

Democratizing Health Services in the Northwest Territories: Is Devolution Having an Impact?

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Introduction

In this paper I will examine the relationship among community health committees, health trustees, and regional health boards in the context of devolution and the democratization of health services in the Northwest Territories. The purpose of this examination will be to determine whether devolution is contributing to increased community control over health policy and planning, and to identify structural factors which constrain or enhance attainment of this goal. This analysis will be largely based on a case study of the Baffin Regional Health Board with supplemental information from other regions.

General Issues Related To Democratizing Health Services

In 1981, with the creation of the Baffin Regional Hospital Board, the Northwest Territories joined other Canadian provinces in an historic attempt to "democratize" health services and ensure broad community participation in the health sector. Prior to 1981, most community health services in the Northwest Territories were administered by a federal bureaucracy. This phase of northern health service history corresponds to the "centralized" approach to health services which characterized the rest of Canada until about 1970 (Warner, 1981). Canadian studies of experiments in community participation in the health sector are rare. A general review of the available literature suggests that the following general themes are important in studies of community participation in health service delivery (Eakin, 1987; Warner, 1981). Northern dimensions to these themes are added in italics.

- 1) Structural differences in the nature of professional (e.g. medical, nursing) vs bureaucratic authority. Although authority in both spheres is hierarchical, professional authority is based on perceived expertise and knowledge while bureaucratic authority is essentially organizational (i.e., based on rank). *There are relatively few physicians in the NWT. Nursing is the predominant health profession but is organized bureaucratically.*

- 2) Resistance of health service power structures to democratization (i.e., chief of medicine and hospital orderly as “unequal” board members). *Health care professions are excluded from direct representation on boards and committees by statute.*
- 3) Public perceptions of relative legitimacy of bureaucracies vs professions. Public generally views bureaucracy as restrictive and supports professional autonomy. Most health professionals in the North are either civil servants or on contract to the government.
- 4) Problems in defining communities, community representatives, and the general fit between boards and their immediate socio-political environment. Hospitals or health clinics may in fact provide services to a variety of different “communities” (e.g. ethnic minorities, elderly, transient, etc). Determining the boundaries of these communities and who represents them may be difficult. *Most northern communities and regions are predominantly aboriginal but rapid social change and an increasing transient non-aboriginal population complicate representation.*
- 5) Relative priority given to health issues by various interest groups in the community. Some studies suggest that for poor and ethnic minorities, health has low priority after jobs, housing, education and security. *Aboriginal politicians have been predominantly concerned with land claims, aboriginal rights and economic development.*
- 6) Extent to which community participation is limited to an “advisory” role. Five models have been identified which demonstrate a range of organizational patterns (Notkin and Notkin, 1970):
 - a. The community advisory committee which is usually appointed by the health agency or government, is relatively powerless and is generally regarded as paternalistic by minority groups. *Community health committees under the federal system fall into this category.*
 - b. The situation where an appointed committee or board tries to arrogate power to itself through a series of conflicts and confrontations. *On occasion, health committees have pursued this tactic. The Gjoa Haven Health Committee sought control over the local nursing station unsuccessfully in 1985.*
 - c. The community-elected board which may have community-based authority but which may lack an understanding of health issues and complexities and may have difficulty assuming authority over health professionals.
 - d. The joint provider-consumer board of trustees where power is theoretically shared between health professionals, other health workers and consumers of health services. While the board members may have collective expertise and authority over administrators, status differences within the Board may constrain effective operation.
 - e. *Regional Health Boards share features of both 'c' and 'd' above but 'ethnicity' rather than 'profession' plays a more important structural role.*

Each of these themes can be examined in relation to the devolution of health services in the NWT. However, health care delivery in the North has a number of unique professional, administrative and ethnic features that require independent analysis.

The Context Of Community Participation In Health Services In The Northwest Territories

Prior to 1960, health services in Inuit communities were administered by the local population. This rather obtuse statement is intended to reflect the unique historical reality of northern communities where organized government services have only been available for the past thirty years. Prior to 1960, most Inuit lived in family based nomadic hunting units, where the health of individuals was the collective responsibility of the group.

Between 1945 and 1969, contact between Inuit and Euro-Canadians resulted in a series of devastating infectious disease epidemics that both undermined the traditional medical system and required an increasingly professional medical presence in the North. Physicians accompanied supply ships, and the religious missions built hospitals in isolated regions. Contact with medical services was crisis oriented and medical authority was paternalistic. For example, during the tuberculosis epidemic of the 50's and 60's, Inuit were required to have regular chest x-rays on board the supply ships that visited each community once per year. If evidence for active TB was discovered, patients were not allowed to leave the ship and were sometimes sent south to sanatoria without the patient's family being informed. Many people remember these experiences and recall incidents where families fled inland to hide from medical authorities when they received news the supply ships were approaching (O'Neil, 1986).

In the 1960's, the federal government initiated a program to construct nursing stations in every Inuit community. Completed in the early seventies, these primary health clinics irrevocably changed the relationship between the communities and their health. In 1976, when I was conducting ethnographic fieldwork on health beliefs and practices in a Kitikmeot community, the standard response to the question "What do you do when you are sick?" was "I go to the nursing station."

Nursing station policy was set in Ottawa. National standards of operation meant that very little change could be negotiated at the community level. The majority of health care providers were also government employees. Local practitioners were in almost all cases

salaried nurse practitioners who reported through a hierarchy of nursing supervisors to senior administrators. In some instances, administrators were physicians, but nursing was not subordinate to medicine. The handful of physicians directly involved in primary care generally functioned in an advisory capacity to local nurses. Specialist physician services were available through universities usually, and were on a consultative basis. With rare exceptions, there were few Native people employed in the health service bureaucracy.

Efforts to increase "community participation" in health services for Native people were limited initially to the "community health worker/auxiliary/representative" (CHR) program which began in the provinces in 1960. CHRs were local people trained to provide basic public health education. This program was reviewed in 1973 and made available to Inuit communities subsequently. The following statement from the Task Force report of Community Health Auxiliaries is illustrative of the philosophical climate at the time:

The Task Force realizes that involving Native people in meaningful discussions affecting the provision of health care can be a frustrating and unrewarding experience. In the first place, the majority of Native people have been conditioned over the years to become tacit recipients of health services. Secondly, the majority of Native people, particularly those in more remote settlements, are suspicious of the white man's intention when asked to participate in the decision-making process. Furthermore, some Native people believe closer participation may lead to erasing of aboriginal or treaty rights; and finally Medical Services is not always able to respond positively to decisions or requests made by the Native people particularly if the request is phrased along the line, "We want a doctor full-time in our community." The Task Force notes that (because of cultural differences and educational deficiencies) Native people have little understanding of the meaning of good health. (Report of the Task Force of Community Health Auxiliaries 1973: 61-62)

The Task Force further found that the integration of CHRs into the health system was largely unsuccessful for two reasons:

1. Lack of support from other health care workers. Nurses and physicians received little orientation regarding the role and function of the CHRs and tended to devalue their contribution.
2. Lack of support from local communities. Although efforts were made to link the CHRs to community development activities by making them band or hamlet employees, CHRs generally worked in isolation without local support.

In an attempt to resolve this latter problem, MSB initiated a program in 1975 to create "Health Committees" in each northern community. These committees were to be periodically elected from the community and were advisory in function. Health committee activities were to be voluntary in nature; no discretionary funds were made available to hire staff, provide honoraria or produce health education materials. Committees were expected to identify public health problems in the community and act as a "liaison" between the nursing station and the community. They could recommend action to either the local nurses (who were expected to attend monthly meetings as observers) or the CHR (who was expected to function as a secretary to the committee), but had no authority or resources to ensure that their recommendations were pursued. Indeed, since most recommendations required a significant outlay of resources (e.g. move the sewage lagoon further from town; hire a dental therapist; set up a homemaker program for elderly people), local health care staff were also powerless to comply. In research conducted in 1976 on health services in one Inuit community, I found that of all suggestions brought forward by the Health Committee over a two year period, less than ten percent ever received any indication of support from federal, territorial or municipal levels of administration. Of the ten percent that were supported, the majority were on the initiative of the local Settlement/Hamlet Council (O'Neil, 1987).

It is little wonder that in most Inuit communities, health committees have had very uneven success. In most communities, they were disbanded after years of frustration. In a few communities, Health Committees have been "resurrected" on several occasions as new, enthusiastic nurses moved to town. In rare cases, Health Committees have established themselves successfully as effective advocacy groups, lobbying health and other services for new community health programs (e.g., Arviat). In these latter cases, there is often one individual in the community with a profound personal commitment to community health whose energy has sustained the Health Committee in the face of overwhelming neglect by the health care system.

At the same time that the federal government was "under-developing" the health committee, the territorial government was establishing a broad program of community participation in most other service sectors. Particularly in the early 1980's, increasing numbers of local Inuit have been hired and trained to provide a range of health-related services such as welfare administration, housing, alcohol counselling, social work and municipal administration. In many of these areas, local committees or boards have also been formed to reflect community

needs and implement territorial policy in collaboration with government departments. The territorial government has provided at least some support for these structures with funding for honoraria and technical assistance. As a result, many Inuit communities now have a number of annually elected boards and committees whose responsibilities are to some extent related to health.

Indeed, the relative success of the territorial approach to community participation in the delivery of human services has contributed to an ironic situation where some communities have more committee positions than eligible citizens. Many individuals sit on several committees and find it difficult to sustain the time and energy required for full participation. As a result, some committees have difficulty achieving regular quorums and most of the committee work is done by two or three regular members.

This situation has also contributed to fragmentation of authority at the community level (Graham, McAllister and George, 1980). Local councils are unable to deal with community issues holistically and although council members sometimes sit on other boards and committees, communication among these various structures is poor. Most communication is directed upwards, to Yellowknife, and much of this communication is limited to expressions of displeasure with government services or policies (Graham, 1989).

In 1977, a third level of government was created with the establishment of the Baffin Regional Council (BRC). This structure consisted of the mayors or chairs from all the community councils and was intended to coordinate Baffin regional interests in relations with Yellowknife. Other regional councils were formed in the late 70's and early 80's.

At the same time, some initiatives were taken to establish other regional coordinating bodies in areas such as education, wildlife management, and business development. The health sector was not represented at the regional level until the creation of the Baffin Regional Hospital Board in 1981.¹ As Graham (1989) has recently described in detail, the relationship among territorial, regional and community authorities has been an uneasy one. The past few years have seen a succession of statements on appropriate policy for future development of each level of government. Central to these discussions are two key themes:

- 1) Extent of authority to be vested in community councils *vis-à-vis* other community organizations and external levels of government.

- 2) Dimensions of the role and authority of regional governments and other regional bodies.

In the remainder of this paper, I will examine the impact of devolution of health services in the Baffin Region in relation to the extent to which local control has been achieved and to the overall coherence of the health care system.

Devolution And Public Participation In Health Services

Establishing Regional Health Boards

Transfer of responsibilities for administering health services was initiated in 1980 by Inuit Tapirsat of Canada (ITC). A motion was passed at their annual assembly in Coppermine requesting that all health services in Inuit communities be administered by the GNWT. The background to this request was quite simply a tidal wave of frustration with a system that resisted all forms of public participation in the policy process (O'Neil, 1989). At the community level, people could see that services administered by GNWT provided more opportunities for individual participation in various training programs, and the various committees and boards that articulated with GNWT structures were generally more successful in effecting changes. At the same time, ITC was strongly against the devolution of other powers from the federal to the territorial government, arguing that devolution threatened the successful completion of the land claims process with attendant self-government provisions.

With federal approval of a staged devolution process, negotiations began for the transfer of ownership of the Frobisher Bay Hospital to the GNWT. This transfer was effected in 1982 when the hospital management board in the Baffin Region began to administer the hospital on the government's behalf. In 1984, this transfer was judged to be a success and negotiations began to transfer responsibility for all nursing stations in the Baffin Region to the GNWT, again to be locally administered by a regional health board. This transfer occurred in September, 1986. Finally, transfer of the remaining health facilities in the NWT occurred in April 1988.

Prior to the Baffin Hospital transfer in 1982, there were hospital boards operating in Yellowknife, Hay River and Fort Smith. Until 1977, these hospitals had been privately owned and operated; one was Catholic, one was Pentecostal and the third hospital in Yellowknife was owned and operated by the Yellowknife Hospital Society, a local philanthropic

organization. In the mid-seventies, GNWT developed a policy that all health services in the Territories should be owned and operated by the territorial government. The Yellowknife hospital was purchased by the territorial government in 1977 and a new facility was built in Ft. Smith to replace the Catholic hospital. In 1978, the Territorial Health Insurance Services (THIS) Act was amended to establish hospital "boards of management" to be appointed by the Commissioner of the NWT. This legislation did not specify the size or representation on the boards, but did exclude individuals with a vested interest in hospital operations, including medical and nursing staff and their spouses. Although this exclusionary principle was implemented without comment at the time, it had the effect of setting Territorial hospital boards apart from their provincial counterparts where health professions are often represented on boards.

In Yellowknife, the old "hospital society" board was rolled over into the new administrative structure. This board determined that there should be fifteen board members. Attempts were made to ensure that there were Native representatives on the board but this representation was not guaranteed. Most board members continued to be prominent citizens of Yellowknife.

More recently, regional representation has become an issue since Stanton Yellowknife Hospital (SYH) serves as a referral centre for remote regions in the NWT. While an effort has been made to include regional representatives on the Board through a consultative process between the Commissioner (now the Minister of Health) and various constituents, this representation is not codified. Given that there are now seven "health" regions, five of which use SYH on a regular basis, the number of seats for regional representatives remains an issue.

The issue of regional representation on the SYH Board has been partially accommodated by the creation of the Territorial Health Board (THB) which reports directly to the Minister of Health and replaces the old Territorial Health Insurance Services (THIS) Board. The THB is structured to ensure regional and aboriginal representation. Four seats are reserved for Native organizations. Seven seats are reserved for one "prominent citizen" from each region (Yellowknife is treated as a region) who must be independent of the various regional health boards. The THB elects its own chair and reports directly to the Minister of Health.

Aside from the regional representation issue, interest group representation on hospital boards has also been proposed. The NWT Registered Nurses Association has lobbied for a designated seat on the YHB which the Board has resisted. Nurses' interests are generally accommodated by

ensuring that at least one “community representative” is a nurse. During the early years of the Board’s development, the GNWT also proposed that the Deputy Minister of Finance be appointed to the YHB during the period when the operational deficit was quite high. Again, the Board resisted this interference, to the point of threatening resignation if the government insisted. In contrast, in Ft. Smith where the local population are largely government employees, most of the community representatives on the hospital board are government officials.

The Baffin Regional Health Board: A Case History

Subsequent to the motion passed at the Annual General Meeting of the Inuit Tapirisat in October 1980, a steering committee was struck with representation from the Medical Services Branch of Health and Welfare Canada (MSB), the Department of Health (GNWT-H); the Baffin Regional Council (BRC); and the Inuit Tapirisat/Baffin Regional Inuit Association (ITC/BRIA).

The BRC and ITC representatives insisted that the new Hospital Board include representation from Baffin communities. Previous GNWT legislation prevented employees of the health system (i.e., physicians, nurses, administrators) from sitting on hospital boards, but did not require broad community representation. As described above, hospital boards then existing in Yellowknife, Hay River and Ft. Smith did not guarantee ethnic or geographic representation. Although the principle of community representation met some early resistance from government officials on the basis of travel costs, all parties eventually agreed.

In July 1981 the Baffin Regional Hospital Board (BHB) was created. This Board functioned in an advisory capacity to MSB for seventeen months until December 4, 1982 when two new administrative structures were established. MSB retained responsibility for the nursing stations and staff of each community, patient transport, and hospital care and patient support services. (e.g., transportation and accommodation) in Montreal. The BHB was responsible for hospital administration and patient accommodation in Iqaluit (Frobisher Bay).

The new Board had eleven members, all of whom were appointed by the Commissioner on the recommendation of the various organizations. The Regional Director (the senior civil servant in the region) was appointed by the Commissioner as the Chair. The BRC was represented by three members, one of whom was the BRC Executive Director; the other two were mayors from Baffin communities. MSB was represented

by one member—the Baffin Zone Director. GNWT was represented by the Assistant Deputy Minister from the Department of Health in Yellowknife. The Baffin Regional Inuit Association (representing ITC) nominated one member. One member was appointed to represent the town of Iqaluit (Frobisher Bay), and the remaining three members-at-large were appointed to represent other Baffin communities. An effort was made to broaden community representation by asking the BRC and BRIA representatives to also represent their home communities. Ethnically, the first Board consisted of seven Inuit and four non-Inuit.

However, the principle of having one representative from each Baffin community was not formally established until April, 1985 when the Board petitioned the Commissioner to expand the Board to fourteen members to be constituted as follows:

GNWT—1 member (Regional Director-Chair)

MSB—1 member (Zone Director)

BRC—1 member (Executive Director)

Baffin Communities—11 members (one of whom would also represent BRIA)

The Board was expanded to its current size of fifteen members in 1986 with the transfer of Baffin community health facilities to GNWT jurisdiction. This allowed for two additional community representatives (one to replace MSB). The Iqaluit representative had previously represented the small settlement of Lake Harbour; the new structure provided a representative for Lake Harbour and expanded Iqaluit representation to two members to reflect the size of the community. Thirteen members of this new Board were Inuit. The new Board was renamed the Baffin Regional Health Board (BRHB).

The evolving structure of the Baffin Board towards increased community and Inuit representation is significant for a number of reasons. As with any regional organization that is based permanently in the region's largest town, concerns are sometimes raised regarding the extent to which broader regional and community specific interests are represented. For example if a pilot project or new facility is to be established in the region, is there a bias towards establishing that "economic opportunity" in the administrative centre? Broader community representation ensures that such decisions reflect regional interests rather than the interests of the dominant community.

On the other hand, administrative efficiency is seriously encumbered by the principle of community representation. Travel and accommodation costs add significantly to the cost of decision-making since Board members from distant communities often spend at least a week in Iqaluit

for Board meetings. Communication costs are also high when Board consultation is required outside regular meetings.

Ethnic representation is also important to counterbalance the tendency of the executive structure to either operate independently of Board control, or to align with non-Inuit Board members in order to control Board deliberations. Inuit cultural concerns regarding health policy are often difficult to communicate to non-Inuit administrators and sometimes require extraordinary amounts of time and energy to resolve in a culturally satisfactory manner. For example, community representatives on the Baffin Board have lobbied extensively for a boarding home to be built in Iqaluit for visiting outpatients from other communities. Board administrators and non-Inuit Board members argue that the current policy of billeting patients in the homes of Iqaluit residents is not only less costly (in terms of capital expenditures) but is good for the local economy. Inuit Board members have collectively argued that important cultural rules about hospitality and interpersonal obligations are being transgressed. They further argue that the personal wellbeing (in spiritual, emotional, and physical terms) of some patients is threatened by cultural differences between Iqaluit and smaller, isolated communities (e.g., amount and frequency of alcohol consumption). The Inuit cultural argument has been difficult to communicate but has not been ignored due to the strength of Inuit representation.

On April 20, 1988, remaining health services (with some exceptions — see Weller, this volume) were transferred from the federal to the territorial government. At this time, health boards were established in the remaining regions previously administered by MSB (e.g. Keewatin, Kitikmeot). Although similar in structure to the Baffin Regional Health Board, these new boards were constituted subsequent to the “Transfer Policy” introduced by the NWT Legislative Assembly (Government of the Northwest Territories, February 1988). Whereas the BRHB (and the hospital boards in Yellowknife, Ft. Smith and Hay River) maintained internal control over functions such as finance, personnel, maintenance, etc., the transfer policy required the new boards to sub-contract these functions through other government departments. As a result, rather than the unified health care delivery system that was the stated goal of devolution, the NWT has three distinct administrative structures in place: (1) the hospital boards of the South Mackenzie area; (2) the Baffin Regional Health Board; and (3) health boards in remaining regions.

Community Representation: The Trustees

Health trustees throughout the NWT are appointed by the Minister of Health on the recommendation of municipal governments (e.g., Hamlet or Band Councils).

The appointment process is initiated by the Minister through the Department of Health in Yellowknife. A letter is sent to the hamlet or band council requesting the names of three community members for consideration for appointment to the trustee position. Generally, the first name on the list is selected by the Minister unless there is an obvious conflict of interest.

In researching the background of trustees in the Baffin and Keewatin Regions no clear pattern emerged. A slight majority of trustees are men, most are middle-aged, with large families, some speak little or no English, and few have any significant formal education. The economic circumstances of trustees varies considerably from a few who engage primarily in traditional economic pursuits (e.g., hunting, trapping, sewing, carving), some who work full time as skilled labourers (e.g., mechanics, heavy-equipment operators, clerical workers), and a few who are involved in private business (e.g., tourism, construction, etc.). With very few exceptions, almost all trustees representing communities are Inuit. This last characteristic is particularly significant in communities where there are long term non-Inuit residents with a strong commitment to community health (e.g., regular election to local health committees or alcohol committees).

In interviews with a variety of municipal government representatives, the following characteristics were listed as important for trustee nominations.

1. Experience in municipal politics and evidence of an ability to understand government structures and policies. Although few trustees have much formal education, most have as much as ten years of experience with various community organizations such as hamlet councils, education societies, housing associations, etc.
2. Initially, many trustees recommended by hamlet councils were the chairs of local health committees. However, since health committees have had an uneven history, and trustees have been appointed for terms longer than health committee chairs, few current trustees are also members (or chairs) of the local health committees.
3. A willingness to travel. Perhaps the most unique feature about community participation in health care administration in the North is the amount of time required for Board activities. Monthly board meetings usually require at

least two full days (as opposed to the 2-3 hours during fall and winter per month expected of hospital board members in southern Canada). For trustees from the more remote communities, regular attendance at regional board meetings may mean that they are away from home one week or longer per month (taking into account scheduled air flights and weather delays). Clearly, this requirement means that some people (e.g., women with large families) are restricted from participating.

4. An interest in community health. From an Inuit perspective, this interest may not resemble non-Inuit approaches to public health (e.g., organizational interest in issues like sewage disposal, housing, suicide prevention, etc.). Inuit define community health in broader spiritual and social terms to mean harmonious social relations and a high moral standard. Trustees are often individuals who are active in local churches and recognized by their communities as role models and trusted confidants.
5. Personal experience with the health care system. As is also the case with people elected to local health committees, individuals with disabilities or chronic illness, or who have similarly afflicted family members, are seen by communities as having "expertise" in understanding the functioning of health care structures.

However, with the exception of experience gained through participation on other regional or municipal organizations, few trustees are appointed on the basis with their managerial success or business acumen (as would be the case of southern hospital boards). Health trustees are generally well respected citizens from their home communities who have limited experience or expertise in health care administration.

The ongoing relationship among Health Trustees, community health professionals and various administrative levels of government is complex and varied. Since coordination of health concerns and issues within the community is one of the trustee's responsibilities, an examination of the trustee's relationship with other community institutions is important. Two case studies are provided to illustrate the issues.

Case Study #1

In one Baffin community, the trustee initiated monthly, Friday afternoon visits to the health centre which were intended to provide an opportunity for the trustee and nurses to discuss public health concerns and patient satisfaction. The trustee indicated that these meetings served two purposes. First of all, they helped the trustee to collect information to report community concerns to the monthly regional Board meetings. They also provided an informal mechanism to perform his liaison function and resolve any tensions between nurses and patients before they escalated into major conflicts. In the trustee's words;

“I wanted to just drop in, have some coffee, get to know the nurses and talk about things. If I don’t know the nurses, how can I help with health problems in the community”.

Unfortunately, this particular Baffin community had experienced considerable turnover in nursing staff and some of the new staff members had not received adequate briefing on administrative relationships and the particular role of the health trustee. Some of the nurses expressed concern that they were unclear as to the extent of the Trustee’s authority over the health centre.

The nurses indicated that they felt community control over the health centre was inappropriate in terms of local administrative competence and issues of professional autonomy. These attitudes translated into a general suspicion of the trustee’s motives; some nurses indicated they understood the trustee’s job was to observe the nurses’ activities and report on their competence to the regional health board.

As a result, the Trustee’s attempts to maintain monthly meetings with the Health Centre staff were rebuffed. The Trustee often found the nurses “too busy” or openly hostile during these meetings. In a later interview the Trustee indicated that he thought the nurses were unwilling to discuss health issues with him because he was Native. He perceived that racial prejudice was a major impediment to the effective functioning of a Health Trustee.

Case Study #2

In a second Baffin community, the senior nurse had instituted a program of producing monthly reports on all local health programs, including information on patient utilization and nurse staffing. These reports were addressed to the local Health Trustee and copied to the Regional Health Board, the Baffin Regional Council and the Department of Health. Prior to regional Board meetings, the Trustee met with the senior nurse to discuss issues relevant to the meeting.

The Trustee had also been asked by health centre staff to mediate several cases where conflicts had occurred between nurses and patients. One such case involved an elderly person who died while in a Montreal hospital. The death occurred on a Friday and a staff nurse in the Community Health Centre was notified immediately.

In this community, the normal procedure for notifying a family of a death is for the nurse to contact one of the local ministers. Various elders and church officials constitute an informal committee who then accom-

pany the nurse to the home of the bereaved family. In this instance, the nurse attempted to contact a local minister on Friday afternoon but was unsuccessful. The nurse then waited through the weekend before attempting contact with the minister again, and the family was not notified until Monday afternoon.

Needless to say, both the family and religious leaders were outraged and immediately contacted the trustee. The hamlet council was also contacted and requests were made to have the guilty nurse banished from the community. The trustee arranged a meeting between the family, the religious leaders and nurses at the health centre. A formal apology was made to the family and the trustee explained that since the nurse was otherwise competent and new nurses were hard to recruit, perhaps the apology was sufficient. The family accepted the mediation and no further action was taken. The trustee expressed the view that prior to "devolution" (and the creation of the trustee position), a conflict of this nature might have resulted in severe and long term damage to the relationship between the health centre staff and the community.

Both of these cases suggest that the trustee's role in community health affairs is an evolving one. Given continuing high turnover rates for Health Centre staff, the successful integration of the trustee into community health administration depends largely on the particular qualities of individual nurses (i.e., those with professional experiences or orientations that encourage local collaboration are more successful in working with trustees). A lack of thorough orientation for new nursing staff appears to undermine the successful development of the trustee's role.

Health Committees

In a series of policy statements, the GNWT has indicated a commitment to centralizing the administration of community affairs under the municipal government structure, e.g., Hamlet Council (Government of the Northwest Territories, November 1988). Known as the "prime public authority" concept, this policy seeks to meet two objectives: to continue the development of the municipal level of government by increasing its jurisdictional authority over other sectors of community life (eg., education, housing, welfare administration, etc.); and to remedy the current situation where every government department or program at the territorial level is represented by a separate "committee" structure at the community level, thereby taxing the capacity of smaller communities to provide sufficient numbers of able persons for all committees.

Indeed, this latter problem is particularly relevant to the history and potential for health committees. Under federal administration, the community health committee was conceived as an advisory body to both the local health centre staff *and* to other municipal organizations (e.g., Hamlet Council, Housing Association, Schools, etc.). Members of the Committee were to be elected volunteers who were usually left to determine their own agenda. Nurses were expected to attend health committee meetings, but not as members and in a consultant role only. Community Health Representatives (CHR's — local persons trained to promote public health) were to act as secretaries to the Health Committee. Otherwise, no resources were made available for Health Committee activities. Members received no payment or honoraria for their participation, no dedicated office space was provided, no monies were dedicated to funding programs developed by the Committee and in the absence of a CHR, no funds were available to hire secretarial help. Although expected to develop public health policies for the community, Health Committees received little developmental training except where particular nurses had a personal commitment to assisting them.

At the same time, a number of other committees were developed at the community level (under territorial jurisdiction) to deal with other aspects of community health. For example, many communities have committees which deal specifically with alcohol counselling, mental health, suicide prevention, elder's health, or more generally with welfare administration, youth justice, and recreation programs. However, since most of these committees were responsible to territorial government departments and were created in the pre-devolution period, there is very little contact (if any) between health centre staff and these various committees. Indeed, local alcohol counsellors in one Baffin community commented on the fact that since the takeover of health centres by GNWT, a growing interest had emerged on the part of community nurses in establishing referral and consultation links with the alcohol committee. Links between these various committees and the local municipal government vary considerably. In some instances, such as the recreation committee, the hamlet council may administer funds and recreation committee minutes may be copied to Council. In other cases, such as alcohol committees, the territorial government distributes funds to each community committee on behalf of the National Native Alcohol and Drug Abuse Program, Medical Services Branch, Health and Welfare, Canada. In these latter cases, some alcohol committees rent buildings, hire staff and run workshops independent of other municipal structures.

Also important to a consideration of “health committees” at the community level are situations where a “mental health” committee has been formed to deal with problems of stress, family violence, generational conflicts, and depression. These committees often consist of lay counsellors, individuals who are highly trusted and considered by the community to have natural abilities to counsel distressed individuals and families. They are often senior members of their churches and elders within large kin groups. These committees are sometimes not part of the official “committee structure” of a community and function on an ad hoc basis (e.g., the “Death Committee” mentioned in Case Study #2 above).

Despite this evidence of considerable health related “activity” at the community level, both the territorial government and the newly-formed regional health boards appear to be approaching community health activities as a “blank slate”. Of particular concern is the impact that the policy of “prime public authority (PPA)” may have on the continued development of health expertise at the community level. PPA is intended to achieve two objectives: to reinforce the authority of municipal governments, and to achieve a more efficient use of human resources which are perceived to be overextended through a proliferation of committees at the community level. To achieve these objectives, municipal governments (eg. hamlet councils) are advised to create sub-committees, chaired by council members, which will be responsible for administering various sectors of community life such as education, health, welfare administration, and housing. Members of each committee would be appointed by council (Government of the Northwest Territories, 1988).

The danger in pursuing a policy of aggressive re-structuring of voluntary health-related activities at the community level is that some of this activity does not fit well with a regulated administrative structure *or* an overt political process. Lay mental health counsellors may be all but invisible to various institutional interests outside the community, but this “invisibility” may be essential for effective functioning (i.e., confidentiality, cultural relevance, apolitical roles). For example, a trusted elder in the local church may be consulted on a regular basis for family problems, mental depression, or intergenerational conflicts. However, such people, particularly in the case of women, may have little interest in local politics or health planning. While there is little doubt that community health activities have suffered from poor inter-sectoral coordination and a lack of structural support — a fact which the PPA policy is intended to address — caution should be exercised so as not to disrupt existing voluntary activities. Otherwise, yet another case of wheel re-

invention may occur, of which northern communities already have too many examples.

Until the "prime public authority" or an alternative policy is implemented, however, community health committees exist in a partial administrative vacuum, and their relationship with trustees, regional health boards and other government structures is poorly defined. Devolution means that health committees are now responsible to the Territorial Department of Health. Resources for the support health committees are included in the global budgets of regional health boards, and Boards are responsible for determining whether monies should be made available directly to health committees, or through the offices of the municipal government.

Health committees, however, have no direct links with either the regional boards or the Department of Health. Health trustees are (or were) sometimes the chairperson of the health committee but as committee membership changes, there are no mechanisms for ensuring that trustees remain members of the health committee or that future chairs be appointed to the trustee position. Indeed, since municipal governments, not health committees, are required to nominate candidates to the trustee position, health committees are essentially excluded from formal representation at the regional board level. Although trustees are expected to attend committee meetings (and, ideally, chair these meetings), this relationship is not formally constituted. Since trustees can be appointed for as long as six years, and health committees change membership yearly, direct communication between health committees and the regional board may deteriorate over time.

Conclusions

In this paper I have examined the relationship among community health committees, health trustees, and regional health boards in the context of devolution and the democratization of health services in the Northwest Territories. The purpose of this examination was to determine whether devolution is contributing to increased community control over health policy and planning, and to identify structural factors which constrain or enhance attainment of this goal. This analysis has been largely based on a case study of the Baffin Regional Health Board with supplemental information from other regions.

Without question, the struggle to democratize an institution characterized by a long history of entrenched, centralized and colonial administration is not easy. Understaffed and overextended, the territorial

government has the huge task of continuing to provide a costly and complex service where error can be measured in human lives. At the same time, they are under considerable pressure from their constituents to radically restructure the system to more adequately reflect local cultural concerns and priorities. To this end, a complex and unique administrative structure has been implemented *at a pace and on a scale never before attempted in the history of health services in Canada*. Innovation in provincial health care systems, in contrast, usually evolves slowly after a succession of inquiries, task forces, demonstration projects and evaluation.

Nonetheless, the foregoing analysis has identified a number of areas where the goal of democratization of health service delivery in the context of devolution in the Northwest Territories has been constrained by structural and ideological (i.e., cultural) factors. These constraints are summarized below.

1. Historic perception that Inuit consider health as low priority in political affairs.

This perception is, of course, linked to the colonial structure of medical services over the past several decades and not to Inuit culture. Indeed the importance of shamanism (and now Christianity) to Inuit culture demonstrates the high traditional value placed on well-being and community health. Furthermore, attention to changing the economic and political conditions of life is also linked ultimately to improvements in health conditions. More attention must be given to revitalizing traditional values related to health and convincing local populations that real changes can be expected through participation in the new health institutions.

2. A perception that without control over resources, authority is somewhat tenuous.

Interestingly, this perception is evident throughout the system, from community health committee members, to senior administrators in the Territorial Department of Health. In other words, regional health boards experience a similar frustration over control of resources as deputy ministers experience in ongoing negotiations for transferring resources from the federal government.

3. A tendency for regional health boards to polarize along ethnic lines.

Since the administrative structures of all boards are predominantly non-Inuit, there is a tendency for Inuit board members to perceive non-Inuit board members as aligned with the administrative structure. Conversely, the administrative structure tends to expect a certain degree of support from non-Inuit board members due to shared cultural understandings. Those non-Inuit board members who actively work to align themselves with Inuit board members are sometimes perceived by administrators and health professionals as disruptive.

4. Unlike hospital and regional health boards in southern Canada, health professional power and autonomy is rarely disruptive to democratic board functioning.

Although the constitutional exclusion of medicine and nursing from hospital and regional board structures has on occasion resulted in lobbies for seats from those professions, neither profession has succeeded in achieving direct representation in the governing structure. As a result, both professions have sought increased autonomy and authority through alternative means; nursing through union activities and medicine through direct appeal for public support. Future developments in this arena are likely to be an important and continuing source of difficulty for the evolution of democratic structures in health care administration.

Finally, this paper has demonstrated that as yet, the Northwest Territories has not succeeded in meeting its expressed goal of creating a unified, decentralized and democratized health care delivery system throughout the territory. Granted the time frame has been insufficient to fairly evaluate the devolution initiative, there remain, however, structural incongruities related to the respective roles and responsibilities of community health committees, health professional and other government agencies; regional boards and governments; and territorial administration. Despite the best intentions, unless these incongruities are addressed directly, "democratization" of health services in the North may be stalled indefinitely. Nonetheless, the experiment in democratized health services presently underway in the NWT is of historic significance and will set an important example for both Canada and the rest of the world.

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NOTE

- ¹ There were of course regional administrative units or "Zone Offices" under the federal system but these structures provided no opportunity for client input into policy or programs.