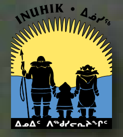

NUNAVUT'S HEALTH SYSTEM

A REPORT DELIVERED AS PART OF INUIT OBLIGATIONS UNDER ARTICLE 32 OF THE NUNAVUT LAND CLAIMS AGREEMENT, 1993

ANNUAL REPORT ON THE STATE OF INUIT CULTURE AND SOCIETY

07
08

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Photo by Elisapee Ishulutak

Sheepa Ishulutak prepares skins from
unborn caribou calves in her home in Iqaluit.

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Iqaluit resident Bobby Ma took part in Nunavut Day games, July 9, 2008.

Photo courtesy of DIAND – Nunavut Regional Office

LETTER OF TRANSMITTAL

November 18, 2008

Article 32 of the *Nunavut Land Claims Agreement* calls for the establishment of the Nunavut Social Development Council. Article 32.3.4 requires that Council to, "Prepare and submit an annual report on the state of Inuit culture and society in the Nunavut Settlement Area to the Leader of the Territorial Government for tabling in the Legislative Assembly, as well as to the Minister of Indian Affairs and Northern Development for tabling in the House of Commons."

In addition to our obligations under the *Nunavut Land Claims Agreement*, the Council, through Nunavut Tunngavik Inc. is committed to improving the lives of Inuit in Nunavut, especially in regard to Inuit society and culture.

Pursuant to Article 32.3.4, and in keeping with the importance Inuit place on social and cultural issues, we are pleased to submit this *Annual Report on the State of Inuit Culture and Society*, entitled *Nunavut's Health System*. This annual report covers the fiscal year 2007/08.

Sincerely,

Board of Directors
Nunavut Tunngavik Incorporated
Nunavut Social Development Council

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Kimmirut, Nunavut

Photo by Franco Buscemi

EXECUTIVE SUMMARY

Article 32 of the *Nunavut Land Claims Agreement* (NLCA) requires the Nunavut Social Development Council* to issue an *Annual Report on the State of Inuit Culture and Society*. The 2007/08 report examines the state of Inuit health and health care in Nunavut. The report addresses three overlapping themes: the condition of Inuit health, the financing and administration of health care, and how health care is organized and delivered.

Inuit are emerging from a period when health care priorities and most aspects of health care practice and delivery were set by non-Inuit. Inuit wish to improve upon the conventional medical system in Nunavut. It does not engage Inuit, does not operate in Inuit language, does not employ Inuit at a representative level, and does not adequately acknowledge Inuit healers or healing practices. Poorly adapted and chronically under-funded health care services and programs based in Southern Canada and delivered primarily in English are no longer acceptable.

In regard to the medical system, Inuit must work more closely and in better collaboration with the Government of Nunavut (GN) and the Government of Canada to make the system more efficient, effective, and reflective of Inuit culture and society. This means accepting, integrating, and respecting traditional Inuit methods of treatment and care, and increasing the employment level of Inuit.

Inuit in Nunavut trail Canadians in many health outcomes. Conventional determinants of health, such as educational attainment, housing, and income levels, provide insight into these alarming discrepancies. Unfortunately, the GN currently lacks the capacity and resources to aggressively work toward improving health outcomes, and struggles to perform its basic functions relating to health care delivery.

Despite our challenges there is hope. The federal and territorial governments are starting to collaborate more with Inuit. Many contributions to the GN-run health system, especially in the area of community wellness, are being made by non-governmental organizations and Inuit organizations that help Inuit live healthier and more fulfilling lives.

It has been nine years since Nunavut was established as a result of the implementation of NLCA Article 4. As a territory, Nunavut does not own its natural resources and, with the least developed economy of any jurisdiction in Canada, Nunavut has no other significant revenue source other than federal transfers. Nevertheless, Nunavut faces the same rising health care costs as every other province and territory and some dramatic additional costs that are unique to Nunavut.

Most Southern Canadians take it for granted that health care means local access to a family doctor and a hospital. Most Inuit do not have family doctors, and there is only one hospital functioning in Nunavut. Much of the delivery of the Nunavut system is not located in Nunavut, but in Ontario, Manitoba, Alberta, and the Northwest Territories. To put this in context: imagine if you lived in Peterborough, Ontario, but when you needed the expertise of a doctor or services only a hospital could deliver, you had to fly to Mexico.

The Qikiqtani Regional Hospital in Iqaluit.

Photo by Franco Buscemi

This is what Inuit face when they encounter the health system. To begin to solve these problems, all stakeholders in Nunavut must work together and be exceptionally creative and efficient in delivery of all health-related programs and services. All agencies with a vested interest in the health of Inuit have a role and must be respected.

* Nunavut Tunngavik Inc, the Inuit organization mandated to ensure implementation of the *Nunavut Land Claims Agreement*, fulfils Nunavut Social Development Council responsibilities.

This report concludes with four fundamental recommendations:

1) Support the primary health care approach. Government (territorial and federal) and Inuit must look to the long-term management of health costs by aggressively pursuing a primary health care approach with a particular focus on maternal and newborn care, strengthening the health surveillance function of public health, building capacity at the community level, devolving health care functions and priority setting to the communities, and coordinating and integrating currently fragmented programs and policies. This includes reorienting the bio-medical system to focus on repatriating hospital and physician services from the South to Nunavut.

2) The territorial government and federal government must communicate with and involve Inuit in the design and delivery of health care. This is the main requirement of NLCA Article 32. Inuit are not merely stakeholders. Inuit participation in design and method of delivery of health care is a legal obligation and a basic principle of a sound primary health care approach.

3) Respect and core-fund the Inuit and community organizations in the system. Productive collaborations between Inuit, government, and non-government agencies should be celebrated. Community-based organizations, which have a vested interest in community wellness, especially Inuit organizations and other non-profit community-based organizations, must be given adequate and stable (multi-year) funding.

4) Invest in human resources. Inuit want a health care system that respects its workers and provides training for Inuit to fulfill NLCA Article 23. Government must also address the problems in the recruitment and retention of staff, particularly the nurses, by providing them with a competitive compensation and training package and improving workplace conditions.

Iqaluit Elder Celestino Erkidjuk (left) and hospital worker Mary Munick

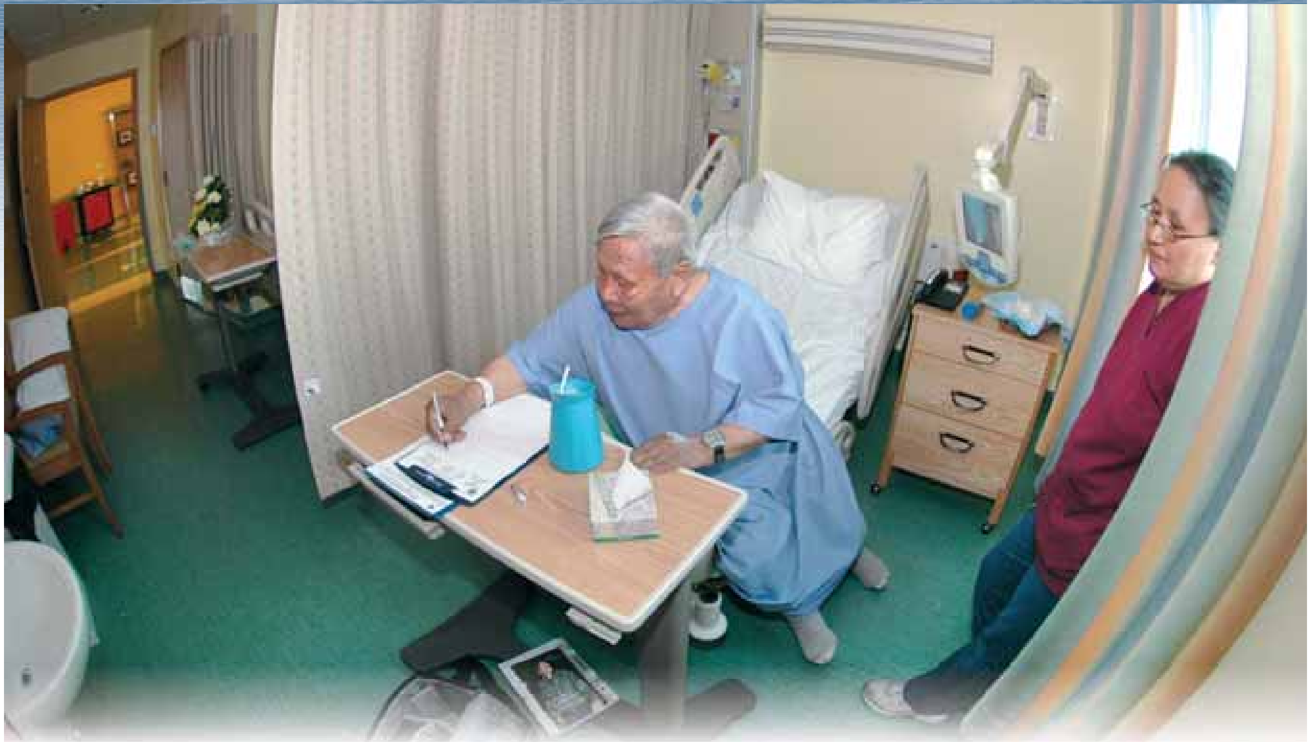
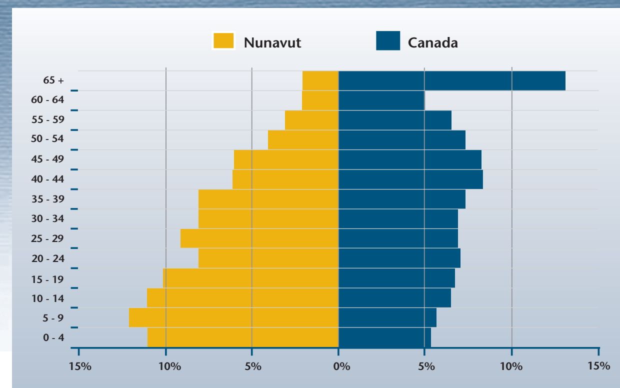


Photo by Franco Buscemi

INTRODUCTION

Health is a vast subject and this report does not attempt to examine all aspects of Inuit health or all aspects of Nunavut's health system. Instead, the report focuses on the current state of Inuit health, how the bio-medical health system is run and financed, and its methodology of care. In this report, particular issues such as the cost of health care, the nurses, public health, community wellness, and the importance of collaboration and engaging Inuit and Inuit knowledge will be discussed.

Figure 1 Distribution of Nunavut and Canadian Population



Source: Nunavut Bureau of Statistics, 2005. Statistics Canada, 2006.

Nunavut Demographics

The population of Nunavut is 29,325.[1] Eighty-five per cent of the population are Inuit living in 25 communities with an average population of 1,179, scattered across three time zones. The population density of Nunavut is 0.1 persons per square kilometre, compared to a population density for all of Canada of 3.5. Sixty-four per cent of the Inuit population speak the Inuit language in the home.

The population of Nunavut is young and growing with a median age of 20 compared to 40 for the total Canadian population. The current population has almost doubled since 1981 (population: 15,600). Figure 1 indicates the much younger age distribution for Nunavut compared to Canadian averages.

Unlike most other parts of Canada, which are experiencing a gradual reduction in the population of small, rural, and remote communities, an examination of population trends over a 20-year period indicates that most regional, medium and small communities in Nunavut are continuing to grow.

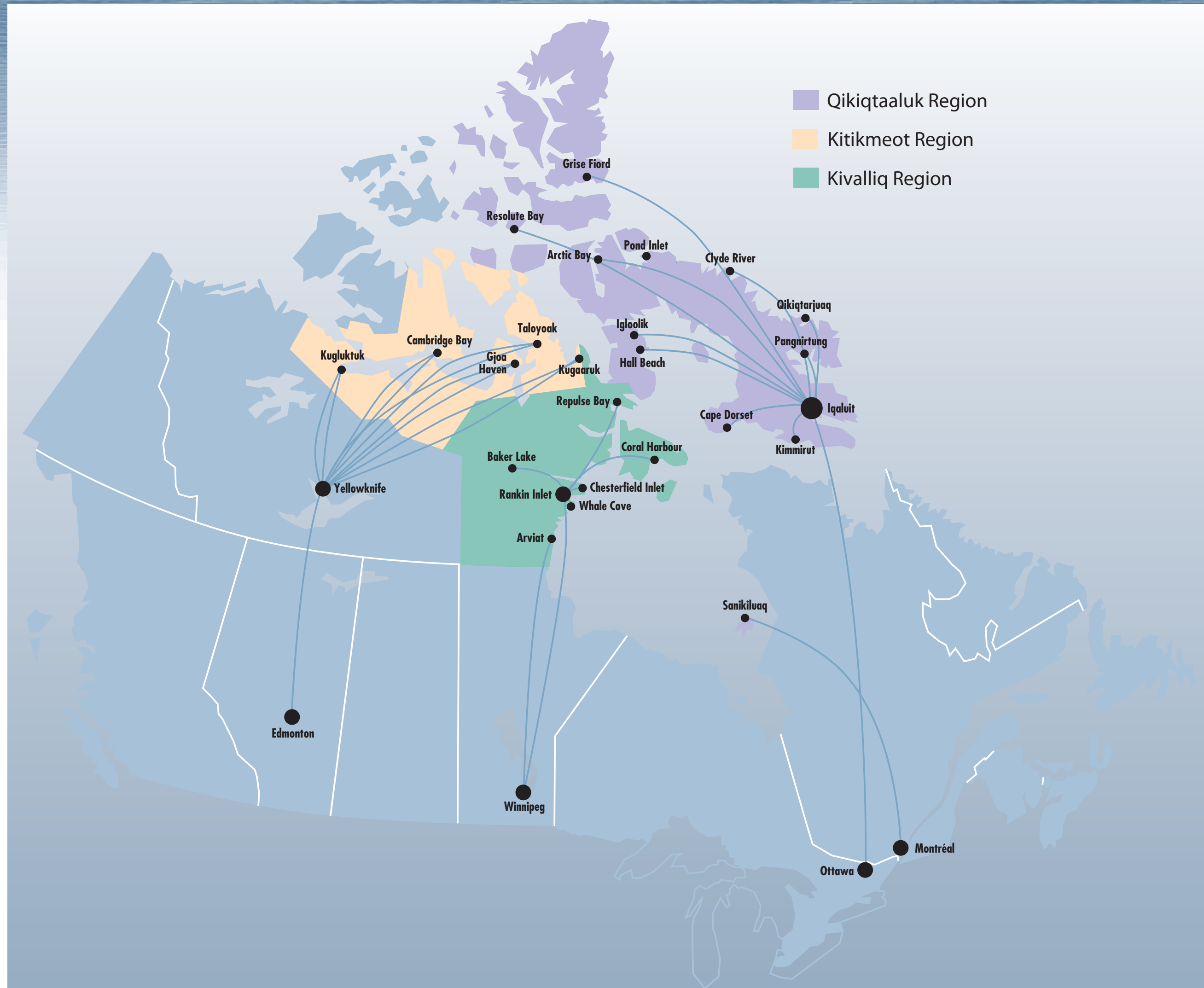
The Geography of Health Care

The distances between communities and referral hospitals in Nunavut's health care system are the largest in Canada, perhaps the world. No other province or territory relies on as many extra-provincial hospitals in as many different provinces as Nunavut does. This is not by design. Nunavut has inherited the most geographically stretched north-to-south health network in Canada. Unfortunately, funding to address this and other issues at the start-up of Nunavut were completely inadequate. It is, therefore, unfair to criticize the GN for the structural problems it inherited. In fact, so much of what is usually thought of as health service is delivered outside of the territory, or relies on outside professionals flying into the territory, that it is somewhat a misnomer to label it Nunavut health care. No other Nunavut government activity, education or housing for example, is forced to pay to deliver so much of its service outside the territory.

Pangnirtung residents Matthew Etooangat (left) and Brian Veevee.

Photo by Billy Etooangat

Medical Patient Referral Flows by Nunavut Region to Southern Canada



Nunavut Tunngavik Inc.

Nunavut's health care system has been devoted to the expensive practice of long-distance patient and doctor travel since the onset of major government involvement in the affairs of Inuit 60 years ago. A tuberculosis epidemic in the 1950s established a pattern of Inuit medical evacuation to hospitals in Quebec, Ontario, Manitoba and Alberta, a pattern of dependence that persists to this day. Nunavut's primary flow of health care workers and recipients is not east-west across its breadth, and certainly not locally focused, but caught in three main north-south flows: between Qikiqtaaluk and Ottawa (previously Montreal), Kivalliq and Winnipeg, and Kitikmeot and Yellowknife and Edmonton. The cost implications are staggering: over half of the $100 million in federal Non-Insured Health Benefit (NIHB) contributions to Inuit health care in Nunavut between 1996-2006 went to transportation costs. This is not so much a health care expenditure as a subsidy to the airline industry.

Health Care in Inuit Society

Inuit have medical and healing traditions to deal with various health problems, and a rich body of knowledge to maintain the health and well-being of Inuit communities. Although medicinal knowledge cited by Elders is extensive,[2] "Inuit medical knowledge refers to much more than healing techniques, it concerns…the body being conceived as a whole in relation with its social environment…In fact, health is conceived less as a personal matter, as in Western societies…because every person is linked to a broader physical, animal and social environment."[3]

Given this tradition of Inuit health care, Inuit wish to incorporate traditional practices and the wisdom of Elders into most aspects of contemporary health care, particularly those intensely personal conditions such as childbirth and mental health.[4] Inuit healing reflects a holistic approach to health and a concern for balance between negative and positive approaches to health (disease versus wellness). "Inuit are interested in research on … concepts of wellness, and wellness indicators."[5] Thus, it is imperative that the Nunavut health care system and health outcomes of Inuit must be interpreted with an Inuit lens to ensure the development of accurate and useful priorities.

The Nunavut Land Claims Agreement

Nunavut is unique among all Canadian provinces and territories. It was established to fulfill an obligation under the NLCA[6] and 85 per cent of its population are Beneficiaries of the NLCA.

The NLCA was negotiated over a period of 20 years to advance Inuit rights and aspirations, and reverse the fragmentation of Inuit society and the state of dependency brought about as a result of the introduction of European diseases, missionaries and traders, and the unsuccessful and often tragic Canadian government policies which included relocation, residential schooling, and forced settlement. Inuit agreed to a public government for the territory of Nunavut so long as Inuit societal values and culture would be at the centre of all that it did. Article 32 is one of the provisions of the NLCA that is intended to accomplish this.

Article 32 requires the Government of Canada and the GN to provide, "Inuit with an opportunity to participate in the development of social and cultural policies, and in the design of social and cultural programs and services, including their method of delivery, in the Nunavut Settlement Area; and endeavour to reflect Inuit goals and objectives where it [government] puts in place such social and cultural policies, programs and services in the Nunavut Settlement Area."[7] No other government in Canada is bound by law to consult* with the majority of its Aboriginal population on most of what it does.

Another key provision is NLCA Article 23 which requires that there must be a representative level of Inuit employment in the government at all levels and in all occupational groups. Inuit understood that power in government lay as much in the bureaucracy as in the legislature. Consequently, although most health care professionals and other employees of the GN's Department of Health and Social Services are non-Inuit, the GN is obliged to ensure that these positions are filled to a representative level by Inuit.[8]

As Inuit work toward creating a health care system that reflects Inuit society, tools such as the NLCA, the public government structure, and the strength and potential of Inuit communities and Inuit organizations must be understood and utilized. The potential for Nunavut's health care system will ultimately be guided by the ingenuity of the people who govern and manage it, and the willingness of all stakeholders to merge Inuit knowledge with Southern health care systems.

Miriam Aglukkaq (left) and Winnie Owingayuk participated in an Elders' conference in Iqaluit.

Photo by Maggie Qappik

* Participation is a higher level of involvement than consultation. See presentation to the Nunavut Implementation Contract Working Group by Doug Wallace, Director of Legal and Constitutional Law, Department of Justice, Government of Nunavut, Iqaluit (Feb., 2002).

THE STATE OF INUIT HEALTH

In the last 50 years, living conditions of Inuit have undergone the most rapid change of any population in Canada. In 2001, Statistics Canada noted that, "Adapting to these new conditions has not always met with success. Indicators show higher unemployment, lower income levels, poorer health and more social problems," among Inuit than among Southern Canadians.[9] The results of the Survey of Living Conditions in the Arctic (SLiCA) survey released last year, however, painted a less dismal picture than Statistics Canada had anticipated. The SLiCA survey found that, "Family ties, social support of each other, and traditional activities," are still very important to Inuit, and well-being is not merely related to wage employment, but also to availability of country food and feeling of involvement and control over local political affairs.[10] SLiCA further reported that, "Despite historical efforts by national governments to assimilate native peoples and encourage them to give up native traditions in favour of wage labour, nine out of 10 Inuit continue to think traditional activities are important to their identity."[11] One out of every two Inuit self-rated their health as, "Very good."[12]

For Inuit, good health is much more than the absence of disease. Inuit determinants of good health have many dimensions and involve complex interactions between conventional factors such as biology, income, housing, education, environment, and other Inuit-specific factors that are not currently captured adequately such as self-determination, culture, and multi-generational proximity. Although determinants of health differ significantly between the Inuit population and other Canadians, the general determinants of health discussed in this section are still valuable in assessing the current situation in relation to the rest of Canada.

1) Housing, and Community Infrastructure

Statistics Canada stated that, "Inuit live in some of the most crowded living conditions in Canada."[13] Nearly four in 10 Inuit in Nunavut live in crowded conditions – a rate 13 times higher than for other Canadians. Inuit homes are nearly four times as likely to require major repairs. Inadequate and overcrowded housing can be linked to high rates of violence[14] and respiratory illnesses in Inuit communities. Tuberculosis rates among Inuit in Nunavut are 70 times the Canadian average.[15] Recent research has shown that, "Inuit infants have the highest reported rate of hospital admissions because of lower respiratory tract infections in the world." This rate is attributed in part to crowded, poorly ventilated homes.[16]

2) Education and Economic Factors

Meaningful wage-employment, economic stability, and a healthy work environment are associated with good health. Therefore it is significant that for persons aged 20-54 in Nunavut, the 2006 census reported the Inuit unemployment rate at 20.8 per cent and the non-Aboriginal employment rate at 3.9 per cent.[17]

Income is an important determinant of health, yet no health study to date has remarked on the biggest ethnic gap between rich and poor in a single jurisdiction in Canada. The largest income differential between two ethnic groups in a province or territory is the gap between Inuit and non-Inuit in Nunavut, where 2001 Statistics Canada figures show the average Inuit income was $13,090 and the average non-Inuit income was $50,128—a gap of $37,038.[19]

For formal education to be worthwhile, it must be meaningful and relevant to students and parents. It must equip its students with the foundational knowledge and skills to function in society, enable them to participate in their community, and increase opportunities

Iqaluit Elder Celestino Erkidjuk.

Photo by Franco Buscemi

for employment. With a 25 per cent graduation rate, Nunavut's institutional education system ranks as the most ineffective in Canada.[20] The average Aboriginal graduation rate in Canada is 54 per cent and, as Thomas Berger noted, "Only 25% of Inuit children graduate from high school, and by no means all of these graduates go on to post-secondary education."[21] In 2006, 30 per cent of Inuit in the territory (aged 25-64) completed some type of post-secondary training. About 10 per cent completed a trades program, 18 per cent had a college diploma while three per cent completed university.

According to Berger, "In my judgement the failure of the school system has occurred most of all because the education system is not one that was set up for a people speaking Inuktitut. It is a bilingual system in name only, one that produces young adults who, by and large, cannot function properly in either English (because they never catch up with the English curriculum) or Inuktitut (because they learn only an immature version of their first language before switching to English). There has been some improvement in Inuit achievement in school in recent years. There is, however, no steady arc of improvement. In fact, there is a danger of a falling back, a danger that Inuktitut will continue to lose ground, and the sense of loss in Nunavut will become pervasive."[22]

3) Food Security

While traditional Inuit food like caribou, seal, whale, char, goose and ptarmigan is still a significant part of the diet, the high cost of hunting equipment and changing Northern economies have led to traditional foods being less available than in the past. The high cost of store-bought foods and their availability is a major problem in the Arctic, with as many as forty-nine per cent of Nunavut households reported having often or sometimes not enough to eat during the previous year. This compares to the Canadian average of seven per cent.[23] Statistics Canada shows that Nunavut food insecurity is by far the highest in Canada, with a rate that is nearly four times that for Canada as a whole (Figure 2).[24]

An Inuit patient is examined while his family waits in the background.

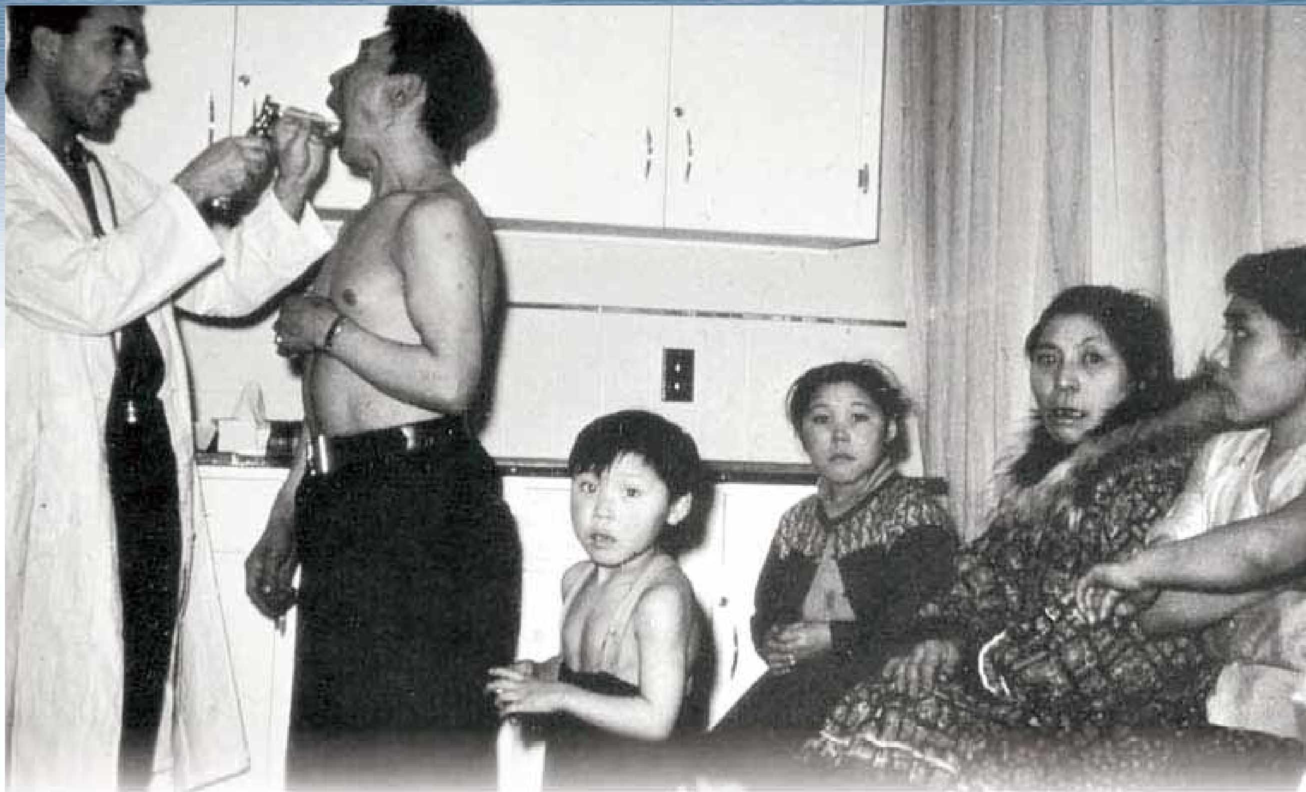
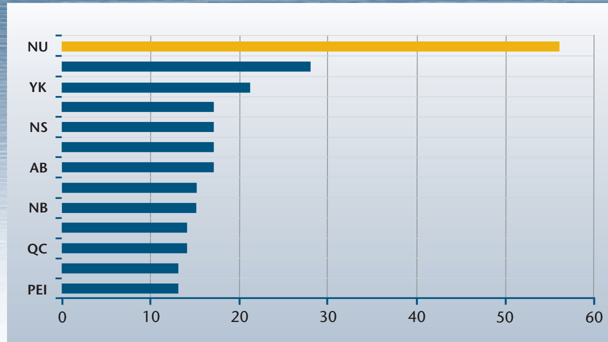


Photo courtesy of Health and Welfare Canada collection/Library and Archives Canada

Figure 2 Per cent of Population Aged 12 and Over Reporting Food Insecurity



Source: Statistics Canada, 2005. Food Insecurity Health Reports Vol. 16 #3.

Increasingly, Inuit are consuming foods associated with a Southern diet, though the adverse affects of that diet, which is responsible for high rates of diabetes and obesity in the South, are just beginning to assert themselves in Nunavut. Traces of trans fats commonly associated with junk food, are now twice as high in Inuit as in Southern Canadians.[25]

The most important support for Inuit consumption of nutritious store-bought food is the Food Mail Program, funded by the Department of Indian Affairs and Northern Development (DIAND). Approximately 60 per cent of total Food Mail Program spending goes to Nunavut region grocery stores to reimburse them for a portion of the air freight costs of flying nutritious food into the territory. For example, the weekly cost of a nutritious basket of food for a family of four in Cambridge Bay is $317. Without the food mail subsidy, that same basket of food would cost $765.86. Without food mail to bring down the cost of food, unemployed Inuit would have to spend, "Well over 100%," of their total social assistance payments on food costs alone, "Leaving no room for spending on other necessities, and leaving people hungry at the same time."[26]

Availability, Acquisition and Consumption of Country Food

Country food plays a positive cultural and health role in Inuit life. The traditional Inuit diet provides, "Important nutrients known to protect against respiratory infections and heart disease, and may also lessen risk factors associated with diabetes."[27] Country food is of, "Fundamental significance in the lives of Inuit individuals, households, and communities, holding nutritional, physical, cultural, spiritual and economic importance."[28] Country food consumption rates show wide variance. Studies of Qikiqtaaluk Inuit[29] show that Inuit men (aged 13-60) consume larger amounts of country food than Inuit women, however Inuit girls consume more country food than Inuit boys, and Inuit women over 60 years old consume slightly more country food than men in this age bracket.

4) Life Expectancy

Annual reports on comparable health status indicators continue to provide an unsettling picture for Nunavut. One of the key indicators of health is life expectancy which provides a picture of a population's overall health, as well as the quality of health care provided when they are ill. A healthy population that has access to quality health care is likely to have a longer life expectancy. In Nunavut, life expectancy at birth for Nunavummiut is 11 years lower than that of other Canadians. The average Canadian can expect to live 79.5 years, the average Inuk between 64 and 67 years. Inuit have the lowest life expectancy among Canada's three main Aboriginal groups.[30] In 2001, life expectancy for Nunavut was about the same as it was in Canada in 1946.[31]

5) Infant Mortality and Birth Weight

Nunavut has the highest pregnancy rate in the country – almost double the Canadian average and, in 2000, Nunavut reported a teenage pregnancy rate of 161.3 per 1,000 births, compared to the national average of 38.2, or four times the Canadian average.

Nunavut has the highest pregnancy rate in Canada.

Photo by Franco Buscemi

A long-established measure of child health is infant mortality. In 2001, Nunavut's infant mortality rate of 15.6 per 1,000 live births was approximately three times higher than it was for Canada. However, the rate of infant deaths in Nunavut has been on a steady decline since they were first recorded in 1991. The decline is presumed to be a reflection of increased early and regular prenatal care, obstetrical care during labour and delivery, as well as postpartum care and maternal education. However, the premature delivery rate of 18 per cent remains almost three times the national average.[32]

Pre-term births account for approximately 75-85 per cent of all perinatal deaths in Canada. Low socioeconomic status is another factor associated with high rates of infant mortality.[33]

Associated with economic circumstances, low birth weight (less than 2,500 grams but more than 500 grams) is an indicator of newborn babies' general health, and a key determinant of infant mortality and morbidity. Low birth weight babies are at a greater risk of dying during the first year of life. They are also at risk of suffering from certain disabilities, such as mental retardation, visual and respiratory problems and learning disabilities.

Low birth weight is associated with social factors, such as exposure to environmental tobacco smoke. In 2001, nine per cent of Nunavut births were low birth weight – about three per cent higher than the national average.

For Inuit parents, there is a general absence of culturally appropriate parenting programs. Photocopied resources from other jurisdictions are usually the only materials given to families, as locally developed Inuit-specific resources are beyond the means of most centres. There is no territory-wide culturally appropriate parenting program.

The most frequently reported health problems with regards to pregnant women are nutritional concerns, smoking and substance abuse, physical abuse and trauma, and emotional and family problems.[34] While the exact percentage of children and adults with Fetal Alcohol Spectrum Disorder (FASD) in Nunavut is not known, FASD is a growing health and social problem.[35]

Most troubling of all, because it reflects a deep malaise in Nunavut society, is that one of the most stressful issues affecting Inuit women of all reproductive ages is abuse and trauma.[36]

6) Personal Health Practices

A report by the RCMP[37] in 2001 suggests 30 per cent of Nunavut's expectant mothers may drink significant amounts of alcohol while pregnant, and a dauntingly high 85 per cent of their children will show symptoms of FASD.[38] In addition, seven in 10 pregnant Inuit women smoke on a daily basis.[39]

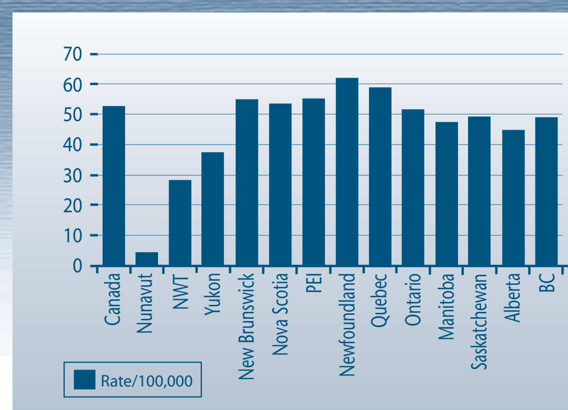
In its 2004 report on teenage pregnancy, Pauktuutit Inuit Women of Canada documents that over 45 per cent of respondents reported that substance abuse was one of the leading reasons teenage Inuit women become pregnant.[40] The rates of heavy drinking are reported at four times that of the rest of Canada.

7) Health Conditions

Heart Attack and Stroke

In 2001, Nunavut's rate for acute myocardial infarctions (heart attack) was more than 14 times lower than the rate for Canada; the traditional Inuit diet may play a role in improving Inuit cardiovascular health. However, while the mortality rate in this disease in Canada is steadily declining, the trend for Nunavut is sloping upward.[41] Nunavut's mortality rate for stroke appears to be lower than the rest of Canada.

Figure 3 Heart Attack Death Rate



Source: Nunavut Report on Comparable Indicators (2004) Department of Health and Social Services, Government of Nunavut.

Lifestyle counselling is an important aspect of adult health promotion, but health promotion and prevention programs are lacking in many communities. Increased community health promotion activities are required to improve the health of adults and this requires more staff.[42]

Cancer

The evidence of cancer is lower for Inuit than it is among Canadians nationally, with the exception of certain types: “Nasopharyngeal, salivary gland, and esophageal cancers,” the so-called, “Traditional Inuit cancers.”[43] In Nunavut, the rate of lung cancer mortality in females is much higher than that of males and nearly ten times higher than that for women nationally.

Lung cancer mortality rates in Canada have been increasing since 1996 and appear to be on the rise in Nunavut. The major risk factor for developing lung cancer, as well as other lung diseases, heart disease and harmful effects on the fetus, is tobacco smoking.

Teenage smoking rates are more than double those for the rest of the Canadian youth population, at 77.9 per cent compared to 32.4 per cent. The use of marijuana was seen as endemic in Nunavut among all age groups.[44]

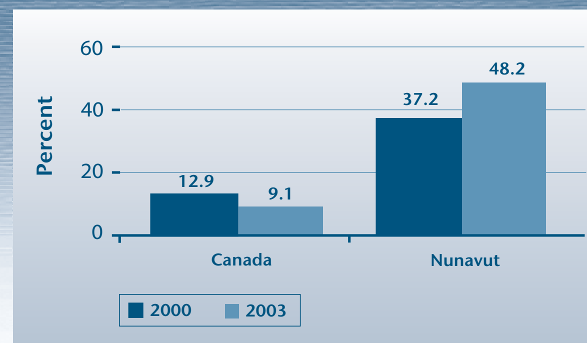
It has been estimated that 65 per cent of Nunavummiut smoke daily – a rate higher than anywhere else in Canada.

The mortality rate for breast cancer appears lower in Nunavut than in every other province or territory in Canada.[45]

Mammography is available in Iqaluit, but it is only available to women with a medical condition and is not currently used in a general screening program owing to staff shortages. Chemotherapy is available in Rankin Inlet but, at the time of writing, it is not available in Iqaluit.

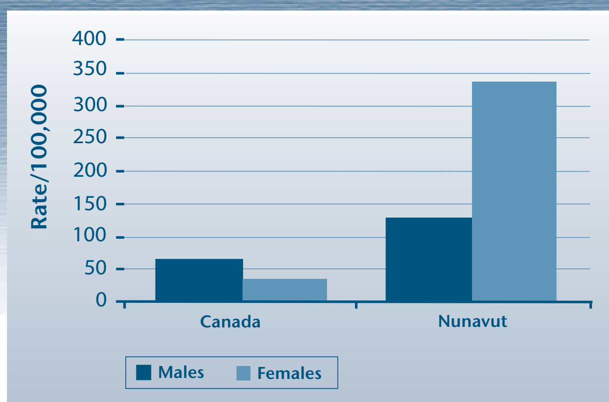
Many communities have comprehensive and well-utilized well-woman clinics, but not all women are receiving Pap smears at appropriate intervals.[46]

Figure 5 Percentage of Population Aged 12 - 19 Who Smoke Daily



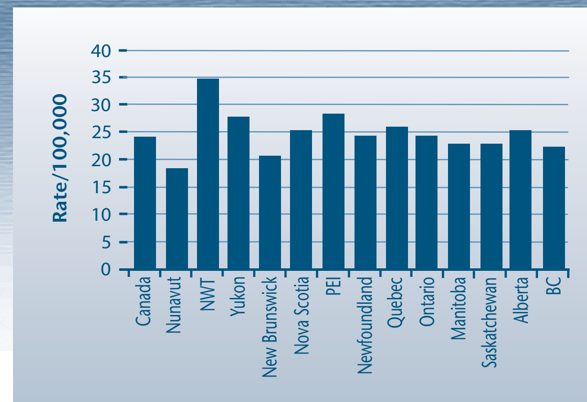
Source: Nunavut Report on Comparable Indicators (2004) Department of Health and Social Services, Government of Nunavut.

Figure 4 Lung Cancer Mortality



Source: Nunavut Report on Comparable Indicators (2004) Department of Health and Social Services, Government of Nunavut.

Figure 6a Mortality Rate for Breast Cancer



Source: Nunavut Report on Comparable Indicators (2004) Department of Health and Social Services, Government of Nunavut.

Diabetes and Obesity

The incidence of diabetes in Nunavut has been relatively stable with an average of 41 new cases diagnosed each year. In 2001/02, it was estimated that 1.72 per cent of Nunavut's population had Type 2 diabetes (4.5 per cent of non-Inuit and 0.9 per cent of Inuit).[47] While 83 per cent of Canadians with diabetes are over 60 years old, in Nunavut, 49 per cent are under 60[48] compared to 4.8 per cent nationally. "However, the still relatively low prevalence of diabetes, when compared to other Aboriginal groups, presents an opportunity for prevention of an epidemic among Canadian Inuit."[49]

Overweight, obese, and physically inactive people are considered at risk for developing diabetes. Concurrent with the emergence of a diabetes epidemic in the latter half of the 20th century in Canada is an increase in the prevalence of obesity.[50]

In 2003, over 28 per cent of Nunavummiut were overweight and 20 per cent were obese. Nearly 60 per cent of Nunavut residents were physically inactive. The lowest rates of physical activity were reported in those aged 45 and over. Smoking is considered a risk factor for complications of diabetes.[51]

8) Infectious diseases

Ever since first contact with Europeans, Inuit health has been ravaged by infectious disease—smallpox, typhoid, influenza were the early culprits. In the 20th century, it became tuberculosis, along with measles and polio.[52]

The main infectious diseases of concern to Inuit today are respiratory infections. Outbreaks of influenza and pneumonia are less severe, but also affect adults in Nunavut.[53] Other communicable illnesses like meningitis and gastroenteritis are also of concern.

In 2007, there was an outbreak in Nunavut of an antibiotic-resistant bacteria (methicillin-resistant Staphylococcus aureus, or MRSA) that causes skin infections and boils. The superbug is found in overcrowded homes where a number of people share the same bed.[54] Overcrowding is rampant in Nunavut, where 1,200 people are on the waiting list for public housing.[55]

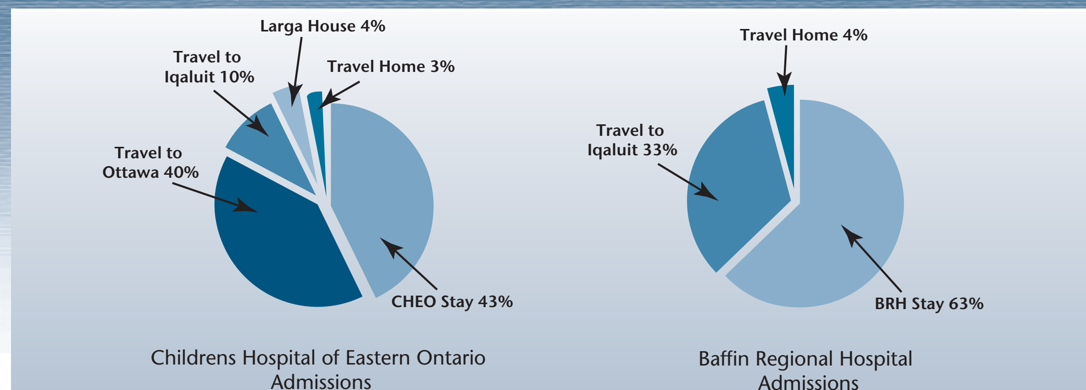
Respiratory Infections

Respiratory tract infections are a serious and widespread problem facing Inuit infants. In one survey period, almost a third of all infants less than six months old were admitted to Baffin Regional Hospital (now Qikiqtani Regional Hospital) for lower respiratory tract infections (LRTIs), such as bronchiolitis.[56] In 2000-2004, a similar study in the Kitikmeot found rates of hospitalization twice that of Qikiqtaaluk. Sixty per cent of all babies less than one year old in the Kitikmeot were likely to be hospitalized for LRTIs, a rate 10 times higher than the overall Canadian population.[57]

Recent research in Qikiqtaaluk region[58] seems to indicate that, "Smoking in pregnancy increased the risk of (infant) admission for LRTI by approximately fourfold." The same study found that, "Breastfeeding is highly protective against LRTI." LRTIs also occurred more frequently in infants from smaller communities outside Iqaluit and infants from families living in overcrowded homes. The study noted that, "It was highly remarkable that all children," who had to be put into intensive care or flown south to hospital came from smaller communities.

Another recent study (Figure 6b) tabulated costs of transportation, hospital and family accommodation for infants diagnosed with bronchiolitis or viral pneumonia in the Qikiqtaaluk region who were admitted to hospitals in Iqaluit or Ottawa, between April 1999 and

Figure 6b Cost Distribution of Treating Respiratory Illness in Inuit Infants



Pg 42 of International Journal of Circumpolar Health 64:1, 2005. Creery, David et al, "Costs associated with infant bronchiolitis in the Baffin region of Nunavut", International Journal of Circumpolar Health 64:1, 2005.

March 2002. Of the 200 admissions, Igloolik had the highest number with 48 cases at a cost of almost $1million in treatment, 33 per cent to 53 per cent of which was due to travel costs.[59]

Tuberculosis

While rates have decreased steadily over the past three years, the incidence rate of tuberculosis in Nunavut remains 70 times higher than the Canadian average. It is difficult to stop the spread of tuberculosis which, "Remains a serious problem," which can cause, "Prolonged and serious illness and can be fatal if left untreated."[60]

Sexually Transmitted Infections

Nunavut has the highest rate of chlamydia infection in Canada.[61] In 2000, 17 times more women and almost 18 times more men were diagnosed with chlamydia in Nunavut than in the whole of Canada.[62]

The 15-24 age group is most at risk of being infected with chlamydia. In Nunavut, women are more than twice as likely to be reported with chlamydia as men.[63] On the whole, chlamydia rates appear to be climbing since 1991.

Nunavut also has the highest Canadian rates of gonorrhoea.[64] Infection rates for syphilis and viral hepatitis B were not known. The high rates of sexually transmitted infections suggest a need for sex education.

9) Mental health

At the Cambridge Bay Mental Health Strategy workshop in 1999, Inuit defined mental wellness as, "Self-esteem and personal dignity flowing from the presence of a harmonious physical, emotional, mental and spiritual wellness and cultural identity."[65]

Conventional medicine tends to evaluate mental health by measuring how many people are seeking treatment for psychological disorders. This measurement is less useful in Nunavut since many people do not seek or cannot access treatment, and because the interpretation of what represents psychological distress may be culturally-conditioned.[66] A recent study of Inuit mental health warned that, "The measures of psychological distress have not been adapted to Inuit culture."[67]

Mental health is not merely the absence of a mental disorder, but is better explained as the presence of emotional and cognitive well-being. This latter definition is closer to the Inuit understanding which does not separate mental health from physical health or all-round well-being.[68] A study of health care delivery for Inuit concluded that, "Until Inuit values, approaches and perspectives are incorporated into health and social services, it is difficult to imagine the system enhancing the mental health and well-being of Inuit individuals and communities."[69] There is currently no territorial government effort to integrate Inuit Qaujimajatuqangit into Nunavut mental health policy or programming, nor has the GN fully implemented its current Mental Health Strategy.

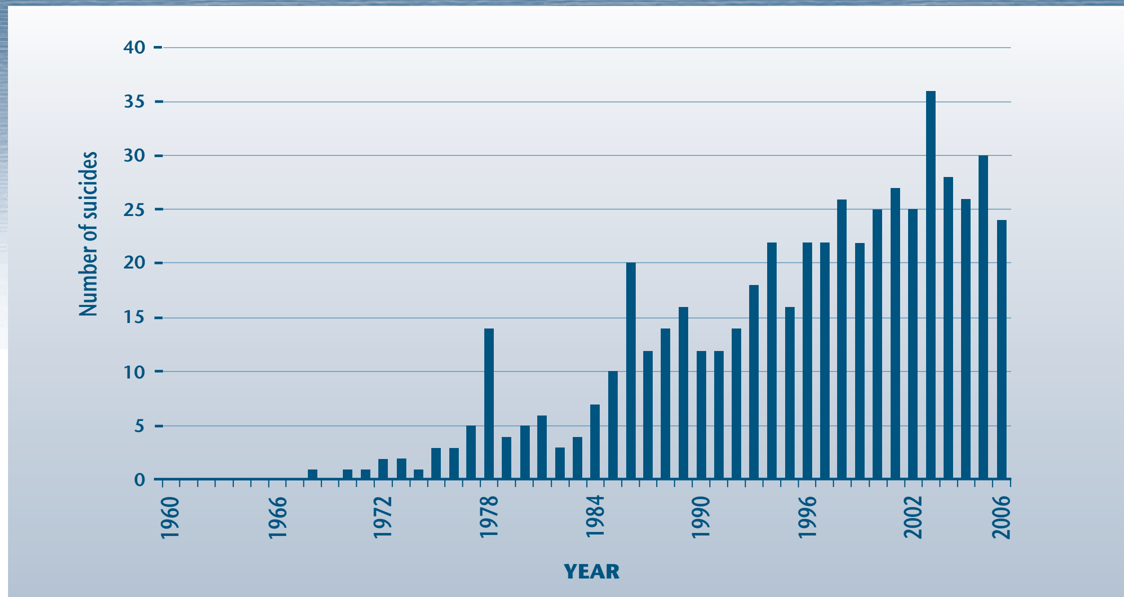
10) Suicide

In Southern Canada, 90 per cent of suicide is associated with individual mental illness, but in Nunavut this connection does not apply. In Nunavut, most Inuit suicide is not associated with mental disorders, according to research by doctors Samuel Law[70] and Miles Hutton, who have reported that, "Psychiatric issues in the Arctic appear deeply interwoven with interpersonal, socioeconomic, and societal changes; effective community mental health services must address a broad spectrum of psychosocial issues beyond the medical model."[71]

Nunavut's highly elevated suicide rate is not the result of elevated rates of mental illness as conventionally defined. The rate of suicide by Inuit men in Nunavut between the ages of 19 and 24 is roughly 50 times that of all men in Canada in that age bracket, but there is no evidence that young Inuit men in Nunavut suffer from mental illnesses at anything like 50 times the rate at which their peers in the South do.

The work of Nunavut researcher Jack Hicks suggests that, "Social determinants," in particular, "Adverse childhood experiences," and other forms of childhood trauma, are the reason why so many young Nunavummiut consider suicide. Noted transcultural psychiatrist Dr. Lawrence Kirmayer described suicide as a, "Barometer of social problems in a community."[72]

Suicide rates in Nunavut were very low in the 1950s and 60s with just one suicide on record in the 1960s.[73] It was in North Alaska in the late 1960s that young Inuit began to take their lives. Youth suicide rates in Greenland rose dramatically in the late 1970s and early 1980s, and then in Nunavut in the late 1980s and through the 1990s. Hicks notes that this order (first Alaska, then Greenland, then Nunavut) is the same order in which Inuit living in those regions had previously undergone processes of, "Active colonialism at the community level," such as being coerced into moving into settled communities, having children subjected to a foreign educational system, and having the active adult hunters largely reduced to unemployed non-wage earners.[74] Kirmayer says that as, "Small indigenous societies," of Inuit were, "Enveloped and transformed by colonizing powers…meaning and the sense of individual and collective worth [was] undermined…and people feel like refugees in their own land."[75]

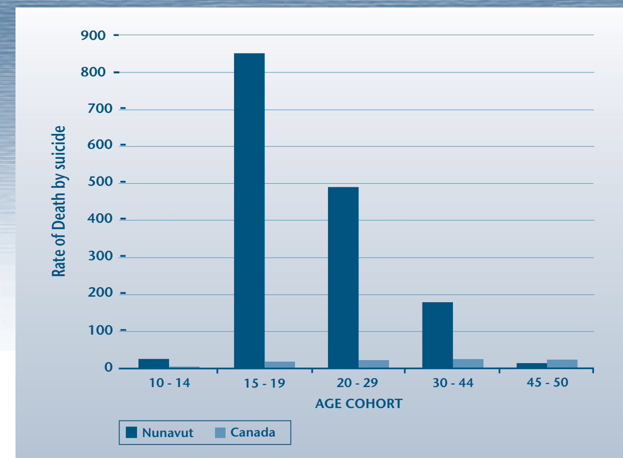


Hicks, J. (forthcoming, 2009).

From 1999 to 2003, the rate of suicide in Nunavut was 11 times higher than in the rest of Canada. Forty-three per cent of all suicides in Nunavut were carried out by young people under the age of 20.[76] Three-quarters were committed by people less than 25 years of age.[77]

Unfortunately, suicide response protocols for Nunavut's nurses, developed by the territorial government in 2001, were not distributed until 2007. Similar suicide response protocols for schools, developed in 2003, had not been circulated by 2007,[78] and may not be in use today.

In the face of this tragedy, Regional Inuit Associations (RIA), community organizations, and other agencies have developed on-the-land programs, resilience workshops, and suicide prevention resources. Notable are the approaches developed by the National Inuit Youth Council and its Inuit Youth Suicide Prevention Framework,[79] as well as workshops on resilience and community wellness developed by our Elders.



Hicks, J. (forthcoming, 2009).

GOVERNING AND PAYING FOR HEALTH CARE IN NUNAVUT

The federal government is the main funding agent for almost all health delivery in Nunavut. Whether the money is for community wellness in Cambridge Bay or the new hospital in Rankin Inlet, most of the funding for the wide spectrum of health care in Nunavut originates in Ottawa.

The GN portion of the health system is almost entirely funded from five federal sources: Territorial Formula Financing, the Canada Health Transfer, the Canada Social Transfer,[80] the NIHB program, and DIAND agreements. The GN delivers health care primarily through the Department of Health and Social Services. No other department has so many different professional and technical people, and such a wide variety of programs to administer—from hospitals to anti-smoking campaigns. It is certainly the most expensive. Health care consumes more than one quarter of Nunavut's budget, and its share will increase over time, driven by factors beyond the control of the GN.

Inuit organizations, hamlets, non-governmental organizations, and charities all participate in the health system by offering health and wellness programs at the community and regional level, the bulk of the funding for which also originates from the federal government —usually from Health Canada, but sometimes from other agencies like DIAND, Heritage Canada or Human Resources and Social Development Canada (HRSDC).

Inuit groups and hamlets must cobble together multiple agreements to exist, which means endless proposal writing and separate accounting for each pot of funding. Some groups also have to top up funding with other monies, often from the Nunavut Trust via RIAs, in order to survive.

The main difference between these two levels of federally-funded health programs is that Inuit groups and hamlets and charities are treated as third level partners, and are not usually considered by the GN as equal partners when undertaking strategic planning or priority setting. Since it is treated as an equal by Ottawa, the GN mistakenly believes it has the ability to unilaterally sign multi-year health-funding agreements on behalf of Inuit, and does not feel obliged to act in conjunction with all other health stakeholders in Nunavut.

In order to fully understand the current structure, it is worth investigating the evolution of government health care delivery in Nunavut.

1) Early History of Health Care

The early experience of Inuit with the Canadian-derived medical system was often painful and culturally disruptive, as the federal government tried to avoid responsibility for Inuit health or tried to pass on the costs of Inuit care to the provinces,[81] churches, or the Hudson Bay Company.[82] Originally, most health care was delivered by churches as Ottawa found them to be the least costly, and approved of their efforts to, "Christianize the Inuit…[as] medical care and cultural change were often viewed by the Euro-Canadian caregivers to be interrelated."[83]

The precursor to the federal government's First Nations and Inuit Health Branch (FNIHB) officially took responsibility for the delivery of health services to all residents of the Yukon and Northwest Territories in 1954. From 1954-1982, control of Inuit health care remained in Ottawa, "In the hands of southern urban bureaucracy… unaccountable to community interests."[84] During this period, Ottawa established the pattern of three separate routes of north-

A doctor gives a needle in Gjoa Haven, 1959.

Photo courtesy of Health and Welfare Canada collection/Library and Archives Canada

south health care flows for Inuit, a pattern that dominates the delivery and cost of health care in Nunavut to this day. Patients and doctors must be flown between Qikiqtaaluk and Ottawa hospitals (previously Montreal), Kivalliq and Winnipeg hospitals, and Kitikmeot and Yellowknife and Edmonton hospitals. Nunavut's previous health minister commented that, "One of every eight dollars in our health care budget goes to jet fuel."[85]

In December, 1982, following talks between the federal government, Inuit Tapiriit Kanatami (ITK) (then Inuit Tapirisat of Canada) and the Government of the Northwest Territories (GNWT), responsibility for the Frobisher Bay General Hospital in Iqaluit was transferred to the GNWT, to be administered by a local health Board. Responsibility for the remainder of federal health services, except for NIHB and the DIAND Physicians and Hospitals Services Agreement, was transferred to the GNWT on April 1, 1988.[86]

2) Transition from the GNWT to the GN

In 1980, the GNWT established three regional health and social services Boards to provide core programs and services. One of the Boards' responsibilities was to provide opportunities for community input into priority setting and decision-making.

Prior to the establishment of Nunavut, the role of the Boards was evaluated by the Nunavut Implementation Commission (NIC) with a view to abolishing them once Nunavut was formed. At that time, Nunavut Tunngavik Inc. (NTI), GNWT, and Ottawa all opposed this idea, with the GNWT warning, "…the proposal to eliminate health boards overlooks the important role of boards in facilitating direct community input into program delivery.[87] The GNWT also pointed out that abolition of the Boards was inconsistent with reforms already underway to move the department away from program delivery and toward a ministry role. There were no precedents for a centralized bureaucracy being the most suitable mechanism for responding to unique local health needs.

Nevertheless, shortly after the establishment of Nunavut in 1999, the GN abolished the Boards and transferred their responsibilities to the Department of Health and Social Services in Iqaluit. As a result, much of the coordination of public health programs was lost as experienced managers and staff took new positions or left the territory. The consequences, which have been serious, are recounted in the Moloughney report[88] on Nunavut's public health system. "Transitions of this magnitude also risk a loss of organizational memory, capacity, and processes requiring a more substantial rebuilding effort. In taking stock of Nunavut's existing public health system, it is [this] …outcome that has occurred. Much of the 'systemness' that previously existed has faded with time.[89]

The loss of organizational memory and capacity continues with nine deputy ministers leaving the Department of Health and Social Services since 1999.

3) Cost of Health Care

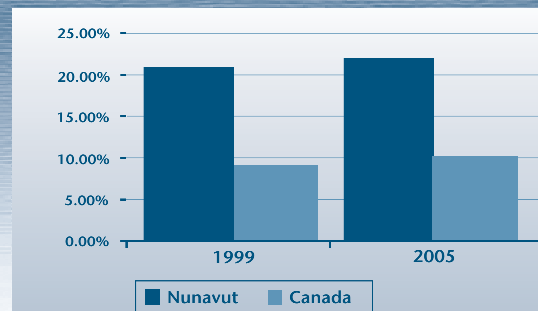
Every province and territory faces a growing demand for health care services fuelled by issues such as demographics, new technologies, and rising pharmaceutical costs. In addition to these new spending demands, the cost of existing services is continually rising.

In addition to cost increases faced by all the provinces and territories, Nunavut faces additional costs caused by its size, a small but widely distributed population, and its traditional dependence on Southern hospitals and medical air travel. Nunavut depends on the Government of Canada for 91 per cent of its revenue. A report by the GN Department of Finance shows that health services in Nunavut are not sustainable without significant new federal funding.[90]

On average, Canadian provinces spend $2,850[91] annually per person on health care. In 2005/06, Nunavut spent $219,693,000 on health care, or an average of $7,454 per person.[92] That amounted to 21 per cent of Nunavut's Gross Domestic Product (GDP), a figure which rose to 26.7 per cent of its GDP by 2007. On average, Canada spends 10 per cent of its GDP on health care.

The GDP measure is important as a degree of the sustainability of the health care system and how it affects the overall economy. So, too, is the percentage of a government's budget devoted to health care. The more resources that health care consumes, the less there is to spend elsewhere. In 2005/06, when the GN spent 25 per cent of the budget on health care, Ontario spent only 13 per cent, but delivered a higher level of health care than Nunavut.

Figure 9 Health Care Spending as a Percentage of Gross Domestic Product



Source: National Health Expenditure Database, CIHI, 2008.

Figure 10 illustrates the cost per person in each province and territory of providing a basic Canadian standard of health care. It is obvious that the North, and Nunavut in particular, is bearing a disproportionate burden and yet still cannot provide the same basic level of health care available to other Canadians.

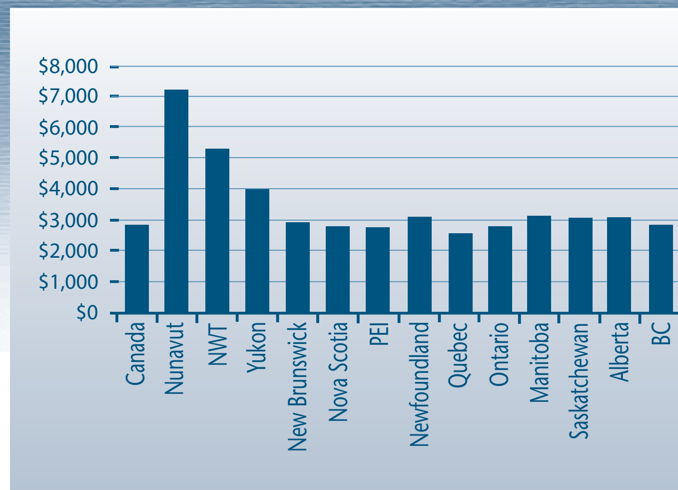
In 2005, almost 14 per cent of total health care spending in Canada was for prescribed drugs. This proportion is increasing over time.[93] In Nunavut, by contrast, only 5 per cent of the total budget went on drugs.

4) Paying for Health Care: A Closer Look at the Federal Role

Provinces and territories are responsible for delivering health care services, guided by the provisions of the *Canada Health Act*. The Government of Canada provides financial resources to the GN, most notably through Territorial Formula Financing.

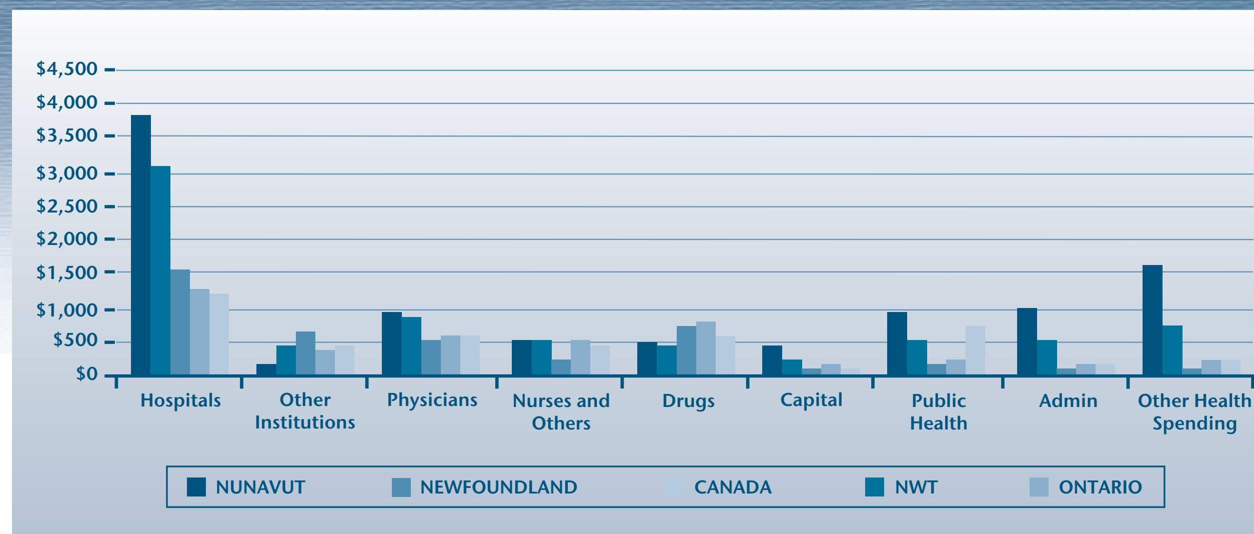
Unlike other Canadian jurisdictions, Nunavut is struggling with the early stages of development and still depends very much on transfers from the Government of Canada.

Figure 10 Province/Territory Health Spending per Person, 2005 to 2006



Source: National Health Expenditure Database, CIHI, 2008.

Figure 11 Total (per person) Health Spending, by Use, Selected Regions, 2005



Source: National Health Expenditure Database, CIHI, 2008.

Territorial Formula Financing is unconditional in order to provide the territories with certainty, flexibility, and accountability. Lesser amounts are transferred through the Canada Health Transfer, and the Canada Social Transfer.[94] Territorial Formula Financing is limited to 3.5 per cent growth annually whatever the growth in the territory's population. Given that Nunavut's population growth, the highest in Canada, uses up much of this annual increase in formula financing, it is not possible for the GN alone to ensure that it will have sufficient revenues to provide essential public services to its people.[95] The current level of Territorial Formula Financing is just enough to provide the basic public services expected of any government in Canada, but inadequate to improve or add significantly to Nunavut's essential infrastructure, or to deal with external cost pressures.

A province can raise provincial taxes, but Nunavut's tax base is relatively insignificant compared to its expenditures. A one per cent increase in revenue in Ontario or Quebec would generally require a three per cent increase in their basic income tax. To achieve a one per cent increase in revenue in Nunavut would require in excess of a 30 per cent tax increase.[96]

5) Non-Insured Health Benefits

Health care services provided by GN are primarily hospital care and primary health care, such as physicians and other health professional services. However, there are a number of health-related goods and services that are not provided by the GN. To support Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's NIHB program provides coverage for a limited range of goods and services when they are not available from the GN. These include a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counselling, and medical transportation for eligible Inuit.

In Nunavut, NIHB is administered by the GN with no Inuit input. In the future, Inuit in Nunavut may wish to administer the NIHB program, following the lead of Inuit in Nunatsiavut. Program spending has actually dropped from $37 million in 2004 to $30.5 million in 2007. However, a shocking 50 per cent of NIHB money is spent on medical travel.

In the period from 1995/96 to 2005/06, total NIHB expenditures increased at a faster rate in Northwest Territories/Nunavut (94 per cent) than in any other region.

Table 1 Major Federal Transfers for All Public Services to Nunavut Government

($ millions)		2004-05	2005-06	2006-07	2007-08
Health and Social Transfers	**Cash**	18	22	22	24
Canada Health Transfer	**Tax**	7	8	8	8
	Total	25	30	31	33
Canada Social Transfer	**Cash**	10	10	10	9
	Tax	4	5	5	5
	Total	14	15	15	14
Health Reform Transfer		1.4			
2004 Wait Times Reduction Transfer		0.6	0.6	1.1	1.1
Total Health and Social Transfers		40	45	47	48
Territorial Formula Financing		756	812	839	893
Total Cash Transfers		785	845	872	927
Total Transfers		796	857	885	941

Source: Federal Transfers to Provinces and Territories, Government of Canada, Department of Finance.

Table 2 NIHB Annual Expenditures ($ Millions) by Region and Benefit 1995/96 to 2005/06

Region	Transportation	Pharmacy	Dental	Other Health Care	Vision
Atlantic	18.3	59.9	15.8	0.7	5.3
Quebec	28.6	50.8	17.5	1.2	1.8
Ontario	25.4	48.3	21.2	1.5	3.6
Manitoba	41.8	39.2	13.4	3.8	1.9
Saskatchewan	25.5	49.4	19.5	2.0	3.6
Alberta	24.7	41.2	16.6	3.7	3.8
BC	15.5	45.5	20.5	1.4	2.8
Nunavut	51.2	17.0	28.2	0.0	3.6
NWT	32.4	38.7	25.3	0.0	3.6
Yukon	26.8	46.6	23.7	0.0	2.9

Source: Adapted from NIHB Program Annual Report 2005/2006. Health Canada.

6) DIAND: The Hospital and Physicians Services Contribution Agreement

DIAND's Hospital and Physicians Services Contribution Agreement pays the Nunavut government $18.8 million to compensate it for health services it delivers to Inuit. The program was born from a 1959 cabinet decision that, "The Federal Government will continue to bear the total cost of hospital care for Indians and Eskimos."[97] In 2001, Ottawa and the GN proposed to NTI that this program be converted into part of the general funding of the Nunavut public government through Territorial Formula Financing. In that same year, NTI informed both governments that Inuit did not agree with the conversion of an Aboriginal-specific program into general funding of the public government, and instead, NTI said that Inuit have the right to review and sign-off on government health funding intended for them. NTI asserted this right under NLCA Article 32, and Article 2.7.3, which states that nothing in the NLCA shall affect the ability of Inuit to participate in and benefit from government programs for Inuit or Aboriginal people generally as the case may be.

As of 2008, neither government replied to NTI's concerns expressed in 2001. However, a recent federal evaluation of the Hospital and Physicians Services Contribution Agreement acknowledges that there is, "Aboriginal opposition," to their plan, but repeated government's intention to eventually convert the program to public funds.[98] The federal government lists the, "Key stakeholder," for this program as the GN. There is no mention made of accountability to Inuit.[99]

7) Human Resources

Most Inuit communities are served by community health centres where the demands of treatment eclipse prevention programs at every turn. Consequently, many community health nurses find they are unable to get out of the clinic to provide community-based health promotion activities.[100]

Doctors are available in larger regional centres and make scheduled visits to the communities. Specialized services are often only offered in Southern centres. This means that most patients must travel great distances to access these services.

The net result is that often disease detection, emergency services, follow-up, rehabilitation, palliative care, and social supports for patients are delayed, unavailable, or are substandard. Few of these services are sensitive to Inuit culture or provided in the Inuit language.

Nurses

Nurses are the backbone of Nunavut's health care system. They are the largest single group of professionals, and as a group, they are on duty 24 hours a day, seven days a week. In 2000, 16 per cent of Inuit children had contact with a doctor while 52 per cent had contact with a nurse. For all children in Canada, 67 per cent had contact with a doctor and 20 per cent with a nurse.

There are approximately 380 nurses registered to practice in Nunavut,[101] but most are casual, agency, or not working. Since the opening of the hospitals in Rankin Inlet, Cambridge Bay, and Iqaluit, approximately 220 nurses are required in Nunavut. However, as of October 2008, only 119 nurses work full-time for the GN and fewer than 15 of these nurses are Inuit.[102] Consequently, the facilities in Rankin Inlet and Cambridge Bay can only operate as health facilities and not hospitals, and the new Qikiqtani Regional Hospital in Iqaluit is currently only operating at fifty per cent of its capacity.

The difficulty of recruiting and retaining nurses in Nunavut is a significant problem confronting the health care system. With 111 employed out of the 200 nurses required, nurses are critically overworked. Such stressful circumstances require superior personnel management, a competitive compensation package, professional development opportunities, efforts to ensure a safe workplace, good accommodation, and other inducements. However, that has not been the way the Department of Health and Social Services has responded. Instead, throughout most of 2007, nurses resigned or resorted to significant union action to get the attention of the department.

Nunavut's problems are made worse by a general shortage of nurses in Canada.[103] There are ten provinces, all richer and more powerful than Nunavut, competing for a part of the diminishing supply of nurses. In Nunavut, there is a continual turnover of nurses and an ongoing dependency by the GN on relief staff drawn from local casuals and contract nurses brought in from Southern agencies. Low levels of staffing in Nunavut and the heavy dependency on agency nurses has unmeasured, but predictably negative consequences for the care of Nunavut's patients. It also creates an additional burden for the regular GN nurses who are obliged to orientate and mentor new nurses from the agencies.

In 2006, the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) published its second *Nurse Recruitment Retention Survey*.[104]

This showed that part of the GN's recruitment problem is self-inflicted. According to the RNANT/NU survey, there is, "General dissatisfaction with human resource processes and anecdotal evidence shows a level of frustration with human resources processes from delays in returning calls to lack of respect and unclear or inappropriate information.[105] For example, five nurse graduates from Nunavut's own nursing program, who were licensed to practice as graduate nurses in August, 2006, waited several months to be recruited.

Community Health Representatives

In the 1960s many communities had, "Inuit lay dispensers," paraprofessionals with, "Six weeks of intensive instruction in basic medicine," who had responsibility for, "Basic diagnostic and medication procedures," in smaller communities, but whose role died out as Southern nurses replaced them in the nursing stations built in the 1970s.[106] In the 1970s, Community Health Representative (CHR) positions were established. John O'Neil, a doctor in Gjoa Haven at that time, called for CHR training to, "Be expanded to include other paramedical functions such as psychological counselling, preliminary physical diagnosis and treatment."[107]

Although that recommendation was not implemented, the CHR role remains central to the delivery of community health care. CHRs are graduates of a nine-month course. They are Inuit, and they come from the communities they work in. As of June, 2008, almost half the CHR positions in Nunavut were vacant.

Adla Newkinga works at the Qikiqtani Regional Hospital in Iqaluit.

Photo by Franco Buscemi

The CHR role has potential to deliver community wellness programs, but this is not being used in the communities. Indeed, regional and territorial support for public health programs consists of little more than support for immunization and communicable disease outbreaks. This is not regarded as enough by most nurses who say, "The preventative public health side is what we don't have time or staff for. We meet the immunization goals, but there is more that we could do."[108]

A functioning CHR who is trained and enthusiastic could take a lot of the community health burden off the nurses who work under enormous pressure providing clinic services. Inevitably, CHRs are drawn into assisting the nurses in the delivery of treatment, leaving them with little time for their primary public health function.[109] In some cases, CHRs are also drawn into unrelated duties such as reception and translation. They receive little support or direction from the regional offices.[110]

NTI believes that the CHR role should be expanded along the lines recommended by Dr. O'Neil. Previous studies of Inuit health care have called for an increased emphasis to be placed on paramedical training. A report prepared for the Royal Commission on Aboriginal Peoples (RCAP) recommended that, "Paramedical health careers should be encouraged for young Aboriginal people as a way of maintaining and strengthening the cultural and social links while earning a living in a position of respect within their communities."[111]

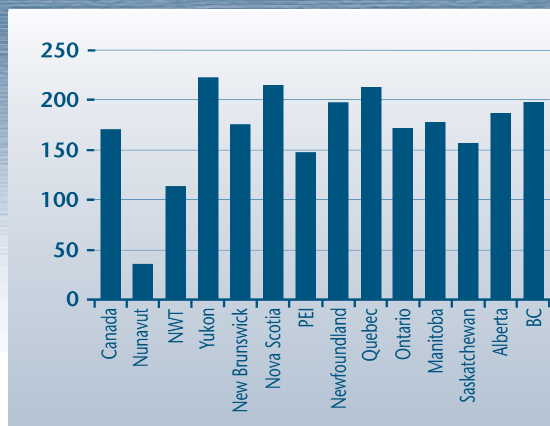
Physicians

As of September, 2008, Rankin Inlet, population 2,350, was without a full-time permanent doctor for one year. As a result, Rankin's 10-bed hospital, opened in 2005, sits largely unused.[112] In Nunavut, patients currently see a physician for primary care in only two communities, Iqaluit and Pond Inlet, although this latter is the result of the doctor's personal preference. In the other communities, patients are seen by a physician for follow-up care only after they are referred by a nurse.

In 2006, there were 35 physicians per 100,000 population in Nunavut, compared to 172 per 100,000 in the rest of Canada.[113] Figure 13 shows that, unique among all provinces and territories, Nunavut suffered a net decline in the number of physicians from 2002-2006. Nunavut, like the rest of Canada, is faced with challenges recruiting and retaining physicians, but it is clear that Nunavut's challenges are quite exceptional.

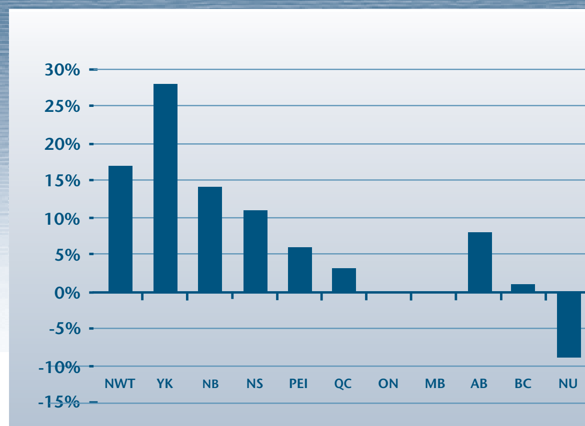
GN physicians only serve the Qikiqtaaluk region. The Kivalliq region is serviced by the University of Manitoba, Northern Medical Unit, and an arrangement with the Stanton Hospital in Yellowknife provides physician care for the Kitikmeot region.

Figure 12 Physicians per 100,000 Population, 2006



Source: National Physicians Database, CIHI.

Figure 13 Increase in Family Physicians, 2002 to 2006



Source: National Physicians Database, CIHI.

Dentists and Dental Assistants

There are some factors specific to Nunavut that limit the nature and frequency of dental care. They include widespread dental disease, geographic isolation, communities too sparsely populated to support a full-time dentist, and philosophical differences in dental practice (treatment versus prevention).[114]

Iqaluit children took part in games on Nunavut Day.

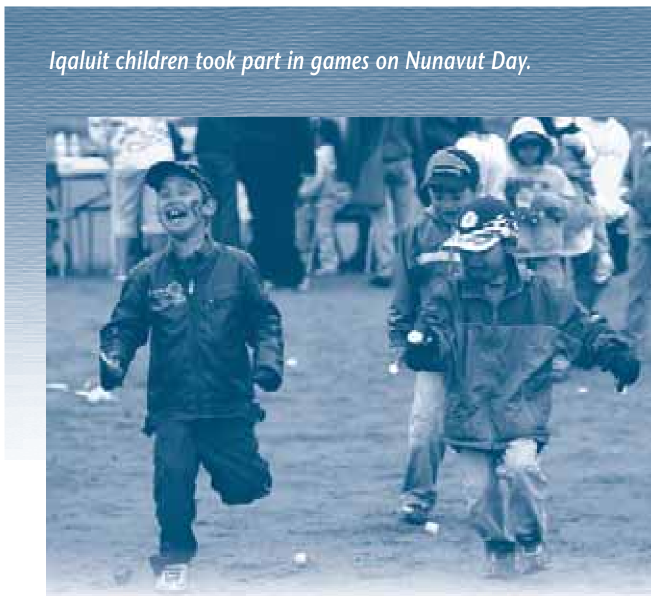


Photo courtesy of DIAND – Nunavut Regional Office

While all Inuit have dental benefits through NIHB, only 45 per cent of those residing in Nunavut visit the dentist each year.[115] Of all regions over the last decade, Nunavut experienced the greatest increase in dental expenditures, now at $6.9 million. Further, Nunavut has the highest per person dental expenditures in Canada at $273 per person.

There is chronic understaffing of all dental positions in the territory. There are no permanent government-funded dentists or dental assistants living and working in Nunavut, a situation that is not expected to change in the foreseeable future. Most dental therapist positions are currently vacant resulting in an extremely high level of need in the community. At present, there are no educational opportunities available in the territory in any area of dental health, and personnel must be trained outside Nunavut.

According to an article in the *International Journal of Circumpolar Health*, the current dental system in Nunavut is badly organized. Through NIHB, dental care in Nunavut is publicly-funded. Consequently, both the Nunavut and federal governments should be concerned with accountability and should set benchmarks to measure performance outcomes and regularly monitor the dental health of residents.[116]

Inuit children, for example, reveal epidemic prevalence rates ranging from 50 per cent to 100 per cent (four-seven age group) with anywhere from 40 per cent to 70 per cent of the 20 primary teeth affected by decay. Less than one third of infants and preschoolers in Nunavut have a dental visit each year.[117] Health officials have estimated that up to half of all children in Nunavut suffer from preventable tooth decay. There were 592 children approved for travel for dental services in 2004/05.

Table 3 Cost of Dental Treatment (extractions) for Children 2004-05
(travel, accommodation, and anaesthetist not included)

	No of children	Basic cost	Total
Baffin Region	177	$1,400	$247,800
+ Iqaluit	54	$1,400	$075,000
Kivalliq Region	163	$1,400	$228,200
Kitikmeot Region	198	$1,400	$277,200
Total			**$828,200**

Source: Community Profile: Education and Development Planning, DHSS, August 2005, unpublished.

COMPLETING THE SYSTEM: INUIT AND COMMUNITY-BASED ORGANIZATIONS

RCAP's *Gathering Strength* called on stakeholders to integrate health programs and pool resources in order to untangle the hodgepodge of short-term funded programs and, "Integrate and coordinate separate services." (Recommendation 3.3.8)[118] Sadly, the coordination called for by RCAP in 1996 has yet to materialize in Nunavut.

There are many wellness programs and health coordinating functions carried out by Inuit and community groups that are part of Nunavut's overall health care system which the government tends to misunderstand or overlook. Examples include funds for multilateral strategic planning, Aboriginal representational involvement, on the land programs run by Inuit organizations, healing programs run by community-based organizations, or Inuit-specific federal programs run by municipalities. These activities all compliment and support the system operated by the GN, but are not always recognized as being a part of it.

Many of these programs and projects are delivered through one-year contribution agreements drawn from dozens of fixed-term federal initiatives. Inuit or community wellness organizations apply directly to the federal agency supplying the funds (such as Aboriginal Healing Foundation (AHF) projects), or through a GN department or Inuit organization that has agreed to administer the funding for the federal government (such as the numerous Inuit-specific health programs funded by Health Canada, but administered by GN Health and Social Services).

In addition, there are private societies that find funding in a less orderly way, scouring the federal system for potential pots of money that are compatible with the society mandate.

In the Arctic, this funding model creates a number of barriers to success. Community organizations that apply for and receive funding often lack the capacity to fill the bureaucratic requirements associated with the funding. Programs, even if popular and productive for clients, are cast aside if they do not show short-term dividends. Unfortunately, the result is that programs, such as tobacco reduction, FASD or sexually transmitted infections awareness and prevention are, "Available to the community one year and gone the next."[119]

This section discusses three different models that are often used to involve Inuit in health care, but are not under the exclusive domain of the GN.

1) Inuit Representational Funding

The federal government recognizes its obligations to consult with Inuit by providing funds for participation of Inuit representational organizations on specific issues or initiatives. At the national level, ITK received $3.4 million in the 2007/08 fiscal year from the federal government to represent Canadian Inuit on issues related to health. The first Inuit Health Summit, held January 16-17, 2008, in Kuujjuaq, Quebec, is a testament to the effectiveness of national Inuit representation ensuring the Inuit perspective is recognized and incorporated into federal priority-setting and decision-making.

In Nunavut, NTI receives federal funding through single or multi-year contribution agreements to help shape federal health priorities, improve health outcomes, and administer federal health initiatives. In 2008/09, NTI signed contribution agreements in excess of $2 million from Health Canada to participate in the Aboriginal Health Transition Fund, the Aboriginal Human Health Resources Initiative, and the National Aboriginal Health Organization Inuit research project.

Federal funding of Inuit coordination and representative work shows that government is well aware that unilaterally imposed solutions to Inuit-specific challenges are not successful. Funding of this kind is also important because it proves that the federal government (particularly Health Canada) understands that it has an obligation to involve Inuit in the critical thinking process that precedes action.

An excellent example of this type of funding is the tripartite project carried out by NTI, GN, and Health Canada's FNIHB. Called the Health Integration Initiative, the project produced plans to integrate health promotion and illness prevention programs in Nunavut.

The Nunavut portion of this Canada-wide initiative was the first tripartite health collaboration to be directly led and coordinated by an Inuit organization in Nunavut, enabling the project to be delivered from an Inuit perspective. The resultant report, released in June, 2006, called *Piliriqatigiinngniq – Working Together for the Common Good*,[120] focused on improving collaboration with every sector and agency which impacts Inuit determinants of health. It details a five-year plan for Nunavut to integrate health promotion and illness prevention programs for dental health, mental health, addictions treatment, maternal health, and child health.

NTI, GN, and Health Canada all agree that the implementation of the report's findings will lead to the development of more effective health care programs for Inuit. To ensure continuity and implementation of the report's recommendations, NTI began a process to expand and formalize the existing partnership and created the Nunavut Tripartite Partnership Committee on Health (NTPCH). This committee, comprised of representatives from NTI, GN, Health Canada, and RIAs, committed to work in partnership to examine ways to improve the design, delivery and development of health programs and services in Nunavut in order to better meet the needs of Inuit.

Over the course of 2006 and 2007, NTI also pursued funding opportunities through the Aboriginal Health Transition Fund to further support the work of the NTPCH and to oversee the implementation of the report. With support from Health Canada, NTI secured a $2.3 million contribution agreement for the Nunavut Community Wellness Project, a project that will implement the report's Community Wellness Strategy.

The Nunavut Community Wellness Project is an example of a collaborative effort to improve Inuit health and the state of the health system by utilizing Inuit-specific opportunities and assets. While NTI's role in leading this process has been recognized by governments and other various stakeholders and organizations, the responsibility to prioritize, incorporate and deliver on any significant change to existing health programs and services still remains in the hands of federal and territorial policy makers and service delivery agents.

Figure 14 Federal Health Program Funding Allocations for Nunavut 2007/08

Allocations	Public Health Agency of Canada	First Nations & Inuit Health Branch (GN)	Healthy Environment & Consumer Safety Branch
HIV/AIDS Fund	$111,925		
Hepatitis C	$61,227		
Population Health Fund	$44,882		
Canadian Diabetes Strategy	$97,462		
Healthy Living	$25,883		
National Native Alcohol and Drug Program		$755,358	
Brighter Futures/Building Healthy Communities		$3,461,936	
Home and Community Care		$5,269,739	
Aboriginal Diabetes Initiative		$1,235,782	
National Aboriginal Suicide Prevention		$504,951	
Drug Strategy Community Initiatives Fund			$70,000
Tobacco Control Strategy			$116,372
Adult Programs	$341,379	$11,227,766	
Community Action Program for Children	$735,180		
Canadian Prenatal Nutrition Program	$737,190	$1,191,440	
Fetal Alcohol Spectrum Disorder	$45,513	$578,804	
Aboriginal Head Start Program	$1,234,000		
Total Children	$2,751,883	$1,770,244	
Grand Total	$3,093,262	$12,998,010	$186,372
Grand Total of Investments **$16,277,644**			

Health Canada. September, 2008.

2) Issue-Specific and Aboriginal-Specific Federal Programs

The federal government spends millions of dollars annually in Nunavut on issue-specific health priorities, such as maternity and child health, nutrition, or mental health and addiction treatment, through third-party contribution agreements between federal departments and delivery agents in Nunavut.

There are 21 federal health-related programs delivered in Nunavut. There is obviously a significant amount of money allocated to Nunavut on health care priorities that are not dictated by GN. Therefore, it would be constructive for the GN to embrace a tripartite relationship with Inuit and the federal government to ensure that funds are coordinated and used well.

The AHF is an example of federal funding that responds well to community needs. To date, the AHF has disbursed 1,345 grants in Canada worth $406 million. In Nunavut, AHF is a keystone funder, providing almost $12 million over four years to 12 community well-ness projects including Tukisigiarvik Society in Iqaluit, Ilisaqsivik

Table 4 Federal Community-Based Health Programs

First Nations and Inuit Health Branch Programs

- Aboriginal Diabetes Initiatve
- Canada Prenatal Nutrition Program
- Maternal Child Health
- NIHB
- Brighter Futures
- FASD
- National Aboriginal Youth Suicide Prevention Strategy
- Building Health Communities
- Indian Residential Schools Resolution Health Support Program
- National Native Alcohol and Drug Abuse Program

Public health Agency of Canada Programs

- Aboriginal Health Start Program
- Canadian Diabetes Strategy
- Healthy Living
- AIDS Community Action Program
- Community Action Program for Children
- Hepatits C Community Based-Programs
- Canada Prenatal Nutrition Program
- FASD
- Population Health Fund

Healthy Environments and Consumer Safety Programs

- Federal Tobacco Control Strategy
- National Anti-Drug Strategy

DIAND Programs

- Hospital and Physicians Services Contribution Agreement (worth $18.8 million per year)
- Food Mail Program (worth $23.7 million in 2006 subsidizing the air transport of nutritious food to Nunavut.)[121]

Health Canada. August, 2008.

Society in Clyde River, Pigiarvik community wellness project in Chesterfield Inlet, Salugat Committee in Pond Inlet, and community wellness programs in Kugluktuk and Cambridge Bay. AHF does not provide the entire budget for these groups, but these and other communities rely on AHF funding as a central support around which they can build the rest of their fundraising. Inuit are concerned that the conclusion of AHF in 2010 may mean the end of their most successful culturally-relevant healing and wellness programs at the community-level.

3) Community-Based Organizations

The federal and territorial governments operate from a position of strength and security. Health Canada and the GN's Health and Social Services receive significant and flexible core funding, which pay for their administrative structure, and the programs and services they provide. No such luxury is afforded the few community-based wellness organizations in Nunavut, which exist against all odds. Their expenses are spread out amongst multiple one-year or event-specific contribution agreements negotiated with three levels of government. That this financial insecurity does not cripple these community groups is a testament to their commitment and ingenuity.

As previously mentioned, there are at least 12 health and wellness initiatives in Nunavut which are being delivered by hamlets or community groups or Inuit organizations at the local level, guided by community input. These include wellness programs operated by the the hamlets of Cape Dorset, Pangnirtung, Pond Inlet, Kugluktuk, and Cambridge Bay, as well as the Tukisigiarvik Society in Iqaluit, Ilisaqsivik Society in Clyde River, and the Pigiarvik community wellness project in Chesterfield Inlet.

The Ilisaqsivik Society of Clyde River is a community-based organization that is an excellent example of healing and wellness programs delivered in accordance with Inuit culture and values. "All Ilisaqsivik programming supports community development and wellness in a way that maintains respect for traditional Inuit teachings and learning, and is accountable to the community."[122] Ilisaqsivik has also developed an important and helpful Inuit Societal Values project which aims to involve and empower Elders to participate and help guide organizations that are addressing social problems in the community.

Ilisaqsivik is also a perfect example of how community-based organizations are not properly respected by the bio-medical health system. Ilisaqsivik receives funds from Health Canada, the GN (departments of Health and Social Services, Culture, Language, Elders and Youth, and Education) as well as from Inuit organizations. Unfortunately, no government or organization will commit to core-funding Ilisaqsivik, even though it is one of the most successful models of health promotion and Inuit healing in Nunavut.

Inuit women from smaller communities travel to Iqaluit to give birth at Qikiqtani Regional Hospital.

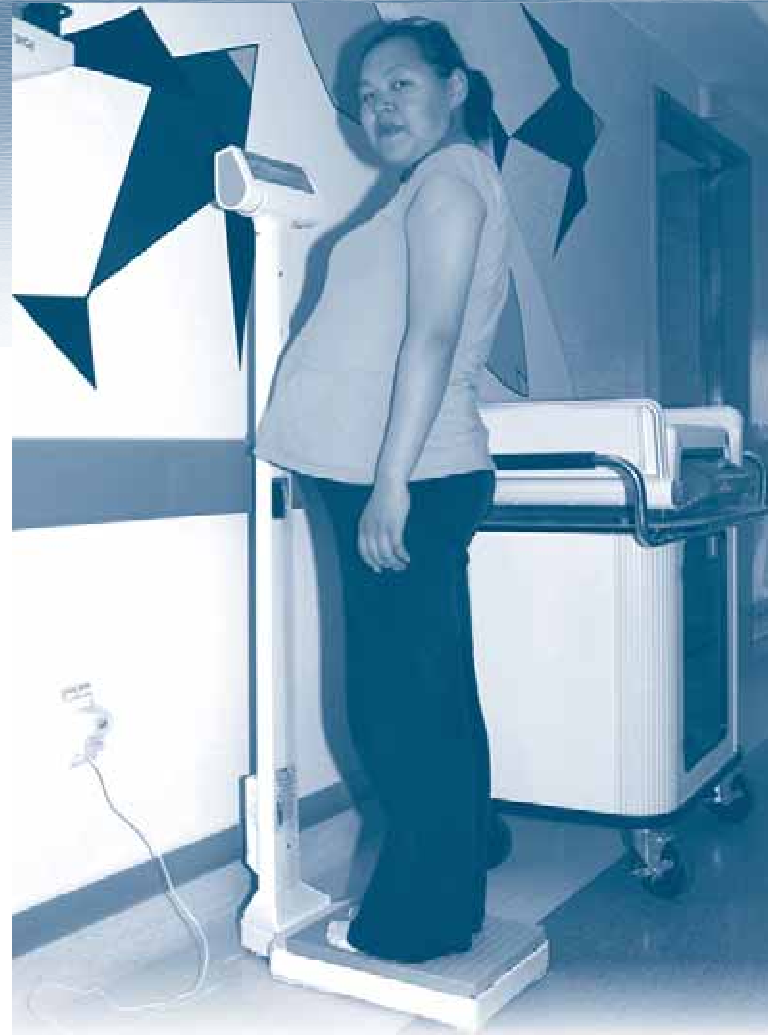


Photo by Franco Buscemi

THE METHODOLOGY OF HEALTH CARE IN NUNAVUT

There are philosophical differences within the health care community in Canada and internationally as to how the scarce resources for health care should be applied. These differences arise over whether to shift scarce and limited resources away from treatment and chronic care into prevention and health promotion, and thereby eventually reduce the demand for treatment and chronic care. The primary health care approach focuses on preventing illness and promoting health. Compared to running a hospital and flying people hundreds of miles for treatment, prevention is cheap. It makes sense for Nunavut to put its resources into prevention, but a shift of resources from the current treatment model will take the support, commitment, and advocacy of the territorial government, Inuit organizations and communities.

1) Primary Health Care

The primary health care approach places the community, rather than the nurse, doctor, and other health workers, at the centre and does not exclude traditional healing methods.[123] The primary health care approach is the most holistic, and therefore, more compatible with the Inuit worldview. Health Canada defines the primary health care approach as, "…an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury."[124]

Nunavut Day emcees Paul Irngaut (left) and Madeleine Allakariallak (right) introduce Iqaluit Elder Enuapik Sagiatuq.

Photo courtesy of DIAND – Nunavut Regional Office

In Nunavut, there are many factors which cause people to be unhealthy and require treatment. Some are social such as trauma arising from the residential school experience, physical or verbal assault, or from addictions. Others are economic such as poverty, high cost of living, poor housing. These factors can be changed, but it requires coordination across many different organizations for a significant period of time before positive changes can be realized.

It is far more effective, from the point of view of health care, that problems should be tackled collaboratively. This has been the view of the World Health Organization which originally advocated the primary health care approach in 1978. It is now the policy of the Government of Canada.

There are five primary health care principles:

- Cooperation across sectors.
- Accessibility.
- Public participation.
- Health promotion.
- Appropriate use of technology.

2) Health Promotion and Illness Prevention

It has been noted by Canada's first ministers that, "Public health efforts on health promotion, disease and injury prevention are critical to achieving better health outcomes for Canadians and contributing to the long-term sustainability of medicare by reducing pressure on the health care system." [125]

Given that most of Nunavut's health status measures are substantially below the Canadian average and that a staggering 25 per cent of Nunavut's health budget is spent on transporting patients to hospitals in Iqaluit, Yellowknife and the South for treatment, it follows that prevention should be a priority for Nunavut, but if funding is an indication, it is not. In 2007/08, the portion of the GN Health and Social Services budget devoted to public health was cut.[126]

Nonetheless, the Department of Health and Social services recognized the importance of health promotion and prevention by developing a *Public Health Strategy*.[127] Unfortunately, according to the Moloughney report, there will be significant obstacles to overcome in implementing this *Public Health Strategy*. "Nunavut's public health care system remains fragmented, lacks coordination, the staff is over-worked and under-supported, and the basic function of collecting information and tracking the population's health is not operating."[128]

Tracking population health is essential for developing appropriate public health policies. Thirteen provinces and territories and the federal government have agreed to track a set of 67 health indicators addressing health status, health outcomes and quality of service, to allow annual comparisons, for example, between the state of health of Nunavummiut and other Canadian jurisdictions.

Unfortunately, staff shortages mean the GN produced only one of these annual reports in 2004. It is impossible for frontline public health workers and senior management to make intelligent and informed decisions about public health without access to information on the state and trends within the population's health. "The first public health information system that is typically established is to track and respond to trends in communicable diseases. That system has been inoperable in Nunavut for at least a couple of years. The lack of dedicated data entry staff at the territorial level resulted in a shut-down of communicable disease surveillance."[129]

3) Public Health Strategy

The GN's *Public Health Strategy* sets out the five core functions of public health, which will also serve as cornerstones for a primary health care approach:

- Population health assessment.
- Health surveillance.
- Health promotion.
- Disease and injury prevention.
- Health protection.

The strategy recognizes that many organizations contribute to public health and it is, therefore, founded on working collaboratively and in partnership with other departments and non-governmental sectors. It is unfortunate that the strategy was not developed collaboratively. Instead, it is primarily founded upon a report prepared by a Vancouver consultant,[130] and there was almost no consultation with other organizations or communities during its development. It was also developed in isolation of a related tripartite effort by NTI, GN, and the federal government to develop the Health Integration Initiative set out in *Piliriqatigiinngniq*.[131]

The Department of Health and Social Services acknowledges that it cannot solve all of Nunavut's problems at once, or even soon.[132] Accordingly, the strategy is a five-year plan which, while maintaining the primacy of the five core functions of public health, will focus on two broad areas which have a profound impact on the health of Nunavut's population.

Healthy Children and Families

- Increasing the incidence of healthy birth outcomes.
- Increasing the number of children achieving age appropriate developmental milestones.
- Improving food security for all families.
- Decreasing the number of people experiencing mental, physical, emotional or sexual abuse.
- Decreasing the incidence of youth engaged in risk behaviours.

Addiction Reduction

- Reducing tobacco use.
- Minimizing substance abuse.
- Increasing capacities of communities to reduce unhealthy lifestyles.

While Nunavut's population trails the rest of the country in significant areas of health, and compared to other jurisdictions its public health system is much less developed and less able to address these issues, the system has some strengths. It has frontline workers who are enthusiastic and thrive on challenges.[133]

Most importantly, the Inuit population is inherently aware, through its traditions and culture, of the many factors in Nunavut which impact community health. Thus, Inuit regional and community organizations are already delivering health and wellness initiatives which compliment and relieve pressure on the bio-medical system.

4) Cooperation and Public Participation

Two primary health care principles, cooperation across sectors and public participation, are emphasized by this report. Health care as a concept must be widened to include participation from Inuit healers, and that overdue respect would lead to increased cooperation across the wide range of agencies, Inuit organizations, charities, hamlets, and government departments that play a role in health and wellness.

Primary health care works best when the administrators openly acknowledge the underlying social, economic and political causes or determinants of ill-health, seek to involve community members actively in their own health care, and build the capacity of local health and wellness workers and community members to take control over local health issues.

The various federal and territorial agencies, such as health, education, justice, policing, and housing, should collaborate and integrate their efforts. The Inuit sector, including Elders' counselling, Inuit midwifery and family care, and culture and land programs, should also be integrally involved in the coordination, planning and delivery of primary health care in Nunavut. Cooperation across these sectors recognizes that health and well-being are linked to economic and social policy, as well as NLCA obligations.

Indeed, many organizations outside the GN are anxious to work with its Department of Health and Social Services to improve public health. FNIHB's Northern Region has a clear mandate to be involved, and NTI, RIAs, and ITK have a vested interest in public health. For a government like the GN that is beset by many problems outside its control and short of money, the key to building an effective health system is to work with other organizations and build on the strengths that it has.

Consequently, a shared weakness in Nunavut's approach to primary health care and its *Public Health Strategy* is its failure to recognize and work with the regional and community-level Inuit organizations, hamlets and local charities in a coordinated way. NTI and the RIAs each have specific mandates to advance the well-being of Inuit in Nunavut. Under NLCA Article 32, the federal and territorial governments are obliged to involve these organizations in the development of social policy. Unfortunately, the territory's *Public Health Strategy* makes no mention of these organizations.

What is the territorial government and its health system missing out on by not recognizing the community and regional Inuit health and wellness sector? How would an increase in Inuit healing strategies affect the bio-medical system? One report found that, "The main reasons for hospital use by Qikiqtaaluk, Kitikmeot and Kivalliq residents were pregnancy (26 per cent), respiratory diseases (18 per cent), digestive diseases (10 per cent), injuries (9 per cent), and mental problems (7 per cent)."[134] Two of the existing healing strengths of Inuit culture—midwifery and counselling—might help address midwifery and mental problems as reasons for hospital use, which makes a strong argument for increased reliance on Inuit healers for cost savings alone. Experience in Nunavik has shown that traditional Inuit maternity centres can dramatically reduce Inuit use of hospitals and medevacs while gaining stronger health results for infants and mothers.[135]

5) Involving and Supporting the Inuit Health and Wellness Sector

It is a basic principle of the primary health care approach that individuals and communities should have the right and responsibility to be active partners in making decisions about their health care and the health of their communities. This is particularly the case with Inuit, many of whose health problems are closely associated with poverty and a problematic history with Canadian government laws and policies. As the Moloughney report points out, "Creating change will be assisted by Inuit principles and values that have a built-in appreciation for the many factors that influence health [and] the interest of other jurisdictions and non-governmental organizations to collaborate with Nunavut."[136]

It was with this in mind that NLCA Article 32 was negotiated. Without limiting any rights of Inuit or any obligations of government, outside of the NLCA, Inuit have the right as set out in this Article to participate in the development of social and cultural policies, and in the design of social and cultural programs and services, including their method of delivery, within Nunavut.

Accordingly, in Nunavut, public participation is not only a basic principle of a sound primary health care approach, it is also a legal obligation. In spite of this, the *Second Five Year Review of Implementation the Nunavut Land Claims Agreement* conducted by PricewaterhouseCoopers (PwC) in 2006 found that, "Throughout the course of our review, we repeatedly heard beneficiaries say that they thought that the implementation of the NLCA would give Inuit the ability to set their own priorities, develop their own policies, and implement them in a way that respected their culture. Many interviewees and participants in our focus groups repeatedly claimed that this was not happening. They indicated that there were many rules being set, and processes being established, and that they were not involved in the decision-making and they were not sufficiently consulted throughout. In addition, all too often we heard Inuit say that they believe their opinions, and most importantly the opinions of elders, are neither solicited, nor respected."[137]

Recently, PwC made a presentation to the Senate Committee on Aboriginal Peoples and reiterated that the lack of participation by Inuit was a major problem. "I believe the most significant failing in implementation lies in insufficient engagement of Inuit in decision-making. During the focus groups we held in the communities, there were numerous times where Inuit were so upset with how shut out and demoralized they've become that they were brought to tears. So many people said 'our elders aren't respected', and they said 'they develop policies, but they don't ask us what we think.'"[138]

Some officials within the GN recognize that it must deliver health and social services that are culturally appropriate and sensitive to the needs of Nunavut's majority Inuit population. However, the majority of health care clients are either unilingual or Inuit who prefer services in the Inuit language, while most of its professional service providers (nurses, doctors, and frontline staff) are English speakers. This language barrier can often lead to misinformation and misunderstanding between practitioners and clients.

"Cultural differences and the inability of health care practitioners to appropriately address these differences contribute toward high rates of non-compliance, reluctance to visit mainstream health facilities, and feelings of disrespect and alienation. When culturally appropriate care is provided, patients respond better to care and this can have a significant impact on the health of the individual."[139]

A way around this difficulty is that the Department of Health and Social Services must support enhanced community-based initiatives that use and integrate Inuit Qaujimajituquangit, community wisdom, and local solutions. There are three traditionally strong Inuit

Nunavut Tunngavik Inc. employee Virginia Lloyd (left) presented Charlotte Zawadski with the Nunavut Nursing Program Leadership Award.

Photo by Franco Buscemi

healing practices that deserve special attention, as they compliment the bio-medical system and they are already being delivered by charities, Inuit organizations, and hamlets (primarily with federal support) in several communities across Nunavut. These three categories of Inuit wellness and healing have been identified by Nunavut Elders in a series of studies,[140] as areas deserving of government recognition, respect and resources.

The three main categories of Inuit health and wellness delivery are:

- Inuit counselling.
- Land-based healing and Inuit traditional nutrition (country food).
- Inuit midwifery and maternal and family care.

Inuit Counselling

Inuit counselling includes therapy, dispute resolution, emotional support, justice, and education. "It is difficult to separate the role of the elder from that of the Inuit healer and every Inuit community in Canada has elders who are respected counselors and advisors and who provide what can be defined as an Inuit healing service."[141] One noteworthy example is Ilisaqsivik Society which provides counseling services to the community of Clyde River. Ilisaqsivik's, "Elder counselors are available for people seeking advice and help and interested in Inuit traditional counseling methods."[142] Additionally, Ilisaqsivik operates the Inuit Societal Values program. "The goal of the (Inuit Societal Values) program is to empower elder participation in community organizations that deal with social issues – for example Day Care, School, and the RCMP. They help these organizations with problem solving, using Inuit Societal Values."[143]

"While discussing traditional health practices and medical knowledge, one could expect elders to give a list of the best techniques to cure sickness…how to deal with boils, infections, fever, eye infections, colds, broken bones, drowning and so on. But the Inuit perspective encompasses much more. Along with techniques to heal cuts and wounds, and to cure sicknesses, elders discussed recollections of how to develop a strong mind and a resilient body."[144]

An Elder's main resource is the Inuit language. According to Mariano Aupilardjuk, "Our language Inuktitut is very powerful. The words have power. The Inuktitut words can heal."[145] Even being cared for in our own language is a kind of medicine.[146] Elders express regret, "That Inuit knowledge is not more recognized. Most medical doctors, social workers, and teachers are not even aware of elders' knowledge."[147]

Land-Based Healing and Inuit Traditional Nutrition (Country Food)

Inuit know the land itself can heal a person by letting them be in touch with nature. Harvesting and, "Traveling upon the land, for Inuit, is not a holiday or retreat but rather is critical to good emotional and mental health and a direct channel towards that health."[148] To this end, the Kivalliq region organizes an annual Pijunnaqsiniq Camp where Elders and youth gather for up to two weeks to share their traditional knowledge, life skills and community building. The Qikiqtani Inuit Association also delivers a Traditional Camping Program in 13 communities across its region.

The Ilisaqsivik Society in Clyde River uses land-based healing programs involving over 60 participants in two-week cultural camps, "To help residents get out on the land and reconnect with traditional activities and places, finding healing by spending, and sharing, time on the land. Many of our land based activities include

Iqalungmiut enjoyed a traditional feast on Nunavut Day.

Photo courtesy of DIAND - Nunavut Regional Office

children and youth, who learn traditional skills."[149] Activities at the camps include hunting, cooking, caching meat, doll and toy-making, tool-making, sewing, and learning to use traditional plants. Moosa Akavak, a counsellor at Baffin Correctional Centre in Iqaluit, emphasizes the importance of Inuit food to healing. "If I take men hunting I want them to eat seal meat or caribou meat for a few days before we go. Especially seal meat because it calms people down and helps them to relax. It also keeps us warm and strong for living on the land…Inuit know that about seal meat and country food. This food is like medicine. Without it we can get very angry and stressed out."[150]

Inuit Midwifery and Maternal and Family Care

Traditionally, midwifery was an important role for an Inuk woman. "Traditional midwives had special status within Inuit communities and were respected and acknowledged for their skills."[151] Inuit midwifery continues to be an important factor in Nunavut today. A recent survey interviewed 75 traditional Inuit midwives currently practicing who had assisted with a total of 516 births.[152] Nunavut Elder and midwife Illisapi Ootoova suggested that Inuit midwifery should be revived in order to save money the government currently spends on unnecessary air evacuations, and redirect the funds to cancer patients and other more needy cases.[153] Given this emphasis on reviving Inuit midwifery, it is unacceptable that provisions within the new GN *Midwifery Profession Act* criminalize Inuit traditional midwifery, extinguishing the Inuit right to practice this tradition instead of giving Inuit traditional midwives recognition and respect.

One of the most critical areas of health care in any jurisdiction is maternal and newborn care. "Enhanced maternal and newborn care is an important part of building healthy communities in Nunavut. We all need to make sure our children get the best start possible in life."[154]

Until the mid-1970s, 70 per cent of deliveries were done in the communities with Inuit midwives heavily involved in childbirth and infant care.[155] However, government policy was developed to, "Discourage traditional birthing altogether in favour of either nursing station births or emergency evacuation to southern hospital for delivery," as much as six weeks before their expected due date.[156]

Women sent out to give birth are isolated from their families and communities, surrounded by strangers and obliged to share the space with other patients including the sick and mentally ill.[157] "I have worked in a health centre for many years,"said Annie Buchan of Taloyoak. "If the birth is at home, then the men are more involved, and men who were present at their wife's delivery seem to improve in their relationship. They care more for the mother and child. Men or partners participating in birth, this is very positive, it improves caring in the community."[158]

In short, there is a crisis in maternity care for Nunavut communities.[159] It has come about by the loss of local capacity and the separation of family and community from childbirth. As a result, maternal care is fragmented and inconsistent.

There has been a notable reduction in obstetric evacuation in Rankin Inlet due to the success of the birthing centre there. But, even more impressive is the evidence from Nunavik's Inuulitsivik maternity unit in Puvirnituq and Irnisursiivik Maternity in Salluit, which shows the path Nunavut should follow. The Nunavik programs prove that a dramatic 90 per cent drop in Southern transfers can be achieved through their model of, "Senior Inuit midwives, supported by rotating midwives from the South to provide back-up and training."[160]

A birthing centre was opened in Rankin Inlet in 1996, and another is planned for Iqaluit. A third is proposed for Cambridge Bay. In 2005, a midwifery program was started at Nunavut Arctic College. However, as of June, 2008, the Qikiqtani Regional Hospital in Iqaluit does not permit midwife instructors or Inuit midwives to supervise midwifery students on their practical training in the hospital. Instead, they must be supervised by doctors and nurses, which reinforces the medical model which the midwife program was intended to get away from.

CONCLUSION

This report documents significant health concerns facing the Inuit population in Nunavut. Therefore, sensible prioritizing and wise allocation of the available funds for health care delivery is absolutely essential for the well-being of Inuit.

A key aspect of NLCA Article 32 is the requirement that Inuit participate in the design of social programs, including their method of delivery. Inuit are therefore, required to participate in the design and delivery of all federal and territorial health programs in Nunavut.

This report develops an overview of the wide range of health programs and healing and wellness activities underway in Nunavut. Many of these programs operate in isolation from an overall coherent plan; they are fragmented and uncoordinated. This report shows there is a system at work beyond the GN bio-medical health system, which is managed and funded by the federal government, influenced in varying degrees by Inuit representational organizations, and delivered by Inuit and community-based organizations which are not treated as equals in health care delivery.

Iqaluit children Reily Barnes (left) and Terrance Kango share a healthy snack.

Photo by Billie Barnes

This report also emphasizes that almost all funds for health care in Nunavut, from community wellness to Territorial Formula Financing, originate from the federal government. The federal and territorial parts of this system are core-funded and considered a higher priority than the Inuit and community-based components, which often struggle for recognition and resources. Inuit and community wellness and healing programs need long-term flexible core funding, similar to the GN health system, to optimize their effectiveness and to ensure their sustainability.

Even though the bio-medical part of the system is core-funded, its funds are insufficient to pay for a system that is so widely spread out and so heavily dependent on Southern hospitals and medical professionals. This unwieldy, fragmented, and logistically stretched bio-medical system is not sustainable. The federal government must invest more money in Nunavut's bio-medical system, which must evolve into a truly Nunavut-centred system.

Within the health care system, there are people in every community working for the general good. These invaluable human resources include CHRs, nurses, community wellness workers, addiction and mental health workers, and health committees of hamlet councils. These dedicated workers must be supported appropriately. They need to be adequately paid and better trained, and there must be more Inuit trained for these positions as required under NLCA Article 23.

The primary health care approach should guide the evolution of all health care in Nunavut. This approach will allow the healing and wellness strengths of our culture and society to be duly recognized and respected. Inuit and communities will participate in our own health care, set and manage health priorities, and be given the resources and autonomy to put them into practice. Operating the health care system in a more holistic and inclusive way will show that government has confidence in its own people and traditions.

RECOMMENDATIONS

1) Support the Primary Health Care Approach

a. Focus on maternal and newborn care.

b. Restore and maintain public health surveillance.

c. Report on comparable health indicators for Nunavut and Canada using statistics that disaggregate Inuit and non-Inuit data.

d. Develop and use Inuit culturally relevant health indicators.

e. Deliver health services in the Inuit language.

f. Establish effective and dependable evaluation criteria with relation to community wellness programs and their role in contributing to the prevention of suicide.

g. Develop a single holistic suicide prevention strategy.

2) Territorial and Federal Governments Must Communicate with and Involve Inuit in the Design and Delivery of Health

a. Devolve administration of Inuit-specific health funding to Inuit organizations, or institute Inuit sign-off on Inuit-specific health funding administered by the GN.

b. As per Article 32.2.1 of the NCLA, the federal and territorial government must provide Inuit the opportunity to participate in the development of social and cultural policies, and in the design of social and cultural programs and services, including their method of delivery.

c. Government should report annually on how many Inuit are flown out to receive medical and dental service, and the associated costs; and also report on the comparative costs of repatriating hospital and physician services from the South to Nunavut.

d. GN should actively support and develop community health committees.

3) Respect and Core Fund the Inuit and Community Organizations in the Health System

a. Government must provide multiple-year funding to Inuit and community healing and wellness organizations to ensure stability and continuity of staffing and program delivery.

b. Give recognition and respect to an ongoing role for Inuit Elders, healers and midwives, provide them with compensation, and fund training of their apprentices.

c. Government must recognize and core-fund the three traditionally strong Inuit healing practices: Inuit counselling, land-based healing and Inuit traditional nutrition (country food), Inuit midwifery and maternal and family care.

d. Build Inuit wellness centres.

e. Publish Inuit healers' resources.

4) Improve Human Resources for Health Care

a. Provide nurses with a competitive compensation and training package and improve workplace conditions and accommodation for nurses. Ensure GN nurses are not paid less than agency nurses.

b. Fill all CHR vacancies.

c. Deliver CHR training in Inuit language, and expand CHR training to include paramedical roles, psychological counselling, preliminary physical diagnosis and treatment.

d. Deliver counsellor training programs in the Inuit language.

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