

**Sagkeeng First Nation:  
Developmental Impacts and the  
Perception of Environmental Health  
Risks<sup>©</sup>**

by

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**Aboriginal Health**  
**RESEARCH**

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April 1997

***EVALUATION OF  
TRANSFERRED HEALTH SERVICES  
IN THE  
SHIBOGAMA FIRST NATIONS COUNCIL  
COMMUNITIES OF  
KINGFISHER LAKE,  
WAPEKEKA,  
AND  
WUNNUMIN LAKE***

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## Executive Summary

- This evaluation covers the first five years of the transfer agreements between Medical Services Branch of Health Canada and the First Nations of Wunnumin Lake, Kingfisher Lake and Wapekeka, which commenced on January 1, 1994. The three communities are the only First Nations in the Sioux Lookout Zone which have sought and achieved transfer.
- These communities in turn delegate certain centralized services to the Shibogama First Nations Council (SFNC), which established the Shibogama Health Authority (SHA). This is consistent with the practice whereby the SFNC provides technical support to locally based, locally managed, and locally controlled services. SHA receives its operating budget from contributions by the three communities.
- The objectives of transfer, as set out in the transfer agreement, are to design health programs, establish health services and allocate funds according to community health priorities; ensure public health and safety by providing mandatory health programs; and strengthen and enhance accountability to community members.
- SHA developed a comprehensive evaluation plan which integrates quantitative and qualitative methods, and provides for the opportunity for community strengthening and capacity-building. The Northern Health Research Unit (NHRU) of the University of Manitoba was contracted to conduct the evaluation, as well as to support and train an evaluation coordinator hired by SHA and research associates selected by the communities.
- The evaluation used three methods of data collection: review of official statistics and reports, including annual reports from the health councils of the communities and audited financial statements; structured interviews of 52 key informants in Sioux Lookout and the communities, and a questionnaire survey of community members. Overall 479 questionnaires were received, representing a response rate of 78%.
- With transfer, the three communities established health councils each headed by a health director. The health directors are responsible for three key areas: nursing/CHR, resource team (for mental health and social services), and administration/finance. Wunnumin Lake also operates its own transportation program with a transportation manager. Nurses-in-charge and resource team coordinators also receive consultation and advice from the nursing director, clinical coordinator and director of Payahtakenemowin of SHA.
- Between FY93/94 and FY98/99 the three communities received \$4,389,231 (Wunnumin), \$4,209,108 (Kingfisher) and \$3,369,101 (Wapekeka) from MSB through the transfer agreements and their various amendments. In addition the communities accessed other sources of funding from federal and provincial agencies and programs.
- It is difficult to compare expenditure level before and after transfer. Expenditures relating to Wapekeka and Kingfisher Lake before 1993/94, other than contribution agreements with the First Nations, cannot be separated from the total expenditures of the nursing stations in Big Trout Lake and Wunnumin Lake respectively, from where visiting nursing services originated.

- While the ultimate test of the effectiveness and impact of a health program is whether it improves the health of the target population it is important to stress that the total size of the population of the three SHA communities is small (< 1,500), the rate of occurrence of most significant health events (eg. deaths, new cases of disease, etc) is very low and the duration of post-transfer follow-up (5 years) is short. Under such circumstances, it would be difficult to demonstrate that any observed trends are due to the direct result of the transfer initiative and not the year-to-year fluctuations expected by chance alone.
- There is an encouraging trend in the decline in the rate of completed suicides and suicide attempts in SHA communities after transfer, compared to the general trend in the rest of the Sioux Lookout Zone. During 1987-93, 22% of all suicide attempts in the Zone occurred in SHA communities, compared to <10% during 1994-98.
- A review of the health services provided under transfer indicates that in general the pre-transfer level of mandatory services has been maintained. In terms of usage of the nursing station, there has been a noticeable and steady increase in the number of patient visits. According to the community survey, nursing stations are heavily utilized, with less than 5% of respondents who did not use them at all in the past year, while more than 50% use them 5 or more times a year.
- A major achievement of transfer in the Shibogama communities is the integration of health and social services within the same administrative structure and service delivery system. It pools the resources of several agencies and creates a client-oriented team at the community level. Wunnumin Lake has gone the farthest in incorporating also welfare services and home care. The resource team concept, however, is not yet fully implemented and some disparities still occur between different types of workers. There is still a substantial proportion of community members who do not believe or are uncertain that they have access to help when needed.
- Nurses employed by SHA are generally enthusiastic about working in a First Nation-controlled nursing station. The high level of enthusiasm and team spirit they display is indeed encouraging. The nurses are well qualified and experienced, and have an impressive grasp of northern health issues. Among factors which may have contributed to the success (relative to MSB) in recruitment and retention are SHA's support for continuing education and upgrading, an attractive benefits package, and the quality of professional and administrative support.
- Overall, transfer has been a very positive experience for the SHA communities. Despite tremendous pressure to "learn on the job" in the early days, the communities now take great pride in their ability to administer their own health services. Success to date has been achieved largely through the enthusiasm of key personnel in SHA and the communities.
- It is imperative that the transfer agreement be renewed, but its continuing success will depend on an adequate level of funding, provision for administrative and professional training, support from other health and social agencies, and understanding and moral support from other First Nations.
- A list of specific recommendations is provided in Chapter 9.

## **1. Introduction and Background**

At the request of the Shibogama Health Authority (SHA), the Northern Health Research Unit of the Department of Community Health Sciences, Faculty of Medicine, The University of Manitoba, conducted a 5-year evaluation of the transfer of health services from the Medical Services Branch (MSB) of Health Canada to the First Nations of Wunnumin Lake, Kingfisher Lake and Wapekeka. The transfer agreements between MSB and the three communities came into effect on January 1, 1994 and will terminate on March 31, 1999, spanning 63 months in six fiscal years.

### **1.1 Transfer in the context of First Nations health care**

The provision of health services in First Nations communities has traditionally been the responsibility of the federal government. Since the 1980s, MSB, the agency responsible for First Nations health care, began a process of transfer of control to First Nations themselves. MSB established a complex set of procedures that First Nations or Tribal Councils are required to follow in the process of gaining control. This process involves a pre-transfer planning phase of health needs assessment and the development of a community health plan, review and acceptance by MSB, and the signing of a memorandum of understanding outlining the negotiation process leading up to a transfer agreement. The agreement is usually in place for 3-5 years, after which an evaluation of the implementation of the community health plan is mandatory.

### **1.2 Transfer in Ontario Region and the Sioux Lookout Zone**

Many First Nations regard health transfer as consistent with their goal of self-determination. In Ontario Region, by early 1998, 17 transfer agreements have been signed, covering 31 First Nations. In addition, there are 21 contribution agreements for “integrated community based health services”, and 14 active pre-transfer projects. Within the Sioux Lookout Zone, Kingfisher Lake, Wunnumin Lake and Wapekeka are the only First Nations which have sought and achieved transfer. While the transfer agreements are with the individual First Nations, they have delegated certain centralized services to the Shibogama First Nations Council (SFNC). This is consistent with the practice whereby SFNC provides technical support to locally based, locally managed, and locally controlled services. The three communities have acquired considerable experience in the areas of education, housing, recreation and economic development. Health care is thus seen as a logical addition to the array of First Nation controlled programs and services. As a result of transfer, the Shibogama Health Authority (SHA) was constituted by SFNC to provide the delegated services and technical advice, as well as to represent the communities in zone, regional and national forums.

According to the terms of the transfer agreement, the objectives of transfer are to enable the community to:

1. design health programs, establish health services and allocate funds according to community health priorities;
2. ensure public health and safety by providing mandatory health programs; and
3. strengthen and enhance its accountability to community members.

### **1.3 Evaluation and the Transfer Agreement**

The transfer agreements between MSB and the three SHA communities stipulate that an evaluation be completed after the agreements have been in operation for 5 years. Appendix C of the agreement, presumably standard in all MSB-initiated transfer agreements with First Nations, specifies the following issues for consideration in the evaluation:

1. Did the transfer initiative achieve its goal of transferring responsibility for health programs to the communities?
2. To what extent have the arrangements resulted in the communities being able to design and deliver health programs in accordance with their own needs and priorities?
3. To what extent have MSB's accountability responsibilities been met and are these requirements appropriate?
4. Did the overall health of the communities improve under transfer?
5. What have been the impacts, both intended and unintended on MSB and the communities over the short and long term?
6. Are there other ways of achieving the transfer of health responsibilities?

Through an amendment to the agreement, the communities were provided with additional funds (\$40,000 per community) in the 5th year's budget to conduct the evaluation.

The 5-year evaluation has significance beyond the three communities and the SHA as it has the potential to serve as a model for community-based and community-directed health program evaluation. An important goal of the evaluation is to enhance the communities' capacity to design, implement, and analyse research that can be used in other projects and activities.



## **2. Design and Methods**

The Shibogama Health Authority developed a detailed evaluation plan, which was adapted and modified by the evaluation consultant team in order to accommodate the shortened time-line. The SHA evaluation plan is comprehensive in scope, integrates quantitative and qualitative methods, and provides for the opportunity for community strengthening and capacity-building. Included in the consultants' roles are support and training of an evaluation coordinator hired by SHA and research associates selected by the communities.

One of the consultants (Kue Young) accompanied the SHA health director (Daisy Hoppe) and the evaluation project coordinator (Eddie Angees) in a visit to all three communities during August 1998. Meetings were held with Chiefs and Councils and the Health Councils to explain the objectives and methods of the evaluation. In late September, a 3-day training session was scheduled in Sioux Lookout, attended by all three consultants from Winnipeg, the project coordinator, and the research associate-trainees from the communities. During this time, the team designed and tested the schedule of interview questions for the key informants and the survey questionnaire for community members [see below].

### **2.1 Evaluation methods**

Three basic methods of data collection are used in the evaluation:

#### *1. Review of agency/program/service statistics and reports:*

A wide variety of data on health status and health service utilization were compiled from sources such as the Sioux Lookout Zone office of MSB, the Sioux Lookout First Nations Health Authority, SHA itself, and the First Nations councils of Wunnumin Lake, Kingfisher Lake and Wapekeka. The actual transfer agreements with their amendments and the annual auditors' reports provide information on the financial aspects of transfer. The narratives contained in the annual reports of the health directors in the three communities provide a chronology of the key events in the organization and delivery of services under transfer. They also provide a glimpse into the type and nature of the obstacles experienced by the health directors and staff.

#### *2. Structured interviews of key informants:*

In consultation with the project coordinator and the community-based research associates, a list of key informants were drawn up for each of the three communities. The individuals identified are considered to be knowledgeable about health affairs in their community. In general, individuals such as Chiefs, councillors responsible for the health portfolio, members of health committees/ health councils, community health representatives, other health care/social services providers, elders, managers of other community agencies, etc, were selected for open-ended interviews.

The community research associates conducted the interviews, following a list of pre-set questions agreed upon between the consultants, the project coordinator and the research associates during the training session in September 1998. Several interviews involving individuals based in Sioux Lookout (eg. MSB, SHA, SLFNHA staff) were conducted by the consultants. Where convenient, the key informants were given the questions in advance.

A total of 8 interviews were conducted in Sioux Lookout, 18 in Wunnumin Lake, 17 in Kingfisher Lake, and 9 in Wapekeka. The questions cover the different stages of transfer, from the negotiations to implementation. Not all the key informants were expected to be able to answer all the questions.

- What were the main reasons why this community wanted health services transferred?
- What were some of the difficulties in negotiating transfer?
- Were you satisfied with the result of the negotiations?
- What may have been your main concerns?
- What problems did the community experience implementing transfer?
- What have been some of the benefits to the community since transfer?
- What have been some of the major problems for the community since transfer?
- What would you like to see changed in the transfer agreement for the next five years?
- Do you have any recommendations for the health board?

The community research associates submitted the notes from the interviews to the project coordinator, who kept track of the progress of the interviews. He in turn submitted the notes to the consultants for analysis.

In addition, two conference calls with all nurses in the communities and the SHA nursing director were convened by Shirley Hiebert, one of the consultants. Subsequent telephone interviews were also conducted with individual nurses and former nurses who had left the region. The majority of nurses interviewed have previously worked for MSB, and several have worked in Shibogama communities both before and after transfer.

### 3. *Questionnaire survey of community members:*

An 80-item questionnaire was developed jointly by the consultants, the project coordinator, and the research associates in September 1998. A copy of the questionnaire is provided in Appendix A. The questionnaires were administered by the community research associates. While the questionnaire measures primarily community satisfaction, it also includes information on demographic, health status and health care use to permit investigations into the factors associated with satisfaction/dissatisfaction.

The variables in the questionnaire can be grouped as follows:

- Basic demographic information: sex, age, language, education;
- Health status: self-rated health, past history of selected diseases;
- Use of health services: hospitalization, visit to nursing station;
- Availability of needed services: CHR, nurse, doctor, medical specialist, eye doctor, dentist, transportation, referral, interpreter, escort, mental health counsellor, home care, health promotion, family violence, etc;
- Quality of services received: timeliness, privacy, courtesy, helpful information;
- Opinions on transfer: improvement of service, trust of health workers, relevance to self-government and treaty rights, overall satisfaction.

The questionnaires were distributed during November, December, and January. The response rates for the three communities are shown in Table 1. Overall, 78% of eligible

individuals responded to the questionnaire survey, a high enough proportion to ensure validity of the results.

**Table 1 Survey response rates in the three communities**

	No. distributed	No. received	Response rate (%)
Wunnumin Lake	250	215	86.0
Kingfisher Lake	215	145	67.4
Wapekeka	150	119	79.3
Total	615	479	77.9

The respondents range in age from 18 to 84, and are about evenly distributed by sex (55% female, 45% male). Over 95% of respondents speak Oji-Cree, and less than 40% have completed grade 8.

## **2.2 Project coordination**

While each community is responsible, under the transfer agreement, for undertaking its own 5-year evaluation, the communities enter into an agreement with SHA to coordinate the evaluation. Within each community there is a community evaluation committee (CEC), which generally includes the chair of the community’s health council, the Councillor holding the health portfolio, the director of the health program, elders and other community members-at-large. The CEC oversees and guides the evaluation within its community. At the SHA level there is also an evaluation committee composed of the health directors from the three communities, the SHA health director, the SHA nursing director, the executive director of the Sioux Lookout First Nations Health Authority, and the medical director of the Zone Hospital. This committee hires the consultants and reviews their reports.

The SHA hires a project coordinator (Eddie Angees) who reports to the SHA health director (Daisy Hoppe). Mr. Angees has previously been the health director in Wunnumin Lake. The coordinator liaises with the consultants and supervises the community-based research associates, who are responsible for data collection in the communities. These research associates, however, are hired by the health council of the community and report to the health director of the community.

### **3. Implementation of Transfer**

In January 1994, some five years of negotiations and planning activities culminated in a signing ceremony that marked the beginning of the multi-year transfer agreements between MSB and Wunnumin Lake, Kingfisher Lake and Wapekeka. At the same time the three Chiefs authorized the Shibogama First Nations Council to develop the Shibogama Health Authority (SHA). While the SHA did not sign a transfer agreement with MSB, there are in fact two levels of transferred health services: services controlled by and delivered in the communities, and services delivered by SHA to the communities with funds contributed by the communities.

#### **3.1 Phased introduction of programs and services**

The health transfer agreement (HTA) with each community covers the period from Jan 1, 1994 to March 31, 1999. During this period, between 7 and 9 amendments were made periodically to cover price increases and the introduction of new programs. The initial HTA, identical for all three communities, covers the following programs and services: clerical; janitorial; housekeeping; health liaison; community health representatives (CHR) and the National Native Alcohol and Drug Abuse Program (NNADAP). Each community had earlier developed a Community Health Plan, outlining the programs and services to be implemented.

New programs were introduced according this schedule:

- Effective July 1, 1994: nursing
- Effective April 1, 1995: Brighter Futures/Building Healthy Communities
- Effective April 1, 1997: second level nursing supervision
- Effective April 1, 1998: 5-year evaluation

A portion of the funds received by the three communities from MSB is in turn forwarded to SHA to maintain its operation. Specific services provided by SHA to the communities include: nursing supervision, some aspects of patient transportation, professional support for community-based social and family support workers, and the planning and implementation of the 5-year evaluation.

#### **3.2 Administrative and organizational structure**

Within each community, a First Nation Health Council (HC) consisting of 4-5 members was established early in 1994. The health council is appointed by and reports to the Chief and Council and is the body responsible for establishing policies and administering the transferred health services. HC members generally hold office for a 2-year term. All HC members sign a code of confidentiality. Each HC has developed its own mission statement.

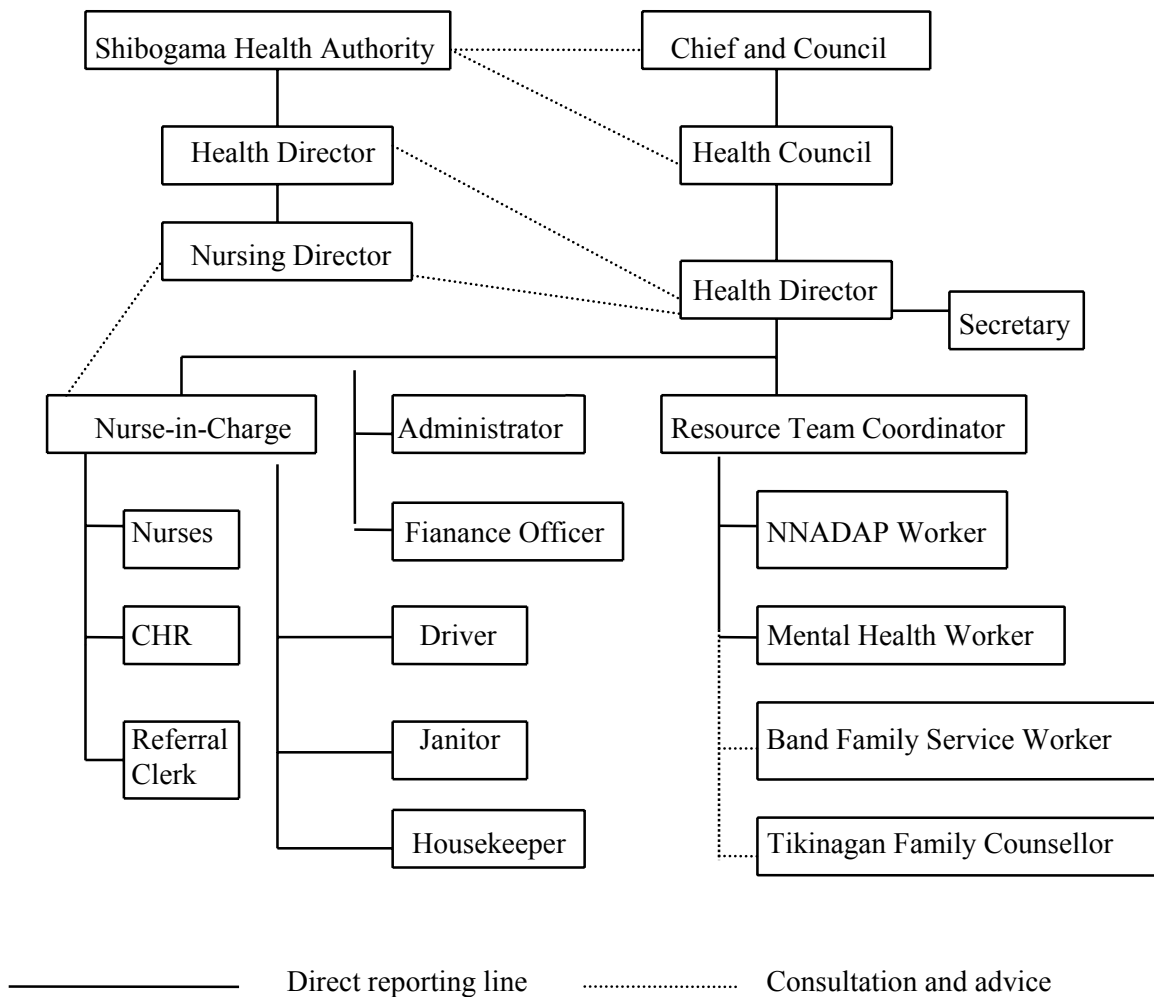
Wunnumin Lake's goal is *“to administer our own health care program to increase the health standards for the community and promote a holistic approach to the delivery of health services. By administering our own health care, the Wunnumin Lake Health Council will ensure maximum community development in the planning and decision making process.”*

Wapekeka places a high priority on *“organizing and coordinating the delivery of high quality, culturally sensitive health care services; advocacy of clients' rights and wishes; providing orientation and education to health care providers within a changing health care*

system; and integrating the planning and provision of individualized, community-based and institution-based health and social services”.

Kingfisher Lake First Nation places health care within the overall context of “achieving self-determination and control which will result in self-government”. To achieve that goal, it has identified several strategies which are relevant, although not specific, to health care. These emphasize the importance of cultural and traditional values, reliance on community-based efforts towards collective and individual needs; building a solid infrastructure for the future; and developing and upgrading the community’s skills to suit the changing times. “The Kingfisher Lake First Nation is to be holistic in its plans and strategies. The community is to maintain a healthy and proper environment in order to sustain sound physical, mental, emotional and spiritual health of its individuals”.

A health director is appointed by each HC to act as its chief operating officer and supervise all the health staff. The organizational charts of all three HC are similar (Fig.1).



**Fig.1 Organizational chart of health councils in the communities**

Not shown in the organizational chart are additional sources of technical advice available to the communities from Shibogama Health Authority. The Resource Team Coordinators can

consult the Clinical Coordinator at SHA on clinical issues relating to mental health, addictions, and child welfare services. The Director of Payahtakenemowin provides administrative oversight and serves as a link between community-based services and external agencies such as treatment centres, professional associations and the provincial social service ministry.

The chart for Wunnumin Lake is also more complicated than the generic model shown in Fig.1. Because the Health Council operates its own transportation program, a transportation manager reports to the health director in Wunnumin. In 1997, the Health Council became a Health and Social Services Council as it took over the welfare (social assistance) programs consisting of a welfare administrator, administrative assistant, homemakers and home support workers.

Wunnumin Lake First Nation organized a training workshop in June 1994 for its health council, covering topics such as conducting and chairing effective meetings, taking minutes, decision making, and responsibilities of the board.

### 3.3 Financial management

The three Health Transfer Agreements are identified as follows. With each subsequent amendment (indicated by A0-#), new money was added to the budget (Table 2). Note that the increase was for new funding for programs available to all communities and not the result of re-negotiation with MSB. Kingfisher Lake differs from the other communities in that the Band Council rather than the Health Council manages the health budget.

Wunnumin Lake:	ON-93/94-522-TR	[re-numbered O94275220]
Kingfisher Lake:	ON-93/94-523-TR	[re-numbered O94275230]
Wapekeka:	ON-93/94-524-TR	[re-numbered O94275240]

**Table 2 Amount of budget increase as per amendments**

	Kingfisher	Wapekeka	Wunnumin
Initial	2,365,388	1,844,176	3,044,007
A0-1	1,028,778	997,393	785,537
A0-2	81,176	83,524	61,320
A0-3	52,701	49,107	55,314
A0-4	299,700	315,339	357,147
A0-5	305,185	18,700	23,410
A0-6	-3,516	20,862	22,496
A0-7	21,256	40,000	40,000
A0-8	18,440	-	-
A0-9	40,000	-	-
Total increase	1,843,720	1,524,925	1,345,224
Final	4,209,108	3,369,101	4,389,231

Each HTA covers (1) health programs, and (2) the Moveable Capital Assets Replacement Reserve (MCARR). Despite transfer, fixed capital assets such as the nursing station buildings and vehicles are retained by the federal government. A certain amount is deducted from the

overall HTA budget to cover MCARR. The future capital needs of the health councils are also not covered by HTA but are included in the capital plan of MSB. The actual amounts received by each community in each of the fiscal years are shown in Table 3.

**Table 3 Actual amount received by health councils by year**

	<b>FY93/94</b>	<b>FY94/95</b>	<b>FY95/96</b>	<b>FY96/97</b>	<b>FY97/98</b>	<b>FY98/99</b>	<b>Total</b>
Kingfisher	171,193	611,845	814,442	854,164	858,732	898,732	4,209,108
Wapekeka	146,241	507,345	654,747	660,402	680,183	720,183	3,369,101
Wunnumin	286,237	676,167	824,818	838,701	861,654	901,654	4,389,231

While the transfer agreement with MSB represents the major source of funding for health programs in the three communities, the health councils also obtained grants and contributions from a variety of other sources, including Health Canada's Non-Insured Health Benefits, Building Healthy Communities, and Brighter Futures Programs, which were subsequently incorporated into the transfer agreements themselves. The communities also accessed non-federal sources such as the Ontario government's Aboriginal Health and Wellness Strategy, Tikinagan Child and Family Services, Nishnawbe-Aski Nation training funds, and the Ontario Ministry of Citizenship.

A summary of the auditor's statement of revenue, expenditure and surplus/deficit for each of the three communities is presented in Tables 4-6. Data on expenditure of the nursing and transportation programs are provided in Chapters 6 and 7.

**Table 4 Summary of health program revenue and expenditure in Wunnumin Lake**

	<b>93/94</b>	<b>94/95</b>	<b>95/96</b>	<b>96/97</b>	<b>97/98</b>
<b>REVENUE</b>	<b>192,294</b>	<b>1,266,129</b>	<b>1,349,859</b>	<b>1,367,435</b>	<b>1,661,488</b>
Health transfer agreement	286,237	676,167	824,818	884,571	861,654
Transfer to MCARR	-99,059	-19,104	-15,246	-15,246	-15,246
NAN conference claim	4,966				
Ministry of Citizenship			2,168		
NIHB		607,114	471,565	466,759	701,008
Building Healthy Communities			15,872		
Aboriginal Health/Wellness Strategy			50,000	15,000	50,000
Tikinagan Child & Family Service					32,600
Shibogama FNC surplus refund					20,953
Other	150	1,952	682	16,351	10,519
<b>EXPENDITURE</b>	<b>159,659</b>	<b>1,224,802</b>	<b>1,377,403</b>	<b>1,507,783</b>	<b>1,643,593</b>
Administration	64,767	178,813	182,022	238,857	232,072
Contribution to Shibogama HA	44,029	234,352	386,234	328,879	365,194
Operation of nursing station	7,443	26,317	24,552	27,421	23,154
Building operation and maintenance	12,472	68,166	71,454	106,179	102,739
Community health programs	30,948	717,154	713,141	806,447	920,434
<b>SURPLUS</b>	<b>32,635</b>	<b>41,327</b>	<b>-27,544</b>	<b>-140,348</b>	<b>17,895</b>
Accumulated surplus at start of year		32,635	73,962	46,418	-93,930
Accumulated surplus at end of year	32,635	73,962	46,418	-93,930	-76,035

**Table 5 Summary of health program revenue and expenditure in Kingfisher Lake**

	93/94	94/95	95/96	96/97	97/98
<b>REVENUE</b>	<b>151,561</b>	<b>609,327</b>	<b>822,363</b>	<b>818,417</b>	<b>847,816</b>
Health transfer agreement	171,193	611,845	814,442	854,164	858,732
Transfer to MCARR	-19,632	-2,518	-6,928	-39,185	-16,666
Building Healthy Communities			14,849		
Other				3,438	5,750
<b>EXPENDITURE</b>	<b>80,328</b>	<b>450,132</b>	<b>739,669</b>	<b>795,176</b>	<b>863,963</b>
Administration	8,915	97,765	133,006	100,935	97,925
Contribution to Shibogama HA	41,835	220,874	313,567	348,492	423,760
Operation of nursing station	1,613	20,158	57,726	41,206	37,603
Building operation and maintenance	6,456	30,826	150,530	164,480	144,575
Community health programs	21,509	80,509	84,840	140,063	160,100
<b>SURPLUS</b>	<b>71,233</b>	<b>159,195</b>	<b>82,694</b>	<b>23,241</b>	<b>-16,147</b>
Accumulated surplus at start of year		71,233	230,428	313,122	336,363
Accumulated surplus at end of year	71,233	230,428	313,122	336,363	320,216

**Table 6 Summary of health program revenue and expenditure in Wapekeka**

	93/94	94/95	95/96	96/97	97/98
<b>REVENUE</b>		<b>562,258</b>	<b>794,241</b>	<b>807,141</b>	<b>830,759</b>
Health transfer agreement		502,480	654,747	660,403	680,183
Transfer to MCARR		-2,012	-11,742	-6,877	-6,877
NAN core training program			20,000	6,221	
NIHB		7,280	9,706	83,716	84,707
Building Healthy Communities			13,441		
Aboriginal Health & Wellness Strategy			21,881		15,000
Tikinagan Child & Family Service		54,510	37,335	36,200	36,200
Wapekeka Education Authority			44,658	800	
NNADAP office rent					6,000
Other			4,215	26,678	15,546
<b>EXPENDITURE</b>		<b>680,417</b>	<b>712,548</b>	<b>848,641</b>	<b>772,679</b>
Administration		160,771	132,160	159,854	103,714
Contribution to Shibogama HA		285,903	287,567	362,692	334,957
Operation of nursing station		45,978	38,911	39,668	57,663
Building operation and maintenance		44,171	78,425	59,979	78,965
Community health programs		143,594	175,485	195,621	168,334
Other				30,827	29,046
<b>SURPLUS</b>		<b>-118,159</b>	<b>81,693</b>	<b>-41,500</b>	<b>58,080</b>
Accumulated surplus at start of year		55,240	-62,919	18,774	-22,726
Accumulated surplus at end of year		-62,919	18,774	-22,726	35,354



In starting up the Shibogama Health Authority, the three First Nations as well as the Shibogama First Nation Council contributed towards an interim budget of \$90,000. It covered the three-month period between January and March 1994 and allowed SHA to hire its first Health Director (Douglas Semple) and nursing director (Sandra Cutfeet). The sources of SHA's revenue and its main categories of expenditure is shown below.

**Table 7 Financing of Shibogama Health Authority operations**

	93/94	94/95	95/96	96/97	97/98
<b>REVENUE</b>	<b>88,093</b>	<b>236,106</b>	<b>280,507</b>	<b>440,374</b>	
from Wunnumin Lake FN	30,833	69,167	82,233	95,951	
from Kingfisher Lake FN	30,835	69,167	82,234	95,951	
from Wapekeka FN	23,334	69,167	82,234	95,950	
from Shibogama FNC	3,091	28,605	33,806	152,522	
<b>EXPENDITURE</b>	<b>88,093</b>	<b>238,084</b>	<b>337,010</b>	<b>448,834</b>	
Salary: senior management	24,991	99,000	98,918	111,668	
Salary: support staff	6,250	42,615	70,000	71,602	
Benefits	2,499	14,736	20,163	24,762	
Staff travel	7,797	28,926	32,414	23,031	
Board travel	5,757	15,750	15,536	37,784	
Nurse recruitment	9,902	389			
Lawsuit			40,386	4,444	
Other administration	30,897	36,668	59,593	172,983	
<b>SURPLUS</b>	<b>0</b>	<b>-1,978</b>	<b>-56,503</b>	<b>-8,460</b>	

Note: Senior management comprises health director and nursing director  
 Support staff includes secretary, finance clerk (since 95/96), and transportation clerk (since 94/95)

It is difficult to compare the level of health care expenditure before and after transfer. Until FY 1993/94, Wapekeka was a satellite of Big Trout Lake Nursing Station while Kingfisher was a satellite of Wunnumin Lake, with nurses from these larger communities providing services on a visiting basis. Expenditures relating to Wapekeka and Kingfisher Lake, other than contribution agreements with the First Nation Councils, cannot be separated from the total expenditures of the nursing stations in Big Trout Lake and Wunnumin Lake respectively. [Wunnumin itself was without a nursing station and was served by nurses from Weagamow prior to 1988]. For FY 1993/94, the year prior to transfer, MSB's direct expenditures in Wunnumin Lake (inclusive of nursing coverage of Kingfisher Lake) totaled \$911,810, which can be broken down as follows:

- Capital: \$635
- Operating: \* Salary/Wages \$198,909
- \* Other: - Controllable \$68,429
- NIHB \$643,837

In addition, MSB signed contribution agreements with all three communities to cover NNADAP, CHR, janitorial/housekeeping/clerical, dental/optometric assisting, mental health, patient transportation, etc. For FY 1993/94, Wunnumin received \$221,198, Kingfisher \$95,159,

and Wapekeka \$119,885. For Wunnumin, the contribution agreement and MSB expenditure totaled \$1.13 million in FY 1993/94, compared to 1.22 million in 1994/95, the first complete year post-transfer.

### **3.4 Human resources**

The health system in place in the communities has the distinction of achieving organizational integration of preventive and curative health services, and between health care and social services. The health director is the key person who holds the system together at the community. The communities have been fortunate in having health directors who are quick learners. They are able to perform their duties despite initial lack of managerial experience.

#### *Diversity of health workers*

As indicated on the organizational chart, a variety of health staff are employed in the community: nurses, CHRs, NNADAP workers, referral clerks, family counsellors, and mental health, addictions, and social support workers. From time to time, dental assistants and optometry assistants are also hired to assist visiting dentists and optometrists.

Nurses play an expanded role combining public health and clinical care in the communities. Traditionally MSB uses the designation “Community Health Nurse” (CHN). The entry level for remote nursing stations is CHN-2. Such nurses tend to have varying degree of clinical experience but have not received formal training in outpost nursing or public health. Nurses with a diploma in public health, a university nursing degree, or have completed the Dalhousie Outpost Nursing Program, the McMaster Northern Clinical or Northern Community Nursing Programs, are classified as CHN-3. A CHN-4 acts as nurse-in-charge of the nursing station. Chapter 5 goes into considerable detail on the work of the nurses, their views on transfer, and how transfer has affected their work.

Community health representatives have been in existence since the 1960s and their role has evolved over the years. In the days before nursing stations, CHRs in the Shibogama communities shouldered the onerous tasks of primary health care in the absence of nurses or physicians, and were often completely cut off from outside help. The Shibogama communities have had very long-term, dedicated CHRs for years who served their communities well. With the establishment of nursing stations, CHRs have become primarily public health educators. They also assist nurses in various clinics and visits to homes and schools. In schools they supervise fluoride rinses and conduct hearing and vision screening. They also collaborate with the EHOs in monitoring environmental quality in the community.

The resource team coordinator (RTC) supervises a team of workers dealing with mental health, child welfare, addictions, suicide prevention, and community healing. As the functions of the four types of workers (mental health worker, NNADAP worker, Band Family Service worker and Tikinagan family counsellor) are not always neatly compartmentalized, the role of the RTC in coordinating team work, case conferencing, training, and communication with outside agencies is critical.

The resource team workers are involved in the assessment, counselling, referral and follow-up of individual clients or families. They also do community work, which may take the form of radio programs, school presentations, parenting workshops, and recreation activities for youths. [Wunnumin Lake NNADAP workers organized “dry” rap dances for teens].

### *Personnel management and employee assistance*

The health councils in the three communities have developed comprehensive personnel policy manuals which cover hiring procedures, orientation, training and development, performance appraisal, leave and holidays, overtime, code of conduct, disciplinary action, appeals and termination. All employees are obligated to sign an oath of confidentiality.

Shibogama First Nations Council has developed an employee assistance program (EAP). All health staff members in the communities are eligible for counselling assistance, as are members of the police, schools, chiefs and councils, as well as service providers of outside agencies while in a Shibogama community. In addition to personal counselling, the program can also provide group counselling, critical incident stress debriefing, staff development, and preventive education workshops. SFNC recognizes that work in the human services field, especially under the new, untried self-government structures, can provoke considerable stress on service providers and their families. The existence of EAP offers sensitive and confidential assistance to employees in sensitive and public positions. When necessary, employees are granted leave and paid travel to Sioux Lookout where a list of counsellors (not employees of SFNC) are available by appointment. Access is also possible by telephone.

### **3.5 Relationship with Medical Services Branch**

According to the Transfer Agreement, MSB retains several residual functions after transfer:

1. sharing of community based program information at annual SL Zone and Ontario Region programs meeting;
2. providing ongoing program resource materials as required by the community in support of the delivery of health programs;
3. providing assistance to the community in recruiting for nursing services through the National Nursing Inventory System and to agree to participate in hiring boards as requested by the community;
4. providing program orientation to new and existing health staff;
5. providing access to centrally administered nursing training programs;
6. providing access to centralized regional NNADAP and CHR training programs on the same bases as other First Nations;
7. providing relief nursing staff or resources during duration of Northern Clinical Program training, once nursing services become part of the agreement;
8. providing any changes to policies and directives related to the scope of practice to the community and advise on scope of practice issues;
9. providing non-transferred health programs now received by all First Nations in Ontario:

MSB continues to provide environmental health services; aspects of NIHB relating to the dispensing of drugs and glasses; the contracting for physicians, dentists and other health professionals with universities and professional associations; and capital facility planning, construction, repairs and renovations.

Several key informants who were interviewed referred to the difficult relationships between SHA and MSB in the initial years following transfer, largely attributed to personality differences and "politics." There was a "we and they" attitude in both camps. The hierarchical

structure of MSB complicated matters. Regional office in Ottawa kept Zone out of the transfer negotiations with Shibogama but then gave the task of solving the problems to the Zone. This was also the time period when MSB started "capping" and "tightening up" the funds for NIHBs, especially paying for escorts. SHA took a lead role among the First Nations in the Zone to oppose these efforts. The SHA had some initial problems with hiring practices and frequently the staffing level of nurses was inadequate. MSB provided relief for the stations although SHA did not want MSB involved in their affairs, telling it "to mind its own business." After a year and a half different administrative players were in place in both MSB and SHA and the atmosphere improved. By then the steep "learning curve" for both sides began to show positive outcomes.

It was pointed out by a member of the SHA evaluation committee that "accountability" appeared to work only one way, from SHA to MSB. Yet, when MSB failed to deliver on certain services that still fall within its responsibility, notably the physician contract, it was not held accountable to the communities. In the case of the transportation program, the SHA communities are held to a fixed limit and are responsible to cover deficits from other programs. MSB, on the other hand, has access to the whole NIHB to bail it out of troubles.

A health director from a community said that after transfer, he has had better access to the regional director of MSB than before, when he had to go through several layers of Zone and Regional staff.

While no other First Nations in the Zone have opted for transfer, MSB had in event transferred some health services to a regional body, the Sioux Lookout First Nations Health Authority (SLFNHA). While originally envisioned to be the successor agency for the Sioux Lookout Zone, to date it has taken over only a few programs, all of which are also available to the Shibogama communities, which are represented on the SLFNHA board. SLFNHA operated programs include the tuberculosis control program, Nodin counselling services, the prenatal attendant program and the woman and child community nutrition program. Tensions do exist between SHA and SLFNHA, particularly as there is a significant perception among many First Nations leaders that SHA has received more than its fair share of resources.

#### **4. Impact of Transfer on Population Health Status**

The ultimate test of the effectiveness and impact of a health program is whether it improves the health of the target population. It is important at the outset to stress that the total size of the population of the three SHA communities is small (< 1,500), the rate of occurrence of most significant health events (eg. deaths, new cases of disease, etc) is very low and the duration of post-transfer follow-up (5 years) is short. Under such circumstances, it would be difficult to demonstrate that any observed trends are due to the direct result of the transfer initiative and not the year-to-year fluctuations expected by chance alone. Despite this caveat, a careful assessment of trends in health status is of critical importance.

Concerns have often been raised that the health status of First Nations communities continues to deteriorate and that health transfer resources may not be adequate to the future needs of the communities. Establishing a pre-transfer baseline and tracking post-transfer changes, albeit only possible for a short period of time at the first evaluation, will serve the purpose of predicting long term resource needs under the transfer initiative.

##### **4.1 Demographic characteristics**

In 1997 the combined population of the three Shibogama communities was estimated by MSB to be 1,182 [Wunnumin 462, Kingfisher 395, and Wapekeka 313]. A complete set of population data for the First Nations in the Sioux Lookout Zone is available from 1972 to the present. During the 1970s, the Shibogama communities were increasing on the average 4.3% per year [Increase = Births - Deaths ± Migration]. In the 1980s the growth rate dropped to 2.9%. In the 1990s the growth rate dropped further to 2.5% per year.

**Fig.2 Trend in population growth in Shibogama communities, 1972-1997**

In terms of the age structure of the population, the Shibogama communities demonstrate the wide-based age pyramid typical of the Aboriginal population in Canada, with a high proportion of young people under the age of 15 (about 35%, compared to 20% among all Canadians). The proportion of the elderly (aged 65 and above), on the other hand, is much lower (<5%, compared to about 12% in Canada). It is estimated that, in the Sioux Lookout Zone, the proportion of young people under the age of 15 would decline to under 30% by the year 2015, while that of older adults will increase.

The slowing of population growth is largely the result of declining fertility. In the Sioux Lookout Zone the crude birth rate [number of births per 1000 population] has consistently exceeded that of the Canadian national population. From the peak in the 1960s, the rate continued to decline, but in the 1980s there appears to be a levelling off. For the Shibogama communities (Fig.3), given that the population is so small and that the number of births per year (about 40 in the three communities combined), considerable fluctuation in the birth rate can be seen, even when rates from 5 years are averaged.

**Fig.3 Trend in crude birth rate in Shibogama communities, 1974-1998**

Fig.4 shows the trend in crude death rate [number of deaths per 1000 population]. It should be recognized that, again, the number of deaths is small - generally less than 10 per year in all three Shibogama communities combined. The rate for the Sioux Lookout Zone has been relatively stable, with 5-year averages between 5 and 6/1000. In the early 1990s, the Shibogama communities experienced high death rates. As will be discussed below, suicide accounts for a high proportion of the deaths in these communities. The upward trend has not been reversed in the 4 years after transfer. Note that deaths are attributed to the community of origin or usual residence and not to the location of occurrence.

While infant mortality rate [number of infant deaths under 1 year of age per 1000 livebirths] is often used as an overall indicator of population health status, this is not applicable in the Shibogama communities. Between 1994 and 1998, Wunnumin Lake reported 1 infant death, Kingfisher Lake none, and Wapekeka 2 deaths. For Wunnumin Lake, no infant deaths were reported for the 15-year period from 1979 to 1993; for Kingfisher Lake, no infant deaths

have been reported since 1984. Within the Sioux Lookout Zone, substantial progress has been made since the 1970s, when infant mortality rates were in the high 30's, to about 15/1000 in the late 1990s.

#### **Fig.4 Trend in crude death rate in Shibogama communities, 1974-1998**

It cannot be overstressed that the 5-year period under which transfer has taken place is too short, and the population size of the Shibogama communities, even when combined, is too small to affect the overall demographic trends.

#### **4.2 Incidence of infectious diseases**

Infectious diseases are no longer the most important health problems affecting Aboriginal communities. Only sporadic cases of new, active tuberculosis are reported - only 2 cases in Wunnumin between 1990 and 1997, and none in the other two Shibogama communities. Accurate statistics on the incidence of infectious diseases, even those that are officially "notifiable", are difficult to obtain. Often the number of cases reflects the frequency of testing rather than the incidence of the disease - this is especially true for some non-symptomatic diseases such as infection with chlamydia, one of the sexually transmitted diseases. Thus the number of chlamydia cases fluctuates from a high of 29 in one community in one year to a low of 4 in another year. The number of gonorrhoea cases is also small, rarely more than 5 cases in any one year in any one community.

From time to time epidemics of specific infectious diseases occur. An epidemic is defined in terms of a higher than "usual" number of cases. Thus in 1996, 12 cases of hepatitis A were reported from Wapekeka, 13 cases of salmonellosis were reported from Kingfisher Lake in 1995, and 42 cases of chickenpox from Wunnumin Lake in 1997. These occurrences are clearly in excess of the usual, when none, or at most one or two sporadic cases are expected.

Again, the number of health events is small, and no conclusion can be drawn on the impact of transfer on the incidence of infectious diseases. [See 5.1 below on the level of immunization coverage in the communities]

### **4.3 Burden of chronic diseases**

Diseases which contribute the most to the burden of suffering and the consumption of health care resources among Aboriginal people today are the chronic diseases. These are diseases such as diabetes, hypertension, heart disease, stroke, cancer, etc, which are not due to infections but the result of lifestyle factors such as smoking, diet, physical activity, etc. These are primarily diseases of adults, and their importance increases as the population ages.

All nursing stations, in the Shibogama communities and elsewhere, maintain a register of patients with selected chronic diseases which require periodic follow-up. Such registers provide an estimate of the number of cases in the community, although to determine the prevalence one would require proper surveys involving standardized examination and laboratory tests.

Fig.5 shows the prevalence of 6 chronic conditions, both in terms of the number of cases per 100 total population, and per 100 population of adults aged 15 and above.

### **Fig.5 Prevalence of selected chronic diseases, Shibogama communities, 1994-98**

It is increasingly recognized that diabetes has become a major health problem in the Aboriginal population, especially in terms of future complications such as blindness, kidney failure, heart disease and amputations. In the Shibogama communities, between 6 and 7% of adults are being treated for diabetes. The actual proportion of the population with undiagnosed diabetes is probably even higher.



Hypertension affects even more people in the communities, between 10 and 17% of adults. The combination of hypertension and diabetes, with the high smoking prevalence, produces a high risk profile for ischemic heart disease in the future.

The burden of chronic diseases does not change dramatically with transfer, and one would not expect it to have such an impact. The manner of health care delivery plays only a minor role in the frequency of occurrence of these diseases. However, such data are important to indicate the future needs of the health system under transfer.

#### **4.4 Injuries and social pathologies**

The category of injuries comprises the health effects of accidents and violence. Shibogama communities, similar to other Aboriginal communities in Canada, suffer from excessive rates of injuries, including fatal injuries. In the 1990s, deaths from injuries account for between one-third to half of all deaths. Of the three communities, Wapekeka, with the smallest population, reports the highest death rate (5.1/1000 during 1992-97, compared to 3.3 in Kingfisher and 1.9 in Wunnumin). Again, the number of cases (one to two deaths per year per community) is too small for any meaningful pre- and post-transfer comparison.

Of all the causes of injuries, suicide, especially among young people, has assumed tragic proportions. Shibogama communities have not been spared the suicide epidemics that swept Aboriginal communities from time to time: 4 cases in Wunnumin in 1993-4 and 3 cases in Kingfisher in 1997-8. For Wapekeka, one or two suicides occurred every year between 1989 and 1997, with the exception of 1996. The Shibogama communities, with 8% of the population of the Sioux Lookout Zone, account for 30% of all completed suicides during the period 1987-1993. In the post-transfer period, the proportion decreases to 10%.

**Fig.6 Rates of suicide and suicide attempts in Shibogama communities, 1987-1998**

While data on completed (“successful”) suicide are reliable, the number of attempted suicide can only be estimated, with under-reporting a common problem. In the Sioux Lookout Zone, suicide attempts are varyingly reported by the nursing stations, the Nodin Counselling Service of the Sioux Lookout First Nations Authority, and the hospital. The Sioux Lookout Zone participates in the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP), which is community based despite its name. In the Shibogama communities, the suicide attempt rate may be as high as 20 times the completed suicide rate. Again, there is some indication of improvements, at least in proportionate terms. During 1987-93, 22% of all suicide attempts in the Sioux Lookout Zone occurred in Shibogama communities, compared to 9% during 1994-98. A key informant pointed out that, because SHA communities are super-diligent in reporting to CHIRPP while non-SHA communities tend to under-report, the discrepancy in injury rates between SHA and non-SHA communities is in fact much larger, and the improvement in the SHA communities is thus even more remarkable.

While it is difficult to produce firm data to support a positive impact of transfer on reducing the incidence of suicide and other injuries, the manner in which the communities respond to suicide has changed. They are more likely to deal with the crises themselves locally and have less reliance on outside intervention.

## 5. Impact of Transfer on Health Services Utilization

Under the transfer agreement, the health councils of the three communities are required to provide certain mandatory services, both preventive and curative. The approach of the evaluation is to determine if the level of services provided after transfer represents an improvement over pre-transfer days, and if the level in the transferred communities is comparable or superior to that of non-transferred communities in the Zone. It should be stressed that high utilization of health care does not by itself indicate effective and efficient use of the health care system. Whereas one can argue that a high participation rate in preventive services (eg. immunization, screening) is desirable, the same cannot be said of treatment services. A high rate of visits to the nursing stations, admissions and medevacs, for example, can be interpreted in a variety of ways - a high level of morbidity or a low threshold for seeking care. Utilization data by themselves cannot provide the evidence that the level of care provided is appropriate to the health needs of the population and the human and material resources available to the health care system.

Nursing stations are the focal point of health care delivery in the communities and they are heavily utilized. According to the community survey, 22% of adult respondents visited nursing stations 10 or more times in the past year, and 30% 5-10 times. Less than 5% of the respondents did not use them at all. These proportions are similar in the three communities. Slightly more than half of the people (51% in Kingfisher and Wapekeka, 59% in Wunnumin) considered the service quick and timely.

The organization of nursing station activities established by MSB has generally been maintained post-transfer. Nursing station hours are generally divided into half-day clinics for special target groups: well babies, well women, chronic diseases, and prenatal women. One half day is generally closed for administration purposes. The remaining five half-days are allotted to "general clinic". These hours are considered adequate by 50-60% of the respondents in the survey. In terms of their convenience to the users, 47% of adults in Wunnumin agreed, compared to 65% in Kingfisher, and 75% in Wapekeka. Accessibility to the nursing station after hours is rated high uniformly, in the 73-83% range.

### 5.1 Public health services

The maintenance of a high level of immunity to several vaccine-preventable diseases is a central task of public health. The immunization rate is thus a useful indicator of the integrity of the public health system, not just the degree of protection against the specific diseases.

In the Sioux Lookout Zone, all newborns receive the BCG vaccine against tuberculosis. If delivered in the Zone Hospital, the vaccination is done prior to discharge. If an infant is born in other hospitals with a predominantly non-Aboriginal clientele, who do not routinely receive BCG, he or she may not receive the vaccine at the nursing station until some months after return to the community. A very high level of coverage, around 90%, has usually been achieved in the Zone, a level that the Shibogama communities are able to maintain in the post-transfer period (Fig.7).

Infants under one year of age are supposed to receive vaccines against diphtheria, pertusis, tetanus and polio. At one year of age, the measles-mumps-rubella vaccine is to be administered. The *Hemophilus influenza b* (Hib) vaccine is a more recent addition. ["H. flu" is a bacteria that can cause pneumonia, ear infections and meningitis - it should not be confused with

the influenza virus]. As Fig.7 indicates, DPTP coverage under 1 year is low, less than 50% on the average; however, by age 5, the level exceeds 80%. There is some inter-community variation, with Wunnumin usually reporting the highest levels.

Throughout adult life, booster doses are administered to maintain immunity against diphtheria, tetanus and polio. Among the elderly, two vaccines are recommended - against influenza and pneumococcal infection. While the target group is the same for the two vaccines, the rate for influenza vaccine is very low, whereas for pneumococcal vaccine, the rate is very high, with almost complete coverage. A key informant reported that the flu vaccine program is not well received by the elderly despite a concerted campaign by the nurses. There seems to be widespread perception that the vaccine is neither needed nor effective. Part of the problem is the strain specificity of the vaccine, with the result that many people still develop flu symptoms despite vaccination. Another key informant also pointed out that there are operational problems with MSB's health information system (HIS) resulting in a falsely-low immunization rate. However, as the problem applies equally to all communities, inter-community comparisons are still useful.

Other mandatory public health programs include communicable disease control. Nurses are involved in contact tracing, treatment, counselling and health education. Notification of communicable diseases is part of the Zone-wide surveillance system. The TB control program is managed on a regional basis by the Sioux Lookout First Nations Health Authority. Shibogama nurses implement the regional policy of tuberculin (Mantoux) screening all children at age 4, with a coverage level in the 70-80% range.

**Fig.7 Selected indicators of immunization coverage of eligible population by vaccine type, Shibogama communities, post transfer**

Public health services are provided by nurses either on an one-to-one basis in special clinics in the nursing stations or on a group basis involving school presentations, community workshops, public broadcasts, etc. In many of these activities the nurses are assisted by the CHRs.

Depending on staffing situation, one nurse is usually designated as a public health nurse with public health as her main responsibility. The volume of public health oriented visits to the nursing station often depends on the staffing level, as acute treatment needs tend to take precedence. For the years 1994-97, the number of public health visits to the nursing station averaged between 110 and 220 per month in Wunnumin, 20-150 in Kingfisher, and 10-120 in Wapekeka. Both Kingfisher and Wapekeka report the lowest figures for 1997.

Environmental and occupational health services are delivered by CHRs supported by environmental health officers (EHO) from Health Canada. The environmental health team monitor water quality, inspect water and sewage installations, food outlets and stores, and provide technical advice to the First Nation council and offer public health education to the community. Since 1996 there has been no medical officer of health (MOH) employed in the Zone; instead, MOH services are contracted from the provincial Northwestern Health Unit based in Kenora.

The community survey inquired if there are enough CHRs in the community, how accessible they are in the nursing station, and if they provide enough health information and check the water often enough (Fig.8).

**Fig.8 Community survey: Assessment of CHR services**

It is evident that only a minority of residents (about 20% in Wunnumin and Wapekeka, 35% in Kingfisher) considered the number of CHRs to be adequate, although a higher proportion was able to see a CHR in the nursing station when they needed to. Of the two key functions of CHRs - providing health information and testing water quality, fewer than 20% thought they were done often enough. However, a very high proportion (ranging from 40-70%) of the people were unfamiliar with these jobs and uncertain of their rating. One key informant reported that CHRs lost a significant number of their duties after transfer, since it coincided with the establishment of nursing stations in Wapekeka and Kingfisher Lake. Many people in the communities do not quite understand the new role of the CHRs who no longer do any treatment. CHRs are often used inappropriately, for example, as interpreters and drivers. A lot of work often goes unappreciated because it is behind the scene. CHRs do not get overtime pay, and over the years they have not received pay raises, unlike the nurses. Clearly the role of the CHR needs to be better publicised.

The public health program delivered by the nursing station staff can be organized according to various stages of the life cycle. Each of the special clinics tend to occupy one afternoon per week in the station, others are incorporated into the general clinic, while others are provided in the homes or the community-at-large:

**Fig.9 Community survey: Care of the pregnant woman**

- *Prenatal/post-natal*: In the post-transfer years, Wunnumin Lake averages about 14 births per year, Kingfisher Lake 11 and Wapekeka 7. Prenatal women are given assessments and advice in prenatal clinics; post-natal women are usually visited at home shortly after discharge from hospital. Fig.9 shows the responses of the community survey relating to this aspect of women's health care.

There are several clear messages from the community survey: the need for continuity of nurses providing prenatal care, more physician availability, helpfulness of prenatal classes, and the importance of post-natal home visits. Opinions are more divided in terms of the frequency of visits, conducting prenatal care at home, and having a choice of delivery in the community.

- *Well baby*: The growth and development of the child is monitored, immunizations given according to schedule, multivitamin and iron supplements administered. Concerns regarding parenting are also addressed. The community survey confirmed an overwhelming recognition of the importance of having one's child undergo regular check-up at the nursing station. However, less than 40% of the people reported that they received adequate information on the growth and development their children (Fig.10).
- *Pre-school*: At 3-4 years of age, children are given the tuberculin (Mantoux) test and undergo vision and hearing screening.

**Fig.10 Community survey: Child health monitoring**

- *Child/adolescent/teen*: Nurses, CHR and resource team workers visit the school to provide health education on dental health, nutrition, safety, first aid training, alcohol and drug abuse, family violence, sexual abuse, and the prevention of STDs. All students undergo physical examination by the nurse, and their immunization status updated, prior to departure for high school outside the community.

- *Adult:* Well women clinics focus on preventive services such as Pap smear screening and breast examination. A well men clinic has been established on a weekly basis in one community. Another community had it established while there was a male nurse working in the nursing station. Well men and women clinics monitor blood pressure, hemoglobin, cholesterol and glucose levels. Immunization status is updated. Diagnosed cases of chronic diseases are followed up, with periodic assessment by the visiting physician.

Fig.11 shows that health education/health promotion activities provided in schools and the nursing stations are generally perceived to be inadequate. A large proportion of “uncertain” responses also attest to the fact that these activities are of rather “low profile”. It was pointed out by a key informant that, since nicotine patches are not covered by NIHB, people may not see the nursing station as a place to get help to quit smoking.

### **Fig.11 Community survey: Assessment of health education/promotion**

Fig.12 covers general women’s health issues such as preventive health services (Pap smear and breast examination) and the availability of nurses to discuss contraception, coping and parenting skills. Note that community members’ perception of adequate preventive health services may not necessarily accord with recommendations of national expert groups. Studies elsewhere, for example, have shown that young women, who are at low risk for cervical cancer, tend to be “over-tested” (i.e. more often than once every three years), while older women tend to be “under-tested” despite their higher risk status.

- *Elderly:* Home visits are key to maintaining the health of the elderly. Kingfisher Lake has its own 4-unit senior complex which officially opened in 1994. The Wunnumin Lake health council expanded its mandate to provide homemakers and home support services in 1997.

Fig.13 shows that less than 40% of respondents were able to see a health worker at home when they needed it, the proportion being the lowest for physicians. Home care services are also generally inadequate (Fig.14). Nurses are well aware of this deficiency, but attribute it to the pressures to provide acute care as a priority.



**Fig.12 Community survey: Services in women's health**

**Fig.13 Community survey: Access to home visits by health workers**

**Fig.14 Community survey: Home care and assistive devices**

**5.2 Treatment services**

Nursing stations operated by the health councils in the three Shibogama communities have the primary function of providing first-contact care of common health conditions, referral of patients to visiting physicians, instituting emergency care of serious conditions and arranging evacuation if necessary.

Fig.15 indicates that the average number of patient visits per month in the three nursing stations has generally increased since transfer, with Wunnumin reporting the steepest rise. [Note that data for 1998 cover only the first three months of the year, before the collapse of the physician visit schedule due to the mass exodus of physicians from the Zone]. For nursing station admissions and medevacs, the annual fluctuation is greater due to the much smaller number of events (Fig.16,17).

**Fig.15 Number of patient visits to nursing station per month, Shibogama communities, 1993-1998**

The “busyness” of a nursing station can also be gauged by the amount of afterhour calls. During 1994-1997, the number of such calls per month ranged from 37-56 in Wunnumin Lake, 20-60 in Kingfisher Lake, and 26-46 in Wapekeka.

Although the contracting for physician services is not part of the transfer agreement, the frequency of physician visits to the communities does affect the workload of nursing station staff. Since 1969 the University of Toronto Faculty of Medicine had been responsible for the recruitment of general practitioners stationed in the Sioux Lookout Zone and arranging visiting medical specialists. In the Shibogama communities, until 1998, there was usually a physician in the community once a month for 7-8 months of the year, each visit usually lasting less than a week. The average number of patients seen by physicians per month from 1994 to March 1998 is shown in Fig.18.

**Fig.16 Number of admissions to nursing station per month, Shibogama communities, 1993-1998**

**Fig.17 Number of medical evacuations by air per month, Shibogama communities, 1993-1998**

In 1998, the contract negotiations between MSB and the university broke down. Without a contract, all but a handful of physicians stayed. The direct impact in the communities was the reduction, even cancellation, of scheduled physician visits. The Shibogama Health Authority made its own arrangement during the summer of 1998 for the services of a short-term visiting physician from southern Ontario. This is an example of the flexibility and initiative under transfer. The physician supply situation remains unsettled as the new contractor, McMaster University, slowly assumes the daunting and unfamiliar role of physician recruitment for remote communities.

As data for the 1998/99 FY are not yet available at the time of the preparation of the evaluation, the full extent of the impact of the physician crisis has not been documented quantitatively.

**Fig.18 Mean number of patients seen by physicians per month, Shibogama communities, 1994-98**

The accessibility of health services can be assessed by several questions in the community survey. When asked if they were able to see a visiting doctor in the nursing station when they needed to, between 60-70% said yes. The proportion was much higher, in the 80-90% range, for eye doctor and dentist (Fig.19).

As Fig.20 indicates, at times of emergency most people were able to contact a nurse (84% in Wunnumin, 89% in Kingfisher, and 92% in Wapekeka). Obtaining transportation to get to the nursing station, however, was possible only for under half of the respondents in Wunnumin, and slightly higher proportions in Kingfisher and Wapekeka (65% and 68%). When asked if there were trained people in the community to whom one could call for help, 84% of respondents in Kingfisher reported that such trained help was available, substantially higher than the 34% in Wunnumin and 46% in Wapekeka. According to a community informant, Kingfisher Lake has gone the furthest in developing an emergency response team, with members trained in first aid and CPR, complete with a paging system and on-call schedule.

**Fig.19 Community survey: Access to visiting health professional when needed**

**Fig.20 Community survey: Access to health care in case of emergency**

In addition to being used for emergency and primary care, the nursing station is also used as an entry point to the larger medical system which extends to specialists outside the community in urban centres. Generally, less than 40% of respondents to the survey indicated that they could see a medical specialist when they needed to. In Wapekeka, 44% complained that referral was not quick enough, compared to 29% in Kingfisher and 34% in Wunnumin.

The community survey also serves as an important tool to assess the users' perception of the quality of the care they receive at the nursing station, in terms of communication (Fig.21) and privacy and confidentiality (Fig.22).

**Fig.21 Community survey: Health care communication in the nursing station**

**Fig.22 Community survey: Ethical/privacy/confidentiality issues**

Since all nurses are non-speakers of Oji-Cree, the availability of interpreters in the nursing station is critical in the health care encounter. Less than 60% of respondents - similar across the three communities - reported that there were enough interpreters. The degree to which users understand matters relating to their health care depends on the type of information being conveyed. For laboratory test results, 48-58% of respondents reported that they understood their meanings, whereas 85-90% understood why they were taking medications.

Only about 40% of respondents felt that enough confidentiality of medical information was kept in the nursing station. A higher proportion (50-60%) considered that the nursing station offered sufficient privacy.

The importance of the ethics of health care is increasingly recognized, a central issue of which is informed consent. While patients are asked to sign consent forms at the nursing station, the proportion who reported that they understood their meaning and implications ranges from 62% in Wunnumin, 71% in Kingfisher, to 77% in Wapekeka.

### **5.3 Mental health and social services\***

A major achievement of transfer in the Shibogama communities is the integration of health and social services within the same administrative structure and service delivery system. It pools the resources of several agencies and creates a client-oriented team at the community level. Wunnumin Lake has gone the farthest in incorporating also welfare services and home care.

Until the early 1980s, there were two mental health counsellors based at the Zone Hospital and a few child welfare workers from the Children's Aid Society (CAS) involved mainly with adoption work who travelled to the communities in the Sioux Lookout Zone. Since then, many of these services have come under First Nations control and employed Aboriginal staff, although they are still based outside the communities. For example, CAS was replaced by Tikinagan Child and Family Service. Nodin Counselling Services, which originated as part of the University of Toronto's professional services contract, became a program of the Sioux Lookout First Nations Health Authority. In addition, First Nations in the area began to operate inpatient facilities such as a family addictions treatment centre, a children's home and a secure facility for young offenders. NNADAP, a MSB-funded program, consisted of MSB paying First Nation councils through contribution agreements to hire "free-standing" addictions counsellors in the communities without professional support. Other types of workers, such as the Band Family Services Workers (BFSW), were also introduced, often working in isolation from the other health and social agencies.

The high rate of suicide in the Shibogama communities [see 4.4 above] in the early 1990s highlighted the inadequacy of the existing patchwork system, where incoordination, duplication, and a failure to share information resulted in clients receiving inconsistent and conflicting services or sometimes none at all. As the number of crises increased, the communities began to reappraise their situation and in 1993 developed a new strategy called Tasekaywin Menoiawin (or Community Wellness) that stressed community control of its own healing. The implementation of transfer early in 1994 thus occurred at an opportune moment.

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\* We acknowledge the paper by Joyce Timpson and Douglas Semple, "Bringing home Payahtakenemowin (Peace of Mind): Creating self-governing community services", published in the inaugural issue of *Native Social Work Journal - Nishnaabe Kinoomaadwin Naadmaadwin* vol 1, no 1, pp 87-101. It provides valuable background information on the origin of the current system in the Shibogama communities.

The Shibogama approach is to create in each community a Resource Team consisting of mental health, NNADAP, BSW and Tikinagan workers, headed by a coordinator (RTC). All team members subscribe to the principle of teamwork and sign a code of confidentiality. The model proposes holding regular case management meetings and share an on-call schedule. The new system was given a boost by the availability of funds from Health Canada's Brighter Futures Program which transferred funds for mental health services to the communities. Under this system, all team members should assume responsibility for all cases regardless of their job title or employing agency. The line of responsibility would then go through the health director to the health council, and no longer to an outside agency. While outside consultants are still required, they would be used less often, and when they are used, they would work under the direction of the resource team coordinator. This model has not been completely implemented - there is still a "dotted line" rather than solid line between the Tikinagan workers and the RTC in the organization chart (Fig.1). Some regional agencies are reluctant to relinquish control to the communities. Even so, there is a degree of cooperation and collaboration that has not been experienced before transfer.

A result of the new system is a broader perspective of community healing beyond individual counselling and case management. The need for parenting courses, marital counselling, and wilderness based treatment programs is recognized and implemented. The need for training goes beyond health workers but to the larger communities - thus elder, school staff and workers in other agencies also receive training in parenting skills, spiritual guidance and response to grief.

Service statistics are highly variable due to the fluctuation in demand; also client contacts represent only a portion of the activities of the team members. In Wunnumin Lake, the community mental health workers average about 15 clients per month and the BSW and NNADAP workers about 3 per month. Wunnumin Lake is studying making all job descriptions of resource team members the same, thereby eliminating discrepancies in workload assignments, realizing the goal of true teamwork.

Nodin Counelling Services, a program of the Sioux Lookout First Nations Health Authority, also provides services to the Shibogama communities. Between 10-40 clients per year are seen in consultation by Nodin, each client averaging 4 contacts. Slightly more women than men are seen, and the average age of the client is 25. Nurses account for the highest proportion of referrals (40%), followed by physicians in the Zone (20%) and the community-based mental health workers (13%). The main reason for consultation is classified as "problems in living", followed by grief reactions (15%) and depression (12%). These referral statistics reflects the established networking between nurses and Nodin. In the past much mental health work was thrust upon the nurses, who made many of the decisions regarding treatment, referral and follow-up. While their role will continue to be indispensable, increasingly it is the resource team coordinator who is the central figure in community mental health care.

Despite the improvements in the quantity and quality of mental health care, there still exists a substantial demand for services that is not being met. According to the community survey, about half of the respondents said they could talk to someone in the community if they had suicide ideas, get help for alcohol and drug abuse, and family violence (Fig.23). There was, however, a substantial proportion (25-35%) of "uncertain" responses, itself perhaps indicative of the lack of awareness in the community of existing resources.



**Fig.23 Community survey: Access to mental health services if needed**

At the Shibogama Health Authority level, the centralization, coordination and pooling of budgets allows the development of new programs and services for all three communities. Some innovative programs not available elsewhere in the Zone include: a college-accredited core training program for resource workers, the development of culturally appropriate training aids in Oji-Cree, and an Employee Assistance Program for service providers.

One can conclude that the innovations in mental health and social support happened because of transfer, specifically the Shibogama model of decision-making by the communities. The communities provide the resources to fund the centralized support services. The Shibogama Health Authority has to respond to the communities' direction and interests, as its very existence depends on the communities' contributions. This is likely why transfer in Shibogama has been able to accomplish much more than other "transferred" but regionally based services that are not directly controlled by the communities.

## 6. The Nursing Program

This chapter focuses on northern nurses, the nursing stations in the three communities, and the Shibogama nursing program. In our meetings and discussions, we have found the educational background and work experience of the nurses and their grasp of northern health issues to be very impressive. We feel that SHA has the “cream of the crop” when it comes to nurses. They speak knowledgeably about northern nursing overall and transfer in particular.

This chapter is divided into three parts. Part 1 presents financial data on nursing station expenditures and attempts a comparison between the transferred and non-transferred communities of comparable size and staffing level. In part 2 we discuss several issues relating to the practice of nursing, issues which are prominent as determinants of the success of recruitment and retention. In part 3 we summarize the viewpoints of nurses regarding transfer and its impact on their work.

### 6.1 Nursing station expenditures

Accounting for the nursing program is done centrally at the Shibogama Health Authority. Each of the three communities contributes to the nursing program from funds derived from its transfer agreements with MSB. The nursing program expenditure consists of salaries, benefits, travel, professional development and miscellaneous supplies, but excludes nursing administration by SHA (Table 8). Nurses’ salaries are by far the most important expenditure, a breakdown of which (into full-time, part-time, overtime and benefits) is shown in Table 9.

**Table 8 Summary of revenue and expenditure of the nursing program**

	93/94	94/95	95/96	96/97	97/98
<b>REVENUE</b>	<b>22,898</b>	<b>591,465</b>	<b>791,838</b>	<b>753,278</b>	
Wunnimum	13,000	205,452	304,000	270,233	
Kingfisher	2,898	149,335	248,812	249,915	
Wapekeka	7,000	236,678	239,026	233,130	
<b>EXPENDITURE</b>	<b>21,039</b>	<b>618,132</b>	<b>765,171</b>	<b>753,278</b>	
Wunnimum	15,898	232,119	277,333	270,233	
Kingfisher		149,335	248,812	249,915	
Wapekeka	5,141	236,678	239,026	233,130	
<b>SURPLUS (DEFICIT)</b>	<b>1,859</b>	<b>-26,667</b>	<b>26,667</b>	<b>0</b>	

The SHA communities were given an equivalent of six positions to staff the three stations. Wunnimin Lake, the largest community, was entitled to more than two full-time positions while Wapekeka was entitled to less than two. Instead of having one nurse staff the smaller station it was decided that each community would have two nurses. This does leave the larger community, Wunnimin, with nearly one nurse short. Staffing in MSB is based on the Community Workload Increase System (CWIS) formula, which is applicable to SHA. A nursing director expressed her concerns to MSB regarding the inadequate staffing, but was told that the staffing, based on the population at the time of transfer 5 years ago, would remain unchanged despite an increase in population and health needs. Also CWIS is directed at public health

nursing and does not take into northern realities and the additional requirements for cross-cultural practice.

**Table 9 Expenditure on nurses' salaries**

		94/95	95/96	96/97
Wunnumin -	FT	134,695	206,471	81,035
	part-time	19,584	4,708	93,937
	overtime	30,238	5,714	35,067
	benefits	16,139	22,498	16,934
		<b>200,656</b>	<b>239,391</b>	<b>226,973</b>
Kingfisher -	FT	39,857	142,341	126,300
	part-time	13,572	35,624	33,131
	overtime	3,888	12,146	30,535
	benefits	6,431	21,643	23,529
		<b>63,748</b>	<b>211,754</b>	<b>213,495</b>
Wapekeka -	FT	115,203	152,996	101,127
	part-time	18,749	35,223	52,401
	overtime	60,228	10,085	26,781
	benefits	8,442	13,225	15,000
		<b>202,622</b>	<b>211,529</b>	<b>195,309</b>

It is important to compare nursing station expenditures in the transferred communities with those reported from non-transferred communities in the Zone. There are two approaches to this exercise. One can compare the per capita expenditure with the Zone average, or any individual community or group of communities. Alternatively one can compare expenditures between the three SHA communities with communities with a similar population.

Using the second approach, the most appropriate communities for comparison with Wunnumin Lake would be Bearskin Lake and Cat Lake, all having population in the 400-460 range during the period 1993-1998; both communities have nursing stations with 2-3 nurses. For Kingfisher Lake, the appropriate comparisons would be with Fort Severn, Sachigo and Summer Beaver Lake, all with population in the 330-390 range and 2-nurse stations. Wapekeka is comparable to Lansdowne House, North Spirit Lake and Poplar Hill, with populations in the 270-330 range. While Lansdowne House has a 2-nurse station, the other two communities are satellites of larger, nearby communities with nursing stations (Sandy Lake and Pikangikum).

Comparisons of pre-transfer expenditures is difficult as Kingfisher was served by nurses from Wunnumin, and Wapekeka from Big Trout Lake. As Table 10 shows, the pre-transfer expenditures of Wunnumin Lake (including Kingfisher) was considerably lower than the Zone average. Compared with Bearskin Lake and Cat Lake, the Wunnumin/Kingfisher per capita expenditure was also the lowest.

In the post-transfer years (data up to 1995/96 only were available for the Zone), the total per capita expenditure for the Shibogama communities, when combined, exceeds that of the Zone average. Wunnumin Lake in the post-transfer years still reports lower expenditures than Cat Lake, but it now exceeds Bearskin. In the post-transfer years, Kingfisher initially has lower expenditures than any of the three comparison communities of Fort Severn, Summer Beaver and Sachigo, but has caught up by 1995/96, being exceeded then only by Summer Beaver.

As mentioned earlier, the situation of Wapekeka is somewhat anomalous. The Shibogama Health Authority decided, wisely, that a one-nurse station is an unsustainable operation. With the consent (and generosity) of Wunnumin Lake, the SHA exercised its allocative authority to establish 2-nurse stations in all three communities. This explains the very high per capita expenditure of Wapekeka relative to other communities in the Zone. In this respect, it is very similar to Lansdowne House, also a community with a 2-nurse station.

**Table 10 Comparison of nursing program expenditures with other communities in the Sioux Lookout Zone**

Community	Total Expenditure (\$)			Per capita Expenditure (\$)		
	93/94	94/95	95/96	93/94	94/95	95/96
<b>Wunnumin</b>	<b>198,909*</b>	<b>232,119</b>	<b>277,333</b>	<b>272*</b>	<b>551</b>	<b>600</b>
<b>Kingfisher</b>	*	<b>149,335</b>	<b>248,812</b>	*	<b>425</b>	<b>630</b>
<b>Wapekeka</b>	-	<b>236,678</b>	<b>239,026</b>	-	<b>805</b>	<b>764</b>
<b>Shibogama</b>		<b>618,132</b>	<b>765,171</b>		<b>580</b>	<b>654</b>
Fort Hope	315,093	354,181	409,857	350	369	387
Lansdowne	61,783	175,354	213,691	220	659	794
New Osnaburgh	270,068	313,522	330,226	331	447	343
Weagamow	371,927	408,385	409,200	597	692	538
Summer Beaver	50,729	196,436	233,437	161	606	720
Webiquie	250,775	265,631	231,473	429	472	392
East	1,320,375	1,713,509	1,827,884	375	503	461
Cat Lake	223,248	309,426	310,977	513	781	697
Deer Lake	225,809	288,996	308,936	306	419	408
Pikangikum	443,481	697,323	713,173	275	428	444
Sandy	442,160	537,809	554,256	293	326	326
West	1,334,698	1,833,554	1,887,342	311	420	419
Bearskin	161,884	215,533	196,955	388	500	379
Big Trout	577,535	600,272	686,238	648	673	711
Fort Severn	193,097	208,372	199,698	519	604	535
Kasabonika	224,947	217,145	260,990	378	318	308
Sachigo	206,548	192,030	208,290	585	674	439
North	1,364,011	1,433,352	1,552,171	519	544	488
Zone	4,019,084	4,980,415	5,267,397	385	479	452

Note: \* Expenditure and population of Wunnumin combined with Kingfisher for 93/94

## 6.2 Issues in northern nursing practice

In our discussions with nurses, we identified several critical issues which affect nurses' decision to work and stay working in a remote, northern setting. These relate to licensure and credentialing; continuing education and upgrading; professional and administrative support, and benefits and remuneration.

### *Licensure and credentialing*

SHA requires that all nurses be registered with the College of Nurses of Ontario (CNO) and with the Registered Nurses Association of Ontario (RNAO). The nurses fees are reimbursed by the Health Councils. The MSB *Scope of Practice* for a northern nurse includes diagnosis, treatment, prescribing of medication as outlined in a formulary, carrying out laboratory and x-ray work and a wide range of health-related duties in collaboration with other health professionals. SHA has acknowledged the MSB Scope of Practice and the Ontario College of Nurses' *Guidelines for Registered Nurses Working in Isolated Areas of Northern Ontario* as realistic standards and guidelines for the northern nurses to follow. Prior to transfer northern nurses were legally covered by MSB in their expanded role. As the possibility of transfer neared, many northern nurses became concerned about how they would be protected in the expanded role. As nurses elsewhere in Ontario, liability for malpractice is obtained by membership in the RNAO through the Canadian Nurses Protective Society (CNPS). Nurses are encouraged by SHA to obtain additional coverage from RNAO for a legal assistance benefit program.

In 1990, northern nurses voiced their concern to the CNO regarding their scope of practice. In response, the CNO established a multidisciplinary task force to develop guidelines for nurses working in the expanded role in outpost settings, recognizing that they were practising beyond the minimal expected standards. It was recognized that in their expanded role northern nurses provide some services generally considered to be the responsibilities of physicians and pharmacists; hence the involvement of these professions in defining the standards of safe, effective and ethical care is critical. In November 1990, a scope of practice which recognized the role of the northern nurses was endorsed by the CNO, the College of Physicians and Surgeons of Ontario (CPSO) and the Ontario College of Pharmacists (OCP). Assumptions for the safe practice of nursing in outpost settings include the possession of a certificate of competence (in this case the Northern Clinical Program), recognition by the employer of the nurse's role in primary and community health care, and the availability of the means to carry out this role and access to physician and pharmacist support. There is no requirement either from the employer or the CNO for a formal agreement between the northern nurse and a physician for the ongoing review of an individual nurse's practice. The impetus for collaboration with either a pharmacist or a physician is left to the discretion of the northern nurse. Nor is there any requirement in place either by the CNO or the employer for continuing education in any clinical area. While the CNO has developed guidelines in the areas of assessment, intervention and the dispensing of medications, it is left to the individual nurse to decide if her practice is within safety guidelines. Ontario nurses are simply urged not to practice beyond their level of expertise or knowledge.

Another contentious issue is the designation of "nurse practitioner". In Ontario a nurse may be registered in the extended class by the CNO and attain the status of a nurse practitioner if she has undertaken the training approved by the CNO and if she is successful at writing a prescribed examination. The northern nurse may go through a series of challenge procedures to be recognized by the CNO in the extended class. Northern nurses in the SHA are frustrated by the lengthy challenge route, the timetable set by the CNO and the location of Sudbury as an

alternative to Toronto for the examination setting. Presently, there are two nurses in SHA challenging the examinations. They are given travel and educational leave by their health councils and their positions are replaced as required. This is not an easy process for the health councils to support given that relief nurses are also attempting to challenge the examinations at the same time. There is a feeling among northern nurses that the nurse practitioner requirements in urban Ontario are not as stringent as those in northern isolated/remote settings. The northern nurses in the SHA regard their scope of practice to be more in depth and autonomous than that of nurses practicing in the extended class in urban areas. Some of the northern nurses in the SHA have acted as preceptors for nurses being educated in an approved CNO program without themselves being recognized by the CNO as "nurse practitioners" in the extended class. They feel that the emphasis in nurse practitioner training is on referrals and in the filling of prescriptions. Northern nurses do not have access to a physician as readily as urban nurse practitioners. In the absence of pharmacists, they not only prescribe medications but dispense them as well. It should be noted that while the term "nurse" is a protected designation, "nurse practitioner" is not. Any nurse may refer to herself as a nurse practitioner if she is registered with the CNO as a nurse.

#### *Continuing education and upgrading*

Nurses were not provided with training courses for their expanded scope of practice until the Dalhousie Outpost Nursing Program was established in the early 70's. This program was well respected by those enrolled in it and widely by nursing and medical professionals. The program was discontinued in June 1997. It was felt to be too expensive as many nurses left soon after serving their required payback period. MSB sponsored two other programs as well for training nurses. The Northern Clinical Program (NCP) began in 1991 following a series of primary skills pilot courses. It is a 4-month course which emphasizes physical assessment skills and includes instruction for specific laboratory and investigative tests. The Northern Community Nursing Program (NCNP) began as an adjunct to the Dalhousie Outpost Nursing Program and catered to nurses who did not have a degree. The NCNP is offered in modules by distance learning. Funding is provided for the delivery of the NCP and NCNP programs by SHA through a contribution agreement with MSB. The sponsorship includes travel, books and salary. One year (52 weeks without overtime) of payback is required after taking the NCP program. It has not been difficult for the SHA to "get a seat" for a nurse to take the NCP course. Some nurses say they do not want to take the course because they feel that their skills are adequate.

Skill upgrading such as certification for basic cardiac/trauma life support (BCLS and BTLS) as well as more advanced courses is supported by the health councils. Nurses relate that the health councils have creatively met the nurses' educational goals which they outline for themselves as a requirement under the self assessment option for license renewal with the CNO. For example, the health council funded one nurse to travel to the US to take part in a nurse practitioner conference. Nurses state there is generally no problem in obtaining the funding, or the time off required, to pursue educational goals they have set.

#### *Professional and administrative support*

Northern nurses have access to visiting physicians as well as telephone consultation with the on-call physician in Sioux Lookout. Since the termination of the University of Toronto contract for physician services in the spring of 1998 there have been periods of time of up to two months when no physician had been in the communities. During this period the nurses found it difficult to work effectively with the physicians employed as locums in Sioux Lookout who were not familiar with the communities. Such telephone advice was no substitute for face-to-face

interactions with a physician. The nurses were pleased when the SHA employed their own family physician last summer for a 3-month period. He took call until 9 pm; after this time and on weekends the nurses called Sioux Lookout when they required physician consultation.

Under the old U of T contract medical teleconferences were held twice a month on topics identified by the nurses, medical staff or MSB staff. These sessions would alternate with ZNO teleconferences on nursing matters and administration. Once or twice a month there were teleconferences on "prenatals" by physicians. Since the change of contract to McMaster University physician service is not yet back to its former level. The nurses are pleased some attempts are being made to reintroduce the former teleconferences. The absence of regular physician services is particularly detrimental to the care of pregnant women. Since May 1998 they have been required to give birth either in Thunder Bay or Winnipeg because the Zone Hospital is unable to offer Caesarian section. Overall, the nurses feel that their clients are compromised by this long lapse of effective physician coverage in the SHA. They have been brainstorming to make their voices heard by the general public and politicians. Since they now work for the First Nation they feel they are not constrained in advocating for their patients and communities. Their voices are not stifled by a "you cannot talk to the press" directive put forward by MSB.

Pharmacy services are available 5 days a week during the day and after hours at the Zone in case of an emergency. Bulletins are sent up to the nurses for educational purposes on a monthly basis. Information is also sent up by the drug companies on new drugs. Medication is dispensed by each nurse. The nurses phone a physician to prescribe medications that are not in the formulary. The physician calls the pharmacy to order the medication which is then sent up. The nurses attempt to get as many medications by prescription as possible. They reason this way the medications are covered by the NIHB budget. They also feel medications are better controlled this way with more continuity and fewer problems for the nurses overall.

The nurses are pleased with the organization of nursing services under the SHA. The nurses discuss specific staffing and nursing concerns with the nursing director who they feel acts in their interest, and refer to the local health director for community-related concerns. The nurses consider the health director as "not just a boss but a friend". A relief nurse who has worked with both Shibogama and MSB was impressed with the administrative support. She was consulted by nursing director on what needed to be done. One nurse expressed concern over her vulnerability to be BCR'd (ordered by a band council resolution to leave the community). She said she tended to protect herself by agreeing with band requests. Another nurse responded by saying that a "BCR is not even in the picture." She remarked that under transfer more effort is made by the band to include the nurses in events. The nurses indicated that they love to go to community functions and they believed the communities view them now as their nurses. The SHA nursing director makes a policy manual available to the nurses. MSB is a useful resource for information from federal sources. The nurses appreciate that they can access the MSB Critical Incidents Management Services as a resource.

The availability of administrative support from the SHA health director and technical support from SHA advisors such as the nursing director and clinical director has taken the pressure off a lot of nurses in the communities. They now feel that they are not alone and have to fight all the battles by themselves. The fact that in the communities the health director is located within the nursing station improves accessibility by the nurses and promotes open dialogue and early resolution of problems.

#### *Benefits and remuneration*

Wages and benefits under SHA are comparable to those in the MSB payscale. Overtime is paid with a flat rate in SHA, whereas, MSB nurses are paid a standby rate with callback allowances. Overtime rates were increased in April 1997, after the rates were viewed as not being reflective of the number of hours actually worked by the nurses. The nurses suggest the overtime is fair and that they prefer the timely method of payment SHA provides. Nurses who submit their overtime for the previous month may expect to be paid by the 15<sup>th</sup> of the following month. MSB overtime payment may take months to be processed. The nurses receive 8 weeks of vacation pay annually as compared to 3-4 weeks of vacation pay with MSB. This increased vacation pay is felt to offset the MSB policy which allows for compensatory time to be accumulated. SHA felt that this approach is an ineffective method for compensating the nurses for time off in lieu of overtime paid. Time off in this method can only be given, if there are nurses to replace the nurse who requests a leave. As well, nurses can only accumulate a certain amount of "comp time" in any given period. Funding for nurses is provided from a budget separate from the auxiliary staff in the nursing station.

On the downside, the nurses have heard comments made by community members like "you people will see us when we want you to." It is not known whether this attitude relates to the flat rate fee nurses are paid for after hours or whether it is due to the fact that nurses are now being employed by the band. SHA is well aware of the difficulty in satisfying community expectations of round-the-clock coverage in the face of staffing limits. The SHA health director indicated that while a policy is being prepared, the communities need to be educated regarding appropriate use.

### **6.3 Transfer: the nursing perspective**

Every nurse we have spoken to is enthusiastic about working for a First Nation-controlled nursing station. While their endorsement of working for a First Nation is not surprising, the high level of enthusiasm and team spirit they display is indeed encouraging. This is in stark contrast to the experience of one of us who has worked as a northern nurse for many years with MSB. Many MSB nurses we have come into contact with frequently express concern about working in a transferred environment and uncertain about their ability to "get along with the Band".

The nurses were unable to report any significant negative aspects of First Nation control. They did express concerns about the staffing system, the ad hoc physician coverage and more recently, possible problems with recruiting nurses, given the nursing shortage nationally. One nurse-in-charge who has been coming to the communities for many years in the employ of MSB and is currently with the SHA noted improvements in the communities. She observed that patients try to become more involved with their health care and there is an increased interest in supporting the nursing station.

After the transition period SHA has not had a problem with the recruitment and retention of nurses. For example, during Christmas 1998, the SHA communities were fully staffed while communities served by MSB were in a staffing crisis. The nurses have been staying in their positions. There are concerns at the present regarding recruitment and retention. It is felt to be reflective of the current nursing shortage in Canada rather than the fact that Shibogama is First Nation controlled. Nurses have told the nursing director that if they would go up north they would go with Shibogama because they have heard positive things about working for bands.



The period before transfer was manifested by staffing and organizational problems. A former Zone Nursing Officer (ZNO) indicated there were many problems prior to transfer. There was a "revolving door" of nurses (27 nurses came and went in the year prior to transfer). A constant conflict occurred between the nurses and the band. The community developed a bad reputation for not keeping nurses and many subsequently refused to go there. While they were not formally BCR'd, the nurses were "pulled out" by MSB prior to this occurring. In a monthly report in January, 1993, one nurse's observations reflects this period: "Nursing station left in charge of CHR for one night due to sudden departure of staff."

All the nurses said they felt a greater commitment to the community than before when they worked for MSB. One nurse suggested working for MSB involved too much "red tape." They all agreed they felt appreciated because people told them so. They indicated they had more job satisfaction. A nurse who had also worked with MSB said: "Shibogama is the best employer I've ever had". One nurse who continues to work with MSB part-time suggested that band control was more efficient overall including less money wasted. She indicated she is more conscious as to how money is spent now that she is not working in a large bureaucracy. A nurse suggested she has her family up there because she is comfortable working in the SHA. She said she would "not even have attempted it with MSB". One nurse who also works with MSB reiterated she hoped Shibogama "...keeps up because I want to continue to work for them". They said they have promoted working for a transferred community to other nurses. They all agreed that MSB should come to these communities to see "how it was done." A nurse who attended an MSB conference where the issue of recruitment and retention came up suggested they not waste their time to try and figure out how to recruit and retain nurses. Rather, they should just call Shibogama and ask how to do things. They said "the record speaks for itself, just look at it". A former ZNO says band control is "the only way to go. They need a feeling of ownership. It is obvious the old MSB model is not working and Shibogama is a good example of a success story".

Generally, the clientele appears to show respect and consideration towards the nursing station. The nurses suggest there is a feeling of pride demonstrated in the way the people conduct themselves in the nursing station and by the questions they ask. Community members come and ask questions "what do you think"" and "they listen." Increasing health awareness is apparent although the nurses caution they are uncertain whether this is due to band control. One nurse thought that mothers now ask more questions about their children. The nurses felt children are seen earlier now for illnesses. Fathers also come to the nursing station now and its not just to hold the child for immunization. They ask questions. Parents seem knowledgeable about child care. One nurse observed they "do not just accept your diagnosis and treatment ....[they] want to know why". Another nurse suggested the "...whole family is taking a more responsible role." More questions are asked about medications. Patients want to know what medication they are receiving and its purpose. They will also come back to the clinic and tell the nurses if the drug is not working. There has been more interest in breast-feeding. The communities are also more supportive of the nurses in the event of a tragedy.

The nurses indicate community members have a sense of pride in their health facility. One nurse compared it to the feeling of empowerment that was apparent when the school was transferred to band control. In the monthly reports written prior to transfer there were frequent references to incidents of vandalism. In December 1989 a nurse wrote:

*... the general bad state of the nursing station. It is unkempt, disorganized and in outer disarray, this applies to most areas both physically and administratively.... I have not seen a N/S before that is in such bad shape.*

In March 1993, a nursing station was described as having "... four holes in the wall above the examination table". The nurses believe that there has been a reduced number incidents of vandalism or break-ins at the nursing stations since transfer. While there was an incident of vandalism in Wapekeka in the summer of 1998 when on two occasions young members of the community attempted to gain entrance to controlled drugs. In this situation, the community took the initiative to deal with the matter to their satisfaction.

In contrast to before transfer the nursing stations are well supplied. Prior to transfer the nurses mentioned problems with inventory control: "... there wasn't adequate stock of supplies in the clinic", with many expired or understocked items.

Cooperation between nurses and auxiliary staff has improved since band control was instituted. One report before transfer describes staff attendance as "a big problem ... clinic staff ...leave early and arrive late. On several occasions we have called .... either in the am or afternoon and no one is in the clinic". In another community in October, 1991, the nurse wrote about prolonged coffee breaks. In reference to another community a nurse wrote: "This appears to be a very depressed community ... Band Council does not seem to be very involved with the health care ..." In November, 1990, another nurse complained that, without the participation of community resources such as CHRs, mental health and NNADAP workers it became "more and more difficult to plan and organize any further community health activities and programs".

There are other improvements that the nurses have noticed. There is much more awareness of the importance of the confidentiality of records. Privacy of patients is respected by providing care behind closed doors with locks. Curtains are pulled around exam tables. Consents for treatment at tertiary care facilities are obtained prior to the patients' departure.

Some nurses expressed concern as to whether women's rights are consistently being respected when family violence is involved. The band has been involved when individuals are referred out to safe houses in Geraltion, Dryden and Sioux Lookout. It is difficult for the nurses to send women out since the prevailing attitude is for family problems to be resolved in the community and that families stay together, sometimes at all costs. This is especially a concern to the nurses if the family is politically connected. There was one incident when one woman was stopped from getting on the aircraft.

While extra staffing is not available to the nurses for community health teaching the nurses are creative in accessing resources that are available in the community, Zone or the province. The community gives input into programs such as the adult flu immunizations held in the fall. When it was announced on the radio that the clinic was to be held, a support group was quickly formed to help out, such as preparing bannock and tea for people while they waited. Health Fairs have been conducted with the input of the Health Director, CHRs, elders, nurses, teachers, police and members of the community. A highlight of one health fair was the presentation on traditional medicines by elders. Healthy lifestyles are promoted. People are now taking part in efforts such as walkathons.

The nurses in collaboration with the community examined ways to improve the diabetes program to better meet the needs of the population. The nurse enlisted the support of the Health Director in educating the community about a proposed screening program, lifestyle and diet changes. Band Council members and elders supported the nurse's request to approach the Northern Store for its cooperation in making nutritionist foods available at the store. The school

was enlisted in efforts to educate children in a culturally appropriate manner to increase the awareness of the role of prevention in NIDDM. The screening program was successfully implemented with the full support of the band including obtaining parental consents where children were involved. The nurses felt success has been achieved in many ways as a result of the program being changed from an MSB model to that of a community based model. Other examples were given by nurses where initiatives had been made with community participation in efforts to improve the health status of the community. Another nurse had initiated a hypertension screening program with success.

## 7. The Patient Transportation Program

The three communities adopt different approaches to patient transportation, with Wunnumin Lake operating its own transportation program, while Kingfisher Lake and Wapekeka delegate it to the Shibogama Health Authority. The Sioux Lookout First Nations Health Authority looks after transportation for all other communities in the rest of the Sioux Lookout Zone.

### 7.1 Administration and financing

Funding for patient transportation in all three communities originates from contribution agreements with MSB, a list of which is shown in Table 11.

**Table 11 Budget for patient transportation as stated in contribution agreements**

Community	Agreement Number	Fiscal Year	Transportation		
			Direct	Admin	Total
Kingfisher	O9516S108	94/95	\$14,103.00	\$1,410.30	\$15,513.30
	O9616S108	95/96	\$9,445.41	\$944.58	\$10,389.99
	O9717S004	96/97	\$12,549.00	\$1,255.00	\$13,804.00
	O9817S004	97/98	\$12,549.00	\$1,255.00	\$13,804.00
	O9917S025	98/99	\$27,273.00	\$2,727.00	\$30,000.00
Wapekeka	O9516S122	94/95	\$6,134.00	\$613.00	\$6,747.00
	O9616S123	95/96	\$6,134.00	\$613.00	\$6,747.00
	O9717S009	96/97	\$6,134.00	\$613.00	\$6,747.00
	O9817S010	97/98	\$6,134.00	\$613.00	\$6,747.00
	O9917S013	98/99	\$22,727.00	\$2,273.00	\$25,000.00
Wunnumin	O9516S125	94/95	\$12,792.92	\$1,267.00	\$14,059.92
	O9616S126	95/96	\$420,789.00	\$42,079.00	\$462,868.00
	O9716S010	96/97	\$420,789.00	\$42,079.00	\$462,868.00
	O9817S011	97/98	\$420,789.00	\$42,079.00	\$462,868.00
	O9917S031	98/99	\$435,393.00	\$43,539.00	\$478,932.00

It can be seen that the budget is primarily static, with the total amount unchanged for several years consecutively. Table 12 illustrates the problem of over-expenditure in most years.

By way of comparison, in 1993/94 (pre-transfer), the patient transportation expenditures under NIHB administered by MSB amounted to \$542,087 for Wunnumin, which included Kingfisher as a “satellite” (a community without a nursing station). In addition, MSB entered into contribution agreements with the First Nations for on-reserve travel: Wunnumin \$13,728, Kingfisher \$13,807, and Wapekeka \$6,618. One can conclude that while such levels tend to be maintained after transfer, there has also been no substantial increase.

A major bone of contention between the communities and MSB is the handling of the deficit in the transportation budget. A health director reported that in the earlier agreements there used to be clause about negotiating with MSB to cover deficits. However, when the Zone Director was approached about it, the health director was told there was no procedure in place for such negotiation. In fact, the Zone Director suggested to the health director to hand the

transportation program back to MSB and let MSB deal with the deficit. In later years, the clause about negotiating deficits was removed from the agreement.

There is no special provision for the high costs associated with “special needs” clients, e.g. those requiring liver transplants or open heart surgery, who often have to go to Toronto for treatment, usually with a family member. The transportation program tends to absorb these costs.

**Table 12 Comparison of budget and actual expenditures in patient transportation, Wunnumin Lake, 1995/96 - 1997/98**

	Budget		Actual	
	95/96-97/98	95/96	96/97	97/98
<b>On-Reserve</b>	<b>\$13,936.00</b>	<b>\$21,012.00</b>	<b>\$22,383.40</b>	<b>\$7,909.88</b>
Direct costs	\$12,669	\$21,012.00	\$21,116.40	\$6,642.88
Administration	\$1,267	\$0.00	\$1,267.00	\$1,267.00
<b>Off-Reserve</b>	<b>\$448,932.00</b>	<b>\$441,145.87</b>	<b>\$536,682.46</b>	<b>\$519,072.69</b>
Direct costs	\$408,120	\$400,333.87	\$495,870.46	\$478,260.69
Administration	\$40,812	\$40,812.00	\$40,812.00	\$40,812.00
<b>Total</b>	<b>\$462,868.00</b>	<b>\$462,157.87</b>	<b>\$559,065.86</b>	<b>\$526,982.57</b>

The transportation program in Wunnumin Lake began in January 1994 as a 15-month pilot project. It was born at the same time as the Health Council. The agreement was continued at the end of the trial period. The program has its own manager reporting to the Health Director of the community. The transportation manager arranges and pays air and land travel and accommodation for patients and escorts. He is assisted by a Sioux Lookout-based assistant, as Sioux Lookout is the focal point of travel to specialist facilities in Winnipeg, Thunder Bay and Toronto. The program operates a minivan in Sioux Lookout to transport patient between the airport and the Zone Hospital.

Until 1997, the program also operated its own vehicle in Wunnumin Lake and hired a driver. The driver was responsible for ferrying patients and escorts between the airport, nursing station, and homes. He also took nurses on home visits and brought in nursing station supplies from the airport. However, the on-reserve budget was inadequate to cover the driver’s salary and overtime, and as a cost cutting measure, the driver position was eliminated and the program contracted the services of a local taxi. This is one example of the program’s effort to live within its budget. Indeed the on-reserve expenditures were reduced in 1997/98 to less than a third of what it had been in 1995/96 and 1996/97 (Table 11). Other economic measures include switching from Bearskin Airways to Wasaya Air, and using buses for trips between Sioux Lookout and Winnipeg or Thunder Bay rather than by air.

Decision regarding eligibility for coverage by the Wunnumin Lake program rests with the Health Director, with appeal to the Chief and Council for compassionate travel. The program has developed a protocol for eligibility and procedures for authorization, notification, and complaints. This protocol also stipulates that responsibility for members of other First Nations living in Wunnumin Lake, and Wunnumin Lake members escorting patients from other First Nations remains with MSB.

Since 1998, the three communities began to cost-share some services. The transportation assistant in Sioux Lookout receives half her salary from Wunnumin and the other half from Kingfisher and Wapekeka.

The transportation programs process a large number of travellers. Records from the Wunnumin Lake program show 692 in 1995/96, 1,002 in 1996/97, and 667 in 1997/98. In 1997/98, there were 404 travellers from Wapekeka and 485 from Kingfisher. The ratio of patients to escorts is quite consistent across the communities, at 2 to 1.

In terms of the destination, for all the communities combined, it is 65% Sioux Lookout, 15% Thunder Bay, 10% Winnipeg, and 10% other. There is some variation between communities. For example, about 7% of travel from Wapekeka is to Big Trout Lake.

## **7.2 Operational problems**

Patient transport, as part of non-insured health benefits, has long been a headache for MSB. It is often perceived as open-ended and non-controllable. It is therefore remarkable that the communities have taken on the challenge. It is often a fine line that separates what is compassionate and based on medical need from what is frivolous and serves primarily private interests. Off-reserve travel, in particular, is difficult to manage because of its unpredictability and high costs.

A major problem, as stated in successive Wunnumin Lake NIHB annual reports, is the demand by escorts and patients to bring along their children. When the request is denied, the travellers refuse to go to the appointment, creating havoc in the system. Or there are complaints about the type of accommodation available in various cities.

The community survey provides some data from the users' perspective. In Wunnumin, 57% of respondents said they were able to escort when needed to, compared to 68% in the other two communities. As shown earlier (Fig.20), less than half of the respondents (49%) in Wunnumin, 65% in Kingfisher, and 68% in Wapekeka, claimed that they could obtain transport to the nursing station in the event of an emergency.

The existence of many players (Wunnumin, Shibogama, SLFNHA, MSB, private carriers, etc) in the transportation business can be expected to create problems of poor coordination and communication. In the early years, there were instances of patients from Wunnumin Lake being ignored by the Front Office of the Zone Hospital. According to the Wunnumin Lake NIHB annual report:

*... the Zone Hospital did not tell the Front Desk that Wunnumin Lake is running its own program. It was a confusion period for them. The Front Desk did not know what their role was to Wunnumin....*

The Wunnumin program and the Zone Hospital worked out a solution to the poor communication. The hospital provides the Wunnumin transportation assistant with a beeper to let her know when a patient has finished with his/her appointment, while the assistant informs the hospital of the location of the patients in town. Similarly confusion arises over Wunnumin members escorting non-Wunnumin patients and vice versa. Wunnumin Lake drafted a protocol in 1995 which clarified the responsibilities of the Health Council and MSB.

## **8. Regional and Community Perspectives on Transfer**

This chapter presents a composite view of transfer from the perspective of regional health care administrators and the communities, based on data from the key informant interviews as well as relevant sections of the community survey.

Open-ended key informant interviews (8) were conducted by members of the consultant team at the regional level with representatives of the Shibogama Health Authority, the Shibogama First Nations Council, Sioux Lookout Zone of the Medical Services Branch, the Sioux Lookout First Nations Health Authority, and other health care providers in the Sioux Lookout area. Similar interviews were conducted in each community (18 in Wunnumin Lake, 9 in Wapekeka and 17 in Kingfisher Lake) by a local researcher appointed by the Community Evaluation Committee. A list of interviewees is included in Appendix B. The results of these interviews are described and summarized in point form according to the central themes of the interviews, followed by a brief commentary.

### **8.1 Relevance and importance of transfer**

#### *Regional perspectives*

- Take advantage of an opportunity to increase level of self-government in region
- Initiative came more from SHA level and communities had to be convinced of benefits
- Primary consideration at the community level was to exert more local control over nursing practice given some of the complaints from community members about poor communication and service from community nurses
- Positive experience of local control of Education after transfer from DIAND in 1988
- Political leaders (Chiefs) generally felt that communities could do a better job running community programs and services than government agencies
- Involvement of several progressive individuals at Tribal Council level provided leadership
- Shibogama First Nations Council had established successful track record in administering programs and services in areas of education and economic development
- SFNC successful in convincing communities to participate because general philosophy has always been to support community interests
- Fragmentation of services at community level resulted in wasted resources, lack of confidentiality between health care workers, and a perception that the community had no influence over the actions of health care workers
- Concerns that increasing involvement of the province in providing community health services would erode Treaty rights
- Perception that medical care in the communities was deteriorating and inferior to care available to non-Aboriginal communities
- Significant problems occurring in areas of patient communication with health care providers, referrals and patient transportation
- Community concerns about lack of local accountability for nurses
- Problems with providing escorts for elders

#### *Wunnumin Lake perspectives*

- Support move to self-government
- Improve relationship with MSB

- Complaints about patient transportation and communication with Zone office
- MSB not responsive to community needs
- No local involvement in health planning decisions

*Wapekeka perspectives*

- Respond to all health needs of community in holistic manner
- Need for full-time nurses
- Dissatisfaction with Medical Services Branch
- Positive experience with local control of education programs

*Kingfisher Lake perspectives*

- Services provided were too restricted and sometimes inaccessible
- Important to maintain Treaty rights
- Part of general move to managing our own affairs
- Needed more information on health services and resources available
- Better development of community-based services
- Make better use of the training and talents of local health workers (i.e., CHRs)
- Opportunity to identify ways to improve local delivery of services

*Commentary*

In general, interviewees identified two primary motivations for pursuing the transfer option. First, administrative and political leaders in the communities and with the Tribal Council had experienced considerable success with taking control over economic development and education and felt that health care was the logical next step in the pursuit of self-government for the region and communities. Second, community members were expressing significant concern about the quality of local health services. Leaders felt that part of the solution to these concerns would be to increase local accountability of the health care system.

In the community survey, community members were asked several questions regarding the relationship of transfer of health services to other political concerns in the community (see Fig.24). In general, approximately 60% of community members believe transfer is an important step towards First Nations control of health care, although there remains a high level of uncertainty. This uncertainty increases with regards to the impact of transfer on demonstrating self-government or Treaty rights. Only 5% of community members indicate opposition to health transfer.

## **8.2 Difficulties in implementation**

*Regional Perspectives*

- MSB policy related to size requirements for communities to run programs required more involvement from Tribal Council than some communities would have liked
- Demand for local control was high in communities but understanding of difficulties to achieve the goal of self-government not as high



**Fig.24 Community survey: importance and implications of transfer**

- Demand for community level accountability meant that resources had to be transferred to communities first and then transferred to Shibogama for central management functions – required two levels of negotiation
- Two communities required significantly more infrastructural development prior to full transfer.
- Initial difficulties with regional supervision of community nurses requiring continued involvement of MSB Zone office created some tension in administrative structure
- Transfer occurred too quickly without any opportunity to train or apprentice administrators – contributed to stress and high turnover of local Health Directors
- Medical Services Branch focus in transfer was more on bookkeeping and administration than on community development
- Local health workers took time to adjust to having local administrative accountability
- Too much early reliance on following the Medical Services Branch model of providing care limited opportunities for flexibility in developing new programs
- Several communities experienced some conflict of interest in appointing health workers and Board members – no clear protocols in place on how to avoid conflict of interest
- Early budget structures for community health nurses restricted compensation for overtime and relief pay – created difficulties for Shibogama to compete with MSB Zone office in recruitment of nurses
- True costs of central administration (Shibogama Tribal Council) not taken into account in transfer negotiations – resulted in larger burden on community resources and too much reliance on surplus from other Tribal Council programs to provide necessary coordination and management services
- Initial attitude at Medical Services Branch Zone office was that Shibogama should operate independently – not enough ongoing support for development of administrative capacity
- Community members understood transfer to mean they would now have 24 hour access to Nursing Stations

- Patient transport budgets different for each community and did not include provision for changing needs – deficits strained other community accounts
- High stress for local administrators who received little training – high burnout among Health Directors
- Personnel protocols were not well developed which contributed to problems with some staff over benefits, overtime, etc.
- Some early conflict over mental health services between Shibogama and Nodin – community members unclear about respective responsibilities for service provision

#### *Wunnumin Lake perspectives*

- High turnover of nurses
- Some community members (e.g., Elders) fearful of transfer
- Inadequate funding
- Lack of training for local health care staff
- Lack of community support for patient transportation policies
- High turnover of staff involved in developing and implementing community health plan
- Other communities in Shibogama area took longer to prepare for transfer
- MSB transfer policy too restrictive and does not allow for new programs
- Inadequate funding and flexibility to respond to community needs
- Problems with identifying appropriate people for Health Board
- Health services more complicated administratively than anticipated
- Lack of funding increases from year to year
- Lack of community consultation – negotiations primarily between Shibogama and MSB
- Lack of training for Health Council
- Inadequate information available during transfer negotiations

#### *Wapekeka perspectives*

- Costs for operating local transportation not in agreement
- Some communication difficulties with nurses
- Inadequate funding at beginning
- Health services outside community not ready to accept local control and were slow to adapt
- Too much overtime required of nurses
- Inappropriate use of escort services
- Lack of training for local staff
- Some problems with local health care staff adjusting to local accountability instead of MSB
- Inadequate training for health care managers
- Inappropriate use of scheduled air services for medical evacuation
- Community members unsure of capacity to manage own health care system
- Some community members felt they had not been consulted about Transfer

#### *Kingfisher Lake perspectives*

- Health Director had to learn on the job because no training was available and no previous experience in health service administration
- No permanent community nurse at first led to continuity of care problems

- Some areas such as facility and equipment maintenance were overlooked in transfer negotiations
- Too much reliance on SHA because communities were not well-informed about Transfer
- General lack of experience and training for Health Managers
- Lack of basic health service infrastructure at time of transfer
- Too much money to SHA
- Transfer negotiators lacked experience with health care
- Some community members lacked confidence in transfer negotiators and doubted possibility of local control
- Community members did not always understand transfer process
- Unanticipated expenses strained budget
- Implementation of dental programs too slow
- Exclusion of operating and maintenance resources from original budget caused significant problems
- Needed better resourcing of SHA to assist with implementation

### *Commentary*

At the regional level, several issues were identified as implementation difficulties. First, there was some tension regarding the role of the SFNC in relation to community management of the process. Second, MSB appeared to take a “sink or swim” approach to Transfer which left communities relatively unprepared for their new responsibilities. Lack of training for new administrative staff was identified as a key concern. Related to this was a concern that inadequate preparation of clear policies and procedural protocols for personnel created considerable difficulty for new administrators.

Communities amplified these concerns and identified inadequate funding and training as major issues. Patient transportation was further identified as a major issue in all communities; respondents indicated that concerns in this area ranged from unrealistic expectations of community members to inadequate funding and protocols for deficit coverage. Unanticipated problems in the area of maintenance and operation of clinic facilities were also identified as a concern.

## **8.3 Benefits to communities since transfer**

### *Regional perspectives*

- More local employment in the health sector
- Flexibility in planning possible but not always taken advantage of
- Despite concerns about underfunding and deficits, communities have more resources for health care than non-transferred communities
- Transferred communities perceive an increase in their political power in relation to both governments and other First Nation communities
- Increase in confidence at local level that health needs can be addressed
- Increased local knowledge and skills in health field
- Greater flexibility in recruitment, scheduling and compensation for physicians
- Teamwork concept has emerged among local health workers
- Easier and more efficient to provide training to local health workers as a group

- Better local understanding of confidentiality and increase in local trust of health care workers
- More stability in employment of mental health workers – less turnover
- Greater confidence in community that they can solve their own problems – increased pride in community capacity
- More proposals and applications coming from community for new programs and resources
- Non-Native health care workers appear more comfortable in relationship with community
- Consultants assume more secondary/supportive role rather than initiating programs etc.
- Increase in consultation and support across three communities for health administrators
- Nursing staff have wider role to play in community development
- Health Boards and staff provide advice and assistance to other non-Shibogama communities
- Increased participation of other local agencies in decision-making about health care services
- Nurses are better supported by local Health Board and Director – respond to problems quicker
- Increase in local understanding of appropriate use of health care services

*Wunnumin Lake perspectives*

- Increase in people's understanding of health problems (e.g., cholesterol)
- Accountability of nursing station to community
- Easier to deal with community member's problems
- Patient transportation improved
- Mental health services improved and more available
- Formation of resource team
- Better sense of financial responsibility in community
- Use of escort services has decreased
- More stability in nurses' continuity
- Recruitment of excellent nursing staff
- Better coordination of specialist referrals and visits to community
- More flexibility in health programs
- Attraction of excellent doctors
- Increase in community sense of responsibility for own health
- Local problems and complaints are addressed by health council
- Better local supervision of health staff and communication
- Coordination of resource team with nurses
- Local people looking after local people

*Wapekeka perspectives*

- Local patient transportation available
- Local full-time nurses
- Faster access to local health services
- Illnesses diagnosed quicker and more accurately
- Improved coordination in health care delivery
- Better acceptance of health promotion efforts by community members
- Improvements in responsiveness of clinic staff
- Flexibility in programs and services
- Ability to select nurses perceived to be appropriate for community

- Ability to develop culturally appropriate health programs (ie., wilderness camps)
- Improvements in coordination and training of resource team
- Better understanding of health issues by health council
- Better local programs for suicide prevention
- Increasing trust in local workers by community members

#### *Kingfisher Lake perspectives*

- Health director very accessible and able to coordinate services
- Patient transportation in the community now available
- Health care staff more accessible
- Native physician (during summer of '98) very accessible and helpful
- Nurses seem to enjoy work environment more
- Easier to arrange patient transportation and escort services
- Mental health worker is more accessible
- Referrals to specialists are easier and quicker
- More employment of community members
- Support for Aboriginal businesses such as airline
- Modernization of nursing station
- Illnesses detected earlier
- More appropriate use of medical technology
- Better and faster response to refilling medications
- Chronic care more consistent
- Availability of air ambulance
- More training available for resource team workers (e.g. counselling, anger management, etc)
- More reliance on internal community resources
- Better transportation for patients and nurses available in community
- Local people have better understanding of chronic illness
- Flexibility in budget allows for planning to meet local needs

#### *Commentary*

At the regional level, interviewees indicated that a major benefit of transfer has been an increase in resources and employment opportunities in communities. Communities have also acquired greater confidence in their ability to deal with other levels of government and solve local problems themselves. An increase in intersectoral and inter-community cooperation is also reported. Improved relationships between community members and health care staff are reported, with a corresponding positive impact on job satisfaction for nurses.

At the community level, the benefits identified are many and diverse. Better coordination and management of local health resources was a major benefit identified, as was improved overall quality of services. Less obvious benefits included an increase in community member's understanding of health risks and an increase in local accountability and responsibility for community well-being.

In the community survey, the majority of respondents indicated that transfer of health services has had a beneficial impact on their communities (see Fig.25). Less than 10% of respondents indicated that they were dissatisfied with the health transfer process. However, between 30% and 50% of community members are still uncertain as to whether health transfer

has had a beneficial impact on their community. This high level of uncertainty could partially reflect lack of contact with health services, but it also suggests health care administrators need to continue to inform community members about changes in programs and services.

## **Fig.25 Community survey: general assessment of transfer**

### **8.4 Problems experienced by communities since transfer**

#### *Regional Perspectives:*

- Some degree of political jealousy from other First Nations but not a major problem
- Sometimes a tendency to get involved in negotiations which should be left to other parties (i.e., the physician contract should have been left to MSB and the University)
- Inequities in compensation package for nurses compared to MSB makes recruitment difficult
- Early concern with erosion of Treaty rights resolved through reference to prophecy about government eventually withdrawing services – supports argument to take control before this happens
- High turnover in Health Directors
- High stress for people with high levels of responsibility in health care
- Some competition between Shibogama and other Tribal Councils regarding transfer of resources out of Sioux Lookout Health Authority
- Perception among physicians in University program that Shibogama contracted physician(s) have less demanding work environment but University physicians still expected to fill gaps in service
- Difficulties experienced in terminating unsuitable nurses due to lack of personnel protocols

#### *Wunnumin Lake perspectives*

- Inconsistency in staffing
- Nurses sometimes poor in providing information to patients
- Burn-out of local health care staff
- Lack of adequate funding for new programs
- High turnover of nursing
- Doctor's visits are too short
- Poor community response to health education workshops
- Some abuse of compassionate travel program
- Inadequate NIHB funding
- Community difficulties with exposure of sexual abuse
- Chief and Council not always supportive of Resource Team
- Cut-backs in patient transportation funding
- Health Board not active enough
- Too much centralization of management at Shibogama Tribal Council
- Health resources sometimes used for inappropriate purposes by Band Council
- No opportunity to re-negotiate funding in five year agreement

#### *Wapekeka perspectives*

- Lack of training for local health care staff
- Confusion in medical transport policy
- Some abuse of medical transportation rules by escorts
- Community members need to use clinic hours better to avoid high cost of nurse overtime
- Overuse of Nursing program by community members resulting in deficit
- Community members do not understand limits and restrictions to budget
- Health Council sometimes slow to take action on community recommendations

#### *Kingfisher Lake perspectives*

- Tight budget created medical transport deficit
- Transportation program deficit requires patients to travel by bus to Thunder Bay – difficult for older people
- Limited funding for emergencies or unanticipated problems such as suicide epidemic
- Limited funding for new programs – restricts creativity
- Limited opportunities and funding for training
- Limited funding results in restrictions on employee benefits and development (i.e., no raises for any staff except nurses)
- Some communication problems between Sioux Lookout hospital staff and Shibogama Health Authority staff
- Insufficient resources for medical equipment
- Too much reliance on Shibogama Health Authority
- Occasional lack of cooperation from Sioux Lookout Zone Hospital staff

#### *Commentary*

At both the regional and community level, interviewees identified ongoing tensions between the Shibogama Health Authority and communities regarding responsibilities and

resource for management functions as an issue. In the regional context, further clarification of roles and responsibilities among different agencies is clearly required.

The stress experienced by health administrators, and resulting high staff turnover was identified as a major concern. Patient transportation protocols and resources are the most significant problems identified at the community level. Communities also identified restrictive budgets as limiting flexibility and creativity in responding to community health needs.

## **8.5 Improvements required for future transfer agreements**

### *Regional Perspectives:*

- Need more effort to persuade local people to pursue careers in Nursing and Medicine
- Need to find other sources of funding new programs and services rather than waiting for MSB to enhance programs
- Convince political leadership that economic investment can be used to support health and health services
- Shibogama Health Authority should help other communities prepare for transfer
- Develop more secondary and tertiary levels of service with accountability to SHA
- Develop a contingency fund for crisis situations and emergencies
- Increase reliance on community care and reduce reliance on transporting people out of community for care
- Further development of policies and procedures protocols so easily understood by all employees and community members
- Refine conflict-of-interest guidelines, accountability responsibilities, and disciplinary procedures
- Bring more secondary and tertiary levels of service under Shibogama coordination
- Increase public health resources and staff available to communities
- Include evaluation of community programs and services
- Broaden community focus away from nursing services to more holistic focus
- Examine MSB transfer formulas to ensure that demographic and health changes are taken into account
- Health Directors need more training, support and better compensation packages
- Improve nurses compensation packages so equitable with MSB but also to encourage and reward nurses who adopt community development approach
- Foster a feeling of ownership and appreciation of Nurses at community level
- Increase involvement of communities in administration of Nursing program
- Decrease reliance of communities on SHA for management functions

### *Wunnumin Lake perspectives*

- Improved exercise facilities
- Diabetes education more often
- Better career opportunities for nurses
- Larger clinic facility
- Improved funding
- Eliminate land travel by bus for patient transport



- Improve nurse retention
- More health education workshops and education in schools
- Increase training and use of local people in health professions
- Decentralize Shibogama management functions
- Need own doctor
- Increase in community members' understanding of local accountability
- Addition of public health nurse and second CHR
- Upgrade Nursing Station equipment
- Shorter term for transfer agreement
- Increase resources and size of Resource Team (e.g., mental health workers)
- Need alcohol and drug treatment in the community
- Need a youth camp
- Transfer Nodin services to community
- Increase funding to transportation program
- Improve environmental monitoring
- Better focus on community development
- Recognize demographic changes in population with adequate resourcing
- Improve interpreter services in Nursing Station
- More community involvement in consultation on health programs
- Better orientation of nurses to Aboriginal way of life
- Centralize all local health services into one building

*Wapekeka perspectives*

- Need local X-Ray facility
- Better attention to patient needs
- Improve policy regarding expectations for medical escorts
- Better communication between Health council and rest of community
- More public health education
- Larger clinic facilities
- More medical equipment such as X-ray and Defibrillator
- Improved funding for full implementation of planned services
- More public education about transfer
- More use of traditional medicines in clinic
- Ensure funding is consistent with Treaty rights
- Train local people for maintenance of Nursing Station
- More resources for local medical transportation program
- Health council more active in community consultation
- Chief and Council should be more involved and supportive of health issues
- More opportunities to train community members for all health care service jobs
- More visits by specialists
- Eliminate inequities in salary and benefit packages between community nurses and other local health care staff
- Physicians available for longer periods
- Expand support and maintenance staff at clinic
- Better security at clinic

### *Kingfisher Lake perspectives*

- Local physician needed
- Medical Services Branch should cover medical transport costs and deficits
- Encourage more men to get regular check-ups
- Shorter renewal period needed on Transfer agreement in case of problems
- Traditional medicine needs to be better supported and integrated
- Contingency funding required in case of emergencies or unanticipated problems
- Transfer agreement should be reviewed more broadly in the community by different groups including health care staff in order to identify potential problems
- More health promotion and illness prevention programs needed
- More teaching about alcohol and drug abuse and consequences
- Better prenatal and infant care education for young mothers
- Health workers become more involved in promoting better nutrition by advising local stores on nutritional foods
- SHA should hire a physician with responsibility for the three transferred communities
- More support services for compassionate and respite care
- Need more Aboriginal staff including nurses and physicians
- More training for local support staff (i.e., computers)
- More home visits by health care workers
- Bigger vehicle needed for Nursing Station to accommodate stretchers

### *Commentary*

A need to ensure opportunities for increasing resources to provide for flexibility in community programs, unanticipated contingencies, and changing demographic and epidemiological trends was identified as a major issue. Further improvement of personnel protocols in areas ranging from compensation to conflict of interest was also identified as a major concern. Several interviewees expressed the need for further discussions around the transfer of secondary and tertiary services (including physician services). However, suggestions were also made to reduce the level of dependence on the SHA for central administration and coordination.

Communities identified a range of specific issues that need to be addressed including health promotion, inclusion of traditional healing (Kingfisher Lake and Wunnumin Lake), and expansion of local clinic facilities. Finally, several informants expressed concern that a five year term for the transfer agreement was too long and suggested agreements should be subjected to wider community review by other sectors (including community health workers) to ensure unanticipated costs are addressed.

In general, health transfer appears to have been a very positive experience for the communities of the SHA. Despite tremendous pressure to “learn on the job” in the early days of transfer, health authorities now take great pride in their ability to provide for their community members needs. Most of the problems encountered in the first few years have been resolved, and the emergence of an integrated, well-functioning health care team, focused on community development and wellness is a major success.

However, concerns continue to be raised regarding inadequate levels of funding, training and support from other agencies and levels of government. The Shibogama communities are justifiably proud of their success, but feel to some extent that this success has been achieved in

spite of rather than with the full support of MSB and other Sioux Lookout organizations. Suggestions have been made to expand the transfer Initiative to include other secondary and tertiary services, but at the same time reservations have been expressed regarding the duration of the next agreement and adequate resourcing.

Success to date has been achieved largely through the extraordinary commitment and enthusiasm of key personnel in the communities and at the SFNC and SHA, but this contribution has not been without its costs, as the frequent references to staff turnover and burn-out attest. The continued development of local health authority in Shibogama communities cannot continue to rely primarily on the personal sacrifices of staff for success; systemic commitment from government and other agencies is required.

## 9. Conclusions and Recommendations

As stated in Chapter One (Section 1.3) the transfer agreement specifies six questions for the evaluation. In this final chapter we shall draw overall conclusions about the effectiveness and impact of transfer by answering these questions, basing on the three types of information – statistical and financial data, structured interviews, and questionnaire survey. While many recommendations for future transfer agreements are sprinkled throughout the report, a consolidated list is provided at the end of this chapter.

1. *Did the transfer initiative achieve its goal of transferring responsibility for health programs to the communities?*

The answer is clearly yes. The health councils in the three communities and the Shibogama Health Authority were established in 1994 and these have functioned continuously with a multi-million dollar annual budget. The health system operates a full range of preventive and treatment services which are well utilized. There is overall acceptance of the change by the community, and an improvement is generally acknowledged. There were growing pains, particularly because of administrative inexperience, but steady progress was soon made.

2. *To what extent have the arrangements resulted in the communities being able to design and deliver health programs in accordance with their own needs and priorities?*

The answer is both yes and no. The current services are primarily modelled on the pre-transfer MSB “standard”, and indeed the transfer agreements and the reporting format are structured in such a way that the MSB model is perpetuated. To the extent that the pre-transfer system “worked”, there is no compelling reason to change for change’s sake. However, there is a need for more flexibility in accordance with the communities’ own needs and priorities that should be fundamental in future transfer agreements. The community health plans that were prepared prior to transfer are primarily paper exercises with minimal direct relevance to the organization and delivery of services after transfer.

3. *To what extent have MSB’s accountability responsibilities been met and are these requirements appropriate?*

All the provisions for accountability to the funding agency (MSB) in terms of annual reports and audited financial statements have been duly complied with. The quality of the annual reports is variable – some of the earlier ones provide insightful commentary on the process of transfer, while others merely follow a MSB-prescribed “cookbook” formula. Since inter-agency cooperation and communication was identified by some key informants as an occasional problem, the central evaluation committee (which includes MSB) established for this 5-year evaluation might provide an ideal forum for regular inter-agency and SHA-wide discussions to monitor the progress of transfer.

4. *Did the overall health of the communities improve under transfer?*

As emphasized in Chapter Four, the small population size, the rarity of significant health events that serve as indicators, and the short duration of observation render it very difficult to demonstrate any health impact of transfer, let alone establish causality. Furthermore it should be recognized that the health status of a population is far less dependent on the quantity and quality of health services than on social and economic determinants. It is, nevertheless, important to

establish baseline indicators and continue to monitor trends into the future. It is increasingly recognized that health planning should be based on health needs rather than historical utilization levels.

5. *What have been the impacts, both intended and unintended on MSB and the communities over the short and long term?*

The immediate short-term impact of transfer – within the first two years – has been disruptive. There was high turnover of staff, administrative inexperience, absence of policies and procedures, and unrealistic expectation of MSB, community members, and the political leadership. However, the health councils and SHA slowly gained confidence. For the long term – 5-10 years and beyond, one cannot but be optimistic that the SHA experience will be overwhelmingly positive and that it will serve as a model for other First Nations. One valuable lesson learned is the recognition that the communities must look beyond the transfer agreement with MSB to respond to the health needs of the communities. The communities and SHA have shown their innovativeness in accessing diverse sources of funding and willingness to cross-subsidize programs/portfolios to deal with deficits/surpluses. The SNFC is considering business ventures and revenue-generation initiatives outside its territory to promote economic development, which ultimately will have a major impact on health status. Without transfer, there would not have been the flexibility or forward thinking to allow these developments to occur. With the experience it has acquired, SHA is well placed to offer its services to other First Nations as a consultant.

6. *Are there other ways of achieving the transfer of health responsibilities?*

The overwhelming majority of people in the SHA communities are in favour of transfer, and few people would have wished that it had not occurred. The status quo, or the MSB model in effect in the rest of the Sioux Lookout Zone, is not an alternative. As to the different models of transfer, the SHA one combines community control with regional planning and support. The very sustainability of SHA itself is dependent on its serving the needs of the communities, which provide the financial contributions to allow it to operate. There is a danger if every community runs its own unique health system, separate and isolated from other communities in the region. At the other extreme, too large and centralized a regional system (be it the Sioux Lookout Zone, the SLFNHA, or Nishawbe-Aski Nation) runs the risk of being remote and removed from community concerns. The SHA model seems to strike the right balance.

There is little evidence that communities are concerned about the larger political implications of transfer, for example, its relation to treaty rights and the constitutional obligation of the federal government towards First Nations. By their overwhelming support for transfer, the SHA communities clearly do not see transfer as a threat to self-government, a view that is held by some First Nations which have refused or are reluctant to proceed with transfer. Again, the SHA experience can be of benefit to First Nations across the country.

## **Recommendations**

### *1. General*

- The transfer agreement should be renewed with MSB, but its continuing success will depend on an adequate level of funding, provision for administrative and professional training, support from other health and social agencies, and understanding and moral support from other First Nations.

### *2. Health Councils*

- The health councils in the three communities should improve accountability to community members and promote awareness of the councils' activities. Annual reports should be re-designed and produced in the form of a small pamphlet (in both syllabics and English) highlighting the year's main accomplishments and widely distributed. Publication and translation costs should be included in the transfer agreements.
- Council members and key management staff should attend continuing education workshops on conducting effective meetings, conflict resolution, financial management, report writing, performance appraisal and other management topics. Funding for such workshops should be included in the transfer agreements.
- Kingfisher Lake Health Council should manage its own budget separate from the Band Council, along the model in place in Wunnumin Lake and Wapekeka.
- Health transfer agreements should be reviewed by other community agencies in order to ensure wider impacts on community resources are adequately addressed.

### *3. Nursing Program*

- The level of nursing station staffing should be re-negotiated. The existing Community Workload Increase System (CWIS) is ill-suited to the health needs of the Shibogama communities. A joint SHA-MSB task force, perhaps with representation from other First Nations in the Sioux Lookout Zone, should investigate and design a new approach to determining adequate staffing levels.
- The minimum level of staffing for Wapekeka should be 2 nurses. The other communities should not have to "donate" an extra position from their own allocation.
- Within each nursing station, there should be one nursing position dedicated to Public Health. It would be desirable that all nurses recruited by SHA be trained and experienced in both Public Health and Primary Care, and that all nurses within a station can rotate through the Public Health position on a monthly or quarterly basis. This will allow all nurses to share in the high-stress acute care and maintain competency in public health.
- Influenza vaccination among the elderly needs to be improved.

### *4. Mental Health and Social Services*

- Kingfisher Lake and Wapekeka should consider following the example of Wunnumin Lake in forming an integrated Health and Social Services Council
- SHA should intensify negotiations with other service agencies to achieve early, full integration of the Band Family Service Worker and Tikinagan Family Counsellor into the Resource Team at the community level.

- The work schedule, job descriptions, and pay structure among the different members of the resource team should be further harmonized. Regular case conferences should become a regular activity of the team.
- SHA should initiate discussions with Nodin to determine how the visiting counsellors can be more fully integrated in the community-based mental health program.

#### *5. Community Health Representatives*

- The role of CHRs appears to be poorly understood by community members, especially in communities with new nursing stations. CHRs need to develop a higher public profile and a separate identity from the nurses and other health workers, for example, by regular appearance on the local radio and hosting special health events.
- The next transfer agreement should incorporate overtime pay for CHRs and a payscale with annual increases.

#### *6. Patient Transportation*

- The transportation budget should reflect and accommodate unexpected expenditures associated with special needs clients.
- There should be explicit mechanisms for managing deficits incurred by the transportation program separate from other “controllable” expenditures.

#### *7. Relationship with Medical Services Branch*

- The cordial relationship that currently exists between SHA and Sioux Lookout Zone management should be enhanced through regular meetings and mutual assistance in nurse recruitment and holiday relief.
- Under the terms of the transfer agreement, SHA and the health councils in the three communities are accountable to MSB in fulfilling their commitment to provide mandatory services. MSB is also accountable to SHA and the communities in discharging its “residual” responsibilities.

#### *8. Surveillance and Monitoring of Health Trends*

- An accurate and timely information system on health status, health determinants and health care use is critical to an assessment of current needs and predicting future resource requirements.
- At the minimum, such a system should include annual population census, births, deaths, new cases of notifiable diseases, completed and attempted suicides, caseload of important chronic diseases, immunization coverage, and use of nursing station services.
- There should be periodic (once every 5 years) surveys of the communities on self-perceived health status, health behaviours and practices, and views regarding the health care received. Funding for such surveys should be incorporated into the transfer agreement.

**Appendix A Community Health Service Satisfaction Survey**









## **Appendix B List of Key Informants in the Communities**

### **Wunnumin Lake**

- Nursing Station Housekeeper
- Nurse in Charge
- Chief
- Health Board Member (2)
- Community Health Nurse (2)
- Transportation Manager (2)
- X-Ray Technician
- Health Board Chairperson
- Resources Team Coordinator
- Health Transfer Negotiator
- Health Administrator
- NNADAP Worker
- Band Administrator
- Health Director
- Health Board Elder

### **Kingfisher**

- Referral Clerk (2)
- Resource Team Coordinator
- Band Family Service Worker (2)
- Chief
- Community Resource Worker
- CHR
- School Janitor
- NNADAP Worker
- Nursing Station Housekeeper
- Deputy Chief
- Band Councilor (3)
- Minister
- Welfare Administrator

### **Wapekeka**

- Caretaker
- Health Council Member
- Health Council Chair
- Health Director (2)
- Health Council Elder
- CHR
- NNADAP Worker
- Deputy Chief