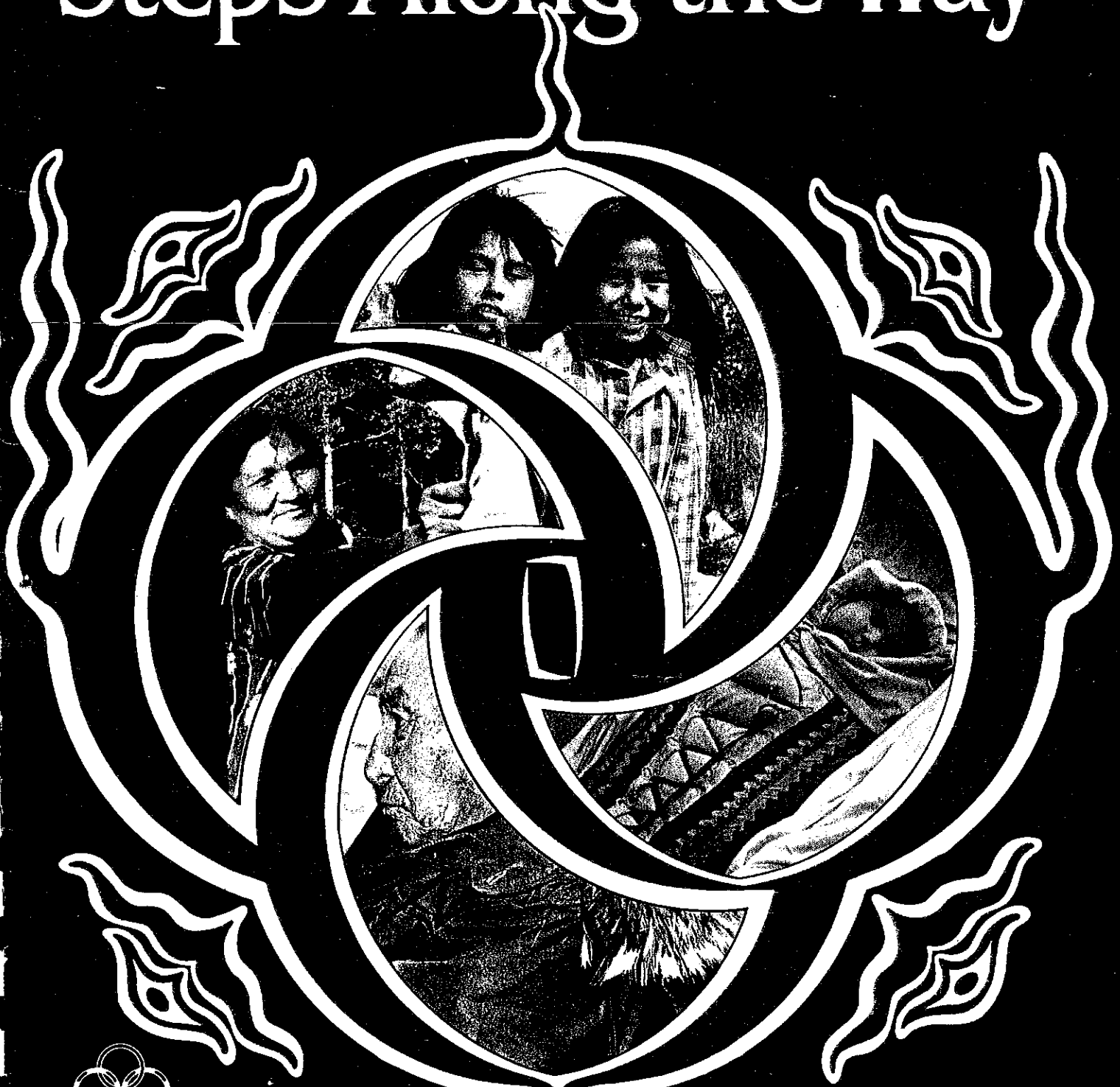
From Here to There: Steps Along the Way



The Report of the Scott McKay Bain Health Panel

From Here to There : Steps Along the Way

Achieving Health for All
in the Sioux Lookout Zone

The Report of the Scott-McKay-Bain Health Panel

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The following is the report of the Scott-McKay-Bain Health Panel and its review of health services in the Sioux Lookout Zone. It is the result of an extensive, year-long study of health care services in the region. The ultimate aim of the review and this report is to improve and promote health among all who live and work in the Sioux Lookout Zone. We invite everyone who reads this report not only to reflect critically on its content, but to recognize that promoting health is everyone's responsibility and become personally involved in "health promotion" where health is seen not just as the absence of illness but as:

> ***"a resource which gives people the ability to manage and even to change their surroundings ... a basic and dynamic force in our daily lives"[1] and***

> ***"the capacity ... to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality."[2]***

Dr. Harry Bain

Mr. Wally McKay

Archbishop Edward Scott

Acknowledgements

The Panel members are deeply grateful to the range of people and groups who have helped them in their work including:

- panel staff
- the people who provide and receive health care in the Zone
- individuals in the tertiary care centres who serve people from the Zone
- individuals responsible for shaping and implementing health policy
- health consultants who have worked in the region and advocated community development and those involved in transfer studies
- chiefs, councillors, elders and residents of communities
- the officers and staff of Tribal Councils and of the Nishnawbe-Aski Nation
- the people involved in the University of Toronto Sioux Lookout Program
- the many concerned persons and groups in Sioux Lookout, Toronto, Winnipeg, Thunder Bay, Manitoulin Island, Montreal and elsewhere in Canada who shared time, energy and experience in making verbal or written presentations to the Panel
- the team from McMaster which assisted in the review.

The Panel would also like to thank the nurses and individuals in the communities who provided accommodation, meals and hospitality.

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Introduction

Background

The Strike

On January 18, 1988, five members of the Sandy Lake Band — Josias Fiddler, Luke Mamakeesic, Allan Meekis, Peter Fiddler and Peter Goodman — began a hunger fast at the Sioux Lookout Zone Hospital. The five men wanted to draw attention to what they described as years of frustration, meaningless consultation, worsening health and deteriorating relations between aboriginal communities and the Medical Services Branch (Health and Welfare Canada) which provides health services in the Zone.

Negotiations with Mr. Dave Nicholson, Assistant Deputy Minister of Health and Welfare Canada, led to an agreement between the native leaders and the federal government and an end to the hunger fast on January 20, 1988.

Under the terms of the agreement both parties — the Nishnawbe-Aski Nation, on behalf of the native communities, and the Assistant Deputy Minister, on behalf of the Federal Government — made a commitment to improving health services in the Sioux Lookout Zone. The Federal Government and the Nishnawbe-Aski Nation agreed to a review of health services, within a framework which would be ***"consistent with, and support, the right of Indian people to determine their own health needs and to control the health delivery system by which their needs are met."***

The Panel

A three-member review panel was appointed with one member nominated by the Nishnawbe-Aski Nation, one nominated by the Minister of Health and Welfare and a third, the chairperson, who would be acceptable to both parties.

- The Nishnawbe-Aski Nation nominated Mr. Wally McKay, Executive Director of Tikinagan Child and Family Services (the first Indian-operated child and family service organization in Ontario), a former Grand Chief of the Nishnawbe-Aski Nation and former Regional Chief of the Assembly of First Nations for Ontario.
- The Minister of Health and Welfare nominated Dr. Harry Bain, former Chief of Staff of the Hospital for Sick Children in Toronto and former Professor and Chairman of the Department of Paediatrics, University of Toronto, who had been instrumental in setting up the University of Toronto Sioux Lookout Project and who had served as Zone (Medical) Director for a year.
- The chairperson agreed to by both parties was Archbishop Edward Scott, former Primate of the Anglican Church of Canada, who had had extensive contact with aboriginal people and served on the Commonwealth Group on South Africa.

The Task

- To review, evaluate and determine the deficiencies of existing health services and programs provided in the Sioux Lookout Zone
- To hold community hearings to document the concerns, problems and suggested solutions from individuals, Band Councils and Elders in the Sioux Lookout Zone
- To establish a process and a plan of action which will provide solutions and rectify the noted problems and deficiencies in the health care system

(A complete copy of the Terms of Reference are included in Appendix I.)

The Scott-McKay-Bain Health Panel held its first formal meeting March 17 and 18, 1988 and began work in earnest in June 1988. The panel's research consisted of:

- gathering both formal and anecdotal information through hearings held in Indian communities and in several urban centres. The Panel heard over 500 presentations from health professionals, individuals receiving care, and persons and groups concerned about health in the Sioux Lookout Zone.
- obtaining hard data on the health status of people in the Zone and on available health services.

Panel members visited all but three of the fly-in communities in the Sioux Lookout Zone — and did so during the winter months. To plan and organize the community hearings, the panel hired aboriginal staff who were fluent in English and in one or more native dialects. One staff person was responsible for organizing special, separate meetings with aboriginal women, and the views of the women — in their own words — can be found throughout the pages of this report. (Panel staff learned a great deal about the health care system in the region, and about community development and organization. Panel members anticipate that some of these individuals will go on to play key roles in implementing the recommendations of this report.)

To analyze the necessary health status information and assist with the review, the panel also arranged a consulting contract with a group from McMaster University.

(For detailed information on the staffing, organization, visits and presentations of the review, see Appendix II.)

The Report

The task of the Scott-McKay-Bain Health Panel was not simply to catalogue and analyze the health care problems that exist in the Sioux Lookout Zone, but to recommend solutions and help the Nishnawbe-Aski Nation and the Federal Government move from the problems and frustrations of "here" to the desired, healthier "there." Therefore, the report is divided into three sections:

- From Here
- To There
- Steps Along the Way

While moving physically from "here to there", from community to community in the Sioux Lookout Zone is challenging enough, it is even more difficult to move from "here to there" in the relationships between the groups involved in delivering and receiving health care in the region. When it began its work, the Panel learned that there was no real agreement between the two groups — the Nishnawbe-Aski Nation and the Federal Government — about either "here", the problems, or "there", the desired outcome.

Not only were there divergent views about the health status of native people and about the quality of health services currently provided in the Sioux Lookout Zone (here), but there was no clear agreement about what services should be provided, where and how they should be provided and who should have control over their provision (there). That lack of agreement was complicated by a low level of trust and unrealistic expectations on the part of persons in both groups.

From Here ...

The first task of the Panel was to try to understand the "here" — the present state of health and health care delivery in the Sioux Lookout Zone — and Panel members did this by listening at hearings (often through interpreters) both to those who provide health care and those who receive it.

Developing a clear picture of the"here" was not easy. In presentations and submissions to the Scott-McKay-Bain Panel, groups and individuals raised many concerns about health care in the Sioux Lookout Zone. Some dealt with the quality of facilities and equipment available; some with the service delivery system; some

with problems of communication between providers and recipients of health care; some with cultural misunderstanding and growing racial tensions in the larger communities of the region; and some with the failure of the health care delivery system to work effectively.

Some of the specific complaints related to events that had happened many years ago. Many of the frustrations stemmed from the dramatic changes occurring in native society including the growing conflict between traditional and modern ways and the impact of external forces such as television.

In the community hearings, Panel members made an effort to listen to what was being said behind the words and to understand the real problems and frustrations — whether physical, mental or spiritual. It became clear that those living in the Sioux Lookout Zone share the desire of all people to have more control over their lives in a 20th century world that makes many feel powerless.

In trying to understand the "here", Panel members did not depend solely on presentations at the hearings. They also gathered and read material written about the region, commissioned specific studies and made many requests for general and specific information. The Panel believes that the first chapter of this report is a well-documented and accurate summary of existing health situation in the Sioux Lookout Zone ("here").

In 1975 people in the north were listening to the radio at night and talking on radio telephones. In 1985 they were watching 24-hour uncensored satellite link-up television and using direct dialing satellite telephones. The microchip had come to the north. Women found that they could not cook bannock in a microwave oven. Children found computer keyboards in their classrooms. Video cassette recorders and video games showed up everywhere. The community halls were empty. The community health was in jeopardy.

Madeline Beardy

Another finding in this [community health status] study is that most people feel that many problems encountered while getting health care are being addressed. Many felt, however, that more attention should be given to substance abuse problems and depression. The other health problems which were identified were: people being overweight, people eating non-nutritious foods, gas sniffing or solvent abuse, suicide or attempted suicides, spouse abuse and over-doses of drugs.

R.M., Bearskin Lake

To There ...

As the Panel members listened, observed and read, they tried not only to understand the existing situation, but to identify a shared vision of health for the region — the "there." To do that, the Panel asked three key questions:

1. What do the majority of the people want?

2. What is possible?

3. What would be in the best interests of all concerned?

That "vision" of health ("there") is described in Chapter Two.

Steps Along the Way

The Panel recognizes that the vision for health described in this report will not be achieved unless specific actions are taken by everyone involved, so in the course of its deliberations it asked:

> **What steps might enable movement to the desired goal?**

The third chapter of the report describes the "steps along the way": the series of changes and actions that the Federal Government, the Nishnawbe-Aski Nation, the health care providers and the communities and individual persons can — and must — take to move from "here" to "there" — to achieve their shared vision of health.

Panel members hope that this report will help everyone involved in health care in the Sioux Lookout Zone work together for a better future.

In addition to this report, the following companion documents — along with other reports and materials — are being assembled and will be given to the Nishnawbe-Aski Nation and the Medical Services Branch:

- ***The Concerns of the Nishnawbe-Aski Women.*** A report prepared by Madeline Beardy, Co-ordinator of Women's Concerns, Scott-McKay-Bain Health Panel
- ***The Lament of Women on "the People, the Land": An Experience of Loss.*** An analysis of Madeline Beardy's Report, by Dennis Willms. McMaster University
- ***Reflections on the Needs of Elders.*** A report prepared by Barry Frogg, Community Co-ordinator, Scott-McKay-Bain Health Panel.
- ***The Use of Health Status Indicators and Other Quantitative Information for Health Planning and Evaluation.*** Prepared for the Scott-McKay-Bain Health Panel by Donald C. Cole, MD, McMaster University Team. May 1989.
- ***Information on the Training of Doctors Working in the Sioux Lookout Zone.*** In English and Cree. Produced by the Scott-McKay-Bain Health Panel and distributed to all Chiefs in the Sioux Lookout Zone.
- Interim Report of the Scott-McKay-Bain Health Panel, December 1988.
- Memo to the Chiefs on the Hospital Issue, February 1989.

From Here ...

Health and Health Care in the Sioux Lookout Zone

Principles of Health and Health Promotion

This report and its recommendations are based on the following principles of health and health promotion:

- the need to strengthen the role of the individual and the community in controlling and improving health
- the importance of health promotion — particularly self care, mutual aid, social support and the development of a healthy environment — in achieving and maintaining health
- the need for greater community involvement in the health care delivery system.

These principles which have been endorsed by the federal and provincial governments, are taken from:

A New Perspective on the Health of Canadians: A Working Document, Health and Welfare Canada, 1975.

Achieving Health For All: A Framework for Health Promotion, Health and Welfare Canada, 1986.

Towards a Shared Direction for Health in Ontario, The Report of the Ontario Health Review Panel, July 1987.

Mental Health for Canadians: Striking a Balance, Health and Welfare Canada, 1988.

They reflect a change in thinking about health and health care, one that stresses empowerment, interprofessional co-operation, individual and community changes and collaboration. In the view of the Panel, this view of health is essential in solving problems and improving health status in the Sioux Lookout Zone.

In addition, the panel relied heavily on the data and information presented in ***Health Care and Cultural Change: The Indian Experience in the Central Sub-Arctic***, by Dr. T. Kue Young. The Panel received a copy of the manuscript of this book which, published in February 1989, deals extensively with the health of aboriginal people in the Sioux Lookout Zone.

The Health of Aboriginal People in the Sioux Lookout Zone

The Indians have always lived as participants in nature, rather than as its conquerors.

Kue Young, Health Care and Cultural Change

Young people are our future.

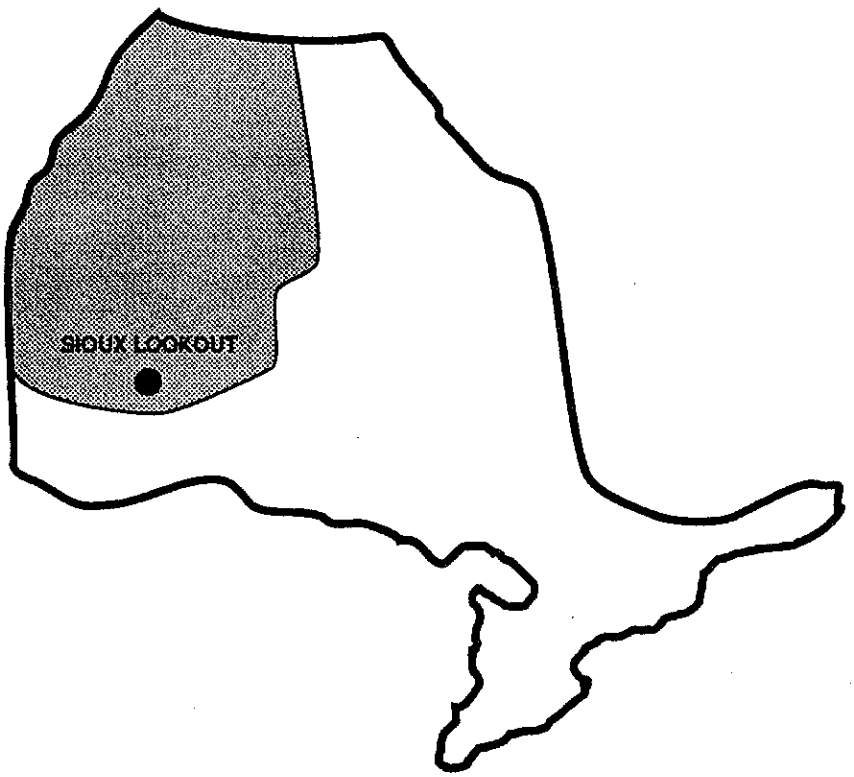
Elder, Webequie

It is important to stress the inevitable constraints that are imposed by geography. The health care needs of a sparse population inhabiting a vast land with a difficult climate are notoriously hard to serve. No jurisdiction in Canada or elsewhere in the world has solved this problem satisfactorily. If anyone — a native trapper, a white prospector or a police officer — sustains a serious head injury on the shores of Hudson's Bay, he will not get the same speedy tertiary neurological care that is available in Southern Ontario. The health care services do the very best they can, but there is some irreducible hazard that has to be accepted by anyone living in remote Canada.

Richard Moulton, M.D. Thunder Bay

The Sioux Lookout Zone and Its People

The Sioux Lookout Zone covers 385,000 square kilometres, or almost one-third of Ontario, and stretches from Sioux Lookout north of the CNR line to Fort Severn on Hudson Bay and from the Manitoba border in the west to Fort Hope in the east.



Scattered throughout this region — are 28 aboriginal communities which range in size from six to 1,500 people. Only three of these communities — New Osnaburgh, Savant Lake and Frenchman's Head — can be reached by road. The other 25 are regularly accessible only by air. Of those 25, seven or eight do not have landing strips and can be reached only by float or ski planes or by helicopter. Winters are long and severe; summers are relatively short. During "freeze-up" and "break-up" — usually a

month long each — communities without landing strips are isolated, which makes transportation and medical evacuation extremely difficult.

The total population of the region is about 18,000: 14,000 of them aboriginal people. Sioux Lookout, the major community at the southern end of the region, has a population of approximately 4,000 — of whom about 800 are aboriginal people and the rest non-native.

Although the region north of the town of Sioux Lookout may seem harsh and forbidding to visitors, it is home to some 14,000 people. The land is inhabited by the Cree in the north and the Ojibway in the south — although the dividing line is not distinct. For them, the region has been their homeland for many centuries. The aboriginal people within the Zone refer to themselves as "Anishinabek" (singular: Anishinabi) which means "The People." There is a mixture of language often referred to as Oji-Cree. With several different dialects spoken in the region, communication and interpretation are major problems.

For many years, the aboriginal people lived in relative isolation and had little exposure to Western or non-native culture. With improved transportation systems, there is greater mobility within the region and beyond. With radio, telephone, television and fax machines, the people within the region are exposed to life beyond the Sioux Lookout Zone and are not able to live in the same isolation. Communities that do not have running water or adequate housing now have satellite dishes and are exposed to North American television. The great contrast between life in the region and life outside has had a dramatic — and often negative — impact on life in the communities.

The growing number of aboriginal people living, working and going to school in the town of Sioux Lookout is a recent trend — a sign of the great changes that have occurred over the last ten years. With greater movement in and out of Sioux Lookout, racial tensions have grown — due to a lack of understanding (and often respect) between different cultures.

The Definition of Health

In its work, the panel decided to address the concept of "total health" as defined by the World Health Organization.

> ***Health is not merely the absence of disease but a state of complete physical, mental, spiritual and social well being. It is "the extent to which an individual or group is able on the one hand to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources as well as physical capacity."***[3]

Most of our people still believe in the healings of traditional medicine of illnesses the people have and, whenever possible, the people will look for the help of a traditional medicine doctor for treatment.

Report from Webequie-Chief and Council

This definition reflects the aboriginal people's traditional, holistic view of health. In aboriginal culture, the medicine man or healer was also the spiritual leader and the tribe's counsellor. He was responsible for physical, spiritual and mental health as well as the community's social well-being and would treat the "whole" person. On the other hand, the Western approach to medicine seems to the aboriginal people to divide life and health into separate parts or fragments, with specialists for each part.

Physical Health

Some aspects of the physical health status of aboriginal people in the Sioux Lookout Zone and in the rest of Canada has improved significantly over the last 20 years, yet it still lags behind that of non-natives. For example, between 1974 and 1983, the infant death rate for children under one year of age declined faster than that for the Canadian population, but is still twice the Canadian rate. The death rate from infectious diseases has decreased 31 per cent for aboriginal people, as opposed to 12.5 per cent for non-native Canadians — yet the age standardized death rate from infections among aboriginal people is still four times as high as that of non-natives. The rate of tuberculosis among aboriginal people has decreased greatly in the last 50 years, but still remains seven to 10 times the national rate — although there are now few deaths due to tuberculosis.[4]

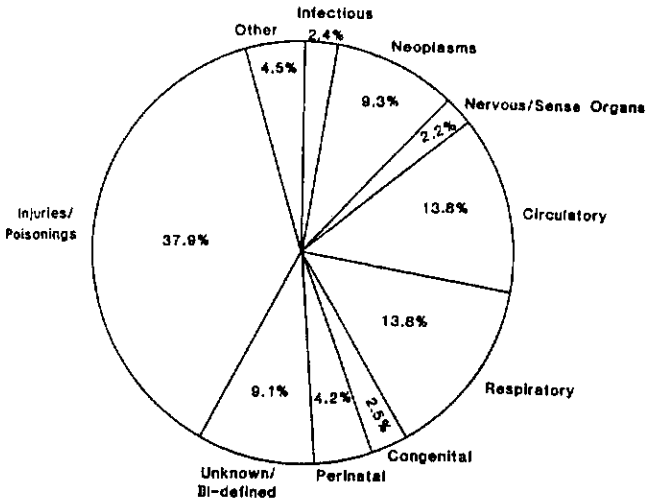
On the negative side, threats to health and health problems have changed. Between 1983 and 1987, between 22 per cent and 38 per cent of aboriginal deaths were due to accidents and violence, compared to nine per cent in the rest of the population.

Accidents, injury and violence — often related to alcohol use — are now the top causes of death in aboriginal people in the Sioux Lookout Zone.

While working in Sioux Lookout, I observed enormous changes in the political, economic and service development of the Nishnawbe-Aski Nation. Obviously the standard of living in terms of housing, overall nutrition, health and employment opportunities has risen in recent decades. Accompanying this change has been a rather disturbing, dramatic increase in problems such as marital discord, spousal and child abuse, adjustment reactions and suicide. In short, one can conclude that rapid social and cultural change has taken its toll on individual health and family life.

Joyce Timpson, MSW
Doctoral Student
Wilfred Laurier University

Causes of Death among Aboriginal People in the Sioux Lookout Zone,

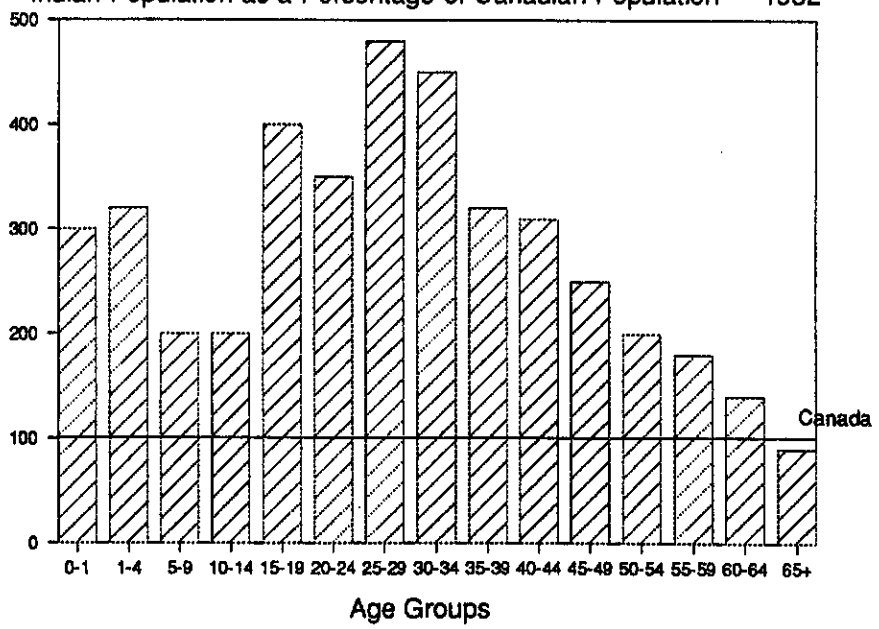


Taken from Young, T.K., Health Care and Cultural Change

The following chart compares the age specific death rate of the Indian population with that of the Canadian population as a whole (1982), indicating significantly higher death rates, particularly among young children and people between the ages of 15 and 44.

Age Specific Death Rates

Indian Population as a Percentage of Canadian Population — 1982



Aboriginal people within the Sioux Lookout Zone have also experienced an increase in chronic illnesses. The following list shows the rank order of chronic conditions for the Sioux Lookout Zone and the Canada Health Survey. It appears that aboriginal people in the region are suffering less from infections, but more from chronic conditions similar to those of the rest of the Canadian population — though the rank order is different. The increase in chronic conditions can be accounted for, in part, by the fact that people are living long enough to develop these illnesses.

Rank Order of the Diagnostic Profile of Chronic Conditions for the Sioux Lookout Zone (SLZ) and the Canada Health Survey (CHS)

SLZ	CHS
1. Cardiovascular Disorders	1. Arthritis and Joint Disorders
2. Arthritis	2. EENT
3. Psychiatric Disorders	3. Cardiovascular Disease
4. Endocrine Disorders	4. Hayfever and Other Allergies
5. Respiratory Disorders	5. Skin Disorders
6. EENT Disorders	6. Respiratory Disorders
7. Neurological Disorders	7. Psychiatric Disorders
8. Other	8. Other

A greater proportion of aboriginal people are complaining of disabilities which increase in prevalence with age. Rates of disability in aboriginal people were almost double the rates of non-native Canadians in each age group. Most of the disabilities were in the areas of mobility, hearing, agility and seeing.

Forty per cent of the zone population consists of children under 15 years of age. Accidents, injuries and violence now account for 40 per cent and non-tuberculous respiratory disease for 14 per cent of the deaths in this age group.

On the positive side, children in the aboriginal communities in the Sioux Lookout Zone have one of the highest rates of immunization and breastfeeding in Canada.

During the hearings, Panel members heard many people compare the health and health services in the Sioux Lookout Zone to that of less developed countries. While it is true that health status in the region is poorer than in the rest of Canada, it is considerably better than in most parts of less developed countries. For example, infant mortality in the Sioux Lookout Zone is 25 to 30 per 1000 births while in less developed countries, it is greater than 50 to 300 per 1000 live births. Maternal death during childbirth is almost

nonexistent in the Sioux Lookout Zone, but it is greater than 500 per 100,000 births in some parts of less developed countries.[5]

Most deaths in less developed countries are due to infectious diseases such as gastroenteritis, measles, tetanus, tuberculosis and malaria. Even though the incidence of tuberculosis is still quite high in the Sioux Lookout Zone (and in native people generally), people in the region rarely die from tuberculosis. Children in less developed countries suffer and die from malnutrition and vitamin deficiencies, while children in the Sioux Lookout Zone are more likely to suffer from obesity and dental caries. While health problems do exist in the Sioux Lookout region, they are very different from those in less developed countries. However, the most important way in which the communities in the Zone do closely resemble less developed countries is in their substandard and inadequate housing, water supplies and sewage systems, and economic development.

Dental Health

Although dental health has improved dramatically, it is still worse among the aboriginal people than among non-native Canadians — due primarily to lack of fluoride in the water and a diet that consists of too much candy, pop and "junk" foods high in refined sugar and carbohydrates.

The incidence of dental caries in school children — who have access to school dental and fluoride programs — has decreased significantly. However, there is still a major problem with dental caries in younger children and infants. Although mothers are given fluoride drops for their babies, they do not always comply with the treatment — likely due to lack of effective education about the benefits of the drops. Dental decay due to baby bottle syndrome (taking sweet drinks through a bottle and nipple) is still rampant. In addition, none of the communities have access to a fluoridated water supply — which is the single most effective way to improve dental health.

Young people in the past listened to their parents and elders. The parents and grandparents told their children how to look after themselves and how to survive. Today, young people do not listen to their elders.

I.A., Fort Hope

Mental/Spiritual Health

Probably the greatest single problem facing the aboriginal people in the Sioux Lookout Zone — and putting pressure on the health care system — is the breakdown of the traditional, extended family unit, the loss of cultural and spiritual values and the resulting decline in mental health. During its community visits, the Panel heard repeatedly the great concern of the people about family

breakdown, lack of respect for elders, and the marked increase in alcohol consumption and substance abuse which is often associated with accidents and violence.

It has been my personal experience through the marriage separations of my own daughter and son, with children involved in both situations. Young as they are, they can understand, see and feel the broken family situation .... and when one of the parents develops new relationships, children are confused and despair. This despair eventuallly leads to rebelliousness and anger towards the parent and, eventually, the children themselves. There is growing lack of respect for the parent and other things in life.

M.O., Elder
Fort Hope

The social/cultural breakdown is exacerbated by high rates of unemployment: a leading cause of breakdowns in mental health. Adults who are unable to support their families become discouraged, depressed and less able to "parent" effectively. The adult generation are also among those who were raised in the residential schools so that much that they would have learned from their parents about traditional culture and parenting has been lost.

Many children and young people have grown up with little exposure to traditional, spiritual values. This cultural breakdown has been aided in part by television which exposes the children to an urban middleclass lifestyle very different from life in the communities. There is very little family support and very few recreation facilities or programs within the communities for adolescents. Symptoms of neglect (including high rates of school drop-outs, sexually transmitted disease, teenage pregnancy and teenage suicide) are commonplace. Several communities were extremely concerned about the alarming increase in suicides and suicide attempts among teenagers and young adults. Suicides in the 15 to 24 year old group have risen to 120 per 100,000, compared to less than 20 per 100,000 for non-natives in the same age group.[6] In addition, marriage breakdown and family violence is increasing and children have few positive role models.

I think mental health [problems] is caused by things we hear and see that are happening locally and outside. Long time ago we never heard or saw anything that was happening outside but we see it on television all the time. I don't understand English, but it still depresses me when I see starving people, floods and earthquakes. Mental health problems are also caused by wishing for things we see on television (e.g. furniture, appliances, ski-doos, etc.). We wish we had money to purchase the things we want.

M.B., Fort Hope

Often when the aboriginal people complain of poor health, they are talking less of physical health than of spiritual and mental health: the ability to function effectively as persons — whether adolescents, parents, grandparents or as a family unit. In the face of cultural change and social pressures, they feel overwhelmed and powerless. The greatest challenge to both the communities and health care providers is developing programs and services that will meet these serious spiritual and mental health needs and help people regain or retain a sense of self-worth and dignity.

Community Health

Many of the illnesses that plague native children — otitis media, gastro-enteritis, streptococcal infection, pneumonia and influenza — could be prevented with better living conditions. Most communities in the region now have airstrips, telephones, electricity, radio and television. However, sewage disposal systems, adequate supplies of drinking water and bathing facilities are virtually nonexistent. If a formal system of public health existed in the com-

munities, people would likely be prohibited from drinking the water.

Housing is crowded and substandard, and the standard of living in the communities is low when compared to the services and facilities available in urban centres and even to those in comparable, remote non-native communities. Indeed, if these houses were in communities in the south, they would be condemned.

In fact, the standards of services and infrastructure — housing, water, sewage, etc. — in the communities in the Sioux Lookout Zone closely resemble those of many less developed countries. Because of these structural, environmental problems, the "health" of the communities within the Zone varies. Some relatively new communities — such as Summer Beaver and Muskrat Dam — are well-organized and self-reliant and have worked hard to establish local health committees, improve housing and sanitation systems and cope with social problems. Some tribal councils have defined the problems and developed strategies for improving community and public health. However, other communities — many of which have been subject to greater external pressure — do not seem to have shown the same initiative and have not fared so well.

Poor housing ... although in recent years the community has been able to build higher quality housing, the majority of band members still live in sub-standard housing with no indoor plumbing, poor insulation and insufficient heating. This is especially difficult for asthmatics, chronically ill seniors and the disabled. Water supply and sewage disposal problems have not yet been solved.

Women's Group
Big Trout Lake

People throw their laundry/dish/slop water in ditches. All this runs down in the lake. I guess that is what we drink.

C.N., Fort Hope

Self-help programs are not successful if run by outsiders. More self-help groups are required for people who have experienced problems with drugs and alcohol, family violence, "residential school syndrome", and child and sexual abuse. Community people must become more motivated, interested and knowledgeable of the self-help process. Self-help requires knowledge, skills and co-operations of all band members.

Brief from Native Nursing Students, Lakehead University

For example, the community of **New Osnaburgh** is located on an unsuitable site with no nearby source of water. Houses are crowded. The school and nursing station need to be replaced. Accessible by road and close to some major mining operations, the communty must cope with the pressure and conflict that often arises from greater exposure to the outside world.

The community itself is in distress: alcohol is a severe problem and the incidence of crime (arson, break and enter, assault, manslaughter and liquor charges) far exceeds other communities in the Zone. In this community of just over 700 people, there have been 85 violent deaths in the past eight years, 11 deaths between November 1988 and April 1989 and three violent deaths in the month between March and April 1989. Social and community problems are accelerating.

There are no adequate recreation facilities; funding for the community's crisis intervention program is coming to an end. In addition, the community has been unsuccessful in its efforts to get funding to replace inadequate housing with log homes or to begin a proposed community-planned alcohol treatment program — one based on the traditional Ojibway lifestyle which focuses on the family and a return to the land — which the Chief is convinced would be more effective than existing treatment programs.

Even communities that have taken creative steps are severely limited by the inadequacy of environmental services. For example,

the community of **Fort Hope** has recognized its health problems and formed a committee to develop and implement preventive health programs and to plan for local health delivery. During the community hearings, Fort Hope presented a wide examination of its physical, social, mental and spiritual needs: the result of extensive discussions with all members of the community.[7] Of all the visits, Fort Hope had the greatest number of people from the community in attendance — and not one was smoking: an indication that the community is taking responsibility for its own health.

However, the community is fighting against almost insurmountable odds. With no water and sewage system, the community's outhouses have polluted the groundwater, and the risk to health is great. With inadequate infrastructure and no jobs, it is unlikely that the community itself will be able to make any more significant gains in health status, without a greater investment in community services.

The problem in Fort Hope was an urban planning process that did not fulfill expectations: houses were arranged and located in a way that would make it easy to connect them to water and sewage systems. Unfortunately, the infrastructure was never built and the community plan then had a negative effect on health.

Lansdowne House is another community that has suffered the negative impacts of social change. The nursing station in the community was closed because of the violence and social disorder in the community. Because of serious social and health problems in the community, a group of residents left Lansdowne House and started Webique, a progressive community of 400 people which now has a nursing station. A second group also left Lansdowne House and established Summer Beaver, a beautiful community that has carefully planned its development, constructing all its buildings from logs, and developed great community pride.

Those who remained in Lansdowne House lost a sense of community and many turned to alcohol. However, the community has learned many lessons from its own experience and that of the new communities, and is now working to re-establish itself and develop a sense of community among its people. However, the community's "recovery" is limited by lack of services and infrastructure.

Economic Health

Many of the communities in the Zone are on land with marginal economic potential. Work is often seasonal (hunting, fishing, trapping, tourism) and there are few career or employment oppor-

tunities for young people. Unemployment often reaches 80 to 90 per cent in a community. Often the major sources of income are social assistance, family allowance and old age pensions.

Although some short-term job creation programs may be available, there are no long-term strategies to create on-going employment. Some service or administrative jobs exist with the Band office, school and nursing station and there may be temporary jobs building housing but there is virtually no productive employment (i.e. handicrafts, manufacturing, stores, etc.).

When economic development does occur in the area around the reserve communities, the aboriginal people rarely benefit from or share in opportunities. For example, the occasional boomlet in mineral exploration and lumber operations in the area offers only low-skilled, temporary jobs while bringing development that may have a long-term negative effect on the aboriginal quality of life.

In addition, governments sometimes adopt both development and conservation policies that do not take into account the potential negative effects on traditional aboriginal occupations. Although there are many pressures which encourage people to leave the traditional land-based activities, a surprising number of aboriginal people are returning to these activities. However, it is extremely difficult for a family to manage economically on these activities alone.

Thus, the health of the communities and their people — which is already vulnerable — is made worse by the lack of economic development and opportunities for people to work to support themselves and improve their status. There is ample evidence in the literature that unemployment has a negative impact on both physical and mental health. Again, there cannot be an appreciable gain in health status, without an improvement in economic opportunties.

The People's Perception of Health and the Health Care System

While the health status of the aboriginal people (as in freedom from physical illness) has improved, the people's perception of the health of their communities has not. And, in spite of real improvements, the health status of aboriginal people in the Sioux Lookout Zone seems to have reached a plateau, remaining poorer than that of non-native Canadians. Disparities and inequities still exist.

The feeling of "lack of health" and the growing number of social, cultural and mental health problems have caused frustration and anger in the communities. Many aboriginal people look to the health care system to solve these problems. Very spiritual, the

aboriginal people see life in more holistic terms than do most non-native people. They are convinced that one cannot have "good health" without right relationships with the Great Spirit. They find it difficult to understand providers talking about a person's "health" and not being concerned with her/his relationships with God, with other members of the community and with nature. They look to the health care system — as they once would have looked to the traditional medicine man or healer — to help them achieve health as they understand it, and are disappointed by what they perceive to be too narrow a focus on physical well-being.

They also expect to turn to their religious leaders (both traditional and Western) to help maintain health and are concerned that these individuals are only minimally involved in the present health care system. This is particularly true when the communities are dealing with their serious mental health and substance abuse problems. The aboriginal people are convinced that these problems are primarily inner and spiritual and should be dealt with accordingly. As a result, many people within the communities still turn to traditional healers.

However, at the current time there is little blending of traditional aboriginal healing practices and Western medicine, which could help to provide more holistic, culturally sensitive care. There are also few positive role models within the communities. This, in itself, is a sign of the larger problem of lack of aboriginal involvement in health care.

The Panel also discovered that many aboriginal people have unrealistic expections of what the present system can do and provide because they have not received enough information about health care or understood the limitations of Western medicine. For example, many complained that they are no longer receiving annual chest x-rays for tuberculosis detection. They did not realize — and had not been adequately taught — that there are now safer, better, more cost-effective techniques to screen for TB. Many people who spoke before the Panel talked about medical equipment such as ultrasounds as though the equipment itself could make the communities well.

These unrealistic expectations not only place pressure on the health care providers, but limit the people's ability to see their own role and the role of the community in health and health care. They reinforce the tendency to look to the doctors to solve problems which, as was explained earlier, cannot be solved without more community involvement, better community infrastructure, more social supports and well-planned economic development.

Long ago people were healthier. They didn't have or see the things we have now. They provided everything themselves. They killed their own food (meat) as they needed it so it was always fresh ... It wasn't until my later years that I started eating the whiteman's food. That's why people of long ago were stronger — even the women ... Deaths were rare ... Traditional medicine was also used. Since the coming of doctors, there seems to be more health problems. Why?

M.S., Fort Hope

From the time I can remember and to the time the doctors began coming up north, I find that there have been a lot of improvements. In the past, I remember, a lot of children died ... at birth or by the time they were one year old ... Today, there are not many infant deaths. In the past, when a person became sick, that person was just watched as she lay dying because people didn't know what to do. Sure, they tried their herbal remedies, but a lot of times, they didn't know what was wrong. Today, we see our children growing.

G.M., Elder
Bearskin Lake

Community Responsibility for Health

If we do not act ourselves in the community and recognize it [the problem] — we will soon see more and more violent deaths in our communities. A new problem exists which perpetuates greater hurts and wounds amongst our people and community.

M.O., Fort Hope

When the Chiefs are talking about self-determination, one of things I see lacking is that many of these leaders do not make an attempt to try and visit people, to find out what they are going through and also what they are thinking.

M.A., Big Trout Lake

There is increasing concern about domestic violence, spousal assault and child abuse in the community. We know these things happen in a community that is under great stress, and we are beginning to talk about it and plan ways to deal with it within the community.

Women's Group, Big Trout Lake

In their discussions with Panel members, many communities agreed that a "healthy community" would be one that took responsibility for itself and tried to identify both needs and available resources. Many of the communities agreed that they should try to identify the needs of particular groups (e.g. children, women, elders, the handicapped) and try to solve them by mobilizing their own resources and not always rely on the government or health providers for solutions. This willingness to take more responsibility for health marks a change in attitude in many communities and is a strength on which the people can build.

Although many of the communities have voted themselves "dry" in an attempt to prevent the social and health problems associated with drinking (a very positive step), alcohol is still a problem. Liquor — subsidized by the government in the region to keep the cost down — is often smuggled into the communities. Individuals indulge in binge drinking which often leads to accidents or violence.

However, even when communities do take the initiative in developing innovative health promotion programs, they often run into barriers such as lack of funding. For example, a nutrition pilot project, developed and implemented in Muskrat Dam, which was evaluated and proved to be effective, was unable to acquire ongoing funding.

Recently aboriginal women in the region have met to search for solutions to health and social problems such as parenting, family violence, the quality of family life, mental health, alcohol and solvent abuse, and health education. They represent a driving and dynamic force in achieving health in the communities.[8]

Health Care Delivery System in the Sioux Lookout Zone

Responsibility for Health Care

When one looks at the medical services provided to natives over time, it has been paternalistic at best and non-existent at worst.

Shirley O'Connor
President
Ontario Native Women's Association

The Zone Director [in 1969] was Dr. Sushil Mallick — in fact he was the only doctor in the entire Zone at the time. He was responsible for surgery, obstetrics and general medical care and a lot of dental extractions. There was one dentist who, of course, could do no more than extract aching teeth. I well remember my first trip to Round Lake — Dr. Mallick pulled teeth until he ran our of local anesthetic and I did the medical work.

Harry Bain, MD

Health services are usually the responsibility of provincial governments. However, because the B.N.A. Act assigned responsibility for "Indians and Indian lands" to the Federal Government, historically the Federal Government has accepted responsibility for providing health services for aboriginal people including those in the Sioux Lookout region. The Panel believes that — ***as long as this basic federal responsibility is acknowledged*** that, with the consent of the aboriginal people, the actual provision of health services can be delegated to the provincial government or to other agencies.

Over the past century, the Federal Government has struggled with the most effective way to provide health services to native communities. Before 1944, the Federal Government Department of Indian Affairs and Northern Development (DIAND) was responsible for native health as well as for other services to native communities (i.e. housing, water, sewage, roads, education, etc.).

However, in 1944, Parliament enacted the National Health and Welfare Act, and in 1945 Indian Health Services was severed from Indian Affairs and transferred to the reorganized Federal Health Department. Since that time, health care services in the Sioux Lookout Zone have been provided (paid for) by what is now known as the Medical Services Branch of Health and Welfare Canada. (Other services, such as housing, water, sewage, roads, education, social assistance, etc. remained the responsibility of what is now called Indian Affairs and Northern Development.)

Before 1949, health care delivery in the Nishnawbe communities consisted of self care, indigenous practitioners, medicines dispensed by traders and missionaries and occasional visits by physicians on contract to the Federal Government. Between 1949 and 1969, Medical Services Branch arranged for the construction of the Sioux Lookout Zone hospital and began building nursing stations and other health care facilities.

Recruiting health care professionals has always been a problem in the Sioux Lookout Zone: in 1968, there was only one doctor who was responsible for the hospital and the entire field operation. In 1969, the Canadian Paediatric Society approached Medical Ser-

vices Branch and offered to assist in providing health care to Native communities across Canada.[9] In addition, Dr. Harry Bain, then Head of the Department of Paediatrics of The Hospital for Sick Children in Toronto, wrote to Medical Services Branch and offered the services of the hospital and its medical staff in any project dealing with Native people.[10] As a result of this initiative, Medical Services Branch contracted with the University of Toronto to provide medical and dental services in the Sioux Lookout Zone.

Since their inception in 1969, the services offered through the University's Sioux Lookout Project have increased and expanded.[11] The number of positions for full-time physicians has increased from three to 10 — however of these ten positions, there have never been more than seven filled and, even then, only for a short period of time. Through the project, approximately 150 additional physicians, specialists (dentistry, psychiatry, obstetrics, gynecology, surgery, optometry, ear, nose and throat, etc), residents and other health providers spend from a week to a month each year providing care in the region and learning about the health problems of aboriginal people.

There is little doubt that the range and quality of health care services in the Sioux Lookout Zone has improved dramatically since the University of Toronto Project became involved, and that more and better services have led to the improvement in health status among the aboriginal people. However, as indicated in the previous section, the people's health status seems to have reached a plateau — at a level lower than that of non-native Canadians. The following pages describe the current health care delivery system and the opportunities to strengthen or enhance it.

I have been with Medical Services Branch for 23 years, working with native people. Coming from a family with native ancestry, I feel I can understand the problems of the native people: the anger and frustrations which are often directed in the wrong direction — i.e. health care, doctors, nurses, administration.

I feel Medical Services provides a good health care program and a very generous one at that ...

Health care has come a long way from the days of eight full cribs in a room that you had to push cribs up against each other to reach the child you needed to attend, and no mothers or fathers to comfort a sick child. These children were very sick and over the years the Paediatric ward has declined to often only one or two children. This alone shows the good preventive medical care given in the north

E. C., RNA

The Cost of Health Care

In 1988/89, the cost of health care in the Sioux Lookout Zone was $24,522,000 — or the equivalent of $1,630.45 per person. This figure does **not** include the cost of services paid for by the Ontario Health Insurance Plan (OHIP) which includes same physician services and hospital treatments.

Between 1987/88 and 1988/89, the single greatest increase occurred in payments for non-insured services which includes transportations, eyeglasses and drugs. The cost of these services increased 46.75% from $6,072,000 to $8,831,000 or from $430.40 per person to $587.17 per person.

The cost per capita for health care is higher in the Sioux Lookout Zone than in most of Canada — which is partly due to the expenses inherent in providing health care in a remote, sparse-

ly populated region (e.g. transportation, lack of economies of scale, etc.).

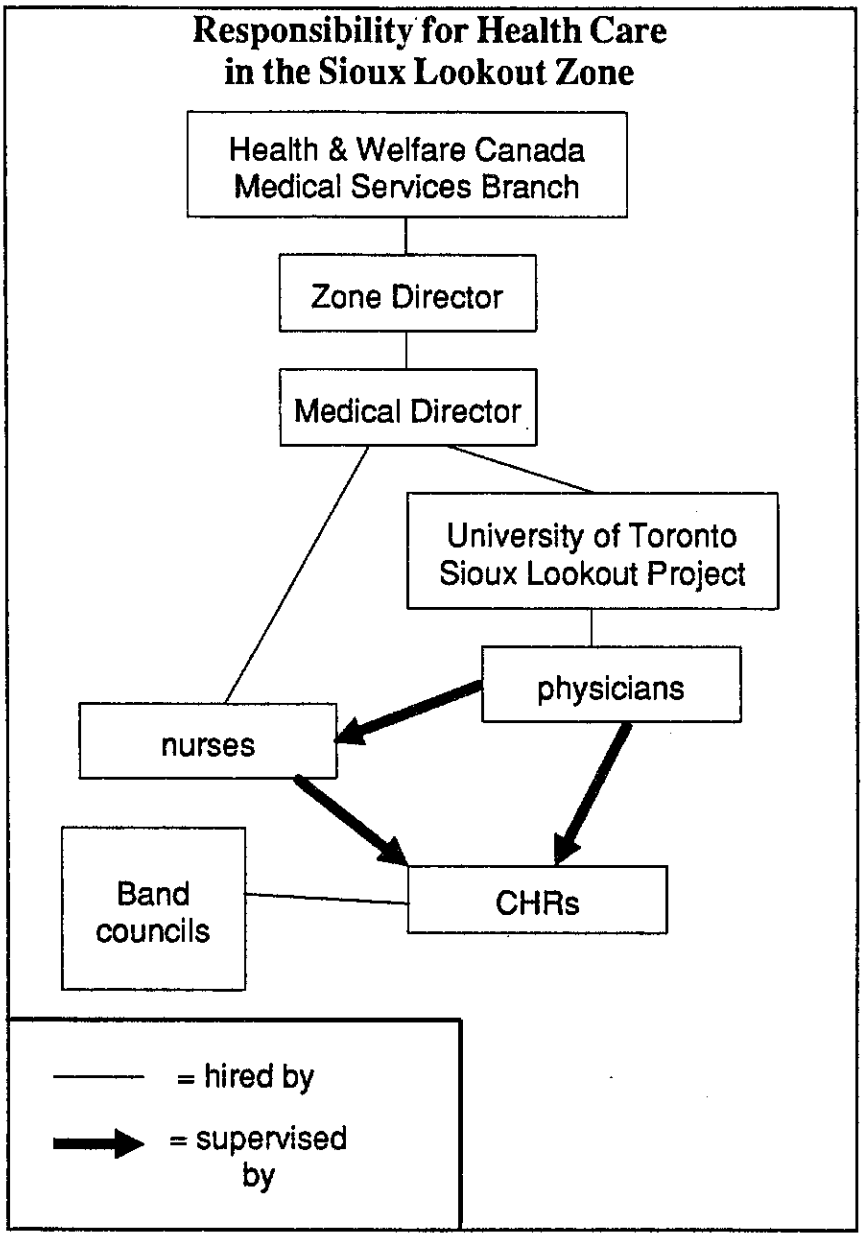
Since the advent of the Ontario Health Insurance Plan in the early 1970s, the Ontario Ministry of Health has paid the premiums of all aboriginal people. The Provincial Government also provides block funding for the Zone Hospital and nursing stations. In 1988/89, the Ontario Ministry of Health provided $3,220,081 of the hospital's $5,471,500 budget, and contributed $998,421 towards the operation of the nursing stations. This does not include the money that the Provincial Government paid in OHIP billings for physician services. In addition, with OHIP coverage, the aboriginal people in the Zone can choose to go to the General Hospital for service — rather than the Zone Hospital — and to use other physicians in Sioux Lookout, Winnipeg, Red Lake and Dryden which many now do.

The Panel is aware that the Federal Government transfers money to the provinces for health care, but these actions by the Government of Ontario are a sign of its commitment to aboriginal people and their health. (It was interesting to learn that most aboriginal people in the region were not aware that the province contributes substantially to their health care costs.)

Planning and Administering Health Services

Medical Services Branch (MSB) plans, provides and maintains medical facilities in the region and has contracts with the University of Toronto Sioux Lookout Project and, recently, with the Ontario Dental Association and the Ontario Optometrist Association to deliver health care. Health programs and services are developed by MSB personnel in the region in collaboration with the University of Toronto Sioux Lookout Project and presented to the Medical Services Branch for funding.

At the present time, health care in the Sioux Lookout Zone is designed by the government and the health care providers and delivered to the aboriginal people. With the exception of one annual meeting involving representatives of Medical Services Branch, the University of Toronto and the Nishnawbe-Aski Nation, the people and the communities have little direct involvement — except as recipients of services. Although some Bands have been given limited administrative responsibility — that is, the right under contribution agreements to hire or appoint their own Community Health Representatives and referral clerks and administer some services such as local transportation — there is vir-



tually no formal aboriginal involvement in developing health policies for the region, in determining the type or level of health services or in designing health care programs.

It should be noted that this lack of involvement is not unique to the Sioux Lookout Zone nor to aboriginal people: consumers of health care in all parts of Ontario and Canada want more control over their health care. This is part of the growing consumer awareness movement that has characterized North American society for the past 25 years. However, the lack of aboriginal involvement in health care in this region is compounded by the fact that there are very few aboriginal health care providers or administrators. The aboriginal people feel they do not have an effective role at any

level of the system. (The one exception is the region's Mental Health Program which is now staffed and organized predominantly by aboriginal people.)

The aboriginal people recognize that it will be a number of years before there will be enough trained aboriginal health providers to help develop a health care system that is more culturally sensitive and appropriate. In the meantime, they are looking for a greater role in planning and administering their health services.

The Federal Government has initiated a process of transferring administrative control of the health care system to local communities, negotiating the transfers community by community.[12] Although the pre-transfer studies have been very valuable for some communities and have given them a meaningful opportunity to examine their health status, the Panel does not believe the present pattern of transfer can or will work in the region because:

- It transfers administrative control only — and does not give the aboriginal people the right or responsibility to develop policies, make decisions or exercise fiscal control over the health care system.
- It does not encourage the aboriginal people to take responsibility for health or to recognize the need to integrate local primary care services with secondary and tertiary care to develop an adequate health care system.

In fact, current transfer discussions are creating a situation where the native communities within the Sioux Lookout Zone compete for limited resources, rather than planning, co-ordinating and sharing services to the benefit of everyone in the region. The Panel feels that the draft proposal made by the Chiefs of the area represents a more appropriate approach.

The Current Health Care Delivery System

The health care delivery system in the Sioux Lookout Zone consists of a base hospital and a field operation of nursing stations and satellite health stations. The model of care in place in the region relies on providing primary care in the local communities which have access — through transportation and communication systems — with primary and secondary care at the Zone Hospital in Sioux Lookout and with tertiary care in other centres.[13] The ability of the system to provide good care depends on the calibre of health care providers, facilities and equipment at each level and on the efficiency of the transportation and communication systems.

Facilities

Facilities include a 50-bed and 10-bassinette Zone Hospital and a 50-bed hostel in Sioux Lookout, linked by telephone and fax machine with Nursing Stations located in 12 of the larger communities in the Zone and by telephone with health stations in smaller satellite communities. In addition, there are regularly scheduled flights between most communities and the town of Sioux Lookout.

The Zone Hospital

The hospital, built in 1949, is completely inadequate, inefficient to operate and extremely costly to maintain. The other hospital in the town of Sioux Lookout, the General Hospital, which serves the non-native population, is also old and inadequate. Discussions have been underway for a number of years on closing the Zone Hospital and either replacing it with a new aboriginal hospital or amalgamating the two hospitals and building a new facility which would serve both non-native and native people.

Long delays in deciding the hospital issue, and apprehension about the possible negative effects of an amalgamated hospital — particularly on aboriginal culture and the ability of aboriginal people to control their own health care — have been one of the main causes of frustration among aboriginal people in the Nishnawbe communities and was a major reason for the hunger strike. Lack of discussion about an amalgamated hospital have also been

a cause of frustration among the non-native community and has been one factor in the growing racial tensions in the area.

During the course of its hearings, the Panel discovered there was a great deal of support among aboriginal people for an amalgamated hospital — ***as long as the aboriginal people could be assured that:***

- Their voices would be heard.
- They would have equal opportunity for input into the operation and services of the hospital (i.e. representation on the Board based on population).
- The hospital would provide care and service that is culturally sensitive.
- An amalgamated hospital would not undermine the Federal responsibility for health care.

The Hostel

Patients disapprove of the size of the hostel and fear to be accommodated at a hotel.

Report from Summer Beaver

The hostel adjacent to the hospital provides lodging for individuals who must come to the hospital for treatment but who do not require hospitalization (outpatients). Initially the hostel was used to house pregnant women who are flown into Sioux Lookout approximately two weeks before they are scheduled to give birth so that they can have their babies in hospital. Now, it also houses people requiring a broad range of medical services.

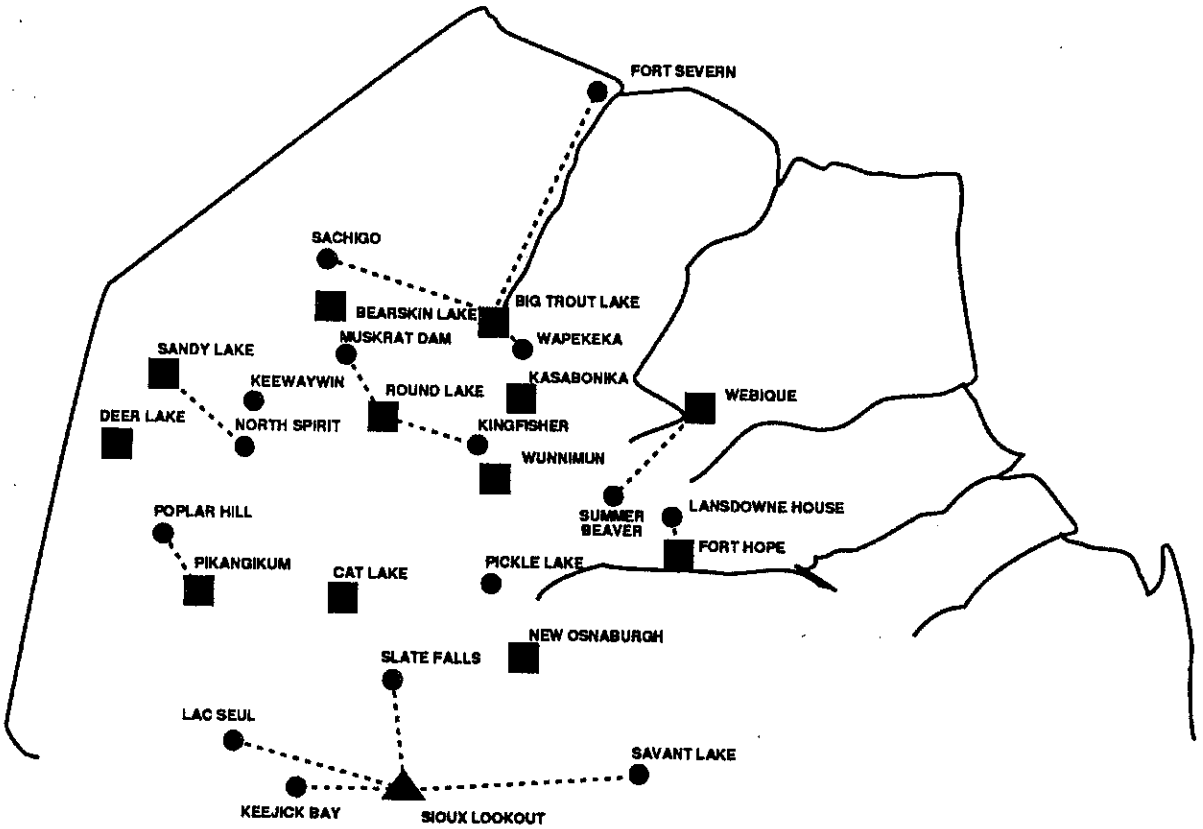
The hostel is always full and is no longer large enough to meet the outpatient needs of the Zone. Many patients must be placed in hotel rooms in Sioux Lookout or Dryden. The building — originally a nurses' residence — was never designed for its current use, is in poor condition and quite inadequate.

The Nursing Stations

In general the nursing stations are in good condition. Some, such as those in Cat Lake and Wunnumin Lake, are well-located, extremely well-designed to meet their communities' present and future health needs and could be models for health clinics anywhere in Canada. However, some of the older buildings are in need of remodelling or replacement (a process which is underway), and a number of communities which have grown to an adequate size are waiting for stations to be built.

The map on the following page show the location of the nursing and health (or satellite) stations.

Nursing and Health Stations in the Sioux Lookout Zone



Two major problems with the nursing stations relate to the housing for the nurses. This housing is attached to the station itself, which means that the nurses find it very difficult to get away from their work. In addition, the type of housing required to attract nurses is far better than the other housing in the communities. This disparity tends to reinforce cultural differences and make it more difficult for the nurses to become part of the community.

The quality of health facilities in satellite stations varies: some are in poor condition while others are quite adequate; in some communities, the stations have been vandalized. Medical Services Branch does have a long-term plan to build new stations where they are needed and to renovate or replace those which have become run down or inadequate. However, many communities will have to wait a number of years before receiving adequate facilities.

Some members of the communities complained that the nursing stations are not adequately equipped. However, the nurses themselves feel they have all the equipment they can use. (See Appendix 5.) This is one concrete example of the lack of understanding many in the communities have about the type and level of service that can be provided in a primary care setting.

We lack a proper vehicle in which to transport patients from the reserve to the airport. With our existing means of transportation, any patient who is ill and requires an I.V. — sometimes the I.V. freezes before the patient gets to the airport. It is too cold in the winter and patients should be inside a vehicle not at the back of a truck.

M.M., Lansdowne House

Transportation

Transportation is a key component in the type of health care system operating in the Sioux Lookout Zone, and transportation within the region has improved greatly in recent years. However, because of the nature of the area — small, remote, fly-in communities — transportation remains a complex issue and a source of many complaints.

We now never hear that desperate crying voice of the nurse at the other end of the radio phone, calling for help with only one doctor in the hospital and weather out for float planes or having to wait for daylight.

Today we have a modern air evacuation plane that arrives at the nursing stations in less than an hour, fully equipped and trained paramedics to transfer the sick to a larger centre where they can get the medical attention they need. The air strips in each settlement are a plus in health care.

E.C., RNA

Within the Communities

Some of the communities are spread over a large area and located a considerable distance from the landing strips. Many complained about problems travelling to and from the nursing stations and to and from the landing strips.

Between the Communities and Sioux Lookout

With the building of landing strips in most of the communities, there are now regularly scheduled daily flights between Sioux Lookout and all the communities with Nursing Stations and some of those with Satellite Stations. Patients referred to the Zone Hospital for testing or treatment are flown in and out of the communities on regularly scheduled flights. Pregnant women are sent out approximately two weeks before they are due to ensure that they will have access to more specialized care if required (e.g. blood transfusions, etc.) during delivery.

Any necessary emergency medical evacuations are provided by the Ontario Ministry of Health Medivac air ambulance program. Bandage 5 is stationed in Sioux Lookout and the emergency helicopter is stationed in Thunder Bay, and are dispatched from a central base in Toronto.

Patients that get flown out receive better examination and are better treated.

E. B.
Weagamow Lake

Last summer, I escorted an elder out to hospital in Sioux Lookout. We sat and waited at the airport for half a day to be picked up. I finally told one of the workers that we were going to the hospital and that we needed a taxi. (At least, that's what I think I said I don't speak English.) Anyway, we were picked up shortly after that.

J.A., Fort Hope

Authorization for a Medivac or an escort have been refused patients at times — even though clinic staff have recommended it. This is frustrating for the clinic staff because the nurses and doctors do not trust their judgement and experience. In some cases the Chief and Council have stepped in and authorized the Medivac or escort, even though the nursing station did not agree. This type of conflict situation places even more stress and pressure on the sick person and the community members who are trying to help them.

Report from Lansdowne House

Within Sioux Lookout

Within the town of Sioux Lookout, patients must be transported from the airport to the hospital. In addition, some services and equipment — such as ultrasound — are shared between the Zone Hospital and the General Hospital so patients often have to be transferred between hospitals for diagnostic and specialist services.

Transportation is also provided between the hospital and hotels for those patients who, because of a shortage of hostel space, must stay in hotels in Sioux Lookout (or, occastionally, in Dryden).

To Tertiary Care Centres

Patients requiring tertiary care are flown to Winnipeg or Thunder Bay either directly from their communities or from Sioux Lookout. Ambulances are often needed to take them to and from the airports at each end of the journey.

Escort Services

As part of the transportation service, escorts will often accompany patients out of the communities to Sioux Lookout or from Sioux Lookout to tertiary care centres and interpret — if necessary — for health providers in Sioux Lookout.

The problems that arise with the complex and often competing demands for medical transporation are:

- The seven or eight communities without landing strips are isolated during "freeze-up" and "break-up" and medical evacuation during that time is extremely difficult.
- Bands can enter into contribution agreements with MSB for funding to provide medical transportation within the communities but, because of the growing demand, costs are extremely high — which means there is less money for other health initiatives in the community.
- When patients travel by regularly scheduled flights, they are sometimes "bumped" to accommodate other travellers, and travellers are sometimes "bumped" off flights in order to accommodate patients, and the situation creates great frustration.
- Bandage 5 stationed in Sioux Lookout cannot fly into a number of the communities because their airstrips do not meet regulations. Instead, the communities must depend on small, local commercial aircraft in medical emergencies.

- Because the helicopter is stationed in Thunder Bay, there can often be a considerable delay before it responds to a call.
- Dispatchers in Toronto are often unaware of local conditions and sometimes do not respond appropriately.
- Because of poor communication and the level of demand on local transportation services, patients often wait an unreasonable length of time before being transferred from the airport to the hospital.
- Ambulances which must be used to transfer patients between hospitals, or between hotels and the hospital, are sometimes not available when emergencies arise.
- People acting as escorts often use the opportunity to get out of the community and do not fulfill their responsibility to assist and interpret for the patient once they arrive at their destination.
- Transportation is one of the major, uninsured health-related expenses in the region.

Getting a patient or injured person out of Summer Beaver, there is always the agony of waiting for what the nurse has to say. The nurse can only hear but not see over the telephone to fully realize what the situation really is.

Report from Summer Beaver

One half of the respondents [to the community survey] had left Cat Lake for medical care during the past two years. Of these, about one third had made one or two emergency trips. The most common place visited has been the Zone Hospital in Sioux Lookout, followed by the Winnipeg Health Science Centre.

Chief Albert Wesley Report from Cat Lake

Communication

Health care in the region depends on effective communication and a number of systems are in place. During the past 20 years, communication systems have improved significantly. In the early 1970s, nursing stations had only unreliable radio connections with the Zone Hospital. All nursing stations and health stations in satellite communities are now linked by phone — and many by fax machine — with the Zone Hospital which has greatly improved communication, diagnosis and care.

Telemedicine

Since 1977, through the initiative of the University of Toronto and the University of Waterloo, the Sioux Lookout Zone has pioneered the use of an audio-visual telemedicine program which uses existing telephone lines to transmit slow scan (freeze frame) video.[14] The system links the Zone Hospital with all Nursing Stations and with the Hospital for Sick Children and Sunnybrook Medical Centre in Toronto. All nursing stations and most satellite stations also have a hands-free phone that staff can use to tie into the program. However some stations still require the hands-free phone and others would benefit from having the necessary video equipment.

The telemedicine system is always available for emergency consultation. Nurses can contact physicians at the Zone Hospital,

who in turn can communicate with physicians in Toronto or in Winnipeg for advice.

In addition, telemedicine is used very effectively for continuing medical education for nurses, doctors, community health representatives and other health care providers. The existing program includes:

- a weekly one hour session between all field units, the Zone Hospital and the Hospital for Sick Children in Toronto
- a monthly medical session with Sunnybrook Medical Centre
- a one hour session every two weeks between Zone Hospital nursing staff and field nurses on medical and nursing problems (nurses working in Moose Factory frequently join in)
- a weekly one hour session for CHRs with resource people at the Zone Hospital
- a weekly session between workers in the Zone Mental Health Program and Dr. Harvey Armstrong, Director of the University of Toronto Sioux Lookout Mental Health Program, to discuss problem cases
- a monthly session between doctors and nurses at the Zone Hospital and the Obstetrical Service of Women's College Hospital to discuss perinatal problems and difficult cases

Trail Radios

Within the region, Wawatay (the local aboriginal news, radio and television operation) rents trail radios to individuals who are working in the bush. With the radios, the hunters or trappers can stay in contact with their communities, call for help in a medical emergency or be contacted if a member of their family becomes ill.

The Media

The local aboriginal news, radio and television system — Wawatay — is an excellent source of information and communication in the region.[15] Wawatay regularly provides health education and information in a way that is culturally sensitive and easy for people to understand. However, more could be done through Wawatay to educate people and encourage them to take more responsibility for their health.

The other media influences are less positive in that they expose the communities to the materialism which is in jarring contrast with life in the region. They also expose young people to violence and pornography — all of which is having a negative effect.

Language Barriers/Interpreter Services

While systems exist to help providers communicate with one another, one of the greatest weaknesses of health care delivery in the region is the perceived lack of understanding or failure to communicate between the providers and recipients of health care. Some of this is due to language barriers. Most non-aboriginal physicians and nurses do not speak Oji-Cree and that greatly limits their ability to communicate, particularly with older patients. When visiting in the communities, they must rely on interpreters who are either members of the patient's family, the referral clerk in the community or a CHR. When a CHR must work as an interpreter, that means that he or she is not available to provide other health care.

At the Sioux Lookout airport, there are now two full-time interpreters to assist people coming in from the communities; at the Zone Hospital, there are seven staff who can interpret in addition to their main job, but there is no one hired specifically as an interpreter and these seven cannot meet all the needs. There is no one who can interpret on duty at the switchboard at night and, therefore, staff must often serach to find someone in the hospital who can interpret, such as a night watchman or a nurse.

The baby was really sick. The doctor examined the baby but he said the baby would be fine in 12 hours ... the baby's fever would not come down. I was really scared and frustrated and I called the nurse in Pickle Lake to see if she could see the baby. She refused. I called the nurse again, again she refused ... I even called the Ontario Provincial Police.

N.K., Osnaburgh

Native people are never believed when they say something.

M.M., Lansdowne House

Cultural Barriers

Some of the communication problems between providers and recipients are due to cultural barriers and misunderstandings which lead to inappropriate expectations and assumptions on both sides. Providers are often insensitive to aboriginal culture and, because this issue has not been taken seriously enough in the current health care system, many providers make little effort to learn from the people or participate in life in the communities. For example, many providers complain that they are not invited into the aboriginal people's homes, and they take this as a sign that the people do not want a closer relationship. But, in fact, it is not the custom of the aboriginal people to extend formal invitations. Instead, their doors are always open and visitors are always welcome. When providers do not "drop in", the aboriginal people assume that they want to remain separate from the community.

On the other side, many aboriginal people have unrealistic expections — because of a failure by providers to communicate to them the capabilities of the health care system. Cultural differences often lead to distrust which affects the aboriginal people's perception of the care they are receiving.

The hospital has a program to orient staff to cultural sensitivity to Native patients, but due to the high rate of staff turnover and the actual program, it has not been overly successful ... if there was a greater degree of cultural understanding on the part of non-native medical personnel of native life and a knowledge of medical practice by natives, many problems would be alleviated.

S.O., Ontario Native Women's Association

Staffing

One of the concerns I have is in the services provided for non-English speaking patients who have to travel to those centres where there are medical facilities. I had an experience, about a year ago, where I had an accident and required medical care outside the community. The only thing that was given to me when I went out was an envelope. I wasn't given a translator or anybody to go with me. When I got to the centre, I had a hard time when the nursing staff were inquiring about what had happened to me. I couldn't tell them anything because I don't speak or understand English. Even though there were services, they are still inadequate to provide what was required for people who don't speak English.

J.M., Big Trout Lake

Caught between physicians and nurses — their clinical superiors — on the one hand, and chiefs and community members on the other, the health aides [CHRs] are expected to shoulder heavy responsibilities far beyond their technical training and preparation. That they have performed admirably well under adverse conditions is a tribute to their commitment and dedication.

Kue Young
Health Care and Cultural Change

Health care providers in the Sioux Lookout Zone consist of:

- the Medical Director
- full-time family practitioners who see patients at the Zone Hospital and make visits to outlying communities (The frequency of the field visits depends on the number of physicians at the Zone Hospital and travel conditions.)
- visiting physicians, specialists and residents who work in the region for one week to one month each year
- medical students who assist qualified physicians
- nurses who work at the hospital
- full-time and part-time dentists and dental interns (fully licensed), based at the Zone Hospital, who visit communities in the field
- Zone Nursing Officers who direct the field operations
- nurses who live in the communities, run the nursing stations and provide primary care
- community health representatives (CHRs) who come from the communities, are hired by the Bands and either work with the nurses at the nursing stations or run the satellite stations in the smaller communities, providing primary care and health education
- referral clerks who are hired by the Bands and act as interpreters
- hospital interpreters
- co-ordinators of mental health programs and the CHR program based in Sioux Lookout
- mental health workers
- support staff, such as lab workers and radiology technicians

All physicians working in the region are hired either through MSB or the University of Toronto; all nurses are hired by MSB; CHRs and referral clerks are now selected and hired by the Bands. While the nurses and physicians report to the Medical Director and the MSB, in theory the CHRs and referral clerks are accountable to the Band and the community. In reality, many of the CHRs complain about being caught between the expectations and authority of the Band (community) and the nurses or doctors (MSB).

During the course of the hearings, it became clear that many in the Zone communities did not have enough information on the skills and training of the health care providers who serve them. For example, many people in the communities told the Panel that they

did not want to be used as "guinea pigs" by medical students, and they included as "medical students" the second year family practice residents and pediatric residents (who are fully trained, qualified and licensed doctors doing post graduate work). Medical students *are* involved in the health care delivery as part of their training, but they work only under the supervision of a licensed doctor and can not provide treatment independently. ***When the people felt they were receiving second class care, they were, in fact, receiving care from the same mix of professionals as patients in large teaching hospitals in major cities.***

This misunderstanding is, again, a symptom of the lack of communication between providers and the aboriginal people. To help address this communication/information problem, the Panel distributed a document that explained (in Oji-Cree) the qualifications and training of medical students, residents, fellows and interns.

Recruiting

While the number of providers involved and the organization of health care delivery in the Sioux Lookout Zone looks impressive on paper and is a major improvement over what was available before the University of Toronto became involved, many of the complaints from the communities indicated that problems still exist. While inadequate communication and lack of cultural sensitivity were the basis for some complaints, it became clear that a major contributing factor is understaffing — which is due both to the inability to recruit health care professionals and an inadequate number of person years available in some categories.

Many people in the communities seemed to feel that the Federal Government has the authority to send doctors and nurses wherever they are needed and is simply refusing to do so. ***This is not the case.*** For example, the efforts by the B.C. government to restrict the number of doctors in parts of the province where there was an over-supply by withholding billing numbers was found by the courts to be illegal. ***Medical personnel must be recruited and retained; they cannot be coerced or ordered.***

It should be noted that the problem of recruiting doctors and nurses is not unique to the Sioux Lookout Zone. Canada and Ontario suffer from an oversupply of medical personnel in large urban centres and a shortage in rural and northern areas. The situation is particularly severe in remote and isolated communities — both native and non-native.

Recruiting health care professionals for the Sioux Lookout Zone is particularly difficult. As indicated earlier, there are positions for 10 full-time physicians in the Zone, but there have never been more than seven on staff at one time. At the nursing stations,

there are positions for from two to five nurses — depending on the size of the community and the number of satellite communities it serves — but there are often vacancies because of the inability to recruit and retain nurses. There are several reasons for recruitment problems:

- Non-native people coming to the region must work in a different cultural context.
- The physicians must travel a great deal, often under demanding conditions.
- Nurses must live in relatively isolated communities, and often work with no one to replace them when they are ill, on holiday, on training courses or when they must leave the community for family reasons.
- All personnel face heavy workloads in the face of almost impossible expectations.
- Until recently, physicians working in the region also faced considerable financial sacrifice.
- There is a severe shortage of aboriginal people — particularly those from the Sioux Lookout Zone — pursuing health careers. Although community health representatives (CHRs) and referral clerks are recruited from the communities, they are seldom encouraged to study and advance to become nurses or to pursue other health-related careers.

One of the greatest problems in the Sioux Lookout Zone has been the lack of community involvement in recruiting and retaining health care providers. However, this is beginning to change. For example, people in Bearskin Lake and other communities have worked hard to make sure the nurses feel appreciated and part of community life.

Present Health Services

Health care in the Sioux Lookout Zone is organized into a system of primary care services provided in the communities, with secondary care provided in Sioux Lookout and tertiary care in Thunder Bay, Winnipeg and Toronto. Panel members are aware that there are differences of opinion in academic circles about the definitions of care — particularly of primary health care — and have chosen to work with the following definitions:

Primary Care. Basic health services for day to day care for patients by physicians and other providers, and requiring the lowest level of technology and special expertise by comparison with secondary and tertiary care. Found in doctors' offices, nursing stations and health centres.

Secondary Care. Intermediate level care provided by family practitioners with special interests and appropriate training, internists, general surgeons, pediatricians, obstetricians and others — usually on referral by primary care providers. At this level, technology is not as sophisticated nor the skills as specialized as in tertiary care. Secondary care usually takes place (inpatient or outpatient) in a general community hospital but may also occur in specially-equipped doctors' offices, clinics or hospitals which also provide tertiary care. ("Grey areas" in secondary care depend on the expertise of the doctors and the sophistication of available equipment. For example, some community hospitals in large centres may do hip replacements, open heart surgery and other complex procedures.)

Tertiary Care. Most highly specialized level of health care services, characterized by highly trained specialists and frequently by highly sophisticated technologies. Usually requires very specialized facilities and professional skills which are commonly found only in university teaching hospitals.

The International Dictionary of Medicine and Biology Vol. 1, John Wiley & Sons Inc. 1986 (modified)

Primary Care

In the local communities, primary care is provided by nurses and CHRS.

The Role of the Nurse

The field nurses — who have been trained in special nurse practitioner or community health nurse courses — of necessity perform

I have also had the experience of working in the northern nursing stations, and I raise my hat to those nurses who give their best up there. This area of health care has improved and become the best it can be — with the shortage of staff.

The nurses are better prepared for northern nursing in isolated areas, and they do their best.

E.C., RNA

I feel the nurses should respect the knowledge of our health committee and leaders, and not have that "I know it all" attitude.

Bryan Beardy
Weagamow Lake

The northern nurse needs more information on native culture. We need to know more to understand the lifestyles of the people we work with — healthy or not. This knowledge helps the nurse to provide better care and feel less isolated ... medicine men could have input into the program ... there may even be co-operative care given by the medicine man and the nurse when one has a patient who has spiritual as well as psychological needs that are unique to native culture.

Tara Cox, CN

many of the tasks normally done by physicians, including diagnosing disease, prescribing treatments and performing minor surgery. In his book, Kue Young summarized a nurse's activities on a typical day:[16]

- holding a regular clinic for a variety of medical conditions
- holding special clinics for immunization, well-baby examinations, prenatal care, chronic disease follow-up (these preventive services constituted up to 20 per cent of all patient visits)
- home visiting, on foot, by snowmobile, canoe, truck or on snowshoes or skis
- in-patient care, which may include sick babies, women in labour, accident victims or other less critical patients
- doing paperwork: forms, reports, transportation warrants, requisitions, etc.
- providing health education, individually or in groups
- preforming in a public relations capacity, attending public meetings with community leaders
- communication with the hospital or satellite communities
- escorting patients on medical evacuation
- making regular and emergency visits to satellites, supervision and teaching of CHRs during those visits
- cooking for visitors (physicians, administrative superiors, etc.)
- taking inventory of drugs and supplies
- shopping for groceries
- maintaining the physical plant — anything from an overflowing septic tank to a malfunctioning furnace.

Their workload is extremely heavy. They are expected to be on call 24 hours a day (and not just for emergencies), to make house calls and to be mental health workers, patient advocates and educators. The nurses in charge of nursing stations find that they spend as much as 50 per cent of their time on administration and paperwork which could be done by someone without medical training.

Attitudes towards the nurses vary from community to community. While most communities appreciate the nurses' work, there is a lack of understanding of the field nurses' competence and training. Some communities still feel that only doctors can provide primary care and that, because they have no resident doctor, they are receiving less-than-adequate care. (This perception may be reinforced by the traditional view of our physician-oriented

health care system and by the fact that a few physicians and specialists fail to treat the nurses as full, key members of the health care team.)

Often the nurses have problems in their relationship with the Chief, Council and individuals in the community. Some of the problems are due to:

- The fact that the communities have little say in choosing the nurses who are appointed and changed with little or no consultation.
- The impossible expectations the community's have of their nurses
- The fact that many of the nurses come to the communities with little previous experience with aboriginal people, do not understand their customs and may not know how to relate to people in the community.
- The lack of a formal grievance procedure for patients if they are disatisfied with the nurse's diagnosis or treatment.

In the view of the Panel, the great differences between native and non-native cultures leads to many of the misunderstandings, frustrations and resentments about health care in the community.

Cultural orientation has not been a large part of the nursing training programs; neither have the communities nor MSB been sufficiently aware of the stress that cultural differences can place on the nurses and other health providers. While some nurses take advantage of opportunities to take courses on both medical skills and cultural orientation, the pressure of their work makes this very difficult. More must be done to make people of both cultures develop realistic expectations and be more sensitive of one another.

(Many of the nurse practitioners who originally served in the region came from Great Britain, Ireland and Australia — where midwifery was an integral part of training — and then, more recently, the nurses in the communities were graduates of the two-year nurse practitioner program at Dalhousie University or the four-month community nursing courses offered across Canada. Unfortunately the four-month CTN programs have been phased out reducing the number of nurses with the skills necessary to work in a remote, primary care health station. The Primary Skills Program has been introduced in some places to replace the CTN program.)

Most of the nurses ... want to work with the Native people but many last for only a year or two for the following reasons:

1. Burnout from lack of time off

2. Distance from family and friends for support

3. The stress of being everything to everybody and of being on call and knowing that someone could walk through the door seriously ill and wondering, "Can I handle it?"

4. Lack of knowledge and training — I learned on the job!

5. Lack of understanding ... of what the nurse's role is. Every nurse is rarely accepted as an individual, but as a representative of an institution which has wielded tremendous power over Indian people in the past. As a result of distrust and fear, there tends to be an over-reaction when a problem occurs

6. The difficult task of communicating to clients their aims and objectives in a manner that is clear, concise and understandable. It is doubly difficult when you must go through a translator.

E. J.
Native Nurse

The Role of the CHRs

Community Health Representatives (CHRs) are responsible for providing care and educating the community to improve health and — with the nurses — are the cornerstone of the health care delivery system in the region. Their tasks include:

... working as a health aide is not an easy job ... When I first started working ... I didn't know much about medical work. The only thing I knew was how to take temperatures.

Every morning from Monday to Friday, I would see patients. Each time a patient came in with a problem, I would call the nurse for advice. She would ask me about the patient's signs and symptoms. I didn't even know what to look for. This went on for a while, not knowing how to handle patients. I was getting frustrated. I almost quit ... finally I had the nerve to ask the nurse or doctor to show me how to take pulse, blood pressure, respiration, check ears, nose, throat and chest ...

I didn't get my training until a year after I started work ...

Health aides are not only dealing with medical problems. We also deal with mental, child abuse, family matters ... You name it and this is what we have to deal with. We should be called Jack-of-all-trades because we have more responsibilities than any nurse or doctor.

letter to the Wawatay News, October 1977

- assessing patients through history, physical examination, urine testing, stools, sputum, routine blood tests, uri-cultures and swabs
- holding clinics (acute care, pre-natal, post-natal, geriatric, etc.)
- taking x-rays
- referring patients to nurses and physicians
- prescribing and dispensing medication (under instructions from nurses and physicians)
- in emergency situations, delivering babies (when mothers are not transported to the hospital for delivery), administering oxygen, starting IVs, putting in sutures, etc.
- public health education (e.g. school health, home safety, blood pressure screening, etc.)
- interpreting for people in the community with visiting nurses and physicians
- doing paperwork involved for transporting patients out of the community
- testing water and improving garbage and sewage disposal (environmental issues)
- explaining the role of the Nursing Station nurses to the community

Because the CHRs were the first aboriginal people to be directly involved in health care delivery, the community expectations of them were extremely high, often unrealistic and sometimes in conflict with the expectations of the nurses and doctors, and so the CHRs feel caught between the community and the other health care providers.

CHRs are often overworked and have no one to cover for them when they are ill or on holiday. When CHRs have to act as interpreters for visiting health providers, their own responsibilities must be set aside. In some communities there are not enough CHRs to meet community needs. In communities without resident nurses, the CHR is the only health care provider and is expected to handle all emergencies, including acting as a midwife when women cannot be transferred to the Zone Hopsital to deliver their babies — even though the CHRs receive no formal training in midwifery.

They often do not receive — either from the communities or the other health care providers — adequate recognition of the important role they play.

Although CHRs are supposed to be trained to provide certain health services, training is uneven. Some start work with no train-

They (CHRs) are truly unsung heroes and deserve considerable support. They must be taught additional skills, like some of the skills taught at "Outpost Nursing Courses".

Tara Cox, CN

The CHR is the link to the community and this role must be respected. Non-Native nurses have not always been sensitive to cultural differences. These nurses can be very stern, strict and present a "scolding" attitude especially if patients call after clinic hours. This attitude does not encourage utilization of nursing services, therefore many community members seek the services of the CHR. Health professional do not give recognition to Native health workers and question their credibility as they do not possess acceptable health credentials.

Brief from the Native Nursing Students

ing. Some have received only in-service education given by nurses and physicians during their short visits. Others are involved in an innovative, culturally appropriate training course initiated by the Windigo Tribal Council[17] with funding from charitable organizations and MSB. Developed by CHRs with the support of Zone health workers, the training program is an excellent example of collaboration among communities, Chiefs and Band Councils, Treaty #3 and Confederation College in Thunder Bay.

However, there are few career change or advancement opportunities for CHRs: if a CHR moves to a different community which already has a CHR, he or she may not be able to work and his/her skills are not available to the people in the region.

All CHR positions have been transferred from MSB to the Bands in order to reduce the number of person years in MSB's budget. Although this move may make CHRs more accountable to their own communities, it has had several disadvantages:

- The Bands do not use any consistent criteria (e.g. skills, education, etc.) in choosing their CHRs.
- Some Bands do not provide training opportunities for the CHRs.
- Now that they are employed by the Bands, CHRs and referral clerks no longer have the liability coverage, pension, benefits and overtime pay they received when employed by MSB.
- Unless there is a specific provision in the contribution agreement, the CHRs are no longer reimbursed for their local transportation expenses.

As the main provider of primary health care in many communities, CHRs have a lot of responsibility, and liability has become a major issue in the Transfer Agreement for health services in the Zone.

Secondary Care

Both "primary" and "secondary" care including obstetrics, surgery, etc., are provided at the Zone Hospital in Sioux Lookout. Individuals with illnesses or conditions that cannot be treated in the communities are referred to the hospital.

In addition, the physicians and specialists visit the communities to see problem cases and provide follow-up. When physician visits to the communities are limited — either because of a shortage of doctors, weather conditions or other emergencies — the nurses and CHRs will consult by telephone with a physician and make arrangements for patients who require immediate atten-

tion to travel to the Zone Hospital where they will be seen by a physician. Under the terms of the agreement with Medical Services Branch, the Chief and council have the authority to order a medical evacuation for someone — if they feel the person needs more specialized care and the CHR, nurse and/or physician have not recognized this need. However, a number of Chiefs and Councils were unaware that they had this authority.

Through this system of physician visits, the aboriginal people in the region now have regular access to physician care — which was not true in the past. However, the physicians delivering this care often change. Because the same physician does not always visit the same communities, there is less personal continuity of care. As a result, the kind of bond and trust that usually develops between physician and patient is often absent. In addition, the aborginal people complain that the physician visits are not long enough or often enough to meet the needs of the communities. However, the frequency and length of the visits often depends on the number of physicians working in the region, the weather and the needs of the communities.

Companionship is probably the most healing process that is needed in the hospitals.

C.F, Sandy Lake

Tertiary Care

Tertiary care is provided at hospitals in Winnipeg, Thunder Bay and Toronto. Both Winnipeg and Thunder Bay now provide interpreter services to prevent the communication problems that can arise through language barriers. However, many patients sent out for tertiary care complain of loneliness and isolation. In Winnipeg, the position of patient advocate has been created to meet these needs. In Thunder Bay, the aboriginal people have organized support groups to keep in touch with patients.

Statistics indicate that some 17 to 18 per cent of people in the Sioux Lookout Zone were sent to tertiary care centres during 1987/88 and 1988/89: a sign of the concern on the part of local providers to ensure that patients receive appropriate care in appropriate settings.

Dental Care

In 1969, there was one dentist for the entire Sioux Lookout Zone, and the only service carried out in the field was the extraction of abscessed teeth to treat toothache. In 1989, the dental program in the Sioux Lookout Zone consists of:

- a dental director hired by MSB

- two full-time dentists provided through the University of Toronto contract
- 20 dental interns provided through the University of Toronto contract (fully qualified, licensed dentists who are taking specialist training) who work for three-week periods in the region
- 30 locum positions provided by contract with the Ontario Dental Association (these dentists frequently return to the same community, and some have been "adopted" by specific communities).

The program is organized centrally at the Zone Hospital where there are two fully equipped "hospital units." All nursing stations have operatories. There are eight permanent and six portable dental offices in the region — however, portable equipment weighs approximately 500 pounds and is difficult to transport.

In 1987, there was the equivalent of six full-time dentists working in the region: a ratio of one dentist for every 2,000 people. (The ratio in large cities is 1:1,300.)

Services include:

- school dental treatment program
- school brushing program
- school fluoride rinse program
- the Zone fluoride supplement program
- referral to the Zone Hospital for oral surgery and restorative services
- the initiation of a sealant program which will prevent tooth decay.

While dental service to the region has improved dramatically and many communities were satisfied with the service, some problems still exist. Some communities complained of infrequent visits or visits that were too short. Lack of accommodation in the field can affect the regularity of visits. Dentist visits may also be cancelled and rescheduled if other visiting health care providers are using the available accommodation. Visits also often have to be postponed or cancelled because of weather, staffing, illness or equipment problems.

It is interesting to note that those communities which were most satisfied with the dental service were ones which had "adopted" a dentist, had some continuity of care and had developed a level of mutual trust, understanding and appreciation.

Although the number of dentists working in the region has increased, recruitment is still a problem. At the present time, there

are no aboriginal dentists in Canada. To address recruitment problems, communities north of 60 degrees latitude are permitted to use dental therapists, graduates of a special training program offered by the National School of Dental Therapy. The dental therapists — many of whom are aboriginal people — provide both treatment and preventive services and work as part of a team with a licensed dentist. Areas using dental therapists have virtually eliminated dental disease.

Unfortunately — because Ontario is south of 60 degrees — the Ontario Health Disciplines Act will not allow dental therapists to provide treatment services — such as extracting teeth — in the province.[18] As a partial solution, the Ontario Dental Association and Medical Services Branch, have developed a proposal for a pilot project, called the Preventive Dental Workers Program, to train aboriginal people as special preventive dental assistants to carry out a dental health program which would not involve treatments or extractions. However, this program has not been funded.

The effectiveness of any dental prevention program in the region will continue to be limited by the lack of a fluoridated water supply.

Mental Health Services

The Sioux Lookout Mental Health Program (known as the NODIN Counselling Agency) is one of the few — if not the only — aboriginal mental health programs that is fully integrated with primary care and nursing services.[19] The program has recognized that, in order to be effective, aboriginal people must be involved and that services must be delivered by aboriginal people who live in or near the communities. NODIN attempts to bring together the elders, aboriginal traditions and Western health expertise to solve mental health problems.

In the spring of 1989, the NODIN Counselling Agency consisted of a program co-ordinator (an aboriginal person) and eight aboriginal mental health workers who are hired by the University of Toronto Sioux Lookout Project and supervised by Dr. Harvey Armstrong, a child and adolescent psychiatrist on staff at the Toronto Hospital for Sick Children, and past Chairman and current Director of the Canadian Psychiatric Association Section on Native Mental Health.

The objective of the program has been to teach local people diagnostic and counselling skills, thereby fostering the transfer of delivery of mental health services to the aboriginal people. The three roles of the program are to:

- manage acute care problems

- develop and upgrade community people to detect problems and intervene early
- assist with community development and eventually attain healthy communities.

Our community has a recreation program for all ages of people. This program really helps to deal with the younger generation and their boredom which could lead to a lot of unnecessary things in our community, like vandlaism, alcohol, drug and solvent abuse, and suicides. I'm not saying we have control of these, but they are at a minimum so that we could deal with them at this time. But they could be a problem for us, too, if we don't get enough programs for our youth.

Report from Webequie Chief and Council

According to presentations made to the Panel, even this progressive program cannot meet the serious, growing mental health needs in the region. Problems or weaknesses include:

- lack of a Federal Government policy on aboriginal mental health and, therefore, no adequate funding for mental health programs
- no qualified social workers in the Sioux Lookout Project
- a shortage of resources in the community for counselling
- no co-ordination among the potential counselling resources within the community (e.g. nurses, CHRs, NNADAP workers, Tikinagan Child and Family Service workers and others)
- mental health counsellors are not trained to conduct workshops in the communities to develop local counselling skills
- no suitable treatment centres within the region so patients must be sent out to receive care
- lack of follow-up services for individuals who have been referred to major centres for therapy and then return to their communities.

Community-Based Programs and Services

People living in the Sioux Lookout region are usually "sent out" to receive special treatment services. However, recently a number of community-based programs have been developed including: a proposed alcohol treatment program in Muskrat Dam, a children's centre in Sandy Lake and Chakabesh Youth Centre in Big Trout Lake. These programs — which serve people throughout the region, not just in those communities — have been developed by the Indian people and have proven to be quite successful. They have the added advantage of being culturally appropriate and of allowing individuals to receive treatment close to their homes and families.

The community of Muskrat Dam also received funding to establish a pilot project for a community-based nutrition education program. Members of the community clearly felt the project was successful (corroborated by evaluation data). However, there was

no on-going funding past the pilot stage and the program has had to be abandoned.

Given that a common complaint about health services provided outside the region is that they are not culturally appropriate, it seems likely that programs developed within the communities would overcome this problem, be more accessible and provide a more cost-effective (lower transportation costs) alternative — particularly for drug and alcohol treatment — to sending people to Kenora, Thunder Bay, Winnipeg and other centres for residential services.

At present, elderly people in need of care are forced to leave their homes, family and community to be taken care of in cities. They become more isolated and lonely, and some seem to die of this loneliness. The community needs a group home where our elderly can live among their community. This home should be near the lake and the clinic. It must have trained staff to look after the needs of our Elders.

Report from Lansdowne House

The major problems faced by elders were: lack of activities of interest to them, needed assistance to get places, excessive burden of child care and travel assistance for medical service both out of and in the community ...

Dealing with alcoholism, gas sniffing and drug overdoses is seen as the major unmet need of Cat Lake.

Chief Albert Wesley Report from Cat Lake

Lack of Health Services

Some people making presentations to the Panel complained about a lack of services in the communities including:

- lack of sufficient nurses and CHRs to meet community needs such as home visits to elders and others in the community requiring home care
- lack of training for CHRs or others in the community to act as midwives in case of emergency
- lack of mental health and other services for adolescents
- lack of extended or chronic care facilities (At the present time, aboriginal people who require extended or chronic care must be sent to Kenora of Thunday Bay, far from their families.)
- adolescent mental health programs

Many of these deficiencies are symptoms of the larger problem of understaffing. The needs of the people that are not being met clearly highlighted the importance of training more people within the community to provide either support services or appropriate types of health care.

Analysis

Most people feel that many problems encountered while getting health care are being addressed. Many felt, however, that more attention should be given to substance abuse problems and depression ...

Most people felt that the problems facing Elders were being addressed although there is a need for activities for Elders and transportation for health care.

Chief Rosie Mosquito
Bearskin Lake

Having examined — to the best of our ability — the current health care situation in the Sioux Lookout Zone, Panel members concluded that:

- The programs and services provided by the University of Toronto Sioux Lookout Zone Project have greatly improved access to a range of health services and continuity of care, and have had a positive impact on many aspects of health status in the region. The concept of a close link between the region and a health science centre is sound, and this relationship should be retained and strengthened.
- Health care providers working in the Zone are generally well-trained, dedicated and committed professionals whose work and efforts are appreciated by the people in the communities they serve.
- Taking into account that health care is being delivered to a small, sparse population in a large, rugged and remote geographical area, the quality of primary care in the communities and accessiblity to secondary and tertiary services are generally good.
- The level of primary care provided in the reserve communities is equal to — and in many cases superior to — that available in many small non-native northern communities.

In spite of the great improvements that have been made, much more must be done to strengthen and improve health care in the Sioux Lookout Zone. Issues to be addressed include:

- People within the region — like many of us — have many unrealistic expectations of health care providers because of a lack of knowledge of the health care system and a lack of understanding of the services available and of the limitations of Western medicine.
- There are serious shortcomings in the operation of the existing patterns of services which urgently need attention including:
  - the chronic shortage of personnel (doctors, nurses, CHRs)
  - the lack of formal public health services in the communities
  - the lack of care for people who are elderly or disabled

- the need for cultural sensitivity on both sides
- poor communication between care givers and care receivers due not only to language barriers but also to cultural factors
- lack of trust between the providers and receivers of health care

According to those interviewed, better water, food, housing and health knowledge are seen as the key changes required to improve the health of Cat Lake residents.

Chief Albert Wesley
Report from Cat Lake

In addition, there is a need to reassess the needs in the region and the services provided based on the following facts:

- The health needs of the aboriginal people have changed drastically. The communities are now threatened less by infectious diseases and more by:
  - accidents and injuries
  - lifestyle-related illnesses (e.g. obesity, diabetes, dental caries, high blood pressure, and illnesses related to behaviours such as smoking and inactivity).
  - illnesses associated with substandard living conditions
  - illnesses related to the breakdown of both the traditional, extended family unit and spiritual values (e.g. mental health problems, marriage breakdown, depression, etc.).
  - illnesses caused by the stresses associated with unemployment

Dealing with problems of alcoholism, dental health, overconsumption of junk food, people being overweight and spouse and child abuse were seen as the major unmet needs of our community.

Bryan Beardy
Weagamow Lake

- There has been a frightening increase in teenage and young adult suicide, violence, vandalism and substance abuse. In the face of such developments, it is hard for people to believe that communities are "healthier."
- The improvement in health status which has been achieved by focussing attention on the treatment of illness seems to have reached a plateau. Attention must now be focused on other health determinants such as housing, water supply, sewage and garbage disposal, recreational facilities and economic development.

We also need a better system for education assistance if we want native health workers. How does a native get into the system?

E. J.
Native Nurse

Looking at the health status of the aboriginal people, the services in place and the research that has been done, the Panel concluded that — except in specific cases — ***there is no indication that more physician visits or more treatment services — beyond those that can be provided by a full complement of physicians — will necessarily improve the health of the people.*** This view is supported by researchers who have worked in the region.

For example, in his research, Kue Young[20] found very little difference in health status between natives living in small "satellite" communities, served only by CHRs and visiting nurses and doctors, and those living in "nursing station" communities, serviced by resident nurses and by doctors and other health care professionals who visited frequently. ***Young concluded that the crucial factor in the delivery of service is the availability of basic primary care in all communities as well as good systems of transportation and communication.*** He thought it unlikely that more intensive medical care — for example, more frequent visits by physicians or more sophisticated facilities — would significantly improve the health of the residents.

In 1983, Duxbury[21] reached similar conclusions. She assessed the relative impact of health service factors (the types and availability of personnel and facilities) and environmental factors (socio-economic status, housing quality, degree of community control, social disintegration, etc.) on the rate of reported cases of respiratory illness and trauma. She found the health service factors, that is the presence of health workers and facilities were relatively unimportant in predicting the level of illness in the community.

The Panel concluded that:

> ***The present concept for providing health services — with primary care at the local level, primary and secondary care at the Zone Hospital and tertiary care in Winnipeg, Thunder bay and elsewhere — is very sound and should be strengthened.***
>
> ***Its future success will depend upon:***
>
> — ***increasing the capacity of the system to recruit and retain medical personnel, and***
>
> — ***encouraging a different "partnership" relationship among care providers — one that makes the most effective use of each provider's skills on the health care team.***

Based on this assessment, the Panel looked beyond the health care delivery system to other social and structural problems and reached the following conclusion:

> ***Any significant improvement in health status will depend on the aboriginal people having more responsibility for and control over their health, and on the ability of the communities and the health care system to address the illnesses that arise from mental health problems, alcohol and substance abuse, lifestyle, disability and aging.***
>
> ***It will also depend on the ability of the people to address the social, economic and environmental problems that are having a negative impact on health. The health of the people will not improve without adequate community infrastructure (housing, water, sewage, etc.) and without appropriate economic development and opportunities — factors which are beyond the individual's control.***

The Role of the Department of Indian Affairs and Northern Development

It is important to note that, while the Medical Services Branch of the Federal Government is responsible for health services in the Zone, Indian Affairs and Northern Development (IAND) continues to be responsible for the services and infrastructure that affect and often determine the health status of people (e.g. housing, potable water, garbage disposal, pollution control, fire protection, access to hydro and economic development.)

This division of responsibility has created a long-standing problem of co-ordination of services for the native communities. For example, the Booz-Allan-Hamilton Report [1969][22] recommended closer co-ordination of activities between Medical Services Branch and the Department of Indian Affairs and, in Canada's National Provincial Health Program for the 1980s, the Honourable Emmett Hall recommended that the Medical Services of National Health and Welfare be transferred to the Department of Indian Affairs to ensure that the Federal Government would have the mechanisms in place to co-ordinate and integrate services to native communities.

A similar problem of co-ordination existed in the United States until the Indian Health Services — instead of the Bureau of Indian

Affairs — was given control over the sanitation measures (i.e. water supply and sewage disposal) on reserves. In a comparative study of North American aboriginal health, It was discovered that the Indian Health Services has a far greater ability to influence the socio-economic elements of aboriginal health than Medical Services Branch. They further stated that there was greater co-ordination of effort between the agencies in the United States than in Canada.[23]

To There

A Shared Vision for Health in the Sioux Lookout Zone

A Collaborative Vision of Health

We realize what is needed in the Sioux Lookout Zone. It is a balance between preventative and curative medcine ... maximum community involvement and the use of traditional medicine, health promotion for improved lifestyles and medical personnel committed to the native culture.

Shirley O'Connor
President
Ontario Native Women's Association

There are many things that both native and non-native must teach each other in order that better health care can be provided.

E. J.
Native Nurse

There are concerns and problems but with a co-operative working relationship, we can improve what we do have today.

Bryan Beardy
Weagamow Lake

The Panel's second task was to look for what could be: a shared vision for health in the region. What were the aboriginal people who made presentations seeking? It soon became clear that the aboriginal people in the Sioux Lookout Zone — like other health care consumers — want:

- a health care system that respects their cultural values.
- control of their own health care system.
- greater availability and equality of access to health care.
- more attention given to all the determinants of health (e.g. adequate water supply, sewage and garbage disposal, housing, recreation and economic development) in addition to the treatment of illness.
- a system concerned about total health rather than the treatment of illness.
- community development.

In short, the aboriginal people envision and desire communities that support and promote health: communities that have adequate housing, water and other services and which offer economic opportunities to their members. It is their vision to build a strong, spiritual base for their children, to cope with the stresses that are causing serious mental health problems and to develop the skills required to lead healthier lives.

The people living in the region want the current health care delivery system to continue to provide the treatment services they need, but also to focus more on health promotion. They want gaps and deficiencies in the system addressed, and they want more indigenous people trained to take their place as health care providers for their communities.

To achieve this vision, the aboriginal people believe they must have control of their own health care so that they can develop a system which is culturally sensitive and takes into account the needs of the whole person. To do this, the aboriginal people are aware that they must develop:

— *a new partnership with health care providers*

— *the necessary planning and administrative skills that will enable them to manage their own health care.*

We are not asking for anything unrealistic, but as the first citizens of this great land and country, all we are asking for is improved and accessible medical care and a delivery system that is as reliable as the one people down south take for granted ...

We, the Native people, have to be more involved in the planning of services we are getting, we have to be the ones to set our priorities, not some lawyer or a Government consultant sitting in the Toronto or Ottawa office who pretends to know what is best for Native people. Until this happens, we are doomed under the government bureaucracy.

Chief Jethro Tait
Sachigo Lake

From Vision to Reality

For a vision to be a motivating force for change, it must be realistic and worth striving to achieve. It must also make sense to the people in the region — who have been shaped by different cultures but relate with one another in providing and receiving health care — and to those who set the policies and provide the funding for aboriginal health care. Those who will be involved in making the changes that will move the communities from "here to there" must share and own the vision of what can be and be willing to enter into a new "health promotion" partnership that will help "achieve health for all."

The panel shares and supports this vision of health in the Sioux Lookout Zone — as do many of the health care providers working in the Zone and many involved in formulating Canada's health policies. What is more, members of the Panel believe this vision to be achieveable.

Too much has been invested — by both the Federal Government, the Nishnawbe-Aski Nation and those who provide health care— to turn back. Expectations in the communities are high. It is now up to Federal Government and the Nishnawbe-Aski Nation — and the health care providers and the communities — to put aside differences and to develop the trust, communication and working relationships that will enable them to take the necessary steps to achieve this shared vision of health.

The presentations to the Panel gave people in the region an opportunity to share both their ideas and frustrations, make suggestions and prepare for a new beginning. One of the greatest benefits of the review was the opportunity for both providers and recipients of health care to listen to one another, learn from one another and appreciate each other's commitment and concern. And this must continue. One of the disappointments was that all too often when aboriginal people were speaking, few representatives of the health care providers were present; and when health care providers were speaking, few representatives of the aboriginal people were present. The same was true of others involved in health care delivery. When representatives of the Nishnawbe-Aski Nation (NAN) spoke, there were often few representatives from MSB (Ot-

tawa) or from the University of Toronto Sioux Lookout Project present — and vice versa.

There must be greater willingness in the future to listen to one another, communicate and work together. The momentum created by the Panel's visits and hearings must not be lost.

Steps Along the Way

The Recommendations of the Scott-McKay-Bain Health Panel

A Model for Health Care Delivery in Remote Communities

Of all the unlikely places in Canada, the Sioux Lookout Zone has the opportunity to place itself on the medical map in health service delivery. It has the ability to develop an effective field network of primary care services and facilities, linked closely — through effective transportation and communication systems — with a hospital in Sioux Lookout. In the view of the members of the Scott-McKay Bain Health Panel, this model of health care delivery — with its university connections and its training function — is the most effective and appropriate means to provide health care in the region.

Although any community in the region which is able to attract a permanent physician should be encouraged to do so, the region must recognize that it is neither possible — nor necessary — to have a physician in each community. The key roles in the communities will be played by the nurses and CHRs, with appropriate support from physicians through effective transportation and communication systems. The basic elements, organization and skills required to operate such a system already exist but they must be improved and strengthened. The five basic problems which must be addressed are:

1. The lack of aboriginal empowerment to develop policies, plan for health care, make decisions, deliver services and accept community and individual responsibility for health.

2. The lack of community infrastructure and economic development required to support and promote health.

3. The weakening of the traditional, extended family due to exposure to Western culture and the loss of spiritual values which has resulted in alcohol and substance abuse, family violence, suicide and other serious mental health problems, and a sense of helplessness and loss of hope.

4. The failure of communication between the two cultures involved in providing and receiving health care

which has led to lack of knowledge of health care, unrealistic expectations and a health care delivery system that is not always culturally appropriate.

5. The focus of current health care services on "treating illness" rather than "promoting health."

Building a Partnership

Achieving the "there" — an environment that supports and promotes health; one that is based on a partnership between those providing and receiving care, with the aboriginal people playing a lead role in developing and delivering their own health care system — will not be easy. There are no quick fixes and no easy answers. It will take time and commitment. But it can be done.

The Panel recognizes that the desired health care system can only be achieved if certain things occur:

- The Federal Government will have to be willing to change policies and attitudes and move from a "top down" paternalistic management approach to a willingness to transfer decision-making to the aboriginal people.
- Concrete steps must be taken to increase co-operation and co-ordination between Medical Services Branch and Indian Affairs, and between the Federal Government and the Provincial Government.
- The Nishnawbe-Aski Nation will have to make health a top priority, and provide the stable and effective leadership the native communities will need to promote health.
- The University of Toronto Sioux Lookout Project must be revitalized so that it can continue to provide leadership in meeting the changing health needs in the region.
- The aboriginal people must develop greater administrative and management skills so that they can truly become partners in planning and delivering health care.
- The aboriginal communities must be willing to continue to co-operate with non-native health care providers because there will not be, in the foreseeable future, enough trained aboriginal administrators or health care providers to meet health needs. It is hoped that both groups can continue to learn from one another, work together and develop the kind of partnership that will promote health and self-reliance.

- Both providers and recipients of health care must become more sensitive to each other's culture, and develop better ways to communicate and share information.
- A more co-ordinated health promotion program must be developed. A successful program will require participation by high level representatives of the University of Toronto, Health and Welfare Canada, the Provincial Ministry of Health and Nishnawbe-Aski Nation. It will also require changes in attitudes among health care providers and recipients.
- Federal funding will have to be continued and increased. (The present economic base of the reserves is not capable of supporting either the present or desired level of health service, and could not become so in the immediate future.)
- The communities will have to take advantage of the opportunity to participate in provincial health funding and programs.
- The communities must be willing to take more responsibility for their own health, contributing financial and human resources to their health programs.

This chapter describes the steps that should be taken.

Planning and Administering Health Care

The only possibility that exists for our people to receive adequate medical care is for Native people to be involved in the administration of the Health Care Services with the Human and Financial resources to run the service to meet the needs of our people.

Webequie Chief and Council Report

The main advantage [of Indian control of health services] is that the services would be more responsive to community priorities. The major disadvantages were seen to be not enough experienced staff, insufficient support, the possibility of mismanagement and difficulties in staff recruitment. However, with staff training and education, it was felt that these could be overcome.

Report from Lansdowne House

The Federal Government and the Nishnawbe-Aski Nation must work together to improve the planning and administration of health care, and to transfer decision-making authority to the aboriginal people. The following are the steps the Panel believes will make this change possible.

Aboriginal Health Authority

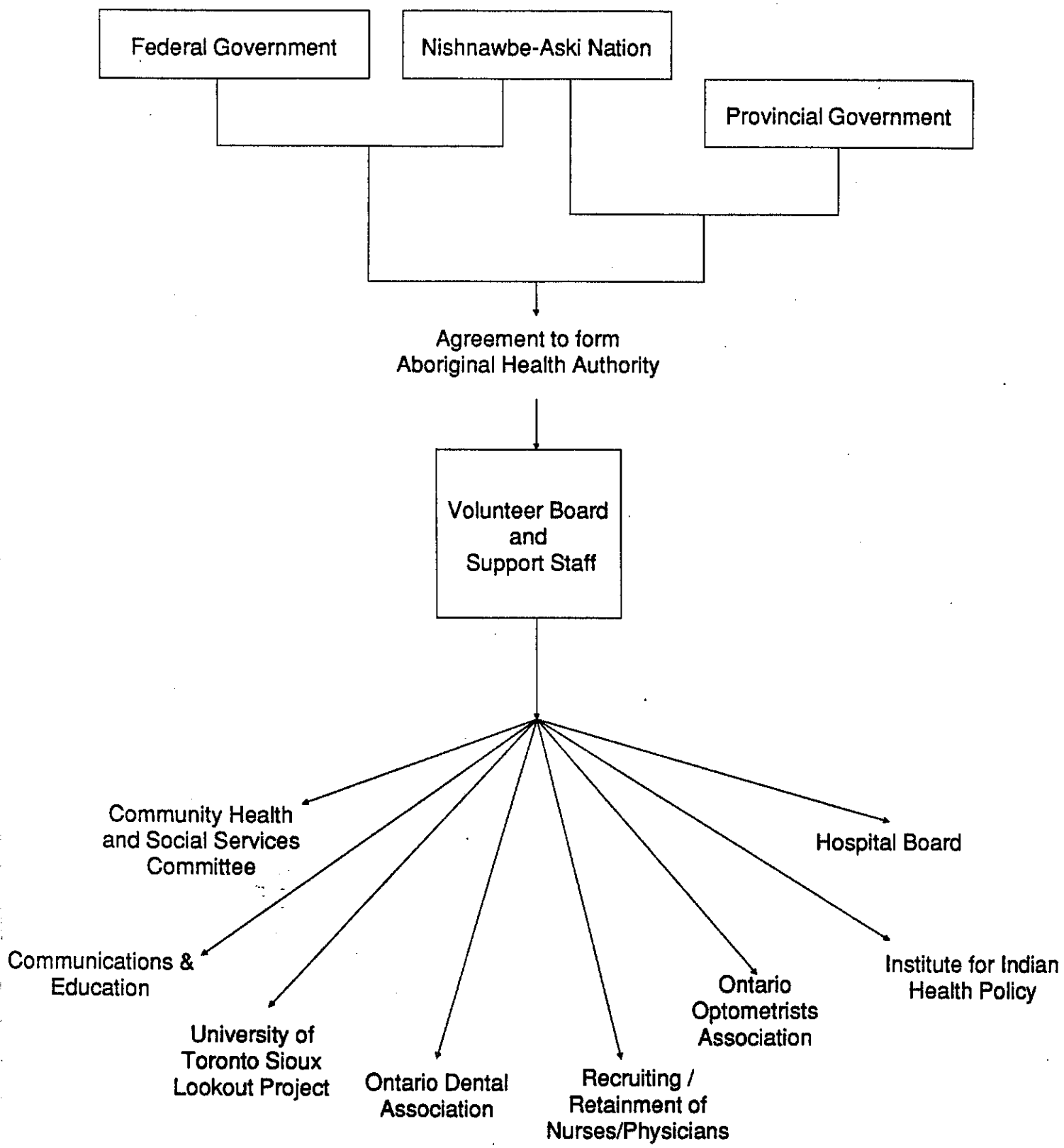
To ensure that aboriginal people have more involvement in and control over their health care, the Panel recommends:

> ***That, as a first step, the Federal Government and the Nishnawbe-Aski Nation enter into a formal agreement to transfer authority for the formation and implementation of health policies in the region to an Aboriginal Health Authority.***

This agreement, ***which should be concluded within six months' time***, would involve a detailed plan for transfer of authority, jurisdiction and responsibility including:

- a commitment to on-going block funding that would cover the costs associated with forming and operating the Aboriginal Health Authority, as well the costs associated with delivering health care services in the region
- accountability to both the Federal and Provincial Government for responsible management of the resources
- accountability to the aboriginal people of the Sioux Lookout region
- a mechanism for ensuring the appropriate training and support for aboriginal people who work for and serve on the Aboriginal Health Authority
- reassurance that such an organization will in no way negate the Federal Government's trust responsibility
- a time-frame for the proposed transfer
- a mechanism for evaluating the effectiveness of the Aboriginal Health Authority.

Aboriginal Health Authority



The Ministry of Health is committed to establishing equitable, native-specific, culturally sensitive health care services to meet the needs of Native Indians ... the government commits itself to support the entrenchment of rights to self-government for aboriginal peoples and will enter into negotiations with the federal government and aboriginal organizations directed towards reaching agreement on the implementation of aboriginal self-government in Ontario ...[aboriginal] groups will be encouraged to establish contact with [District Health] Councils, participate in the planning process and learn the procedures that are in place for the submission of community-based health care proposals to the ministry.

Ontario Ministry of Health Submission to the Scott-McKay-Bain Health Panel

Although health services for aboriginal people have traditionally been a federal responsibility, the communities of the Nishnawbe-Aski Nation also have a unique relationship with the Government of Ontario which was a signator to Treaty #9. The Panel believes that people in the Sioux Lookout Zone would benefit from access to provincial health (and other) programs, and that this relationship should in no way undermine the federal responsibility to the aboriginal people. Therefore, the Panel recommends:

> ***That, as a second step, the Nishnawbe-Aski Nation and the Provincial Government enter into a formal agreement on access to provincial programs. This agreement should be completed within the next 12 months.***

This comprehensive agreement — which is consistent with Ontario's current trend to regional planning and administration — would outline the jurisdictional responsibilities of the Provincial Government and the Aboriginal Health Authority, encourage flexibility and innovation in health care in the region.

The Role of the Aboriginal Health Authority

Whereas the present transfer process pits one community against another, competing for available resources, the Aboriginal Health Authority would represent the needs of all communities in the Zone. It would also encourage aboriginal people to develop the skills required to work for the Authority and plan for their own health care needs. The Panel recommends:

> ***That the Aboriginal Health Authority focus its attention on four priority areas:***
>
> — ***recruiting health care providers and administrative staff — including developing programs to assist aboriginal people in developing these skills.***
>
> — ***educating people in the communities about the health care system and the role they can play in their own health.***
>
> — ***developing appropriate and effective cultural orientation programs for non-native health care providers.***

— ***integrating the planning and provision of health and social services in the communities.***

The Aboriginal Health Authority would, as a minimum, replace the role now filled by the Medical Services Branch in the Sioux Lookout Zone in that it would:

- negotiate with and account to the Federal and Provincial Governments for funding
- negotiate and oversee medical services contracts such as those with the University of Toronto, the Ontario Dental Association and the Optometrists Association of Ontario
- work with the Sioux Lookout Project and Medical Services Branch to develop health policies for the Zone which are culturally appropriate and develop health programs to meet all health needs, including chronic care
- manage the CHR program, including providing a benefits package, ongoing training, support for career advancement; up-grading, developing and maintaining a data bank of trained and available workers; and solving the liability issue
- develop a mechanism to handle grievances and requests for second opinions
- develop and implement treatment and prevention programs
- manage the NODIN Counselling Agency
- manage the NNADAP Program in the region
- nominate individuals to serve on the hospital board.

The Role of Medical Services Branch

Medical Services Branch will have to work closely, first, with the Nishnawbe-Aski Nation and then with the Aboriginal Health Authority to transfer responsibility for health care to the aboriginal organization. In the view of the Panel, this is an important step in the government's stated goal of transfer and in the aboriginal people's desire for self-government. As the primary funding/monitoring agency, the Panl recommends:

That Medical Services Branch focus its efforts on assisting the Aborginal Health Authority in planning budgets and in collecting and maintaing data that can be used in evaluation.

That Medical Services Branch monitor the operation of the Aboriginal Health Authority in order to develop a possible model for transferring responsibility for health services to other aboriginal people across Canada.

In addition, the Panel recommends:

That Medical Services Branch continue to provide funding for pre-transfer studies to allow communities to undertake health status studies.

The Role of the University of Toronto Sioux Lookout Project

As stated earlier, the close relationship between the region and the Univeristy of Toronto is a sound and effective means of enhancing health care services in the Sioux Lookout Zone and one that should be strengthened. However, the Project may not have kept pace with the health needs of the region. Therefore, the Panel commends the University of Toronto Sioux Lookout Project for its innovative work in the past and recommends:

That the University of Toronto expand and revitalize its Sioux Lookout Project, working with the Aboriginal Health Authority to identify health programs and services that will meet the changing health needs of people in the region so that the Project may have the same positive impact over the next 20 years as it has had over the last 20 years.

That, in the next fiscal year, the University of Toronto Sioux Lookout Project appoint a full-time director and provide appropriate administrative and secretarial support — to:

- *be in charge of the program and help to revitalize it*
- *have regular, personal contact in the region, and*
- *work with the Aboriginal Health Authority to provide leadership in meeting health care needs.*

The Role of the Communities

It would also be the responsibility of the Aboriginal Health Authority to encourage the communities in the Zone to accept more responsibility for the health of their members and to play an active role in local health programs by establishing and supporting community health committees.

To encourage the communities themselves — and their members — to take more responsibility for health, the Panel recommends:

> ***That, within the next 18 months, each Chief and Council in the Zone form a Community Health and Social Services Committee, made up of a volunteer board of members of the community which will be responsible for promoting health and implementing local health programs. These committees should build on the strength and initiative already in place in each community.***

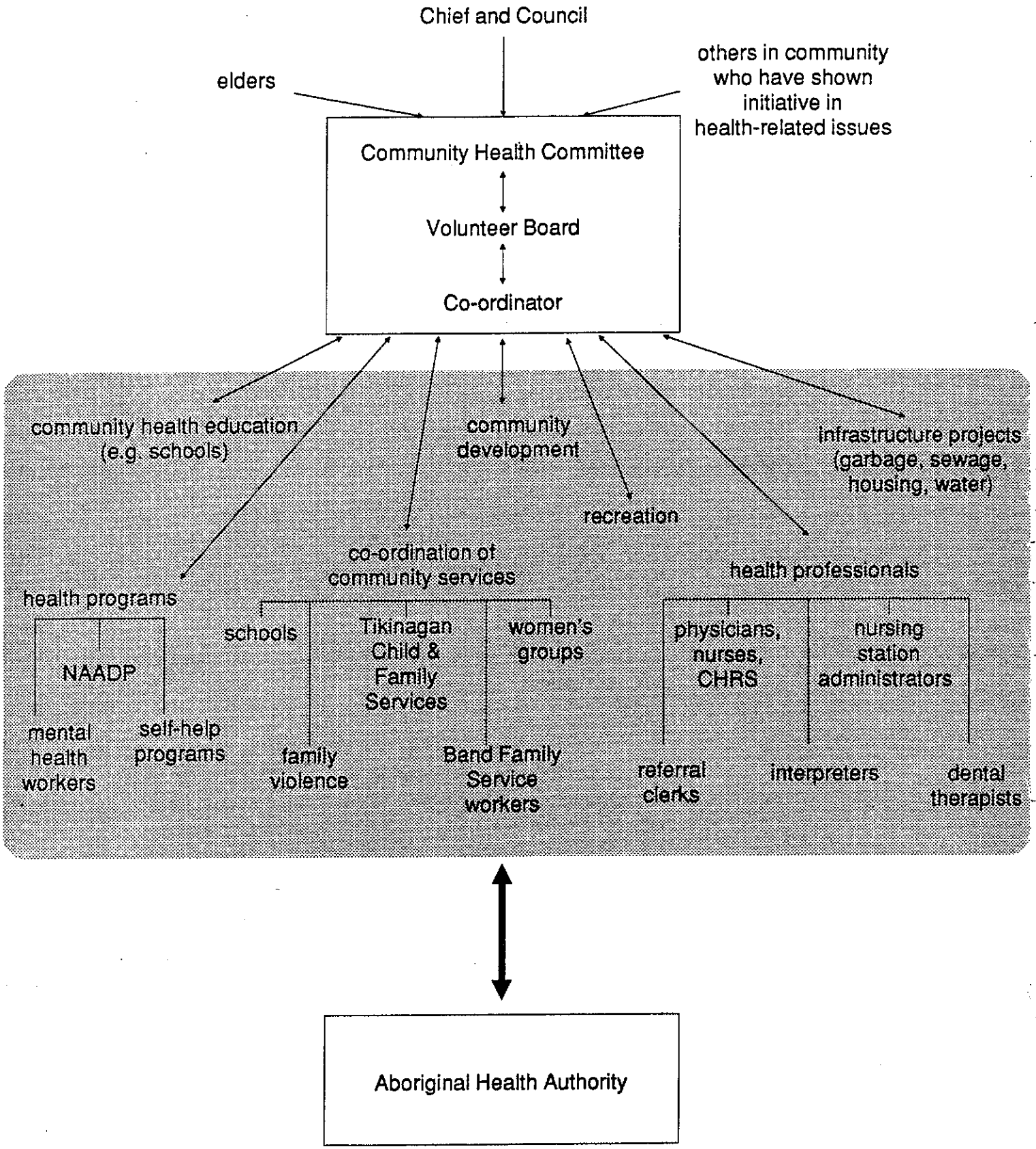
> ***That the Community Health Committees bring together into a network all the health and social services in the community including: mental health workers, social workers, CHRs, NAADAP workers, the Tikinagan Child and Family Services workers, the Welfare administrator, women's groups, nurses and other health care providers, teachers, the elders and traditional healers.***

> ***That the Aboriginal Health Authority provide financial and technical support for the community health committees. This support would include training for committee members to help communities develop skills for managing their health care system, and funding to hire part- or full-time co-ordinators, as needed.***

The Health Committees, which would have a co-ordinator, would work closely with the Authority to select health care providers and develop local programs. The committees would use resources in the community (such as elders) to:

- increase personal and community responsibility for health
- educate members of the community about the role of health professionals
- educate people about the health care system

Community Health and Social Service Committee



- help members of the community develop more realistic expectations of health care professionals and more demanding but realistic expectation of themselves
- work with the CHRs to plan community education programs on illnesses related to mental health and to lifestyle (e.g. alcohol and substance abuse, obesity, tooth decay, diabetes, heart disease)
- educate the community about the importance of environmental health including clean water, sewage, garbage disposal, dog control, etc.)
- provide better support for the nurses
- encourage more young people in the community to pursue health careers
- encourage self-help programs
- encourage elders and others in the community to act as role models for younger people
- encourage the development of recreational facilities for young people, elders and others in the community

The message that Community Health Committees will deliver is that ***"health is everybody's business"*** and that the community can mobilize its members to help solve its problems. Part of their task is to fight the sense of powerlessness that has threatened many Zone communities and contributed to ill health.

Research into Aboriginal Health

Health programs and services provided in the Sioux Lookout Zone should be based on a clear, accurate assessment of health problems and needs. Therefore, the Panel recommends:

> ***That a full time epidemiologist be appointed to the University of Toronto Sioux Lookout Project to monitor health status in the region and work with the communities to plan and develop appropriate research projects.***

> ***That the Federal Government provide a research budget that would allow the epidemiologist to employ Health Science students to be involved in research projects which would be planned and developed in and by the local communities.***

As part of the University of Toronto/University of Waterloo Telemedicine Research Project (1977-79) health status data (illness episodes, patient visits, etc.) were routinely collected, aggregated and computerized. This data was of inestimable value, not only in evaluating various aspects o the University of Toronto Sioux Lookout Project, but also in carrying out health research projects. Through an agreement with the University of Waterloo, this data collection service has continued. However, since 1986, when the Federal Government made the decision to standardize computerized data systems across Canada, the data has not been computerized and, therefore, has been unavailable to those working in the region. A valuable research database is at risk of being lost. The Panel strongly recommends:

> ***That either the new computer system be implemented within the next six months, or adequate resources be given to the Department of Medical Records at the Zone Hospital to update the system previously in place.***

Although a great deal of general research has been undertaken in Native health over the years, there is no central clearinghouse or "centre of excellence" in Ontario to co-ordinate, encourage and promote strategies to improve native health. To address this deficiency, the Panel recommends:

> ***That the University Health Science Centres, the Federal Government, the Provincial Government, the Nishnawbe-Aski Nation and other interested parties establish, within the next 18 months, a task force to prepare a plan for an Institute for Aboriginal Health Policy.***

> ***That these groups determine an efficient means to provide the necessary funding and administrative support for the task force.***

The task force, which would be closely linked with the Aboriginal Health Authority, the full-time epidemiologist in the University of Toronto Sioux Lookout Project and comparable health planning groups and individiuals serving aboriginal people in other parts of the province, would:

- review what has already been done in this field
- determine possible goals and programs for the Institute
- negotiate secure ongoing funding

- establish terms of reference and membership of the Institute Board
- establish whether such an Institute would be best operated
  - as a free-standing organization with links to universities and medical centres
  - under the wing of a university
  - attached to a hospital

Once established, such an Institute could:

- act as a clearinghouse for research and information
- become a centre for research into aboriginal health
- conduct seminars, workshops and training sessions for individuals working in aboriginal health (from physicians to clerks)
- advise University Health Science Centres on curriculum for professional education
- publish journals or papers on aboriginal health
- assist aboriginal people's organizations in doing research, formulating health policies and responding to government initiatives and changes
- provide training for aboriginal health care administrators and board members
- organize and offer complete training and certification programs for CHRs.
- access granting organizations and solicit funds for research

The Recommended Health Care Delivery System

...we would like to say that the new hospital we have in our minds be built jointly with native and non-native, with a mind of equality for our children in the future ... we recommend that a study be undertaken to look at the advantages and disadvantages of the new hospital.

Report from Summer Beaver

In response to the current debate on the amalgamation of the two hospitals in Sioux Lookout, we have taken the position that we risk inferior service should there be a separate Indian hospital, and that it is more important at this time to focus on achieving control of resources for our community and to develop our own resources.

Report from Lansdowne House

This [amalgamation] is an issue that remains unsettled on the minds of my people. The chiefs and leaders ... have delivered a clear and concise position: no amalgamation. I, as chief of this community, fully support this position ... under the context that we have to maintain the trust responsibilities of the government of Canada to its first nations citizens.

Chief Frank Beardy, Muskrat Dam

Facilities

The Hospital/Hostel

Resolving the hospital issue would be a major step in improving the quality of care and reducing frustration about health care in the region. It would also provide a means to promote better race relations and understanding.

Within the region, the Panel found wide support — among both aboriginal and non-native people — for an amalgamated hospital. Based on the high level of community support and its own assessment, the Panel strongly recommends "one hospital for all." Planning for a new hospital/hostel facility could be an effective means of building the partnership between non-native and aboriginal people, allowing both cultures to gain greater understanding, awareness and appreciation of one another.

However, in anticipation of one hospital, several steps must be taken immediately. Therefore, the Panel recommends:

> ***That Medical Services Branch provide the necessary funding and work directly with the Nishnawbe-Aski Nation:***
>
> — ***to appoint an interim aboriginal board for the Zone Hospital, and***
>
> — ***to provide a recognized training program for Board members.***
>
> ***The Board, which would include appropriate representation from the region and have the authority equivalent to any other hospital board, would provide a training ground for aboriginal members so that skilled and experienced aboriginal people will be available to take their rightful place on the new hospital board. The interim board should be appointed and training should begin within six months.***

The hospital should engage in an aggressive affirmative action program to recruit native people.

Shirley O'Connor
Presdient
Ontario NativeWomen's Association

In all of the cases that I've come across where there have been harmonious relations between ethnic groups that are usually at odds with one another, this harmony comes, I think, in the perception of the other as competent and, therefore, deserving of respect. In situations where the groups are interdependent in whatever way, then it means that the other group can also be trusted to carry out their side of the activity/obligation. How then to increase mutual perceptions of competence?

One idea is a slow but steady media diet of native success stories, of both individuals and groups, and these could first go through Wawatay, so that native people have first crack at them, and then into the wider media.

Phil Lange,
McMaster University

The tasks of the Zone Hospital Board would be to:

- commission a hospital needs assessment for the Zone
- work with the Board of the General Hospital to
  - commission a hospital needs assessment for the catchment area
  - begin now to co-ordinate planning, services, equipment, facilities and personnel between the two existing hospitals — to make the best possible use of resources in the community
  - study and resolve the issues associated with forming one hospital
- make recommendations to the Federal and Provincial Governments about hospital services in Sioux Lookout
- work with the Aboriginal Health Authority to develop a policy for hostel services

Immediate steps must also be taken to resolve racial tensions in the town of Sioux Lookout and to create an environment in which "one hospital for all" will provide appropriate care for both the aboriginal and non-native population. Therefore, the Panel recommends:

That representatives of the town of Sioux Lookout and of the Nishnawbe-Aski Nation begin to meet immediately to develop education programs and community events that will help to reduce racial tensions.

The main target of these programs should be school-age children — of both races — who may be particularly vulnerable to negative racial stereotypes. However, education and awareness programs should also be aimed at the business community, individuals currently associated with both hospitals and the general public.

Similar programs should also be considered by the Nishnawbe-Aski Nation and the towns of Pickle Lake and Red Lake.

Help for such programs is available from appropriate provincial and federal government bodies.

The question of amalgamation ... has been an outstanding issue and I would like to say for the record that I support amalgamation because of these reasons:

1. attraction of professional and para-professional doctors in their fields

2. better equipment and facilities

3. abandoned buildings could be used to house out-going patients if hospital got over-crowded.

... and for a lot of other reasons that might benefit Natives and Euro-Canadian Society. As I said, we are people and I don't see why people can't work together.

Webequie Chief and Council Report

By having a broader, flexible and co-ordinated funding arrangement, with both levels of government, this hospital — with the aid of community and district health councils — will ensure that no person, whether non-native or native, whatever their status or residence, will fall between the cracks of federal/provincial jurisdiction.

Shirley O'Connor, President Ontario Native Women's Association

One new combined hospital/hostel facility offers many benefits to people in the Sioux Lookout Zone. The "one hospital for all" would:

- replace the inadequate existing buildings
- eliminate the need for transportation between hospitals
- ensure that the region makes the best possible use of available health care resources and personnel
- strengthen the partnership and understanding between the non-native and aboriginal communities
- make it easier to recruit physicians and specialists
- offer culturally sensitive care, making northern Indian healing and spiritual practices — as well as Western medicine — available to patients
- emphasize out-patient, ambulatory services
- maintain and foster the close affiliations of the current hospitals with the Faculty of Medicine at the University of Toronto, the McMaster University Northern Ontario Medical Program and various training programs at Lakehead University, Confederation College in Thunder Bay, Cambrian College in Sudbury and Atkinson College at York University in Toronto.
- improve working conditions and offer a better on-call system for physicians, designed to free up more physicians to work and visit in the region
- provide interpretation, patient advocacy and chaplaincy services
- reduce operating costs which would free up resources that could be used for community-based health promotion and disease prevention programs.

Therefore, the Panel recommends:

That the Federal Government, the Provincial Government and the Nishnawbe-Aski Nation enter immediately into negotiations to resolve the barriers to having one hospital to serve both aboriginal and non-native people in the region. These negotiations, which should be completed within six months, would include:

— ***reassurance that an amalgamated hospital would in no way negate the Federal Government's trust responsibility***

— *the specific steps that will be taken to ensure that care and services provided in the hospital are culturally sensitive*

— *a formula for Board membership which will ensure that the aboriginal people have appropriate and effective representation*

— *a plan for a hostel facility specifically designed to meet the needs of patients coming in from the communities.*

— *a mechanism to ensure community involvement and education.*

Nursing Stations

To ensure the quality of care in the communities, new nursing stations must be built in certain communities and some exisiting facilities renovated. Medical Services currently plans on a five-year cycle which means that many communities will have to wait several years for adequate facilities. To provide the facilities required within a shorter period of time, the Panel recommends:

That Medical Services Branch consider a more innovative approach to capital funding and enter into agreements with the Nishnawbe-Aski Nation and the Bands that would allow the communities to construct the facilities immediately. The goal would be to have all nursing stations up to adequate standards by the year 1995. Two possible approaches would be:

— *loan guarantees, based on future capital plans, that the Bands could use as assurances to borrow money from the bank to build now*

— *a lease-back system that would allow the Bands to build the facilities and lease them back to MSB over a reasonable period of time to recover the costs.*

That, when a nursing station is built in Summer Beaver, Medical Services Branch or the Aboriginal Health Authority (whoever has jurisdiction at the time) ensure that the building meets the standards and requirements (e.g. log buildings) of the community

Further, the Panel also suggests that consideration be given to building the nurses' housing separate from the nursing station so that nurses can become more integrated into the communities.

The Panel also recommends:

That the community health committees ensure that the communities develop a sense of "ownership" and pride in the stations in order to prevent future incidents of vandalism.

Transportation

To address the complex transportation problems in the Sioux Lookout Zone, the Panel recommends:

That standard policies and procedures be developed — either by the Aboriginal Health Authority or other appropriate aboriginal organization — for all aspects of the transportation system related to health care, including transportation within the communities, between the communities and Sioux Lookout, within Sioux Lookout and between the region and tertiary care centres.

That these policies and procedures include specific guidelines for escort services that would be applied consistently in all communities.

Communications

To improve communication/health education within the region, the Panel recommends:

That the Aboriginal Health Authority provide funding for Wawatay to produce or find health-related radio and television programming and to use its communication network to play a stronger role in educating aboriginal people about the health care system and healthy lifestyles. The contract should stress the most specific and urgent health education needs including:

- ***accidents and injuries***
- ***alcohol and substance abuse***

— *suicide*

— *family violence*

— *nutrition (obesity, diabetes)*

— *smoking*

— *dental health*

— *role models for young people including pride in cultural traditions and self-esteem*

— *opportunities for young people to pursue health careers*

That the Aboriginal Health Authority establish criteria for interpreter services in the communities and develop a glossary of medical terms.

That the communities explore ways to use drama, art, story-telling and other experiential methods to:

— *give young children positive aboriginal role models*

— *provide health education*

That a full-time interpreter be hired immediately to work at the front desk/switchboard at the Zone Hospital at nights and on holidays.

That more aboriginal people be hired and given formal, recognized training — within the next two years — to provide medical interpretation services where needed. That this same training program be available for volunteer interpreters in the communities.

That all health stations have a hands-free phone to take full advantage of the telemedicine program.

That consideration be given to using the telemedicine program to assist in providing cultural orientation programs for non-native nurses.

Staffing

The northern stations and satellite communities need more staffing. Staff is not only needed to hold clinics and be on call for emergencies evening and night-time, but to allow them to be more involved in public health/preventative health pursuits.

Tara Cox, CN

The chronic shortage of primary care staff — particularly nurses and CHRs — is a serious problem which affects the quality of care in the region. Therefore, the Panel recommends:

> ***That "person years" for nurses, CHRs and interpreters be increased, and that the role and responsibilities of each be clearly defined, so that each is able to do what they are trained to do to the best of their ability.***

If a qualified nurse cannot be resident in the community, that at least we have a nurse for our break-up and freeze-up seasons on a continuing basis.

Report from Summer Beaver

Current and recommended levels of staffing are as follows:

Position	Current Level (in person years)	Recommended Level (in person years)
Nurses	32	39
CHRs	28.5	36.5
Clerks/Interpreters (in nursing stations)	16	21
Nursing Station Administrators	0	6
Interpreters (at hospital)	7 (not dedicated staff)	11
Social Worker (at hospital)	0	1
Native Trainers (at hospital)	0	2 (nursing/administration)
Support Staff (labs, records, stores)		5

> ***That priority be given to the urgent need for more CHRs, and that these individuals be recruited, trained and in place in the field operation within the next two years.***

> ***That — in communities where there is a need — interpreters and nursing stations administrators be hired and trained to relieve the pressure on CHRs***

and nurses and give them more time for their health care responsibilities.

That more nurses be recruited and given appropriate orientation and training in order to provide a registry or pool of health care providers — including nurses willing to work part-time or shift work — available to relieve staff under stress or during severe health crises (e.g. epidemics), to prevent burn-out and to cover for providers away for training or due to illness, holidays or family matters.

That provisions be made to have nurses reside in those communities which do not have landing strips during freeze-up and break-up each year.

That certain key staff be added at the hospital including: interpreters, individuals to conduct native training programs in nursing and administration, a social worker and necessary support staff.

Recruiting

Recruiting and retaining health care providers is a chronic problem, and will require greater innovation and co-ordination among the communities, the Aboriginal Health Authority, governments and universities.

The Role of the Communities

The Panel recommends:

That the community health committees — with the support of the Aboriginal Health Authority — actively develop innovative strategies for recruiting and retaining health care providers.

That the community of Bearskin Lake document the community development process it has used to encourage health care providers to become integrated into the community to provide a model for other communities.

The communities should:

- strive to make the nurses and other health providers feel welcome and appreciated
- invite the nurses into their homes
- give nurses and other providers the opportunity to learn the native language and involve them in community activities.
- "adopt" a physician and a dentist, so the people in the community and the doctors have regular contact and develop a personal sense of continuity of care and build a relationship.

The Role of the Aboriginal Health Authority

The Panel recommends:

> ***That the Aboriginal Health Authority take a lead role in recruiting and retaining health care providers, and develop cultural orientation courses for providers that will help prepare them for life in communities in the region.***

The Aboriginal Health Authority should:

- actively co-operate with the Ontario Ministry of Health Underserviced Area Program, which has proven highly effective in attracting health care providers to the North. (The program has placed over 700 doctors in 220 communities and was responsible for recruiting most of the physicians now serving the town of Sioux Lookout and the General Hospital.)
- appoint representatives to sit on recruiting/retention committees with university providers and others where they can learn the problems and techniques associated with recruiting
- help potential candidates develop an awareness of working conditions and cultural differences in the region.
- ensure that working conditions and reimbursement in the region will attract health care providers
- "market" the benefits of working in the region
- make benefits for nurses working in the communities — such as holidays, visits out and training or teaching opportunities — more attractive
- work with physicians, nurses and other health providers to help develop challenging and appropriate roles for them in the health care system — roles that will help to attract providers to work in the region.

- continue to offer opportunities for residents and medical students — particularly those in family medicine, pediatrics and psychiatry — to participate in health care delivery in the region. It is from this pool of physicians that future family practitioners and consultants will be recruited for the Zone.
- provide an extensive orientation program for all non-native physicians, nurses, residents and medical students to help them become more sensitive to aboriginal culture and values. (This program should be developed and delivered by the Aboriginal Health Authority in consultation with local communities.)

The Panel also recommends:

> ***That the Aboriginal Health Authority aggressively encourage aboriginal people to train as health professionals by:***
>
> — ***offering career development/counselling programs in elementary and secondary school***
>
> — ***offering scholarships to aboriginal students who want to pursue a health career and agree to return to the region to work for a certain length of time***
>
> — ***budgeting and creating opportunities for students to have summer or part-time jobs in health care***
>
> — ***encouraging aboriginal people currently employed in the health care system to act as role models for young people***
>
> — ***negotiating supportive programming on Wawatay***
>
> — ***if necessary, working with universities and community colleges to develop appropriate training programs***

The Panel strongly supports every effort to attract into health careers aboriginal people who will serve as role models to the youth in the communities. However, people in the region must recognize that, under the best of conditions, it will be many years before there will be enough aboriginal doctors and dentists to serve the native communities.

The Role of Government

Training programs must be available if the Sioux Lookout Zone is to recruit providers with the skills required to work in primary health care delivery in remote areas. Therefore, the Panel recommends:

> ***That Health and Welfare Canada continue to support training programs which prepare nurses and CHRs for the responsibilities of providing primary care in remote areas and make a long-term financial commitment to programs such as the Primary Skills Training Programs, CHR Training Program, Native Nurses Entry Program, Indian Health Careers Program and the co-op health administration program.***

The Role of the Universities

The Panel recommends:

> ***That the University Teaching Centres play a more active role in solving the problem of maldistribution of health care professionals.***

University Teaching Centres could encourage more students to practice in remote areas. For example, university post-graduate medical programs could give preference to doctors who have practiced for at least one year in an underserviced area (whether in the north or in poor areas of major cities). This would make 400 to 500 doctors in Ontario alone available for general practice. (There is a precedent for this strategy: the late W.E. Gallie, Professor of Surgery at the University of Toronto, frequently sent doctors who were to be accepted into the Post Graduate Surgical Program to Sudbury and Coppercliff for one year of family practice.)

As such programs are even more important to family practitioners, University Teaching Centres could also give priority for teaching appointments to those who have practiced in an under-serviced area. Each university would have a list of places to practice and the doctors would have multiple choices. This, in turn, would ensure that each area would continually upgrade its working and living conditions in order to attract a continuing supply of physicians and encourage some of them to stay.

The quality of health care in the region depends on the ability of care providers to be full partners on the health care team, with the appropriate individual — whether a CHR, nurse, physician or specialist — providing appropriate services at each level of the health care system.

Health Care Services

Primary Care

The health of the aboriginal people in the Sioux Lookout region depends on effective, quality primary care which is delivered in the communities by nurses and CHRs, supported by members of the communities and by the physicians.

The Role of the Nurses

Our greatest hope is that the nurses will work with the community to resolve cultural shock and problems.

Queqish, Round Lake

The Panel recommends:

> ***That the important role of nurses in providing primary care be recognized and strengthened, and that there be more support for nurses working in the Zone.***

> ***That non-native nurses working in the region make every effort to become culturally sensitive to the people they serve, take advantage of opportunities for continuing education and work with members of the community to improve health.***

To strengthen the ability of nurses to provide primary care in the region, and to make full use of their skills, certain steps should be taken.

- Through the Community Health Committees, members of the communities should be educated to understand the role of the nurse, appreciate her/his medical skills and abilities and have realistic expectations. To assist in this process, the nurses' CVs should be made available to the health committees
- Although nurses will continue to be employed by Medical Services Branch (where they receive pension and benefits and are able to move from one part of the country to another easily), they will be recruited by the Aboriginal Health Authority — in consultation with the communities. Communities and the nurses should have greater opportunity to "select" one another to ensure a better, more co-operative long-term relationship. (Eventually, it is hoped that the nurses would be employed by the Aboriginal

Health Authority and enjoy the same benefits and mobility they have with MSB.)

- The Federal Government must continue to support appropriate training programs such as the Native Nurses Training Program and the Dalhousie Outpost Nursing Program and develop more like the old CTN and current Primary Skills Program.
- An effort should be made to ensure that nurses' work is challenging and rewarding. More opportunities for career development for nurses must be created. For example, nurses could play a greater role in educating CHRs or others in the community.
- To free nurses in charge of Nursing Stations from the burden of paperwork and give them more time to devote to patient care and health education, the Aboriginal Health Authority should hire and train Nursing Station Administrators. Where possible, the administrators should be chosen or recommended by the community on the basis of criteria provided by the Aboriginal Health Authority. (Until the Aboriginal Health Authority is operational, administrators could be hired and trained by MSB.)
- To help improve the relationship between the communities and health care providers, the Aboriginal Health Authority should establish a formal grievance procedure that patients can use if they want a second opinion. Within the community, the health committee would be responsible for administering the grievance procedure using guidelines developed by the Aboriginal Health Authority.

The Role of the CHR

The Panel recommends:

> ***That Community Health Representatives (CHRs) be recognized as primary care givers in local communities, and be given appropriate training and support.***

To enable CHRs to fulfill their role in the community, several steps must be taken:

- Physicians, nurses and others in the medical community must recognize CHRs as partners in health care delivery
- Members of the communities must be educated to recognize the training and skills of their CHRs, and to have reasonable expectations about the kinds of services their CHRs can provide.

I found the experience of being away from home very frightening for the following reasons:
1. Rural living vs. city lining
2. Prejudice of non-natives to native people
3. Distance from family for support and guidance
4. Lack of knowlege on how to access the government and educational systems
5. The constant search for my identity — Who am I and how do I fit in the system?
... I also consulted my grandmother. You see, my grandmother was excited that I was a nurse because, for years, she had been the local midwife. She told me many stories of being called to homes to deliver babies. She told me about the times when one lost both mother and baby, and about her successes. My grandmother also told me about the different herbal medicines she used.
... for the 9 years before I same to Sioux Lookout, I worked on the ambulance in Sudbury, I worked in the emergency and intensive care units in Sudbury and I worked for the Province of Ontario on the helicopter based in Sudbury.

E.J., Native nurse on the challenges for a Native person becoming a nurse

- More CHRs must be hired and trained in order to provide back-up and relief for CHRs absent due to illness, holidays or family matters and meet the needs of the communities. The required number of CHRs should be hired and trained within two years.
- A standard, accredited training course for CHRs should be developed, managed and funded by the Aboriginal Health Authority and provided on a continuing basis through the Indian Institute for Health Policy. An excellent program, developed by the Windigo Tribal Council, already exists. Based on the actual work of CHRs, the course is presented in short modules which is well-suited to the CHRs' family and community commitments.
- The Federal Government should provide assured funding for the CHR training program in Thunder Bay.
- The Aboriginal Health Authority should also develop ongoing training programs for CHRs which would give them the opportunity to up-grade their skills and to move into other health care professions. It is hoped that, in this way, CHRs would aspire to become dental hygienists, radiology technicians, mental health counsellors, health care administrators, nurses, doctors and dentists — thereby increasing the number of aboriginal people in the health care system and providing role models for young people.
- The CHRs, who will be employed by the Bands through the Aboriginal Health Authority, should be chosen in consultation with the community. They should also be responsible to the community, through the community health committee. The communities themselves should play a major role in selecting individuals for CHR training, based on criteria provided by the Aboriginal Health Authority. (Employed by the Band through the Aboriginal Health Authority and graduates of an accredited program, CHRs should then be covered by the Authority for liability and have access to pensions and other benefits not currently available.)
- The primary role of the CHRs should be preventing illness through health education. In Satellite Stations where CHRs are also responsible for primary care, more CHRs will have to be hired in order that they may fulfill their role in health promotion.
- CHRs should also be responsible for educating the community about environmental/public health issues (e.g. sewage disposal, clean water, etc.).

The CHR should be showing us how to make proper outhouses; should also show us how to bank out outhouses; should be the one to oversee where to put our houses. I never hear the CHR talk to people ... CHR should set example.

M.B., Fort Hope

- To help reinforce the CHR role in health promotion, certain duties should be transferred to CHRs including: prenatal and post-natal care, well child care, school health services, prevention of dental caries, health promotion activities for lifestyle-related diseases (e.g. smoking, alcohol abuse, stress, etc.), and nutrition education — particularly to prevent diabetes. To enable CHRs to take on these responsibilities, new modules will have to be developed in their training program.
- To provide much needed chronic care services, CHRs should be jointly responsible — with nurses and physicians for home care for the elderly and disabled.
- To relieve some of the pressure on CHRs, interpreters should be hired or recruited as volunteers to take on the primary responsibility for that function.
- An effort should be made to enable CHRs to be more mobile, and to provide employment opportunities for them when they move between communities.

The Role of the Community

Much can be done by members of the Zone communities to contribute to and strengthen primary health care. Some excellent resources exist in the communities such as the elders — but are not used. Therefore, the Panel recommends:

That the communities — with leadership from the Community Health and Social Services Committees — encourage their members to become active participants in health through volunteerism, self-help groups, etc.

That the Aboriginal Health Authority and the communities work together to make Treaty Days a focus for a health event (e.g. physical examination of children before they start school).

That the Aboriginal Health Authority work with the communities, CHRs, nurses and physicians to develop chronic and extended care facilities and services, which will be a cost-effective means to provide the care the elderly and disabled people will require and keep the elders as close as possible to their communities and families.

This poem is dedicated to my Father who died Nov. 11, 1987. It was written because I strongly feel — as my father did — that when you are getting old, there is no way you can become young again. It's just time to die as humbly as possible with minimum suffering ... we wrote the poem to make people in the medical profession realize that Natives, too, when they get to the age when they have to die to be left with that peace of mind, that they slip away quietly.

May I Die
Pardon me doctor, but may I die?
I know you're full of ethics which require you to try to keep me alive
So long as my body is warm and there is a breath of life,
but listen doctor, I have buried my loved ones.
My children are grown and on their own,
My friends are all gone and I want to go too.
No mortal man could keep me here, no mortal should keep me here,
When the call from God is unmistakably clear.
I deserve the right to slip away,
My work here is done and I am tired.
Your motives are noble but now I pray,
You read in my eyes what my lips can't say
Listen to my heart and you'll hear it cry,
Please Doctor, but may I die.

D.M., New Osnaburgh

Secondary Care

Aboriginal people in the communities will continue to require access to high quality, responsive secondary care.

The Role of Physicians and Specialists.

The Panel recommends:

> ***That the University of Toronto Sioux Lookout Project ensure that physicians and specialists:***
>
> — ***continue to make regular visits to communities to see problem cases and do follow-up,***
>
> — ***work to develop a stronger relationship with patients in the region, and***
>
> — ***undertake a more active role in education for CHRs, nurses and the communities.***

- To provide continuity of care, communities and physicians should "adopt" one another. Whenever possible, the long-term physician should live in the community/communities for two to three weeks at the beginning of her/his term in order to learn about the community, its people and their culture. The physician should refer patients to his/her own appointment clinic at the Zone Hospital — rather than to other physicians and admit any patients to hospital under his/her own care.
- Whenever possible, all physician and specialist visits should be scheduled well in advance so that the community has time to plan for them, and the nurses and CHRs can ensure that those who need a physician's services will be at the Station. Physicians should visit each community at least three days each month — and preferably three days twice each month; specialists should be available to visit communities as needed.
- Physicians and specialists should conduct clinics in the communities, using the opportunity to do in-service training with nurses and CHRs and with members of the community. For example, it is important that the physicians teach CHRs and nurses how to stabilize more seriously ill or injured patients to prepare them for Medivac transportation.
- Physicians and specialists should discuss treatment plans with the Nurse in Charge or with the CHR, depending on

the community. With the CHR, nurse or interpreter, the physician should make house calls on chronically ill patients and the elders. Physicians should also have regularly scheduled meetings with the Zone Nursing Directors and Zone Director to discuss strategies and problems. The specialist must discuss all the patients seen with the CHRs and nurses in the communities, and also with the appropriate physician at the base hospital. The specialist should also provide a list of all patients seen, complete with treatment plans.

- Each Nursing Station and Satellite Station should maintain a list of patients requiring specialist services so that they can be contacted when the visits are planned. CHRs should also maintain a list of those people wishing to be seen and those who were seen that can be reviewed regularly by the community health committee.
- The physicians and specialists should act as a consultants to the community health committee, and have regular contact with the Chief and Band Council. The physician should report regularly to the community about the health status of its members. The physician should also be available to assist the community in developing health research projects designed to improve the health of the community.

Dental Care

Great strides have been made in dental health in the region, but significant improvements can still be made.

The Role of the Communities.

The Panel recommends:

That the focus for preventive dental care continue to be within the communities and that communities which have not done so "adopt" a dentist and explore the possibility of providing more adequate accommodation for visiting dentists and other health care providers.

That the Aboriginal Health Authority, Wawatay and the local schools develop creative programming that will encourage aboriginal people to reduce the highly refined carbohydrates (junk foods) in their diet and return to more traditional foods.

That the communities develop other initiatives that will improve dental health such as encouraging community stores to provide alternatives to pop and candy for children.

The Role of Government

The Panel recommends:

That the Federal Government immediately move to fund the proposed Preventive Dental Workers Program.

That Indian Affairs and Northern Development develop water supplies for the communities that can be fluoridated.

That the Ontario Ministry of Health explore the possibility of revising the Health Disciplines Act of Ontario to permit dental therapists to work in those Ontario communities which are similar to those north of 60 degrees latitude (e.g. remote, difficult to reach, small population, lack of dentists).

This would create opportunities for aboriginal people to be trained to work in the communities and encourage more native people to consider a career in dentistry. (At the moment there are no aboriginal dentists in Canada.)

The Role of the Profession

The Panel recommends:

That the Ontario Dental Association continue and expand its successful "adopt a dentist" program.

That health care providers reassess fluoride supplement programs in the Sioux Lookout Zone to improve compliance.

Mental Health Services

A small word should be said on the high use of alcohol and the stereotyping of natives as alcoholics. While it is certainly a problem, alcohol is not always the root cause of the malaise besetting native communities; it is but a symptom of greater problems.

Shirley O'Connor
President
Ontario Native Women's Association

Most of the communities in the region are in crisis. They are facing severe mental health problems due to the breakdown in the traditional extended family, the pervasive influence of Western culture and the lack of employment. Although the mental health program in the region, the NODIN Counselling Agency, is an excellent model more must be done immediately.

The Role of the Aboriginal Health Authority

The Panel recommends:

That all those involved in health care in the Sioux Lookout Zone recognize the urgent and growing social and mental health problem and give priority to the mental health services in the region, particularly:

- ***drug and substance abuse***
- ***marriage counselling***
- ***parenting***
- ***children's mental health***
- ***depression/suicide***
- ***family violence***
- ***child abuse/neglect***

That the Aboriginal Health Authority move immediately to develop effective mental health services and programs for adolescents in the communities.

That the Aboriginal Health Authority make the development of both short-term and long-term residential mental health services — in the region — a priority.

That traditional and Western spiritual leaders, elders and others in the community be encouraged to become involved in mental health programs and services, providing support and role models for teenagers and young adults.

Joe being one of his kind [i.e. Native], he felt Joe understood his problems better and he trusted Joe as his counsellor.

Helen Chan
on the benefits of aboriginal mental health workers

That an elder be hired through NODIN to act as a co-ordinator to organize a volunteer network of elders interested in helping with counselling services.

That the community health committees promote greater co-operation and co-ordination among all community services (e.g. nurses, CHRs, Tikinagan Child and Family Services, NNADAP, etc.) so that they can make effective use of all possible counselling and mental health resources.

More aboriginal workers must be trained to provide counselling services. Mohawk and Cambrian Colleges are setting up Native Mental Health Worker programs under the auspices of the Union of Ontario Indians, and more people from the region should be encouraged to enroll. In addition, the communities need more aboriginal people trained as psychologists and psychiatrists.

It will also be necessary for the communities to re-teach the parenting skills that were lost in the two generations of aboriginal people who attended residential schools.

While the present mental health program has applied for funding for a mental health community organizer and a community educator, that funding has not yet been approved. In addition, there is a need for qualified social workers and for educational materials, a video camera and one-way mirrors that these workers can use to train counsellors in the communities.

The Role of the Federal Government

The lack of mental health programs and services for aboriginal people is largely due to the absence of a Federal Government policy or direction. Therefore, the Panel also recommends:

That the Federal Government develop a policy on Native mental health which reflects the principles in Mental Health for Canadians: Striking a Balance so that there is a basis on which the government can provide funding for appropriate services.

That the Federal Government provide the funding required immediately to provide a mental health community organizer and a community educator for the Sioux Lookout Zone.

The Role of the Sioux Lookout Project

If communities are going to develop strong, effective mental health programs, they will require the support, creativity and expertise of the Sioux Lookout Project. Therefore, the Panel recommends:

> ***That the University of Toronto Sioux Lookout Project, in collaboration with the Ontario Ministry of Health and the Royal College of Physicians and Surgeons, create a position for a permanent resident in psychiatry for the Sioux Lookout Zone and actively recruit qualified physicians for the position.***

The appropriate official bodies (Royal College of Physicians and Surgeons, the Department of Psychiatry, the Post-Graduate Education Committee and the Province of Ontario) will have to agree to this position which is essential to support the work in the communities.

Community-Based Programs and Services

Some of the deficiencies the aboriginal people identified — such as back-up midwives and home visits — will be addressed through adequate staffing and innovative recruitment programs. However, one health service that is completely lacking in the Sioux Lookout Zone is extended care or chronic care facilities. Although it would be impossible to establish extended/chronic care facilities in each community, services should be available within the region so residents can remain close to their families.

In addition, a more active program of Home Care should be developed within the communities so that elders can remain in the community as long as possible. This is particularly important, given the increase in chronic illnesses in people in the region: a trend that will only continue.

Therefore, the Panel recommends:

> ***That the Aboriginal Health Authority, in consultation with the communities and the University of Toronto Sioux Lookout Project, establish appropriate extended care/chronic care facilities and services in the region by 1992.***

> ***That the Aboriginal Health Authority and the Community Health Committees work with the CHRs, nurses and physicians to develop appropriate home care***

programs which would include a strong volunteer component.

The Panel applauds the recent trend to develop community-based treatment programs and services — particularly for alcohol and drug abuse — and recommends:

That the Aboriginal Health Authority and the communities continue to develop appropriate, effective (as determined through evaluation) community-based programs so that more services can be provided within the region.

That the Aboriginal Health Authority re-examine the Muskrat Dam nutrition pilot project and — based on the evaluation information — give serious consideration to providing on-going funding for this community program and expanding it to other communities in the region.

That the Aboriginal Health Authority commission further study into the potential benefits and risks of midwifery and home deliveries in the region.

Community and Economic Development

It is apparent that Health and Welfare [Canada] must fulfill its responsibility of providing additional financial resources for community development which would promote better living conditions.

Bryan Beardy
Weagamow Lake

Things needed to achieve healthier communities were seen to be:
1. Education especially on nutrition and first aid
2. Clean water
3. Better housing
4. Improved sanitation

Chief Rosie Mosquito
Bearskin Lake

Community Health

As stated earlier, long term improvements in health status will not be possible without dramatic improvements in both community infrastructure and economic opportunties.[24]

The Role of the Nishnawbe-Aski Nation and the Federal Government

Because the lack of co-ordinated planning between MSB and IAND has been a chronic and major barrier to improved health in the region, the Panel recommends:

That representatives of the Nishnawbe-Aski Nation, Health and Welfare Canada and Indian Affairs and Northern Development enter into a comprehensive agreement on a major capital program to provide fluoridated water, sewage and power systems comparable to those in neighbouring non-native communities for the communities in the Sioux Lookout Zone — which will be completed by 1995. The new infrastructure should be culturally appropriate and include a community centre and bathhouse. In addition, the communities themselves should be directly involved in setting standards and planning the services.

That, to prevent another situation similar to the one that occurred in Fort Hope, the Federal Government make a commitment that, in the future, no community planning or building will be undertaken without the resources required to implement the necessary, adequate infrastructure (i.e. water supply, sewage system, etc.).

That the Federal Government, the Nishnawbe-Aski Nation and the Bands enter into a comprehensive agreement which the Bands can use now to borrow

money to make the necessary infrastructure improvements in a shorter period of time.

That the Federal Government, the Province of Ontario and the New Osnaburg First Nation enter into tripartite negotiations with the view to concluding a framework agreement. The aim of such an agreement would be to commit the parties to pursue strategies to address the serious socio-economic problems faced by the community in a manner that would respect community initiative and direction, and which would not be limited by current government funding and policy restrictions. Such strategies would involve careful analysis of the successes and failures of previous special initiatives in New Osnaburg and other communities.

That Indian Affairs and Northern Development work closely with the communities to address broader environmental concerns.

That the two Federal Government Departments responsible for services to the Sioux Lookout Zone — Medical Services Branch and Indian Affairs and Northern Development — and the Province of Ontario work to improve co-ordination of services to aboriginal people in the Sioux Lookout Zone.

That, if the two Federal Government Departments responsible for services to the Sioux Lookout Zone cannot improve co-ordination, then serious consideration be given to transferring all health-related services currently administered by Indian Affairs to Medical Services Branch (as was done in the United States).

Beyond the physical infrastructure of the communities, there are other structural systems which do not promote health and, in fact, contribute to health problems. For example, because food must be flown into the communities, it is very expensive — particularly fresh foods, fruit and vegetables. Alcohol, on the other hand — which must also be flown in — is subsidized by the government and available at the same price in the region as in cities in southern Ontario. A significant improvement in health could be made simp-

ly by ensuring that the aboriginal people have access to healthy foods at prices they can afford. Therefore, the Panel recommends:

That the Federal Government subsidize food supplies to the region — particularly those foods which are healthy and would contribute to a balanced diet.

The Role of the Aboriginal Health Authority

In its role as health planner for the region, the Authority must ensure that the determinants of health — community development, infrastructure and economic development — are recognized and addressed by each community. Because of the initiative and great amount of work undertaken by Fort Hope, the Panel recommends:

That the Aboriginal Health Authority provide support to the Fort Hope Health Committee for a five-year demonstration project to foster community development and self-reliance and, based on the results of that project, provide a model for other communities in the region.

That the Aboriginal Health Authority pay particular attention to the needs of the Lansdowne House community and provide the support the community will need to rebuild.

That the Aboriginal Health Authority continue to plan and advocate for the improvements in community infrastructure that will promote health.

The Role of the Communities

Within the communities, the people themselves have excellent ideas for improving health. One of the most innovative suggestions presented to the Panel came from Louie Tait of Sachigo Lake. He recommended a Day Care Centre in his community for both children and elders which would allow parents to work. The Centre would have bath and shower facilities and a laundromat — services in great need in the community. The Centre would provide transportation for the elders and a playground for the children.

Not only would the Centre provide a service for elders, but it would give them an opportunity to interact with the children, building bridges to the next generation. This type of development would also help build community spirit and identity and provide employment in the community for supervisors, trainers and janitors. The Panel recommends:

That every effort be made to encourage community development, building on the resources of each community, creating a healthier more supportive environment for its members and making individuals more aware of broader environmental concerns.

That local communities be encouraged to develop projects to meet existing needs in their community, raise part of the funds for each project and seek support from outside funding agencies to complete such projects.

Economic Health

The long-term health and viability of the communities in the Zone depends on appropriate and effective economic development. Many of the traditional indigenous livelihoods have disappeared. Some no longer offer the opportunities the people themselves want to share in the nation's wealth. The aboriginal people must have the opportunity to support themselves and their families, to develop their own industries and to share in the economic benefits of appropriate growth and development. The Panel recommends:

That the Federal and Provincial Governments work with the Nishnawbe-Aski Nation to develop culturally sensitive and appropriate, long-term economic development programs.

That the communities themselves form economic development committees and develop self-help initiatives.

The Role of Traditional Aboriginal Occupations

The recent report of the Social Assistance Review Commission supported the concept of aboriginal people developing their own forms of employment.[25] The Income Security Program for Cree Hunters and Trappers, developed as part of the settlement for the James Bay Project and in place in Quebec since 1974 may provide a useful model for the Sioux Lookout region.[26] Anyone participating in the program is not eligible to receive welfare or social assistance. The program — which has reduced by over 60 per cent the number of people on social assistance in that part of Quebec:

- provides a basic guaranteed income to individual Cree who want to pursue hunting, trapping or fishing as a way of life

— enough to support the individual during the hunting season in the bush who, in turn, provides meat, furs and bush products for the communities

- supports and has revitalized a traditional way of life
- is operated by a regional board (three Cree members and three government representatives
- employs aboriginal people to administer the program, including an experienced hunter in each village who ensures that the individuals are eligible, collects the records of their catches and travel to the bush

The Panel recommends:

That the Nishnawbe-Aski Nation, the Federal Government and the Provincial Government explore the possibility of developing an employment incentive program similar to the Income Security Program for Cree Hunters and Trappers in the James Bay region of Quebec.

The Role of New Economic Opportunities

Not all aboriginal people living in the communities will choose to return to a traditional way of life. For these individuals — and particularly for young people — the communities must develop other productive forms of employment.

That the Nishnawbe-Aski Nation and the Bands work with both the Federal Government and the Provincial Government and local businesses and industries to:

- ***develop a long-term economic strategy for the region that will be culturally-sensitive and ensure that the communities benefit***
- ***take advantage of regional and economic development programs to develop productive employment***
- ***develop markets for their products within the region and beyond.***

That the Nishnawbe-Aski Nation work with the town of Sioux Lookout to examine the economic potential of the region as well as the possibility of joint ventures and pooling economic resources.

Funding

There must be adequate financial resources made available to improve the present services and implement new services or programs that would benefit the people.

Chief Jethro Tait
Sachigo Lake

While the Panel is convinced that the basic problems with health and health care in the region are not primarily financial, there is no doubt that the recommendations included in this report — the Aboriginal Health Authority, additional staff, a new hospital facility, better community infrastructure and the enhancement of services available in the Sioux Lookout Zone — will require additional funding. The resources currently available are ***not*** adequate to support the existing system let alone the changes that will be required to improve health.

While some large, initial investment will be required, the Panel would like to stress that many of its recommmendations will lead to long-term opportunities to reduce health care costs. For example, the Aboriginal Health Authority will not be an add-on to the current system, but will take over responsibilities currently performed by MSB staff. One hospital for all will lead to major savings. A new hostel facility will decrease the costs associated with transportation and accommodation. Better prevention programs may reduce costs associated with treatment.

The Role of the Federal Government

In ***Achieving Health for All***, the then-Minister of Health, the Honourable Jake Epp, acknowledged that Canada's aboriginal people were, in fact, disadvantaged in health care and that, therefore, special steps may be required to provide aboriginal people with the same opportunities to achieve health that other Canadians enjoy. Therefore, the Panel recommends:

> ***That the Federal Government increase its financial support for health care in the Zone.***

More funding is needed immediately to be able to:

- increase the number of person-days for nurses and CHRs
- hire nursing station administrators
- enable the Nishnawbe-Aski Nation to negotiate with the Federal and Provincial Governments
- establish the Aboriginal Health Authority
- fund health needs and hospital needs assessments for the catchment area

- support initiatives that will encourage communities to take more responsibility for the health of their members
- secure funding for the Native Nurses Entry Program, CHR training, Primary Skills Training, the University of Toronto Indian Health Careers program, and other appropriate training programs, etc.
- revitalize the University of Toronto Sioux Lookout Project by allowing it to hire a full-time director and an epidemiologist

The key to the recommendations contained in this report is the transfer of authority and control over the health care system to the aboriginal people. As the main representative of the communities in the region, the Nishnawbe-Aski Nation will be a major player in the negotiations to establish the Aboriginal Health Authority, to upgrade community infrastructure, develop economic opportunities and explore the possibility of an Institute for Aboriginal Health Policy. The Nishnawbe-Aski Nation will require financial support to fulfill this important role. Therefore, the Panel recommends:

> ***That the Federal Government enter into an agreement with the Nishnawbe-Aski Nation to provide the funding that will allow the Nishnawbe-Aski Nation to undertake the negotiations recommended in this report.***

To ensure that the communities are able to develop other possible sources of funding without jeopardizing their long-standing relationship with the Federal Government, the Panel recommends:

> ***That the Federal Government provide assurances to the Nishnawbe-Aski Nation and the Aboriginal Health Authority that any efforts to find other sources of funding or any participation in provincial health programs will not affect the basic federal responsibility for native health.***

The Role of the Nishnawbe-Aski Nation

However, if the aboriginal people truly wish to move from the "paternalistic" approach to one where they have control over their own health and health care, they, too, must be willing to contribute. Therefore, the Panel recommends:

That the communities of the Nisnawbe-Aski Nation recognize that they are partners in health care system and accept responsibility for their health care system by:

Aboriginal people should be made aware of what medical services have done and cost.

R.B., Bearskin

- *encouraging greater participation by volunteers*
- *accessing and co-ordinating other possible sources of funding (e.g. Foundations, etc.)*
- *being willing to contribute themselves to the cost of health care and community development projects (e.g. through profits of co-op stores, a cigarette tax on reserves, etc.)*

To improve the situation [in health and recreation, etc.], native people will have to make sacrifices.

B.M., Big Trout Lake

- *developing cost-effective programs and innovative approaches to control health care costs.*

In the current environment of cost containment and burgeoning health care costs, all individuals should be made aware of the real costs of their health care. Therefore, the Panel recommends:

That, as a means of educating people in the region — and all citizens of Ontario — about health care costs, that the appropriate group (Aboriginal Health Authority, Federal Government, Provincial Government, OHIP) send individuals statements indicating how much has been spent on health care for them each year.

The Panel believes this should be the practice for all people in Ontario.

Conclusion

The Committee recommends that the federal government commit itself to constitutional entrenchment of self-government as soon as possible. In the meantime, as a demonstration of its commitment, the federal government should introduce legislation that would lead to the maximum possible degree of self-government immediately. Such legislation should be developed jointly.

Indian Self-Government in Canada
Report of the Special Committee, 1983
(Penner Report)

The government endorses a pro-active, developmental approach to Native affairs which will:
. assist Native people to become more self-reliant and less dependent on government services
. take into account the views of aboriginal groups
. recognize the ongoing responsibility of the federal government for Native programs
... Negotiations with respect to Native control of the design and delivery of Native health care programs are expected in the future.

Ontario Ministry of Health
Presentation to the Scott-McKay-Bain Health Panel

The changes recommended by the Scott-McKay-Bain Health Panel are designed to empower the aboriginal people in the Sioux Lookout Zone, giving them more control over both their health and their health care. Our recommendations are based on the principles that:

- it is more effective to promote health than to treat illness
- many health services — particularly preventive ones — can be best delivered by individuals other than physicians, including CHRs, nurses, other health professionals, elders and members of the communities
- great initiative and resources exist within the communities and this knowledge, skill and commitment must be harnessed

The organizational structure that we have recommended clearly supports both regional planning and aboriginal self-government. We believe that the health of the people will only improve when the aboriginal people themselves are responsible for health programs and planning decisions. In spite of the structural, social and health problems the communities in the Sioux Lookout Zone face, many people living there showed a great desire to become self-reliant and to improve their health and that of their communities.

It is they who must analyze the benefits and risks of continuing their traditional way of life in isolated areas and decide what type of health care personnel they need for their communities and what level of training is needed. They must spearhead a move to provide better housing, a safe water supply and sewage disposal systems, recreational and other facilities for their children, and job opportunities for their adults. There must be economic, political and social development of the native communities — but with much more involvement of the aboriginal people themselves.

In this effort, they must be supported by the Federal Government, the Provincial Government, the University of Toronto Sioux Lookout Project and the health care providers.

The process outlined in this report is a key step in developing self-reliance and will bring the people of the Nishnawbe-Aski Nation and the Federal Government one step closer to negotiating self-government.

To ensure that the recommendations of this report are implemented, the Panel has one final recommendation:

That an independent group be established to monitor the progress of the Federal Government and the Nishnawbe-Aski Nation in implementing the recommendations in this report.

The monitoring group, which would be made of representatives of appropriate organizations would meet twice a year to review what has occurred , make recommendations to assist or speed the process and, where necessary, work with representatives of the Nishnawbe-Aski Nation and the Federal Government to suggest modifications to the original recommendations that will assist in achieving the goals of this report. The Panel is in the process of contacting a number of groups so that the necessary fiscal and human resources will be available for an independent monitoring process.

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Appendices

Appendix 1

Statement

As a result of the drastic action taken by Messrs. Josias Fiddler, Luke Mamakeesic, Allan Meekis, Peter Fiddler and Peter Goodman of Sandy Lake who were protesting the condition of health services in the Sioux Lookout Zone;

A. The Nishnawbe-Aski Nation agrees that the native communities of Sioux Lookout Zone make a tangible and binding commitment to improve the health services in the Sioux Lookout Zone and the establishment of an Indian Hospital.

B. The Federal government agrees to commit the Department of Health and Welfare to a review of the health services in the Sioux Lookout Zone according to the attached Terms of Reference.

It was further agreed that the findings of the review will be consistent with, and support, the right of Indian people to determine their own health needs and to control the health delivery system by which their needs are met.

Mr. Dennis Cromarty, Grand Chief of the Nishnawbe-Aski National on behalf of the communities and Mr. Dave Nicholson on behalf of the Minister of Health and Welfare have agreed to the attached Terms of Reference for the Review as endorsed by their signatures affixed below.

Dated on this 20th. day of January, 1988.

Dennis Cromarty Grand Chief	Dave Nicholson Assistant Deputy Minister

Terms of Reference

For the Panel of Review on the Health Services in the Sioux Lookout Zone

General Functions

1 To review, evaluate and determine the deficiencies of the existing health services and programs provided in the Sioux Lookout Zone.

2 To hold community hearings to document the concerns, problems, and suggested solutions from invidiuals, Band Councils and Elders in the Sioux Lookout Zone.

3 Establish a process and a plan of action which will provide solutions and rectify the noted problems and deficiencies in the health care system.

Specific Functions

4 Review the health status of communities in the Sioux Lookout Zone.

5 Through community meetings, individual interviews, and submissions, document community complaints, individual incidents of problems, and general concerns of the communities.

6 Investigate these complaints, incidents and general concerns, to determine which factors can be changed or improved in order to avoid these from occuring in the future.

7 Through meetings, interviews and submissions from the health professionals and para-professionals, currently and recently involved in the Zone operations to document their complaints, problems, and general concerns about the existing health care services and the adequacy of its resources.

8 Review the objectives, directives and standards of the Zone and Hospital operations to determine their appropriateness for the health needs of the zone, and recommend additions, or changes to these objectives to better meet the needs as identified by the communities.

9 Assess and determine the adequacy of the human and financial resources to meet the current and recommended objectives.

10 Review the administrative and operational structure of M.S.B. to determine ways it can be altered to improve its ability to provide health care.

Expected Results

1 A public document containing the problems, complaints and difficulties experienced in the health services and collected from the communities and health care workers. Such a document will include the Panel's comments and assessments of these problems, complaints, and diagnosis of the systemic problems that have lead to them.

2 A process and a plan of action to impliment solutions, to rectify noted problems in the health care services.

3 A process and plan of action to establish Indian control of the Indian health services, in the Sioux Lookout Zone.

Membership

1 The Panel of Review will consist of three individuals. One member to be appointed by the Minister of Health and Welfare, a second to be appointed by the Nishnawbe-Aski Nation. The Panel would be chaired by an individual, mutually agreed to by the Minister and the NAN, and who is an individual widely respected by native and non-native Canadians.

Resources And Support

1 Resources, researchers and other staff shall be provided by the native communities, organizations and by Health and Welfare according to a plan agreed to by the Panel during their initial meetings.

Time Frame

1 The Panel should be identified within 10 days.

2 The work of the Panel should be outlined and started within thirty days.

3 The work of the Review Panel should be completed within one year of the starting date.

4 The final report must be delivered in a translated form to the people of the Sioux Lookout Zone and the Federal government by April 1st. 1989.

Comments on the Time Frame:

It was not possible to adhere to the time frame set out in the terms of reference. The Panel Chairman was not confirmed until February 16/89 and then accepted appointment only on the recognition that it would be impossible for him to give much time until the middle of May when his term of office as President of the Canadian Council of Churches ended, and that he would not be able to give more than part time until the middle of July.

The work of the panel began in earnest in June 1988. and the report will be completed about one year form that date.

Comments on the Mandate

The Panel believes that through its activities and in its report it has performed all of the general and specific functions assigned to it with the exception of the 10th. specific function. The panel lacked the time, expertise and budget to be able to undertake this function. It reported this fact to the Assistant Deputy Minister and to the Grand Chief and this reality was acknowledged by both. Some of its recommendations have implications for the administrative and operational structure of M.S.B. and for the policy framework within which it acts. These are areas which require urgent re-examination. A letter is being sent to the Minister of Health and Welfare and to the Prime Minister about this need.

Appendix 2

Panel Organization and Staff

From the beginning, panel members recognized that they were expected to act as a unit. The decision to use three names in the title was an indication that the Panel would seek to work by consensus. However, Panel members agreed they would each take the central role in different areas:

- Wally McKay would take the central role in relation to the community visits and the community hearings and with the band and tribal councils.
- Harry Bain would take the central role in relations with the health professions and in the organization of hearings where they would be the major presentors.
- Ted Scott would take the central role in co-ordination, in relations with MSB, with the Nishnawbe-Aski Nation, with the McMaster Group and in financial matters and public relations.

Offices and Staff

The main office was in Sioux Lookout, with a second office in Toronto. Panel accounts were kept by the Adminstration and Finance Department of the General Synod of the Anglican Church of Canada.

Panel staff were as follows:

- Elsie MacDonald, Executive Secretary
- Johnny Yesno, Office Manager and Co-ordinator of Community Visits
- Josias Fiddler, Pethabun Tribal Council Co-ordinator
- Brian Beardy, Windigo Tribal Council Co-ordinator
- Barry Frogg, Shibogama Tribal Council Co-ordinator
- Christine Yesno, Mattawa Tribal Council Co-ordinator
- Madeline Beardy, Co-ordinator of Women's Concerns

In addition, interpreters were hired in the local communities and translation services were contracted to individuals in the region.

The Tribal Council Co-ordinators' main responsibility was the preparation and follow up for the community visits. Each community was to be visited at least three times: once to prepare for the hearings, once during the hearings and once to follow up after the presentation of the report. In the case of independent communities the visits were made by the Co-ordinator of Community visits.

The Co-ordinator of Women's Concerns visited and interviewed women in many of the communities prior to the community visits and was present at all of them. She recorded in the native languages and transcribed into English many interviews with women who felt they were not able to make public presentations. She has prepared a special report which will be available on request from Medical Services Branch and the Nishnawbe-Aski Nation.

The panel published two newsletters which were circulated with the Wawatay News and reached most of the homes in all the communities.

Appendix 3

The Panel Hearings

A major part of the panel's work was the holding of hearings, most of which were public but a few were "in camera". In addition to hearings special meetings were conducted with a number of persons and groups whom the panel felt ought to be consulted. The purpose of these hearings and meetings was threefold:

- to gain factual data.
- to discover what people were feeling, recognize that the feelings were real, identify the causes and seek to determine if they were justified.
- to solicit suggestions or recommendations about changes that might improve the delivery of health care.

Hearings in Major Centres

There were two main kinds of public hearings. The first type, held in Sioux Lookout, Toronto, Winnipeg, and Thunder Bay, provided an opportunity — primarily for those providing health care and groups and individuals supporting or concerned about the provision of such care — to share their views. The second type, held in the communities within the zone, was primarily to provide an opportunity for the recipients of health care to share their concerns, complaints and suggestions.

The following is a list of the location and dates of hearings and of the main meetings that were held and of the number of formal presentations made at each. There were also opportunities for informal conversation at each of the hearings.

Location	Date	# of Presentations
Sioux Lookout	Sept. 12 - 16; 19 - 23/88	45 presentations involving about 150 persons.
Toronto	Oct. 3 - 7/88	16 presentations involving about sixty people.
Winnipeg	Oct. 17 - 19/88	14 presentations involving about 30 people.
Thunder Bay	Oct. 24 - 25/88	10 presentations involving about 40 people.

The persons and groups making presentations were both aboriginal and non-native and included: doctors, nurses, medical technicians, administrators and persons involved in groups or agencies who provide support for aboriginal people undergoing treatment or coming for special examinations and citizens concerned about health matters.

Local Community Hearings

At the community hearings most of the presentations were made in the native languages and each community provided one or more interpreters.The chief was responsible for the organization of the local hearing and they always opened with prayer, usually taken by one of the elders.

Location	Date	# of Presentations
Sandy Lake	Dec. 4 & 5	26
Sachigo Lake	Dec. 6 & 7	12
Bearskin Lake	Dec. 8	18
Fort Severn	Dec. 9	14
Weagamow Lake	Dec. 12 & 13	29
Muskrat Dam	Dec. 14	14
Big Trout Lake	Dec. 15 & 16	26
Kasibonika	Dec. 17	11
Lac Seul	Jan. 6/89	9
Fort Hope	Jan. 9/89	30
Lansdowne House	Jan. 10/89	11
Webeque	Jan. 11/89	13
Kingfisher	Jan 12/89	10
Wunnamin Lake	Jan. 13/89	17
Cat Lake	Jan. 18/89	13
Pikangiukum	Jan. 19 & 20/89	13 including a special presentation by the Tikanagen Child and Family Service and the Patricia Centre for Children and Youth.
Keewaywin	Jan. 20/89	6
Poplar Hill	Jan. 23/89	8
Deer Lake	Jan. 24/89	15 and a meeting with eight young people many who were high school graduates.
North Spirit Lake	Jan. 25/89	16
Slate Falls	Jan. 28/89	10
Osnaburgh	Jan. 27/89	14

Hearings on Manitoulin Island

Location	Date	# of Presentations
Wikwemikong	Feb. 21/89	11
Sheshegwaning	Feb.22/89	7

Community Hearings held in Sioux Lookout

The Panel was not able to visit three of the communities in the course of our tours, so these communities were invited to send representatives to Sioux Lookout to make presentations.

Community	Date	# of Representatives
Summer Beaver	March 7/89	3
Wapekeka		3
Savant Lake		5

The Panel also agreed to receive further presentations from the Co-ordinator of the Nodin Mental Health Program and from the Tikanagan Child and Family Service Agency and from the Patrcia Centre for Children and Youth. Eight people were involved.

Further Toronto Hearings

Date	Organization/Individual	# Involved
Feb. 2/89	Union of Ontario Indians	2
Feb. 13/89	Don Stewart, Native Health Care Unit of the Ontario Government	1
	Carrie Hayward, Health Consultant Union of Ontario Indians	1
	Key persons in the University of Toronto, Sioux Lookout Project	4
Feb. 14/89	Representatives of the Ontario Government's Ministry of Northern Development and Mines	2
	Dean S. McLeod, Department of Medicine, McMaster University	1

Ottawa Meetings

Date	Organization/Individual
Feb. 16/89	Representatives of the Ontario Region, Medical Service Branch
	Assistant Deputy Minister, Department of Health & Welfare
Feb. 17/89	Native Council of Canada
	Representatives of the Transfer Division.
	Senior Personnel of the Department of Indian Affairs and Northern Development.

Other Meetings

Meetings with Native Nurses:

The panel believed that Native nurses would have much to contribute and arrangements were made to meet with seven of them in "in camera" sessions at different dates. Several nurses also submitted written presentations.

Meetings with other Aboriginal Health Programs

Dr. Harry Bain visited the Director of the Northern Health Module, responsible for the James Bay Cree health care programs in Montreal (March14). On behalf of the Panel, Dr. Chan Shah visited Moose Factory (March 3-8/89) to report on health programs and services in that region.

Sioux Lookout Community Events

In the course of its work, the Panel became aware that both Native and non-native people were concerned about racial attitudes and racial tensions in the town of Sioux Lookout. The Chairman of the panel spoke at two public meetings addressing these issues and also addrssed the students in each grade at the high school. In consultation with the Mayor and with the help of a local committee which included aboriginal and non-native representatives, a special invitational community event was held (Mar.6)to help people become more aware of the factors that lead to racial tension and to begin to work together to address this issue. It is clear that the future of Sioux Lookout as a growing regional centre depends upon it becoming a community in which aboriginal and non-native people can live and work together and co-operate in the economic development of North Western Ontario. That co-operation will depend on increased respect and understanding between races and cultures.

Appendix 4

Functions of the McMaster Consultant Team

I Examination of current theory on community health and health care as it applies to the Sioux Look-out Zone situation through:

- Interpretation and application of recent government reports on determinants of health, the place of health service delivery within the total system and applications of the recommendations. This included operationalizing the concept of "health as a resource for living". (Epp, Evans, Spasoff, Spasoff)
- Recommendations for facilitating community education, shifting community norms, and stimulating community ownership of the issues through the hearing process. (Allen, Abrams, Farquhar, Kahn, Kettner, Daley and Nichols)
- Assessment of feasibility and appropriateness of various organizational structures to support recommendations for addressing identified health issues.

II Recommendations regarding how to identify and interpret the problems in the Sioux Lookout Zone by:

- Providing methods and instruments (participatory research protocols) for systematic qualitative data collection and analysis designed to identify:
  - the health problem areas as understood by the people, elicited through a voicing of their perceptions and experiences and their recommendations for change
  - hypotheses which emerge from these discussions which then led to lines of questioning in focus groups and throughout the hearing process
  - emergent hypotheses which guided the gathering of quantitative sources of information
- Facilitating the gathering of key data related to health status and determinants of health status from the scientific literature, Medical Services Branch, Nishnawbe Aski Nation, Department of Indian Affairs and Northern Development, Windigo Tribal Council and specific community reports.
- Demonstrating the use of the "Measurement Iterative Loop" (Tugwell) as a planning and priority setting tool. This analytic process begins with identification of the major health problems(burden) and moves through identification of the determinants of the health problem and how intervention can be applied to reduce the burden. The comparative efficiency of intervention (cost per reduction in burden) can then be examined when appropriate data are available. and following implementation of a partiuclar approach, the monitoring of impact is important to complete the full process.

  The McMaster group assisted the panel in looking at three major health problems applying this model in order to gather information regarding

the question, Have Medical Services made a positive impact on the health of the people in the past twenty years?

- Advising regarding interpretation of statistical data and recommending specific needs for appropriate methodologies in future assessment and monitoring of health status and services.

III A matrix approach to identifying key determinants of the major health problems which:

- Combines the information gathered through the quantitative approaches with the more qualitative themes that emerge from the hearings and the reports. Areas of emphasis that reoccur with several health problems can then be identified which, if addressed through culturally appropriate intervention, may impact on multiple health issues.

IV The setting of educational objectives for the Indian community, the health worker community and for organizations and government following:

- An understanding of the direction of the Panel's recommendations, educational objectives were suggested for knowledge, skills and attitudes shifts needed to move in those directions.

  The emphasis in these recommendations was on skill development for improved communication, preventive medicine and health promotion.

Members of the McMaster Team

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Donald C. Cole, M.D. Community Medicine Residency Programme.
Sylvia Farrel, B.A. (Research Assistant).
Philip A. Lange, M.A. (Research Assistant).

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Appendix 5

Medical Equipment

- complete equipment for taking and developing x-rays (portable)
- microscope
- equipment for taking blood pressure
- laboratory equipment for taking routine blood tests — hemoglobin, white blood cell count, sedimentation rate (C.S.A.) — and routine urine tests
- incubator for certain laboratory tests (e.g. bacteriology)
- refrigerator for certain laboratory specimens
- oxygen tents, oxygen and equipment
- courgette (mist tent) for babies with respiratory infection and disorders (e.g. croup, tracheites, etc.)
- OH10 transport incubator for premature newborns and other small babies with heart or lung problems
- illuminated eye chart for testing vision
- wall-mounted oto-ophthalmoscope for eye and ear problems
- schatz tonometer to measure eye pressure
- autoclave for sterilizing equipment
- electrocardiograph machine
- audiometer to test hearing
- stethoscopes
- fetascope to listen to unborn baby's heart
- ear curettes and irrigating syringe to clean wax from ears
- assorted surgical instruments for suturing wounds, cutting, changing dressings, removing splinters
- equipment to make and apply casts for fractures
- electric cast cutters
- plastic shears and spreaders
- equipment to perform vaginal examinations
- equipment and supplies to administer intravenous fluids, plasma, medication, etc.
- equipment for patient examination (e.g. table, lights, etc.)
- Gomco suction equipment
- cold mist humidifier
- thermometer
- telemedicine equipment (in some stations)
- fax machines (in some stations)

FACILITY	YEAR OF COMPLETION	STAFF	STAFF REQUIREMENTS	RENOVATION
Nursing Stations				
Pikangikum	1972	3 RNs 1 Clerk 1 CHR 1½ Housekeepers 1 Caretaker	1 RN 1 Interpreter 1 CHR	1989 Will have accommodation for 4 nurses. Fiscal year 89/90
Deer Lake	1983	2 RNs 1 Clerk 1 Housekeeper 1 Caretaker 1 CHR	1 RN to cover North Spirit Accommodation alright.	
Sandy Lake	1972	5 RNs 1½ Clerks 1½ Housekeepers 1 Caretaker 1 CHR 2 Mental Health Workers	1 Clerk 1 Female CHR 1 Nursing Station Admin.	Complete renovation 1988/89
Bearskin Lake	1983	2 RNs 1 Clerk 1 Caretaker 1 Housekeeper 1 CHR	1 RN to cover Sachigo Lake	
Big Trout Lake	1974	4 RNs 1½ Clerks 1½ Housekeepers 1 Caretaker 2 CHRs	1 Interpreter 1 Nursing Station Admin.	Complete renovation 1989/90

FACILITY	YEAR OF COMPLETION	STAFF	STAFF REQUIREMENTS	RENOVATION
Kasabonika	1986	2 RNs 1 Clerk Interpreter 1 Housekeeper 1 Caretaker 1 CHR	1 RN to cover Wawakapewin	
Wunnumin Lake	1988	2 RNs 1 Clerk Interpreter 1 Caretaker 1 Housekeeper 1 CHR	1 RN to cover Kingfisher	
Webequie	1981	2 RNs 1 Clerk 1 Caretaker 1 Housekeeper 1 CHR	1 RN to cover Summer Beaver	Renovation planned for 1991/92 Accommodation available for third nurse.
Fort Hope	1985	3 RNs 1 Clerk 1 Caretaker 1 Housekeeper 1 CHR 1 Mental Health Worker	1 RN for Public Health and Lansdowne - accommodation available. 1 Nursing Station Admin.	
Round Lake	1985	3 RNs 1 Clerk 1 Housekeeper 1 Caretaker 1 CHR	1 Interpreter 1 Nursing Station Admin.	

FACILITY	YEAR OF COMPLETION	STAFF	STAFF REQUIREMENTS	RENOVATION
Cat Lake	1986	2 RNs 1 Clerk 1 Caretaker 1 Housekeeper 1½ CHRs		
New Osnaburgh	1969	2 RNs 1 Clerk 1 Caretaker 1 CHR ½ Housekeeper	1 Nursing Station Admin. 1 CHR	In Capital Plan for replacing as soon as the community makes their decision as to where they want the new community to be.
Clinics				
Fort Severn	1983	2 CHRs		Nursing Station planned for 1992/93
Sachigo Lake	1983	1½ CHRs		Nursing station planned for 1990/91
Angling Lake (Wapekeka)	1982	1 CHR ½ Referral Clerk		Replacement clinic 1991/92
Kingfisher	1983	1½ CHRs		Nursing station planned for 1993/94
Lansdowne	1984	1 CHR ½ Referral Clerk		Replacement clinic in new settlement 1992/93

FACILITY	YEAR OF COMPLETION	STAFF	STAFF REQUIREMENTS	RENOVATION
Summer Beaver	1978	1½ CHRs		Nursing station planned for 1990/91
Muskrat Dam	1988	1½ CHRs		
Lac Seul	1988	1 CHR ½ Referral Clerk		
North Spirit Lake	1984	1 CHR ½ Referral Clerk		
Slate Falls	1981 rented cabin	1 CHR		Clinic 1989/90
Poplar Hill	School Clinic	1 CHR ½ Referral Clerk		Clinic 1989/90
Frenchman's Head	1988 rented space	1 CHR ½ Referral Clerk		