A DECADE OF CHANGE IN THE MUSHKEGOWUK TERRITORY (1987-1997): MOVING TOWARDS A SELF-GOVERNING HEALTH CARE SYSTEM

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Abstract / Résumé

There have been dramatic changes over the last decade in health coverage and health services in the Mushkegowuk Territory of Ontario, including an increase in the level of coverage by physicians, dentists and optometrist. 1995 can be viewed as the start of a self-government health care system. With the transfer of the regional hospital to First Nation control in 1996, First Nation people now have a say in the spending of health care monies. In spite of start-up problems, a new era of health care has arrived for Native people.

Il s'est produit des changements importants au cours de la dernière décennie en ce qui a trait à la couverture de la Santé et aux services de la Santé à l'intérieur du territoire de Mushkegowuk (Ontario); ces changements incluent un élargissement des services offerts par les médecins, les dentistes et les optométristes. On peut considérer l'année 1995 comme le début d'un système de santé autonome. Grâce au transfert de l'hôpital régional aux mains des Premières Nations en 1996, les peuples autochtones ont désormais droit de parole quant aux dépenses rattachées aux services de la Santé. Malgré des problèmes initiaux, une nouvelle ère dans les soins à la Santé s'est mise en place.

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Introduction

In Canada, provincial/territorial governments are responsible for the provision of health care (e.g., public health programs, acute care) to all residents Aboriginal and non-Aboriginal. While the federal government:

> does not specifically acknowledge a constitutional responsibility for hospital care. It does, however, recognize a 'fiduciary,' (*with confidence and trust*), responsibility for Aboriginal community health care services over and above those provided by the province (Weeneebayko Health Ahtuskaywin, 1996:4).

Thus, other non-insured health benefits not supplied by the province/territory have been provided to registered Natives by the federal government. These additional health care benefits include non-emergency medical transportation, prescription drugs, medical equipment (including prescription lenses), and dental care. This federally administered program "is the single largest native health program, costing the federal government more than $500 million nationally" (Weeneebayko Health, 1995:2).

Although a large sum of money has been spent on Native health care programs in Canada, Aboriginal people ("Indian" [status, non-status], Inuit and Métis) have according to 1990-1991 data, the:

> poorest overall health status... still have seven years less life expectancy than the overall Canadian population... and almost twice as many infant deaths—a higher rate than the poorest neighbourhoods in urban Canada (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996:30).

It is clear that the delivery of health care to Native Canadians must change to improve the dismal state of Native health.

Health care in Canada is now generally considered a continuum which includes not only acute treatment by doctors at hospitals but also the promotion of health, the prevention of disease, and the care of the elderly, disabled and dying (National Forum on Health, 1996). In other words there is movement "away from institutional delivery of services toward increased community-based services" (National Forum on Health, 1996:5). In Aboriginal communities, this general trend towards community-based health care also exists; however, many more obstacles need to be overcome compared to non-Aboriginal communities. The National Forum on Health (a consultation process with the Canadian people over a two year period) in particular, noted that:

> In Canada, Aboriginal communities face poor housing conditions, high unemployment rates, low incomes and, given the *long history of external control* (my emphasis), more significant

> impediments to community action. Furthermore, most illnesses occur much more frequently among Aboriginal peoples, and health status indices are worse than the country's average (National Forum on Health, 1996:3).

In this paper, I report on major changes in the health care system that occurred during the period 1987-1997 in the Mushkegowuk Territory (also known as the Moose Factory Zone, Ontario Region). Further, I discuss the move towards a self-governing health care system by First Nations (FN) of the Mushkegowuk Territory.

Study Area

Health Canada is the federal department responsible for Aboriginal health care. The Aboriginal health care program is administered through Medical Services Branch, Health Canada. Medical Services Branch divides Canada into regions. Within these regions there exists zones. In the Ontario region, there exists four zones: Sioux Lookout, Thunder Bay, Southern Ontario, and Moose Factory.

The Moose Factory Zone is located in the western James Bay region of northern Ontario, Canada. This region is also identified as the Mushkegowuk Territory and is populated by approximately 10,000 Cree. The Moose Factory Zone contains six First Nations (New Post, Moose Factory, Fort Albany, Kashechwan, Attawapiskat, and Peawanuck) as well as one town, Moosonee. The regional FN governing body is the Mushkegowuk Tribal Council.

Medical Facilities

The dispensing of health care to Cree of the Mushkegowuk Territory is a complicated matter because both provincial and federal medical facilities are located in this region. Historically, there has been very little cooperation between the two levels of government, provincial and federal. The result has been overlap in some health care services and deficiencies in others. Native health care has suffered due to this lack of cooperation. To fully understand this complex arrangement the history of health care facilities of the western James Bay region must be examined. I will give a brief history and description of provincial and federal health care facilities of the region.

Provincial Health Care Facilities

In the early 1900s, the Oblate Fathers and Grey Nuns established the Assumption Hospital in Moosonee, St. Anne's Hospital in Fort Albany, and St. Mary's in Attawapiskat. When the Moosonee hospital burnt down in

1969, the provincial government assumed control of the three Roman Catholic hospitals when the diocese could not afford to rebuild the Moosonee facility. The name of the hospitals were changed to James Bay General Hospital (Weeneebayko Health Ahtuskaywin, 1997b).

In 1985, a modern provincial hospital was built in Attawapiskat replacing the old Roman Catholic/provincial hospital. This new facility housed eight acute (four paediatric, three medical/surgical, and one obstetrical) and eight chronic care beds. In 1987, a new provincial hospital (basically, a mirror image of the one in Attawapiskat) was built in Fort Albany replacing the old Roman Catholic/provincial hospital. Both "wing hospitals" of James Bay General Hospital (JBGH) maintain 24 hour nursing staff. Wing hospitals also maintain radiographic facilities, dental suites, and a heliport for medical evacuations (Weeneebayko Health Ahtuskaywin, 1997b). The province provides ground and emergency transportation to coastal communities (Woodford, 1996), while the federal government provides funding for non-emergency medical transportation.

In 1993, a health centre was built in Moosonee and contained no in-patient beds; however, 24 hour on-call nursing and/or physician care was available (Weeneebayko Health Ahtuskaywin, 1997b). The administrative offices for JBGH as well as the ambulance service are also located in Moosonee.

At present, medical staff at the provincial wing hospitals consists of registered nurses, nursing assistants, and a mental health worker. Nursing staff provide both acute and chronic health care. Federally funded health professionals (e.g., physicians and dentists) are supplied through Weeneebayko General Hospital (WGH) and make monthly visits to the provincial hospitals. One physician is employed indirectly (through WGH) by JBGH and is stationed in Moosonee.

Federal Health Care Facilities

Moose Factory General Hospital (now known as WGH) was established in 1949 (Weeneebayko Health, 1995) on the island of Moose Factory as a tuberculosis hospital. This hospital serves as the regional hospital for the Mushkegowuk Territory and is fully accredited. Personnel will be discussed in a later section.

In addition to the federally funded regional hospital, there are also two community-based nursing stations (Kashechewan - six nurses and one Community Health Representative [CHR]; Peawanuck - two nurses and one CHR) as well as three community health centres (Moose Factory - three Community Health Nurses [CHN]; Fort Albany - one CHN and one CHR; Attawapiskat - one CHN and one CHR) (Weeneebaykó Health, 1996a).

The nursing stations are functionally the same as provincial wing hospitals with similar personnel and facilities. The only difference is that nursing stations do not have chronic care facilities.

The two community health centres in Fort Albany and Attawapiskat although physically located in JBGH (the federal government rents this space) are not functionally a part of the provincial hospital. The CHNs are employed in general by the federal govemment (although the CHN in Fort Albany is employed by the band). The nurses perform immunizations as well as provide health education to the school and the community with disease prevention being stressed. Community Health Nurses do not normally perform acute treatment on patients, these patients are referred to hospital or nursing station nurses (Weeneebayko Health, 1996a).

Community Health Representatives are employed by First Nations and work in conjunction with the CHN. The CHR

> program is a community based program of Public Health combined with a limited amount of treatment. The CHR is a valuable member of the health team and provides services in a culturally appropriate manner at the community level (Medical Services Branch Ontario Region [MSBOR], 1996:15).

Major Changes in Health Care Services in the Mushkegowuk Territory, 1987-1997

The major changes in health care services from 1987 to 1997 have been increases in the level of coverage as well as increases in the type of services available.

Physicians

In 1987, medical staff of Moose Factory General Hospital (MFGH) included: four full-time general practitioners; one full year equivalent paediatrician; one full year equivalent anaesthetist; a general surgeon; and interns. General practitioner locums and specialty clinics (e.g., cardiology) were also utilized to dispense health care services. In Moosonee, only one physician practised.

During 1997, medical staff of WGH (formerly MFGH) included: 6.5 family practice physicians (B. Helt, Family Practice Director WGH, personal communication; this number fluctuates) in a new family practice wing of the hospital; one full time equivalent anaesthetist; and one full-time general surgeon. The paediatric department no longer exists, being replaced by specialty paediatric clinics. Other specialty clinics are scheduled annually and interns/residents are still being utilized to dispense health care.

Dentists

In 1987, dental staff of MFGH included: one University of Toronto, Faculty of Dentistry intern stationed in Moose Factory (as well as visiting senior dental students and interns) and one locum general practitioner dentist servicing Peawanuck (C. Tsang, former Director of Dental Services MFGH, personal communication). A provincially sponsored dentist provided services to Moosonee on a monthly basis (A. Yee, Moosonee dentist, personal communication).

In 1997, dental staff of WGH included: three full-time dentists and two long-term locums servicing Fort Albany and Peawanuck. Senior dental students and interns still provide dental care. Specialty clinics have been scheduled in the zone (e.g., orthodontics) and others are being considered (e.g., oral surgery - B. Katapatuk, A/Director Dental Services WGH, personal communication). Dental services have not changed from 1987 in Moosonee (A. Yee, Moosonee Dentist, personal communication).

Certain dental services which were restricted in 1987 (e.g., crowns) are now available. There is also greater emphasis on prevention of dental disease than treatment of the disease state.

Optometrist

In 1987, the optometrist visited the zone on only two occasions. At present, the optometrist services the zone on a weekly basis (M. Flondra, Zone Optometrist, personal communication).

Community Health

Only one coverage change has been made in the zone since 1987. As of 1994, a full-time CHN has been employed in Peawanuck where only previously a CHR had been stationed (MSBOR, 1996). At present there are two CHNs stationed at Peawanuck (Weeneebayko Health, 1996a).

The major change in community health has been the establishment of the Regional Tuberculosis Control Program. This program will eventually be transferred to FNs of the region. Zone Tuberculosis Control Nurses have been hired as of 1994:

> to conduct active case finding, contact tracing, the training of front-line workers (e.g. Community Health Representatives)... revision of the Regional Tuberculosis Control Manual... develop culturally appropriate tuberculosis educational materials for First Nations communities (MSBOR, 1996:10).

Mental Health

In 1987, no formal mental health program either provincial or federal existed in the Mushkegowuk Territory. Presently, five organizations (Peeta-

beck Keway Keykaywin, Alemotaetal/Anemotaeta, WGH Psychology Department, Sagashtawao Healing Lodge, and Western University) provide mental health services to the region with Payukotayno (James Bay and Hudson Bay Family Services) offering family support services (Francoeur, 1995; Omushkego Arrow, 1996; Weeneebayko Health, 1996a; Weeneebayko Health, 1996d).

Peetabeck Keway Keykaywin is the St. Anne's Residential School Survivor Association. Allegations of physical and mental abuse including sexual have been made by former pupils against the Roman Catholic Church. St. Anne's Residential School was operated by the Roman Catholic Church in Fort Albany from 1904 to 1973 with students attending from both Attawapiskt FN and Fort Albany FN. In 1992, a healing conference was held in Fort Albany for students who attended the school to allow people to talk about their experiences and problems in order to help heal these people. People from across Canada attended this conference (E. Metatawabin, President Peetabeck Keway Keykaywin, personal communication; Milne, 1996). It should be stressed that J. Leguerrier (Bishop Emeritus) has always maintained that he did not know "of any sexual abuse of the children at the residential school throughout the years," however, this "does not mean that instances of abuse never happened" (Leguerrier, 1994:20).

Alemotaetal/Anemotaeta is the JBGH mental health program and was founded in 1990. This program provides services through community mental health workers in Moosonee, Fort Albany, and Attawapiskat. There is a Clinical Director based in Moosonee (L. Loone, Mental Health Worker JBGH, personal communication).

The Western University federally funded psychiatric program employs two long-term locum psychiatrists who make monthly visits of two to three days per month to the communities of the Mushkegowuk Territory (except Kashechewan). These psychiatrists work in collaboration with the JBGH mental health workers.

In 1996, a Zone Psychology Department was established being based out of WGH under the guidance of the Director of Social Services and Patient Advocate. The department is small consisting of one psychologist (a Ph.D. in psychology) and a psychometrist (a person who administers psychological tests). The psychology department was established to "compliment the psychiatry services that are already provided by...Western Universities' visiting psychiatrists" (Weeneebayko Health, 1996a: 4). The future of the Psychology Department is uncertain with the departure of the psychologist (Weeneebayko Health Ahtuskaywin, 1997c). It should also be noted that a psychologist cannot dispense medications to treat mental illnesses, only psychiatrists (who have not only a medical licence but also

specialty training) can dispense medications. This is an important point because mental illnesses are often organic in nature and require the use of medications to properly treat a patient.

The Sagashtawao Healing Lodge is a federally funded treatment centre located in Moosonee. The healing lodge is a modern facility housing 12 treatment beds, a weight room, living rooms, and various other rooms used for healing circles (MSBOR, 1996; Omushkego Arrow, 1996). Alternative mental health services, such as, traditional healing is offered (Weeneebayko Health, 1996d). The Sagashtawao Healing Lodge provides "services to Natives and is governed by Natives" (Omushkego Arrow, 1996:11).

Diabetes Education

Prior to the establishment of the Northern Diabetes Health Network (NDHN) by the Ontario Ministry of Health, no formal diabetes education program existed in the Mushkegowuk region. This is surprising since the incidence of diabetes in Aboriginal Canadian communities is three to five times greater than the general population in Canada (NDHN, 1996). The NDHN program was established

> to address the high rate of the disease and lack of services for it in Northern Ontario...to help people with diabetes and their families better manage the condition and reduce hospitalizations...to ensure people in Northern Ontario have reasonable access to a broad range of diabetes programs and services to improve their quality of life (NDHN, 1996: Aug. '96).

To accomplish their ultimate goal of reducing the incidence of diabetes in northern Ontario, diabetes educators are being trained in management planning and education techniques (e.g., group classes and individual counselling), while afflicted people are being trained in self-care (NDHN, 1996). Diabetes educators are to provide both initial and follow-up education and management (NDHN, 1996). Education and management:

1. reduces acute diabetes complications
2. decreases foot problems
3. shortens or eliminates the need for hospitalization
4. improves long-term blood sugar control (NDHN, 1996: July '97).

In the Mushkegowuk Territory, the NDHN education program is administered through Mushkegowuk Tribal Council, the regional FN political organization. There is a Diabetes Coordinator in Moose Factory and Diabetes Educators in Fort Albany, Kashechewan, Attwapiskat, and Peawanuck. The educators work closely with the dietician based in WGH (Nakochee, 1996).

Other Programs and Services

The National Native Alcohol and Drug Abuse Program (NNADAP) was established in the early 1990s by the federal government (M. Solomon, Health Coordinator Fort Albany FN, personal communication). This preventive program

> consists of community-based workers providing education and awareness, counselling, community development activities and organizing social opportunities for community individuals to participate in as an alternate to alcohol related activities (MSBOR, 1996:16).

This community outreach program addresses not only alcohol abuse but also solvent and drug abuse (Fort Albany First Nation, 1992). One community worker is located in each First Nation and is employed by their respective Band Council.

In 1995, a Patient Advocate/Translator was hired to work in Timmins, Ontario (the hub of air traffic to the Mushkegowuk Territory) by WGH "to assist patients and their families in accessing health services at Timmins and District Hospital and other area medical centres...to make health services in Timmins easier to access and more culturally sensitive" (Weeneebayko Health, 1995:1). The advocate greets patients at the airport and escorts them to their accommodations and appointments while also acting as their advocate/translator at Timmins and District Hospital. The advocate/translator is accessible having an office at the hospital (Weeneebayko Health, 1995). Eventually, a Timmins Native Out-Patient Facility (similar to Hotel Dieu in Kingston where transportation, translation, and accommodations for patients and families are available) is envisioned (Weeneebayko Health, 1995). Further, the advocate/translators job has been made easier with the publication of the English/Cree Medical Dictionary (Weeneebayko Health Ahtuskaywin and Mushkegowuk Tribal Council, 1996). This compilation strives to "improve the effectiveness of diagnostic and treatment services through better understanding by the patient" (Weeneebayko Health, 1996a:8). There are sections dealing with: anatomy, body systems (e.g., reproduction), birth and prevention, surgical procedures, bereavement, mental health, medical conditions/diseases, pharmaceutical, medical equipment, general terms, and a syllabic chart (Weeneebayko Health Ahtuskaywin and Mushkegowuk Tribal Council, 1996).

Patient services have also been improved since 1987 at WGH with the addition of a physiotherapist (a new full-time physiotherapist is required [Weeneebayko Health Ahtuskaywin, 1997c]), a sound booth for full audiological assessment, and a hydraulic lift for the minivan to aid in patient

comfort and hospital efficiency (Weeneebayko Health, 1995; Weeneebayko Health, 1996a).

The first Nurse Practitioner arrived in the zone in 1997. A Nurse Practitioner is a registered nurse who has received additional training and can treat out-patients while working under the supervision of a physician. The Nurse Practitioner can treat patients, order diagnostic tests (e.g., radiographic and laboratory) as well as prescribe medications. Patients are referred to physicians for further assessment or treatment if required. These nurses enhance the health care team by allowing physicians more free time to deal with other health care matters (Weeneebayko Health, 1996c).

Moving Towards Self-Government in the Health Care System

In an effort to increase the level of health of FN people, the federal government introduced the concept of a self-governing FN health system in 1986 (MSBOR, 1996). The transfer process although introduced in 1986 did not take effect until 1989.

> On June 29, 1989 Treasury Board approved authorities and resources to support the transfer of Indian health services from Medical Services Branch, Health Canada to First Nations wishing to assume the responsibility for the delivery and management of health programs.
>
> Health transfer enables First Nations to design and manage health programs according to community specific priorities, mobilize community participation leading to improved health status, become recognized as an equal participating health care provider within the Canadian Health Care System, be autonomous and accountable to their membership and to enhance First Nation self-government advancement (MSBOR, 1996:5).

There are three phases to the health transfer process to allow sufficient time for adaptation. Phase I involves research planning and development (Community Health Plans). Phase II involves negotiation with the federal govemment (Memorandum of Understanding). Phase III is the actual transfer of monies (Transfer Agreement - MSBOR, 1996).

In Ontario, the first Transfer Agreement was signed in December, 1993 in Timmins, Ontario with the Wabun Tribal Council (representing Wahgoshig FN, Mattagamis FN, Matchewan FN, and Brunswick House FN). As of 1994 in Ontario: 18 Community Health Plans have been

completed; six Memorandum of Understanding have been signed; and four Transfer Agreements have been signed (MSBOR, 1996).

Partners in Change

Since 1985, there have been numerous attempts in the Moose Factory Zone to establish a FN Board of Directors for MFGH for the eventual transfer of health services to the Mushkegowuk region (MSBOR, 1996). The chronology of events leading up to the signing of the Memorandum of Understanding between Medical Services Branch and the regional health board (October 1995) and the actual transfer of administration of MFGH to the board (April 1996) is presented in Table 1. The signing of the Memorandum of Understanding was viewed as a "historic event, not only as far as how health care will be delivered in the future, but also in terms of evolving self-government in the process" (Weeneebayko Health 1996a:1). The Memorandum of Understanding offered two assurances:

> verifies the government's commitment to transfer the federally operated hospital in Moose Factory to the First Nation's Health Board on April 1, 1996

and initiates

> the planning process and resources for the replacement of the existing facility and the development of a new health services plan for the area (Weeneebayko Health, 1996a:1).

The signing of the Memorandum of Understanding can be viewed as the starting point of a self-governing health care system for the Mushkegowuk Territory with the transference of administrative control from Medical Services Branch to WHA by April 1, 1996. However, it must be stressed that all health professionals working at WGH were not automatically transferred. Health care personnel working at nursing stations, CHNs, and NNADAP workers remained federal employees (Weeneebayko Health, 1996a, Figure 1). Physicians who were previously employed by Queen's University (even though they worked at WGH) were not signed with WHA until July 1996 (Weeneebayko Health, 1996c). Health care professionals who provide Non-insured Health Benefits (e.g., dentists employed by the University of Toronto to work at WGH) are as yet not employed by WHA.

The other assurance of the Memorandum of Understanding that of community planning will now be examined.

Health Services Planning Process

The Mushkegowuk Territory health services planning process has a sunset date of 1998. The objectives of this process are threefold: 1. To establish a Health Services Planning Office that will develop regional health

Table 1. Chronology of the transfer of Moose Factory General Hospital (MFGH) to the Mushkegowuk Territory regional health board, Weeneebayko Health Ahtuskaywin (WHA).

1985-1989	Numerous attempts in the Mushkegowuk region to establish a First Nation (FN) board to administer the transfer of health services to region.
1989	Two day meeting attended by representatives from FNs, federal and provincial health agencies and hospitals. Partners in Change process initiated in an effort to create "positive changes to health care delivery for the Mushkegowuk people" (Wesley, 1997:11).
July 1993	Renewal of the process to transfer MFGH to a regional FN board based on the Partners in Change principles.
Sept. 1993	Mushkegowuk Tribal Council endorses the establishment of a regional health board.
Oct. 1993	The health board meets for the first time and is comprised of 17 members (two members from each Mushkegowuk FN and Moosonee and MoCreebec) and the MFGH Chief of Staff.
Dec. 1993	The board incorporates under the name Weeneebayko Health Ahtuskaywin (WHA). Head office in Kashechewan.
Mar. 1994	WHA administration offices established at MFGH.
Oct. 1994	WHA Chief Executive Officer appointed.
Feb. 1995	MFGH changed name to Weeneebayko General Hospital (WGH) to reflect the regional nature of the hospital.
June 1995	WGH three year accreditation.
Oct. 1995	Memorandum of Understanding signed between Medical Services Branch (MSB) and WHA. WHA to administer WGH on behalf of MSB. MSB Transition Manager in place until Mar. 1996.
Apr. 1996	Administration transfer of WGH to WHA.

Sources: Weeneebayko Health, 1995, 1996a; MSBOR, 1996; Weeneeayko Health Ahtuskawyin, 1996.

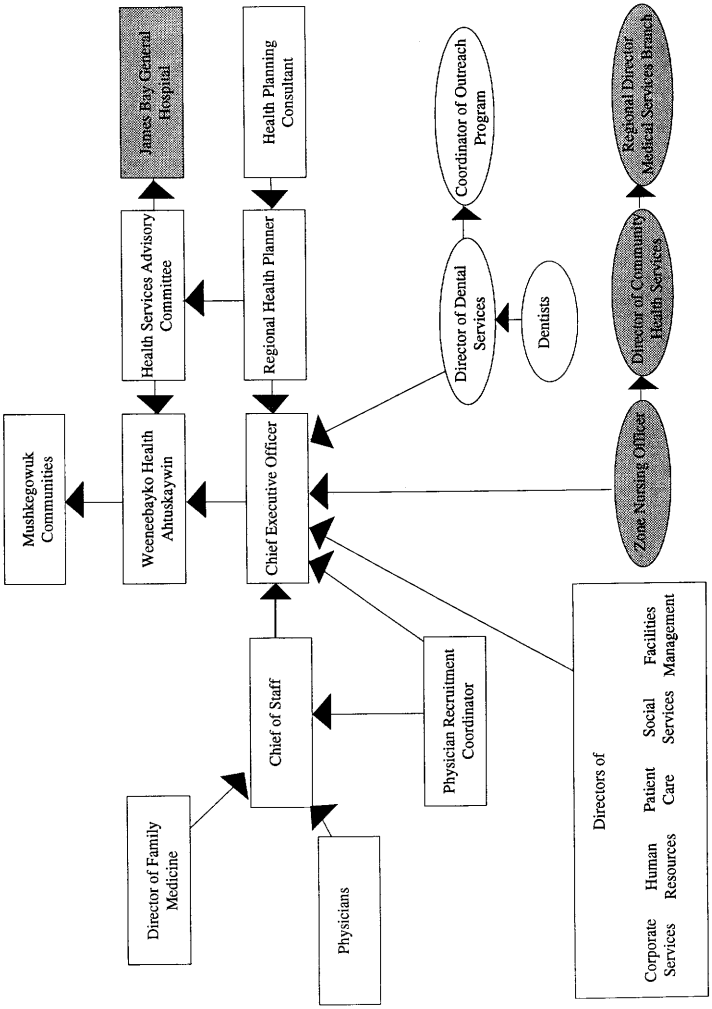

Figure 1: Organizational chart of health services for the Moose Factory Zone (Mushkegowuk Territory). Open boxes represent health services already under Weeneebayko Health Ahtuskaywin control (First Nation Regional Health Board). Open ovals represent health services still under University of Toronto, Faculty of Dentistry control. Shaded ovals represent health services still under Medical Services Branch, Health Canada control. The organizational structure of James Bay General Hospital (JBGH - shaded box) is not presented graphically. The Wing Director, Director of Patient Care, and Clinical Coordinator from JBGH Attawapiskat Wing and Wing Director and Support Services Director from JBGH Fort Albany Wing report to the JBGH Chief Executive Officer located in Moosonee. Modified from various sources (Medical Services Branch Ontario Region, 1996; Weeneebayko Health 1996c).

policy based on regional data. 2. To perform a regional health needs assessment at the community level with the goal being the improvement and expansion of community-based health services under local control. To gather data to be used in the generation of a model specifying type of health facility and services to replace WGH. 3. Unification of federal and provincially funded health services (Weeneebayko Health Ahtuskaywin, 1996a).

Health Planning Officer

In October 1996, a new department was established at WGH, the Health Planning Office. The Health Planner reports to the Health Services Advisory Committee which is made of representatives from Medical Services Branch, Ontario Ministry of Health, WHA and JBGH (Figure 1). The Health Planner works in collaboration with consulting teams. In general, the duties of the Health Planning Office include: development of a health services plan for the Mushkegowuk Territory; data collection and analysis; liaison work among and between communities, FNs, government representatives, and agencies; exploring funding opportunities; and follow-up of community forums (Weeneebayko Health, 1996c, d). Specifically, the Health Planning Office (Planner and consultants) are to provide information facilitating the regional health services planning process. That is:

- Inventory of Hospital-based programs, resources, and services;
- Utilization of... Community Hospitals... Regional Hospital... and Community-based facilities...
- Regional Health Status; including demographic survey, identification of health determinants and indicators;
- Inventory regional Long-Term care programs and services;
- Regional Health Issues/Priorities...
- Alternative Models of Health Care Delivery... options for the integration of conventional and traditional aboriginal medical practices (Weeneebayko Health, 1996d:6).

Hopefully, this process

> will ensure that federal and provincial health resources are planned and utilized based on community and regional priorities not external initiatives (Weeneebayko Health Ahtuskaywinj, 1996a:7).

Community Forums

Although data will be collected from records obtained from WGH, JBGH, Medical Services Branch, and Ontario Ministry of Health, a partici-

patory approach has also been adopted. An interactive approach will help identify important issues such as, gaps and overlaps in health services, community health priorities, and type of facility to replace WGH (Weeneebayko Health Ahtuskaywin, 1996). Questionnaires, surveys, and community forums will be used. First Nations of the region will be kept informed through community radio, television and video, newsletters, brochures, flyers, and local publications. Community forums began in 1996 (Weeneebayko Health, 1996c, d; Freighter, 1997a; Weeneebayko Health Ahtuskaywin, 1997a) and ended in 1997 (Weeneebayko Health Ahtuskaywin, 1997c). Follow-up discussions will continue into 1998 (M. Kelly, Health Planning Office consultant WGH, personal communication)

Unification of provincial and federal health services

Since 1995, JBGH and WHA have been meeting regularly in an attempt to formulate a plan for the unification of health care in the Mushkegowuk Territory. In February 1996, JBGH and WHA boards agreed to work together supporting a joint proposal

> for provincial funding to buy teleradiology equipment for the communities...The equipment will give doctors and nurses new diagnostic tools, with the ability to see and transmit high quality x-rays and other still images over regular telephone lines (Weeneebayko Health, 1996b:3).

Moreover, on October 23, 1996 JBGH and WHA signed a Joint Board Resolution dealing with the unification of the health care system (Weeneebayko Health, 1996c). The Joint Board Resolution

> reinforces the Health Boards' commitment to preserving and enhancing the provision of quality health care services by unifying the health care system in the Mushkegowuk Region. In doing so, support was given—by both Boards—for a comprehensive regional health needs assessment to take place (Weeneebayko Health, 1996c:1).

The Future

Weeneebayko Health Ahtuskaywin has adopted a Strategic Governance Plan that has two main goals. First, the construction of a replacement facility for WGH by the end of 1999. Second, the unification of health services (provincial and federal) under the guidance of a self-governing FNs controlled health board before the year 2000 (Weeneebayko Health, 1996a). Unification of JBGH and WHA is possible; huge provincial hospital budget cuts have already affected the operation of JBGH (Freighter, 1997b)

and make amalgamation more attractive than in recent years. However, amalgamation of JBGH with WHA is only one of the options.

Recently, community health authorities have been established in the communities of Fort Albany, Attawapiskat and Kashechewan. In Fort Albany and Attawapiskat there have been discussions about local health authorities taking control of the JBGH facilities (P. Chilton, former Moose Factory Zone Director and health consultant for Fort Albany FN, Kashechewan FN, and Attawapiskat FN, personal communication). If this were to happen, WHA would not control these facilities unless a separate arrangement were worked out between WHA and Fort Albany and Attawapiskat. Local control of the Kashechewan nursing station has been proposed. Unification of provincial and federal health services in the Mushkegowuk Territory is a complicated endeavour.

Physicians

Almost a full staff of physicians has been employed by WHA during 1997 (a full staff is 7.5 physicians; I. Fyfe, Physician Recruitment Officer WGH). However, number of physicians have fluctuated dramatically during the year. Retention of physicians should be a primary concern of WHA (B. Helt, Family Practice Director WGH, personal communication). Perhaps, medical auxiliaries such as nurse practitioners will be used to cover a shortage of physicians. As the Chief of Staff WGH has noted:

> Employing Nurse Practitioners is a natural progression for this area. Weeneebayko Health Ahtuskaywin (WHA) employs many Registered Nurses from Weeneebayko communities, but no doctors from this area. Therefore, the Nurse Practioner's role will complement the physicians services because the future Nurse Practitioners will probably be people originally from the Weeneebayko communities; thus, they will remain in the communities (Weeneebayko Health, 1997).

In fact, one Moose Factory resident has returned to school to complete the Nurse Practioner's training program (Weeneebayko Health, 1997).

There have been numerous discussions in the Mushkegowuk Territory dealing with the use of midwives and birthing centres. Although community birthing centres have been discussed, a cautionary note must be raised. Although birthing centres are becoming more common in large Canadian urban centres, these centres are associated with hospitals in case of complications during and after childbirth. Community birthing centres in the Mushkegowuk Territory (except in Moose Factory) would not have this type of access to emergency facilities. Further, 40.3% of the birth weights for

children in Moose Factory Zone for 1993 were at least 4.0 kg (MSBOR, 1996). Large babies can make for difficult births and complications.

Dentistry

At present, dentists working in the dental department are employed by the University of Toronto through a Medical Services Branch contract (Figure 1). Eventually, dentists like physicians may be employed directly by WHA.

The regional board is also pursuing a dental therapist program. Dental therapists are trained over a two year course to do restorations, simple extractions, cleaning and preventive procedures (e.g., fluoride application, cleaning). Their quality of work is comparable to a dentist. However, dental therapists cannot do dentures, endodontics, complicated surgery, diagnosis and treatment planning. Only in an emergency can therapists initiate any treatment that has not been diagnosed by a licensed dentist (Weeneebayko Health, 1996b).

Weeneebayko Health Ahtuskaywin believes dental therapists "could enhance the current dental service to the Mushkegowuk Territory; as well as potentially result in the employment of board members in this field" (Weeneebayko Health, 1996a). Although a trial dental therapy clinic was scheduled in 1995 for Kashechewan, it was cancelled because the Royal College of Dental Surgeons of Ontario threatened to revoke the licence of any dentist participating. Participation of a dentist in the therapy program would be contrary to the Ontario Ministry of Health's *Regulated Health Profession Act 1991*. The *Act* states that it is

> illegal for a dentist to delegate any controlled act to anyone who does not have the appropriate training and who, furthermore, is not governed by their own College (Weeneebayko Health, 1996a:13).

There are only three ways in which dental therapists could be employed in the Mushkegowuk Territory:

1. ministrial interpretation or exemption,
2. regulatory change or legislative exemption, or
3. legislative change to the *1991 Regulated Health Profession Act* (Weeneebayko Health, 1996b:10).

In the future, treatment by dental therapists may become a reality in the Mushkegowuk Territory. However, the Royal College of Dental Surgeons of Ontario (as shown by their dealings with dental hygienists) do not want to lose their authority to govern the provision of dental services. Moreover, dentists in the Timmins area have even expressed concern that if dental

therapists are given the right to practice in the Mushkegowuk Territory, therapists may eventually be given the right to practice anywhere (A. Yee, Moosonee dentist, personal communication).

Optometrist

At present the optometrist is reimbursed through a provincial program and private fees (M. Flondra, Zone optometrist, personal communication). Since it is the goal of WHA to implement a Non-insured Health Benefits program, then the optometrist will eventually have to be employed by WHA.

Community Health

At present, the community health program is administered by Medical Services Branch (Figure 1). This program will also be transferred to the regional board.

One program that has to my knowledge not been mentioned in the transfer process is the FN Environmental Health Program. This program is delivered by the Environmental Health Officers (certified Public Health Inspectors) of the FNs, and Inuit Health Program Directorate, Medical Services Branch, Health Canada. This program will be one of the most important programs to be transferred to Native people because as Health Canada (1995:1) points out:

> Our lifestyle plays an important role in keeping healthy. Conditions in our environment—our social, cultural, economic and physical surroundings—influence our ability to achieve and maintain good health.
>
> In any community, a safe environment means safe water and food supplies, suitably built and maintained housing, and proper disposal of wastes . . . an environmental health program involves identifying, preventing and correcting environmental problems which affect the health of community members.

This program takes a Native holistic approach to the environment and health which will be important in improving the health of Cree residing in the Mushkegowuk Territory.

Other Programs

Mental health programs will be one area where there will be and needs to be an increase in the amount of services provided to the region. The Psychology Department at WGH will now be utilizing two visiting Clinical Psychologists. Moreover, a return to a holistic spiritual approach to mental health is envisioned with the use of traditional healers and Native legends to bring back to the people, spiritual healing and traditional values (E.

Metatawabin, Peetabeck Keway Keykaywin President, personal communication).

The Northern Diabetes Health Network will continue the much needed diabetes education program in the Mushkegowuk region. A diabetes research program has recently been established at WGH for the region. The study will initially be descriptive (B. Helt, Family Practice Director, WGH, personal communication) but hopefully, diabetes research will expand into clinical research. Diabetes is the second most prevalent chronic disease in the Moose Factory Zone (MSBOR, 1996).

Discussion

During the last decade (1987-1997), there have been dramatic changes in the level of coverage and type of health services offered in the Mushkegowuk Territory. At present, the zone has fluctuating medical coverage of up to 7.5 physicians when fully staffed. Dental coverage is stable at this time (3 dentists, 2 long-term locum dentists) but the situation may change. Optometrical coverage is stable with a long-term locum optometrist. Services that were once not available (e.g., mental health and diabetic services) are now available.

Unification of the federal and provincial health services under Aboriginal control will ideally mean no overlap of services resulting in monies being made available to be used to fill in any deficiencies in the health care system. A prime example of overlap in services is in Fort Albany. With the opening of the Fort Albany Health Centre scheduled for fall 1997 (the opening has been delayed indefinitely, due to lack of electrical power), dental, optometrical, community health, diabetic, and mental health services will be moved from JBGH to Fort Albany FN. The health centre was originally intended to provide services directly to residents and school children in the village. Residence was also to be provided for visiting health professionals, especially during break-up when Fort Albany FN is inaccessible except by helicopter. The health centre (federally funded) was originally designed as a two-storey building with living quarters in the top level for visiting medical staff. The health centre that was built is only one-storey and does not contain the promised living quarters. Further, the new school promised for Fort Albany will not be built for several years. The health centre will not provide any of the original benefits promised. The health programs could have stayed in their JBGH offices. Hopefully, this type of situation would not happen under a unified health care system or locally governed Aboriginal health board.

Although the first year of transfer has been difficult with many unforseen expenses (a $550,000 one time grant was given to WHA to partially cover

the deficit - L. Loone, Chair, WHA, personal communication), the formation of the Weeneebayko Foundation may help offset expenditures. The Weeneebayko Foundation was formed to explore alternative means of funding being incorporated as a charitable foundation. Statement of activities include:

> Solicit funding from public and private sources... improving health care within the region. Provide an alternative or supplementary source of funding... in support of the mandate of the WHA... culturally sensitive... include traditional Aboriginal medicine and social practices. Acquire assets directly or indirectly related to the provision of health care in the region... Enter into agreements with other institutions/agencies for the purpose of research and the development of innovative health program and services... Provide opportunities for academic institutions to learn and experience the unique cultural and geographical characteristics of the James Bay area (Weeneebayko Health, 1996d:8).

In closing, it is evident that having control of health care funding allows FNs to have a direct say in how health care dollars are spent. Further, health services specific to the people can be realized with proper management (Weeneebayko Health, 1995: front leaf). However, the onus of responsibility for money expenditures has been shifted from the federal government to FNs. It will be interesting to see the new face of health care in the Mushkegowuk Territory either under full regional Aboriginal control or a system where there is both regional and community FN control.

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