) at this time but will await the completion of the next trip to Qikiqtani.

I look forward to our next teleconference which should be booked this week.

Bob McMurtry

Appendix III

Trip of June 2-5, 2003

June 2
The itinerary began in London with a 6:45 am flight to Ottawa, then First Air flights in 2 Stages to Iqaluit and Pond Inlet. I arrived in Pond Inlet and was met by Diane ("Di") Shulze the Nurse-in-Charge of the Community Health Centre of Pond Inlet. She indicated that we would begin the day (Tuesday June 3rd) at 9:30 a.m. when I would be picked up at the hotel.

As is so often the case I encountered individuals on the trip and in the hotel who lent valuable insights to my understanding of Nunavut and matters related to the health care system.

The first was a man Brian M. who has been a patient in the Nunavut health care system (HCS) on many occasions. While he is a southerner he has spent most of his adult life in the north, principally in Yellowknife. About 7-8 years ago he moved to Clyde River and has married an Inuk to whom I was introduced when our flight made a refueling stop. Both are artists.

The tragedy of Brian's problem is that has vision of 40% in one eye and none in the other. He is a candidate for corneal transplant. From what I could understand he has had one that has failed and once the infection is controlled a further operation will be done. Unfortunately he has had a number of negative experiences with the HCS and is in the process of formally pursuing a grievance through the Government of Nunavut. He has been in touch with both Minister Picco and William Riddell who is the Fair Practices Officer of Nunavut, an ombudsman-like position. I gave Brian my coordinates which he passed onto Mr. Riddell and the latter has been in touch with me by e-mail. I hope to be able to learn more about Brian's case (he has given his consent) as well as the pattern of concerns that Mr. Riddell is hearing.

(Note : spoke with Mr. Riddell subsequently) i.e. June 13.
Mr. Riddell explained his role to me. He has been three and one half years on the job as Fair Practices Officer. His role is extensive as it includes investigation, mediation and adjudication. He made a number of points of which many relate directly to DHSS.
He is hearing a large number of concerns being expressed but since his clients can't get access to lawyers many are not surfacing as they might in the south. There is a legal aid system but their activity is consumed in dealing with criminal cases.
He went on to say that "Serious neglect (in the HCS) is occurring for both Inuit and non-Inuit." As an example a seriously injured man ("crushed leg and facial injuries") was put on scheduled flight – not a medivac. Inuit and Non Inuit have both claim they have had very poor care, no supports for them when they are vulnerable (ill or injured). Non Inuit are often placed in hotels in Ottawa without supports. Other cases indicate a problem with records. These insured people are simply "lost" in the system. Many anecdotes of medical and health care misadventures have come to his attention. Unfortunately the documentation of these events is thin. I have asked for what is

available. I should note however there is a disconnect between these anecdotes and the discussions with OHSNI (Ontario Health Services Network Inc.) However the staff at OHSNI did indicate there are problems with non Inuit patients because they often do not receive communication from the Iqaluit end.)

The second was a man "Jean-Pierre" who is the head of the construction crew building the new health centre. He indicated he had lost his entire crew of 5 men in the preceding few days. Apparently they were unprepared for the working conditions in Pond Inlet/Nunavut and asserted that they could not carry on. On a positive note a replacement crew was expected on June 5. He stated that this is not an unusual experience.

There were several points that this encounter raised for me. First the fragility of the specialized work force in all spheres, health, construction and others. Secondly he indicated the cost of replacing the crew would be about $25,000. Thirdly he informed me that if all the outside work is not finished by October that the project would be set back one year. These realities are less appreciated in the south in general and by the federal government in particular. There is obvious importance to this Nunavut reality in calculating or creating a formula for transfer payments.

The third person I met was Geoff B., who works for Spearman Refrigeration. This company actually manages all manner of appliances and utilities. Geoff for his part was on his own and enjoys the Territory enormously. Perhaps it is because his father preceded him doing similar work.
The lesson I learned from Geoff is that all machinery, gas lines, wiring etc is managed remotely. He cited his ability to do monitoring and remote remediation from anywhere in Canada for all the equipment for which his company is responsible. The is the case for existing equipment as well as new. The former has been retrofitted and Geoff claims not at great expense.
This has obvious implications for telehealth and delivery of health care services to remote communities. As will be indicated in the subsequent sections of this report there are many initiatives in progress including by different departments of the government without any apparent linkages.

June 3
NIC Di Shulze arranged a formal itinerary which included;
Itinerary - morning
Pond Inlet Secondary School
Visitors' Centre and Library
Qikiqtani School Operations (QSO)
RCMP

Itinerary - afternoon
Tour of the Community Health Centre (CHC)
Meeting with all CHC Staff

Itinerary – evening
Wellness Council Meeting
Walking Tour of Pond Inlet (informal and invaluable)

Morning

- Secondary School Grades 7-12 and about 260 students
  - excellent physical plant, attractive architecture
  - gymnasium busiest facility with basketball game. Noted high individual skills but less understanding of team play. "cooperative individualism"
  - truancy overall at about 75-80%
  - over the year averages about 40% according to the teacher of IT
  - in computer learning centre 3 of 17 students present. Equipment of high standard.
  - Graduation – 12 students this year, a record, normally 4-5
  - 6 grades (7-12) with about 260 students indicates low completion rate
  - Home Economics class, well equipped, kitchen contemporary urban without capacity to deal with large kills from traditional hunting
  - Library apparently good selection of books in Inuktitut and English
  - No librarian
  - Reciprocity with southern standards not in place

- Visitors Centre
  - outstanding facility, location, building and contents
  - excellent learning resource centre
  - "museum" of traditional way of life but dynamic and captivating
  - no-one in attendance except staff and us

- Library – same building, different management
  - the librarian committed and able
  - another valuable learning resource centre
  - good collection of books, videos, computer with Internet access etc
  - unique and important circum-polar collection with original books dating from the early 20th century up to the present
  - no clients/users in attendance
  - the librarian made the telling point that there are no archives in Nunavut although an archivist has been appointed recently.

- QSO
  - again excellent physical plant
  - co-located with Sustainable Development and Public Works
  - roomy but active
  - staff were in board room meeting
  - included their visiting IT expert. No connection with health related IT.

(Note this theme of independent development of IT resources and systems was uniformly in evidence)

- RCMP
  - good facility
  - Ian Monteith was "our tour guide"
  - Described a lot of responsibility for social services type of work. There are no social workers in Pond Inlet at present although plans to recruit 3 are underway.
  - Described as well a pattern of resident Inuit to seek institutional solutions to family problems e.g. "Come and discipline my kids" or "please get this person out of my home"
  - 3.5 F.T.E. police are on-call 24/7
  - claimed that some form of substance abuse may be as prevalent as 90% of the population.

Afternoon

Meeting with Staff of Health Centre including Dr De Maio and the NIC

- good attendance and high level of interest
- introductions made and my role explained with an emphasis on my role to listen and learn
- each staff member was invited to contribute, express concerns or compliments and all did participate
- the following lists some of the highlights of a rich discssion

* Key Points
  - Quality of working life again emerged as the principle issue
  - There is a need to "streamline logistics" as too much time is spent trying to make the system work
  - Flexible working hours were identified as a need
  - The biggest health issue for the centre is mental health and addiction
  - There is a need for outreach to the home. The new investment by Health Canada in home care programs is important to build on and sustain
  - No respite care
  - Social workers are required and 3 positions may be forthcoming which are being supported by the hamlet (there is some question as to the funding source in the mind of the staff)
  - Parenting is a major concern. It is particularly a problem with the generational gap, thought to be created by the Residential Schools and other external influences. Most young mothers have not had mentoring and often are much less respectful of elders than traditionally

- Housing is a very serious issue and often leads to inter-generational strife and possibly violence. The safety of the elders is a matter of significant concern for the staff. They feel there is a need for a hospice or other facility for elders which should be combined with palliative care.
- Another issue included the deficiency in acculturization for new health care staff, inadequate support for CPD
- There is also a need to improve education of some staff on the culture of the work-place and the importance of punctuality, processes of performance appraisal and other standard operating procedures of accountability
- Community capacity building was seen as a key strategy as well as the fundamental importance of education and health literacy

Evening 7:00 – 8:30 pm

In the evening Di Shulze invited me to attend the meeting of the Wellness Council of the Hamlet of Pond Inlet. The meeting was held in the Hamlet Council Chamber with simultaneous translation. I was invited to address the Council after I was introduced.

I explained that I was there in my role as Special Advisor to the Deputy Minister and my task was to listen and learn. I acknowledged the 4,500 year History and the remarkable legacy of their people and how much Canadians can and do learn from them. I also spoke briefly about the Romanow Commission and the hearings in Iqaluit and the presentations we heard. I noted that the challenges that were identified were formidable but that after visiting Nunavut it is possible to find many reasons for optimism if the right path is taken, informed by the elders, the communities, Inuit Qaujimajatuqanqit and values contained in the Bathurst Mandate.

I then asked their views on health and well-being and the about the progress their council was making.

The responses came from all but one member (7/8) and were very thoughtful. It is difficult to do justice to the exchange and I will therefore highlight some key points. I was also given an excellent document which captured some key elements of the dialogue – "Pond Inlet Wellness Strategy 2001" – some 52 pages.

Key Points

- "we must cut the chain" of anger and resentment
- "look forward and not to the past" in regards to the legacy of the residential schools
- address the need for mentoring of parents
- stress education and make use of elders and survivors of adversity

- seek alternatives to southern culture which influences the young Inuit through mechanisms like television
- there is a need for more community resources
- the current health care centre should be taken over the Wellness Council when the new centre is built
- there is a need for local program initiatives with stable funding
- there is a need to focus on children and youth, the youth are angry
- Inuit language, culture, spirituality and identity are crucial to maintain

Most memorable quotes

"We are an unwell community"
"..strength-based approaches.." are necessary
"enlightenment leads to empowerment"
"..reaffirmation of Inuit values" is needed
"we now understand the mental can cause the physical (disease)"

Several concerns were also expressed about health care services that were highly congruent with those heard elsewhere. Examples included inadequate support associated with medical travel, poor escorts, insufficient interpreters, getting lost, lack of respect and many anecdotes of negative experiences in Ottawa.
One intervener stated that ***options to patient travel must be found...***(insightful!)

June 4
Meeting with Ruby Watson, Assistant Senior Administrative Officer/Director of Finance.

As has so often been the case RW portrayed passion and commitment for her work. She also demonstrated concern and insight for the social and health challenges facing the people of Pond Inlet.
She spoke to some difficulties in her work relating to the inconsistency of contract requirements among the levels of government and in particular to the requirement to shape local programs to the generic guidelines set out by the federal government and Health Canada. There were also concerns expressed with DHSS's functionality and systems. (This is a recurrent theme)

We were joined by Esther L of the Wellness Council who described her role as an "emissary for the community". She also expressed the sense that "we are tiny and we are not seen" and that it is necessary to spend 2 hours per day "swimming upstream" in dealing with the administrative systems. Finally she pointed to significant deficiencies in communication with DHSS in Iqaluit.

My next appointment was with the Mayor of the hamlet introduced to me as "Peter". I asked him what he, as Mayor, saw as the most important thing he saw as being needed in Pond Inlet. He spoke the priority of mental health and the necessity of the people of the hamlet to become "whole beings" again. He identified a "severance of family relationships" as a source of ill-health as well as the decline of Inuit culture. It is essential "to nurture the community vision" and "to heal ourselves".
(Note that Esther L was present and acted as an interpreter. She is very eloquent herself and possibly she influenced the translation. I say this in the context of her doing her best and in no way is the comment intended to be critical.)

The next event was a tour with a home care nurse which included a home visit. (There is little doubt that this Health Canada program represents a very positive investment. In all 3 regions it is clear to me that it is a program that is making a difference and in Pond Inlet it certainly is.) For me the home-visiting experience was very compelling not only for the care given, but also the presence of an interpreter and the sense that the client/patient had a meaningful say in his care. He is afflicted with Chronic Obstructive Pulmonary Disease (COPD) and is on home oxygen as needed.

As a small sidebar his youngest son (about age 8-9) was at home although school is still is session and was watching television.

The remainder of the late morning and lunch was spent with the staff of the community Health Centre. We all chatted informally among the approximately 10 people present. What is who noting is the esprit de corps and ease of relating that exists among all the health care professionals and other staff.

It was then time to take the flight to Iqaluit. When I said good-bye to all whom I had met, I particularly thanked Di Schulze. She arranged a wonderful itinerary. Her spirit , energy, commitment and talent as a nurse and leader left a lasting impression on me.

Dinner June 4
An arrangement for dinner was made in the evening after I had checked into the Capital Suites in Iqaluit. Don Ellis and I met with Dr. Paul Stubbing. It was a very interesting evening from 7:00 to 10:00 p.m.
Dr. Stubbing has a unique perspective of Nunavut and Iqaluit. His engagement as a primary care physician had been for 25 years. What he offered was a longitudinal view that I had not heard from any other physician in the Qikiqtani Region.
He noted that there has been a lot of positive developments over the time of his practice in Iqaluit. For example he indicated that the incidence (in his opinion since there is no data of which I am aware) of the following have all fallen significantly and included;

- Spousal abuse
- Smoking in houses
- Sexually transmitted disease
- Mortality secondary to exposure ("freezing")
- Random violence

He also commented that the physicians have a very fair arrangement in terms of remuneration, that good care continues to be delivered and has been for a long time. He describes the work as fascinating from a professional stand-point and he harbours a great admiration for the people.

On the challenges side of the equation he made a number of points;

- Health records in Baffin Regional Hospital is very weak (commonly held view)
- Instability over the past 6 years at the senior administrative level of the hospital has been very problematic. In one 3 year period he claimed that there had been 9 people either acting or in the role of Executive Director
- Weak administration
- Turnover of health care professionals is the number one issue
- DHSS should not be running the operations of the hospital, an independent board model would be preferable in his view
- There is a lack of connection between Public Health and the Health Care System
- The dental health is an enormous problem. He is now witnessing very expensive reconstructive procedures being carried out regularly for children which would not be needed if there was good dental hygiene.
- Finally he opined that the negative perceptions of the Baffin Regional Hospital are due to poor staff morale more than compromise in care

Clearly this is a summation of a very extensive discussion which I found to be very interesting and certainly presented a unique perspective.

June 5

The following morning I was free and worked on a preliminary draft of this report and then went to the airport. I was booked to fly to Kimmurut at 1:30 p.m. but unfortunately a delay was announced which when I talked to the ground staff of First Air was estimated to be 2 hours and with continuing uncertainty. In view of the fact that I was now slated to arrive late in the afternoon and my booking for departure was at 10:05 am the following morning I cancelled the planned visit to Kimmurut and returned to Ottawa and London one day early. Mr. Don Ellis was informed (voice-mail) so that the people in Kimmurut were duly informed.

I connected again with Mr. Ellis while in Ottawa to ensure he had received my voice-mail Message and he confirmed the notification of the Kimmurut staff. It also presented an opportunity for an extensive debriefing.