

The Devolution of Authority for Health Care Services to the Governments of the Yukon and the Northwest Territories

GEOFFREY R. WELLER

1. Introduction: The Development of Health Care Services in the Territorial North

On April 1, 1988, responsibility for the delivery of health care services in the Northwest Territories was transferred from the Government of Canada to the Government of the Northwest Territories (GNWT). This marked both a significant moment in the devolution of province-like powers to the Northwest Territories and in the development of health care services. A similar devolution of authority for health is also likely to occur in a few years in the Yukon.

The health care system existing in the Northwest Territories and the Yukon has very largely been developed since the end of the Second World War. The responsibility for health services to Native peoples resided with the federal government; in 1945, the Department of National Health and Welfare (which had been created the previous year) had this responsibility transferred to it. In 1954, this responsibility was considerably enhanced with the creation of the Medical Services Branch (MSB) of the Department and the beginning of the development of a network of health care services covering the two territories and the provinces.¹

The system that was established across Canada consisted of three levels of care and a system of connectors. The smaller communities received nursing stations that had basic medical supplies and drugs, x-ray and basic laboratory equipment, an examining room or two and a few beds. The staff consisted of from one to six nurses and one or two indigenous people as clerks, interpreters or nursing assistants. The nursing stations provided primary care including outpatient care, uncomplicated childbirth in some cases, emergencies and the holding of patients for evacuation. The secondary level of care consisted of a series of small or 'zone' hospitals which served a number of communities. They usually had 20-30 beds, four or five general practitioners, more elaborate

laboratory equipment and a more extensive nursing staff than the nursing stations. These hospitals dealt with minor medical and surgical matters, more elaborate diagnosis and more complicated childbirth. The tertiary level of care was provided by large hospitals in major southern cities, namely Montreal, Toronto, Winnipeg, Edmonton and Vancouver. The system worked on a system of north-south linkages that were effected by visiting specialists, increasingly sophisticated telecommunications among the three levels, and increasingly effective air transportation. Very similar systems were set up at much the same time in the other nations of the circumpolar North.²

This system was expensive to maintain and operate, especially if judged on a per-capita basis. However, it had a marked impact on morbidity and mortality. The health care status of Canada's indigenous and northern peoples was extremely poor at the point of creation of the system and this, indeed, was one of the main reasons for establishing it.³ The system, which was curatively oriented and, essentially, an adaptation of southern systems to a northern locale, had a fairly rapid impact on infant mortality rates and the incidence of the major infectious diseases. While the situation in these regards is now not as good as it is for southern Canadians it is a vast improvement over the earlier period. While these systems have been quite effective within the context of their original purpose the continuing cultural and economic marginality of the northern Native peoples and relatively poor community infrastructures has led to a different disease pattern with which the system is not well equipped to deal and with which it will never be able to deal by itself. This new disease pattern is characterized by remarkably high incidences of violence, alcoholism and suicide and problems that generally relate to a changed lifestyle and diet.⁴

The federal system in the territorial North became increasingly sophisticated over the years and underwent a number of changes. In 1974, the Northern Region of the MSB was divided into the Yukon Region and the Northwest Territories Region. In 1980, the headquarters for the Northwest Territories Region was relocated from Edmonton to Yellowknife. In 1982, in an experiment in local control or self-government, the federal hospital in Iqaluit (Frobisher Bay) was transferred to the GNWT which established a regionally representative Board of Management for the hospital. This was followed in 1986 by the transfer from the federal government to the GNWT of nursing stations and regional public health in the Baffin region.

Over the years after the creation of the MSB, territorially controlled health facilities and insurance programs developed alongside the federal

system. By the date of the full transfer there was essentially a bifurcated health care system. In 1960, the Northwest Territories Hospital Insurance Services Board and the Yukon Hospital Insurance Services were founded. In 1970, the NWT joined the national medical care insurance plan which ensures that all residents, both Natives and non-Natives, can receive doctors' services without direct cost to patients or their families. The Yukon joined the national medical care insurance plan in 1972. Thus, at the point of full transfer in the NWT in 1988, the GNWT and the YTG were participating in both the national hospital and medical care insurance programs. Insured hospital services were provided at the point of full transfer from four hospitals in the Northwest Territories and three in the Yukon. With the transfer of health facilities in the Baffin region, the total NWT inventory was four hospitals (Yellowknife, Hay River, Fort Smith, and Iqaluit), the Inuvik long term care facility, twelve nursing stations and one public health centre.

The full transfer effected on April 1, 1988 in the NWT represented, as far as was possible, the consolidation of the two systems.⁵ Constitutionally, the federal government had to retain responsibility for the delivery of non-insured health benefits to Inuit and Status Indians, but by means of a Contribution Agreement the administration only of those benefits became the responsibility of the GNWT.⁶ The transfer also involved some 600 positions and a \$58 million budget being moved from the federal government to the GNWT. It also involved the transfer of two more hospitals (Inuvik and the cottage hospital in Fort Simpson) and all the remaining nursing stations in the central and western Arctic.

This paper will analyze the motivations for the transfer of health services and will then discuss why the Yukon is not on the same schedule for the devolution of health care as is the NWT. It will then discuss the process by which the transfer in the NWT was effected. This will be followed by detailed discussions of the financial, personnel, programs, facilities and property involved in the transfer. The new structures resulting from the NWT transfer will be described and then the likely effect of the transfer on the GNWT Department of Health and the MSB will be discussed. Finally, the likely effect of the transfer on health care services and levels in the NWT will be analyzed. The conclusions will comment not only on the NWT transfer but also upon how the NWT experience is likely to affect the process of devolution in the Yukon.

2. The Attitudes Toward Transfer in the Northwest Territories and the Yukon

The attitudes toward transfer differ markedly between the Northwest Territories and the Yukon. In the Northwest Territories in the mid 1980s there was support for the transfer of responsibility for health care from the GNWT, the Aboriginal organizations and the federal government. The motivations for support were different and they will be analyzed in turn. In the Yukon there was little support for the transfer of responsibility of health, at least in the immediate future, on the part of either the YTG or the Aboriginal organizations. The reasons for this will be discussed but they primarily relate to the fact that there was a failed attempt to effect a transfer of responsibility for health in the Yukon in 1978.

The GNWT has been pushing for the transfer of province-like powers for the past few years. In 1985, it identified some thirty programs over which it wished to assume control in the future.⁷ With the election of the Progressive Conservative federal government in 1984 it thought it probably had a four year window of opportunity (ie. the life of the federal government) in which there was real opportunity to make headway in the area. The GNWT also thought that if a number of transfers were well underway by the end of the period then, even if there was a change in government, the transfer process might be continued. Consequently, the GNWT put on a big push to effect transfers beginning in 1985. However, the GNWT became so heavily involved in the two large transfers, forestry and health, that a number of the anticipated smaller transfers were not effected.

The GNWT was also motivated to push for the transfer of responsibility for health care services because of what might be termed organizational factors. Transfer was regarded as a way in which a single administrative regime would replace the split administrative regime between the federal government and the GNWT. The GNWT believed that the single system would administer financial matters more efficiently, would eliminate extraneous influences imposed in the North by generalized federal government policies such as hiring freezes, and would allow for the introduction of programs that would be specifically suited to the needs of the Northwest Territories and not all of Canada. It was also thought a single administrative regime would speed up the response time to health issues by government.

The Aboriginal organizations in the Northwest Territories were motivated to support the idea of the transfer of authority over health to the

GNWT largely by the belief that it would allow them to have more direct control or influence over health care matters. They tended to agree with the organizational arguments put forward by the GNWT but added that the new health care regime in the North should be fully responsive, both organizationally and programmatically, to the needs of the Native peoples. Moreover, they argued for the need to have the Native groups involved in the transfer process to ensure the desired service outcome.⁸

The federal government was motivated to support the transfer of health services to the GNWT for a variety of reasons. Firstly, successive cabinets were sympathetic to the general process of the transfer of more province-like powers to the GNWT. Secondly, it was always regarded as a possibility that one day the GNWT would assume such responsibility. When the Medical Services Branch was established, the founding legislation indicated that the MSB was only a temporary creation that would be phased out when the GNWT was ready to assume responsibility for the delivery of health care. Even so, vested interests and bureaucratic inertia may well have made the MSB and the Department of National Health and Welfare resist a transfer had it not been for two factors. The first of these was that federal departments had been given downsizing targets by the new government and a transfer would allow them to more easily meet the person year target without actually changing very much. The second was the fact that Mr. Epp, the Minister of National Health and Welfare, was personally in favour of a transfer and brought in a new Director, Mr. David Nicholson, with a mandate to make it happen. Mr. Nicholson did, indeed, give his Regional Director the responsibility to negotiate a transfer with the GNWT.

The situation in the Yukon has differed quite markedly from that in the Northwest Territories in terms of attitudes towards devolution in general and the devolution of health care services in particular. The YTG has not been as concerned with effecting a transfer of authority for health as has been the GNWT either for constitutional/political reasons or health care reasons. In constitutional and political terms the Yukon has considered itself in advance of the Northwest Territories and has generally, therefore, paid less attention to specific program transfers. It has been more concerned with land claims issues and economic development than devolution. Within that general context, the Executive Council of the YTG has not placed a high priority on the transfer of health and has clearly been worried about the size and cost of such a transfer as well as the possibility that it would lead to a loss of staff. It was feared that people would not want to work in a very small bureaucracy

with a truncated career path. The attitude of the Council of Yukon Indians (CYI) more or less mirrored that of the YTG. That is, the CYI has also been concentrating upon land claims matters and has not turned its attention fully to devolution. Moreover, the CYI appears to have been more concerned, over the years, with natural resource rather than health issues. Its attention will only be likely to shift to health when these other issues have been dealt with. In these circumstances the federal government has wisely not sought to link developments in health between the two territories and has adopted the attitude that health matters can develop in each at their own pace. All of the parties are not unfavourably disposed to an eventual transfer of health responsibilities (although in the case of the CYI there would be many stringent conditions) but two of the parties clearly have higher priorities at the moment.

The current and different situation in the Yukon no doubt has a great deal to do with the fact that there was an abortive move to a transfer of health services in the Yukon in 1978 which followed the movement of responsibility in the other direction, to the federal level, in the 1950s and 1960s. With the expansion of population in the Yukon in the 1940s territorially delivered health services expanded. By the 1950s, the federal government was arguing that it was not sensible to have a federal service for Indians and a territorial system for everyone else side-by-side in an area with a small population overall. They argued that the health system in the Yukon would be enhanced by pooling resources and eliminating overlap.⁹ The cathartic event for change appears to have been the weaknesses in the bifurcated system revealed by a polio epidemic in 1953.¹⁰ The following year the Yukon Territorial Council gave tentative approval for a unified health service for the Yukon. Many services were transferred to the federal government on April 1, 1957 and the remaining services in 1962. The federal government had already largely financed a new hospital in Whitehorse which opened in 1959. The Mayo and Dawson hospitals became federally administered in 1970. Thus, in stages, authority over health was transferred to the federal authorities.

The move towards the abortive 1978 Yukon transfer was a consequence largely of YTG criticisms of the federal government's operation of health services. The YTG complained that the federal government allowed a chronic shortage of public health nurses to develop, that they concentrated on the health of Indians and paid much less attention to others, and that they allowed the YTG little influence over the nature of the health care system. Thus the YTG reversed its earlier stance and argued for a transfer of responsibility for health care back to them. By the mid 1970s, the federal government agreed to work towards a transfer of

all health care services as long as the Yukon Indians were party to negotiations and a transfer agreement. In October 1977, the YTG gave an approval in principle to such an agreement and April 1 was then set as the transfer target date.

However, everything unravelled in February 1978 when the Council of Yukon Indians informed the federal government that it would no longer agree to a transfer. The federal government then withdrew from the negotiations. The CYI gave several reasons for its change of heart. Firstly, they stated that they believed a transfer would lead to a deterioration in the level of medical services in the Yukon. They especially feared that many health care personnel would leave the Yukon rather than join the Yukon public service. Secondly, they stated that there was a lack of support for the move in the Indian communities. Thirdly, they argued that the YTG had not achieved sufficient maturity to assure them it would fairly administer a transferred health system.¹¹ The YTG's arguments that they would give Indians certain guarantees and would have specific programs designed for them were not persuasive. It is to be noted that the issue of Native support and the worry about the effects on staffing of a transfer became central concerns in the later NWT transfer.

The fact that an effort to devolve health care had failed in the Yukon provided some useful lessons in the Northwest Territories. Key among these was that the support of the Aboriginal organizations was extremely important, if not vital, and that great care would need to be taken to ensure that the services of health care professionals were not lost to the territory. Another important lesson was that a real effort would have to be made to assure all residents that they would be treated fairly under a new territorial health care system. Yet another lesson that was learned was that matters should proceed slowly or in stages. By a combination of design and good fortune the process of devolution of health care in the NWT largely avoided the pitfalls experienced in the Yukon. It is to a detailed analysis of the successful health transfer that this paper now turns.

3. The Transfer Process and Mechanisms in the Northwest Territories

The health transfer process in the Northwest Territories was a three phase process involving first the transfer of responsibility for a hospital to the GNWT, then the transfer of all the nursing stations in one region and then the transfer of facilities and services across the Northwest Territories. While the process was not always smooth it worked with

reasonable efficiency and speed given the number of groups and the complexity of the issues involved.

The initial support for the transfer of health services to the GNWT came from the Inuit Tapirisat of Canada (ITC) in 1980. A motion was passed at an ITC meeting that year stating that all Inuit communities should have health services provided by the GNWT. The GNWT approached the federal government with this idea but the federal authorities wished it scaled down. Finally, it was agreed that initially a transfer would only cover the Baffin Regional Hospital in Iqaluit (Frobisher Bay). The negotiations began in January 1981. In the summer of 1981, the GNWT Department of Health established a Board of Management that would assume responsibility for the hospital after transfer. It was agreed that the federal government would pass authority to the GNWT which, in its turn, would have the Board of Management operate the hospital on behalf of the GNWT. The transfer was completed by December 1982. The Board, which included representatives from communities in the Baffin Region, ran the hospital for two years and then was evaluated. The evaluation indicated that the transfer and the Board style of management had been a success.¹²

This positive evaluation set the stage for what became known as Baffin Phase II which consisted of the transfer to the GNWT of responsibility for all the nursing stations in the Baffin Region. Phase II began in the summer of 1985 with the transfer being completed by September of 1986. The process used in this transfer established the model for the transfer process to be used in the main transfer of health care to the GNWT.¹³ The process was characterized by a system using a steering committee and three working committees practising wide ranging consultation and with the full support of Aboriginal organisations.

Once the authority had been received to begin negotiations, a steering committee was established to coordinate the process. The steering committee included representatives of the Department of National Health and Welfare, the GNWT (Health), the ITC, the Native Women's Organization, the Baffin Regional Council and the Baffin Regional Hospital Board. Three working committees were established to deal with personnel, finance and capital, and operations. The working committees received contributions from a number of GNWT departments. The Department of Public Works and Highways advised the Department of Health on the current value of facilities and what was necessary to upgrade them. The Department of Personnel gave general advice on personnel matters and a member of the Department chaired the Working Committee on Personnel. The Department of Justice

reviewed the documents involved. In addition, the Department of Health received money and support from the GNWT's Devolution Office.

The Baffin hospital transfer and the Baffin Phase II worked quite well and thereby provided some useful lessons concerning how the full transfer might be reasonably effected. It was clear that a precondition of success was the agreement and support of Aboriginal organizations. It was also clear that it was important to establish the steering and working committees on a broadly representative basis, especially in relation to the Aboriginal organizations. Further, it was seen to be important to establish, well ahead of time, a regionally representative organizational structure to which authority would be passed by the GNWT. This helped to convince the Aboriginal organizations that local or regional control was a real possibility. This was vital as such control was the main reason for their support of transfer. Other important lessons were also learned, including the need to involve other GNWT departments so that their expertise could be used in personnel matters or in matters relating to physical facilities.

Having learned important lessons from the staged transfer of health services in the Baffin Region the GNWT began organizing a full transfer of responsibility for health care services. It began by trying to ensure that the Aboriginal organizations supported the idea. This was necessary not only because the Baffin experience indicated that it was a condition of success but because the federal government had adopted the position that, since it had the responsibility for non-insured health benefits for Inuit and Status Indians in perpetuity, the transfer would have to be acceptable to the major native organizations. The experience in the Baffin Region not only meant that the ITC supported full transfer but it meant that the Keewatin and Kitikmeot Inuit Associations also agreed, as did the Committee for Original Peoples Entitlement (COPE). The Dene Nation and the Metis Association of the Northwest Territories wanted guarantees concerning the process and its outcomes in writing and argued for a formal Participation Agreement. The Metis Association eventually withdrew from this process and never did come back in. They withdrew because they simply did not believe that they would have a significant role in the process and felt that they would be sidelined. However, the Dene signed a Participation Agreement with the GNWT and the federal government on February 13, 1987.¹⁴ Thus most of the Native groups made something of an exception for health services even though they had deep concerns about the impact of the general process

of devolution upon the issues of land claims and division of the Northwest Territories.

The Dene and Inuit agreed to the health transfer because the implied regionalization would allow them a say in the delivery of health services and because the necessary monies would essentially be passed through the GNWT to the proposed Regional Health Boards. In addition, they agreed because they had a voice in the transfer process itself and because the whole idea of local or regional control over health care services fit with their concepts of self-government. The Dene insisted on a Participation Agreement because they did not trust the GNWT. They wanted to ensure that they would be consulted, that the health transfer came within the Memorandum of Understanding on Devolution that they signed with the GNWT¹⁵ and that the health transfer would not interfere with or prejudice discussions concerning self-government and land claims. The Métis did not agree with the health transfer but they were unable to halt the process because of their legal and constitutional status or more accurately, lack of status. If the Dene or Inuit had objected, the transfer could not have taken place.

With the Inuit and the Dene having agreed to the full health transfer three steering committees (Arctic, Inuvik and Western) were established to conduct the discussions for transfer. The Regional Director of the MSB and the Deputy Minister of Health of the GNWT were on all of the steering committees and an official of the GNWT Devolution office acted as the secretary to all the committees. Otherwise, the committees were broadly representative of the major groups within each region. For example, the Inuvik Health Transfer Steering Committee included representatives of the Inuvialuit Social Development Fund, the Dene/Metis Mackenzie Delta Regional Council, the Beaufort Delta Conference Group, the Shihta Regional Council, the Inuvik Hospital Advisory Board and the Town of Inuvik. The steering committees were responsible for guiding and negotiating the preparation of the necessary documentation, coordinating the operations of the working committees and making the final determinations.¹⁶ The work of the steering committees was vital and it is fortunate that what they recommended did not vary greatly, for the result had to be a single transfer document. Fortunately, the Baffin transfers had established the parameters of their discussions and the GNWT and federal representation across the committees ensured some consistency of approach.

Three working committees were established under each of the steering committees. In each case they dealt with Operations, Personnel and Finance and Administration. Each committee was co-chaired by a

federal and a GNWT employee and the members represented each of the groups that belonged to the steering committees. The three Finance and Administration Working Committees had to identify, inspect and evaluate all affected properties. They also had to identify all of the financial resources that should be transferred and assess their adequacy.¹⁷ The three Personnel Working Committees had to have all the federal jobs reclassified to the GNWT system, counsel all employees on the effect of the transfer, and liaise with the unions involved.¹⁸ The three Operational Working Committees had to identify the level of health services to be transferred, define the residual responsibilities of the MSB and identify the monitoring data for non-insured health benefits. As mentioned earlier the tasks of these working committees involved the use of a great deal of expert help from a number of government departments.¹⁹

While the steering and working committees were undertaking their work, the GNWT was going into the regions to try and ensure that the necessary infrastructure was in place for the formation of the broadly representative regional health boards that the Baffin transfers indicated were likely to be the key structures in the new system. It was hoped that a network of community health committees would form the basis of the transfer and the representatives on the Regional Boards. These CHCs were also regarded as necessary to act as both buffers between the users and the nurses and as support structures to the nursing station. While the MSB had established CHCs in many communities it had not, in the years prior to transfer, paid a great deal of attention to them; many became defunct. Work was therefore required to re-establish and strengthen CHCs. The strengthening was largely done in the form of workshops for CHC members. At the same time, the Director of Hospitals and Health Facilities was appointed Public Administrator pursuant to the Territorial Health Insurance Act and was sent into the regions to prepare the legal documents necessary for the creation of the regional boards.²⁰

4. Finance, Personnel and Programs in the Northwest Territories

The preparations for the health transfer in the Northwest Territories involved lengthy and complicated negotiations over matters related to finance, personnel and programs. By and large these negotiations went smoothly, perhaps largely because of the experience with the earlier Baffin transfers. In this section each of the areas of negotiations will be discussed in turn.

The GNWT was quite optimistic that it could correctly estimate the financial sums that should be involved in the transfer. This, in part, was because it had been reasonably satisfied with the financial aspects of the Baffin transfer. The Baffin Regional Hospital transfer had added \$3.1 million in 1987/88.²¹ Just before the full transfer, the federal authorities gave the GNWT a snapshot picture of the resources that were then dedicated to programs and this formed the basis of negotiations. The full transfer, throughout the Northwest Territories added \$58.6 million to the 1988/89 budget (about 7% of the total) and an additional \$4 million to the 1989/90 GNWT budget. Of this total, \$49.9 million affected the expenditure base for the receipt of formula funding from the federal government. Of the total sum \$10.6 million was a payment to the GNWT for them to administer Indian and Inuit health care and is a sum which will be negotiated annually.

The capital value of the facilities that were transferred was established as the result of a complex process. The then current cost of facilities was established by taking the actual cost at the time of construction and adding the cost of any renovations done. The GNWT and federal departments of Public Works then agreed on a building life of 25 years in the Northwest Territories. Every building was inspected by a team to get the years of life left averaged by region within the Northwest Territories. A calculation was then made of the amount to be transferred based upon the need to replace the buildings at a certain point. It was agreed that buildings undergoing renovation or construction at the point of transfer would remain the possession of the federal government until completion and then they, and the lands upon which they were situated would be transferred and become the property of the GNWT pursuant to the Territorial Lands Act.²²

The financial and property dealings were lengthy and complicated but accomplished without a great deal of rancour and on time. The number of properties involved (as previously indicated) was large, and there were some complications such as what to do about the grants in lieu of taxes paid by the federal government on buildings that were to be transferred. In addition, all public property listed in the Health Public Property Register (which included vehicles, equipment, food, linen, drugs and supplies) had to be transferred to the GNWT on April 1, 1988.

In terms of personnel, the federal government declared that one of their major concerns in the transfer process was the well-being of affected employees. Federal employees were to be given every possibility

for re-employment if they did not want to transfer. All federal employees were to be offered jobs by the GNWT and, if they accepted them, care would be taken regarding the level of their responsibilities, should there be any change. Moreover, federal employees who accepted job offers with the GNWT would have priority status for federal public service positions for one year following the transfer. Clearly, however, despite these safeguards and the assurances given, the idea of transfer created uncertainty among the more than 500 people who were affected.²³ The task of classifying all of the jobs involved was lengthy and complicated but the real problems occurred with the movement of employees.

As soon as it became clear that transfer would indeed happen, personnel problems began to occur, as one would expect. The idea of transfer created uncertainty and people began to look for jobs elsewhere. Obviously, the most experienced or best qualified of those who wished to leave were able to depart before the date of transfer. In addition, the federal government had increasing difficulty replacing people who left because of uncertainty created by the impending transfer. For whatever reason it would seem that federal hirings were reduced for a period before the transfer. However, at the point of transfer most of the people involved did transfer, including 85% of the nursing staff. Earlier, many of the nurses had stated that they would not sign their GNWT job offers if they had to become members of the Union of Northern Workers (UNW) and drop their membership in the Professional Institute of the Public Service (PIPS). A group of the nurses took the matter to court, but lost when Justice M.M. de Weert rejected their arguments.²⁴

A personnel-related matter caused a major upset in what had until then been a fairly smooth process. This was the announcement in February 1988 of a Transfer Policy by the GNWT just prior to the health transfer date of April 1, 1988.²⁵ The aspect of the Transfer Policy that created the upset was the fact that it called for the transfer of individuals in personnel, public works and the like to these departments, not to the Department of Health of the GNWT, and hence to the Regional Boards. The major Native organizations and those likely to be involved in the Regional Boards thought that the Transfer Policy was specifically designed to reduce the authority of the Regional Boards and hence reduce the significance of Native participation. A further irritant was the fact that the policy was not to be applied *ex post facto* to the Baffin Regional Board. Some of the Native organizations thought the episode revealed bad faith on the part of the GNWT.²⁶ GNWT officials argue that the timing of the announcement of the Transfer Policy was unfortunate and accidental and did not imply an effort to reduce the authority of

the Regional Boards. In fact, they argue that while, indeed, the location of service personnel in the related department rather than Health is more efficient for the GNWT it is also likely to be helpful to the Regional Boards, especially the smaller ones.

Some personnel problems remain after the transfer. A number of the employees left the employ of the GNWT under the federal government's one year period of grace. There have been some teething troubles with the equivalence of pay and conditions after transfer. In addition the new (post-transfer) hires do not get the same beneficial terms and conditions, thus causing some friction.

However, it seems likely that matters will sort themselves out reasonably well, largely because of two factors. The first is that jobs with the GNWT are becoming increasingly attractive. The GNWT public service has rapidly become quite large and expert and the career paths for employees are quite reasonable. In terms of the nursing staff, for example, there is a career path that could take them from nursing stations to a hospital environment and, perhaps, to headquarters in Yellowknife. In addition it is likely that work at the nursing stations will be somewhat easier with CHCs and Regional Boards as support structures. The second is that continued employment with the federal MSB is becoming less attractive. This is because of the uncertainty created by the possibility of transfers south of 60° to Native self-government units. By way of a final note it should be borne in mind that, even prior to the transfer, the turnover of nursing staff in the Northwest Territories was very high with some regions having greater than 100% per annum.

Prior to the transfer, the two levels of government operated different types of programs. The GNWT operated Medical and Hospital insurance and a variety of other programs such as pharmacare, family life education, health information and promotion, and physician recruitment. The federal government operated community health programs such as nutrition, careers, environmental health, dental and communicable disease control. With transfer, they all became the responsibility of the GNWT.

However, the federal government retains some functions, largely in the area of non-insured health services, but also matters such as health services to federal employees, civil aviation medicine, and health services under the Quarantine and Immigration Act. Non-insured health services include drugs prescribed by a licensed physician, prescribed appliances, ophthalmic services, dental treatment, transportation and alcohol treatment. Although non-insured health services were not transferred, the GNWT administers them under the terms of a Contribution

Agreement²⁷ whereby the GNWT provides staff, office space and other services and the federal government supplies the needed money (\$11.6 million in 1989/90). The Contribution Agreement can be cancelled upon one year's notice by either party. While the GNWT is the administrative agent for non-insured health benefits it does not have a major role in determining the nature or the level of services. These matters are determined by the federal government in discussion with Native organizations. The forums for these discussions are determined in the Contribution Agreement which calls for a Dene, an Inuit and an Inuvialuit Committee. These Committees are broadly representative of Native groups but include a representative of the GNWT Department of Health and they are chaired by a federal government representative.

5. The Post-Transfer Situation in the Northwest Territories

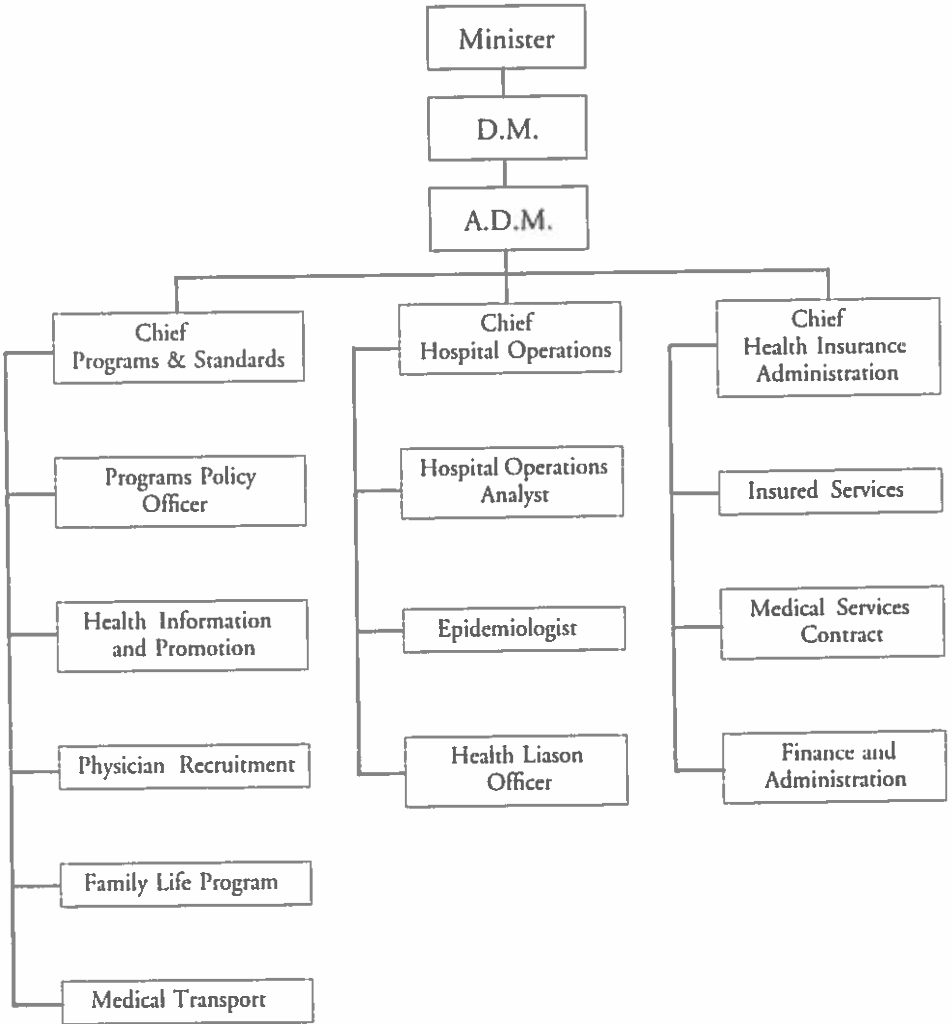
The transfer of health services precipitated major structural changes within the GNWT Department of Health. These involved a complete revamping of the organization of the Department at Headquarters and the creation of Regional Boards and a Territorial Board. The transfer of health services also created the possibility that the programs and facilities might change over time to reflect different and more locally-determined priorities than was previously the case. Both areas will be analyzed in turn.

The health transfer had a major impact on the Department of Health of the GNWT and, indeed, on the GNWT public service generally. The health transfer involved the addition of over 500 people to an establishment of about 3,800 and \$58.6 million or 7% of the total GNWT budget. It sparked a major restructuring of the GNWT Department of Health as illustrated in Charts 1 and 2. Basically the Department changed from a three column structure (Community Health and Standards and Insurance and Institutional Health) headed up by chiefs²⁸ to a two column structure (Community Health and Standards and Insurance and Institutional Health) headed up by Assistant Deputy Ministers.²⁹ This new structure was developed to reflect the new responsibilities of the Department, to better distinguish the line and staff operations, and to emphasise operations within an expanded organization.

As was remarked earlier, the main reason that the transfer of health services took place was that the major Native organizations were supportive. They were supportive because it was understood that after the transfer there would be a regionalization of the health care delivery

Chart 1

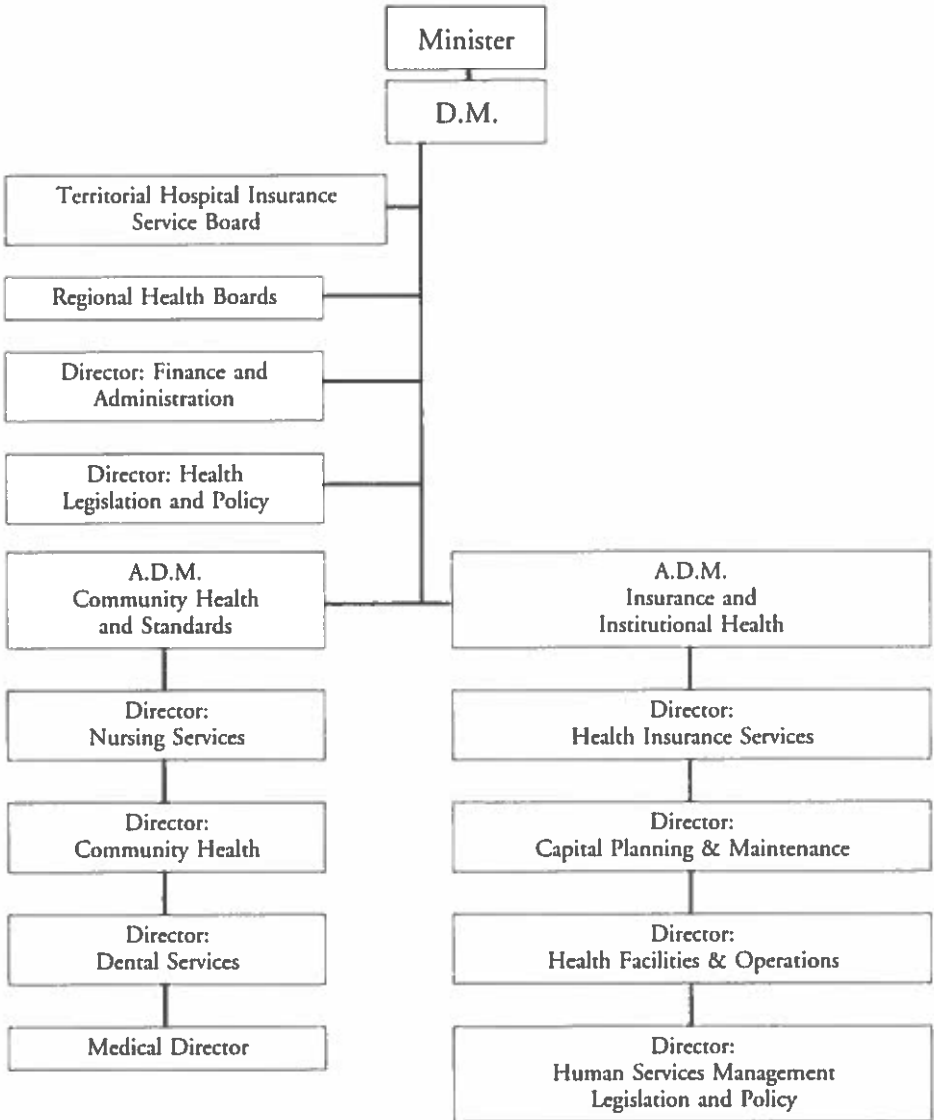
The G.N.W.T. Department of Health: Pre-Transfer



Source: G.N.W.T. Main Estimates 1988/89

Chart 2

The G.N.W.T. Department of Health: Post Transfer



Source: G.N.W.T Main Estimates 1989/90

system that would enable them to achieve a high degree of local or regional control of health services. The model for this regionalization would be the regional Health Board established after the Baffin transfer. After the full transfer in April 1988, a system of regional boards, along with a territorial board, was set up under the Territorial Hospital Insurance Services Act.

Under the Act there are five Regional Health Boards, one each for the Keewatin, Kitikmeot, Mackenzie, Inuvik and Baffin regions. Each of them is broadly representative of its region. For example, the Keewatin Regional Health Board is comprised of one member from each of the eight communities and a representative for each of the Keewatin Inuit Association, the Keewatin Regional Council and the Churchill Health Centre Board. Initially, these Regional Boards were chaired by the GNWT Regional Directors (who no longer have line authority) but the intention was to move to a lay chairperson, as is already the case with the Baffin Regional Board. The members of the Regional Boards are appointed by the Minister of Health from nominations made by municipal or band councils; the nominees are generally members, or chairpersons, of Community Health Committees.³⁰

The Regional Health Boards are important creations because the GNWT has gone on record as being committed to a high degree of local control in general and of health services in particular. Local control is intended to make the services more responsive to local needs and more responsive to inter-ethnic needs, as well as improve the level of satisfaction with the services delivered. The Regional Health Boards have been given major responsibility in the planning, management and delivery of health care services, including the delivery of medical and dental services, and the operation of the hospitals and nursing stations within their regions. The Regional Health Boards will operate as autonomous managers of health program delivery as described in a master agreement between the GNWT and each of the Boards. The Boards will each negotiate separate support service contracts with GNWT service departments for the provision of direct and indirect services.³¹ In those regions with a hospital, the chief administrator of health services is called a Chief Executive Officer while in those without a hospital, the chief administrator is called an Executive Director.

In addition to the Regional Health Board there is also a Territorial Health Board.³² This Board is intended to ensure that public participation in policy and management continues to have a territory-wide focus. It is comprised of representatives of the main Native organizations who

are nominated by those organizations and of 'eminent persons' nominated by the Regional Health Boards. The Territorial Board is chaired by an official of the GNWT Department of Health. The Territorial Board has responsibility for maintaining reasonable equality of facilities, services and standards by region. It is argued that, for example, uniformity in terms and conditions of work is necessary to prevent the Regional Health Boards competing with each other for staff.

It is too early to say with any certainty whether or not local control will indeed be effected by the structures just described. While it is possible that it might, there are several forces that could operate to defeat the stated objective. If the Territorial Health Board establishes an extensive and uniform regulatory system, this would detract from local control. If the physicians are able to exert greater influence in a decentralized system, as may well be the case, this would detract from local control and would affect the mix of services likely to be provided. If the Regional Chief Executive Officers and Executive Directors dominate the Boards because of their expertise, or feel they are more answerable to central authorities than to the Regional Boards, then local control would also be diminished. A great deal also depends on the degree of expertise and the willingness to work and exercise control on the part of members of the Regional Health Boards. The GNWT Department of Health is trying to tackle this side of things by revitalizing the Community Health Committees and by establishing a training program for Community Health Representatives in cooperation with Arctic College. The Department has also prepared a trustee manual to help with the training of the members of the Regional Health Boards.

The combined effect of the transfer of health services to the GNWT, creating a more unified health care delivery system and the attempt to establish, within that context, a high degree of local control may well lead to a significant program reorientation over the years. This is certainly the hope of those who think that the pre-transfer health system was somewhat inappropriate for the health problems encountered. That is, the emphasis on curing infectious diseases did not match well with the health problems encountered which were really social pathologies and chronic illnesses.

However, there are a number of difficulties that may minimize such a shift in orientation. In the first instance, the facilities and the programs taken over are of the old sort. Changing or adding to either facilities or programs is likely to be costly. In the second instance, there may well be professional resistance to such a reorientation. In addition, there could be local resistance as communities may well be conditioned into think-

ing that the only 'proper' health services are those of the existing system dominated by curative acute care services.³³ Indeed, if what is regarded as a satisfactory level of existing services is not maintained, those who could not afford it might go elsewhere to receive acute care services.

There are some initial encouraging signs that indicate a shift in orientation may come about and there are some changes that might be helpful whatever the orientation is of health services. Perhaps symbolic of reorientation is the renaming, after transfer, of the nursing stations. They are now called "Community Health Centres." A generally useful change is that the separation of the nursing staff from the community will be reduced by having them live in regular houses in the community and have them do things such as ordering food in the same way as everyone else in the community. In the same vein, the intention is not to have visiting specialists and others stay at the nursing station but in the community in the normal facilities others use. The GNWT Department of Health is hoping to place a greater emphasis on health promotion and education than was the case under the previous federal system. In fact, there are plans to develop a new health education program. It is also hoped that the supply of certain types of health manpower will be increased. An attempt, for example, is being made to increase the number of Community Health Representatives.

Two other intentions relating to a new orientation are of considerable significance. The Minister of Health, Nellie Cournoyea, has stated, "we expect to make inroads into the areas of attracting Native people into health careers."³⁴ In the long run, this is probably the key to having a truly representative health care system in the Northwest Territories, namely to have it reasonably representative in its composition of the people it serves. The other intention that is significant is that the GNWT Department of Health intends to provide more health services and facilities within the Northwest Territories. This is reflected in the expansion and upgrading of facilities and services at the Stanton Yellowknife Hospital and the construction of a boarding home for Inuit. There are also plans to build a boarding home for Dene and Metis in Yellowknife. It may also be reflected eventually in such things as the phasing out of the Churchill Health Centre in northern Manitoba and the construction of a small hospital in the Keewatin Region.

6. Conclusions

In terms of process, the health transfer to the GNWT was effected relatively smoothly and effectively. Very clearly the major reason for this

is the fact that the whole process was staged and valuable lessons were learned in the early stages, namely the two Baffin transfers. Also important was the fact that all major groups were at least initially in favour of the transfer, although not all for the same reasons. The two big disruptions in the process were the dispute over union representation in connection with the nurses and the adoption by the GNWT of the Transfer Policy. Because of the latter incident, the major Native groups are still suspicious that the GNWT seeks to undercut the authority of the Regional Boards. Only time will tell if they are correct.

In terms of outcome, the health transfer to the GNWT has set the stage for generally positive potential developments. The structures put in place should enhance local autonomy and authority. The fact that Native peoples have majority representation on those new structures gives them the opportunity to enhance their role and influence. The transfer integrates all health services within the Northwest Territories and beyond that within the regions. This, along with the greater local control, increases the likelihood of better and beneficial linkages being made with related non-health agencies. The transfer should also allow a much needed shift in program emphasis over time, while also allowing for a reasonable balance to be achieved between territory wide standards and local control.

There are renewed efforts in the Yukon to devolve authority over health care to the YTG. It seems likely that the process will take place in stages with the first stage being the takeover of the Whitehorse hospital. The experience in the Northwest Territories would indicate that a staged process is probably a sensible one. The experience in the NWT also confirms many of the lessons that were learned in the Yukon's unsuccessful 1978 attempt at the devolution of health care. It confirms that great care has to be taken with personnel matters, especially in relation to nurses. That is, it confirms that the Yukon Indians back in 1977/78 were correct in being worried about the possibility of a serious loss of medical staff. A loss did indeed occur in the Northwest Territories, although it was not disastrous. The experience of the NWT also confirms that the support of Aboriginal organizations is vital. However, the experience of the Northwest Territories also indicates to the Yukon that the pitfalls can be managed, if not avoided, and that there is a strong possibility that health care for all citizens will be enhanced under a unified delivery system.

Geoffrey R. Weller is President of the University of Northern British Columbia.

NOTES

- ¹ Canada, *Establishment of Northern Health Services*, Memorandum to Cabinet by Paul Martin, Ottawa: Department of National Health and Welfare, October 12th, 1954.
- ² See Geoffrey R. Weller, "The Delivery of Health Care Services in the Canadian North," *Journal of Canadian Studies*, Vol.16, No. 2, Summer 1981, pp. 69-80.
- ³ See R. Quinn Duffy, *The Road to Nunavut*, Kingston and Montreal: McGill-Queen's University Press, 1988, chapter 2, "Looking After Health," pp. 51-94.
- ⁴ *Ibid.*, pp. 91-94. See also John O'Neil, "The Politics of Health in the Fourth World: A Northern Canadian Example", *Human Organization*, Vol. 45, No.2 Summer 1986, pp. 119-128.
- ⁵ Government of Canada and the Government of the Northwest Territories, *Northwest Territories Health Transfer Agreement*, Tabled Document No. 125-88(1), 31st March 1988.
- ⁶ Government of Canada and the Government of the Northwest Territories, *Contribution Agreement*, Tabled Document No. 127-88(1) 7th April 1988.
- ⁷ Interview Mr. Horne, Manager, Devolution Office, Government of the Northwest Territories, 13th February 1989.
- ⁸ See *Healthbeat*, Vol. 9, No.2 Summer 1987, p.2.
- ⁹ See Janet Moodie Michael, *From Sissons to Meyer: The Administrative Development of the Yukon Government, 1948-1979*, Whitehorse: Yukon Education, Libraries and Archives Branch, June 1987, p. 29.
- ¹⁰ *Ibid.*, p. 28
- ¹¹ *Ibid.*, p. 99
- ¹² See Lynn Elkin Hall and Associates, *A Recommended Outline of the Devolution Process Based on the Baffin Health Phase II and Forestry Transfers*, Yellowknife: Lynn Elkin Hall and Associates, December 1986, p. 10.
- ¹³ *Ibid.*
- ¹⁴ Government of Canada, The Commissioner of the Northwest Territories and the Dene Nation, *Participation Agreement on the Devolution of Health Services within the Dene/Metis Settlement Area in the Northwest Territories*, 13th February 1987.
- ¹⁵ Government of the Northwest Territories, Dene Nation and Metis Association of the Northwest Territories, *Memorandum of Understanding on Devolution of Power and Authority to GNWT from Canada with the Involvement of the Dene and Metis*, Yellowknife, 24th April 1986.
- ¹⁶ Government of the Northwest Territories, *Steering Committees, Transfer of N.W.T. Region. Terms of Reference* Yellowknife: G.N.W.T., 14th January 1987.
- ¹⁷ Government of the Northwest Territories, *Administrative and Finance Sub-Committee, Transfer of NWT Region Terms of Reference*, Yellowknife: G.N.W.T., 14th January 1987.
- ¹⁸ Government of the Northwest Territories, *Personnel Sub-Committee, Transfer of the N.W.T. Region, Terms of Reference*, Yellowknife: G.N.W.T. 14th January 1987.
- ¹⁹ Government of the Northwest Territories, *Operations Sub-Committee, Transfer of NWT Region, Terms of Reference*, Yellowknife: G.N.W.T. 14th January 1987.
- ²⁰ Interview J. McGraw 14th February 1989.
- ²¹ Government of the Northwest Territories, *Audit Report, Baffin Regional Health Board, Transfer of Health Care Responsibilities*, File 91-04-31-800, no date. The transfer of the nursing stations received a special audit which indicated that, indeed, the estimates had been correct.
- ²² Interview Mr. Horne, Manager, Devolution Office, G.N.W.T. 13 February 1989.
- ²³ See Hon. Jake Epp, *Notes for an Address at a Ceremony Transferring Responsibility for Health Care to the Government of the Northwest Territories*, Yellowknife: August 25, 1988, p.5.
- ²⁴ See *News North* 25th April 1988, "Most Nurses Accept Job Offers."

- ²⁵ Government of the Northwest Territories, *GNWT Transfer Policy*, Yellowknife: G.N.W.T., 24th February 1988.
- ²⁶ See, for example, Inuvialuit Regional Corporation, *Press Release on Transfer Policy*, Inuvik: I.R.C., 30th March 1988.
- ²⁷ Government of Canada and Government of the Northwest Territories, *Contribution Agreement*, Tabled document No. 127-88(1), 7th April 1988.
- ²⁸ See Government of the Northwest Territories, *Main Estimates, 1989/90*, Yellowknife: G.N.W.T., 1989, p. 14-04.
- ²⁹ See Government of the Northwest Territories, *Main Estimates, 1989/90*, Yellowknife: G.N.W.T., 1989, p. 15-02.
- ³⁰ See J. Epp, *op. cit.*, p. 6.
- ³¹ See Government of the Northwest Territories, *Institutional Structures, GNWT Health System*. Yellowknife: G.N.W.T., 6th July 1987, pp. 7-8.
- ³² *Ibid.*, pp. 9-10.
- ³³ See A.P. Ruderman and G.R. Weller, "Health Services for the Keewatin Inuit in a Period of Transition: The View from 1980" *Inuit Studies*, Vol. 5, No. 2, 1981, p.55.
- ³⁴ The Hon. N. Cournoyea, *Address at the Health Transfer Ceremony*, Yellowknife, August 25th, 1988, p.4.