A POLITICAL ECONOMY OF DENTISTRY IN NUNAVUT

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A thesis submitted to the Faculty of Graduate Studies
In partial fulfilment of the requirements for the degree of

Master of Science

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THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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Acknowledgments

Thank you to everyone involved (in all form and presence) throughout the completion of this work, especially my family, my advisors, and my friends. All interpretation and conclusion are ultimately the responsibility of the author.

Abstract

What factors influence the development of dental care in Nunavut communities? Using an ethnographic case study design (with data collected through participant observation, stakeholder interviews, and document reviews), this investigation proposes that four factors impact on dental health care development in Nunavut: 1) Geography and Disease Burden impact care by complicating the practices associated with service delivery in remote communities to a population with a high prevalence of dental disease; 2) Indigenous Self-Determination impacts care through the challenging social reorientations that are necessary in the context of building Canada's first Inuit 'self-government through public government;' 3) State/Indigenous Relations impact care by situating this service's development in a series of unsettled, unclear, and politicised debates, that compromise effective delivery of service; and 4) Dental Practice and Philosophy impact care by informing service delivery in a manner that is generally ill equipped to meet the needs of such a population, and by shifting attention from public to private interests. It is proposed that the latter two factors require attention if dental care in Nunavut is to meet both the health needs of individuals as well as the aspirations of Inuit for a health care system accountable to the broad community.

Keywords: Indigenous Health, Aboriginal Health, Oral Health, Dental Care, History of Dentistry, Inuit, Nunavut, Self-Government, Health Policy, Political Economy, First Nations and Inuit Health Branch, Non Insured Health Benefits.

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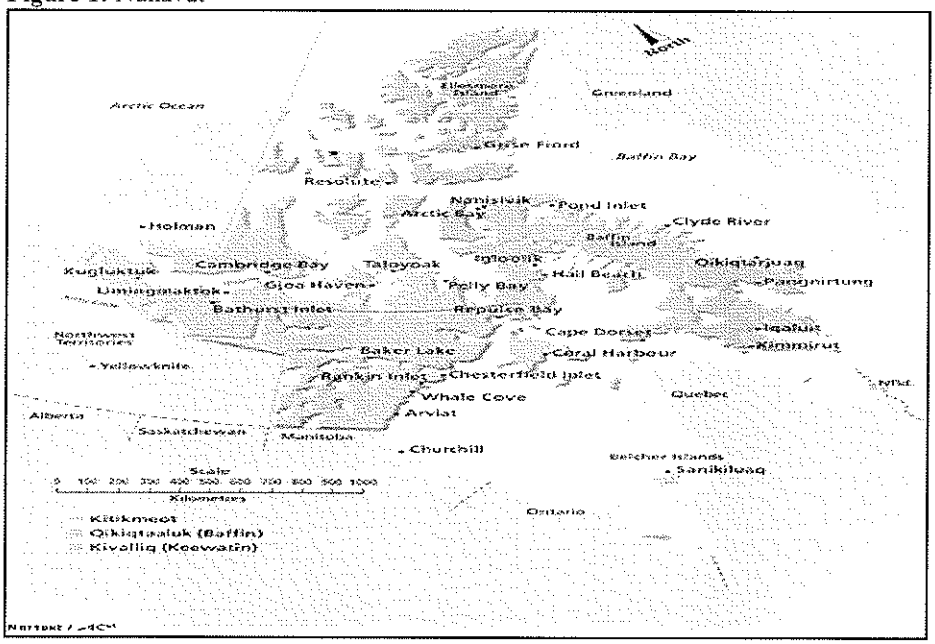
Chapter 1. General Introduction

I. Statement of the Problem

Inuit[1] populations exhibit morbidity and mortality rates that can exceed those of developing nations.[2] The current state of oral health[3] and oral disease[4] in what is now Nunavut[5] is one such case. Epidemiological studies, governmental and non-governmental discourse, journalistic accounts, and clinical observance, all confirm that oral disease remains at unacceptably high levels in northern communities.[6] This proves negative for the quality of life of Nunavummiut,[7] experienced as regular periods of severe pain alongside acute psychic tension, the loss of productive time, and as a handicap in daily living.[8]

Figure 1. Nunavut



If this is recognised as such a serious problem, why has little changed to improve the situation in Canada's newest territory (See Figure 1)? Have governments taken no action? Have stakeholders not enacted measures towards a solution (see Table 1)?

Although much has been debated and calls for change are constant, individuals remain sick in the midst of governmental and civil criticisms regarding the amount of resources consumed (or not consumed) relative to any notable improvement in health; this for disease processes that are easily treated in their early stages, and most often wholly preventable.

Table 1. Stakeholders

Professional	**Description**
Community-Minded Dentist Public Health Dentist	Community-minded dentists are those professionals that have historically delivered services to marginalised populations (both geographically and socially). While public health dentists are those professionals (of this kind) possessing a professionally recognised 'public health dentistry specialty,' thus often engaging in the management of governmental dental public health programs.
Private Practice Dentists	Private practice dentists are those professionals that have historically delivered dental care in private clinics to populations that generally have access to services both financially and/or geographically. There are 'private practices' in and across isolated regions.
Dental Therapists Dental Nurses	Dental therapists are paraprofessional practitioners trained at the federally funded National School of Dental Therapy. Predominantly mandated to deliver services to children in isolated Aboriginal populations. Dental nurses are a historical form of this same paraprofessional, trained at a different facility. Individual who refer to themselves as dental nurses practice to this day.
Governmental	
Federal	The Canadian State, which holds significant, particular, and legislated relations with Canada's Indigenous Peoples.
Territorial/Provincial	The political entities that constitute Canada's confederation (3 territories/10 provinces), each with different numbers, involvement, and legislated relationships with Canada's Indigenous Peoples.
Ethnonational	Governance organisations that act as a form of political representation for Canada's Indigenous Peoples.
Grassroots	
Non-Governmental Organisations	Organisations that are involved in the lives of Canada's Indigenous Peoples across many sectors (i.e. political, social, service delivery)
Community	Community mobilisation and/or organisations linked to community interests and values.
Person	
Patient	As per the historical and current relationship between clinician and patient.
Client/Health Consumer	As per the historical and current reality that dental care is a market-based health service, thus individuals are constituted as 'clients' and/or 'consumers.'

II. The Research Environment

This environment demonstrates one negative outcome of colonialism and/or the general subsuming of Indigenous peoples into Western States.[9] In Canada, in response to the inequities of the past, Indigenous groups have moved to retain ideological, governmental, administrative, bureaucratic, business, and essentially full-scale control over the processes that govern their lives.[10] As such, the 'devolution' and/or 'transfer'[11] of responsibility for health services (*e.g.* dental services) from Federal to Inuit and First Nations[12] governments continues, generating one of the largest experiments in Canadian health care reform history.[13]

For Inuit and First Nations communities alike, control over health and social services is grounded in social, political, and economic development, and forwarded as a mode by which to improve health.[14] Most agree that this 'passing of control' "contribute[s] to the healing process currently underway in many Aboriginal communities."[15] In Nunavut then, this has and continues to hold major implications for the administration of health services, and ideally, for the wellness of Nunavummiut in terms of improved dental services and healthier mouths.

Control over service delivery is one factor among the multitudinous that establish states of health and disease. For oral health, this includes genetic constitution, frequencies of self-care, environmental exposures, and of particular relevance here, historical and current social conditions, viz. from 'micro to macro.'[16] There clearly exists a complexity and dynamism in the oral health of individuals, families and communities, and in the social systems meant to deal with these conditions

The dental sciences have accessed this reality predominantly through biological,

behaviouristic, individualistic and psychological approaches to health, demonstrating how genetics, oral environments, oral hygiene practices, and dietary habits contribute to health and disease, only relatively recently tackling the social determinants, whereby social status, material conditions, social inequity, and oral health care systems become considered. Precious little also exists in the 'medical social sciences and humanities' and their critical consideration of this dynamic.

III. The Research Approach

A political economic[17] approach provides an opportunity to accurately describe macro level structures, their role in establishing oral health and disease, and their part in people's experiences within a system of care. In addressing these macro factors, this investigation represents them through the interrelationships of stakeholders, demonstrating their influence, and their shaping, delimiting, and/or constraining effects on the actions of those same stakeholders as they attempt to delivery care in such environments. These factors clearly impact the provision of health services, and by extension, impact health through such mediating action as decreasing quality, diminishing access, and creating less than optimum conditions for health promoting behaviours.[18]

IV. The Research Question, Method, and Argument

This study asked: "What factors influence the development of dental care in Nunavut?" To answer this central query, an ethnographic case study method was utilised that outlined the major historical and structural dimensions of dental health ideology and

practice within the region. With data collected through participant observation, stakeholder interviews, and document reviews, this researcher argues that four factors influence the development of care:

1. Geography and Disease Burden;
2. Indigenous Self-Determination;
3. State/Indigenous Relations;
4. Dental Practice and Philosophy.

In shaping dental services in Nunavut, these factors delimit the 'positions and practices' of individuals within this system of care, ultimately contributing to (or taking away from) the ability for positive change in the health of Nunavummiut.

a. Geography and Disease Burden

Geography clearly plays a significant role in determining service provision. For example, isolation means that only a handful of service delivery trips are available per year in most Nunavut communities. It means itinerant care of two to three week periods, with difficulties in shipping equipment and supplies and in maintaining clinics. It means long periods of travel and long clinical days with little or no professional support. It means high rates of professional turnover and a limited pool of providers. In short, it means increased costs and difficulties at all levels.

Such disease burden on the other hand means that whatever care is available is often only capable of relieving pain and discomfort. It means that curative services consume an inordinate amount of system funds, as clinicians and administrators are initially motivated to address the immediate human requirements of such disease. In

short, it means an overburdened system that has difficulty responding to global needs.

Isolation will, for the conceivable future, remain a permanent fixture, but one that can be addressed. Stakeholders suggest that health centre clinics be fully stocked, so that nothing needs to be shipped. They suggest improved recruitment and retention strategies for professionals, as well as 'dental' educational opportunities for Nunavummiut to decrease or remove the dependence on southern/external expertise.

Disease burden is harder to address as it involves changing people's behaviours in an environment where preventative measures such as individual and community education, and individual and community health promotion, are poorly funded and enacted. Stakeholders do recognise that prevention is a necessary component for improvements in oral health and maintain some activity in this regard. Nevertheless, preventative modes of care have not proven as effective as once thought, and most definitely do not exhaust the available 'preventative' opportunities to address such overwhelming disease presence. Significant intervention is also observed through social legislation that, while difficult to enact as per political economic realities, can and do result in improved levels of health (*e.g.* policy aimed at removing the barriers of a cost-prohibitive diet, policy aimed at addressing the base level health determinants of housing, clean water, food security, and education).

b. Indigenous Self-Determination

Indigenous self-determination and ethnonationalism,[19] where Indigenous groups enact a process of resistance aimed at changing the relations of power between them and the Nation State, also impacts care in Nunavut communities. As Canada's newest territory, Nunavut represents a significant advance in these relations.[20] Nunavut is a public

government (a Canadian Territory), but insofar as it stems from a 'land claims agreement,' it is also a form of Indigenous 'self-government.' As a model for 'self-government through public government,' Nunavut acclaims a people's right to prosperity and cultural recognition.

Practices have in turn developed to politically and/or economically control health and social services.[21] Buttressing this is social and economic development policy that recognises the need to employ and train local individuals, and support local, territorial and Inuit business interests.[22] So, much like other ethnonational movements in Canada, Nunavut has created opportunity for control over local service economies.[23]

In northern dentistry, local territorial business interests in the form of dental corporations (chiefly non-Inuit owned dental offices run by resident dentist sole-proprietors) have found historical support in this policy stance. It is business and personal residence (and at times ethnicity) that have constituted success in the competition for government contracts. More recently, the ability for Inuit interests to produce their own proposals, or to improve non-Inuit ones, has had a definitive impact on dental services.

c. State/Indigenous Relations

For Indigenous groups, control over the structure and delivery of governmental services is closely tethered to their historical/political relations with the Canadian State. These relations ground all health programming delivered to Aboriginal populations by the First Nations and Inuit Health Branch (FNIHB) of Health Canada.[24] For dental care, these

relations are generally constituted in debates surrounding the Non-Insured Health Benefits Program (NIHB).[25]

With an annual budget of over $1 billion dollars, FNIHB represents roughly half of Health Canada's total budgetary expenditures. Roughly half of the FNIHB budget represents costs associated with the NIHBs, the other half with 'community health programs' (*i.e.* medically insured services and public health services). These costs have become a hotly debated issue at all levels, especially for the NIHBs.

As federal public administrators continue significant efforts at cost-containment in their response to repeated criticisms by governmental and civil leadership,[26] Aboriginal groups present the case of limited services that are poorly developed and funded, and are in fact a 'right' associated with their status as Indigenous Canadians.[27] Federal authorities answer that NIHBs are not part of any fiduciary[28] / aboriginal / treaty right, but are delivered out of policy and out of need: a needs-based approach versus a rights-based one.[29] This issue increasingly garners the attention of taxpayer and generally conservative watchdog groups who struggle with the fact that half of the annual budget of a national department is used for roughly 720,000 people, and associated with rights that they do not believe any Canadian should have.[30]

The devolution/transfer of responsibility for the administration and delivery of NIHBs (and other FNIHB programs) also constitutes a substantive object of relations between the Federal Government and Aboriginal political structures, whether these are ethnonational organisations or communities themselves. These debates have surrounded the relevance and outcomes of current policies, the adequacy of funding associated with devolved/transferred programs, and the potentiality that Indigenous Canadians are being

'set up to administer their own misery.' Control of the NIHBs has also come to represent a debate concerning the 'rights and responsibilities' of both groups relative to their historical/political relations, a debate where fundamental disagreement remains.

So are the NIHBs a 'public program' or a 'public insurance system for private services?' Are NIHB services a 'right or a privilege?' More broadly, is 'health and access to health services' an Indigenous right? These confusions are all expressed on the service delivery front as the unclear rights of the Aboriginal patient/health consumer, the unclear responsibilities of governments, the problematised reimbursement of health professionals, and the inability to achieve long-term oral health programming (as resource shortages are constant). State/Indigenous relations, it can be seen, do much to impact the development of dental care in Nunavut communities.

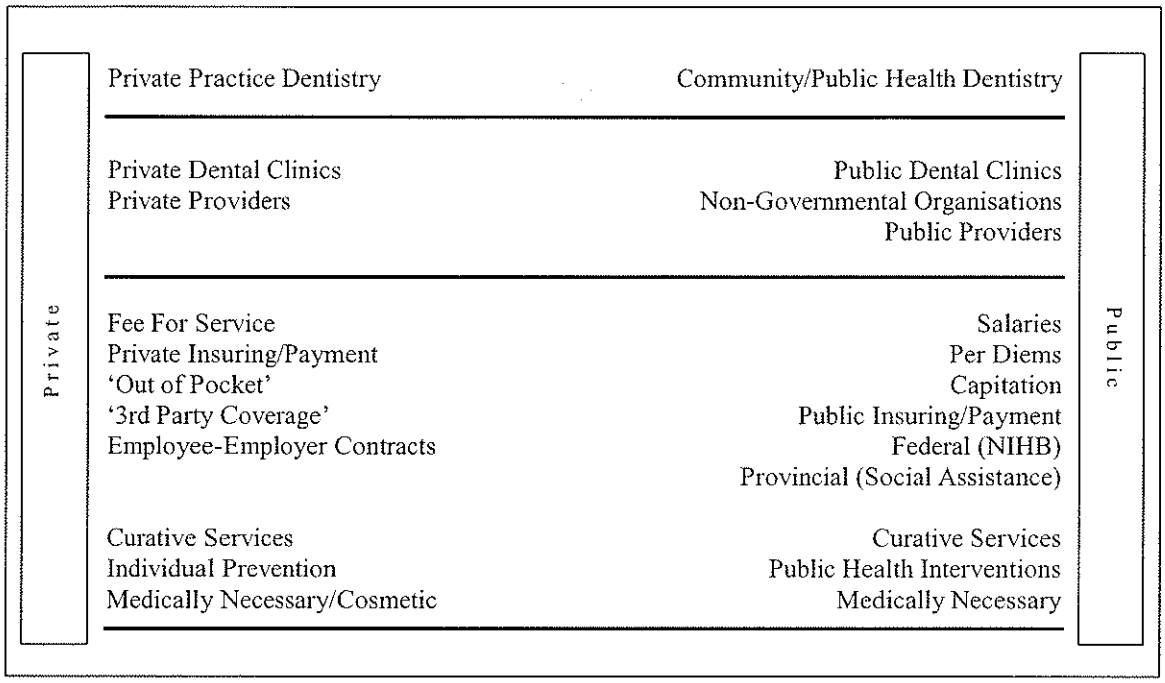
d. Dental Practice and Philosophy

Northern dental professionals and their organised representation actively raise complaints about the NIHB dental care system, and more importantly, with the levels of oral health experienced by those it is meant to insure. Routine criticisms are made on irregularities in billing from region to region, on irregularities with the processes of remuneration, with the cumbersome approval needed for the delivery of some treatments, with the problematised auditing of professionals, and with the clear lack of preventative and curative services available to Inuit and First Nations patients/clients. Less obviously, dentists and their profession have also played a role in establishing these realities.

The NIHB dental program is couched within a greater historical system of care (see Figure 2), a system that plays a definitive role in establishing how dentistry is

practiced and thought about in Nunavut. In fact, stakeholders often note that this greater system 'does not work' in a northern context.

Figure 2. Dentistry 'Private to Public' Spectrum of Care, Payment, and Treatment



What may not work is the manner in which dental care has come to be delivered in such communities, this being a manner that concentrates almost exclusively on curative forms of care, as it recognises the need to employ dental public health intervention, yet often does not. As some stakeholders comment, in a context of much disease and high need, it makes no sense to wait for problems to arise (as they surely will), rather, it makes better sense to try and prevent disease through social legislation and other preventative measures.

What may also not work is the way dental care has been structured in Nunavut communities. This structure has developed piecemeal over time, region-to-region, for the most part adapting to the greater structure and practice of dentistry in Canada (both in terms of human and capital resource). The greater system is characterised by a series of

predominantly private, and to a much lesser extent public providers (private practice dentists, dental hygienists, denturists, public health dentists, dental therapists), and through a continuum of predominantly private forms of care, and to a much lesser extent public forms of care (private practice dentistry, community or public health dentistry). As such, 'dental cultural' interactions in Canada mostly occur in relation to the care delivered in private dental offices by private practitioners and their auxiliary, and to a much lesser extent in relation to public services delivered by community/public health dentists, dental hygienists, and dental therapists in public dental clinics.

Dental cultural transactions also overwhelmingly occur relative to a private system of remuneration, as payment, whether by individuals or by a third party (*i.e.* private and public dental insurance), and most often involves the flow of capital through the market and does not involve any significant governmental mediation. Dental insurance is constituted primarily through private market carriers, or through employee-employer contracts that provide this insurance (as in an 'employee benefits package').[31] This system does not include the global coverage of dental care to all Canadian citizens, with not everyone enjoying access. Yet select types of public insurance do exist, such as Federal and Provincial specific plans for specific populations.[32]

As a result of this overwhelmingly private system of care, the minimal sub-forms of public care constitute through quasi-public/quasi-private transactions, where public insurance pays for what is nominally seen as a non-insured private care in private dental settings (*e.g.* the dental NIHB, Social Assistance, Refugee Coverage, amongst others). On the public side of the Canadian dental spectrum are those public institutions (academic and/or non-governmental organisations) that deliver services to marginalised

populations mostly using public forms of insurance or out of pocket contributions.[33] In terms of truly public forms of care (*i.e.* State salaried employees, public clinics, public funding), some has and continues to exist in care delivered by salaried community/public health dentists and dental therapists in publicly housed clinics.

These structural and transactional realities have come to fund Nunavut's privately based, predominantly fee-for-service system delivered by dentists, where publicly leaning forms of care are well represented through academic institutions, community/public health dentists, and dental therapists (as employees or contractors of the Nunavut Government). Yet this is not enough in the context of populations with high levels of disease and need that would necessarily benefit from more financially accessible and preventatively oriented care. Nevertheless, the current structure and its supporters often resist the option of salaried providers delivering curative and preventive care at little or no cost.

It is through these historical practices that the NIHB program has become problematised (by not being able to answer need and structuring services such that broader gains in health are difficult). The program is now long described as fraught with mistrust between practitioner and insurer, between organised dental representation and federal administrators, and between practitioner and health consumer.[34] In short, the development of dental care in Nunavut is effectively tied to the maintenance of Canadian dental practice and professional ideology.

V. The Structure of the Argument

With this early description, Chapter 2 continues with a discussion of the philosophical underpinnings, methods, and ethical considerations undertaken when answering the research question. Chapter 3 then develops the historical basis for this political economy. Chapters 4 through 7 will detail the argument that four factors (Geography and Disease Burden, Indigenous Self-Determination, State/Indigenous Relations, and Dental Practice and Philosophy) delimit dental services and their development in Nunavut communities. Chapter 8 concludes with the notion that it is in the latter two factors (State/Indigenous Relations and Dental Practice and Philosophy) that substantial answers lie in relation to improvements in oral health and disease and in the system meant to deal with such health states. It is in reconciling these higher-level debates that change is effectively made in the two former delimiting factors (Geography and Disease Burden and Indigenous Self-Determination).

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[1] Inuit are the Indigenous population that make up a great majority of Canadian Arctic. For the purposes of this study, Inuit will refer to those individuals of the Central and Eastern Canadian Arctic, or those Inuit citizens of the Nunavut Settlement Area that constitute Nunavut (see Figure 1).

[2] **Jenkins AL, Gyorkos TW, Culman KN, Ward BJ, Pekeles GS, Mills EL** (2003) "An Overview of Factors Influencing the Health of Canadian Inuit Infants." International Journal of Circumpolar Health 62(1): 17-39; **Bjerregard P and Young TK** (1998) The Circumpolar Inuit: Health of a Population in Transition. Copenhagen: Munksgaard.

[3] In this study, the Canadian Dental Association's definition for oral health is used. It not only refers to the presence or absence of disease, but also to the lived processes that are hindered in the experience of such disease. Oral health will refer to "a state of the oral and related tissues and structures that contributes positively to physical, mental and social well being and the enjoyment of life's possibilities, by allowing the individual to speak, eat and socialize unhindered by pain, discomfort or embarrassment."

[4] Oral disease refers to a wide range of entities associated with the oral structures and related tissues (e.g. disease of the teeth, of dental and orthognathic or 'jaw' development, periodontal or 'gum' diseases, oral cancers). Generally, when referring to oral health and disease, dental caries and periodontal conditions are the referents as these disorders provide the substantial portion of epidemiological and clinical evidence in northern oral health and disease experience.

[5] Nunavut, meaning 'our land' in Inuktitut (the Inuit language), is the Inuit 'representative and responsible' Canadian territorial government. This territory was created as per the Nunavut Land Claims Agreement

(1993), the Nunavut Act (1993) and the Nunavut Political Accord (1992), all parts of a modern day Treaty between the Inuit of the Nunavut Settlement Area and the Canadian State, guaranteeing a particular form of sovereign Inuit territory. On April 1st 1999, Nunavut began a process of consensus government, modelled after the notion of 'self-government through public government,' whereby Inuit self- governance is part of the public governing of a Canadian Territory. This situation is subtle, as Nunavut is not statutorily recognised as an 'Aboriginal self-government.' The key to Nunavut lies in that roughly 85% of its population is of Inuit decent, and for the foreseeable future will remain so, necessarily acting as a natural conduit for Inuit social, political, and economic concerns of a clear cultural relevance.

[6] **Archibald L and Grey R** (2000) Evaluation of Models of Health Care Delivery in Inuit Regions. Ottawa: Health Canada; **Elliot I** (1997) "Statistics are Staggering – The fuel of the North is not gas, diesel or kerosene: it's soda pop!" Northern News Service October 13; **Rae E, Thompson G, Moffatt M, Young T, O'Neil J** (1994) "Dental health in Keewatin region adults." Arctic Medical Research 53(2): 754-756; **Schuller P, Thompson G, Moffatt M, Young T, O'Neil J, Schwartz A** (1994) "Periodontal health of Keewatin, Canada children and adults." Arctic Medical Research 53(2): 761-764; **Galan D, Odlum O, Grymonpre R, Brecx M** (1993) "Medical and dental status of a culture in transition: The case of the Inuit elderly of Canada." Gerodontology 10(1): 44-50; **Jock R** (1993) "A call to action." Journal of the Canadian Dental Association 59(2): 99.

[7] Nunavummiut refers to the citizens of the Nunavut territory.

[8] **Locker D and Matear D** (2000) Oral disorders, systemic health, well-being and the quality of life. Community Health Services Research Unit, University of Toronto: Toronto; **Slade GD** (1998) "Conference summary: assessing oral health outcomes--measuring health status and quality of life." Community Dental Health 15(1): 3-7; **Leao A and Sheiham A** (1995) "Relation between clinical dental status and subjective impacts on daily living." Journal of Dental Research 74(7): 1408-13; **Gift HC, Reisine ST, Larach DC** (1992) "The social impact of dental problems and visits." American Journal of Public Health 82(12): 1663-8; **Reisine ST** (1988) "The effects of pain and oral health on the quality of life." Community Dental Health 5(1): 63-8; **Kiyak HA and Mulligan K** (1987) "Studies of the relationship between oral health and psychological well- being." Gerodontics 3(3): 109-12.

[9] Colonialism is defined as the policies of a nation seeking to extend or retain authority and control over other sovereign peoples and their territories. In Canada, colonial policies have at times proven brutal and destructive towards the Indigenous populations they were meant to govern and maintain. Consider for example the residential school experience, where thousands of Aboriginal children were taken from their homes and families and entrenched in Western philosophies and ways of being. More recently, processes that attempt to rectify and heal the actions of the past are slowly degrading the colonial relationship. This includes the devolvement/transfer of governance power to Indigenous authorities (e.g. Nunavut), or the process of addressing global and/or specific issues (e.g. the Royal Commission on Aboriginal Peoples, the Aboriginal Healing Fund, Specific and Comprehensive Land Claims). For a thorough discussion of colonialism and its impacts of the health and well being of Canada's Indigenous populations, see **Warry W.** (1998) Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government. Toronto: University of Toronto Press; **Waldram J, Herring D, Young T.** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[10] As a governing entity, Nunavut is now positioned almost six years into an Inuit-specific and representational territorial government, at the fourteen-year mark in terms of a signed land claims agreement with the Canadian State, and at the end of three decades of self-government negotiations in relation to control over the processes that constitute Inuit life.

[11] 'Devolution' is the general signifier for the process of passing control to Inuit populations and Territorial governments, while 'transfer' refers to this same process within the First Nations (some existing within Territorial boundaries). The terms are different, involving different governments and different cultural groups, yet they generally represent the same process of passing programmatic activity from Federal authorities to Indigenous ones.

[12] For the purposes of this study, First Nations refers to most other Indigenous groups in Canada apart from Inuit and Metis. The terms Indigenous and Aboriginal will be used interchangeably depending on relevance, with clear demarcations made between the First Nations and Inuit populations if relevant.

[13] **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[14] **O'Neil JD, Lemchuk-Favel L, Allard Y, Postl BD** (1999) "Community Healing and Aboriginal Self-Government: Is the Circle Closing?" in Hylton JH (Ed.) Aboriginal Self-Government in Canada. Saskatoon: Purich Publishing; **Dickerson M** (1992) Who's North? Political Change, Political Development and Self-Government in the Northwest Territories. Vancouver: UBC Press and Arctic Institute of North America; **Duffy R** (1988) The Road to Nunavut: Progress of the Eastern Arctic Inuit Since the Second World War. Kingston: McGill University Press.

[15] **O'Neil JD, Lemchuk-Favel L, Allard Y, Postl BD** (1999) "Community Healing and Aboriginal Self-Government: Is the Circle Closing?" in Hylton JH (Ed.) Aboriginal Self-Government in Canada. Saskatoon: Purich Publishing

[16] **Brown P, Inhorn M** (1996) "Disease, Ecology and Human Behaviour." In Sargent C. and Johnson T. (Eds.) Handbook of Medical Anthropology. Westport: Greenwood Press.

[17] As per **Sayer A** (1995) Radical Political Economy: A Critique. Oxford: Blackwell, political economy is defined as an approach that views "the economy as socially and politically embedded and as structured by power relations."

[18] **Armstrong P, Armstrong H, Coburn D** (2001) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. New York: Oxford University Press; **O'Neil JD** (1986) "The politics of health in the Fourth World: A Northern Canadian example. Human Organisation 45(2): 119-127.

[19] Ethnonationalism describes a modern social movement constituted by Canadian Indigenous groups who, in their attempts at improving the lives of Indigenous populations, live out a process of political lobbying and negotiating, with responsibilities across social and economic sectors. This, for more Indigenous control over Indigenous lives, and to ultimately change the relations of power between them and the Canadian State.

[20] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J and Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives. Copenhagen: IWGIA.

[21] Control over services can be construed on numerous axes: ideological, political, economic, administrative, governmental, non-governmental, public, private, business, local, regional, ethnonational, et cetera.

[22] Keeping things 'local' in a place where most resources are 'not local' or 'brought in from the south,' is firmly tied to notions of self-determination and governmental control in northern communities.

[23] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia; **Whittington M** (1986) Native Economic Development Corporations: Political and Economic Change in Canada's North. Ottawa: Canadian Arctic Resources Committee.

[24] FNIHB is the current name given to the administrative structure of the Canadian State that coordinates and manages health care services to certain Canadian Aboriginal populations (i.e. First Nations/Indian,

Inuit, Innu). In contradistinction to most other Canadian health services, which are administered and delivered by the Provinces, FNIHB directly (or indirectly through contractors) delivers services to these Aboriginal populations as per their historical/political relationship.

[25] The NIHBs provide for a certain number of uninsured health services to First Nations and Inuit populations. These services lie beyond those insured for the general Canadian population as per the 1984 Canada Health Act (i.e. physician and hospital services) and are thus considered 'non-insured.' They are most often accessed in the health marketplace and have come to be defined by FNIHB as "pharmacy (including prescription and over-the-counter drugs and medical supplies/equipment), dental services, glasses and other vision care aids and services, transportation to access medically required services, health care premiums [in two Canadian provinces], and other health care services including crisis intervention, mental health counseling and selected other health services." As per current policy, they are provided under the determination of 'medical or dental need.'

[26] **Government of Canada** (2003) Standing Committee on Health: First Nations and Inuit Dental Health. Ottawa: Senate of Canada; **Government of Canada** (2000) Standing Committee on Public Accounts Tenth Report on the October 2000 Report of the Auditor General of Canada: Health Canada – First Nations Health: Follow-up. Ottawa: Parliament of Canada; **Auditor General of Canada** (2000) Chapter 15: Health Canada – First Nations Health: Follow-up. Ottawa: Auditor General of Canada; **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada; **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[27] In Canada, the inherent collective rights of Indigenous populations are recognised under the Canadian Constitution. Accessing and enacting these rights constitutes the 'special fiduciary relationship' shared between some Aboriginal populations and the Canadian State. The extrapolated details of these rights lying in relation to historical and modern legislation such as the Indian Act, the early and modern Treaties, and potentially oral histories.

[28] It is understood that a special and particular 'fiduciary relationship' exists between Indigenous Canadians and the Federal Government. This is enacted through the idea of having some sort of Indigenous 'status' that predetermines the relational activity between both groups. For example, this is observed in that a person with Indigenous status (e.g. First Nations, Inuit, Innu) receives some services directly from Federal authorities, as opposed to from the Provinces or Territories in which they reside. These services are either directly delivered 'on-reserve' (Indian land within Provincial boundaries held in trust by Federal authorities, thus viewed and acting as a Federal jurisdiction), or delivered through the sole or joint management of programs with and by ethnonational and/or territorial authorities.

[29] This is in line with how other Canadians receive access to dental services or other market-based services, as when Federal and Provincial authorities provide access as per a judgement on need (e.g. the impoverished, the institutionalized, refugees). As Aboriginal Canadians experience some of the worst inequity in this country, it is naturally so that services are provided out of need, viz. in political contradistinction to the notion that there is a particular Indigenous right to these services.

[30] Nominally 'right-wing' groups are often critical of the reality of a special racial category for Aboriginal Canadians, pointing to the inherently racist aspects of the system. They are also critical of the fact that First Nations and Inuit Canadians have access to uninsured services beyond those available to the general Canadian population, in line with the conservative belief that rights are inherent to the individual (as negotiated with the State) and not to the group.

[31] In the case of the NIHBs, the State is directly involved as a payer of services. Irrespective of this fact, the State's role still predominantly rests in the negotiation of a professionally controlled health service monopoly (relative to public safety and interest), in establishing fee schedules with professional dental associations, and in supporting social mechanisms for the health insurance coverage of individuals and the remuneration of professional providers through employee-employer contracts.

[32] Programs include those for Aboriginal populations, refugees, institutionalized persons (i.e. the hospitalised elderly, the developmentally challenged, the incarcerated), and the socioeconomically marginalised. The Canadian Armed Forces also share a long and proud history in dental service delivery through its well-supported dental corps.

[33] These include dental faculties across all Provinces. Some faculties have held long-term, large-scale 'community outreach programs' servicing many marginalized sectors (e.g. rural and urban Aboriginal populations, the developmentally challenged, the elderly). Dental faculties at the University of Alberta, Saskatchewan, Manitoba, and Toronto are noteworthy examples.

[34] **Davey K** (1988) "Primary Dental Care in Canadian Arctic Communities." Arctic Medical Research 47(Supplement1): 562-563; **Mayhall J** (1984) "The Oral Health of the First Residents: Who's in Charge?" Arctic Medical Research 38: 431-435; **Milnes A, Rubin C, Karpa M, Tate R** (1992) "A retrospective analysis of the costs associated with the treatment of nursing caries in a remote Canadian Aboriginal pre-school population." Community Dentistry and Oral Epidemiology 21: 253-260; **Messer J, Forgay M, Clovis J, Graham B** (1991) "A collaborative approach to developing dental health resources for Northern communities." Arctic Medical Research 50(Supplement 5): 666-667; **Messer J** (1991) "The effect of non-insured health benefits on dental treatment provided in four coastal Labrador communities by salaried dentists." Arctic Medical Research 50(Supplement 5): 662-663.

Chapter 2. Meta-Theory, Theory, Method, Ethic

I. Fundamental Considerations

To form a conceptual and practical base for the research question, and/or to ground an understanding of a 'political economy of dental care services' as an object of scientific study, some fundamental considerations must be reviewed. By the very nature of social scientific investigation, these include:

1. A statement on underlying principles, ontologic, epistemic, and logical,[1] that delimit the object of study (meta-theory);
2. A description of the referential frame used in relation to the object of study (theory);
3. A description of the process of investigation, or how the study was completed (method);
4. A statement on the principled considerations taken in relation to the subject matter and those involved with the study (ethic).

II. Meta-Theory

Meta-theorising, or metaphysical-ising theory to bring forth ontologic, epistemic, and logical currents within social scientific theory becomes necessary when confronted with the numerous modes of thought associated with the lived reality of social life. This critical social theory, while offering implicit ontologies, has left the question of what is real and knowable in social reality uncomfortably open. Truly, can a clear answer be

given to the question of what social scientists seek when describing 'structural' and 'agential' realities?

While not considered in any detail herein, an effective answer to this question is offered by the metaphysical positioning of 'critical realism' (as expounded by Bhashkar and others).[2] These scholars' ontologic and epistemic understandings definitively impact the modes of conceptualisation and explanation used to answer this researcher's central query. 'Critical realism' allows for the grounding of a natural social ontology that establishes the necessary qualities of reality in order for human intelligibility (and science) to be possible, viz. that reality is stratified, open and differentiated. Importantly, it also delimits an object of social inquiry: the social structures that emerge, shape and are shaped by the creativity of human agents. It further establishes a discrete historicity to social scientific analysis and explanation, since in the social world, time grounds the necessary pre-condition for relevant human interaction. Historical 'reasons' thus become 'causes' for events (in the empirical sense). This 'philosophy of social science' ultimately grounds the ontology that guides the epistemology of this political economic theory.

II. Theory and Political Economy

So what are these generative structures that constitute the object of social inquiry? Social theory has been chipping away at these structures (and people) throughout its history of shy ontologising, allowing a progressively refined understanding of what these structures are (they are establishing a necessary truth *a posteriori a fortiriori*). From Levi-Strauss's

ultimate 'structure' to Foucault's 'biopower' to Bourdieau's 'habitus,' a truthful logic of structure(s) and their reciprocal mediation with people has indeed been present.

Noteworthy (as per critical realism), is that any logic of structures must understand them as different than people. Structures are real and must have the property of historicity/temporality in that people access a pre-existent structure that establishes legitimate social practice. As is the mistake with conflationary approaches, viz. the downward and upward conflation of Durkheim and Weber respectively and the centralist conflation of Giddens (which do not recognise the out of sync or tensed character of agency and structure), the social world is a jumbled mess of actuality.[3] Necessarily, structure does not exist in synchrony with people, as it presupposes its creators through a discrete historicity. Structures are ontologically separate from individuals, as ultimately evidenced by the fact that the powers of social forms are very different from the powers of people who engage and harness those pre-existing forms (*i.e.* people do not constrain others' actions in the same way that societal forms do and *vice versa*).

Any theoretical explanation of social reality must understand the tensed nature of structure and agency and the mediating system that exists between them. This researcher's notion of political economy accepts the reality of a pre-existing natural system or structure that is conferred as 'positions' (places, functions, rules, tasks, duties, rights, *et cetera*), occupied (filled, assumed, enacted, *et cetera*) by real living people, who, by virtue of occupying these positions, engage in the agency of 'practices' (legislation, activities, et cetera) that change or maintain current social forms.[4] Structures allow positions that allow practices that constitute structures, and thence the tensed, time-dependant moving reality of social life.

a. Political Economic Explanation

"Political economy is the dominant research tradition in North America offering a critique of contemporary health care reform."[5] As the term suggests, political economy understands politics and economics as integrally related. To a political economist, "[s]tates, markets, ideas, discourses, and civil society [*i.e.* structures] are not independent variables but interrelated parts of the same whole."[6] To date, the specific research problems addressed by political economic approaches to health care are numerous: from such topics as state/corporate/medical relations and their consequence for the power of the medical profession,[7] to the relations of power involved in the decolonisation of health services within Canada's North,[8] to the role of neo-liberalism in the drive to privatise health care in Canada.[9] Intuitively, political economy is simply legitimated as a result of its analytic power.

In the public health sciences, these considerations generally involve an understanding of how political economic realities impact health and disease through their shaping of health service structures and delivery mechanisms. In this regard, the power of the medical profession significantly shapes the quality, access, and funding of health services,[10] while the decolonising of health services in Canada's Arctic results in cultural frictions lived out at the clinical level,[11] inasmuch as the drive to privatise health care may fragment an already ailing system and thus decrease access to services.[12]

Political economies include people, groups, communities, cultures, professions, municipalities and states (*i.e.* positions, practices and structures). They can be local, national or global. For that matter, anything that "represents an organised dynamic

whole, a system of sufficient persistence and identity to justify being named,"[13] can be bound as a political economy. There in turn exists: a political economy of globalisation; a political economy of global markets; a political economy of health care systems (*e.g.* a political economy of an oral health care system); a political economy of hospitals; a political economy of an individual hospital; and a political economy of the clinical event. One can even venture and suggest a political economy of the self.

With this conceptual closure, political economy is specifically defined herein as an approach that "views the economy as socially and politically embedded and as structured by power relations."[14] As such, the economy (or the social redistribution) of dental services and resources is socially and politically embedded and structured in the power relations of stakeholders. It is in these structures where the interrelationships of stakeholders play out-- influencing, shaping, delimiting, or constraining the actions of those same stakeholders as they attempt to deliver and improve care in such environments.

The direction taken with this theoretical perspective directly builds on the work of O'Neil concerning the history, ideology, structure and praxis of biomedicine in the Baffin region of Nunavut.[15] His analysis is specifically structural, whereby the social relations of power between key stakeholders in their positional practice throughout the Baffin region are described and outlined, ultimately commenting on the "extent to which the devolution of health services in the Baffin region has resulted in the decolonisation of the health services system."[16] The assumption is made that "devolving health services achieve[s] a system in which local residents assume greater responsibility for the health services provided and the health status of the population."[17]

This investigation is also informed by the work of Tester, who partly continues O'Neil's analysis in his ability to answer the question of whether devolution did in fact result in greater local control.[18] In addressing this and other relevant aspects of northern health services, Tester concerns himself with the Keewatin region of Nunavut, whereby he traces the evolution of a health services planning body (*i.e.* the Keewatin Regional Health Board) and the development of its involvement with private sector interests in public medicine.

Importantly, both authors fundamentally concern themselves (at one level or another) with the power relations between people, between the private and public sector, and between governments, specifically in the context of sociopolitical change (*i.e.* that change associated with the drive for Indigenous self-determination and self-governance). Similarly, this analysis also deals with the development of northern health services in relation to this change.

Since political economy is a theory of power, this study will be infused throughout with a general concern for the power that structure, position, and practice can afford. This analysis partly rests on a Foucauldian notion of space, whereby 'every space is a container for social power.'[19] Although Foucault's thesis deals with space directly as it pertains to the body and mechanisms of social control--through the actions of biopower[20]--this study abstracts it to the aforementioned conceptions of structure, position, and practice. For instance, as will be demonstrated, whichever individual, group or corporation (public or private) happens to control a relevant space, whether ideological or structural or physical, they become the recipients of a large amount of

influence over the interactions that occur in relation to that space.[21] With this understanding, a description of how this study was carried out follows.

III. Method and Process

The open and dynamic system of northern dental services was primarily accessed and delimited through the experience of the researcher as a northern clinician. Phenomenologically and existentially, this allows for a rich conceptualisation of the experience, but as a sole source of knowledge, it lacks the critical awareness of a full and thorough understanding. Stakeholders were thus interviewed for their knowledge of this system, in addition to undertaking significant reviews of discourse related to the phenomenon.

a. Ethnography and Case Study Design

This study proposed the scientific observation of a phenomenon that has no clear geographic and/or historical boundaries: the oral health care services of the roughly 27,000 inhabitants of 25 communities in a place roughly the size of continental Europe. With the previous determination that the objects of study in the social world are those structures that pervade it, and coupled with the knowledge that to understand structures and people one must also account for people's histories, positions and practices with and through these structures, a method was needed that would accommodate for these analytical necessities. The method had to flesh out those structures (and thus the factors) that determined people's social positions and that shaped people's past and current

practices in the development of dental care in Nunavut. The ethnographic method was adopted due to its historical success as the premiere method for this type of analytic access.

The term is easily deconstructed: ethno- from the Greek "ethnos" for race or people, and -graphy, from the Greek stem "grafi," which means to describe something in words or images. Ethnography has a long practical and theoretical history and has evolved from the original connotation associated with cultural anthropology, a connotation that tended to focus on the cultural patterns of village life. In the public health sciences, medical anthropologists have incorporated ethnography into their considerations of medical systems as cultural systems, as well as into their analyses of the experience of health and disease.[22] Morse and Field state that ethnography "was incorporated into health care research by nurse-anthropologists," whose research "[focused] on the effects of culture on health care, [health] institutions as cultural settings, [and] professional groups organised as cultural systems."[23] Ethnographies are classifiable into many types, a discussion of which is not pertinent here. What ethnographies do share is that they are based on observed experience abstracted through the development of a thorough contextual understanding of the lived phenomenon. This allows one to understand how things are, and the reasons for why things are the way they are.

In ethnography, multiple methods of data gathering are used, including participant observations (noted in field notes), interviews, and document reviews (*i.e.* gathering everything and anything that is and can be relevant to the field of study). In this case, the use of this approach and method of data gathering evolved as a result of the researcher's

role as a clinician in seven Nunavut communities over the course of four years (strengthened by an ethnographic comparison with experiences in several southern First Nations communities). Before discussing the relevance of this ethnographic context, some comments on case study methodology and design are warranted.

Case study methodology has been widely used in the social sciences and is the preferred strategy "when the focus is on a holistic understanding of how and why certain events or decisions have occurred over time."[24] Yin has defined the case study as "an empirical inquiry that: a) investigates a contemporary phenomenon within its real-life context, b) the boundaries between the phenomenon and context are not clearly evident [*i.e.* it is an open system], and c) multiple sources of evidence are used."[25] This is evidently the case in this investigation, whereby the contemporary phenomenon of the open system of dental services in Nunavut is studied within its real-life context, using participant observations, interviews and documents as differing sources of data.

Case study research is largely exploratory and descriptive, rather than causal in a positivist sense. It is nonetheless important to note that reasons can be construed as causes in the social world. As such, the logic of internal and external validity is not always appropriate, yet as an empirical method, the case study must face these issues.

Using multiple sources of evidence and providing for the participation of stakeholders in the analytical process satisfies notions of construct validity. In qualitative science, analytic strategies are also used to address issues of validity. For example, by 'triangulating' data (*i.e.* finding convergence among different sources of information and different methods of data collection), the internal validity and reliability (*i.e.* the accuracy of information and whether it matches reality) of the study was refined.[26]

'Transferability,' or whether general themes that emerge from data analysis can be applied under similar conditions, contexts or circumstances, enhances external validity.[27] Synthesising the results of studies that examine the same phenomena but in different contexts and then comparing and contrasting the results also provides for a measure of generalisability.[28] This was partially achieved through a general comparison between past studies the northern dental care, and through a comparison of northern and southern systems of dental care for Indigenous Canadians. This aside, due to the uniqueness in using this approach within the dental sciences, and in the uniqueness of the phenomenon under investigation in general, external validity is limited.

Case studies and their designs must also grapple with a definition of the 'unit of analysis.' According to Yin's typology, this case method is of a 'single-case holistic' type.[29] As Yin notes, "the holistic design is advantageous when no logical subunit can be identified and when the relevant theory underlying the case study is itself of a holistic nature."[30] Dental care in Nunavut has no clear logical subunits as it involves many individuals, policies, institutions, and regions, with the political economic perspective attempting to consider the development of oral health care in an open fashion. The whole case will thus be considered the 'unit of analysis.'

b. Special Considerations in Data Collection

The context and impetus for the study of the political economic nature of dental care in Nunavut (as ensconced by this researcher's involvement as a clinician in Nunavut for two and a half years) came immediately prior to any formal training in ethnographic methods and qualitative research. Additionally, the formulation of a question as to what factors

impact the development of dental services in this region came intuitively prior to any academic focus. These two facts create an interesting conundrum in the ethical collection of data for the purposes of answering the research question.

This becomes clearer when one considers the personal and professional intimacy associated with two and a half years of clinical services within a social milieu that is now, for the purposes of this study, characterised as a 'political economy.' A large majority of potential study participants knew or had heard of the researcher, with two years as an employee of a contractor for dental services in Nunavut allowing this researcher experiences and access to information that, under normal circumstances, is not openly known or open for public scrutiny (*i.e.* participant observations, emails, administrative documentation, et cetera).

This researcher has had experiences, has heard comments (that were subsequently noted), and has had access to documentation from fellow clinicians and administrators that speak directly to the ways in which the politics of self-determination and the economic considerations of stakeholders have influenced and impacted the development of oral health care services in Nunavut. Knowledge also exists relative to how local behaviors and beliefs impact on the maintenance of oral health, with much awareness of the clinical event and relationship. While all these points prove to be fundamental in a successful interpretation of events and in the ability to answer the research question, they do hinder an ethical methodology. This confuses data collection, and places the researcher in a privileged position relative to sensitive information.

To report the exact details of these observations as illustrative cases would be unethical and unfair to the individual actors, as they were not interacting in the context of

a research study. Yet the research study remains relevant, with an answer to this question proving fruitful to improvements in this system. Two questions immediately arise. If utile, how can the data be represented such that illustrative cases and people are not apparently and easily recognisable to the stakeholder community? What information can qualify for the purpose of the study when some data was collected in the context of 'life' and not that of a research study with explicit ethical rigour?

Answers to these questions are difficult to negotiate. One must first consider that it is impossible to separate a person from their experiences. One must also recognise that inevitably, some of these observations will influence the analysis and conclusions of the study.

To answer the question of how to characterise cases, this study presents composite case studies of people and events such that they are less recognisable in time, place, and person. This noted, due to the small stakeholder group, amongst them recognition is possible. In answering the question of what data can be collected ethically, a mechanism was developed that allowed the use of data collected prior to the commencement of the study in a fair and ethical fashion. This was accomplished by both enhancing research participant anonymity and by enhancing the rights of participants in terms of data accessed through them prior to study commencement (to be reviewed shortly).

Before describing the specific mechanisms of data collection, the researcher will clearly state that the goal was not to show how individuals or individual behaviors impact the development of dental care services in Nunavut. Rather, it is to describe and explain the broad social and historical (*i.e.* structural) factors that influence the development of

dental care. It was the experience of this researcher that most stakeholders contacted expressed willingness to participate, some with reservations, others with full disclosure.[31]

c. The Data Collection Process

Due to the special circumstances of the study timeline: that fieldwork was completed before it was academically thought of as such; a mechanism was needed to attain sensitivity to this. In terms of presentation, this was aimed for through the use of composite case studies, always keeping in mind that cases could be recognisable by stakeholders. In terms of the data collection process, this sensitivity was developed both by allowing enhanced choices as to participant anonymity, and by also requesting participants to grant access to personal data, whether collected prior to or after study commencement. Data collection was structured via the following understanding: that there be data collected retrospectively and prospectively (as per the status of some data being collected prior to study commencement), and that there be data characterised as private and public (as per the status of some data being potentially viewed as private property). This data collection and organisational schema is presented in Appendix A.

Regarding ethnographic interactions and possible participation in the study, stakeholders were contacted through email, phone, or in person. In (re)acquainting the stakeholder with the researcher and the research relevance of current and past interactions, stakeholders were asked to sign consents allowing for permission in participant observation, interviews, or retrospective and prospective data collection. In all possible circumstances, potential participants were made aware of the study and

undertook the informed consent process prior to any research interaction (see Appendix B).

As mentioned, since part of the gathered data included general commentary made prior to study commencement, the participant was given increased choice as per identification through the use of a series of nominal options (see Appendix B). These included: past or present private administrator; past or present public administrator; past or present provider; Inuit stakeholder; anonymous, or by name. This allowed for a participant to determine how they wanted to be characterised in the study, if they so wished involvement in the first place. Importantly, this researcher attempted to elicit past opinions and commentary in known interview situations (as when being tape-recorded) or in known researcher/participant interactions (as when stating to the participant that our loose conversation was noted as relevant research data and information).

Regarding interviews, participants were asked if they could be audio recorded, knowing that the recording would be transcribed, checked for accuracy, and then destroyed. Interviews were semi-structured and were similar in that general questions regarding dental care in Nunavut were asked of all participants. Differences depended on the origin of the participant relative to stakeholder group, as in governmental or non-governmental, corporate or academic, Inuit or non-Inuit (see Appendix C). The semi-structured interview proved fruitful in that participants were allowed to explore their ideas, aided with trigger questions used to delve deeper into areas of relevance. A total of 15 formal interviews were completed, while the total number of relevant ethnographic interactions was innumerable. All 15 allowed for interviews, with 4 allowing for participant observations, meaning that they would allow me to observe them in the

context of meetings and interactions and use those interactions for study purposes, two allowing access to private data collected retrospectively, and two allowing access to private data prospectively.

As a result of the low numbers of individuals not providing access to important data, every attempt was made to establish the private data as one contained within the public domain. This approach proved very successful, but the reality remained that some data was clearly off limits. Other sources of data (*e.g.* field notes, newspaper and archival materials) were developed and collected throughout.

d. The Data Analysis Process

In general, data analysis involved the gross description, cognitive resolution, and theoretical re-description of complex and relevant events and states. This involved a process of empirical description, followed by retroduction to plausible causes or reasons for 'why things are the way they are,' followed by the elimination of competing alternatives causes or reasons, and finally, identification of the factors (or structure) at work in shaping the reality of 'why things are the way they are.' More realistically, during the process of manuscript development, a complex iterative interaction of ethnographic experience, thematic development, the limits imposed by data points, and stakeholder recognition of analytical findings, constituted analysis.

Regarding an analytical timeline, in this study, the ethnographic experience of a clinical life in northern dental services informed much of the questioning related to the development of a coherent research question. Before any interviews and most definitely before any formal analysis, a thematic understanding of relevant contexts was possible.

This proved very profitable in the areas developed that may not have otherwise been without this experience.

Specifically, data was collected and filtered relative to region, common themes and/or events. After the formal period of data collection was finished (informally it has never stopped), an initial housekeeping and log of data was completed. Again, this data was grouped relative to region, developing themes and event occurrences. A second and third analytical milling of this sort occurred, whereby more and more links and connections between events and states were made, and more and more distilled and subtle understandings of the study context made possible.

Hundreds of data points were derived from all interview, documentary and observational material. Data points were triangulated as much as possible to achieve a higher form of reliability. Where some theme or event was unclear, more data was sought, usually in the form of stakeholder conference and direction on the issue in question. Finally, an analytically critical and reasoned answer to the research question was found, viz. that the factors currently influence the development of dental care in: 1. Geography and Disease Burden; 2. Indigenous Self-Determination; 3. State/Indigenous Relations; and 4. Dental Practice and Philosophy.

IV. Ethical Considerations

The ethics of this study are of interest, as they pose significant questions about the researcher and research participant relationship. This essentially reduces to a consideration of power and its intersection with the rights of both parties. For example,

is this research at all ethical considering the amount of knowledge gathered prior to the commencement of an official study?

The ethics of power in research relationships is generally understood as being one where the researcher has power over the research subject, and that it is through understanding this power dynamic that ethical research practice is achieved. Under conditions where a researcher encounters a stakeholder community constituted by marginalised individuals or an 'at-risk' population, one can accurately consider the power relations between researcher and community as disparate and in need of careful consideration and practice. Yet, when one encounters a stakeholder community made up of stable and established persons (such as practitioners, administrators and entrepreneurs), are these power relations slanted differently?

George E. Marcus considers this dynamic in his discussion of the ethnographic relationship he shared with individuals comprising several dynastic fortunes in the American State of Texas.[32] Here, the representation of the 'vulnerable subject' is effectively turned on its head. As Marcus states, "[it is] clear that dynasties are not a special case or an exotic phenomenon in the problems that their study poses for the ethnographer [...] [s]cientists, professionals, as well as the credit-card carrying middle class are potential ethnographic subjects."[33] This study's stakeholder group represents a series of stable and established ethnographic subjects who, importantly, were and remain this researcher's social equals and/or employment superiors. As such, the risk that the research participant is in an inequitable power relationship, unable to protect his/her own interests in interactions with the researcher, is clearly not present.

Nonetheless, through the informed consent process devised for this study, ethical sensitivities were kept at a maximum. The procedure outlined minimised the potential risk to research subjects by establishing (in them) the ability to provide direction and control as to how they wanted to be represented, and as to what data was usable in the study (accessed through them). Moreover, all data was stripped of any direct and/or contextual descriptors before incorporation into the research text.

After considering these elements of the proposed research, the use of retrospective participant observation and documentary data was justified. From an epistemological perspective, the participant observations contained in field notes added much to the success of answering this research question in a full and thorough manner, leading to a more ethical study. The unnatural epistemic and ontologic separation of past experience from analysis was also adequately addressed. Such was the success of this approach that it now informs a series of studies related to the social dynamics of Canadian Aboriginal health systems, and also acts as a template for a health research ethics board reviewing qualitative studies of this type. With this description, establishing the history that funds the positions and practices of people within northern dental services now follows.

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[1] Ontologic refers to what is real. Epistemic refers to what can be known about that which is real. Everything and nothing can be real, with the possibility, or no possibility, for knowledge, or no knowledge, of that which is, or is not, real. There are ranges here that delimit the limits of human existence, reason and understanding. Logic refers to the real nature of reasoning, as in making truthful knowing assessments about these ranges, and by extension, about that which is, or is not, real.

[2] Critical Realism, in its purist form, purports to rationalise the existence of a very real world in relation to our relativist knowledge and experience of it. This type of realism is fundamentally tied into the ideation of Roy Bhaskar. His work stems from the need to ground a philosophy of sciences (and by extension social science) that takes into consideration modern understandings of the natural and social worlds, viz. it attempts to reconcile the fact that the laboratory and quantitative sciences are very capable of explaining the natural world yet fail absolutely in their scientific understandings of social phenomena. Critical realisms provides for a strong, realist ontology of social existence, something that modern social science has generally been unable to ground in their relativist conceptions of social reality. For an introductory and detailed summary see **Archer M, Bhaskar R, Collier A, Lawson T, Norrie A** (1998) Critical Realism: Essential Readings. New York: Routledge.

[3] **Ibid.**

[4] **Ibid.**

[5] **Mykhalovskiy E** (2001) "Towards a sociology of knowledge in health care: Exploring health services research as active discourse." In Armstrong P, Armstrong H, Coburn D (Eds.) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. pp. 146-167. New York: Oxford University Press.

[6] **Armstrong P, Armstrong H, Coburn D** (2001) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. New York: Oxford University Press.

[7] **Navarro V** (1973) Medicine Under Capitalism. New York: Prodist.

[8] **O'Neil JD** (1986) "The politics of health in the Fourth World: A Northern Canadian example." Human Organisation 45(2): 119-127.

[9] **Coburn D** (2001) "Health, health care, and neo-liberalism." In Armstrong P, Armstrong H, Coburn D (Eds.) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada pp. 45-66. New York: Oxford University Press.

[10] **Navarro V** (1973) Medicine Under Capitalism. New York: Prodist.

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[12] **Coburn D** (2001) "Health, health care, and neo-liberalism." In Armstrong P, Armstrong H, Coburn D (Eds.) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada pp. 45-66. New York: Oxford University Press.

[13] **Engel GL** (1981) "The Clinical Application of the Biopsychosocial Model." The Journal of Medicine and Philosophy 6: 101-23.

[14] **Sayer A** (1995) Radical Political Economy: A Critique. Oxford: Blackwell.

[15] **O'Neil JD** (1990) "Democratising health in the Northwest Territories: Is devolution having an impact?" The Northern Review Summer (5): 60-81.

[16] **Ibid.**

[17] **Ibid.**

[18] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[19] **Harvey D** (1990) The Condition of Post Modernity. Cambridge: Blackwell.

[20] **Ibid.**

[21] Consider for example the power related to residency and ethnicity in relation to the competition for northern dental contracts.

[22] **Helman CG** (2000) Culture, Health and Illness 4th ed. Oxford: Butterworth Heinemann.

[23] **Morse JM and Field PA** (1995) Qualitative Research Methods for Health Professionals 2nd ed. Thousand Oakes: Sage.

[24] **O'Neil JD** (2000) An Examination of Factors Contributing to the Development of a First Nation Controlled Health Care System in Manitoba. A Community Alliance for Health Research Initiative. Unpublished Manuscript. University of Manitoba.

[25] **Yin R** (1994) Case Study Research: Design and Methods 2nd ed. Thousand Oakes: Sage.

[26] **Morse JM and Field PA** (1995) Qualitative Research Methods for Health Professionals 2nd ed. Thousand Oakes: Sage.

[27] **Ibid.**

[28] **Ibid.**

[29] **Yin R** (1994) Case Study Research: Design and Methods 2nd ed. Thousand Oakes: Sage.

[30] **Ibid.**

[31] Of import as well, as is noted by Morse and Field "[r]esearch becomes a risky endeavour when driven by the personal agenda of the researcher." **Morse JM and Field PA** (1995) Qualitative Research Methods for Health Professionals 2nd ed. Thousand Oakes: Sage. The ideal thus becomes to clearly iterate one's own personal perspectives, political or otherwise, and to attempt a clear and reasoned view of the research setting. This researcher always approached study participants in a respectful and truthful way, emphasising the nature of contact with them as a researcher and as part of a research study. This involved the delineating of the researcher's role as a community minded clinician (of under-serviced communities and populations) through an academic department acting as a contractor for dental services in Nunavut communities.

[32] **Marcus GE** (1998) Ethnography Through Thick and Thin. Princeton: Princeton University Press.

[33] **Ibid.**

Chapter 3. A Short History of Oral Health and Care in Nunavut

I. Introduction

This chapter presents the historical basis (epidemiological and social) of this political economy. Firstly, it will describe the state of Nunavummiut oral health. Secondly, it will outline major dimensions in the development of northern Canadian health care. Thirdly, it will turn to specific developments in dentistry.

II. Oral Health, Disease, and their Determinants in Inuit Populations

Lack of information and limitations of analysis hamper an accurate account of pre-contact health status amongst all North American Indigenous populations, although "broad generalisations about disease over time and space are often made out of necessity."[1] Nevertheless, the dentition and its surrounding structures have proven a fundamental source of information regarding disease, diets, lifestyles, and a host of other aspects related to pre-contact life. Signs of acute and chronic occurrences are often particularly discernible in the teeth and bony oral structures of the maxilla and mandible.[2]

There is the historical assumption that "[Inuit] had [...] a high immunity to dental caries, in striking contrast with modern civilisation."[3] This impression was derived from Arctic explorers such as Stefánsson and Boas, and conforms to archaeological findings in Thule and Inuit skeletal remains,[4] which indicated well-developed muscles of mastication, few instances of dental dystrophy, and a very low incidence of dental caries.[5] Considerable wear of the dentition is also common in specimens due to the incorporation of sand into food, and as per the status of the mouth as a tool for softening animal skins. Early researchers hypothesised that the use of the mouth as a tool led to the formation of

periapical abscesses, the end result of a process referred to in dentistry as 'occlusal traumatism,' whereby one literally 'grinds their teeth to death.'[6] Other oral pathologic processes noted in the skeletal record include osteomyelitis, osteoperiosteitis, and sinusitis.[7] This provides some evidence against the historical notion that pre-contact populations were disease free.[8]

Whether disease free or burdened, it was incomparable to the illness experience with the coming of the European. It is generally accepted that as isolated populations, Inuit only recently came into sustained contact with Europeans. This may not be the case. As McGhee argues, "[Inuit] were the first North American group to contact Europeans, and by the time of Columbus's voyage they had been experiencing encounters with the Greenlandic Norse for approximately 300 years."[9] By the end of the sixteenth century, the coasts from Nova Scotia to Labrador were places of European activity. By the eighteenth century, there were regular encounters off the coasts of Greenland, Labrador, Baffin Island, and even Hudson Bay.

"A more critical period of contact occurred with the expansion of the whaling industry into Arctic waters in the middle of the nineteenth century."[10] Whaling allowed sustained contact with Europeans from 1820 onward, providing the environment for transmission of disease and epidemics. In 1899 for example, an epidemic brought by three whalers killed all but five of the Sadlimiut of Southampton Island.[11]

The whaler practice of hiring Inuit and rewarding them with much sought after trading goods and alcohol further impacted on traditional Inuit social organisation.[12] Acculturative influences reached different parts of the Arctic at different times, but despite regional variation "the overall effect of the fur trade and the establishment of

trading posts was similar in all areas."[13] The concentration of Inuit around trading posts provided new ways of living that increased the level of exposure and susceptibility to infectious agents, establishing the basis for the entrenchment of Western diseases such as tuberculosis and diabetes.[14]

The patterns and causes of dental disease also changed over the course of Arctic history, with these changes best understood in the context of an 'epidemiologic transition.'[15] When one analyses dental surveys of different communities at different times, a pattern of distinct dental health phases becomes apparent. Surveys conducted in Alaska, Canada and Greenland in the early 1900s presents traditional lifestyles resulting in minimal caries and little tooth loss even into old age.[16] Diets predominantly consisted of animal products, with little or no sticky, starchy, carbohydrates (or a disease promoting diet). As southern cariogenic foods were brought north, surveys detected differences in dental health (especially in the context of traditional oral hygiene techniques that stressed the removal of meat from between one's teeth rather than the use of a brush). So as traditional diets remained associated with high levels of oral health, southern diets resulted in increased levels of disease.[17] Studies in communities that had been exposed to southern diets for substantial periods showed a uniformly poor level of oral health.[18]

Zammit and others conducted the last reported epidemiological study concerning dental disease amongst Inuit.[19] More recent studies have been conducted in other Arctic and sub-Arctic Indigenous populations, confirming that dental disease continues to exist at high levels, and remains a considerable source of morbidity.[20] It is reasonable to assume that the same is true for Canadian Inuit populations, as is evidenced in much

social and political debate.[21] In fact, it was recently noted that northerners drink ten times more pop than southerners when the tonnage of shipment in colas is measured.[22]

Irrespective of availability and consumption, the determination of oral health and ill health does not solely turn on dietary habits. It also depends on a wide range of factors that include dental morphology, the practices of the self (*e.g.* oral hygiene habits), socioeconomic status, residency, and on the characteristics of the health system under investigation.[23] Oral health is determined by factors within and out of individual control, viz. individual and/or system or structural factors. The latter represent the determinants of oral health and disease that are of import to this study.

Although no data exist for Inuit or Nunavut, in Canada, system or structural qualities and outcomes are describable through recent research that demonstrates disparities by province and household income relative to insurance coverage, access to dental care, and oral health outcomes.[24] For example, the National Population Health Survey of 1996/97 indicates that only 53% of Canadians are covered by private or public dental health insurance plans and programs,[25] with high-income persons (those least likely to need dental care) seven times more likely to have dental insurance when compared to persons of low-income.[26] Household income and insurance coverage were powerful determinants of the ability to acquire dental care.[27] Canadians with dental insurance coverage were 2.7 times more likely to report a dental visit within the last year. While 78% of those with high incomes reported a dental visit, only 41% of those with low incomes did so.[28] In Nunavut, these disparities do occur, as presaged by the fact that the average income for all persons is roughly $20,000 per year, a low figure when compared to other regions.[29]

As presented in Chapter 1, the oral health care sector in Canada is structured around a private and public admixture of providers and places where one accesses care, and is financed through private and public methods of payment for that care, all very much slanted towards the private. Dental public health researchers are often the first to comment on the marked inequity of this type of system.[30] Regardless of the group considered (woman, elderly, children, adults, aboriginal, non-aboriginal), the indicator of socioeconomic status used (occupation, income or education), the level of analysis (individual, household, or area-based), and the disease or outcome measured (early childhood caries, coronal caries, root caries, periodontal conditions, the psychological and/or social impact of oral ill-health, insurance coverage, self-reported oral health), fine gradients exist among socially stratified groups.[31]

While many clearly observe inequity, one fails to find a thorough consideration of how these social realities are established in their role as factors leading to inequity in the first place. As Locker notes:

> "[F]urther studies demonstrating oral health inequalities are redundant; the point is to begin to identify the factors involved in generating and maintaining inequalities and their implications in terms of policy and service delivery."[32]

Here, a link is made between a social system (*i.e.* an oral health care system) and the population that it serves, contextualised in more than just the empirical demonstration of inequity. Surely, 'policy and service delivery' extend from political and economic environments, 'generating and maintaining' any inequity.[33]

In this context, improvements in Indigenous health have been understood in terms of the politics of self-determination, and the level of control exerted over governmental processes and services (*i.e.* the 'factors involved in generating and maintaining inequity and their implications in terms of policy and service delivery'). The development of

health care in Nunavut is thus partly congruent with the development of self-determination and control over health structures. This is the case in most critical accounts of northern health history, whereby sociopolitical change is the relevant axes on which analysis turns.

III. Northern Health Services

a. Services before 1970

The epidemiological picture of Inuit health has changed, predominantly in tandem with Inuit sedentarisation in and around the Distant Early Warning sites of the Cold War. These sites were a place for employment, and provided the context for much social crisis and sickness.[34] Early on, religious missions and mining companies tended to the health needs of Inuit at these sites.[35]

By 1943, "the [Northwest Territories] NWT had eleven hospitals, nine of them owned and operated by the missions and two by mining companies."[36] This can be considered the real beginnings of Western health services in Canada's North, and came to include the Church, mining companies, the American Military, and the yearly supply ships of the Federal Government.[37] Duffy argues that at this time, health care in the Arctic was 'in shambles' as a consequence of poor organisation.[38] While the Federal Government did provide funds for such hospitals, it was still not directly involved in the provision of health services. World War II American Forces construed this as a lack of Canadian responsibility, and often reported on the destitution and poor state of Inuit populations.[39] This criticism was often used as a lever for the American campaign to subsume the Arctic as an American Territory-- to war strategists of the time, the Arctic

was a choice locale.[40] So with a threat to its northern sovereignty and a system in shambles, the Federal Government answered its critics by enhancing the role of the Eastern Arctic Patrol, or the Federal supply ships of the Eastern Arctic.[41]

In 1946, following the publication of a report concerning health services in the NWT, the health responsibilities of the Indian Affairs Branch of the Department of Mines and Resources were brought under the administrative structure of the newly formed Department of National Health and Welfare.[42] This department (which is now Health Canada) essentially housed the administrative and bureaucratic body under which health services to Aboriginal peoples became organised. Through time, this division becam characterised as the 'Indian Health Service,' the 'Northern Health Service,' the 'Indian and Northern Health Service' (INHS), 'Medical Services Branch' (MSB), and most recently as the 'First Nations and Inuit Health Branch' of Health Canada (FNIHB).

By 1950, the INHS had expanded the Eastern Arctic Patrol with a new ship. It had an operating room, beds for six patients, a dispensary, a complete dental office, an x-ray room and a dark room.[43] Though providing necessary treatment for many Inuit, "the handling of Inuit patients throughout this period was [still] scandalous."[44] Inuit would often board ships and were never seen again. Often taken to sanatorium in the south, they were kept there, isolated from family and familiarity until they died, or until they were taken back, sometimes to places hundreds or even thousands of miles from their homes.

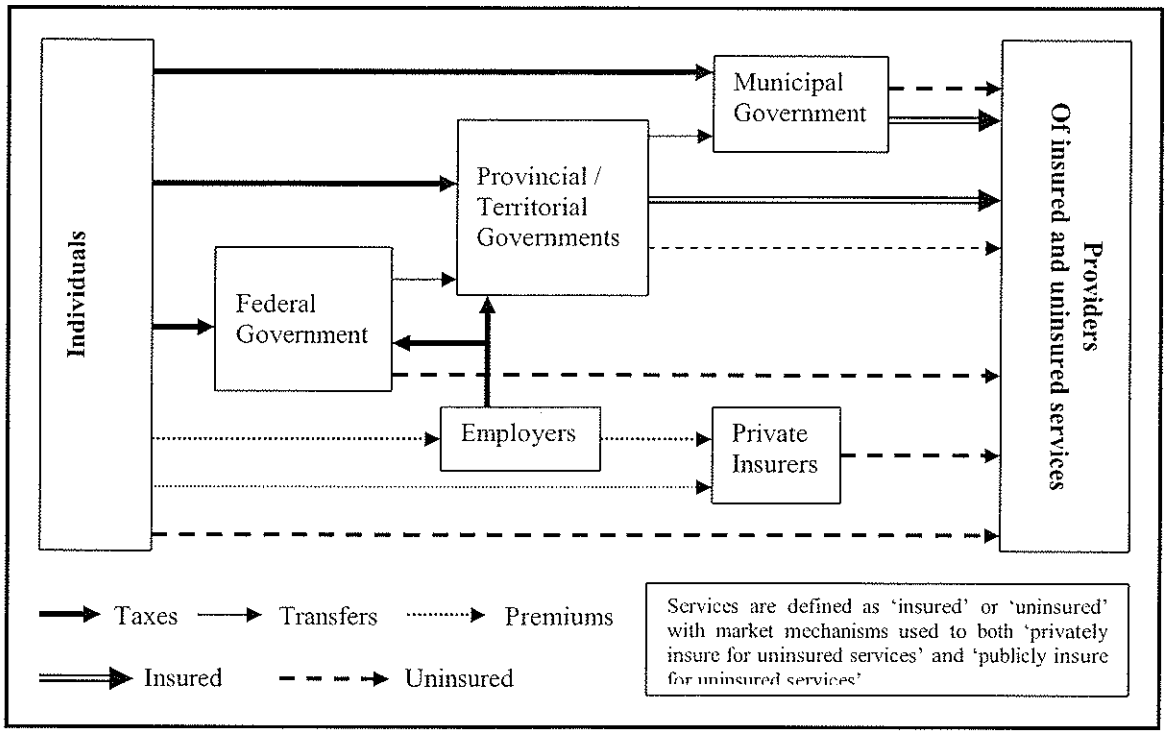
By 1956, Church and business now acted more as 'operating contractors' than as administrators.[45] Federal authorities had taken full responsibility of everything else, from logistics to planning to administration, and across the Aboriginal regions of Canada were now "operating 18 hospitals (growing to 22 by 1960), 33 nursing stations (37 in 1960),

52 health centres containing dispensaries, and 13 other health centres employing full-time physicians or nurses (83 health centres by 1960)."[46] Services in the Eastern Arctic were still sparse though, INHS activity largely constituting in an advisory committee that coordinated the points of juncture between the northern and southern administrative bureaucracies.[47] In fact, between 1920 and 1950, territorial government spending on health services had increased only by seven per cent,[48] and there seemed to be more planning than actual services. Another government reorganisation in 1962 saw the elimination of the INHS and the creation of a new branch, MSB, which brought more unity to northern and southern bureaucracies, and increasingly began to provide health services to all residents under federal jurisdictions (including the two northern territories: the old NWT and Yukon).

A discrete 'Aboriginal health service' was now observable, with the greater Canadian system of health holding influence over its development. The Hospital Insurance and Diagnostic Services Act (HIDSA) of 1956 publicly insured the curative and diagnostic services delivered in hospitals, and included provisions for the universal coverage of Canadian populations, comprehensive inpatient services, and portability of benefits across provinces. Canada's 'universal, comprehensive, portable, and publicly administered' health system was born.[49] HIDSA was aimed at Federal/Provincial concerns over the general Canadian population, and with jurisdictional complications surrounding the management of Indigenous populations 'Aboriginal health' was not a significant focus.[50] Yet HIDSA did provide an early context for the debate in health services that Aboriginal Canadians are a federal responsibility, and less so a provincial and/or a territorial one.

The early 1960s then saw medical insurance (as opposed to hospital insurance) enter the national social discussion. Resulting in the 1964 'Royal Commission on Health Services,' this commission endorsed a comprehensive range of benefits that would be federally subsidised and provincially administered, legislating its ideas through the *Medical Care Act* of 1966, enacting them in 1968 through the 'Medical Insurance Program.' This settled Canadian health care (that included both hospital and physician services) as a publicly financed and administered, publicly and privately delivered national health system.

Figure 3. Financing of the Canadian Health Care System (as per Lavoie[51])



These events also neglected Aboriginal health, as concerns were of the greater Canadian population and not those of a much lesser developed and jurisdictionally problematised Aboriginal health service.[52] What the *Medical Care Act* did do was establish the social redistribution of health resources along the notion of insured and uninsured services (or non-commercial and commercial social goods). This demarcation

naturally applied to Aboriginal health services but enacting in its own particularity due to the Inuit and First Nations context, viz. that there exist unclear rights to services and unclear responsibilities as to who holds authority over them (whether territorial/provincial, indigenous, or federal governments). This subtlety and outcomes of this dynamic are developed throughout the remaining chapters.

By the late 1960s, with a federal Aboriginal health system continuing to develop in an '*ad hoc*' fashion,[53] Aboriginal health care issues finally enter into the general Canadian social lens. Extending out of a time of social reconsiderations, the 'ethnonationalist movement' was a reaction to clear social inequity, and crystallised to some extent in relation to the Federal Government's 1969 White Paper on an Aboriginal social policy. This paper proposed to repeal major federal legislation (the *Indian Act*), abolish reserves, terminate the Ministry of Indian and Northern Affairs, and incorporate Aboriginal people into the fabric of Canadian 'multi-culturalism' on an individual basis, thereby shifting responsibility of Indigenous populations to provincial and territorial authorities.[54] Firm social pressure from coordinated ethnonationals and their supporters resulted in the movement away from this policy position, and shifted some of the relations of power between Aboriginal Canadians and the State.

With ethnonationalism came more Inuit involvement in health care and in other governmental sectors.[55] In considering an Inuit role within medical care throughout this period, O'Neil describes that Inuit involvement in service provision was present.[56] In the 1960s the 'lay dispenser' received intense instruction for six weeks in order to fulfil their legitimated duties. In areas with no nursing stations, lay dispensers were responsible for basic diagnostic and medical procedures.

Yet by 1970, the building of nursing stations across the Arctic was complete, and the lay dispenser role diluted. Also complete was the entrenchment of the nurse practitioner model of care, buttressed by itinerant physician care. Each community over 100 had a fully equipped station that provided outpatient services through these providers, acting as a referral centre to secondary and tertiary level care in southern Canada.[57] In time, this structure--health centres acting as the main source of care and the conduit for services outside of the Territories run by nurses and visited by itinerant professionals--comes to represent the basic organisation of health services to Aboriginal populations across Canada.[58]

b. Services in the 1970s

The 1970s and onwards can be considered the truly modern era of Canada's northern health services. With health centres and hospitals, a growing federally supported economy and culture develops. This 'northern and/or Aboriginal health culture' is significant, crosscutting many sectors, both public and private, and constitutes much substance in the general political economy of Canada's North, with health and social services resources representing some of the most robust capital and working budgets within territorial governments.

As more and more medical doctors ventured north, and as more and more health resources became available (whether technological or human), a fledgling northern health system became infused by the major medical culture of the time: biomedicine. Biomedical practice calls for both curative and preventative services--specifically delivered by biomedical practitioners like nurses and doctors--yet only significantly

enacts the former. This form of health service delivery came to dominate northern health services, with southern professional stakeholders determining much of the direction taken by this northern health culture.

This ideology is supported by the rubric of Primary Health Care (PHC):

> "Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[59]

Although idealistic to the point of almost being unrealistic, the PHC approach was a step forward in that it openly recognised the political nature of health (and thus effectively accommodated developments in ethnonationalism). It also recognised the need for involvement of all stakeholders in decision-making processes. Practically, this ideology has not always found its way into care, as several studies confirm the problematised involvement of Inuit in their health care.[60]

For example, by the mid-seventies, the role of the lay dispenser had been recreated. The 'clerk-interpreter' was involved in everything from filing charts, to contacting patients, to interpreting, to informing biomedical practitioners (dentists, doctors, audiologists, psychiatrists, amongst others) of relevant community and patient information that may prove useful in clinical interactions. Kaufert and others have described the role of clerk-interpreters in nursing stations within the old NWT.[61] Their analysis shows that in practice, clerk-interpreters exercised influence over the realities and outcomes of northern health services simply due to the nature of their employment. To get a sense of the influence held by clerk-interpreters, one only need consider the skill (or 'art and science') of medical interpreting (especially if done well), and the realities of administering a health centre. Clerk-interpreters also form a relatively stable 'unit of

longevity' at health centres, as it is they that live and work in northern communities year 'round (much more so than any southern professional). Ethnographic observation points to their necessary and fundamental role in services, and also confirms Kaufert's assessment that these stakeholders are not always recognised or allowed to make a full use of their skills.

Another concrete form of social 'health' positioning, responsibility and influence came in the form of the Community Health Representative (CHR). Established by federal authorities to locally enhance and develop the delivery of care to isolated regions (in line with PHC), the CHR was to bring community-based endeavours and locally relevant health discourse to northern health care. 'On the ground,' this role has meant the delivery of public health education efforts, but also involves other, sometimes unrelated tasks and responsibilities (such as those of the clerk-interpreter). Whereas some communities have a very active and supported CHR, others are poorly received and supported.[62] Nonetheless, the CHR continues to be an avenue by which to deliver public health efforts, including dental public health care, with some even promoting the development of a 'dental CHR,' or encompassing 'dental responsibilities' through training in current positions.

Community Health Committees (CHC) also became part of northern medical life at this time. They are considered shortly, but note now that like the CHR, they have been described as confused and ill defined.[63] These two structures were formed for the purposes of increased Inuit and local control over the decisions that impact the northern health care system, this in a time when the ethnonational ideal of special 'Indigenous rights' and control over governance and its services was quickly developing.

One of the most politically relevant examples of the disconnectedness between Inuit and the processes that mitigate their health system is found within the need for medical travel. Historically, tuberculosis was the prime reason one left their community, but eventually, this became a routine endeavour for many northern residents, for everything from paediatric dental surgeries to childbirth.[64] The most critically documented example of this is the evacuation of women for pregnancy and birthing purposes.[65] This has (at times) become the premiere political issue for northern stakeholders, viz. it has proven to be an axis on which the politics of self-determination, self-government, and health care can revolve due to the emotionally charged fact that routine evacuation does not prove positive for women involved in births many miles away from home, isolated from family, friends and comfort.[66] This ideological struggle--where the dominant biomedical ideology determines the continued travel of women in order to mitigate biomedical risk for her and her baby (*i.e.* medicalisation)--is balanced by attempts (for the most part) of northern women and their coordination of ethnonational representation, seeking different options for birthing in their home communities. A call for more Aboriginal midwives and northern birthing centres have been made, with some of these requests proving successful.[67]

This issue was one of many that troubled Indigenous leaders, and was the context in which ethnonationalism developed its representative capacity. In response, federal authority attempted to clarify a position on Indigenous health services as far back as 1975. They stated that it was 'a matter of policy' rather than 'statutory or treaty obligation' that the federal government provided 'certain health services' to Aboriginal populations.[68] In 1978, the government then attempted to place limits on the 'uninsured

medical and dental benefits' for those Aboriginal persons on federal land that passed a means test, "only to meet with continued resistance from Aboriginal groups."[69] In the face of continuing opposition from the Indigenous community, federal authorities ended the decade by developing the 'Indian Health Policy.'[70]

Table 2. The Three Pillars of the 1979 Indian Health Policy[71]

Community Development	"The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being."
Traditional Trust Relationship	"The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations. This relationship must be strengthened by opening up communication with the Indian people and by encouraging their greater involvement in the planning, budgeting and delivery of health programs."
Canadian Health System	"The third pillar is the Canadian health system. This system is one of specialized and interrelated elements, which may be the responsibility of Federal, Provincial or Municipal Governments, Indian bands, or the private sector. But these divisions are superficial in the light of the health system as a whole. The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant Provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community. Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health."

The Indian Health Policy authorised the withdrawal of the proposed 'guidelines for uninsured medical and dental benefits,' as well as situated Canadian Aboriginal health policy along 'three pillars.' These 'pillars' aimed to increase the "level of health in Indian communities, generated and maintained by the Indian communities themselves."[72] Significantly, federal authority recognised the need to involve 'the community' in the health system (through 'community development'), and further recognised this

involvement within the 'traditional' State/Indigenous relationship. Yet federal authority failed to recognise (under the third pillar) that, at that point, they had delivered organised curative and preventative services to Aboriginal populations within provincial and territorial boundaries for over 20 years. Strategically, only the 'public health activities, health promotion, and the detection and mitigation of hazards to health in the environment' were recognised as significant federal commitments. 'Indian' overlapped with Inuit enough that this policy came to heavily inform developments for both populations.

Yet difference was the norm. For example, the 'Report of the Advisory Commission on Indian and Inuit Health Consultation' was released in 1979 as well. This was "the first systematic inquiry into Aboriginal dissatisfaction with the health care system [and] recommended that Inuit and Indian health be addressed separately, given the vastly different traditions and problems faced by the two groups."[73] This report also called for the development of locally controlled health systems, whereby First Nations were to be assisted through the creation of a 'national Indian health council,' and Inuit through the context of ongoing sociopolitical developments (such as the then proposed Inuit territory of Nunavut, or the then newer Inuvialuit land claims agreement).[74] Both this commission and the Indian Health Policy set a definite direction aiming for culturally relevant health services and local control over them, a direction that rings true for all Aboriginal groups.[75] Differences have largely been observed in the terms of 'passing control to Inuit,' 'passing control to the First Nations,' and passing control as 'devolution' in the north or 'transfer' in the south. Today, some Inuit populations engage

in 'transfer' inasmuch as First Nations populations are part of 'devolved' programming if north of the 60th parallel.

c. Services in the 1980s

Local and regional control over services (and the manner in which they are enacted) becomes the means by which to advance Indigenous self-determination and self-government in health care. In the late 1970s and early 1980s, this took the form of territorial, local and ethnonational pressure on the Federal Government to devolve control to the then current NWT government. Yet this 'wresting away of control' was not just for the purposes of the old NWT, it was also an important step forward in Inuit self-determination and self-government practice. As Hicks and White note:

"[A]lthough Inuit were vitally concerned with decisions, programmes and funding from the Government of the Northwest Territories, their principal political focus was on creating Nunavut. Inuit leader John Amagoalik once observed that the Members of the Legislative Assembly elected to the territorial legislature in Yellowknife were the Inuit 'B Team'; the 'A team' was working on the land claim."[76]

So as power relations were shifting from Federal authorities to Territorial ones, they were also shifting in the way of Inuit self-determination and self-government. If one follows the trail of perceived control between Traditional, Federal, Territorial, and Ethnonational authorities, one observes a flow from traditional health governing structures, to federal authorities, then to territorial/regional authorities, and finally, as will be presented, to a combination of public and ethnonational governance structures embodied through the 'self-governing public government' ideal of Nunavut.

This social movement held clear consequences for health services. For example, in 1980, as an adjunct to territorial attempts at the devolution of health services, the Inuit Tapirisat of Canada (ITC) passes a resolution towards that very same end. In 1984, O'Neil documented the 'Gjoa Haven Gambit,' a community's attempt at local control over their nursing station.[77] Although nothing becomes of the requests, this beckoned a significant step towards political and administrative control over health services and its structures by territorial, local and ethnonational bodies.

O'Neil's work in the Baffin region of the old NWT critically considers the issues surrounding the health devolution process in Canada's pre-Nunavut regions.[78] Others include Weller and Tester, the former dealing with the territory in general, the latter with the Keewatin/Kivalliq region in particular.[79] As stated in Chapter 2, O'Neil's work in the Baffin region and Tester's work in the Keewatin region will act as central informing examples throughout this study.

The devolution of health services to the Baffin region of the old NWT was a result of the perceived Federal Government's ineffectiveness at meeting new health challenges.[80] O'Neil presents a helpful diagrammatic progression of this devolution. Figure 4 is a representation of the general health service relationships affected by the process of sociopolitical change. Figure 5 is the old NWT health care accountability structure as officially published in the NWT Health Board Trustee's Handbook. Figures 6 and 7 are a progression of the structure of health services from the NWT to pre-Nunavut. O'Neil's analysis essentially maps the structural relationships of accountability and accordingly, social power.

Figure 4. Relations Affected by Devolution (as reproduced from O'Neil[81])

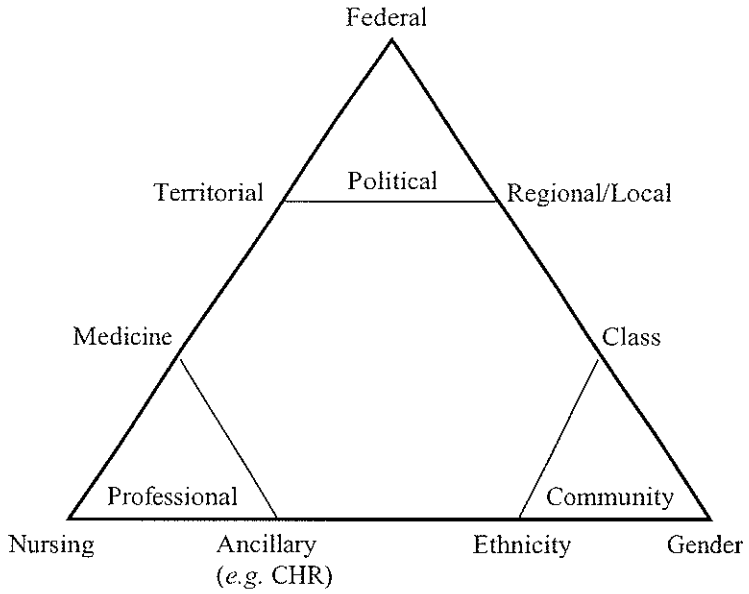


Figure 5. Old NWT Health Care Accountability Structure (as reproduced from O'Neil[82])

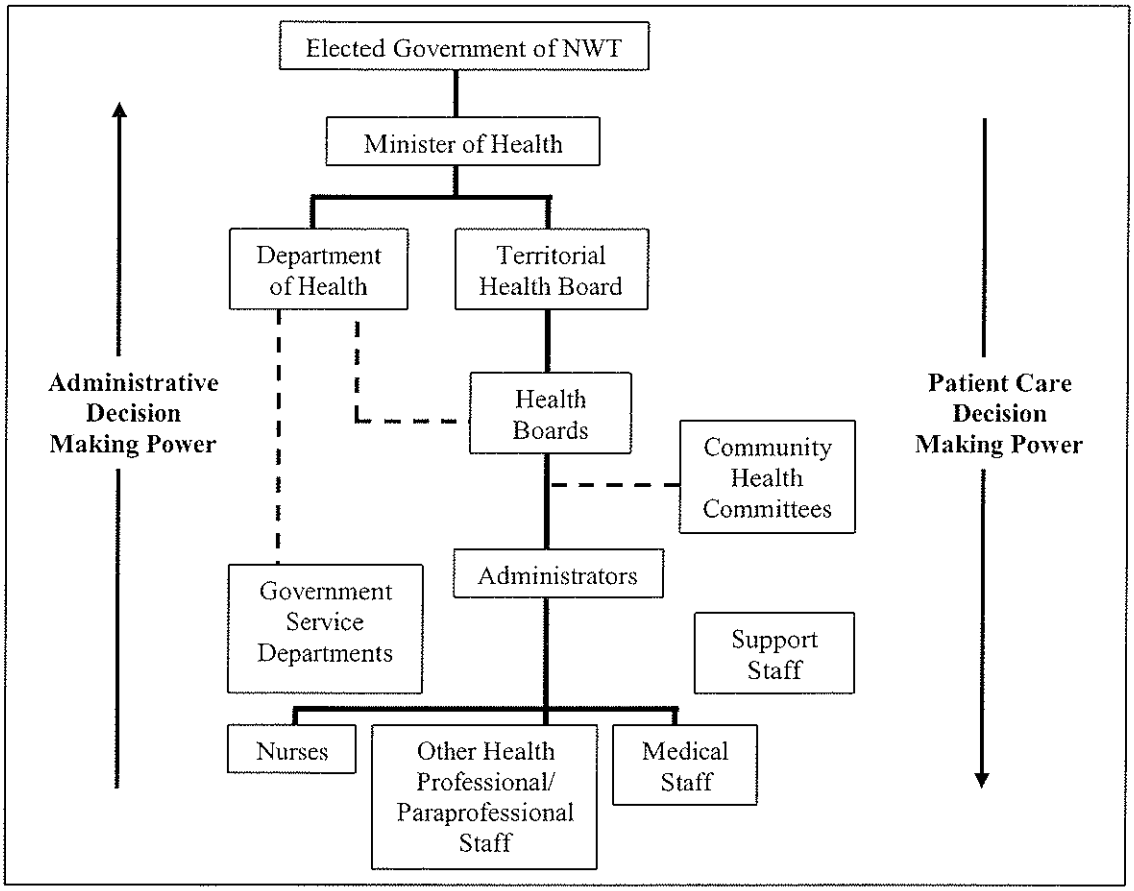


Figure 6. Pre-Devolution Health Service Structure (as reproduced from O'Neil[83])

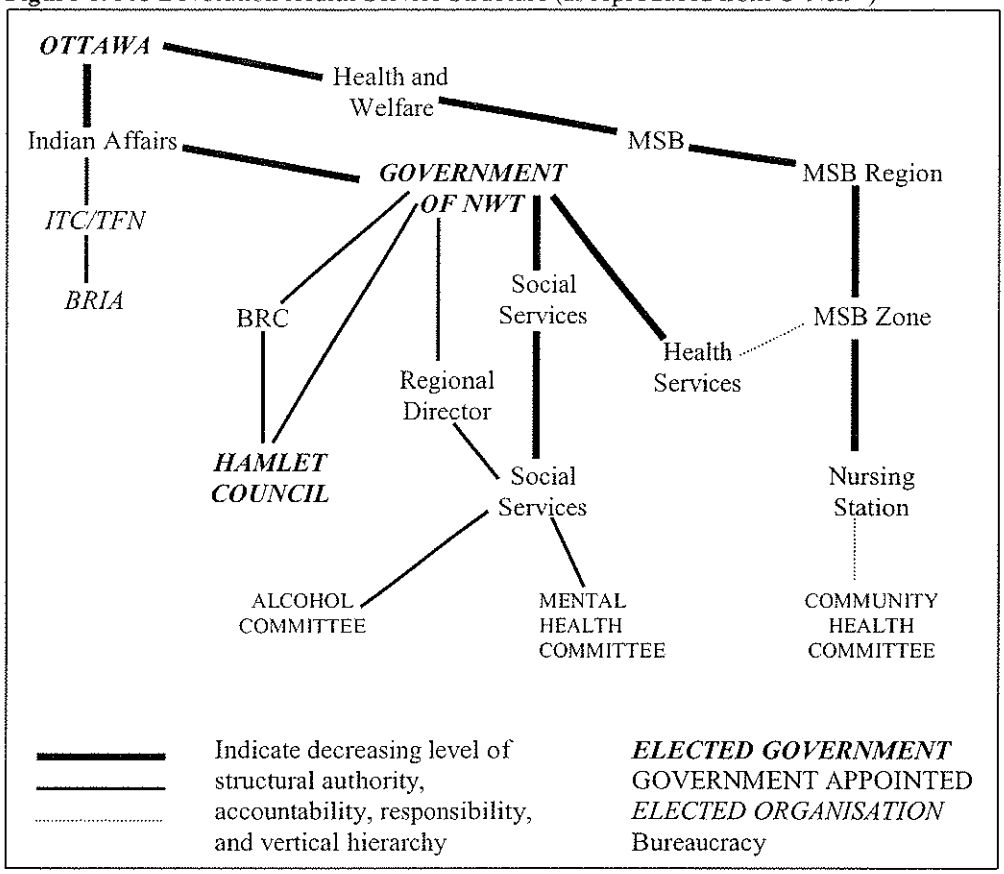
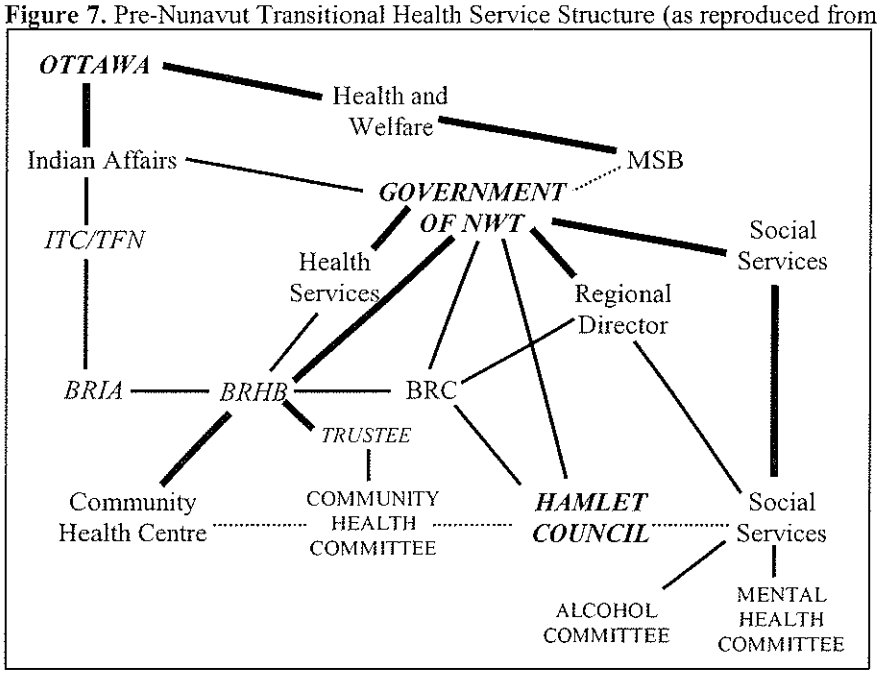


Figure 7. Pre-Nunavut Transitional Health Service Structure (as reproduced from O'Neil[84])



Initially, it was the Baffin Regional Council (BRC) and the Baffin Regional Inuit Association (BRIA) that began to lobby the MSB for control over their hospital.[85] Successfully, in 1981, the Baffin Hospital Board (BHB) was formed to assess and plan the transfer of control of the Baffin Regional Hospital. The first hospital board consisted of eleven members, seven Inuit and four non-Inuit.

By 1986, the BHB became the Baffin Regional Health Board (BRHB). The new Baffin board consisted of fifteen members, thirteen representing Baffin communities and one each from the Territorial Government and BRC. It was now responsible for the hospital in Iqaluit and health centres throughout the region. Its inception was followed by the creation of health boards in the remaining four regions of the old NWT in 1988.

With the structures presented in Figure 5 and 6 and with the data contained in Table 3, O'Neil clearly presents ambiguities concerning authority in policy development and planning. As O'Neil noted, '[w]hile health boards are expected to "define broad policies in relation to community needs," the Department of Health "sets health care standards" and "evaluates and regulates performance" of the health board.'[86] Contradictions and conflicts as to 'who exactly has power over what things' became apparent.[87]

Figures 6 and 7 demonstrate how devolution changed relations between federal, territorial, regional and local institutional structures (challenging then existing power relations). For example, in the pre-devolution health service structure, the BRIA did not have a role in the decision making chain, but in the transitional health service structure, it gains power in the space created by the BRHB. With the creation of the BRHB, Health Trustees and CHCs, many more individuals now had potential social access to decision-

making power with respect to health services. Social services structures like the Alcohol and Mental Health Committees now also held avenues by which to impact the health services in communities.

Table 3. NWT Health Care Participants and their Responsibilities (as reproduced from O'Neil[88])

Minister of Health (and elected government) • decide total annual health care expenditures • determines major priorities • appoints health trustees • has final authority
Territorial Health Board • is appointed by government • monitors all health boards • protects the rights of NWT residents to participate in health care decisions
Department of Health • assists Minister of Health • sets health care standards, evaluates and regulates performance • administers health insurance benefits
Regional Health Boards • define broad policies for their health services in relation to community needs and internal organisation • protects patients and appoints all health care staff • appoint administrators for evaluation of performance and financing of health services • provide adequate personnel, equipment and facilities to meet needs for patient care, health education and research
Health Trustees • appointed by the territorial government • are responsible and trusted members of the community • endure that the health services meet needs of community and are of the highest reasonable quality for the lowest reasonable cost • represents authority for the conduct and operation of all activities within the health region or health facility
Community Health Committees • are advisory groups on health issues • associated with local government • undertake fund-raising for health related projects • have no financial or health management authority • nominate members to the health board

Nevertheless, in summing up this process, O'Neil notes:

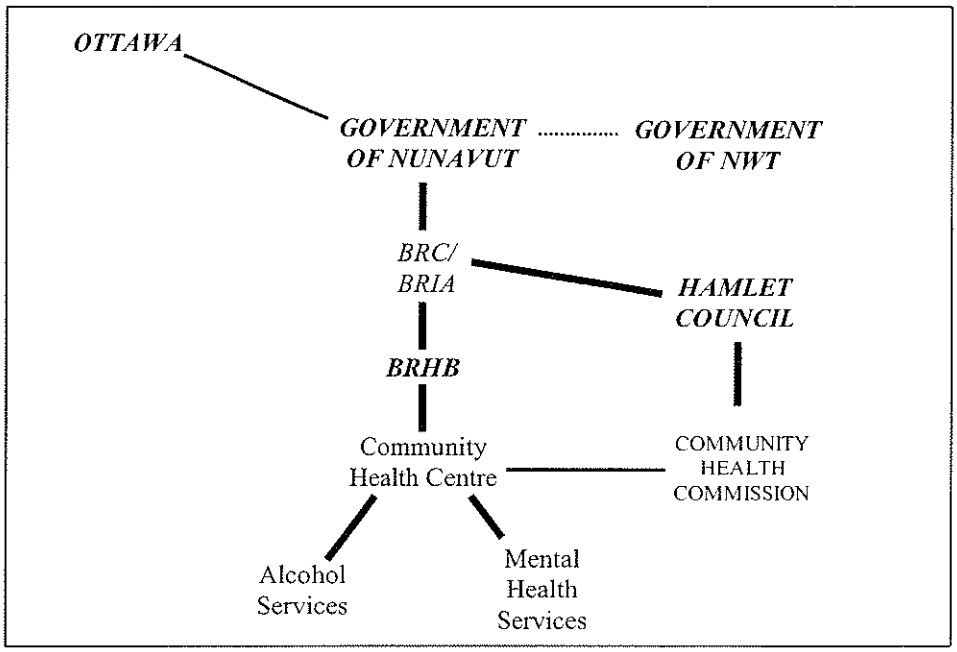
> "[C]hanging the colonial medical relationship is a fragile and complex process. The rhetoric on health promotion and empowerment often assumes that superficial institutional changes are all that is required to motivate individuals to take greater responsibility for their own well being. In the North, the creation of CHCs by the Federal government is a good example of this attitude. CHCs had only advisory status but were expected to provide for community input into health policy and planning. In most northern communities, health committees have been politically ineffective."[89]

Although there were now more formalised social spaces for Inuit in the political economy of health care in the Baffin region, their shaping and influence over the structure and

ideology of health services was not overtly successful. This of course had the potential to change with the signing of the Nunavut Land Claims Agreement (NLCA) and the formation of Nunavut.

O'Neil attempted to forecast what this change might look like by providing an example of the possible health care structure following the formation of Nunavut (see Figure 8). As an opportunity for the advancement of a self-determination and self-government agenda over health and social matters, O'Neil warned that whatever health governance structures did arise from Nunavut, it would potentially be challenged by ethnic tensions and professional dominance as per his observance of the BRHB.

Figure 8. Possible Nunavut Health Care Structure as Prognosticated Before its Creation (as reproduced from O'Neil[90])



Weller also provided an analysis of devolution prior to the creation of Nunavut, and also prognosticated on its outcomes. Weller suggested that local control could become problematised by the regulatory system developed by the Territorial board, or by physicians being able to exercise greater power in a decentralised system, which was one

of the goals of Nunavut.[91] Weller also recognised that since acute services are the norm, they might continue to be emphasised even though the majority of stakeholders involved, Inuit and non-Inuit alike, recognised the need for preventative services in order to achieve improved health outcomes.[92] Weller was positive about the possibility for a more progressive health agenda, as local control might indeed shift the emphasis from curative services to health promotion and health education. Yet earlier work completed by Weller and Manga had discussed then current trends in the 'reprivatisation of health care services' in British North America, suggesting its impact on the circumpolar north.[93] As was recently demonstrated by Tester, regional control (and the increased possibility of health education and health promotion) did not necessarily mean a progressive agenda, and may have demonstrated that Weller's earlier prognostications were the more accurate.[94]

d. Services in the 1990s

Tester picks up where O'Neil and Weller left off. Using news coverage and ethnographic experience as his main sources of data, Tester details events in the evolution of northern health care during the 1990s, dealing with the Keewatin Regional Health Board (KRHB) and the controversy generated as per its involvement with private sector interests. Tester offers the developments of the KRHB who, under the political influence of privately motivated stakeholders, attempted to restructure services with the inclusion of the private sector. Tester suggests that this, while an attempt to improve the health system in the face of a funding crisis, was also clouded in more opportune realities.[95]

The KRHB advanced the idea of a 'P3' plan, where 'private, public partnerships' could alleviate some of the economic struggles associated with delivering health services in the Arctic, primarily through the P3 role in infrastructure development, and possibly in revenue generation.[96] The details of this situation are forthcoming, but noteworthy now is Tester's argument that the KRHB (like O'Neil's BRHB) could have indeed been an avenue to gain greater democratic control over health care matters, but as he discovered, cuts in federal transfers and the increasing opportunities for private sector interests became major detractors in any significant Inuit control.[97] Tester goes further: "It can be argued that [this situation] left the citizens of Nunavut – created to bring greater voice and control to Inuit – with less community control over health than they had in the 1980s under the former Government of the Northwest Territories."[98]

Privatisation of the health care sector was a real option for health boards of the old NWT. This in an environment where a fair amount of service provision (and at times administration) is based on the territorial tendering of health contracts (for insured and non-insured health services, or non-commercial and commercial social goods). Contracting was the case historically (using Church and Industry), and throughout time, in the quest for modern provisory amenities, ties to southern contractors (for health professional services) became entrenched. From nursing to psychiatry to audiology to dentistry to medical transportation to medical lodging, all of these services, amongst many others, are part of some contract tendered to meet need. The southern providers who meet this need have generally been private and public institutions, the former constituted by capitalist human health resource agencies or sole-proprietors, the latter by

academic health professional faculties, with both offering practitioners and their services.[99]

Less obviously, in an environment of 'tendering and bidding,' the possibility for business and fiscal opportunity (and passive privatisation) improved. Consider Tester's case example, where a local non-Inuit conglomerate of real estate firms begins to play a role in health services by owning shares in professional health corporations and thereby making those corporations more attractive as per then current policies that favoured northern business interests. Tester documents how this initially non-Inuit real estate conglomerate comes to include private Inuit interests, in this fashion taking further advantage of policies that favoured Aboriginal northern business. More recently, there is the case of Piruqsaijit Limited (a company owned by the same conglomerate), which attempted to build a private for-profit 'state of the art' mammography-imaging clinic in Rankin Inlet,[100] a concept that in and of itself violates the *Canada Health Act*, and one that attempted to use technology not approved for use in Canada. As Tester notes, a "complete history [of northern health services] might be entitled: Prayerful, Public and Private Provision."[101]

Continuing this theme, the debates of the 1990s included the interests of Regional Inuit Organisations (RIO) in the development of health services. For example, the Qikiqtaaluk Corporation, a member of the Qikiqtaani Inuit Association (QIA), an RIO who acts as the main ethnonational presence for Inuit of the Baffin region, offered the Baffin Health and Social Services Board $25 million dollars for the building of a new hospital.[102] With existing government funding, this would have advanced any project, as the current hospital, built in 1962, was in great need of improvement (some say

demolition). In 1997, the Baffin Regional Health and Social Services Board declined the offer noting 'privatisation' as an issue. Despite this, all three regional Inuit 'birthright corporations' eventually enter into contracts to build and lease back new hospitals and health centres for their respective regions.[103]

The 1990s also saw the continuation of the devolution policy in the health sector. Planning for Nunavut clearly involved discussions around what an Inuit representative public territorial body might control. They would of course control what had already been devolved, as guaranteed in negotiations and enshrined in clauses within the Nunavut Political Accord.[104] Many programs and services would be controlled 'in house,' with some programs seeing shared control with federal authorities, or administered by federal authorities on behalf of a new Nunavut Government (or *vice versa*).

e. Services from 1999

With the creation of Nunavut in April 1999 (and with lessons learned from events surrounding the KRHB), the inaugural Inuk Premier Paul Okalik abolished regional health boards and established a single Department of Health and Social Services (NDHSS).[105] "The premier gave three reasons for the decision: that the boards were not elected and not really accountable. That the MLAs would be more accountable to the electorate for health services in Nunavut. Finally, he suggested that there would be savings of $3 to 4M a year."[106] Leadership still had to answer the obvious question: How were local, regional and Inuit involvement guaranteed in this new structure? The answer lay in several considerations.

Firstly, the nature of Nunavut is to guarantee involvement, as the Territory is an Indigenous-specific and -representative government. Secondly, "the government announced that it would seek input and advice in the making of health policy from the [Nunavut Social Development Council][107] set up under article 32 of the Nunavut Agreement."[108] Thirdly, it also proposed that new community health councils be developed with financial support from the health ministry.[109] In March 2000, the Legislative Standing Committee on Health and Social Services announced that communities that did form such councils would receive $5000 in order to run them, but as Tester notes: "By May 2001, it appeared that while most communities had created committees, they had no operating budgets and their role in affecting policy was not obvious."[110] In contradistinction to 2001, recent data demonstrates that the new style of CHC (now termed 'Committees of Council') is underway in several communities, with significant and clear planning apparent.[111]

In this environment (where health services are controlled and administered through the NDHSS, at times with significant Federal involvement, including Inuit involvement), health services have seen expenditures rapidly increase, the result of the complex series of health services whereby general practitioners and specialists provide itinerant services, and health centres and regional hospitals provide in-patient care.[112] As noted by Tester:

> "By 1999, the budget of the Baffin regional board was $42,423,369 for a population of approximately 13,000 people. Approximately 20% of this budget was being spent on medical travel in a region where communities are only accessible by air. By comparison, the Nunavik region of Arctic Quebec was getting $37.5 M to serve the needs of 8000 people, about $1400 more per capita in spending. Health care in Nunavut is grossly under-funded."[113]

Of the total Nunavut budget for 2001, that being $547M, the health and social services budget was set at $112M, approximately 20% of the total, a percentage that is among the

lowest of any administration in the country,[114] others jurisdictions being as high as 40% of total budgets.[115]

As a result, recent debate between the Nunavut authority and the Federal Government has turned on the need for more funding,[116] and less so on Indigenous self-determination/self-government and local control. The latter is better represented in the interests of ethnonationals like the Inuit Tapiriit Kanatami (ITK), Nunavut Tunngavik Incorporated (NTI), and/or other RIOs. This does not mean that the Nunavut Government is out of this debate as it is clearly not, but it is in these ethnonationals that the current ideal of achieving local and/or regional Inuit control over services is found.[117] The Nunavut Government appears more concerned with alleviating funding crises and less so with changes in ideological control over governmental procession.

In a recent meeting between the Provinces/Territories and the Federal Government to discuss health care issues, the northern Premiers rejected the deal penned and agreed to by the Provinces, one based on per-capita funding, clearly not beneficial to the sparsely and thinly populated Territories.[118] In order to bring attention to their needs (and to the reality of gross under-funding in a system meant to treat some of the sickest members of Canadian society), these Premiers made significant protests and eventually gained the support of the Provinces through a joint statement that recognised the special needs and situation of the Northern Territories.[119] These actions resulted in a special fund for the Territories, and in the arrival of a 'one time only' cash infusion.[120]

Apart from funding, contentions have also come in relation to bringing northern health services 'up to date,' viz. achieving parity with the modern technologies and services available in the south. Relative to isolation, much has been placed on the ability

of 'telemedicine' or 'telehealth' to alleviate this barrier. Telemedicine is a system whereby southern and/or regionally located specialists make real-time, geographically separate consultations. It has even been suggested that one day, 'remote-control' surgeries may be possible, where a surgeon remotely directs a technician (or possibly robotic technology) in procedural care. Ethnographic observation confirms the timeliness and usefulness of current technology in its use for mental health consultations, cancer support networks, public health programming, and nursing education. Yet concerns do remain over the developmental costs of this technology (as expressed by administrators), the problem of local capacity to support such an endeavour (as expressed by administrators and community membership), and the potential liability associated with long distance consultations (as expressed by medical practitioners).

'Home and community care' has also become a consideration.[121] As in the rest of Canada, as the population ages and constitutes more of the total population, considering the service needs of this cohort becomes necessary (in the context of personal care homes, delivering care to the home bound, minimising the need for medical travel in the eldest elderly). In Nunavut, this has included the disbursement of a jointly run (FNIHB/Nunavut Government/ITK) 'First Nation and Inuit Home and Community Care Program.' Its development has been slow, and problems have been documented: the community struggle to meet complex documentation requirements; the practical reality that in Nunavut, shipment of supplies can only occur in a narrow window; the concern that the program was developed in a southern context and not a northern one.[122] Funding continues, and developments are discussed as positive, sometimes presented as an ideal of the working relationship between Inuit, First Nations, and the State.

Developments also continue in the collection of health data and its use in public health surveillance, and in the goal of 'evidence-based' clinical and policy decision-making. The perceived need for this 'evidence' has steadily grown in Canada, represented in increased legislation, and in the creation of the Canadian Institutes of Health Information. Initiatives like the 'First Nations and Inuit Health Information Systems' form part of the 'Canada Health Infoway' or 'e-Health strategy,' conceivably accessible by providers and communities across Canada.[123] In Nunavut, the 'Inuit Health Information Initiative' (IHII) is developing along with a strong statistical and information systems department, these initiatives firmly rooted in the development of self-government.[124] ITK has been steadfast in its attempts to ground the IHII in capacity building exercises in order to develop an 'Inuit-specific infoway' controlled by Inuit organisations and Inuit programmers and researchers.[125]

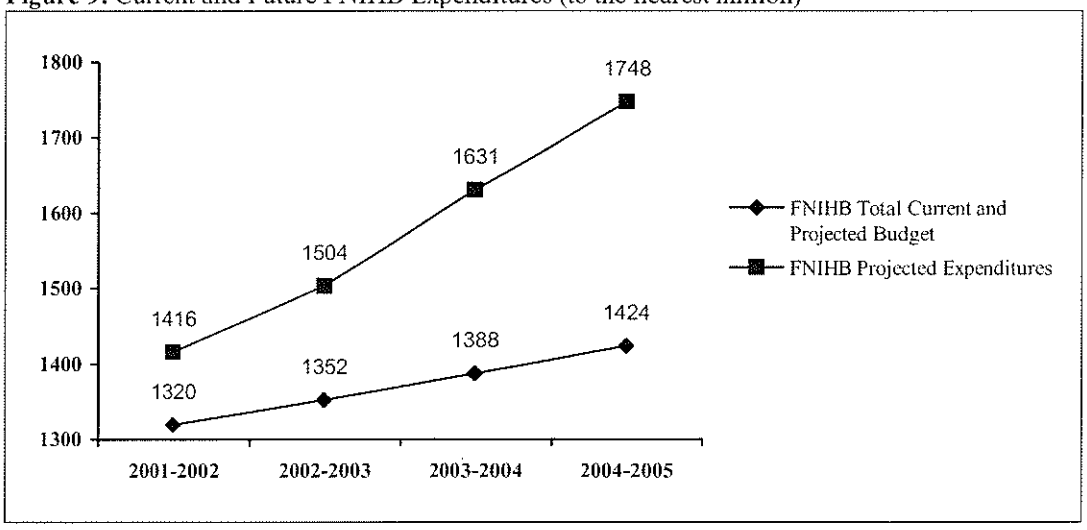
Funding and bringing northern health services into the future are not the only areas of debate. The 'ways in which things are done' also constitutes long-standing contentions in northern health services. A salient example of this is an NIHB consent form that Inuit and First Nations clients were asked to sign. As will be outlined in Chapters 6, both ethnonational and professional groups claimed that the new consent form was heavily flawed: ethnonationals predominantly in relation to the privacy rights of Indigenous clients, and professional groups predominantly in terms of the unclear position it placed them in when asked to acquire this consent. This has entered Canadian Aboriginal health services into the debate surrounding state surveillance of citizenry, and intensified the current debate surrounding health services and Indigenous rights.

The contentions of most relevance to this study surround the NIHB program. Events like those surrounding the 'informed consent process,' and those involving the increased rejection of service claims (whereby the Nunavut Government bills Federal authorities for services delivered), have resulted in the Nunavut Government taking the position that they are no longer interested in administering and/or acting as the primary contractor for the NIHBs. The long-standing question of 'who exactly is responsible for what' is part of this positioning. The Nunavut Government takes the stand that the Federal Government is responsible for programs such as the NIHBs since they are structured in relation to federal fiduciary responsibilities for Aboriginal Canadians, and not Territorial responsibilities for Aboriginal citizenry. It has also noted that the NIHBs routinely cost more than the monies allotted by the Federal Government, a stance adopted by the many that have taken on the management of governmental health services, such as ethnonational organisations and Aboriginal communities. Why govern a program that drains resources they ask, or one that is structured around Federal (not Territorial) responsibilities?

As of this year, the Nunavut Government is undertaking a review of their NIHB programming. Something similar was conducted by the current NWT as part of a larger overhaul of their health governance situation, the details of which extend beyond this investigation.[126] Yet it can be noted that the shift away from devolution towards a desire to 'evolve' program responsibility back to federal authorities (in the context of fiscal uncertainty) may be increasing. Under the current environment, federal authority appears to be finding ways to accommodate this change in the devolution trail.

The Federal Government has created the Northern Secretariat (as part of FNIHB), a structure specifically meant to consolidate the administration of federally funded programs within the territories. The Secretariat takes the 'Population and Public Health Programs' of Health Canada, some Indian and Northern Affairs programming, as well as all FNIHB programming, and groups it together to provide a 'one window' approach to health care services as per a 'Territorial Wellness Initiative.'[127] A 'Territorial Advisory Committee' made up of relevant Assistant Deputy Ministers (Indian and Northern Affairs Canada, FNIHB, Nunavut, Yukon, NWT) and Territorial ethnonational organisations, sets direction for the Secretariat.[128] The importance of this new Federal structure can be gauged by the fact that in 2002, it grew from a handful of staff to over 65 individuals with an estimated budget of $65M.[129] As the Nunavut Government moves away from wanting to control services (*e.g.* dental services), the Federal Government appears to be accommodating this. Recent ethnographic observation speaks to the federal belief that it is important to bring services and programs 'closer in' in order to control developments in costs, and the very real question of sustainability.

Figure 9. Current and Future FNIHB Expenditures (to the nearest million)[130]



Sustainability and cost-control have now become the main consideration for all stakeholders. For contractors and administrators alike (who often run programs over a vast expanse), cost-containment and sustainability in the context of much sociopolitical change (as is inherent in the early beginnings of any government, let alone a decentralised and Indigenous-specific one) is proving a challenge. Ultimately, in the search for sustainability, equitable costing, and service improvements, changing the 'the way things are done' continues as a central theme. This desire for change is currently referred to as 'health renewal.'

The development of health services in Canada's North can be seen as paralleling the sociopolitical change associated with wresting away decision-making control away from federal authorities, and as an ideal, placing it at the local level. More often than not, control is placed at the territorial and/or ethnonational levels. To date, the involvement of 'self-government' structures in northern health care (beyond their traditional watchdog role) is developing slowly, sometimes problematically, as is evidenced in the now defunct health original Nunavut Social Development Council.[131] Inuit involvement has also come in the form of private sector interests in northern health contracting. So as this history of health services has outlined, the notion of control over Inuit specific services on ideological, governmental, and business sector fronts establishes the very real notion that Indigenous attempts at local/regional control continue to play a role in the development of northern health care services.

IV. Northern Dental Services

a. Services before 1970

According to Gullet, the first recorded dentist in the Canadian Arctic was W.P. Millar who, in 1922, in responding to requests from the Hudson's Bay Company, spent six months in the far west of Canada's North.[132] In addition to Millar, dentists who had a thirst for adventure, supplemented by an interest in physical and cultural anthropology provided the earliest dental services in these areas. With clinical and scientific intent, C.H.M. Williams, R.W. Leigh, and C.S McEuen, all ventured north on federal supply ships or through their involvement with the military.[133] Other archival evidence exists placing dentists in the Arctic in and around the 1930s,[134] while between 1948 and 1956, a British dentist named Terrence Hunt worked for the Department of National Health and Welfare, and was sent across the Arctic.[135] Apart from this sparse clinical care, there was little sustained dental treatment available, and no consistent or formal Western dental system.

Western-style dental services were poorly developed in Canada's North up until the mid seventies. To this time, it fell to missionaries, nurses, priests, the medical crew of yearly supply ships, and/or just about anyone who had gusto for exodontia to deliver this form of 'dental service.' However, it should be noted that oral and dental care were surely part of traditional healing and 'practices of the self.'[136]

Throughout these early years, dentistry in Canada maturied in technology, in public and private expenditures, in education, and in expanding work categories, in all, a general expansion in the dental culture. The 1960s represented the 'golden age of dentistry,' wherein the profession took on its modern aspect: a market-based, privately

insured service delivered in private practices buttressed by significant policy and intervention efforts in public health (*i.e.* municipal water fluoridation, industry linked dental education). This was coupled with both the rise of the modern culture of the self (where straight and white teeth eventually become the ideal), and the epidemiological shift in dental caries within the greater Canadian population (where basic infection and disease became a rarity, largely in insured populations). Yet early on, public interest and expenditures followed private investment (to a lesser extent), with the general discussion about 'rights to health' in Canada moulding dentistry to insure care in certain socially and geographically marginalised populations (*e.g.* children, refugees, the military, some institutionalised populations, Aboriginal Canadians). This involved the State in the direct and indirect delivery of care, and in the Aboriginal context, initiated dentistry within the State's conception of the 'uninsured medical and dental benefits' that it provided to Aboriginal Canadians as per their developing historical/political relationship (*i.e.* the NIHBs).

b. Services in the 1970s

The history of organised dentistry in the Canadian Arctic can only truly be said to begin in the early seventies. While nursing stations were now delivering a full complement of health services, the infrastructure for dental services was still lacking.[137] As noted by Bedford and Davey, "government salaries were too low to attract good personnel" and "dentists were far too busy in their private practices to have any interest in providing more than emergency care to Indian patients."[138] The seventies were not a boom in terms of human resources, but were instead a time for laying down the fundamental practices of

how dental care was to be delivered in Canada's North. Early on, this necessitated the development of both human and infrastructural resources.

In 1971, a plan was put into action by MSB to counteract the lack of service in northern Aboriginal communities. MSB moved to contract the University of Toronto to develop and operate The National School of Dental Therapy (NSDT). A vision was struck that saw the training of an adjunct dental health practitioner (*i.e.* a dental therapist) for work in isolated communities. This concept was influenced by the New Zealand Dental Nurses Program,[139] given impetus by need, and then propelled forward by the accommodation of then current dental health policy, which maintained the stance that there must be availability of curative and preventative dental care for children or for those that were deemed socially in need.[140] As adjunct dental health practitioners, dental therapists were to provide care to children and emergent care to adults, particularly in places where dentists did not often practice. Dental therapists have been fundamental in the development and delivery of dental services for many isolated aboriginal communities in Canada.[141]

Initially, the Canadian Dental Association (CDA) and regulatory dental authorities resisted the arrival of dental therapists by questioning their knowledge and technical capabilities.[142] Of note here is the 'politics of profession,' whereby organised dentistry is much more powerful than organised dental therapy, resisting this new service provider as a perceived derogation of professional dominance. Organised dentistry exerts pressure to maintain complete market dominance, and exercises great control over the predominance of its 'philosophy of care' in Canadian society (this in terms of how and where a person can access dental care). The idea of dental therapy as a form of care has

been degraded through this 'polity of profession.' For example, in Ontario and Quebec, dental therapists are not allowed regulated practice, although practice is allowed (in some form or another) everywhere else in Canada. Surely, as an idea, dental therapy appears to be a very good one, especially in the context of isolation, need, and low professional service coverage. However, this polity of profession continues to limit an already inhibited system by degrading the ability of policy makers to address the issue of oral health inequality relative to access (as in the wider use of auxiliary dental health practitioners), let alone consider or possibly advance alternate options for the delivery of care.

With the history of organised dental therapy beginning in tumult, it nonetheless experienced a period of great success throughout the late 1970s and well into the 1980s (as is evidenced in stakeholder commentary about the 'the heydays of dental therapy'). As a developing service provider organisation, with cohesion and numbers, it continues to be somewhat ill defined, with little power and control over its mode of production. While historically positive, dental therapists are decreasing in number, and have seen their educational institution (the NSDT) receive heavy criticism at the hands of an external review (to be reviewed in Chapter 7).[143]

By the mid-seventies, the economies of scale now became present for dentists to consider practice in the old NWT. As regional centres became larger with social and economic activity, a population base was now present for the success of a dental practice. Few dentists took this opportunity, but there were some. For example, in 1973, the 'Hay River Dental Clinic' became one of the first 'private practices' in the old NWT, with a handful of others eventually seeking similar opportunity in other regional centres.[144]

As resident service providers in the 1970s, these practitioners were contracted by federal authority to travel to outlying communities and deliver services. For federal authorities, contracting for dental services through a few resident dentists became an obvious step to fill need. In fact, contracts existed with any professional who was willing to travel. So while contracting was the case historically (and continues to be), not many contracts existed, as there were relatively few clinicians willing to explore these areas. Still waiting for the first substantial waves of dental therapists, the question of how to attract practitioners and develop dental services remained.

In southern isolated communities, an answer to this question had come in the form of historical relations between MSB (through its regional dental departments) and dental practitioners. There had always been that dental practitioner who would travel and deliver care in rural and/or high needs communities, most often complementing their private practices in urban centres. It is generally accepted that those that did travel to isolated communities did so because of their 'social' inclinations, and/or because of their interest and affiliations with 'community' or 'public health dentistry.' In their contractual relationships with MSB, they were categorised as 'community-minded clinicians,' and later (with the creation of both formalised training and professional specialty status), some as 'public health dentists.'

In addition to being sole-proprietors, these clinicians were also often associated or employed in the university/academic sector, and/or by governmental dental departments (federal or provincial). At times, clinicians held congruous employment in two, and in rare instances, all three structures. According to Dean Emeritus Arthur Schwartz, by the 1960s, a well-established connection existed between governmental departments

(provincial and federal) and these community-minded dentists. It was these same dentists who played a role (in some form or another) in shaping policy and the inner-workings of government dental health departments, sometimes acting as administrators and/or consultants and/or contractors. Consequently, as will be developed in Chapters 4 and 7, the community/public health dentist is a fundamental player in this political economy.[145]

Of significant interest to this study is the developing relationship of governmental authorities with academic health faculties. As noted by Schwartz, in the Province of Manitoba, this relationship existed through the use of clinical faculty who supervised students in delivering services to white, rural, under-serviced communities. In the academic setting, these service trips came to be described as 'externships' or 'community outreach rotations.' Manitoba's dental faculty and their long-standing relationships with the Keewatin region is touched upon by Tester, this faculty eventually becoming involved with the Baffin region as well, continuing the use of professional interns (and much less so student-accompanied clinicians) as another mode by which to meet need, paralleling other academic institutions in Canada.[146] The detailed relevance of these points is developed in Chapters 4 and 7 as well.

The late seventies thus saw the continuation of a particular, long-term relationship between 'community/public health dentists,' the academic sector, federal/territorial authorities, and the more private end of dentistry. A relationship constituted in contracting for the delivery of dental services in isolated Aboriginal communities through clinicians employed through 'community dentistry' departments and their 'outreach units,'[147] and/or through their own practice activity. So with the first wave of dental therapists now working across the isolated regions of Canada, and with both resident and

non-resident clinicians providing dental care, a system was indeed developing. For example, in Canada, private sector spending (*i.e.* private insurance and direct payments) increased by roughly 10 times, public sector spending (*i.e.* public forms of insurance) increasing by a factor of 129 times.[148] While growth is dramatic in public expenditures, they still paled in comparison to private ones: $1.2M public versus $108M private in 1960, and $176M public versus $1.1B private in 1980.[149]

c. Services in the 1980s

By the early 1980s, dental markets had now become saturated in the south, with practitioners struggling to keep busy so as to maintain their standard of living.[150] In North American dentistry, this became known as the 'busyness problem.' As the "[dental] profession began to experience a surplus of dentists [and] were becoming less busy, the dental community became more interested in treating Native people."[151] With new interests (and with yet no clear official policy to describe the responsibilities of MSB in the area of Aboriginal dental care), governmental authorities began a process of entrenching an already developing contractor position.

Across Canada, contracts for dental services to isolated Aboriginal communities were now forming a recognisable part (however small) of the general dental economy, one based on both sole-proprietors and academic institutions providing services. Contracting for services from dental markets became a stable form of acquiring care, and came to involve a series of integrally related, yet contrasting providers. This construct can benefit from the use of a typology for dental care operating contractors (one that is used throughout this study):

1. The resident private for-profit dental corporation;

2. The non-resident private for-profit dental corporation;

3. The university-based public for-profit dental corporation.

This study differentiates between these three forms via the following logic. The resident private for-profit dental corporation is easily recognisable. This translates into an individual, partnership, or group practice that are resident in the communities that is serviced, and is the most common form of service delivery in Canada. As they are residents of Nunavut, they administer services within Nunavut and interact with the Nunavut economy more so than a non-resident provider, a point that is fundamental in this political economy. Non-resident private for-profit dental corporations are those individuals or groups that deliver services themselves and/or employ dentists from the south, also administering services from the south. The university-based public for-profit dental corporation has examples across Canada. These are public academic institutions that hire dentists to deliver services (faculty or otherwise), with net profits reinvested into the organisation for educational, research, and clinical purposes. They too administer from afar. The notion of residency plays a crucial role here, as it is in residency (and ethnicity) that favourable contracting policies arise for those that live in Nunavut (and for those that are of Inuit descent).

Regardless of characterisation, each of these contractors delivers services in a very similar fashion when considering the majority of isolated Aboriginal communities. While residency allows for regional centres to enjoy a consistent and potentially long-term relationship with one or several practitioners, isolated communities experience itinerant care from all contractors, provided in two three week periods, often by different

providers throughout the year. Care is overwhelmingly of an acute nature, with two weeks simply not allowing for comprehensive treatment, or for the committed and substantial efforts required for any sort of dental public health program planning and dissemination. Across northern communities, federal and territorial authorities now delivered services directly (through dental therapists and community/public health dentists) and/or indirectly by contracting private practitioners, institutions, their practitioners, and all their corporations. This has become the main federal, territorial, provincial, and ethnonational practice in the delivery of dental services across the isolated regions of Canada (under their jurisdiction).

With these options, services remained limited by the inability to recruit and retain providers (even in the context of a saturated southern dental market). While contractors were increasing in number, the fact remained that improving access and quality was a challenge. To focus efforts, special targeted dental treatment and public health programs, and more aggressive human resources recruitment strategies were adopted in an effort to improve the limited system.

Clinical treatment programs took the form of paediatric operating room (OR) access (as in paediatric oral surgery for rampant caries), and access to the treatment modalities of orthodontists and oral surgeons. The improved access and quality of services meant that larger more complex cases could be treated in the OR, whereas otherwise they would not have been attempted. Accessing these services meant travel to regional hospitals and/or southern centres (with similar complications as those associated with any medical travel).[152]

Dental public health services predominantly took the form of disbursing public health dental educational material. This material 'dental health' culture was the result of dental therapy efforts in federal and territorial departments, and/or through dental therapists in the field. Some also stemmed from CHRs or nurses with a penchant for oral health. Ethnographic observation speaks to the substantial literature found in basements and storage areas of health centres, much of this produced in the 'heydays of dental therapy,' when their numbers were at their highest and when the original focus of treating children with both curative and preventative modalities was still heavily practised (as will be presented shortly, FNIHB has recently been criticised for losing this initial focus). This material was most often aimed at children, expectant mothers, and the mothers of young children (especially in relation to 'baby bottle tooth decay/early childhood caries'). A consistently touted example of success comes from a dental therapist in Manitoba, who through community partnership, developed what was considered a 'culturally sensitive' example of dental health education material.[153] This history is not completely lost either, as evidenced by recent media coverage of dental public health efforts across the Arctic.[154]

Recruitment and retention strategies then focussed on attracting foreign dental graduates. Foreign professionals had already come to the north,[155] and due to continued rural dental professional shortages, more were given the opportunity. By allowing entry into Canada (with a commitment to practice in a northern under-serviced area), these professionals were given legislated practice in the territories and charged with undertaking a series of three exams to obtain Canadian licensure. Dentists were initially registered as per the creation of a special legislated category of dental professional under the NWT dental registry: Part III of the dental register, which in turn resulted in them

becoming known as 'Part III dentists.'[156] Attracting Part III clinicians occurred in relation to the interest (and conceivably through the contacts) of already established resident foreign-trained providers. Processes were developed whereby resident dental corporations were assisted in recruiting foreign graduates, with the resident clinician acting as their Canadian 'sponsor.'[157]

These providers became dental associates of northern clinics and travelled to isolated communities to deliver services. They would ideally work for the duration of their 'contract' (discourse speaks to a range of 2 to 3, and possibly up to 5 years), but most would eventually leave within 3 years, gaining Canadian credentials and resuming their clinical careers in the south. Those that did stay established clinics of their own and have come to provide much needed care.[158] At one point, these newer resident for-profit dental corporations came to service most of the three regions of Nunavut. These professionals are important in this political economy as they form a specific cohort in northern dental services (particularly in terms of competing for contracts), and in contradistinction to most academic and southern professionals, these stakeholders have established residential and social ties in the north, forming meaningful parts of their communities.[159] As addressed in the next section, the use of Part III dentists eventually becomes problematised when stakeholders raise concerns about the quality of services delivered by this tier of professional.[160]

By the late 1980s, changes in dental services begin to take place (especially for the Keewatin region). This occurs in relation to a new resident foreign-trained northern practitioner, who, in 1987, established a practice in the Baffin region, quickly expanding with a clinic in Keewatin's regional centre. As noted by Tester, this dentist claimed that:

"[H]aving a viable practice required being allowed to service outlying communities and that doing so was in 'accordance with a government push towards privatisation.'"[161] Another non-Inuit local businessperson started a petition in the Keewatin Chamber of Commerce in support of this clinician and his claim.[162] With this activity, when contracts were renewed, all communities were consulted as to whom they would prefer: the University of Manitoba (by now the long-term contractor in the region), or the new clinician. All said the University, except two communities. The board renewed its contract with the university excluding these two communities. Less obviously, as noted by Tester, these communities held the most significant business interests in the region and were actively involved in promoting private forms of care as a result of these interests.[163] These interests would eventually become part of a new dental corporation, one that took advantage of favourable contracting policies for both northern and Aboriginal businesses. Over the next ten years, this corporation would become involved in one of the most difficult periods in northern dental service history.

d. Service in the 1990s

With the 1980s being a time of expansion and maintenance, most northern dental programs now became described as fraught with patient and practitioner dissatisfaction, as well as steeped in administrative problems at the local, regional, and national levels.[164] Stakeholders explained this dissatisfaction relative to administrative difficulties, the high turnover rate of dental personnel (dental therapists and dentists), the minimal length of clinical visits, the lack of specialist care and support, and the other numerous problems associated with the NIHB program (the objects of these complaints hampering the

delivery of significant and/or complicated treatment, and stifling any notion of 'continuity of care').[165] With these difficulties, the 1990s became a decade of significant Territorial controversy and significant Federal cost-containment.

For regional leaders of the time, the P3 plan ('public, private partnerships') was seen as a way to meet the needs of capital ventures such as building hospitals and health centres,[166] particularly in the context of global federal cuts established by the new *Canada Health and Social Services Transfer Act.*[167] For dentistry, the P3 plan came early.

Effective March 31st 1992, the KRHB cancelled its contract with the University of Manitoba. In a move towards the private sector, the KRHB decided to contract with Kiguti Dental Services Limited, a newer resident for-profit dental corporation created by the stakeholders who several years earlier took possession of service provision in two Keewatin communities. This corporation had two dentists as majority owners, and a single minority owner, a subsidiary of the aforementioned real estate conglomerate (who initially began their support of these contractors with the petition to the Keewatin Chamber of Commerce). This dental corporation now held substantial Inuit participation through this subsidiary, in turn creating much legitimacy relative to then current contracting policies that favoured local and Aboriginal business ventures. In completing past goals, Kiguti's owners became responsible for all dental services within the region.

Services continued in this regard for four years, Kiguti using Part I and Part III dentists to deliver services to communities of the Keewatin region. The Kitikmeot region used services from another resident for-profit dental corporation (owned by a Kiguti shareholder) delivering services in the same fashion. While in the Baffin region, private

care continued through a clinic in Iqaluit (also owned by a Kiguti shareholder), with the involvement of both university-based practitioners (not under a university contract but through their own separate arrangements) and other smaller private contractors. Across these three regions, care was structured very similarly, whereby regional centres could rely on some form of consistent care, with outlying communities still receiving services from itinerant practitioners who overwhelmingly delivered care in an acute fashion (treating immediate needs and concerns, largely ignoring prevention). Acute treatments the norm (being the only thing possible in a two to three week period), public health initiatives were now effectively viewed as the responsibility of Federal/Territorial authorities and their dental therapists.

By the mid 1990s, Federal authorities were strongly addressing the rising costs of FNIHB programming. Total costs for the NIHBs rose from $36 million in 1979 to $80 million in 1983, to $166 million in 1987, and by 1993, the sum had grown to $442 million.[168] For dental care, this occurred through the addition and expansion of services in the 1980s (paediatric ORs, orthodontic and oral surgery services, and to a lesser extent dental public health interventions), and of more fiscal relevance, through changes made to the *Indian Act* by the Legislative Bill C-31 in 1985. This bill repealed discriminatory provisions within the Act that had resulted in some Aboriginal people losing their 'Indian status' (through such things as marrying a 'non-status Indian,' or by gaining employment, by wishing to consume alcohol, amongst others).[169] Many now became eligible for benefits under the NIHB program. To address this issue and the nature of Aboriginal demography (a young and growing population), Federal authorities embarked on a cost-containment campaign that continues to this day.

The need for 'National Program Directives and Administrative Procedures' (*i.e.* national standards and best practices) stemmed from two sources. Firstly, since their inception, costs were ballooning, and 'program directives' were a method to immediately limit those services that were and were not covered. Through these directives, eligible services were defined and fixated throughout all of the NIHBs, allowing FNIHB to reject all expenditures beyond evermore-strict program limits. Secondly, as the NIHB program had itself substantially grown and developed regionally, some process was needed to provide an understanding of what was happening across Canada. Ideally, this would flesh out the 'best' administrative practices and standardise them, with 'best' meaning those that effectively contained costs. This provided federal authorities with a clearer sense of what MSB/FNIHB had become responsible for (region to region) throughout the eighties, an important advance since it is easier to control what one understands.[170]

The pre-Nunavut regions saw major cutbacks as a result. "By 1995, the [NWT] was running a deficit of more than $50 million [and the] federal budget of 1995-96 [...] cut a further $50 million from transfers to the [NWT] for health, education and welfare."[171] The old-NWT had been administering some aspects of dental services (and other NIHBs) since early 1990s, and by this time, were coming to terms with the reality that federally transferred funds were not enough to cover actual costs. All of this was necessitating the need to deliver programs more cheaply, as in the proverbial 'do more with less,' clearly supported by the continuation of the P3 plan.[172]

In 1997, the KRHB announced that the management of all regional dental services would be handed over to Kiguti. While already providing services to the whole region, this corporation would now service it 'completely' in that they would now

administer services as well as subsume those services delivered by regional dental therapists. The KRHB moved to terminate contracts between dental therapists and the regional school board (dental therapists most often work in schools delivering care to children thus their contracts are structured under education), and in doing so, enacted measure by which to save money (by not having to administer a program), and also possibly create a source of revenue. Why this is so requires some detailing.

Dental therapists are salaried employees. The costs associated with them stem from funds transferred by Federal authorities through a 'contribution agreement' for 'community health programming,' viz. it is a public program. With the structuring of dental therapy as an 'in house' cost, there exists fundamental control over dental therapy fees, as costs do not involve any form of private provision and/or transaction (as they do for dentistry), further likening these services to insured ones.

In contradistinction, the costs associated with care delivered by dentists also stem from federal coffers, yet they flow from a different pool of funds, viz. those remuneration claims for the delivery of a non-insured service as directly billed by dentists. As dental fees are much higher than dental therapy ones, and as the program is contracted out, there exists much less control over associated costs (ultimately contextualised by the pressures of the open market).

Under the Kiguti P3 plan, all dental services would now be billed to a program associated with a publicly insured private non-insured service (dental care delivered by dentists) and not that of a publicly insured public service (dental care delivered by dental therapists). Further (as KRHB logic followed), since remuneration for dental services was more the responsibility of federal authorities than territorial ones,[173] an opportunity

was taken to save money by ending the dental therapy program, and structuring it so that service costs flowed largely through federal authorities in its remuneration activities surrounding private fiscal claims. So in a plan that became considered nothing more than a 'cost-shifting exercise,' the old NWT may have thought (almost naively) that it would keep its community program funding intact and reinvest any monies saved from not employing dental therapists.

On the 'private side' of this P3 plan was Kiguti's new role. In subsuming the dental program, Kiguti would have to lease space in the form of community health centre clinics, providing some revenue for territorial authorities. It was presumed that Kiguti-contracted dentists would reimburse Kiguti administration for rented public space and for any administrative costs. Money was available not only for government, but for Kiguti as well, as it was essentially reimbursed for any costs. Through what can be construed as a form of passive privatisation, governmental costs were seen as dropping, with a subsequent increase in the flow of capital and earning potential, all possible through the contracting of a private sector health corporation in the management of a quasi-public/quasi-private delivery mechanism (the nature of which is developed in the remaining chapters).

This was to good to be true. Socially, the KRHB decision was not accepted, seeing three communities take strong stands against the plan. These communities, with support from the Keewatin Divisional Board of Education, the United Northern Workers Union, the Keewatin Inuit Association (KIA), and the NSDT, all rejected having dental therapists removed (and by extension, service administration handed over to Kiguti). In their fight to maintain the current system, an investigation conducted by the United

Northern Workers Union raised damning conflict-of-interest allegations against one health board member and their connection to Kiguti through the complex ownership structure of the local real estate conglomerate.[174] These communities eventually went as far as requesting to separate from the health board, and to be allowed the management of 'their funds for their dental programs.'[175]

Through the actions of KIA and other northern stakeholders, MSB quickly acted.[176] Viewing this as the passing on of additional costs to the centralised NIHB program, they readily stated that dental therapy monies would be removed from the current contribution agreement and applied to Kiguti dental billings if the P3 plan went forward. Federal officials then moved to not honour fee-for-service billings submitted by Kiguti subcontractors during the tenuous period, and also portrayed the practices established by this new contractor as a form of 'double-billing,' a breech of the *Canada Health Act*.[177] Importantly, federal officials did not claim that a KRHB contract whereby a private corporation administers a public service was wrong, as this is common governmental practice, but simply that the KRHB practice of removing dental therapists and billing for those services under another structure was unacceptable. What became of this controversy will be detailed shortly, relevant now is that Federal strategy not only allowed authorities to politically display their 'devolution goodwill' -- by carefully not overstepping boundaries, only ever disagreeing and not quashing the KRHB plan -- it also presented federal authority with the opportunity to address a situation they were long keen on remedying.

For much of the 1980s and 1990s, little or no competition in northern dental markets meant that regional dental fees were often inflated with special premiums so as

to attract clinicians (*e.g.* dental fees in the old-NWT came with a 20-25% premium).[178] While always being able to control costs through the renegotiation of fee guides with professional authority, this depended on difficult and highly politicised interactions, the outcome of which most often meant a disappointed professional constituency. As competition slowly developed through the increasing numbers of professionals requesting government contracts of their own, coupled with the fact that the major professional players in northern dental care were now marred with controversy, an opportunity was taken to address what were now observed as over-inflated fees. In addressing the new costs associated with Kiguti dentists, and in a move that essentially boiled down to heavy handed cost-containment, as of April 1st 1998, fees in the northern territory were cut by as much as 39% with the roughly 20% premium removed.[179]

Controversy could not have come at a better time for federal authorities. Already addressing costs through the increased implementation of program directives and administrative 'best practices,' this allowed both the reintroduction of historically unpopular administrative measures (*e.g.* the more stringent application of NIHB's 'payer of last resort' principle), and the introduction of newer ones (*e.g.* 'pre-authorising' and/or the 'pre-determination of benefits').[180] As a result, some success in cost control was noted, as reported by the Auditor General: "[FNIHB/MSB] had successfully implemented some cost management initiatives [mostly as a result of the pre-determination system], resulting in a reduction in the rate of increase in direct program costs for non-insured health benefits from 22.9 percent in 1990-91 to 5.6 percent in 1995-96."[181]

With this controversy, much also came to be reported about the perceived realities of dental services in this and other northern regions. Complaints were now openly raised

about the quality of services provided by Part III dentists, the lack of services in general, and the 'crisis' in dental recruitment and dental health.[182] In reviewing the basis for these and other complaints, the Hechter Report concisely reflected what was occurring throughout this time.[183]

This report firstly stated that there were two fundamental issues in the delivery of dental care in these regions. These were the geographic and political division of the NWT into Nunavut and Western Arctic in 1999, and "the fiscal realities of the funding envelope which includes medical, pharmacare, vision care, dental care, and transportation."[184] Not prognosticating on the future, Hechter concentrated on the reality of funding and stressed that "[i]ncreases to the envelope are essentially capped."[185] The report also spoke to "[the] inter-related issues [of] governance and accountability; [the] objectives of the program; strategies to accomplish the objectives; recruitment and retention of dental personnel; [and] short term recommendations."[186]

Regarding 'governance and accountability,' by 1997, the regional governance model in the old NWT saw individual health boards negotiate directly with MSB. "In actual fact and very regrettably, this method of negotiations [between health boards and MSB] has resulted in significant variability by region in a variety of aspects including remuneration to providers [and] anecdotally, this reality was unknown to many providers."[187] While instability was felt relative to the creation of Nunavut and its impact on northern administrative life, the report more immediately recognised then current dynamics of an organisationally cumbersome and inconsistent system that needed rectification in and of itself. Questions were also raised relative to the ability of administrators to track the services delivered (and by extension track costs) in the context

of poor and unclear administrative mechanisms for 'program evaluation.'[188] In relation to sociopolitical change, the report states:

> "[The] ideal arrangement for governance and accountability of allocated resources for the delivery of dental care would revolve around local self-government. In this governance model, decisions (including treatment objectives, services covered, delivery models, and the like) would be determined at and by the members of the community. This governance approach may not be immediately viable, however all governance models should be sensitive to, solicit, and incorporate individual community input and needs."[189]

Regarding 'oral health strategies and objectives,' the report presents an administration with little or no clear objectives. In affirming this researcher's ethnographic observance, this report notes that "[i]nterestingly, every stakeholder agreed that prevention was a critically important element to achieve improved oral health, however few strategies have been developed or implemented."[190] The report also noted a lack of culturally appropriate literature and information (especially in Inuktitut). While the 'heydays of dental therapy' produced much public health literature, the 1990s saw a dramatic drop in relevant and timely material, mainly as a result of the decreases in dental therapy graduates and federal support. The report also describes the regular discourse amongst practitioners as to the fact that they do not provide dental public health type interventions since they are not paid for them.[191] Moreover, poor coordination existed between dental practitioners, whether between dentists, or between dentists and dental therapists. "In most situations, there is very little, if any, communication between dental providers [...] resulting in the repetition of procedures."[192]

It is conceivable why dental therapists were easily disbanded in the Keewatin. Whereas community members saw dental therapists as vital, therapists were not seen in this light by local resident dentists, who did not often effectively communicate or interact with them (and *vice versa*). Finally, the report confirms previous discussion concerning oral health care planning: "A somewhat uncharitable view is that the elimination of the

dental therapists and their program is part of a corporate plan to increase revenue to a privileged few under the guise of responsible privatization."[193]

In addressing the 'recruitment and retention of dental personnel,' the report stressed the need for proactive and persistent approaches to recruitment. The report also commented on the important and fundamental need for the education of Aboriginal persons in order to produce a cadre of Aboriginal professionals. More immediate were the report's comments on the substantive issue of Part III dentists and concerns over the quality of their services.

The report quickly pointed to the obvious first reaction of a perceived lack of quality associated with foreign-trained professionals. With this understanding, and carefully noting that the report was not a quality assurance audit, it pointed to the real concerns regarding Part III clinicians. In doing this, the report pointed to the fact that many Part I dentists (now northern clinic owners) were at one point Part III dentists themselves, and since these clinicians were clearly capable (as per their status as Part I dentists), no generalisations concerning the skills of Part III dentists were appropriate. In recognising the political outcomes of heated citizenry complaints (especially in the context of the then current turmoil): "[The] government of the NWT is overtly attempting to discourage the employment of Part III dentists."[194] As a result, changes were made to the *NWT Dental Act*, which nullified Part III of the register, and allowed a year and a half grace period for then current Part III dentists to attain Canadian certification.[195]

The report's 'short term recommendations' concentrated on the reallocation of dental contract days and on changes to the current model of care. Contracts were now long structured around the notion of 'contract days,' whereby a certain number of days

were allocated to communities relative to their population. The problem was that eventually, political pressure allowed some communities to gain more contract days than others, essentially nullifying this population proportion method.[196] Another report produced in the same period recognised that, "[s]ince 1985, the population of communities served by the NIHB dental contract has increased by 27 percent yet there has not been an increase in the number of dental days [and] [f]urther, the distribution of existing days to the regions is inequitable."[197] Both reports recommended that the number of days should be increased to meet real need, and that contract days for communities with full-time clinics serviced by resident dentists should be eliminated. Hechtor's report further offered the use of other methods that placed more impetus on the community to take full advantage of contract days (as sometimes contract days were not utilised effectively as a result of poor patient attendance).[198] The current mode of care whereby contract days are funded through contribution agreements received criticism in Hechter's report, especially for its inability to really answer the problem of oral health in northern communities. Again, only curative services were significantly funded and as noted: "Regrettably, many treatment decisions have been, and are continuing to be, based on the Revised Schedule of Dental Services (*i.e.* what is COVERED under the plan) rather than on comprehensive dental care."[199] Only providing a certain number of days must necessarily result in a system that focuses on the acute forms of treatment, anything else is simply not feasible to clinicians faced with such overwhelming need (especially in the context of not receiving payment for public health type services).

By the middle of 1997, with this report in hand, and with the existing turmoil, governmental authorities continued the implementation of changes. Again, Part III

dentists were nullified (with a grace period), dental therapists were re-instated (some with pending law suits against the old NWT), cost-containment measures were implemented (specifically decreasing the fee guide and establishing the pre-determination system), and days were reallocated (still recognising polity, but also recognising equity through a redistribution of the negated dental days from communities that had resident clinics). So with negotiations over fee schedules between federal authorities and northern clinicians quickly running sour, Kiguti eventually stepped away from providing services on such a grand scale, and returned to previous clinical activity: delivering services in resident clinics throughout Nunavut.[200] New contracts were then tendered in 1997, as regions were looking for a fresh start in their response to the Hechter report and to then current developments within the NIHBs.

The specific story of northern dental contracting life now becomes relevant. In the pre-regions of Nunavut, contractors included the three structures: the resident private for-profit dental corporation, the non-resident private for-profit dental corporation, and the university-based public for-profit dental corporation. As is demonstrated in the remaining chapters, the relations between dentists (community/public health dentists and private practice dentists), their respective corporations (public and private for-profit), and their sometimes employers (governments and universities), are fundamental as they represent a substantial flow of decision-making activity within this political economy. This importance was felt when contracts were tendered in 1997, most assuming that the Keewatin region would surely return to its historical delivery structures (*i.e.* revert back to university-based care). This proved not to be the case.

As it stood, university-based clinicians (some community/public health dentists, some not) also saw opportunity within the outcome of the Kiguti turmoil. Previous practice had these clinicians deliver service through their university employer, but also independently (most often in relation to contracts for individual trips and/or in response to a community's emergency needs). With previous independent contractual relationships with pre-Nunavut authorities, the tendering of contracts was met with their own for-profit dental corporations. A new contract player (with much power as per their significant history and experience in the north) entered the contractor competition circle, looking to acquire large contracts (*i.e.* more communities) as resident clinicians and their corporations were essentially out.[201]

The heated competition that ensued will be detailed in Chapter 5, but note now that this competition also raised questions for federal/territorial authority. For example: Was it good or bad to establish a 'market of competition' in northern dental services? Should regions only have one provider? Should they have many? In kind, should large contracts or small ones be given out, and if so, to corporations or individuals, and with fee for service or per diem arrangements?

In the end, only services in the Kitikmeot remained with a resident clinician. Nowhere else were resident clinicians (all associated with Kiguti) given contracts. University-based care also received a contract, this time to service communities in the Baffin region, while in a perceived coup, services in the Keewatin and the remaining communities in the Baffin were given to a new for-profit dental corporation stemming from stakeholders within university-based care. With this relatively new structure, the

creation of Nunavut and its impact on dental services now became the main focus for administrators.

e. Services from 1999

For all departments, Nunavut would impact the daily acts of administration within the regions. For dental administration, services were to remain coordinated on a regional basis, feeding back to a central administrative authority ensconced within the singular NDHSS. Where this central administration would be located and how it would look remained unclear, with administrators assuming that they would be touched by the idea of a 'decentralised' and 'Inuit representative' government.

Early on, significant concerns did exist over the potential move of the dental department to a smaller 'decentralised' community (*e.g.* problematised shipping and receiving, greeting and training new dentists, coordinating with regular ones). As it stands, dental departments have not been chosen for 'decentralisation' and remain in regional centres. The idea of an Inuit representative bureaucracy was already established by this time, and in dental departments, Inuit were often employed, usually as administrative support.[202] Apart from these considerations, analytic significance still lies within the NIHBs.

Problems and concerns over the NIHBs essentially distilled to a consideration of the true costs of the program, with Nunavut claiming that the real costs of the NIHBs outweigh what FNIHB provided in contribution agreements, and FNIHB pointing to the realities of centralised cutbacks and the clear opportunities for Nunavut to improve their management of programs by not providing and billing for services beyond established

program directives. Paralleling both positions, the Auditor General of Canada recognised the problematised nature of the NIHBs in terms of Federal responsibilities (not just in Nunavut), and also pointed to the poor management practices of the Nunavut Government in terms of overspending, and also with the significant funds that lay outstanding waiting to be claimed from federal authority (as per poor claims-billing processes).[203]

The NIHB program has been described as 'a nightmare' and 'out of control' by those involved. With ever-looming costs (now somewhat under control through a ten-year central campaign of cost containment), funding was not increasing as more and more rejected NIHB claims poured in from FNIHB/NIHB. Contractor relationships were now significantly strained with discontent about poor NIHB remuneration practices, and with the ever-present need of such populations (need now seen as ignored to the lack of program planning aimed at improving the situation).

By late 2000, the CDA and Provincial/Territorial Associations (or Dental Regulatory Authorities) began a concerted effort to settle long-outstanding issues. For example, in the last three years, dental discourse in northern and national media has considerably increased with everything from exposés on northern practitioners (dental hygienists, dental therapists, and dentists), to direct criticisms of the NIHB programs by northern dental leaders relative to the administrative complexities, and naturally, with the poor condition of Inuit and First Nations dental health.[204] In the three years prior to 2000, there were approximately 20 news articles written in relation to northern dental care and dental NIHB issues, whereas in the three years after 2000, roughly 40 articles appeared.

Through the efforts of a strong central lobby, organised dentistry placed significant and intense pressure on FNIHB/NIHB officials. Through lobby partnerships with ethnonational authorities, this intensity increased and came to include meetings with Ministers of Parliament and direct discussions with Federal and Territorial/Provincial Health Ministers.[205] This pressure was aimed at both the weaknesses of FNIHB processes (*e.g.* claims processing, pre-determination, new consent forms, auditing practitioners), and the clear lack of any formalised strategy by FNIHB for the 'problem of Aboriginal oral health.' With the effectively voiced complaints heard by the Parliamentary Standing Committee on Health in 2003, these stakeholders have achieved some success.[206]

FNIHB/NIHB and those who deliver dental public health interventions on their behalf (*e.g.* the Nunavut Government), began addressing the issue of a formalised strategy for Inuit and First Nations dental health with increasing discussions around an oral disease prevention-type effort. In their 2000 budgetary address, the Nunavut Government states that "[it] will examine the development of a comprehensive dental program focused specifically on pre-schoolers [and that] [s]uch a program would improve the dental health of our children."[207] By 2001, FNIHB "also recognize[d] that a major prevention initiative is needed to improve the oral health status of the patient group and that funding for the initiative must come from outside the current NIHB budget."[208] By late 2002, preparatory steps were being taken to roll out a national oral health disease prevention strategy involving the application of topical fluoride to school age children through community dental therapists.

Dental services have also become problematised by the business of dental contracting. In the search for new contractors in 1997, need was met by a resident for-profit corporation, university-based care, and by the new surprising contractor from within the university. By 2001, with contracts re-tendered, all contractors were much more organised and serious in terms of their competitive approaches (as per the lessons of 1997). Yet by this time, an even newer cadre of dental corporations emerged.

With Nunavut, authorities are to recognise the rights and advantages of Inuit in such matters as government employment (Article 23), government contracting (Article 24), and in the share of royalties from non-renewable resources, amongst other efforts aimed at social and economic development.[209] The directly applicable provision of the NLCA to dental health services is Article 24. To paraphrase, the Nunavut Government will engage in "preferential contracting policies, procedures and approaches intended to maximise local, regional and northern employment and business opportunities, [as well as] implement measures [that will] increase participation of Inuit firms in business opportunities in the Nunavut Settlement Area."[210] Article 24 also states that bid criteria should include "the existence and proximity of head offices, administrative offices or other facilities in the Nunavut Settlement Area, [as well as] the employment of Inuit labour [and] engagement of Inuit professional services."[211] This policy direction became formalised in the Nunavut Government as the Nangminiqaqtunik Ikajuti Policy (NNI).

As a result of the increasing competition and with a new official policy that showcased Inuit self-determination and self-government practice, stakeholders quickly reacted. Again, new corporations were created with Inuit majority or Inuit minority ownership that had residency in Nunavut (as Kiguti had done), while older non-resident

for-profit corporations began building resident practices (even though their owner-dentists were still based in the south). Repeating the path established by Kiguti, these corporations hoped to take advantage of residency and ethnicity clauses in the new NNI policy.

Competitors also began to claim that they would aid or take over the administration and practices of dental public health services. With heated competition, the provision of dental public health efforts became a competitor-perceived contractual need for the Nunavut Government (a service easily offered since both university-based care and other corporations had public health dentists as leaders, or had public health expertise at their disposal). The Nunavut Government appeared to have several options and directions in terms of the services it could acquire, and/or in the type of operating contractor it wanted for care. In making this choice, the Nunavut Government was mandated to facilitate greater Inuit control over the health care system, and since every stakeholder knew this, the movement surrounding attempts to meet governmental need became highly aggressive, stakeholders placing significant pressure on each other to back away from contracts, or by forming strategic partnerships that created larger and more expertise-rich corporations.

As early as July 2001, and more recently by mid 2002, government dental contracts were awarded to a non-resident for-profit corporation (with a northern dental clinic), as well as to two new resident for-profit corporations (one with Inuit majority ownership and one with significant Inuit administrative involvement). All of these contractors now had fortified plans to offer dental public health services (either through internal dental public health expertise or with alliances with university-based care).

Almost all competitors now had some level of residency, some with Inuit involvement. It seems clear that throughout their recent development, dental services in Nunavut have been more about competition and administrative debates rather than a about a cohesive vision aimed at relieving the suffering associated with dental disease.

V. Conclusion

So as it was in medicine, it too was in dentistry. This history has flowed relative to notions of control over Inuit specific services on ideological, governmental, and business sector fronts, and on the tension between acute and preventative forms of care and between professional stakeholders. Significant challenges remain in this system, which is still suffering from a lack of providers, clinical time, and funds. Nunavut's service delivery milieu has developed in an environment that is difficult geographically, administratively, and less obviously, politically. With this historical basis, the factors (or structural interrelations) that impact this system are developed in the remaining chapters.

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[1] **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[2] Discerning between trauma and acute and chronic degenerative processes is often possible in the mineralised oral structures, as caries, distinct forms of periodontal or 'gum' diseases, and tooth loss due to extraction or disease, all leave clear tell-tale signs of their occurrence.

[3] **Price W.** (1936) "Eskimo and Indian field studies in Alaska and Canada." Journal of the American Dental Association 23: 417-437.

[4] **Mayhall, J** (1974) "Inuit culture change and oral health: a four-year study." In International Symposium on Circumpolar Health. Yellowknife, Northwest Territories: University of Toronto Press; **Leigh R** (1925) "Dental pathology of the Eskimo." The Dental Cosmos 67: 884-899; **Waugh L** (1930) "A study of the influences of diet and of racial admixture on the development of the jaws and face of the American Eskimo." Journal of Dental Research 12: 426-429.

[5] **Leigh R** (1925) "Dental pathology of the Eskimo." The Dental Cosmos 67: 884-899.

[6] **Price W** (1936) "Eskimo and Indian field studies in Alaska and Canada." Journal of the American Dental Association 23: 417-437; **Waugh L** (1930) "A study of the influences of diet and of racial admixture on the development of the jaws and face of the American Eskimo." Journal of Dental Research 12: 426-429.

[7] **Leigh R** (1925) "Dental pathology of the Eskimo." The Dental Cosmos 67: 884-899.

[8] **Bjerregard P and Young TK** (1998) The Circumpolar Inuit: Health of a Population in Transition. Copenhagen: Munksgaard. Noteworthy is the fact that the Inuit diet of this time was primarily animal-based and contained no refined carbohydrates (as in breads and other grain products). As the presence of undisturbed refined carbohydrates play a major role in the formation of caries, their occurrence is significantly reduced in this environment. As noted, this does not mean that Inuit populations did not experience occurrences of other oral diseases, such as the more chronically associated diseases of the peridontium (the gums and bony supporting structures). In fact, there appears to be quite a difference amongst North American Indigenous populations and their experiences with caries and other dental disease. Research has demonstrated both high and low levels of dental caries across distinct populations, whereas in some populations all teeth were commonly present, others had significant numbers of them missing and/or removed. For details see **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press. Information also exists in relation to the healing methods of Indigenous groups for the oral structures. More often than not, these healing modalities use pharmacopoeia to treat pain, as well as to loosen painful teeth prior to extraction. See for example **Hoffman-Axthelm W** (1981) History of Dentistry. Chicago: Quintessence Publishing.

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[10] **O'Neil JD** (1979) "Illness in Inuit society: Traditional context and acculturative influences." Na'pao 9(1 &2): 40-50.

[11] **McGhee R** (1994) "Disease and the Development of Inuit Culture." Current Anthropology 35(5): 565-94; **O'Neil JD** (1979) "Illness in Inuit society: Traditional context and acculturative influences." Na'pao 9(1 &2): 40-50.

[12] **O'Neil JD** (1979) "Illness in Inuit society: Traditional context and acculturative influences." Na'pao 9(1 &2): 40-50.

[13] **Ibid.**

[14] **Bjerregard P and Young TK** (1998) The Circumpolar Inuit: Health of a Population in Transition. Copenhagen: Munksgaard; **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press; **McGhee R** (1994) "Disease and the Development of Inuit Culture." Current Anthropology 35(5): 565-94; **Wenzel G** (1981) "Inuit Health and the health Care System." Études Inuit Studies 5(1): 7-27; **O'Neil JD** (1979) "Illness in Inuit society: Traditional context and acculturative influences." Na'pao 9(1 &2): 40-50.

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[24] Ibid.

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[46] **Ibid.**

[47] **Ibid.**

[48] **Ibid.**

[49] 'Universality, comprehensibility, portability, and a public administration' constitute four out of the five oft-mentioned 'pillars of the Canadian health care system.' The fifth pillar 'accessibility' was added in the 1980s.

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[55] As is reflected in then Inuit-supported NWT legislative efforts to secure a 'representative and responsible government' and more independence from federal authority.

[56] **O'Neil JD** (1986) "The politics of health in the Fourth World: A Northern Canadian example." Human Organisation 45(2): 119-127.

[57] **Ibid.**

[58] Nursing stations/health centres hold an interesting mystique for patient and practitioner alike. For the former, they are a place for healing and resources, and for the latter, they are a place that takes them to adventure in Canada's North. While to date, no one has produced a significant critical ethnographic account of health centre life, it is important to note that these places act as both, a major centre for northern cultural life, and a significant part of a community's economy (in the sense that they are a major employer in communities where generally few jobs exist).

[59] **World Health Organisation** (1981) Health Program Evaluation: Guiding Principles. Geneva: WHO.

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[64] **Archibald L and Grey R** (2000) Evaluation of Models of Health Care Delivery in Inuit Regions. Ottawa: Health Canada; **O'Neil J and Kaufert P** (1995) "Irniktakpunga! Sex Determination and the Inuit struggle for birthing rights in Northern Canada." In Ginsburg F and Rapp R (Eds.) Conceiving the New World Order. Berkeley: University of California Press.

[65] **O'Neil J and Kaufert P** (1995) "Irniktakpunga! Sex Determination and the Inuit struggle for birthing rights in Northern Canada." In Ginsburg F and Rapp R (Eds.) Conceiving the New World Order. Berkeley: University of California Press; **O'Neil JD** (1990) "A Study on the Impact of Obstetric Policy on Inuit Women and their Families in the Keewatin Region, NWT: Final Report." Northern Health Research Unit, Department of Community Health Sciences, University of Manitoba/National Health Research and Development Program, Health and Welfare, Canada.

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[74] **Ibid.**

[75] Even though the Inuit of Nunavut partly mitigate their relationship with the State through a public government (as opposed to many First Nations that deal 'more directly' with FNIHB), the goal still equates culturally relevant services in an environment where the Indigenous group in question maintains meaningful control over those services.

[76] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[77] **O'Neil JD** (1984) "The Gjoa Haven Gambit: An Inuit community's attempt to exercise responsibility in local health services." Unpublished Manuscript.

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[80] **O'Neil JD** (1990) "The impact of devolution on health services in the Baffin region, NWT: A Case Study." In Dacks G (Ed.) Devolution and Constitutional Development in the Canadian North pp. 157-193. Ottawa: Carleton University Press.

[81] **Ibid.**

[82] **Ibid.**

[83] **Ibid.**

[84] **Ibid.**

[85] **Ibid.**

[86] **Ibid.**

[87] The question of 'who exactly has power over what things' has been the historical raison d'être of northern politics. This makes sense when one considers that many other parties, as opposed to northern populations themselves, have had a hand in the decision-making processes concerning the development of Canada's North. For example, the Federal Government is critically linked to the everyday occurrences at the Territorial level insofar as an overwhelming amount of the Territories' budgets stem directly from federal coffers. As well, the programs that are delivered to northerners are sometimes directly administered by Federal authorities or are administered in tandem with them. Ethnographic observation confirms that channels of communication are open constantly and are used often. For upwards of forty years, northerners have fought to recreate that critical link as one of cooperation and partnership instead of one of control over a colony.

[88] **Ibid.**

[89] **O'Neil JD** (1990) "The impact of devolution on health services in the Baffin region, NWT: A Case Study." In Dacks G (Ed.) Devolution and Constitutional Development in the Canadian North pp. 157-193. Ottawa: Carleton University Press.

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[91] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia; **Weller G** (1990) "The Devolution of Authority for Health Care to the Governments of the Yukon and the Northwest Territories." The Northern Review: A multidisciplinary journal of the Arts and Social Sciences of the North. Summer pp. 37-59.

[92] **Weller G** (1990) "The Devolution of Authority for Health Care to the Governments of the Yukon and the Northwest Territories." The Northern Review: A multidisciplinary journal of the Arts and Social Sciences of the North. Summer pp. 37-59.

[93] **Weller GR and Manga P** (1987) "The politics of health in the circumpolar north." Arctic Medical Research 46(2): 52-63; **Weller GR and Manga P** (1983) "The push for reprivatisation of health care services in Canada, Britain, and the United States." Journal of Health Politics, Policy and Law 8(3): 495-518.

[94] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[95] **Ibid.**

[96] **Ibid.**

[97] **Ibid.**

[98] **Ibid.**

[99] **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press. Examples of private-for-profit firms include companies like Med-Emerge International Incorporated, a large health resource agency that provides health professional services to northern Canadian communities (as well as consultative support). Some of these firms are not so expansive and include smaller outfits like those corporations owned by sole-proprietors who, either deliver services themselves (i.e. a small contract), or do so through a relatively small series of colleagues and/or other professionals. Academically based firms include the historical Northern Medical Unit of the University of Manitoba, and units at McGill University in Montreal and the University of Ottawa. Most medical (and dental) faculties in Canada have some form of unit that specifically services marginalised communities and/or populations. Care stemming from Canadian universities has provided a significant resource for northern and centralised health administrators.

[100] **Bell J** (2002) "Picco orders review of Rankin Inlet cancer clinic scheme: Piruqsaijit proposal might violate Canada Health Act." Nunatsiaq News October 25; **Bell J.** (2002) "Kivalliq firm puts on gala PR night for cancer clinic: Evening of hope? Or evening of hype?" Nunatsiaq News October 18.

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[102] **Bourgeois A** (1997) "Baffin board says no to private money." Nunatsiaq News September 26.

[103] Atuqtuarvik Corp, Qikiqtaaluk Corp, Nunavut Tunngavik Inc **(2002) "Inuit advance $1 million to Kitikmeot General Hospital Project." Press Release November 7;** Atuqtuarvik Corp, Qikiqtaaluk Corp, Nunavut Tunngavik Inc **(2002) "Inuit advance $2.75 million to Qikiqtani General Hospital Project." Press Release November 7;** George J **(2001) "New hospital work to begin this fall, Nunavut health minister says: After dumping the much-ballyhooed 'P3' method of building new health facilities, the Nunavut Government will lease new buildings from the birthright development corporations in each region." Nunatsiaq News January 26.**

[104] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62; **Government of Canada** (1969) Statement of the Government of Canada in Indian Policy. Ottawa: Government of Canada.

[105] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[106] **Ibid.**

[107] As is developed in Chapter 5, the Nunavut Social Development Council (NSDC) is an organisational body that unofficially approximates the 'health authority' of Nunavut governance. It was created by the NLCA to represent and advance Inuit interests in relation to health and social issues. Like other ethnonational organisations in Nunavut, the Nunavut Government is to consult the NSDC in relation to matters of concern regarding health and social services. How this is happening has not been smooth and generally seen as ineffectual. See for example **Nunavut Tunngavik Inc** (2002) " Nunavut Tunngavik Takes Control of Nunavut Social Development Council – Dismisses Council Members." Press Release March 22; **Nunavut Tunngavik Inc** (2002) "Nunavut Social Development Council to be Restructured to Deal with Nunavut's Social Crisis." Press Release March 5.

[108] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[109] **Ibid.**

[110] **Ibid.**

[111] **Gjoa Haven** (2001) Committee of Council Phase I: Strategic Planning Document. Gjoa Haven: SolutionsNorth; **Kugaaruk** (2001) Committee of Council Phase I: Strategic Planning Document. Kugaaruk: SolutionsNorth; **Taloyoak** (2001) Committee of Council Phase I: Strategic Planning Document. Taloyoak: SolutionsNorth. All of these planning documents are extremely thorough and demonstrate knowledge of accountable and measured practice, viz. they have significantly considered a mandate, a mission, a statement of membership, values, key functions, and a terms of reference. All of this with a fundamental understanding of their health programs and services, their current objectives, coupled with established methods on how to measure performance (e.g. an objective for adult health is stated as: "Adults will maximize their social, emotional, intellectual, spiritual and physical well being," this being provided by a list of well detailed programming, all measured in terms of the community's cancer mortality rate, potential years life lost to injuries, potential years life lost to respiratory ailments, amongst others, all information collected as per the First Nations and Inuit Health Information Systems and its sub Inuit Health Information Initiative).

[112] **Archibald L and Grey R** (2000) Evaluation of Models of Health Care Delivery in Inuit Regions. Ottawa: Health Canada; **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press; **Dickerson M** (1992) Who's North? Political Change, Political Development and Self-Government in the Northwest Territories. Vancouver: UBC Press and Arctic Institute of North America; **Duffy R** (1988) The Road to Nunavut: Progress of the Eastern Arctic Inuit Since the Second World War. Kingston: McGill University Press.

[113] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[114] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[115] **Armstrong P, Armstrong H, Coburn D** (2001) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. New York: Oxford University Press.

[116] **Author Unknown** (2003) "Premiers win new funding for health" CBC North February 20; **Author Unknown** (2003) "Keep health minister home, premiers tell feds." CBC North February 13; **Author Unknown** (2003) " Premier's stand on health lauded in North." CBC North February 6; **Author Unknown** (2003) "Northern health fund on premier's agenda." CBC North February 4.

[117] Increasingly, ITK has been able to find its way to the negotiation tables that were often only set for First Nations ethnonationals and Federal authorities. Over the last four to five years, ITK and other RIOs have developed their health portfolios, formed health committees, and substantially increasing or improving their health lobby efforts.

[118] **Author Unknown** (2003) "Okalik wins northern clause to health accord." CBC North January 23.

[119] **Ibid.** The Honourable Roy Romanow (who headed the most recent Canadian Royal Commission on Health Services) also garnered additional support for the northern premiers through his public commentary on the northern situation. His timely commentary on the northern health system and its special needs likely added more impetus to the efforts made by these premiers.

[120] **Bell J** (2003) "Ottawa gives Nunavut some extra health dollars." Nunatsiaq News July 18; **Author Unknown** (2003) "Premiers win new funding for health." CBC North February 20; **Author Unknown** (2003) "Okalik wins northern clause to health accord." CBC North January 23.

[121] **Barnes J** (2001) Home Care Presentation to Inuit Tapirisat of Canada Health Committee. Iqaluit: Government of Nunavut Health and Social Services.

[122] **Ibid.**

[123] **Inuit Tapiriit Kanatami** (2002) Inuit Nipingat Qanuinngittiarnirmut (A Voice for Inuit Health) – Inuit Health Information Initiative, Aboriginal Health Infostructure, Telehealth, Health Research. Ottawa: ITK.

[124] **Ibid.**

[125] **Ibid.**

[126] **George B Cuff & Associates Ltd** (2001) Report on the NWT Health and Social Services System. Yellowknife: Government of the Northwest Territories.

[127] **Ibid.**

[128] **Smith S** (2002) Presentation to the Canadian Society for Circumpolar Health on the Northern Health Secretariat. Ottawa.

[129] **Ibid.**

[130] **First Nations and Inuit Health Branch** (2002) Social Cohesion and the Health of Aboriginal People. Public Presentation August 21.

[131] **Nunavut Tunngavik Inc** (2002) "Nunavut Tunngavik Takes Control of Nunavut Social Development Council – Dismisses Council Members." Press Release March 22; **Nunavut Tunngavik Inc** (2002) "Nunavut Social Development Council to be Restructured to Deal with Nunavut's Social Crisis." Press Release March 5. One must note that this is not the case for Inuit woman's groups (e.g. Pauktuutit, the national Inuit women's association), who have consistently and historically been involved 'on the ground' and generally bypass a lot of the higher-level political morass in their attempts at improving the quality of life of Inuit women and their families.

[132] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press.

[133] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press; **McEuen CS** (1938) "An examination of the mouths of Eskimos in the Canadian eastern Arctic." The Journal of the Canadian Medical Association 38: 374-377; **Leigh R** (1925) "Dental pathology of the Eskimo." The Dental Cosmos 67: 884-899.

[134] **Author Unknown** (c.1930) "All Saints Hospital, early 1930's, lady in dentist chair." Northwest Territorial Archives. Accession number N-1979-050-0076(1570065); **Author Unknown** (c. 1930) "Person – possibly a dentist inspecting someone's teeth, Coppermine." Northwest Territorial Archives. Accession number N-1987-033-0789(1750076).

[135] **Pennington J** (1994) Terrence Hunt Photographs: An Inventory. Culture and Heritage Division, Department of Education, Culture and Employment, Government of the Northwest Territories. NWT Archives. Accession Number N-1979-062.

[136] While a discussion of traditional dental care in Inuit society lies beyond this study, it is important to note that it existed. As ethnographic interaction noted, the importance of flossing (with sinew) in relation to a

diet consisting mostly of meat was a significant aspect of modern and traditional oral care. Another ethnographic note concerns the use of 'patik,' which as explained to the researcher is the bone marrow of caribou (of particular significance in this instance was the marrow of the hind limb tibia), for the treatment of oral ulcers, especially for infants and children. This makes sense when one considers that bone marrow is made up of cells associated with the body's (human or otherwise) immune system. One assumes that direct contact with a lesion may possibly provide some effect.

[137] **Bedford W and Davey K** (1993) "Indian and Inuit dental care in Canada: The past, the present and the future." Journal of the Canadian Dental Association 53(2): 126-132.

[138] **Ibid.**

[139] **Ibid.**

[140] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press; **Brown BI.** (1969) "The Canadian Dental Association dental health plan for children." Can J Public Health 60(7): 258-61.

[141] At this time, there were also programs run for dental auxiliaries in both Saskatchewan and Manitoba. Saskatchewan (who holds historical significance in social approaches to health care in Canada) was funding a local college (Wascana College) in an attempt to meet similar service needs. Wascana produced 'dental nurses.' The Manitoba program was based in The Pas (a northern mostly Aboriginal community) and trained dental public health auxiliaries as opposed to auxiliary curative clinicians. Both of these programs have political economic histories of their own, involving changes in provincial governments, professional polity, amongst others, the details of which are partly developed in Chapters 7.

[142]**Bedford W and Davey K** (1993) "Indian and Inuit dental care in Canada: The past, the present and the future." Journal of the Canadian Dental Association 53(2): 126-132.

[143] **Hardwick F and Schwartz A** (1999) External Review of the Dental Therapy Program of the Saskatchewan Indian Federated College National School of Dental Therapy. Ottawa: Health Canada Medical Services Branch.

[144] **Canadian Dental Association** (2003) "Dentists North of 60: A Breed Apart." Communiqué September/October. Ottawa: CDA; **McCluskey K** (2000) "Stalemate continues: Dentists and feds still far apart." Northern News Service July 10.

[145] Schwartz himself (who some consider 'the father' of the academic provision of dental care to northern Aboriginal populations) is a clear example of this 'positional practice.' Schwartz was considered a community-minded clinician who, for many years, practiced on behalf of the government in marginalised Aboriginal communities. He then entered more significantly into the delivery of services as an administrator, eventually becoming a regional director for MSB. Since Schwartz had played the role of clinician/contractor in the delivery of services to isolated southern Aboriginal communities, as an administrator, he continued the use of sole-proprietors like himself, but as he notes, also developed existing relationships with academic institutions. Schwartz eventually became Dean of the University of Manitoba's dental faculty and as per his philosophical inclinations to care, strengthened community dental programs within the faculty, as well as continued to foster the existent relationship between this dental academy and the delivery of services to isolated populations well into his retirement.

[146] **Odlum O** (1995) "Meeting the needs of under-serviced communities: one university's externship experiment." Probe 29(5): 175-7; **Levine N, Sigal MJ, Munroe CO** (1986) "Outreach dental programs. A viable adjunct to dental faculty education." J Can Dent Assoc 52(8): 709-13; **Waldman HB** (1977) "Departments of community dentistry--are they a threat to the dental profession?" J Am Coll Dent 44(2): 80-92, 109; **Jenny J and Frazier PJ** (1974) "Departments of community dentistry as viewed by teachers of clinical practice, basic science, and community dentistry." J Public Health Dent 34(3): 161-73;

Petterson EO (1973) "The development of community dentistry in dental educational curricula: activities and resources of departments." J Public Health Dent 33(4): 238-44; **Petterson EO** (1972) "Teaching departments of community dentistry in the United States of America." Br Dent J 133(5): 193-7.

[147] Health faculties across Canada have always been involved (at some level or another) in the delivery of health services to isolated and marginalised populations, so much so that an official document now exists involving medical faculties, their stakeholders, and Health Canada regarding their responsibilities in this regard. **Health Canada** (2001) Social Accountability: A Mission for Canadian Medical Schools. Ottawa: Minister of Public Works and Government Services Canada. No such document exists between the Government of Canada and Canadian Dental Faculties.

[148] **Ibid.**

[149] **Ibid.**

[150] **Burt BA and Eklund SA** (1992) Dentistry, Dental Practice, and the Community (4th ed.) Philadelphia: W.B. Saunders Company; **Best EG** (1986) "Socio-Economic Change in the Professions: A Study of Architecture, Dentistry, Law and Medicine in the United States." Dissertation Abstracts International (A: The Humanities and Social Sciences) 47(3): 1078-A; **The American Dental Association** (1984) "Dentistry's blueprint for the future. A report on the strategic plan developed by the Association's Special Committee on the Future of Dentistry." Journal of the American Dental Association 108(1): 20-5, 27-30.

[151] **Bedford W and Davey K** (1993) "Indian and Inuit dental care in Canada: The past, the present and the future." Journal of the Canadian Dental Association 53(2): 126-132.

[152] In the paediatric OR, children are most often given treatment for something known as 'baby-bottle tooth decay,' an ever-increasing disease entity in this and other marginalised populations. Eventually coming to be known as 'early childhood caries,' this is a disease entity that to date, while much is known about the general factors that contribute to its causation, remains somewhat of an aetiological / pathophysiological / pathomorphological mystery. This disease significantly contributes to the early establishment of an overwhelming burden of illness, impacting negatively on childhood development, and draining large amounts of resources.

[153] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[154] **McCluskey K** (2002) "Robin Stout is on a mission. The three-year resident of Iqaluit wants to do what she can to end tooth decay among Nunavummiut." Northern News Service July 08; **Neary D** (2001) "Fending off cavities: New dental therapist eager to promote proper care." Northern News Service November 02; **Gorrill M** (2001) "Teeth wars." Northern News Service June 15; **Barrera J** (2001) "Booklet to combat baby tooth decay." Northern News Service May 14.

[155] **Canadian Dental Association** (2003) "Dentists North of 60: A Breed Apart." Communiqué September/October. Ottawa: CDA

[156] 'Part I' being for Canadian trained professionals, 'Part II' for Canadian trained specialists. **Annual Volumes of the Statutes of the Northwest Territories** (1988) Dental Profession Act (as appropriated by the Nunavut Court of Justice). Yellowknife: Government of the Northwest Territories.

[157] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[158] **Canadian Dental Association** (2003) "Dentists North of 60: A Breed Apart." Communiqué September/October. Ottawa: CDA.

[159] As leaders in their communities, these professionals are called to sit on important decision-making committees as well as lead community issues. Consider for example **Poole N** (2003) "Hay River dentist honoured: Dr. Jim Tennant is business person of the year." Northern News Service June 02;

[160] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[161] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[162] This individual eventually becomes a regional Member of the Legislative Assembly of the old-NWT, Minister of Finance for the old NWT, and thus a general force in the involvement of private sector interests in the provision of northern health services throughout the long-term.

[163] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[164] **Milnes A, Rubin C, Karpa M, Tate R** (1992) "A retrospective analysis of the costs associated with the treatment of nursing caries in a remote Canadian Aboriginal pre-school population." Community Dentistry and Oral Epidemiology 21: 253-260; **Messer J, Forgay M, Clovis J, Graham B** (1991) "A collaborative approach to developing dental health resources for Northern communities." Arctic Medical Research 50(Supplement 5): 666-667; **Messer J** (1991) "The effect of non-insured health benefits on dental treatment provided in four coastal Labrador communities by salaried dentists." Arctic Medical Research 50(Supplement 5): 662-663; **Davey K** (1988) "Primary Dental Care in Canadian Arctic Communities." Arctic Medical Research 47(Supplement1): 562-563; **Mayhall J** (1984) "The Oral Health of the First Residents: Who's in Charge?" Arctic Medical Research 38: 431-435.

[165] **Ibid.**

[166] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[167] **Ibid.**

[168] **Waldram J, Herring D, Young T** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[169] **Lavoie JG** (2003) "Governed by contracts: the development of Indigenous primary health services in Canada, Australia and New Zealand." NAHO Journal of Aboriginal Health (forthcoming).

[170] The reality of regionalisation is an important one to consider. MSB/FNIHB is organised by region, with 'zones' and 'provincial regions' having options in relation to their administrative processes (more often than not developing them from local historical practice). This 'regionality' forms the basis of confusion at a national level, hence the need for something like a national directive or standardised administrative practice. Differences do exist amongst Territories that result in national administrative complexity. Regionality also causes confusion in relation to the standardisation of costs across regions (for such things as dental services, medical transportation, amongst other NIHBs). Regional differences in cost clearly result because costs are not the same region to region. Consider the southern and northern differential costs associated with shipping and attaining petrol (medical transportation), shipping and attaining supplies (medical equipment and supplies, pharmaceuticals), recruiting and retaining personnel (as in dentists and doctors and other health professionals), et cetera. Regional differences also exist in relation to the establishment of the costs which are negotiated with regional parties, as in the negotiation of a fee schedule

between federal / provincial / territorial / professional authorities. Consider that some negotiations go better than others, and some provinces and/or territories have differing levels of remuneration (differing levels that do not solely depend on the reality of isolation between north and south). Regionality has resulted in professional and ethnonational criticisms, some placing forth notions of regional parity, other regional inequity.

[171] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[172] **Ibid.**

[173] This position (that federal authorities are more responsible for the dental services than territorial ones) is supported by administrative acts that see services rendered by dentists billed to federal authorities and not territorial ones (regardless if the money flows through the territories or not). In fact, almost all claims processing for services billed by dentists occurs on the federal side, the majority conducted through a federal contractor that has a contract for claims processing. Thus most (if not all) monies and remuneration activities stem from the federal NIHB program (regardless of who is managing what and who is covering what costs).

[174] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[175] **Ibid.**

[176] **Ibid.**

[177] **Bell J** (1997) "Ottawa says no to Keewatin dental deal: Health Canada officials say they won't honour fee-for-service billings submitted by dentists working for Kiguti Dental Services in the Keewatin." Nunatsiaq News September 26.

[178] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[179] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia; **Bourgeois A** (1998) "Ottawa cuts take big bite out of dentists' fees." Nunatsiaq News April 30.

[180] The 'payer of last resort' principle stems from the reality that some Aboriginal clients are insured for dental care (and other NIHB services) through other means. Thus federal authorities take and enforce the stance that they are the 'payer of last resort' when other insurance coverage exists. The 'pre-determination of benefits' was the most significant step towards cost containment, whereby dental clinicians now had to receive approval for services extending beyond a certain amount (in 1997 that amount was $600) or for certain treatments. This approval coming from a geographically distant clinician contracted to review submitted cases.

[181] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[182] **MacDougall C** (1999) "Tooth trouble: Northern children's dental health a 'crisis,' say dentists." Northern News Service November 22; **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa:

Medical Services Branch; **Pastori C** (1998) "Crisis in dental recruitment (letter to the editor)." Nunatsiaq News November 06; **Colbourne J** (1997) "Dental care inadequate: Health Canada report calls for more dentist days." Northern News Service September 10.

[183] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[184] **Ibid**

[185] **Ibid.**

[186] **Ibid.**

[187] **Ibid.** Note the recognition of the 'regionality' issue. Significantly, when knowledge of remuneration disparity becomes known, it constituted a significant contentious issue in northern dental State/Professional relations. The reality that this was unknown less obviously speaks to the general under-organisation of northern dental associations. Only recently have northern associations improved their coordination and organisational capacity, as is evidenced by their increasing frequency in the media as well as their increasing involvement with national dental stakeholders. Substantially, all of this is a result of the increased cohesion of national/provincial/territorial authorities in contraposition to FNIHB and the issues surrounding the NIHBs.

[188] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch; **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada; **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[189] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[190] **Ibid.** Since this is seen as the responsibility of FNIHB, dentists do not often observe the responsibility of delivering public health measures (other than a few rare public appearance to discuss oral health and disease). If they did though, it would likely prove ineffective as a result of both, the possible frequency of intervention, and the lack of dental public health training or knowledge of community oral health promotion practice.

[191] Clinically, the delivery of dental public health interventions includes the concept of administering fluoride gels or varnishes and/or delivering 'Oral Hygiene Instructions,' which most often involves the demonstration of dental prophylaxis technique. Supported by current dental public health thinking, FNIHB has stopped remunerating for these services. Irregular and/or random clinical interactions 'showing and telling' someone to brush his or her teeth does not routinely improve someone's oral health. This is not to say that sustained and well-planned oral health education does not work, but chair-side intervention, while important, does not necessarily constitute a public health intervention.

[192] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[193] **Ibid.**

[194] **Ibid.**

[195] **Volumes of the Statutes of the Northwest Territories** (1988) Dental Profession Act (as appropriated by the Nunavut Court of Justice). Yellowknife: Government of the Northwest Territories. Interestingly, the section in the Act that allows for the registration of Part III dentists is still intact (regardless of whether it

was nullified by new additions). The Act still describes the potential existence of a Part III clinician and the conditions for licensure, viz. getting NDEB certification and sponsorship by another resident dentist. This begs the question of whether keeping the Part III section of the act allows for potential future changes as per need.

[196] Long-time Baker Lake MLA Glenn McLean is a good example of this type of pressure. For many years, this MLA has been insistent and consistent on increasing the days to his community. So much so in fact, that in the last request for proposals made by the Nunavut Government for dental services in the Keewatin, his stands above all other communities in the number of days available, even when compared to other communities of similar size. As a result of political pressure, this community receives a total of 100 service contract days, whereas a community of similar size in the Baffin region only receives 72. **Government of Nunavut** (2001) Request for Proposal (RFP) to provide contracted dental services for Health and Social Services Baffin and Keewatin regions. Iqaluit and Rankin Inlet: Government of Nunavut.

[197] **Uswak G** (n.d.) Redistribution of NIHB Dental Service Days in the NWT. Ottawa: Medical Services Branch.

[198] Some administrators comment that the 'contract day' method is too rigid, as it does not allow them to answer real need. Also, contract days are seen to allow FNIHB the opportunity to save money, as once the number of contract days are used up, FNIHB is no longer willing to cover the costs associated with any additional those service days. So while a dentists can stay for longer than the days allowed, FNIHB will not fund the costs associated with such things as lodging and travel (costs that the Nunavut Government then absorbs).

[199] **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch. (capitalisation in original).

[200] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia; **McCluskey K** (2001) "Dentists counter offer: Waiting for Health Canada." Northern News Service April 02; **McCluskey K** (2000) "Dentists frustrated: Minister silent on plea for income parity." Northern News Service November 13; **McCluskey K** (2000) "Dental talks at impasse." Northern News Service June 19; **Bourgeois A** (1998) "Ottawa cuts take big bite out of dentists' fees." Nunatsiaq News April 30; **Korstrom G** (1998) "Gritting and bearing the dental plan changes." Northern News Service February 02.

[201] Before this, sizeable contracts (the ones containing more communities) were only seen in relation to resident corporations like Kiguti and academic institutions like the University of Manitoba. All other contracts were of a much smaller scale and associated with individual clinicians.

[202] While dental departments do employ Inuit, other than one Inuit dental therapist, no person has risen in the immediate 'dental' administrative ranks. In this sense, Inuit with 'dental' affiliations have taken to seeking out opportunity in the private sphere of contracts and resident dental clinics.

[203] **Government of Canada** (2003) Standing Committee on Health: First Nations and Inuit Dental Health. Ottawa: Senate of Canada; **Author Unknown** (2002) "Nunavut not billing Ottawa, millions owed." CBC North December 4; **Author Unknown** (2002) "Departments overspending, warns Auditor-Gen" CBC North December 3; **George J** (2001) "Picco says he'll press Ottawa for more NIHB money: Health minister says Nunavut isn't getting its fair share of aboriginal health funds from Ottawa." Nunatsiaq News February 23; **Government of Canada** (2000) Standing Committee on Public Accounts Tenth Report on the October 2000 Report of the Auditor General of Canada: Health Canada – First Nations Health: Follow-up. Ottawa: Parliament of Canada; **Auditor General of Canada** (2000) Chapter 15: Health Canada – First Nations Health: Follow-up. Ottawa: Auditor General of Canada; **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada; **Auditor General**

of Canada (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[204] **Fletcher S** (2002) "Biting Back." The Globe and Mail June 25; **Wente M** "First Nations People, Third World Teeth." The Globe and Mail June 18; **Bickford P** (2002) "Q&A with Dr. Jim Tennant." Northern News Service June 17; **Author Unknown** (2002) "First Nations dental health alarming: dental association." CBC News Online June 07; **Author Unknown** (2002) "Yukon dentist criticises non-insured health benefits." CBC North May 14; **McPhee J** (2002) "The drill on your dentist: Doctor dispels myths, shares secrets." Northern News Service March 11.

[205] **Canadian Dental Association** (2002) "CDA discussed NIHB and other issues with Federal Health Minister." Communiqué May/June; **Canadian Dental Association** (2002) "MP Contact Program Reactivated." Communiqué July/August; **Canadian Dental Association** (2001) "NIHB Dominates Discussions with MPs." Communiqué May/June. Ottawa: CDA; **Canadian Dental Association** (2001) "CDA Adopts New NIHB Strategy." Communiqué March/April. Ottawa: CDA.

[206] **Canadian Dental Association** (2003) "Non-Insured Health Benefits Program: Agreement reached at last." Communiqué January/February; **Canadian Dental Association** (2000) "Oral Health Resourced Distributed to Native Communities." Communiqué May/June.

[207] **Legislative Assembly of Nunavut** (2000) "Government of Nunavut Budgetary Address." Hansard of the Third Session of the Legislative Assembly. Iqaluit: March 23.

[208] **Canadian Dental Association** (2002) "MP Contact Program Reactivated." Communiqué July/August

[209] **Government of Canada, Department of Indian Affairs and Northern Development and Tunngavik Federation of Nunavut** (1993) Agreement Between the Inuit of the Nunavut Settlement Area and Her Majesty the Queen in Right of Canada (Nunavut Land Claims Agreement). Ottawa: Government of Canada.

[210] **Ibid.**

[211] **Ibid.**

Chapter 4. Geography and Disease Burden

I. Introduction

This chapter begins an analysis into the characterisation of those factors that delimit the practice of dentistry in Nunavut. Through composite case examples, this chapter will establish how both geography and the current level of disease limit the possibility of 'positions and practices' that stakeholders can enact. This chapter concerns itself with the clinical challenges of delivering dental care in Nunavut, using stakeholder commentary and experience, as well as administrative and ethnographic data to illuminate and comment on these difficulties.

II. Geography and Northern Dentistry

Geography is the definitive challenge to any service delivery. It complicates such things as the ease of travel, the opportunity for clinical support, dealing with equipment loss and failure, stable professional recruitment and retention, and any possibility for consistent access to care. The whole concept of dental services in Nunavut revolves around the very idea of trying to deliver services to an isolated place. Less obviously, geography also delimits other, more nebulous, aspects of northern dental cultural life. For example, the very idea of 'going north' and being 'a travelling clinician' in areas where little dentistry occurs has become associated with a particular style of dentist, and a particular style of dentistry. Historically, in a significant and general sense, geography has impacted any and all care delivered to such populations.

As noted, regional health boards were created in the 1988 devolution in order to better answer the specific needs of the different geographical regions. Regional boards administered and functioned relative to a regional centre, tethered to the larger more centralised administrations of the capital and of the south. Regions have established unique relationships with different parts of northern and southern Canada, and have historically consisted of: Kitikmeot/Cambridge Bay/Yellowknife/Edmonton, Keewatin/ Rankin Inlet/Churchill/Winnipeg, and Baffin/Iqaluit/Ottawa/Montreal/Winnipeg. The further one goes south, the more one finds the staple of services and professionals needed to provide care to the Nunavummiut population. These relationships group discrete northern and southern ties, constituting in the exchange of professional, economic, and political resources.

A premiere example of this exchange includes a 'memorandum of understanding' between the Province of Manitoba and the Nunavut Territory. Aiming to strengthen intergovernmental and trade partnerships, these governments' considerations included the possibility of road access, hydropower transmission from Manitoba to Nunavut, cooperation in the health care service industry, and tourism ventures.[1] On November 26th 2001, as Nunavut dental contracts were tendered, provincial leaders saw "great opportunities to build new partnerships in areas such as transportation, tourism promotion, business development, training and education in many fields, alternative energy and hydro generation, improved health care and dentistry services, cultural exchanges, to speak of just a few."[2] This search for mutual advantage is obvious in the context of regions that are directly connected. In this case, the northern Manitoba community of Churchill has acted as a major access point to general and higher-level

health services further south, relations long existing in both the medical and dental academic sectors, and with the private markets associated with delivering health and social services (*e.g.* medical transportation, medical lodging, and youth services, among other secondary and tertiary services).[3]

In dentistry, servicing Nunavut has generally meant contracts with sole-proprietors, academically based dentists, their corporations, and university-based care. There exists a direct relationship with the National School of Dental Therapy, whose graduates are directly hired as employees. Dental expertise clearly originates elsewhere.[4] So as a delimiter in the development of dental services, geography is quickly situated in questions surrounding the realities of northern clinical/cultural life. What is it like to deliver services in such an isolated place? Why 'go north' in the first place? Who 'goes north' for that matter? Is it all about the adventure? Or is it all about the money, as people often infer? Less obviously, what insurers of dental care, dentists and styles of dentistry have become synonymous with care in isolated regions such as Nunavut? A consideration of such questions (relative to the delimiting role of geography) now follows.

a. Northern Practice

For both a new and experienced clinician, practicing dentistry in Nunavut can be challenging, hectic, exhausting, frustrating, and ultimately, rewarding. A regular two to three week trip begins when a clinician arrives to a community through a major northern centre, whether Iqaluit, Rankin Inlet, or Yellowknife. This in itself can be problematic, as inferred in this passage from a practice manual:

> ***"In theory, when you continue your trip to a community, arrangements should have been made to meet you at the airport and take you to the nursing station."***[5]

This manual uses expressions like 'in theory' and 'should have been,' since when travelling to isolated communities, events do not always unfold as planned. This makes sense when much service planning occurs at a distance, sometimes as far as southern Canada. Coordinated efforts between local, regional, territorial and southern administration easily become challenged, with the 'problem' experienced by the clinician often beyond the influence of administrators 'one community away,' let alone 'one thousand miles away.'

Ethnographic experience speaks to occasions where one is not met at an airport, and getting to a health centre or establishing where one will lodge appears an intimidating task. While this may appear suspect (as surely the one dentist in a community of 600 that everyone has been waiting for will be accommodated), for the new clinician, or for one that is shy about effectively communicating with local authorities or persons, these constitute real problems. Consider these statements from a manual for the new clinician:

> *"**Once you arrive in Iqaluit, you may or may not be met by the Regional Dental Manager or his/her assistant.** They may give you one of several items, i.e. an envelope containing pre-authorizations or dental consumables. You will then be flying further onto the first community that you will service. **Again, you may or may not be met at the local airport by the Head Nurse or one of his/her representatives. If not, do not panic, there are usually many people present, i.e. Taxi Driver, Airline Agent, etc., who will know how to get you where you need to go, i.e. Health Centre, Transient Housing, or Hotel."***[6]

On rare occasions, securing housing and missing equipment have proven non-welcome surprises for clinicians arriving to communities. These difficulties do not result from a lack of preparation, but rather from the simple reality of distance and its role as an ever-present delimiter of northern dental services.

Once arrived and settled, clinical responsibilities begin. The following excerpt from the same manual describes many necessary considerations for practice:

*"**Setting up - Once you have arrived in a community and have settled in, it is now time to begin setting up your dental office.** Your equipment may or may not have been delivered to the Health Centre. If not, the Nurse in Charge (NIC), any Health Centre Clerk-Interpreter will know whom to contact. Each community Health Centre will be different, but the process of setting up should be the same.*

***Your equipment will either be in boxes or already set up for you.** If already set up, it is suggested that you go through all the equipment present, as there may be some items that you will want to set up in a specific manner.*

***Ideally, all consumables should have been replenished either prior to your arrival or with those that have been sent with you. Please check to see if everything you need is there as sometimes there is confusion as to what consumables were used up at the last visit.** Of particular importance are anaesthetic and gloves, as these for some reason seem to always be either in abundance or in short supply.*

Once you are sure that everything you need is present, you should begin booking your clinical days. On a side note: the Nurse in Charge (NIC) may take this time to discuss issues of concern, i.e. patients, clinic schedules, etc. At this time you should ask for a key to the Health Centre (if one has not already been given to you), as surely you will be working at times that the NIC will not. Please try to begin your relationship with the NIC positively, and try to adjust to his/her Health Centre rules. For example, sometimes, an NIC will allow you to dispense your own medications, but others will not. Some may ask for a prescription, some may not. Obviously, each NIC is unique and each has their different methods of administrating the Health Centre. Remember that if you treat an NIC with respect, there is no reason why he/she will not do the same.

Clerk-Interpreters - Since this is your first visit, a Clerk-Interpreter will have been chosen for you. The Clerk-Interpreter is as important if not more important than the dentists themselves are; without them, you will not be able to book appointments, effectively interact with your patients, and deliver care. In essence, a Clerk-Interpreter can "make or break" your community visits.

***Unfortunately, some communities do not have consistent Clerk-Interpreters.** Your Clerk-Interpreter, whoever they may be, must be clearly explained their duties and what will be expected of him/her. Specifically, Clerk-Interpreters should: Interpret; Fill out NIHB claim forms; Book appointments; Wash instruments; Develop radiographs; Inquire about patient frequencies and $600 limits.*

It is also important to note that the Clerk-Interpreter is your window into the community. They will know whom and why people need to see the dentist, therefore you should trust their judgement at first with respect to booking patients.

***Clinical Schedules - You will be present in any one community approximately between 10 days and 2 weeks.** Considering this limited amount of time, it is necessary that you have a strategic plan as to how you will structure your visit. During your absence, many people have developed abscesses. To properly address these emergent patients, it may be prudent to set aside a portion of the first and last day of your visit for individuals that are seeking extractions.*

In terms of a daily clinical schedule, a normal workday should be from 9am to 5pm with an hour for lunch. With the amount of treatment need present in Nunavut communities, it is asked that you work several evenings as well as several hours on Saturday.

***The amount of non-attendees varies from community to community. Experience has shown that an afternoon walk-in clinic may attract patients that would otherwise not attend, i.e. those that cannot make appointments as they may have no phone.** It is very important that if you choose to try this, the Clerk-Interpreter should announce it through local radio well in advance.*

Another way of attracting certain patients is to have "special" clinical days just for them. A one-day paediatric clinic is a good thing to try, as there is high disease burden among children. Another "special" clinical day is the denture day. There is a high rate of edentulism in these communities and having one day aside for their needs will surely be a successful endeavour. Not only will you directly attend to a high need group, but you will identify patients that will need denture fabrication at the next Denture Team visit. Again, as with walk-in clinics, these "special" clinics should be announced well in advance by local radio.

Usually, a Clerk-Interpreter will be inundated with phone calls for appointments. It is very important that you not allow all your clinic time to be eaten up. While you may be able to book your whole trip in your first two days, this may not be prudent, as many patients will not show up for an

appointment that was made a week-and-a-half in advance. *It is a good idea to tell the Clerk-Interpreter to only book you several days in advance. This way, you will have sufficient clinical time available for patients that are highly motivated and for those that you wish to finish treatment on.*

The patients that are not given appointments should be placed on a list so appointments can be made when time is made available. The need for dental care is high in communities, and as such you will not be able to see everyone that wants to be seen."[7]

As described in this manual, the usual two-week community visit begins with the unpacking of equipment and the setting up of a clinic. It then turns to meeting or reacquainting oneself with health centre staff, of great import being the 'dental clerk-interpreter,' who can often play a significant role in managing a transitional dental clinic. Some communities have one consistent dental clerk-interpreter, while others have a few (all usually female). Clerk interpreters provide input and information to clinicians that may otherwise remain unknown (sometimes at medical risk to the patient). Treatment then occurs up to seven days a week, with a strong incentive (both administrative and fiscal) to work long hours so as to meet the high need. This involves a high volume of patients and the common panic associated with emergency care, 'no-shows,' and equipment loss and failure. For example:

"[Y]ou get up, you walk to work, [...] the nurses are there because they start at 8:30 [...] ***I usually start at nine [...] the phone will start ringing, hopefully the nine o'clock patient shows [...] you work right through till supper, and at night*** *[...].* ***When you first come in there's a list of emergencies*** *that you have to go through from the nurses and people phoning in, and those are* ***mainly abscessed teeth and extractions*** *[...]* ***after that you start*** *[...]* ***seeing people that you took a tooth out [last visit] or that you know need fillings*** *or a few fillings and then you start rebooking them. [...]* ***9 out of 10 you're not gonna finish all the treatment that is in the community in three weeks, or 9.9!"***[8]

"[Y]ou're the only game in town [...] you have to deal with large volumes of patients, you have to be able to size-up situations and deal with all kinds of added stress that you might not down south because you don't necessarily have your clinic manager, your receptionist, your two or three dental assistants and a hygienist, I mean you're basically everything with often times a locally-trained dental assistant, who has to juggle and answer phones too."[9]

"I guess more oral surgery and more restorative [...] you're not doing as much, well you're barely doing any aesthetic dentistry[...] ***it's hard to expect anyone to do anything when you fly a dentist in and they're just bombarded by all these people that have to be seen*** *[...] and we're just like* ***'whoa!', 'what's going on here?', 'I have so much work to do', and then you leave and can't believe how much work there was."***[10]

"[W]hen you come into a community that has say 500 hundred people and ***you're there for three weeks and you're working [...] you know 12 days, [...] you're not going to see all the people.*** *The*

people that you do see you're not gonna finish all their treatment needed, if ***they have like you know 13, 14, 15, 16 cavities or fillings or extractions*** *[...] because you don't want to spend all your time on one person, you know, I mean,* ***you spend one day on one person, you're gonna see 12 people.***"[11]

"[o]ne of the problems that ruins the whole effort is moving equipment, *not big equipment but lights and things, but [in] moving equipment and supplies around, one of the things that happens way more frequently that it should is that hand instruments or small kinds of* ***instruments and supplies get sent out ahead of the dentist and then disappear into space somewhere.*** *I just had an example of that last week actually, it was a box of supplies that we still haven't tracked down and everybody denies its existence,* ***somewhere there's a huge warehouse that's full of things that were once destined to northern places and just gone, they just store them there indefinitely (laughter).***"[12]

"[There are] problems with certain equipment not working, ***you kind of have to be sort of a MacGyver of dentists in order to try and repair it sort of on the spot*** *otherwise as you know,* ***some of the communities only get two small flights a week,*** *if the weather is good,* ***you're quite isolated [so] that if you can't fix it, it will take a couple of days which is sort of lots of time in order to fix equipment or whether you get stuck by weather, it's just the nature of the beast I guess.***"[13]

These statements clearly address the challenges of northern dental practice as a result of isolation. Where sometimes equipment can fail with no recourse for repair, unless the dentist, assistant, or 'someone else in town' can do it, and where clinical situations can become challenging simply due to the fact that there is little professional support. The pressure of feeling that one has to meet 'so much need' is also discussed amongst clinicians, most often referred to as a 'draining' influence.

A system does function nonetheless, and barriers do not present as overwhelming when practitioners stay and practice for longer terms. Regularity of northern practice (like regularity in anything) allows stability in a challenging environment. This results in the positive benefit of significant clinical relationships with and within communities, and can allow for intimate knowledge of how to deal with the realities of northern dental life. This can stabilise a community's care for example, as longer-term clinical relationships often result in more familiarity and trust between a clinician and a local population, making a community more likely to respond to accessing, utilising, and investing in their services. This also provides for a nominal 'continuity of care' (as much as is possible with no local dental clinic accessible all year 'round), establishing a situation whereby it

is not a different clinician every few months, making it easier to track patient needs and treatment outcomes.

So as clinicians stay longer, they realise that it is not impossible to get themselves from the airport to their housing, and if need be, one can find housing by speaking with the 'right local person' as opposed to the 'right centralised administrator.' One comes to understand that equipment can often be fixed by one's self, by an assistant, or by the local mechanical guru. One also comes to understand that it is not possible to meet all the need that is evidently apparent.[14]

While challenges are common and possible to overcome, they can prove too much for some. Geography substantially impacts this system by creating a high professional turnover. For example:

> *"**I think a lot of people who come north think it's going to be an adventure**, and they sit and realise that it wasn't something they expected [...] and **a lot of people just get frustrated** that the clients just don't seem to care what's being done, or there's no demonstration that they want to participate in their own health care, so it's frustrating, it's a variety of factors. Some people, **some dentists are built for the north, some come and thrive, and eventually others get disillusioned and leave. It's a hard life, you're living in hotels, you're living in health centres and you continue to move around year 'round and you don't have a base, it's hard if you have a family, you can only be away so long, so it takes a certain individual who's willing to do that, it's a short term endeavour. Very few people come and stay, very few people continue to work over in the long-term.**"*[15]

> *"**[In discussing who will not be successful in the North, it's likely to be] someone who's not flexible, someone who expects a perfect clinical setting,** someone who expects clients to show up on time, to participate. **If you're expecting a perfect world, it's not gonna happen because you don't have the best clinical setting, you don't have the best equipment,** you're gonna be weathered out, so if you're worried that you're gonna be stuck in a three-day blizzard and how am I going to bill whatever I wanted to bill per day, you're not going to do well. You know, **you have to deal with the language barrier, cultural barriers. You have to be adaptable to all kinds of situation.** You have to be independent. **You can't rely on a support organisation [...] you have to be good at fixing your equipment, for troubleshooting in the field. [...] because you're the only provider in town, you have to do it all, and if you're not able to do that or if you're not self-sufficient, you're not gonna do well, and you won't return, almost all don't return.**"*[16]

What stakeholders observe as difficulties in travel, keeping track of equipment, trying to fix equipment, and attempting to answer unbeatable need (amongst others) clearly demarcate geography's role in this political economy. Regardless of challenges and the

possibility for improvement, one must understand the fundamental nature of geography in delimiting what positions people are placed in, and the practices that endure as a result.

b. The NIHB Program

The NIHB Program insures some non-insured health services (*e.g.* dental care) for particular First Nations and Inuit populations. In Nunavut, this insurance program acts as the major insurer of dental services. In almost two years of daily practice in different Nunavut communities, this researcher could count on one hand the number of private insurance forms encountered. Dental care in Nunavut communities is intimately tied to the debates and developments of the NIHBs (developed and strengthened throughout the remaining chapters).

As the major 'public' form of insured dental care (and also the major form of insured care period) the NIHBs act as a 'public insurer of a non-insured service,' in this case for a group that is both socially and geographically marginalised. 'Social geography' is also ensconced within this researcher's conception of geographic delimitation, so aside from the impositions of spatial geography, practitioners are also problematised by a system aimed at the socio-geographically marginalised: the FNIHB/NIHB system associated with claiming expenses for dental care delivered in Nunavut communities.

This 'dental claims system' has developed over the course of northern dental history, with layer upon layer of policies, procedures and restructuring having resulted in what is now known as the 'predetermination system.' The current face of this system holds a twofold purpose: to control costs for FNIHB and to curb practitioner over-billing.[17]

> "[I]n 1995, the Non-Insured Health Benefits dental program spent $123 million on fee-for-service dental benefits for 640,000 registered First Nations and Inuit clients across Canada. The rate of expenditure growth reached about 11% that year, while the budget allowed for only 6% growth in 1995-96 and 3% in 1996-97. The Regional Dental Officer and a working group [made up of First Nations polity and professional stakeholders] developed an alternate approach to manage the dental program known as predetermination. This approach allows the program to provide benefits in accordance with the needs of individual clients. This involves reviewing the proposed dental work for clients to ensure they do not receive unneeded dental work [and by extension limiting costs]. "[18]

This system is structured around the use of a 'Dent-29' form. This form is filled out when making a 'claim for services delivered' (or to make a 'claim for services billed'). It is also used when requesting the 'predetermination' (or pre-authorisation or adjudication) of dental benefits, this being when either a particular financial limit has been exceeded, or when seeking to provide a treatment that lies beyond basic coverage.

'Claiming for services billed' means sending the Dent-29 form to several authorities and then waiting for payment (at one point the form was in triplicate as federal, territorial, and private dental personnel required a copy). The federal government further contracts with a private claims processor to remunerate practitioners.[19] All of this is simple enough, but geography complicates matters once again. Sending forms across large expanses and through different administrations is clearly open for complication. Forms are also sent back if they have errors. Ideally, these rejected claim forms are returned to the original dentist for correction and then back to the different authorities. Yet by the time a form is processed and returned, whatever dentist is associated with the rejected claim is not likely to be in the relevant community, let alone 'up north.' This negates the possibility of examining the patient for resolution of the discrepancy, as clinicians are busy enough treating other patients (yet if contractors want to get paid, re-examining the patient is often the outcome). Many forms are rejected with no recourse for correction, inhibiting the ability for accurate and timely

remuneration, something that frustrates and angers practitioners, equally frustrating corporations that deal with this problem across several clinical providers. For example:

> ***"[I]t is a nightmare, it's a burden unto itself [...] I wouldn't be surprised if [...] 25 to 50 percent of the time used for treatment [...] goes to filling out the paperwork, and then to have it rejected a lot of the times, all those things sort of role into making people unhappy."***[20]

> ***"The biggest thing is the claims process, it takes so long to get paid, and it's so ponderous and cumbersome, that it might take four months before you get paid for what you've done. So where's the incentive? Well I mean you're there to do a job and if you're not getting paid, it's very frustrating. That's one reason why there's high turnover in providers. They can't, they can't deal with the billing system and the claim system."***[21]

As all insurance forms, the Dent-29 form requires the indication of a tooth number relative to the treatment delivered. In a geographically isolated population experiencing high levels of disease and many different providers, a commonly resulting and very frustrating problem is clearly stated by this stakeholder:

> ***"The system is flawed because number one, everything you do, that is submitted, is based on what someone else said they did before. So if ten years ago I filled out a chart wrong and called a 14 a 15 [i.e. tooth number], well the system's in error, so when I go and do the work on that 15, well they say it's already been restored, it's already been extracted. You can't do a restoration on that. Well I see the tooth in the mouth, I know what I did, so it's sort of an obstructive system."***[22]

The predetermination system also involves regulations associated with dental fees and available treatments. When dental fees were cut in 1998 and special northern premiums terminated, a $600 predetermination limit was set up, beyond which practitioners had to 'preauthorise/predetermine' treatment. For treatments listed as needing 'predetermination' (*i.e.* those that are not considered basic care within the NIHB plan), the adjudication of a claim using the Dent-29 form also became necessary. To clinicians, this meant increased frustration with newer more stringent and complicated remuneration processes:

> ***"NIHB [...] give these sort of regulations to these dentists as what they're supposed to do, and there's a fee guide so they're sort of bound by this fee guide and in that fee guide there's no health promotion or disease prevention, [they're] getting very, very sticky with fluoride treatment, I mean they reject probably 60% of the time that you do put fluoride [...] you're allowed to do it only on children 17 and under. After that you know, you cant do it."***[23]

> ***"[…] the 600 dollar pre-determination gets in the way of providing oral health care, when you have to say to someone, well I can do this much, I'm pretty sure Health Canada is going to approve it, but you don't go on [because you might not get paid]."***[24]

In fairness, one provider commented positively:

> ***"[Y]eah, it's a lot of paper work and to be honest with you as long as you know, if the paper work is explained to you properly when you first go in and if you make a very conscious effort as far as trying to fill it out, then you don't have a problem. But you know, if you're sloppy in doing the paper work and you're not doing it right, then you're not going to get paid then you get frustrated*** *[...] for the most part they're understanding, very co-operative. You know, the paperwork a pain in the ass, but you know, as long as you take the time to do it properly then I don't think there is a big issue with that.* ***And every time I've called NIHB to discuss certain issues they're very co-operative."***[25]

Nonetheless, the majority reflect impressions like these:

> ***"[I]t would help [to not see] a huge percentage of their claims rejected or having treatment plans rejected, things like that, where I feel often it is either heavy handed application of rules, rules that change in midstream where nobody really knows till you've made the mistake or until you've broken the rule then its too late, that's how you find out that the rule has changed. I mean this really pisses people off, they've already started in their minds they've already spent the money and the reasons for the changes and the denials and things are often not very clear at all so you lose good people."***[26]

> ***"The rules for payments, for procedures are very complicated, often changeable, [...] the rules change almost constantly [...] I'm really mystified by the way the government very often is surprised that there aren't dentists breaking down the door to work up there."***[27]

For clinicians, federal 'claims adjudication' has become specifically bothersome. Adjudication usually involves a federally contracted dentist in a regional centre (usually a public health dentist) hired to assess the validity of the treatment proposed. Amongst private practitioners, this raises the belief and annoyance that dentists are 'asking for permission' from a federal authority 'who isn't even there' or seen as far removed from the 'private practice setting.'

While adjudicating claims is a common third-party insurance practice, frustrations with NIHB process result from the contrast between these processes and the often-smooth transactions available through 'CDANet,' the claims-billing system developed between the dental profession and the insurance industry. CDANet functions so that most dental claim transactions can occur electronically, from adjudications (through digital

radiographs and photographs), to claiming services, to payment for those services. Dentists most often deal with a private insurance system where the idea is for transactions to occur quickly and smoothly so as to maintain quality market relations. So much so is this the case that dentists are rarely questioned as to the validity of their proposed treatment plans (in contradistinction to a federal public insurer which is attempting to limit costs). Clinicians stress that they are not so stringently adjudicated in the private system, as they are 'more trusted.'

Another critique levelled by the CDA and provincial dental authorities is the 'cumbersomeness' of the NIHB claims-billing system, and its lack of modern development (through the use of and/or link with CDANet for example).[28] While improvements have been made within FNIHB by moving towards more electronically based claims processing and remuneration, this is clearly not available in all places (such as in the great majority of Nunavut communities). Attempted improvements are not always directly relevant to all practitioners, with frustrations remaining.

A final example of problematised realities are found within the presentation of a composite case:

> ***An 11-year old girl presented for an orthodontic consultation. Accompanying the young girl was her mother. Upon clinical examination, several missing deciduous molars were noted. She had no emergent conditions and had a high level of oral health. Her mother's concern was with the crowding of her daughters' teeth. In validating the mother's chief complaint, the dentist explained how policy demanded that her daughter be re-evaluated when she was 13-years of age, as it is not until this age that orthodontic treatment can be sought from a specialist through the NIHB Program. Furthermore, her daughter must not develop any caries in this time, as she must be caries-free for a minimum of 6 months prior to seeking orthodontic treatment.***
>
> ***The mother of the patient informed the dentist that she wanted the process to start now because of her experiences with a second daughter. In paraphrasing, she expressed the difficulty of seeking and acquiring treatment in her community. Dentists visit only three times a year, and since her job entails regular travel, coordinating appointments is hard. She complained how little or no coordination existed between general practitioners, the health board and specialists due to the fact that no one 'stayed long enough to see the work through.' Thus her daughter dealt with the reality of problems that caused pain and discomfort with lapses in treatment effects due to a lack of professional support.***

This clinical encounter provides insight into current practitioner and patient frustrations. Since the costs for orthodontic treatment lies well above the $600 per year cap on dental treatment (just recently increased to $800 after pressure from the profession and ethnonationalist polity), a care-provider must apply for the 'predetermination of benefits.' For orthodontic work, this application process is supplemented with an orthodontic referral. This referral includes the making of plaster models of the patients' maxillary and mandibular intra-oral structures. When this information has been collected, the case is sent south for evaluation by a non-treating clinician. When the treatment sought is 'approved' or 'not approved,' a letter is then sent to the patient or their guardian regarding this decision. If treatment begins, appointments are arranged through the local health centre and the regional dental administrative office. A specialist contracted by the health board delivers treatment in one of three larger centres. For patients in isolated communities, this necessitates repeated travel to one of three administrative centres. Compounding this process is the inability of specialists and general practitioners to coordinate and communicate on treatment and/or deal with complications as a result of the high turnover rate of dental personnel.

In this protraction, geography--social as in the problems with the NIHB system, spatial as in the problems with isolation--clearly hampers the delivery of any type of significant or complicated treatment. Dental health consumers are in turn dissatisfied with those involved as is evident in this example. Both stakeholder commentary and the composite case confirm previous beliefs that northern dental programs experience patient and practitioner dissatisfaction, and administrative problems at the local, regional, and national levels.[29] At this point, the question begs asking: If so much of it is so frustrating,

why do practitioners continually 'go north?' Developing an answer constitutes the next section of this argument, whereby geography is seen as delimiting, maintaining and funding a significant aspect of northern dental cultural life: the 'community-minded/public health dentist' and the notion of 'community/public health dentistry.'

c. A Typology of Northern Clinicians and Practice: Adventurers, Idealists, Misfits, Mercenaries, Public Health Dentists and Public Health Dentistry, Private Practice Dentists and Private Practice Dentistry

Apart from physical and environmental limitations, geography also shapes and supports a system of professionals (within the larger profession) that constitute their practice through providing care to geographically isolated and/or socially marginalised populations (*i.e.* the socio-geographically marginalised). Not everyone chooses to 'go north,' or deliver care to poorly insured populations. Within the dental profession, these clinicians are often characterised by specific rubric: as someone who 'wants to make money,' who is 'looking for adventure,' who 'wants to help,' or who 'is escaping problems.'

When stakeholders were asked about who goes north and for what reasons, they replied:

> ***"[W]ell I would say a lot of them go for the adventure, second finance, in that it's possible to earn a very healthy income with virtually no overhead and I would say those are the two major reasons."***[30]

> ***"From my experience, in addition to going up north for the money, some dentists go up north to escape social problems in urban areas, some even think they're helping, but from my perspective the vast majority of dentists that go up north go for the monetary gain."***[31]

A long-term provider turned contractor adds more context to this:

> ***"[W]hat I see is we tend to get, you know relatively new graduates, some that have maybe struggled for a while [...] in the dental market areas that are perhaps over-served or very well served. So***

they've struggled a lot and not really made a decent living and they're still labouring under student loans. ***[We] get people that are at the end of their career and have sold their practice and are kinda knocking around looking for something to do*** *[...] they're usually bored and retirement isn't cracked up as well as it should be, and then some cases found that their income wasn't keeping them as well off as they had hoped, their retirement income. Then again,* ***there are some people that are*** *[...]* ***fairly well established and maybe they have an associate or two working for them and they wanna go for the sense of adventure*** *[...] but for the most part [...] we are getting a better selection of people now, so that we're not, I wouldn't take too many cripples and weirdoes."*[32]

Another long-term provider, turned administrator, turned contractor sums up:

"There's no rhyme or reason why someone goes and there's no rhyme or reason why someone stays. And if you look at people who stay, there's a million and one half different reasons why. Someone's running from someth... you know there's alot of dentists who don't like the clinical practice down south. There's alot of dentists who couldn't handle private practice down south, there's idealists, there's mercenaries, there's misfits, you know, it's an individual thing why someone chooses to come North."[33]

One can make several careful generalisations about who goes north and why they do. Not totalising ones, but descriptive ones that give meaning to what factors play a role in someone's decision to undertake this challenge. Stakeholder discourse points to mitigating factors such as adventure, idealism, fiscal gain, and escapism, all embodied by the categories 'adventurers, idealists, misfits, and mercenaries.' These descriptors are reminiscent of Brody's early ethnographic representation of non-Inuit northern social life, where in the 1970s, southern Canadians (some 'misfits') were seen to be 'in the north' so as to increase their financial and professional success, while concurrently experiencing a short-term adventure.[34] So much so do these capture the factors involved in why dentists go north, that most if not all of the above describe this researcher at some level: a young idealist, confused as to the direction a career should take, buying time, making decent money, exploring parts of Canada that very few Canadians ever see, and in pursuing employment through an academic institution, developing expertise as a community/public health dentist and in community/public health dentistry. It can be said that geography (as in 'going north') plays a role in grouping and selecting out some of

those clinicians that choose to deliver services to socio-geographically marginalised populations (Nunavut being one example).

In turn, care for the socio-geographically marginalised has become associated with a particular sector of Canadian dental culture: community/public health dentistry. This researcher began practicing in Nunavut through the auspices of an internship in community dentistry at a community dental department that acted as a public for-profit dental corporation. This position was by no means discrete to this researcher and this academic institution, as academic service delivery has provided significant numbers to care in isolated (predominantly Aboriginal) areas across Canada (through the use of students, professional interns and faculty). In fact, at the time this researcher delivered services, there were two other concurrent interns, an additional three from the previous graduating year, and a whole cadre of other dentists with a history of delivering services through university-based care (some now delivering services independently or through other contractors).

The importance of university-based provision is demonstrated by considering the proportion of care that they constitute. For example, a list provided by a long-term stakeholder yielded 15 names (not including this researcher's cohort of 8 to 10) that at some point within the last 20 years, held involvement with service delivery in the regions of Nunavut (through this and other academic institutions). These regions have been serviced, via these institutions, by at least twenty-five dentists over twenty years, a rate of roughly one and a quarter dentists per year.

To place this researcher's specific cohort in context, consider that the CDA recently reported "[...] that there are around 90 dentists practicing at some point

throughout the year in the three northern territories [35 resident and 55 itinerant]."[35] To gain an estimate of what the numbers are in Nunavut, at maximum capacity (that being a dentist in every community and the potentially three or four in Iqaluit, Rankin Inlet, and Cambridge Bay), the total is 33. At maximum capacity (something that never happens), roughly one third of Nunavut dentists are potentially associated with university-based care (10/33). In actuality, there is roughly a half to a full dozen dentists at any one time in the Nunavut territory, and in applying the previous ratio there should be 3 to 4 academically associated dentists. As of November 2003, this was the case, as there were 5 clinicians who were associated with this care. The provision of services in Nunavut is inexorably linked to academic institutions and the care that they offer.[36]

Geography (in the broadest sense) has provided a means for the development and actions of a 'style of care' within the profession of dentistry, insofar as community/public health dentists have played a large role in meeting the planning and clinical needs of isolated and marginalised areas. This is not to say that private practitioners have not played a role, just that the connections between academic departments, their community/public health dentists, and governmental authority (through employment, partnerships and/or contractual obligations), constitute much of the decision-making apparatus associated with the quasi-public forms of care that predominate isolated (often Aboriginal) areas (*i.e.* NIHB coverage). The *raison d' être* of public health dentistry is the management, support, and practice of public health approaches to care (for individuals and populations), and through their preventative and clinical dental programs, endorse more 'socially-leaning' forms for financing and structuring dental care[37] (*i.e.* economically accessible public care in public clinics heavily employing preventive

technologies). In observing dental care in this way, public health dentistry comes to lie in contraposition to the larger professional ideology, which views dental care as a predominantly private endeavour, where the rights of the individual in accessing care concern their freedom to choose any practitioner, and less obviously, their ability to pay within the context of a market health economy (irrespective of whether the ability to pay stems from private or public forms of insurance). Public health dentistry is part of an important and healthy tension within dental care in Canada, one that flexes in relation to the recognised need (by both public health and private practice dentists) for equitable access to basic dental care, in a system that functions as a market-based health economy yet still guarantees basic access relative to social need (to be developed in Chapters 6 and 7).[38]

Nevertheless, because a dentist travels to isolated areas in order to deliver services (and by this very fact is assumed to deliver them in a socially minded fashion) does not mean that these are the actions of a community-minded/public health dentist, let alone does it guarantee and/or establish dental public health practice. In fact, most effective public health action is muted simply by the structure of services (*i.e.* two to three week blocks of care across the year). More significantly, dental care in Nunavut is shaped by the pressing drive to respond to overwhelming need, something that is almost always constituted through the relieving of pain from infection, requiring immediate attention, making public health interventions, while more urgently apparent, (clinico)spatiotemporally and (clinico)practically irrelevant.

III. Disease Burden and Northern Dentistry

Clinically engaging an individual who has not brushed their teeth for days or weeks, that is in severe and acute pain, and that needs days, weeks, or even months of dental treatment, can at times feel overwhelming. This is significantly frustrating to clinicians who, while aiming to meet need, cannot do so under such geographic and time constraints (let alone addressing the challenge of human behaviour). In a very real sense, encountering such levels of disease and pain tears at one's humanness. To grasp at what it means to be faced with such disease burden, and to understand its role in impacting the development of care, an epidemiological and existential exploration[39] of this level of disease is now presented.

a. A Life-Course in Disease: Epidemiology and the Burden of Illness

Having such a high-level of disease is expounded upon through two composite case examples. The first will consider a 7½ year-old girl, who, on the morning of the last clinical day in her community, presented seeking care for acute pain associated with a significant mandibular swelling. The second, a 30 year-old man, who, presenting with pain across several teeth and seeking dentures, had all but two teeth in his mouth, with those remaining completely decayed to the level of the gum. In employing the general principle of clinical epidemiology (that population level knowledge of patient and clinical characteristics can be used to gain accurate assessments of prognostic realities), the earlier and later aspects of a life with poor oral health are considered.

> ***She was 7½, in clear distress, and shakily pointed to the tooth, asking for its removal. She had not slept, feverish, kept awake by a sharp hot throbbing pain that tore across her face and jaw any time she moved. The dentist proceeded with an examination, but she quickly flinched away, as any sensation would drive the shocking pain. Clinically, this was known as a 'hot tooth,' meaning that***

the tooth was so infected, sensitive, and painful, that looking at it the wrong way could make it ache. It also meant that achieving profound or deep anaesthesia could be difficult, since often, the pus produced by an aggressive infection can neutralise the effects of local anaesthetics, resulting in numerous, sometimes painful injections before full 'freezing' is achieved.

The tooth was a lower molar, perfectly shelled out by an active carious process occurring over the one and half years that the tooth had been in her mouth (the first lower molar erupts at approximately age 6). It was almost gone, only a wedge remained, the rest overgrown with tissue. Of her other 24 teeth, twenty deciduous and four permanent, her six maxillary front teeth were missing (only possibly due to exodontia), and of the remaining, most if not all required removal. This is known as 'gross decay,' and in paediatric populations, a distinct clinical and etiological entity has been causally identified, known as baby-bottle tooth decay, and more recently, as early childhood caries. Its risk factors include the use of sweetened liquids in bottles (or any other ingestion of cariogenic foods and/or liquids), parental education, socioeconomic status, and the area where one lives, ultimately associated with inequitable social practices that economically and socially isolate this little girl and her family, where access to water, sanitation, food, and education can still sadly present as a problematic Canadian reality.

This lower molar needed immediate attention and had most likely imposed several acute episodes of extreme pain and cognitive distress, and now needed significant and technique-sensitive treatments, the least of which could now potentially be a difficult extraction, as a result of the lack of tooth structure to grasp, further complicated by problematic anaesthesia. To be sure, this could prove a difficult case when one considered her age and physiologically stressed state. Tremendously, all of this was completely preventable, if only she had brushed her teeth, but things are obviously not so simple.

The fact that she rarely brushed her teeth allowed the bacteria in her mouth to multiply, creating larger bacterial communities (plaque), and in changing the local microenvironments on her teeth, resulted in disease. This process involves trillions of bacterium whose digestive by-products create an increasingly acidic environment, the acid slowly dissolving away tooth structure, the eventual end being a painful hole and a raging toothache. So regardless of whether the bacteria in her mouth thrived on her diet of soft drinks, highly processed, sticky and starchy foods, this diet still constituted the cheapest and most financially available foodstuffs in her community.

It's interesting how such a slow process ends with such a quick decision: the tooth needed to come out. Since it was the last day of the clinical visit to this community, realistically, an extraction was the only option available if a relatively immediate and sustained relief from pain was to occur. Moreover, the treatments that would attempt to save her tooth needed prior approval from NIHB. Even if this were done, at a clinical level, temporary measures to relieve her pain would likely not sustain until the next clinical visit. Furthermore, even if treatments do exist so as to maintain her tooth, these were treatments that took significant planning and execution, possibly requiring the expertise of specialists, and generally, not at all possible through the half-dozen two to three week periods (often with different providers) comprising dental care in this girl's community. In fact, these treatments would not be covered under the NIHB plan, surely not passing the adjudication process, especially considering her established level of oral care and her status as a low-attendee of dental care (which both decrease the success of treatments). The prognosis for her tooth was effectively considered poor.

Attempting anything else is said to be 'heroic dentistry,' and potentially 'crazy' on the last treatment day. Moreover, several other emergencies were already waiting, the last clinical day in any community often rushed with people seeking a last chance to relieve pain, as their next opportunity would not be for two to three months. It was not clinically conceivable to think of anything else. Now, the task at hand was to remove the tooth in the most efficient and comfortable manner possible.

Looking forward, the large amounts of acute care (through exodontia) that this girl would probably come to experience, could possibly leave her in a difficult position. For example, the ill-effects of the premature extraction of the deciduous dentition, which has been described as a 'collapsed dentition,' often leads to irregular eruption and alignment of the permanent teeth. Moreover, it establishes the increased difficulties and disabling effects associated with significant oral disease (as in difficulties in eating, socialising, and productivity).

This composite case presents as a common example of paediatric clinical presentation throughout Nunavut communities, where a child is in acute pain and the only practical treatment is exodontia. This young girl had experienced this before, and would surely again. Less obviously, this is traumatic for everyone:

> ***"[T]he hard cases are where you have, you know, the babies that come in [...] you're like well, this is what we have to do [...] we have to basically hold the child down and freeze them like we would any other patient [...] and the mom doesn't really know what's going on because I mean, the child's screaming obviously, scared. I'm sure the freezing, it doesn't feel that great [...] and just, you know, having three people holding down your baby doesn't, I don't like doing it but I mean it's better than them walking around with abscessed teeth."***[40]

> ***"The first experience I had with extracting teeth with children was, it was something that you kind of had to do and just like you know in the long run you know you're doing something really good, like you know you're helping a child out, but to physically have to restrain a child, like a two-year old child to take out their four anterior teeth, I don't know, it's not something I look forward to do."***[41]

A possible option was to access care under general anaesthesia in an OR (so as to minimise patient stress and increase ease of treatment), but this is not possible for all children, with many exposed to consistent traumatic dental encounters at a very young age. In 1999, "243 children [were] waiting for a chance to have cavity-ridden teeth pulled, filled or crowned in Baffin Regional Hospital's operating room,"[42] and in 2002, NWT hospital staff shortages stopped dental surgeries in one area.[43] Ethnographic experience speaks to the possibility of providing a constant flow of children for treatment of this kind.

This case also gives insight into how disease burden limits the clinical options one has available, simply due to the fact that some clinical procedures lie beyond the skills of general practitioners. For example, the treatment needed to restore the molar of this young girl, especially in relation to her other significant treatment needs, would ideally have necessitated global treatment by different specialists. The difficult surgical extraction needed is a good example as well, ideally completed by an oral surgeon or a

paediatric specialist with the use of intravenous sedation (so as to minimise psychological impact and decrease the risks associated with an inhaled general anaesthetic). Her needs also necessitated regular observation and maintenance, something not possible with the structure of itinerant care. Regardless, none of these treatments are covered by the NIHB plan, and if they were, would not pass the adjudication process due to the poor prognosis.

Here is a clear example of how disease burden can outweigh the ability of services to meet need. In this way, disease burden structures services insofar as the overwhelming need for complex care drives the dental system to firstly respond by the addition of more acute and complicated services (such as attempting to increase the number of OR days available or attempting to establish access to specialist care). Administrative stakeholders often comment on the emotional frustration present when called by a mother or nurse advocating for the large numbers of children or for a specific case, their first response to try and find one more OR space or less possibly, access a southern specialist.

In the face of this need, communities voice concerns about the services that they are not offered (even when medically necessary). Professional stakeholders routinely call for the addition of services, even with the knowledge that service dollars are essentially capped and with awareness that more treatments may do little to improve the situation globally. Yet when services are added, they are done so in an illogical fashion. For example:

> ***"Well, the distribution of the population clearly, and access, human resources are problematic, but I think its even more basic than that, quite candidly I think the orthodontics in the grand scheme of things is a very minor player when you think of all the other determinants of health. There are disparate priorities set by individuals. So in the absence of education, employment, nutrition, orthodontics specifically, clearly is well down the line of importance regarding health and yet it has***

taken on, for a variety of different reasons, a disproportionate importance, in terms of desir… appearen… appear to be desired services. I don't think there's any question in my mind that I would be looking for first line and, I don't want to be trite here, there are first generation questions that need to be answered and ortho is a third or fourth or fifth generation question."[44]

This stakeholder comments that these services have taken on 'for a variety of different reasons, a disproportionate importance.' These reasons may represent the initial intuitive push from community-stakeholders and practitioners (as parents and care-givers) to attempt to meet immediate need with immediate relief, and less obviously, aim for great improvements in care (*e.g.* orthodontics) even though they hold little gain in the context of basic health needs that are still not met. As further commented, it does not make sense to debate access to orthodontic care when economic access to non-cariogenic foods is still an issue. As a result:

"[P]eople are somewhat happy that […] they're getting their fillings fixed or their tooth out […] or getting dentures so they can eat. But I mean, it's […] not like we're actually, as providers we're supposed to be promoting health, which I don't think we are, we're just basically, uh, we're going in there, we're you know, we're drilling and filling and extracting and we're getting out."[45]

"[B]asically what […] I feel is going on right now is the providers are coming in […] into the communities and it's emergency clinic only. There's no real health promotion […] or disease prevention, there's no real programs in place."[46]

"You know, there needs to be a public health focus. Take the […] treatment to the population, and […] just treatment alone is not gonna get it done, I mean you have to have prevention."[47]

So as geography heavily delimits clinical options, so to does disease burden, since when faced with such need, it appears that stakeholders still place a heavy emphasis on curative care, emphasising public health intervention (and less so social legislation), yet not practicing it. This likely as a result of the immediate human reaction to relieve pain: suffering is hard to ignore.

This case example also offers insights into the tremendous consequences associated with dental pain and treatment at such an early age. From a societal perspective, the loss of time, of productive work, of productive activity in general, is

deemed immense as a result of dental pain and visits to the dentist. On the individual level, it is established as inhibiting, disabling, and handicapping. As recognised in a dental services proposal: "Poor oral health condition results in pain, suffering and loss of function and compromises infant development, learning and nutrition."[48] Further, in an environment where food insecurity makes it such that a highly cariogenic diet is the only economically viable one, inequity is quickly observed.

This is not without the recognition of other realities as well. For example, an editorial written to a major northern periodical stated:

> "Yes, healthcare in Nunavut has a lot deficiencies. Yes, Nunavut has its own particular problems due to its physical size, as well as climate. [...] [Yet] [w]e are responsible for what we eat. If we choose to persist eating foods that put us as risk for diabetes, heart attacks, cancer and high blood pressure, and smoke, why should the government subsidize this lifestyle. Children of three, four and five are still having either all their teeth pulled or capped, yet their parents continue to indulge them with pop, chips, candy and chocolate bars."[49]

In a similar vein, these statements made by an Inuit member of the Nunavut Legislative Assembly:

> "How do we balance the thoughts and feelings from the social problems [...] We can start by banning some stuff that is as bad or even worse than alcohol, smoking is one of them [...] soda pops. How many children's teeth are affected, not just teeth but their health is affected by candies and soda pops. [...] We as Nunavummiut should start looking at ourselves and say okay what causes the health risks to children and adult lives [...]."[50]

While social inequality results in much dental pain and suffering, oral hygiene behaviours appear to be so particular to the individual (not implying that they are), that people quickly blame the issue of poor oral health on the lack of individual responsibility (to be developed in Chapter 7). In returning to the case of the little girl, because she does not brush her teeth (as a result of reasons within and beyond her control), she may possibly continue her life-course in disease, and as a result, suffer immeasurably. To flesh out what can become possible, the second case is now presented.

> ***A 30 year-old male patient presented to the clinic seeking the relief of pain from several teeth and wanting dentures. Clinical examination revealed what was a perfectly preserved example of***

upwards of 30 years of dental neglect, pain, and suffering. Literally every tooth in his mouth (all but the two missing) was decayed to the gum line, that being 30 of them. All had that distinct, leathery black, partially remineralised appearance indicative of long-term decay. When asked how he could have lived with this situation for such a long time, he stated that he had never sought treatment after his first dental experience. It had been traumatic, painful, essentially terrifying.

To get a sense of what this means, if one assumes that each tooth gave him only one acute episode of pain (an assumption that is highly suspect), this means that, counting his 20 deciduous teeth along with his 32 permanent, he would have potentially experienced a total of 52 tooth aches in his 30 years.

What needed to happen clinically was now significant. Every tooth in his mouth had to be extracted. Extracted in a manner that would preserve bone in order to effectively support a functional prostheses (dentures) for many more years (considering his relatively young age of edentulism). The treatment would call for 'immediate dentures.' This involves the removal of all remaining teeth in one clinical appointment (most often involving surgical procedures by an oral surgeon or a surgically skilled general practitioner, ideally under intravenous sedation), immediately followed by the insertion of a pre-surgically fabricated denture. This treatment preserves the most amount of bone, and if done well, can significantly decrease post-operative discomfort after so many extractions and significant surgical manipulation.

Of course, this was not possible in the environment of itinerant care. So much so is this the case that immediate dentures are no longer inured under the NIHB scheme. Since the need for consistent observation and recall procedures are not often achievable in socio-geographically marginalised populations, this treatment is seen as having a very poor prognosis.

Some other clinical proposal now became necessary, especially in the context of a patient strongly desiring an expedient resolution to his situation. He wanted 'his situation settled once and for all.' Even clearer was his desire to be free of pain and in a future possibility of effective masticatory/oral functioning. He openly commented on how his situation impacted his ability to eat and his ability to socialise as a result of not wanting to smile and show his black leathery teeth. Thus his treatment regimen came to include four staggered significant oral surgery procedures under local anaesthesia, followed by a healing period that held no recourse to any mid-term follow-up as the dentist was leaving in a week. He then waited six months until a travelling 'denture team' could fabricate his dentures.

This case again presents the difficulties associated with delivering treatment in a northern context, where geography limits the provision of 'ideal treatment.' Providing 'immediate dentures' was not possible under the NIHB plan due to the poor prognosis in such an itinerant context. In the longer term, due to this patient's early start with edentulism, he would have to wear dentures for many years. This is associated with significant functional difficulties in the later future, whereby the bone that supports the denture literally 'wears away.' When considering the more traditional diet of meat (something that requires much chewing, wearing down and stressing a denture), a future with dentures can prove dissatisfying to the wearer. For example:

> ***"[Y]ou have a population that's, the edentulous rates or partial edentulousness is quite high, and given that dentures can need special attention, especially people who eat a country diet, the denture service, one denture every eight years is not, is not realistic."***[51]

> ***"[Y]ou know country food, I mean, a patient or client who eats country food, is not, is not the best client to have a complete denture because a complete denture can't even approximate normal teeth for chewing. So, I mean that's the whole idea, if you can prevent it, because it's what we have to do to restore function, for, for Inuit is not the same, we, we can restore function easier for non-Inuit clients because of the diet that they eat, whereas if someone's eating country food, it's harder to get them back to where they're satisfied with the prosthesis."***[52]

These comments reflect how such a burden of illness and/or gross level of disease can impact the outcome of care, viz. the possibility for a successful and functional prostheses.

This case study also points to the tremendous existent realities associated with a life of toothaches. In this man's 30 years of life, a minimum of 52 toothaches were expected to have occurred, let alone all the other acute exacerbations associated with carious processes and tooth infection (*e.g.* recurring acute periods of infection and severe pain, sharp jagged edges of teeth that cut the inner oral structures, pain on eating, pain on opening one's mouth in the cold wind or when drinking hot tea, loss of productivity, not wanting to smile, amongst other individual and social impacts). As a potential future for a little girl, this remains socially unacceptable.

IV. Conclusions

With composite case examples, this chapter established how both geography and the current level of disease in Nunavut communities delimit the possibility of positions and practices that stakeholders can enact, ultimately impacting what treatment is possible and the success of those treatments. Chapter 5 now turns to another challenge, the role of Indigenous (Inuit) Self-Determination in delimiting the development of dental services in Nunavut.

[1] **Government of Nunavut** (2001) "Premier Okalik strengthens ties with Manitoba." Press Release October 25; **Government of Nunavut** (1999) "Manitoba and Nunavut Premier Discuss Long-term Cooperation Goals." Press Release November 22.

[2] **Legislative Assembly of Manitoba** (2001) "Ministerial Statements: Nunavut Ministerial Visit." Hansard of the Province of Manitoba Legislative Assembly. Winnipeg: November 26 [underline mine].

[3] This is an important aspect of Inuit self-determination, as it is this very thing that Nunavut is attempting to remove itself from, viz. dependence on the south. As an ideal, Nunavut wants to provide their own staple of professional caregivers and administrators. This is evidenced through provisions in the NLCA that guarantee education and training, and attempt to improve and/or guarantee Inuit involvement across most sectors, all trying to improve and maintain local resources and capital (material and human).

[4] Apart from a single Inuit dental therapist, there appears to be no other dental professional of this background. Positively, northerners are interested in the profession, as is evident in the article **Kearsy T** (2002) "The future of Northern dentistry: Three high school grads plan to return as dentists." Northern News Service July 03. Attempts at attracting and maintaining a substantial flow of northern professionals have not proven overtly successful. See for example **Hardwick F and Schwartz A** (1999) External Review of the Dental Therapy Program of the Saskatchewan Indian Federated College National School of Dental Therapy. Ottawa: Health Canada Medical Services Branch.

[5] **Dental Manual** (c. 1999) Untitled. Produced by a community/public health dentist and provided to clinicians of university-based care.

[6] **Dental Manual** (c. 2000) Nunavut Dental Manual. Produced by a community/public health dentist and provided to clinicians of university-based care.

[7] **Ibid.**

[8] **Present Provider** (2001) Personal Interview. Winnipeg, Manitoba. June 11.

[9] **Past Provider, Past Private Administrator, Present Public Administrator** (2001) Personal Interview. Toronto, Ontario. December 12.

[10] **Present Provider** (2001) Personal Interview. Winnipeg, Manitoba. August 23.

[11] **Present Provider, Present Private Administrator** (2001) Personal Interview. Toronto, Ontario. April 16.

[12] **Present Provider, Present Private Administrator** (2001) Personal Interview. Winnipeg, Manitoba. June 27.

[13] **Present Provider, Present Private Administrator** (2002) Telephone Interview. Winnipeg, Manitoba. July 28.

[14] This particular point becomes very important when considering how disease burden delimits care. As will be argued, when faced with so much need, the initial response by those involved is to increase and/or improve access to curative services. This, even though public health intervention and social legislation are understood and recognised as a more effective tool when aiming for long-term sustained improvements in health across populations.

[15] **Present Provider, Present Private Administrator** (2001) Personal Interview. Winnipeg, Manitoba. June 27.

[16] **Past Provider, Past Private Administrator, Present Public Administrator** (2002) Personal Interview. Winnipeg, Manitoba. July 02.

[17] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada. In this chapter, the Auditor General directly refers to both the 'over-servicing of dental care providers' and the 'over-billing of services by providers.'

[18] **Treasury Board of Canada** (1997) Description of Dental Program Redesign Initiative for Health Canada. Ottawa: Treasury Board of Canada.

[19] Insurance companies that have taken on this contract include Blue Cross, Liberty Health, and First Canadian Health.

[20] **Past Provider, Past Private Administrator, Present Public Administrator** (2002) Personal Interview. Winnipeg, Manitoba. July 02.

[21] **Past Provider, Past Private Administrator, Present Public Administrator** (2002) Personal Interview. Winnipeg, Manitoba. August 01.

[22] **Present Provider, Past Public Administrator** (2002) Personal Interview. Toronto, Ontario. April 17.

[23] **Present Provider, Present Private Administrator** (2001) Personal Interview. Winnipeg, Manitoba. June 27.

[24] **Past Provider, Past Private Administrator, Present Public Administrator** (2002) Personal Interview. Winnipeg, Manitoba. August 01.

[25] **Present Provider, Present Private Administrator** (2002) Telephone Interview. Winnipeg, Manitoba. July 28.

[26] **Past Provider, Present Administrator** (2001) Telephone Interview. Winnipeg, Manitoba. August 16.

[27] **Past Provider, Present Administrator** (2001) Telephone Interview. Winnipeg, Manitoba. August 17.

[28] **Canadian Dental Association** (2001) "NIHB Dominates Discussions with MPs." Communiqué May/June. Ottawa: CDA; **Canadian Dental Association** (1999) "Efforts to Improve NIHB Continue." Communiqué July/August. Ottawa: CDA.

[29] **Milnes A, Rubin C, Karpa M, Tate R** (1992) "A retrospective analysis of the costs associated with the treatment of nursing caries in a remote Canadian Aboriginal pre-school population." Community Dentistry and Oral Epidemiology 21: 253-260; **Messer J, Forgay M, Clovis J, Graham B** (1991) "A collaborative approach to developing dental health resources for Northern communities." Arctic Medical Research 50(Supplement 5): 666-667; **Messer J** (1991) "The effect of non-insured health benefits on dental treatment provided in four coastal Labrador communities by salaried dentists." Arctic Medical Research 50(Supplement 5): 662-663; **Davey K** (1988) "Primary Dental Care in Canadian Arctic Communities." Arctic Medical Research 47(Supplement1): 562-563; **Mayhall J** (1984) "The Oral Health of the First Residents: Who's in Charge?" Arctic Medical Research 38: 431-435.

[30] **Past Provider, Past Public Administrator** (2002) Personal Interview. Winnipeg, Manitoba. August 30.

[31] **Past Public Administrator** (2002) Personal Interview. Ottawa, Ontario. June 02.

[32] **Present Provider, Present Private Administrator** (2002) Personal Interview. Winnipeg, Manitoba. February 3.

[33] **Anonymous** (2002) Personal Interview. Winnipeg, Manitoba.

[34] **Brody H** (1975) The People's Land: Eskimos and Whites in the Eastern Arctic. Harmondsworth: Penguin.

[35] **Canadian Dental Association** (2001) "CDA Forges Ties With Northern Dentists." Communiqué September/October. Ottawa.

[36] The University of Manitoba's dental faculty is the premiere example. This institution has upwards of a 20-year history in the delivery of dental services to isolated and marginalised southern and northern (Aboriginal and non-Aboriginal communities). While other dental faculties also have established histories with marginalised sectors in their outreach and community dentistry capacities, no other faculty does it on such a large scale, and in this sense the University of Manitoba is recognised as a leader across Canadian dental faculties in this regard. **Canadian Dental Association** (2002) "The Flying Dentists: Manitoba's Outreach Program Serves Remotest Areas." Communiqué November/December. Ottawa.

[37] In a letter to the Honourable Roy Romanow (commissioner of the most recent Royal Commission on Health Services in Canada), The Ontario Association of Public Health Dentistry (likely the most powerful public health dental organisation in Canada) raised significant concerns about the commission's report and its clear lack of inclusion regarding oral health care issues. In raising its central issue of inequitable access, the letter recognises the support and common position held by such agencies as the Emergency Nurse Association of Ontario and the United Way (amongst others). **Ontario Association of Public Health Dentistry** (2003) "Letter to the Honourable Roy Romanow." OAPHD Hamilton, Ontario. February 24.

[38] An analysis of professional ideology will be developed further in Chapter 7. Contraposition does not mean opposition. While there are ideological differences, both public health dentists/social forms of care and private practice dentists/capitalist forms of care are governed by a profession with significant cohesion and cooperation. As one stakeholder has commented, dental care in Canada 'is what it is:' a non-insured service as per the Canada Health Act, to be accessed in the private market health sector (supported by government through the negotiation of a professional monopoly and supplemented with governmental practice for the insuring of populations). These ideologies cannot be considered in isolation, as each house aspects of the other, or more accurately, they constitute a range that can define Canadian dental ideology.

[39] 'Existential exploration' means that the episodes of pain (i.e. toothache) associated with infected teeth will be presented as a measure of the amount of experience one has with suffering and its epidemiologically-demonstrated existent results, viz. inability to eat, problems socialising, psychic stress, loss of time of productive time, amongst others.

[40] **Present Provider, Present Private Administrator** (2002) Personal Interview. Winnipeg, Manitoba. February 3.

[41] **Present Provider, Present Private Administrator** (2002) Telephone Interview. Winnipeg, Manitoba. July 28.

[42] **MacDougall C** (1999) "Tooth trouble: Northern children's dental health a 'crisis,' say dentists." Northern News Service November 22.

[43] **Pickford P and DaCruz M** (2002) "Summer halt to dental surgery in Hay River: Staffing shortages at H.H. Williams Memorial Hospital." Northern News Service June 24.

[44] **Anonymous** (2001) Telephone Interview. Winnipeg, Manitoba. August 26.

[45] **Present Provider, Present Private Administrator** (2001) Personal Interview. Toronto, Ontario. April 16.

[46] **Present Provider, Present Private Administrator** (2002) Telephone Interview. Winnipeg, Manitoba. July 28.

[47] **Present Provider** (2001) Personal Interview. Winnipeg, Manitoba. June 11.

[48] From a proposal for dental services provided as private data.

[49] **Fisher K** (2002) "Individuals are responsible for their own health." Letter to the Editor. Nunatsiaq News December 06.

[50] **Legislative Assembly of Nunavut** (2001) "Member Statements." Hansard of the Fourth Session of the Legislative Assembly. Iqaluit: December 4.

[51] **Anonymous** (2001) Telephone Interview. Winnipeg, Manitoba. June 02.

[52] **Present Provider** (2002) Telephone Interview. Toronto, Ontario. February 23.

Chapter 5. Indigenous Self-Determination

I. Introduction

This chapter demonstrates how Indigenous self-determination[1] acts as a delimiter in the development of dentistry in Nunavut. Colonialism, ethnonationalism and the creation of Nunavut are briefly developed, paying close attention to the emerging reality of Nunavut governance, whereby a public territorial government combined with a quasi-public/quasi-private ethnonational entity are to rule as 'self-government through public government.' Both a public and Indigenous government, Nunavut is structured to enhance and promote Inuit ideological forms and control over services, bringing forth policy with the definite agenda of shaping the way care is thought of and delivered. Key examples include the incorporation of Inuit Qaujimajatuqangit (IQ),[2] the enactment of the Nangminiqaqtunik Ikajuti Policy (NNI),[3] and attempting to constitute all human resource sectors as representative of the population (roughly 85% Inuit, 15% non-Inuit). Education and training initiatives across health care, education, public administration, and resource management (amongst others), as well as the creation of new health structures (*e.g.* 'Community Wellness Coordinators') and the reinvigoration of older ones (*e.g.* CHRs, CHCs), are all setting the stage for increased Inuit control.

Significant today is Inuit self-determination and its intersection with the NIHBs, and in kind, with the modern competition for dental contracts. Advancing cultural self-determination has allowed for much complexity in stakeholder relations (territorial, ethnonational, federal, professional), especially so with the particular historical/political relationship between Inuit and the Federal Crown. At the Nunavut Government level, this complexity is expressed in the financing and the delivery of the NIHBs (with debates

essentially turning on the question of responsibility for these services). In terms of the competition for contracts, since competition is constituted through the market of governmental contracting, and since Inuit self-determination has developed in an environment where local economic and business interests are generally favoured in attempts to enhance local, regional, and ethnic control, an Inuit-majority resident private for-profit dental corporation would do much to realign competitive power dynamics. These shifts in power hold a fundamental capacity to impact the delivery of dental care in the Nunavut regions. For example:

> "[In] April 1997 [circa the rise and fall of Kiguti] - Dental Therapy services were withdrawn from the region. Dental Therapists were planned to be replaced by Dentists. The numbers of dentists never reached a level to replace the services provided by dental therapists. Our children were left without dental care for two school years in most communities. "[4]

This firmly places Indigenous self-determination in the present and future 'positions and practices' of this political economy.

II. Colonialism, Ethnonationalism, Nunavut, and Northern Health Care

a. Colonialism

In the medical social sciences, developments in the Canadian North are often considered in relation to two diachronic processes: colonialism (federal impositions) and ethnonationalism (resistances).[5] As Dacks stated in 1981, "the North can be studied as a society [...] but it can only be understood as a colony."[6] Even though much has changed in the relations of power between Inuit and the State, the basic struggles echoed in Dacks' statements (between a centralised and peripheral authority) are evident today.

For example, Nunavut is perceived as a politically independent Canadian Territory (acting as a form of Indigenous self-government), yet it is still very much

dependent on centralised authority and power, taking direction from federal programming and intervention, and basically acting within the limits of federal monetary and policy transfers. Administrative interactions are in fact situated in a roughly 200 year-old legislative framework that guides the delivery of services to Aboriginal populations. Responsibilities and decision making authority often settle at the federal level, evidenced in a recent NWT Government study reappraising its health governance after the separation of Nunavut, where 25 Federal Acts, countless associated regulations, ministerial directives, contribution agreements, and memorandums of understanding, are all tied to its health and social services delivery.[7] Arguably, the same holds for Nunavut.

Most critically, in all of Nunavut's budgets, over 90 per cent of revenues flow from federal coffers, this representing the truest barrier to independence and sovereignty (whether under Indigenous control or not). As long as the territory remains "the most fiscally dependent jurisdiction in Canada,"[8] Nunavut will constitute through a modern colonial situation.[9] While dependence has defined a history, change is a constant, the rise and continuing efforts of ethnonationalism doing much to redefine this relationship, with the formation of Nunavut being a salient example of social change in ideology and structure.

b. Ethnonationalism and the Creation of Nunavut

The Federal Government did not take an earnest interest in the pre-regions of Nunavut until the mid twentieth century, the main northern sociopolitical forces then being the Church, the Hudson Bay Company, and the Royal Canadian Mounted Police.[10] With the entrance of American soldiers, the Canadian State's "minimalist northern presence gave

way to active intervention, replete with social engineering plans for aboriginal societies."[11] Sedentarisation was at points forceful and coercive, seen as a necessary step for the improvement (and/or attempted Westernisation) of Inuit populations. Believing that Inuit could take greater advantage of social assistance, pensions, health services, education and housing, they were still nonetheless integrated into the North American wage economy, forced into welfare dependency, and grouped as a colony, with no role in politics or government.[12]

In parallel to this lay the development and social rise of a politically astute Indigenous sector, moving to change then current power relations. Occurring within the greater 'socialist' and/or 'leftist' mobilisation of the 1960s, concern over the processes of government (relative to war, social inequality, justice, *et cetera*) sparked debates at all levels. In this case, the debates centred on those governing processes and (sometimes brutal) activities of the Canadian State with its Indigenous populations.

The Hawthorn Report represented an early step towards socially perceiving crisis in Indigenous Canadian life.[13] The report was the first comprehensive survey conducted on the living conditions of Indian reserves, demonstrating destitute material conditions and inequity, recommending a shift away from the historical dependence of Aboriginal people and from the management efforts of the Canadian State in relation to them. Hawthorn observed 'economic development' as the key for improving social conditions. It can be argued that this message was heard, 'economic development boards and/or corporations' becoming strongly supported by future governmental policy. Less obviously, positive change and impact in Aboriginal life was closely situated to the

corporate gains of such institutions. The detailed relevance of this fact is developed throughout this work.

The impetus for sociopolitical change came in 1969, with the Federal Government's release of a 'White Paper' outlining its direction for an Aboriginal social policy. Authored by Pierre Trudeau's Liberals, centralised authority proposed to repeal major federal legislation, terminate governmental structures associated with Aboriginal life, and incorporate Aboriginal people into the fabric of Canadian 'multi-culturalism' on an individual basis (also shifting responsibilities to other authorities).[14] The response of Indigenous Canadians and their supporters was to change the face of Canadian domestic polity and politic forever.

Aboriginal groups across Canada began a process of systematic resistance, political organisation and political action, all aiming to gain control over the processes that governed them. This is 'Indigenous ethnonationalism,' whose goal is to "represent the interests of their people in the courts and legislatures of Canada [and] recast the institutions responsible for structuring the relationship between Aboriginal communities and Canadian society in a way that [will] recognise Aboriginal cultural principles, including community autonomy."[15] Then often described as the 'Eskimo Brotherhood' (in parallel to the 'Indian Brotherhood'), Inuit leaders created the Inuit Tapirisat of Canada (ITC), now the Inuit Tapiriit Kanatami (ITK).

The excitement and charge of this time is heard in statements made at a 1971 political gathering:

> "At this very moment there is need for a close look at our own situation in our communities, because in the past only the government has been handling our affairs. During the early stages when the government first came into our communities, it was quite all right for them to look after our own problems, administration, and so on. In the past there was nothing bothering us, but right now at this very moment there is something interfering with us Inuit. Our culture is still here, but in the near

> future it is not going to be the same as it used to be. If this continues too long from now into the future, there won't be any power left in us. The white people will be just overflowing our culture and there won't be anything left that we can do if it continues this way. But if we say right now that we want the government to handle our problems, our affairs and our lives, we will never be able to do things on our own, like decision-making, if we let the government continue to look after us. So we have to find an organised voice amongst ourselves so we may direct our lives the way we want them to be. Maybe we should have something like an Inuit organisation. Right now is the time to act so we may control ourselves in the kind of life we would like to have in the future. It is for these main reasons I think we are here at this very moment."[16]

In response to countless politically and emotionally effective messages, federal authorities began a process of land claims negotiations with all who were willing. Their goal was twofold: to provide clarity on the notion of Aboriginal rights and land title, and to minimise and/or settle conflict in areas of economic potential.[17] In 1974, the Federal Government announced that it would provide funds for ethnonational organisations (such as ITC) to conduct research into the recognition of Aboriginal rights, especially as these rights applied to their territory and its resources.[18] The State was steadfastly beginning the modern concretisation of its special fiduciary relationship (of responsibility) with Indigenous people.

Between 1976 and 1979, ITC presented the Federal Government with three distinct versions of a lands claim. Inuit affirmed that the settlement of a comprehensive claim would "set out and enshrine Inuit use of their lands and would compensate them for past and future use of lands by non-Inuit [and] a new government in the eastern and central Arctic with capacity to protect and foster the Inuit language, culture and social well-being."[19] In 1982, the Tunngavik Federation of Nunavut (TFN) was incorporated to pursue land claims negotiations on behalf of the Inuit of Nunavut, taking their mandate from ITC (TFN also acting as an 'economic development corporation').[20]

Negotiations between the Federal Government and Inuit were often strained, Federal officials not readily accepting the ethnonational demand for a separate Nunavut

territory, consistent in their reluctance to sign a land claims document that included such a clause (let alone a formal statement on the right to self-government).[21] Negotiations continued throughout the 1980s and "bit by bit, sub-agreement by sub-agreement, a comprehensive land claims settlement was put together."[22] What remained unanswered was whether Inuit would accept a settlement that did not include a self-governed territory.

The Conservative Brian Mulroney government (who followed Trudeau's Liberals) was not convinced either. Then the Mohawk Nation uprising at Oka, Quebec in the summer 1990 provided a political opportunity that was not wasted. These events (a community's resistance to the building of a golf course on traditional lands) resulted in violence and State military intervention, reverberating around the world. With new political pressures on the Federal Government as per the launching of Canadian-Aboriginal relations on the national and international stage, a compromise with Tunngavik Federation of Nunavut was quickly sought to ease tensions.

By 1992, the Federal Government and TFN had agreed upon the formation of Nunavut and had signed the Nunavut Political Accord (NPA), laying the foundation for the guaranteed development of a new Canadian Territory. In June 1993, the NLCA was ratified by Parliament through the *Nunavut Land Claims Agreement Act*. Immediately after, the *Nunavut Act* was ratified, setting into motion the creation of the Nunavut Territory and Government. With this legislation, Inuit were recipients of a 'modern day treaty,' one entrenched under the *Constitution Act* of 1982 (see Tables 4, 5 and 6).

Table 4. Preamble to the Nunavut Land Claims Agreement[23]

To provide for certainty and clarity of rights to ownership, use of lands and resources, and of rights for Inuit to participate in the decision-making processes concerning the use, management and conservation of land, water and resources.
To provide Inuit with wildlife harvesting rights and the right to participate in the decision-making processes concerning wildlife management.
To provide Inuit with financial compensation and means of participating in economic development.
To provide Inuit with the means for self-reliance and social well-being.

Table 5. Major Provisions of the Nunavut Land Claims Agreement[24]

In exchange for the rights and advantages obtained by the agreement, Inuit will cede, release and surrender all their aboriginal claims, rights, titles and interest to lands and waters anywhere within Canada.
Capital transfer payments of $1.148 billion to be paid over a 14 year period and administered by the Nunavut Trust on behalf of Nunavut Tunngavik Incorporated (NTI), the successor organisation to TFN.
Rights and advantages regarding government employment (Article 23), government contracting (Article 24), shares in the royalties of non-renewable resources, amongst others.
Inuit will have collective title to 353,610 square kilometres of land, roughly 18% of the Nunavut Settlement Area (NSA), of which 36,257 square kilometres includes subsurface mineral rights.
Priority rights to harvest wildlife for domestic, sport and commercial purposes throughout the lands and waters of the NSA.
The agreement creates and puts into place five co-management boards known as Institutes of Public Government (IPG) that work with government but are not part of it. These IPGs will have representation from NTI, Regional Inuit Organisations (RIO) and from the Government of Nunavut. They are: 1. the Surface Rights Tribunal, which levies and establishes compensation from developers regarding surface rights, 2. the Nunavut Wildlife Management Board that oversees wildlife harvesting and management, 3. the Nunavut Planning Commission that is responsible for land use planning, 4. the Nunavut Impact Review Board, which conducts environmental and socio-economic reviews of development proposals, 5. the Nunavut Water Board that concerns itself with water management. As well, a Nunavut Social Development Council (NSDC) was established, which promotes the principles and objectives of government obligations regarding cultural and social matters (Article 32). There also exists the notion of a Designated Inuit Organisation (DIO), which describes NTI and all entities that act in relation to the Act. Furthermore, NTI has the power to designate the status of DIO to any organisations that functions to fulfil the 'power, function or authority' of the Act on behalf of NTI.
The government of Canada will contribute $13 million for the education and training of Inuit specifically targeted to build capacity in regards to the implementation of the NLCA.
A commitment to create the new political territory, Nunavut.

Table 6. Important Features of the Nunavut Political Accord[25]

The Nunavut territory begins on April 1st, 1999.
The political power of Nunavut will be equal to that of the NWT.
The laws of the NWT will apply to Nunavut until such time as they are modified or changed by Nunavut.
The creation of a ten member Nunavut Implementation Commission (NIC) that will plan the political structure of Nunavut.
The Government of Canada will pay the costs associated with creating and implementing the Nunavut territory.
The education of the Inuit of Nunavut will be a priority so as to maximise capacity for future government employment as well as to take advantage of the economic opportunities associated with division of the NWT.

The Inuit of Nunavut were now achieving legislated control over the daily processes of a government that for over 50 years had functioned independently of their participation, with the creation of NTI and IPGs being a major step. In a strict legal sense, these co-management bodies are advisory in nature, only making recommendations to government. In practice, they can and are supposed to act as

powerful institutions in the decision-making chain.[26] NTI is of particular relevance, the main self-governmental ethnonational in parallel with the public Nunavut Government (in their dual role as an Indigenously self-governed public government). NTI "wields a unique blend of political and economic power as it promotes the rights of – and manages the responsibilities of – its beneficiaries."[27] Unlike other ethnonational organisations, NTI represents an overwhelming majority of the population within its region, "[i]ndeed, nowhere else in Canada does a non-governmental organisation exist with anything that even begins to approximate the clout and legitimacy that NTI carries in Nunavut."[28]

A high priority was to establish a framework to manage relations between the Government of Nunavut, IPGs, and NTI (and to a lesser extent RIOs, DIOs, and other Inuit organisations). Nunavut Premier Paul Okalik and then current President of NTI Josie Kusugak signed the framework several months after the creation of Nunavut. The Clyde River Protocol (CRP) "[outlined] in broad terms the two organisations' understanding of their respective spheres of influence, the importance of respecting and consulting one another on areas of mutual concern and the communications processes to achieve co-operation."[29] Relations between and within both groups have, at times, proven difficult, as one could expect four years into a new governance process.

The Nunavut Government also drafted 'The Bathurst Mandate,' setting out the 'priorities, principles and objectives' for the government relative to the NLCA. This document outlines how 'Nunavut needs to provide options and opportunities in order to build [the] strength of individuals, families and communities.'[30] Importantly, 'the value of teaching and learning shall be acknowledged at all levels and from sources inside and outside Nunavut communities.'[31] The Bathurst Mandate also establishes a vision of how

Nunavut should exist by the year 2020, being a place where Nunavummiut have opportunities available to them within revitalised and healthy communities.[32] If anything, Inuit have laid a rich ideological and structural base to continue gaining control over the processes that govern them as a Canadian population.

c. Self-Government Through Public Government

The idea that a public government can act as a form of Indigenous self-government has immanent political economic consequences: how is this government to look and function? While a consideration of 'self-government through public government' as a mode of self-government lies well beyond this investigation, it is important to understand that this model has led to particular confusions.[33] For example, Tester argues that since Nunavut is seen and promoted as a form of Indigenous self-government (as represented in a public territory), funding and program cuts are now not as easily contextualised by Inuit polity as discrimination based on race, or on the need established by colonial inequity. Is it not true that Nunavut has formally addressed this issue in the settlement of a lands claim, and in the enactment of a State supported 'Inuit self-governing public government,' or a 'self-governing Inuit public government' (whatever the case may be). The ability for clear ethno-political responses aimed at improving the health and welfare of Nunavummiut can be degraded.

As Tester notes, the boundaries between institutional realities have become blurred, whereby 'being Inuit' and the rights contained therein (as in ethnonational institutional representation) are sometimes conflated with 'public governance.' So debates surrounding the former are now possibly swallowed in debates surrounding the

latter. Irrespective of this blurring (and of final political significance), the fact remains: Nunavut is not 'by rule' an 'Aboriginal government,' it is a public Territorial Government. Even though the very idea of Nunavut ensconces cultural and political self-determination (sometimes potentially muffling its political capacity), there also exists the great capacity for federal authorities to officially, yet artificially, bracket out this fact (when negotiating for federal transfers for example).

Politically, all of this may not be a disadvantage for Inuit polity, as it is well within their rights to point to the treatment of Nunavut as reflective of discrimination based on its status as an Indigenous self-government. Ethnonational authorities also continue to maintain significant discourse related to discrimination and their status as Indigenous Canadians, seeing self-governing structures like Nunavut as one mode of reparation for this discrimination, a discrimination that nonetheless continues.

The blurring or blending of institutional realities extends out of a history of social and economic development policy that has done very much the same thing. Indeed, the central recommendation of the Hawthorn Report called for 'economic development' to improve social conditions, conceivably interpreted in part through the creation of what Whittington describes as 'ethnonationalist capitalist organisations' or 'native economic development corporations.'[34] Whittington provides a useful framework for understanding ethnonationalist corporations, distinguishing between them in terms of their 'sectoral focus' (whether renewable or non-renewable), their 'investment mix' (between capital- and labour-intensive enterprises), and their 'philosophical' approach (whether institutional or entrepreneurial). Ethnonational corporations are involved in such sectors as resource entrepreneurialism (*e.g.* Nunavut RIOs and their role in mining

and natural resource development) and basic level industries (*e.g.* Nunavik's Makkivik Corporation and its stake in northern air travel, NTI and its stake in petroleum products and northern shipping), and/or act as investment corporations (*e.g.* the Nunavut Trust). In Nunavut, one even observes the notion of a 'birthright corporation,' an ethnonational created from NLCA funds, in their capacity across many capitalist sectors aiming for corporate success and the improvement of life for Inuit beneficiaries.

These corporations are also conceived as a form of governance (*i.e.* the blurring and blending). While NTI and RIOs are all 'private sector operations,' their roles and actions are a legitimated part of Nunavut's public governance dynamic. They act in a public manner insofar as they are part of the ethnonational governance arm of Nunavut, ruling over an Inuit citizenry interest through developments in population planning and programming efforts (*i.e.* control over services), ultimately structured as private forms with essences as corporations, trying to increase revenues for Inuit shareholders. What was originally the conflation of economic and social development is now the routine conflation of Indigenous governance (in a public sense), control over services (through governance, programmatic, and corporate activity), and Indigenous regional capitalist economies (that play a role in governance and providing services).[35] Put another way, Indigenous social and economic development (through 'self-determination and self-government') has been tied to Indigenous success in the capitalist marketplace (through 'self-determination and self-government'), as represented in these corporate/governmental (quasi-private/quasi-public) ethnonational entities. In a continuation of O'Neil's structural representations, this corporate self-determined control is now considered.

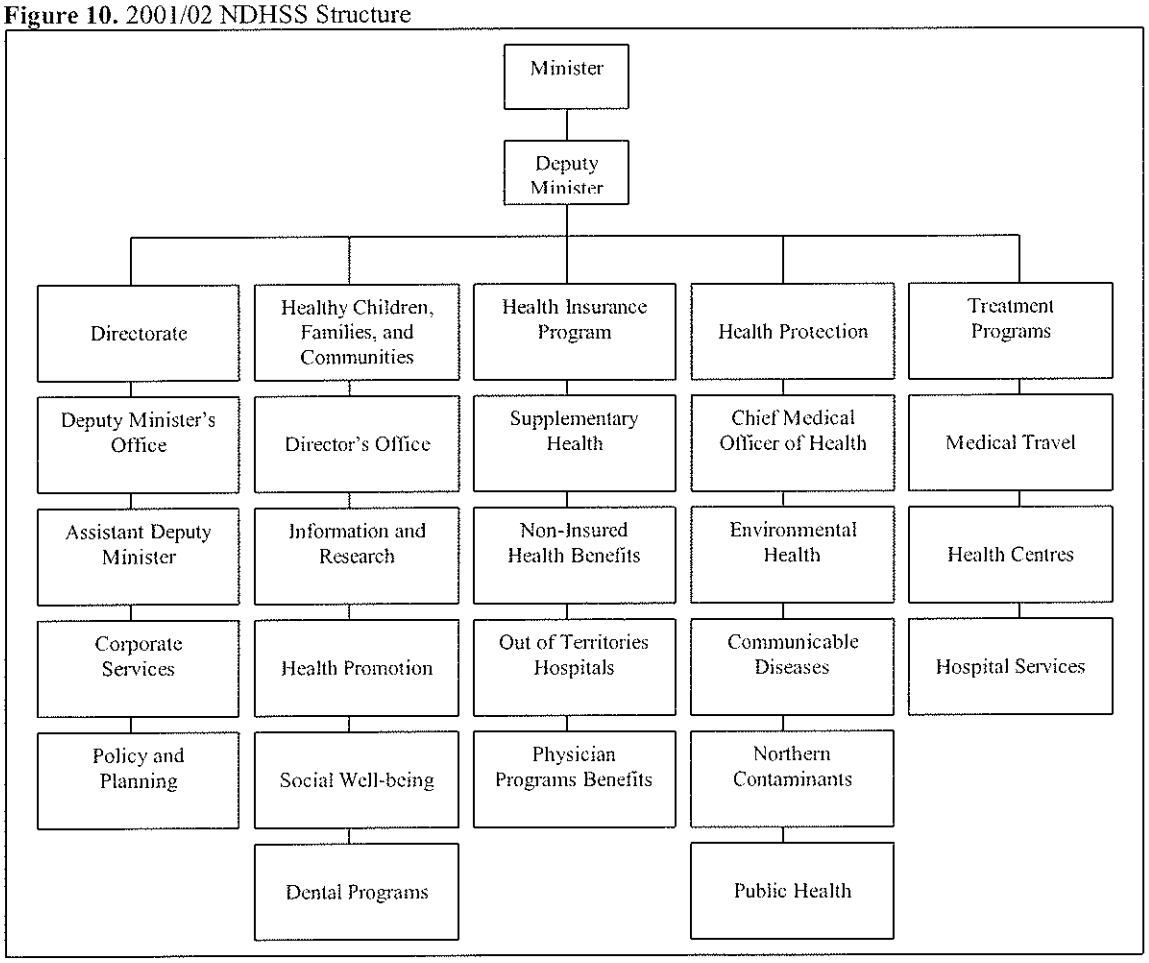
d. The Power in Structure

Early on, Inuit ethnonationalism (and/or the push for self-determination) was active on several fronts. There were Inuit polity that settled the historical land claims agreement and established a Nunavut territory (through the work of TFN). There were Inuit polity that aided and developed the establishment of a responsible and representative NWT government (through representation in the old NWT Legislature and in pressure for the devolution of control over services to the old NWT Government).[36] Often not considered were Inuit polity constituting in sectors such as health policy advocacy (*e.g.* Pauktutiit - the National Inuit Woman's Organisation, NIICHRO - the National Indian and Inuit Community Health Representative Organisation), and in other organisational structures with varied interests (*e.g.* ICC - the Inuit Circumpolar Conference). Due to the numerous modes by which self-determination processes actuate, there is a complex structural existence in Inuit power and influence over northern political economies. Political economies that, as per the previous description of the NLCA and NPA, extend across many sectors, broadly characterised as administrative, governmental, non-governmental, ethnonational, public, private, and business (in this case 'health and social services').

As described in Chapter 3, both O'Neil and Weller prognosticated on the future of a Nunavut power/governance structure. Tester discusses these scholars' future considerations, demonstrating how their inferences did not come to be.[37] What resulted was the creation of a single NDHSS, and (as proposed by Tester and supported by this researcher) a social dynamic where federal cutbacks and regional/local business interests aided in the establishment of less Inuit and/or ethnonational control over services.[38]

Yet the idea of Inuit control is still very much alive and present. For example, the term 'Inuinisation' has entered the Nunavummiut lexicon.[39] As explained to this researcher, Inuinisation refers to the attempts of Inuit organisations and individuals at control over traditionally colonial structures such as education, housing, and health care. These efforts translate pragmatically into dual approaches: the placement of political pressure on government as a result of the NLCA so as to influence and shape policy, and the concerted efforts of Inuit to gain employment in local and regional structures (the goal of both to provide avenues for substantial self-determining control).

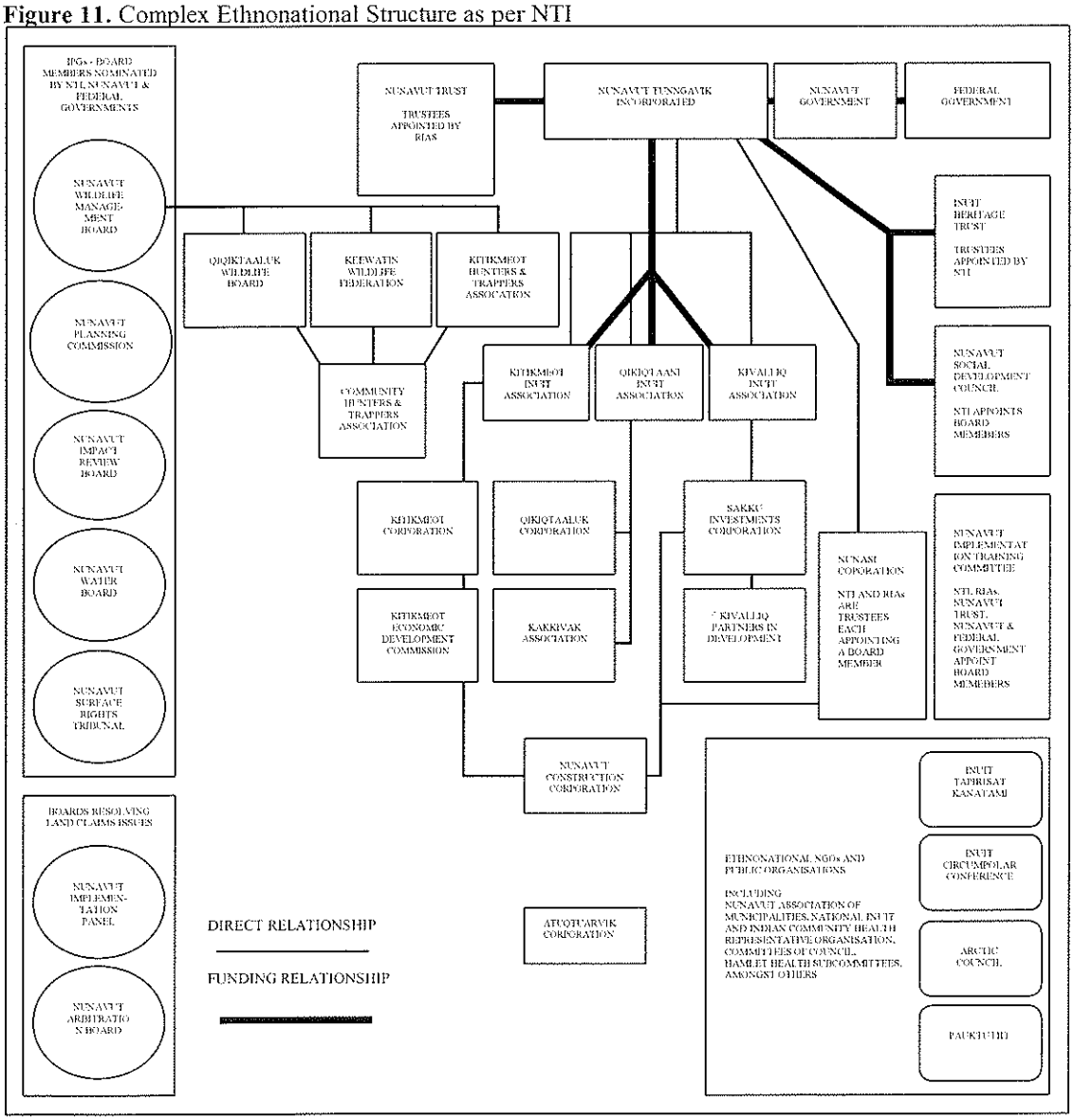
Figure 10. 2001/02 NDHSS Structure



The current governmental/power structure is represented in Figures 10, 11, 12, and 13. Figure 10 is the 'public' structure as outlined by the 2001/02 NDHSS budget.[40]

Of particular importance to this study are the divisions of departmental sections that deal with the NIHBs. This includes all or some portion of the Medical Travel, Non-Inured Health Benefits, and Dental Programs sections (their financing and structural details are considered later).

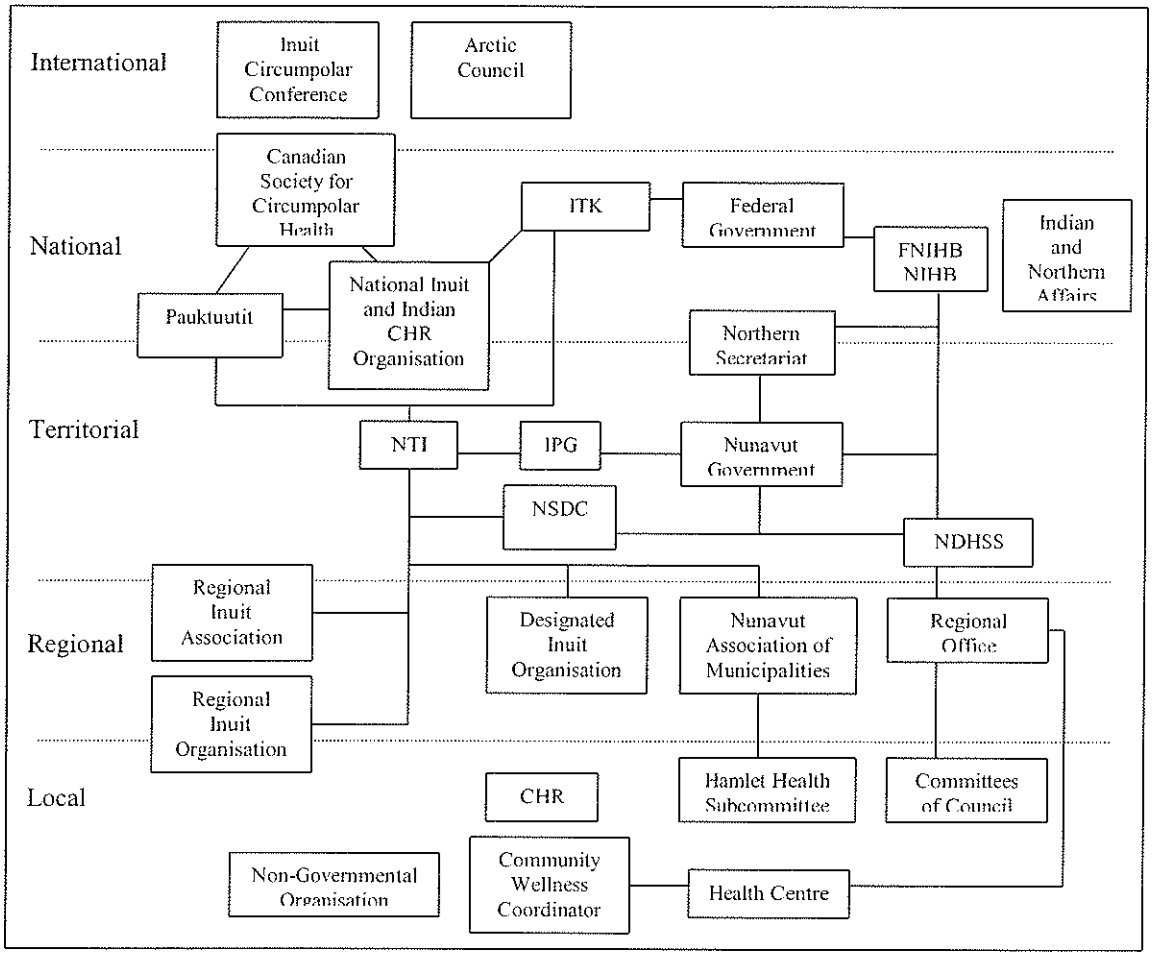
Figure 11. Complex Ethnonational Structure as per NTI



This represents one-half of Nunavut governance, with ethnonational authority constituting what hinges on the 'public government' across a variety of sectoral focuses (through all manner of ethnonationalist organisational form). This structure is provided

by NTI itself, describing entities whose mandate and goals distil to advancing Inuit success and wellness (see Figure 11). This figure shows many relevant stakeholders, and in addition to those represented here (*e.g.* Inuit Circumpolar Conference, Pauktutiit, ITK, RIOs and IPGs), others include the Nunavut Association of Municipalities (NAM),[41] and the oft-mentioned CHC and CHR. It is important to note that the Nunavut Government is, less obviously, a 'public' ethnonational structure.

Figure 12. Geographically Layered Ethnonational Structure



Inuit self-determination practices can be grossly filtered into five levels: local, regional, territorial, national, and international (see Figure 12). Nunavut ethnonationals are thence involved with the events of all Inuit, whether geographically or by sector. In

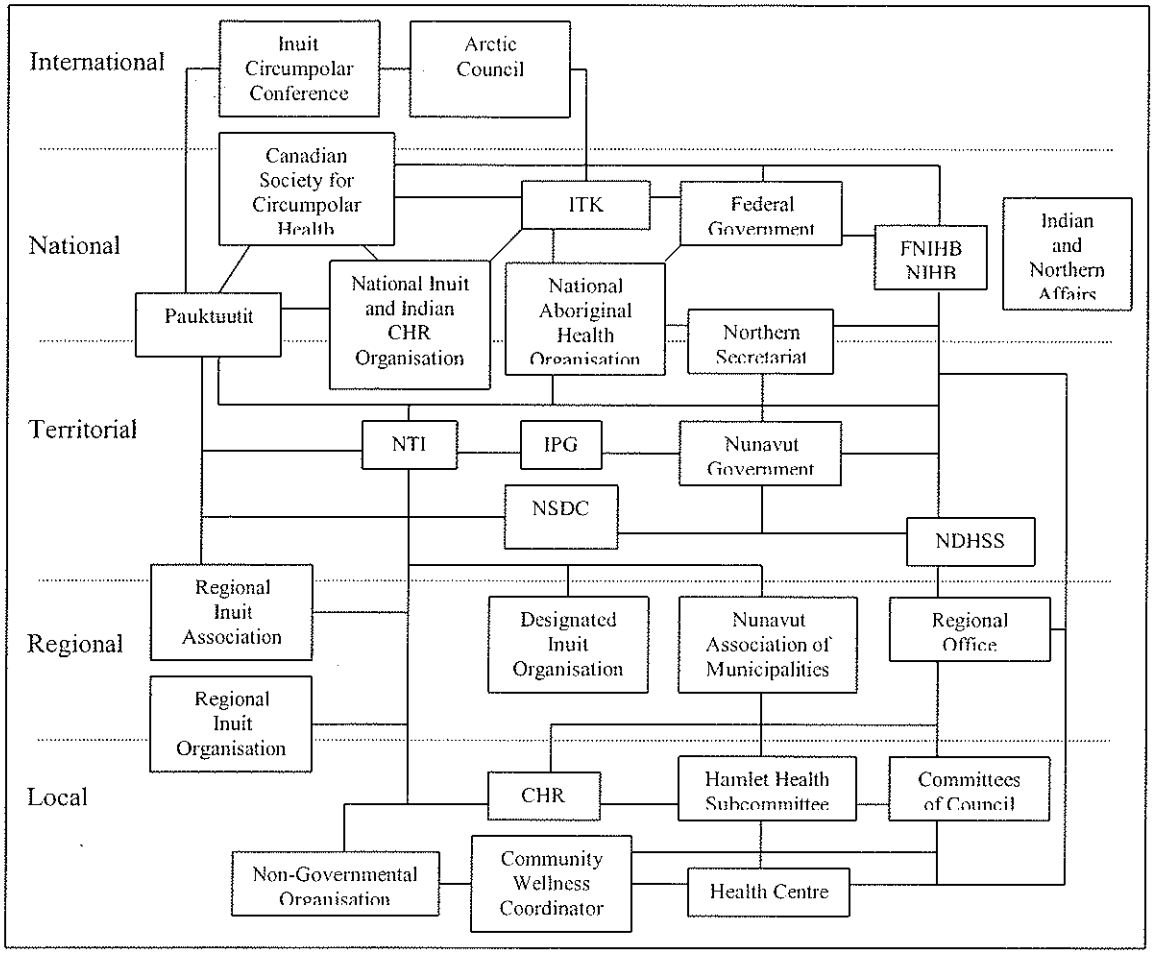
terms of health and social services, these structures can be seen as feeding into ITK, observed in the development of a strong central health program and the involvement of this ethnonational as a key player in many Nunavut health debates and developments (*e.g.* Home and Community Care, the Health InfoWay, Aboriginal Diabetes Initiative, amongst others).[42]

Local polity also acts regionally through their possible involvement with RIOs, IPGs, and organisations such as NAM, and nationally through contact and/or representation within organisations like ITK and Pauktutiit (and possibly internationally through contact with the ICC or Arctic Council). On the reverse, ICC has contact with ITK, Pauktutiit and NIICHRO, which all have clear ties regionally and locally through their representation and programmatic efforts. The same stakeholders populate and enact various positions of power and influence in these pan-geographic ethnonational sectors, often employed by the varied organisations across a career.

There further exists Inuit and/or Inuit-based representation in academic and professional sectors (*e.g.* Inuit and non-Inuit advocates/employees of ethnonational organisations, Inuit and non-Inuit nurses). In their involvement with such organisations as the Canadian Society for Circumpolar Health and International Union for Circumpolar Health (CSCH/IUCH), ethnonationals play a role in changing the relations of power between academic health researchers and practitioners and the circumpolar populations they study and treat.[43] For example, ITK, NIICHRO, the National Aboriginal Health Organisation, and the Assembly of First Nations, all hold mandatory representation on the Executive Committee of the CSCH/IUSCH. The past three presidents of the CSCH have been of Indigenous decent. The complexity in relational influence is represented in

Figure 13, connections having been plotted relative to known and established relationships.

Figure 13. Structural Complexity of Pan-Geographic Ethnonational Sector



This leads to the observation that in Canada's north, colonial, ethnonational, and public governance relations are fundamentally congealed if not blended, blurred, or conflated. Ethnonational and public governance stakeholders are recognised to have influence, where both can come together in the 'ideal of Nunavut,' or lie in contraposition, both groups containing Inuit and non-Inuit actors. Indeed, the structure of 'self-government through public government' leads to interesting circumstances, whereby non-Inuit ethnonational advocates can claim that Inuit bureaucrats are degrading or standing in the way of progress. Irrespective of possibilities, one reality is assured:

that the structure provided by the creation and enactment of Nunavut sets a tone of increased Inuit control. A review of recent debates and problems associated with 'self-government through public government' now follows.

e. The NSDC and the NNI Debates

The early articulations of power in this 'public Indigenous self-government' are worth reviewing. This dynamic is well represented in two examples-- in the problematised existence of the NSDC, and in debates surrounding the implementation and application of the NNI policy.

The NSDC was created under Article 32 of the NLCA:

> "Inuit have the right [...] to participate in the development of social and cultural policies, and in the design of social and cultural programs and services, including their method of delivery, within the Nunavut Settlement Area. [...] [Public government responsibilities are fulfilled] by [...] endeavouring to reflect Inuit goals and objectives where it puts in place such social and cultural policies, programs and services in the Nunavut Settlement Area."[44]

While this provision is not readily clear on the role of such a council in the health sector, it was not a far cry for health realities to be constituted as social ones, and an avenue of interest for this council, particularly so in the context of a single NDHSS acting as a natural governance counterpart.

Early on, the NSDC attempted to tackle issues of substance. For example, in an open letter written by Mary Ekho Wilman, then President of the NSDC stated:

> "[R]egarding the Government of Nunavut's efforts to secure a more appropriate funding arrangement for NIHB programs from the federal government [...]. What I did not read, however, is how you are planning to involve the [DIO] that represent Inuit in Nunavut in this process. I did not read about how you plan to use the rights Inuit have and the obligations that government must fulfil under Article 32 of the [NLCA]."[45]

A significant issue, the NIHBs represented a social environment so problematised, that using them as an entry point into an uncharted relationship of mutual governance, may

not have proven the best approach. Reporting then presented the a lack of impetus by Nunavut ethnonationals to engage and/or access health-funding opportunities (as was the specific responsibility of this council).[46] Over time, the council was perceived as ineffective, and the ethnonational result was decisive.

Cathy Towtongie, then President of NTI, noted that the NSDC "was not living up to its mandate" and that "since the creation of NSDC eight years ago, there hasn't been solid evidence of what it has done to improve Inuit life socially."[47] She further stated:

> "[We] are facing a social crisis [with] [h]ousing, health care, suicide rates, substance abuse, family violence…the list is long. […] The Inuit voice on social issues and social policies must be strong, firm and united, so that our needs are heard, understood and respected by governments. […] Under the current arrangement, our voice is divided and muted. That weakens our negotiating position with governments and makes it harder to access funding for badly needed social programs."[48]

NTI board members "concluded that restructuring [the] NSDC and making it an integral part of NTI would significantly strengthen the voice of Inuit on social issues."[49] NTI revoked the appointments of the NSDC members, moving to pass a resolution revoking the NSDC's designation as DIO. New members were appointed to the council from the NTI board to "oversee the efficient and timely windup of the corporation and the smooth transfer of assets and liabilities […] NTI [now assuming] responsibility for Article 32 of the Nunavut Land Claims Agreement."[50]

Here is an example of the failed attempts of a DIO and the substantial governance/power response by NTI. As noted by Towtongie, "[s]trong and decisive action has to be taken to address the grave social issues facing Nunavut today."[51] This gives a sense of NTI's authority, and its willingness to adapt to the realities of governance.

The implementation and application of the NNI policy has also proven a substantive issue of decisive action between ethnonational and public governmental

authority. Showcased as the first concrete example of Nunavut governance, the details of the NNI policy were arrived at through the specific dealings of a Nunavut Government / NTI Contracting Working Group. The policy was derived from Article 24 as the 'Nunavummi Nangminiqaqtunik Ikajuuti,' or 'Aiding Nunavut Businesses.' This policy outlines the methods by which government contracts are tendered and processed, and entrenches the notion that local, regional, northern and Inuit interests should be promoted and supported through governmental procedure.

The NNI grows out of the 'Nunavut Business Incentive Policy' (in place prior to 2000), and the old NWT's 'Nunavut Contracting Procedures for the Nunavut Settlement Area.' It mediates any contract where the Nunavut Government or any of its public agencies or boards provides for more than 51% of the total contract funds. As listed, the policy objectives of the NNI are "a. Good value and fair competition; b. Strengthening the Nunavut economy; c. Inuit participation; d. Nunavut education and training."[52] Seeking good value for its contracts, it recognises the high costs of doing business in Nunavut, and employs measures to equilibrate northern and southern contractor costs in order to strengthen the Nunavut economy and Inuit control.

An evaluation process is clearly laid out: "[I]f the contract tender meets minimum contract requirements [...] [then] all tenders shall then be adjusted based upon Nunavut Business status, Inuit Firm status, and Local status."[53] This translates into 'adjusting' (or decreasing the dollar amount of) a bid by 14% if the business is located in Nunavut, 3% if the firm has Inuit Firm status (51% Inuit ownership and registration in the Inuit Firm Registry), and an additional 3% if the persons running the business are resident or local. The notion of 'Inuit content' is then established as necessary for all Requests For

Proposals (RFPs). If Inuit are employed, the bid is adjusted another 10%, plus an additional 5% for Inuit ownership. Bids are also given bonuses and charged penalties if they do or do not meet requirements associated with 'Local Inuit Labour,' 'Nunavut Inuit Labour,' and 'Inuit management content.' The cheapest bid is taken after adjustments.

A 'grandfather clause' recognises the need for a transition time for businesses that have long serviced the NWT or Nunavut, these firms given two years to comply with new contracting rules. This policy also situates the Nunavut economy in education and training, providing a basis for Inuit to train and learn in industry. The NNI specifically states its link to the Bathurst Mandate and in the CRP.

Rich in ideology, initial disagreements over the policy stemmed from the creation of the NNI appeals board that would hear disputes over awarded contracts. The Nunavut Government blamed NTI for "holding up" the creation of the board, NTI feeling that the Nunavut Government was "too strict on what kind of appeals can be made."[54] For example, the NNI appeals process solely constituted in appeals relating to whether the contractor's status as 'northern, Inuit or local' were improperly determined, or whether the bid adjustment was calculated incorrectly, with NTI not observing this as a broad enough interpretation of the policy. As noted by then President of NTI Paul Quassa:

> "Let's say an Inuit firm doesn't win a bid and goes to the appeals process saying 'Look, this government of Nunavut is not getting us to participate in the economic development of Nunavut as the Article 24 states.' Now, according to current interpretation on the appeals board, that Inuit firm can't argue on that basis."[55]

This was a firm basis relative to the NNI's contextualisation in education, training, and in ideological statements like the Bathurst Mandate. Some Inuit firms were in turn "stuck waiting for appeal."[56]

After the completion of a jointly conducted inaugural NNI review, more contentions developed over a sudden one-year extension granted by the Nunavut Government to 35 non-Inuit firms.[57] The extension added to the grandfather clause (that originally only granted two years), since some firms were still not able to meet NNI standards. With the recent review containing no mention of extending this clause,[58] such unilateral action was a clear point of conflict. NTI blamed the Nunavut Government for buckling to the lobbying efforts of non-Inuit firms, and more significantly, for violating the NLCA, the CRP, and their clauses guaranteeing Inuit consultation and involvement in the process of governance. The Nunavut Government did not provide any response to these claims, which seemed to validate NTI's interpretations. NTI eventually sought legal recourse to quash the NNI clause. The Nunavut Government filed motions that sought to dismiss NTI motions on the ground that NTI lawyers did not follow proper legal procedure.[59] No juridical mediation became necessary as disputes were settled through a joint agreement that ensured no further extensions to the clause, and included a statement ensuring that there would be full consultation on any further issues of change regarding the NNI.[60]

Irrespective of debates, there are real problems with the NNI policy. For example, one non-Inuit firm pointed out that there was no one of Inuit ancestry that had the means to buy 51% of their company.[61] This left the option of 'development companies' (economic development corporations), but they were noted as 'not being interested.'[62] There is also the case of a company that is 100% Inuit owned (owned in equal shares by the Inuvialuit of the Western Arctic and the Inuit of Nunavut) but does not meet the 51% Inuit (of Nunavut) ownership clause, failing to comply with the NNI.

The articulations of power associated with this early Nunavut political economic structure are well represented here. In the problematised existence of the NSDC, a DIO and its inability to effectively deal with its issues of concern represent the power and willingness for decisive action by ethnonational authority. In debates surrounding the implementation and application of the NNI policy, one observes the ready engagement of grievances in this new Indigenously self-governed public government, and its sometimes unclear and socially developing fit to the 'ideal of Nunavut.'

f. Ethnonationalism, Social and Economic Development, and Northern Health Care

With institutional realities becoming conflated, it is no wonder that the Kivalliq-based real-estate firm described in Chapter 3 can identify themselves as involved in 'development.'[63] When being self-referential as a development vehicle representing a global Inuit interest, these corporations place themselves in relation to Inuit self-determination and how the quality of Inuit ownership is part of their business success (and in turn the social and economic success of all Inuit). As presented later, this was the case for an Inuit majority-owned dental corporation, whereby Inuit self-determination was a lever on which the corporation depended for their success in the competition for contracts. Less obviously then, with the line between ethnonational and public governance blurred, so too the line between public governance provision and ethnonational capitalist market opportunity (in essence, a conflation between the public provision of services to an Indigenous population and the private opportunities associated with that provision).

In the current contracted health care sector, one naturally observes ethnonational involvement and attempts at market control.[64] For example, all three RIOs (and their privately based ethnonational corporate subcontractors) are building and leasing-back hospitals and other health facilities within their respective regions. More entrepreneurial is the development and attempted establishment of ethnonational opportunity in the private health care sector, as represented by Piruqsaijit Ltd. (the firm that attempted to build an Inuit-owned and operated for-profit mammography clinic, also claiming to offer dental services, medical services, mental health services, and pharmacy services), or Nunavut Business Initiatives Ltd. (a firm offering boarder home services and nursing care services).[65]

The potential for control over the public provision of services with private models of institutional existence (*i.e.* private for-profit health corporations placing themselves in line with Indigenous self-determination and their role as part of the constitution of an Indigenous public self-government) raises many issues:

> "Their involvement in the health care sector raises questions about whether money which has been budgeted for health should be generating profits for corporations that exist to benefit all Inuit, or whether this is still problematic in that it diverts resources that would otherwise be available for services to a corporate entity that still exists to make a profit. [...] On the other hand, the lack of capital for facilities raises questions about where and how such capital can be raised. The BRHB's idea of creating a non-profit entity to raise funds and build facilities is an alternative, but a difficult one. Such foundations, unlike birthright corporations, lack the collateral to easily secure loans. However, the Nunavut Government could, if it so chose, create a government-backed corporate entity to borrow funds for hospital construction on the market using the government's assets as collateral and thus eliminating debate over whether corporations, regardless of their ownership structure, should profit from health. Finally, there is nothing to stop birthright corporations from providing public capital facilities at cost, but this begs the question of why they would do so instead of government."[66]

Profiting from basic governmental economies like 'health and social services' is not that unique globally, with state structures fully constituting some market economies (*e.g.* contracts for infrastructural needs, contracts for military needs). Yet this economy has a separate and fundamental notion that guides it: ethnicity.

As a result, even more subtle boundaries have been created and at the same time blurred: that of public economies and (public) ethnonational economies, that of public and private ethnonational economies, and that of public (governance) economies and private (governance) ethnonational economies. This complexity is possible through the existent conflation of the ideas of public and ethnonational governance (*i.e.* control over services), public provision and opportunity (*i.e.* social and economic development), and public and private enterprise (*i.e.* capitalist development), actuating in the realities of a corporate Indigenous self-governing public control over services. In a Canadian environment where the line between the private and public provision of health care is a fine (and often morally associated) one, the mix of 'private' yet 'public' (or *vice versa*) corporations taking part in the direct governmental management and provision of health services with a further involvement in the governing (or decision making activity) of the (public governmental) private contracting of those same services, can present a challenge in finding that line.

A final example of this ethnonational / social / economic / private / public development milieu is found within the NIHBs. This is developed fully in Chapter 6, but note now that since these services are uninsured and constitute in the health marketplace, control over NIHBs present interesting opportunities for social and economic development. In the mid to late 1990s, there was discussion of some transferring some NIHB administration to the Kivalliq Inuit Association.[67] Here, one could have observed the possibility of a 'more public' ethnonational (yet essentially private) taking on the responsibilities that the Nunavut Government now undertakes (mostly NIHB regional coordination and regional administration). This could have also resulted in the wholesale

transfer of many FNIHB programs to this ethnonational (as it has in FNIHB pilot projects in southern Canada). Programs could have also been administered together.[68]

One can again see many boundaries blurred: the devolution/transfer of control over the public administration of a publicly insured non-insured health service to a quasi-public yet fully private ethnonational entity acting as a self-determination vehicle enacting the goal of a public self-governed Inuit territory (all for potential social and economic growth). Nunavut's complex structural existence clearly presents a challenge to current Canadian norms surrounding the delivery of health services. To date, this challenge seen in the increased involvement of the ethnonational governance, whereby involvement equals a quasi-private/quasi-public interest that has observed control through forms of passive and active privatisation.

III. Nunavut Governmental Practice and Inuit Self-Determination

As self-determination and self-government practice, the Nunavut Government has concentrated its role in part by advancing the structural qualities of IQ, of a decentralised form, and of a representational government administration. It has created opportunity for education and training, created new and reinvigorated older health structures, and further aided Inuit involvement across all sectors. This section will describe these developments in relation to a composite case study of a Nunavut Government administrator soon after the creation of Nunavut.

> ***Dozens of times per year, dentists used to sit there for hours, waiting for planes, on their way up- or down-island, watching him negotiate the problems of Nunavut dental care. All the calls were long distance, coming in from across Nunavut and from across the country. 'Funny thing' he used to say, 'to call across the country to fix problems right here in Nunavut.'***

On the phone was his senior dental therapist (also his highest-level Inuit employee) telling him that there was still no answer from any of the dental therapists that he had tried to recruit on his recent trip to the NSDT. The lack of recruits was always a problem.

Especially frustrating was the fact that he would soon lose this senior employee (and another Inuit employee) to the private market of dental contracts. Not only did they represent a critical part of his operation, they also represented the ability to meet the early goals set by the government for a representative Inuit bureaucracy.

The dentists sitting with him were there for an operating room visit, but due to the shortage of nurses, there would be no service this month for the large number of kids waiting to be seen. So they helped him catch up with the backlog of paperwork generated by running such an operation.

Whether it was a patient in a community complaining about a dentist, or a Nurse In Charge 'laying down the law' as to their health centre rules, complaints were a daily occurrence. If it wasn't a contractor, it was a dentist calling every day stressed about equipment failure and the result: not making money. He joked with his colleagues about the fact that much like a toothache, in the world of northern dental services, abrupt changes in weather and resources (in the broadest of terms) leads to sharp, pulsating waves of stressful and chaotic feelings and events.

All of this pressure was especially negative, as he increasingly felt it was not his to bear. 'It was FNIHB funding not his planning efforts that resulted in a lack of services.' Daily pressure from the Legislative Assembly came to answer need, and he could do nothing. He knew his budget was already spoken for, and still he had to come up with more dental days. Again, this frustration for something that he could effectively and reasonably argue was beyond his control and not his responsibility.

The NIHB dental program wasn't necessarily his program, even if Inuit clients/beneficiaries were his responsibility as citizens of Nunavut. The NIHBs were 'between Ottawa and Inuit' since services stemmed from the 'special fiduciary relationship' Inuit had with the Federal Crown.

In the inherent confusions about 'who was responsible for what and for whom,' he had done an excellent job, his model for care being extended throughout the regions of Nunavut. This model based on a perceived balance found within controlled competition, with several contractors competing for and forming the core of services, that core being the fixed number of service days made available by federal authority.

As his visitors took several days sifting through claims, listening to the frustrations of limited resources confronted by overwhelming need, it became clear that many questions remained unanswered for this new government. Through all the regular challenges, the real concerns were more in the order of 'what was next?' He used to be an employee of the now old NWT, and now part of a brand new, history making government. Although he had seen and lived throughout the formation of Nunavut, by his own self-admission, he couldn't predict what going to happen. What was 'decentralisation' going to do? What about the Inuit 'hiring initiative?' How would Inuit self-governance be enacted in his department? Would he have to work with the new 'community health committees' and 'community wellness coordinators?' Would Inuit organisations really have a say? What else would the NLCA do to dental services? Who knew? It was too early to tell.

a. Decentralisation, Inuit Qaujimajatuqangit, an Inuit Representative Public Service

As the head of a 'dental department,' this administrator was a part of, and responsible for, the implementation of initiatives that reflected Inuit values and customs. Initiatives were part of the 'dream of Nunavut,' where communities' share in the opportunities provided in a decentralised form, all governmental practices informed by the knowledge of the

past, and of the present through a majority Inuit bureaucracy. Enhancing Inuit control was at the forefront of these initiatives.

The notion of a decentralised model of government has a well-established history:

> "[In 1994] [t]he NIC recommended that Nunavut's government should be highly decentralized, with programs and services delivered at the regional and community level to the fullest extent possible. [...] NIC recommended that: [1] the size of the headquarters staff in the capital of Nunavut be kept to a minimum to allow; [2] for the sharing of government employment opportunities with as many communities as reasonably possible; [3] the community that is selected to be the capital should not continue to be a regional center as well; regional offices located in that community should move out to other communities in that region; and, [4] a high level of program, financial and personnel authority and accountability should be delegated to managers and officers at the regional and community level."[69]

In 1999, the Nunavut Government affirmed its commitment to decentralisation, and set a three-year timeframe for meeting their goals. A 'Decentralisation Secretariat' was established in the Department of Executive and Intergovernmental Affairs.

The decentralisation of governmental departments was particularly menacing to administrators, simply because early on, it had yet to filter down who exactly would be decentralised and/or how it was going to happen. Decentralisation was not necessarily perceived as a good idea by higher level public servants, with one of the first questions asked being: 'How am I going to administer from a smaller community?' When describing the movement of 71 jobs from a regional centre to a smaller community, a northern periodical stated that "[i]t's part of the Nunavut government's oft-criticized, but determined, effort to decentralize government jobs to communities outside the capital."[70]

This administrative stakeholder shared the same opinion, as he was very comfortable working out of a regional centre. Surely, this was 'where all the action was,' and the first logical place one would think of when wanting to coordinate services for a region. Consider that for this dental department, all equipment and southern personnel arrived through the regional centre, presenting problems for the early coordination of new

practitioners, with the coordination of specialist and hospital services, and for processing shipments. He would now be faced with having to administer from 'one more place away.'

Decentralisation itself would have to deal with a host of infrastructural challenges (both human and capital). For instance, the availability of housing in smaller communities frustrated some efforts, as well as the slow progression of the incorporation of Inuktitut into the community workplace.[71] One employee commented "[that] work can be done effectively from any location, as long as there's access to an adequate communications network."[72] The reality in fact is that 'an adequate communication network' is not in place, with no regional governmental computer network or modern digital connection between communities as of yet. With the difficulties in attracting southern expertise to regional centres, the idea of a job in a smaller community proved detrimental to the ability of the Nunavut Government to fill positions. Yet one of the very reasons for decentralisation is to combat this need for southern professional expertise, which has been observed as a way to build human resource capacity at the community level. The positive logic of decentralisation is demonstrated in the Territory's 2002/03 Budget Address (which also neatly situates decentralisation relative to much of this discussion):

> "Nunavut's economy continues to be heavily dependent upon the government sector. As our government becomes more established we will ensure that benefits from government activity reach as many Nunavummiut as possible. Our decentralization initiative has and will continue to result in long-term stable jobs spread throughout the territory. Of course, a large degree of this progress will depend upon Nunavummiut having the required skills and trades. [...] Decentralization has generated an increased demand for goods and services in our communities. Also, as a result of increased government and private activity, we see our service sector continuing to grow and becoming a larger part of the economy to support that activity."[73]

The NDHSS has decentralised in several ways. Main operations remained in regional centres, with Iqaluit retaining the NDHSS Directorate and its Policy and

Corporate Services. Rankin Inlet received Nunavut's Vital Statistics Services, Pangnirtung the Baffin Regional Office, Kugluktuk the NDHSS Operations and Practice office.[74] The decentralisation mandate was completed in August of 2003, having had to deal with all past criticisms, and with the new reality of perceived 'have' and 'have not' communities.[75] In the end, dental departments were never moved.

Among the other ideas constituting the 'dream of Nunavut' was IQ, a traditional knowledge base that could inform and better represent the majority Inuit citizenry of Nunavut in relation to the policies and processes that governed their social life. Inherently lying at the heart of Inuit self-determination and its political process is the notion that Inuit 'ways of knowing'[76] should suffuse an Inuit-relevant governance structure. Yet much like decentralisation, to this administrative stakeholder, how IQ was to be incorporated was yet unknown (especially with the exit of Inuit employees).

In early Nunavut, a Legislative Standing Committee on Health produced three reports that spoke to IQ, and in this sense to the reality of sociopolitical change.[77] The first and most detailed is the Report on the 1999/2000 Six-Month Departmental Update. This report carries a specific section termed 'A New Direction for the Department – Promotion of Health and Prevention of Illness,' affirming the involvement of Elders and the incorporation of IQ in the planning and development of health services (note the incorporation of Inuit involvement in the context of public health and not curative care).[78] The concept 'Inusikatiarniq' was to guide new directions in promoting health and preventing illness (one assumes in planning and development). According to NDHSS policy, Inusikatiarniq means "treating people as a whole, including their bodies, their spirits and their cultural values."[79]

In this early report, models of health service delivery that involve the public and are based on self-determination precepts like cultural appropriateness and local involvement are seen as important to increases in health status.[80] The 2001/02 Department of Health and Social Services Mission and Goals could not be clearer:

> "Our mission is to promote, protect and enhance the health and well-being of all Nunavummiut incorporating Inuit Qaujimajatuqangit at all levels of service delivery and design. [...] To provide a supportive environment for individuals, families and communities in making decisions that affect their health and well-being. [...] To develop health and social services policy relevant to the needs of the population of Nunavut. To deliver flexible, culturally sensitive programs and to demonstrate the effective use of public resources."[81]

Independent of departmental directions, to this administrative stakeholder, IQ remained a very nebulous concept. As a non-Inuit person, he had little hold on what Inuit traditional knowledge could be congruous with his department. Since this was most likely the case for many non-Inuit administrators, by mid 2001, the departments of Health And Social Services, Culture, Language Elders and Youth, and Sustainable Development, had all appointed IQ coordinators to promote its integration.[82] As noted in a northern periodical, "[w]hen policies or procedures are introduced, [an IQ coordinator] reviews them to make sure they are culturally sound and practical, [making] recommendations for changes to ensure the department operates in a manner suited to Inuit culture and traditions."[83]

An 'IQ task force' was also established. This task force, made up of Government of Nunavut employees, NSDC members, and Elders, was to develop ways of bringing IQ "into the daily workings of the territorial government."[84] By 2003, this task force emerged as the 'Inuit Qaujimajatuqangit Katimajiit,' an Elder's council that is to continue providing advice. Through these processes, "[t]he Government of Nunavut [believes to have] taken the next major step in ensuring that Inuit culture, values and knowledge are incorporated in its decision making."[85]

Attempts at incorporating IQ must become operationalised to be implemented throughout the public sector.[86] Most often, the first step in this process is to develop a theoretical framework or a 'structure of practice.' Consider IQ as developed and represented by Jaypetee Arnakak of the old NSDC (also a past IQ advisor and coordinator): IQ is a 'living technology' based on six guiding principles:

> 1. Pijitsirniq (the concept of serving); 2. Aajiiqatigiingniq (the concept of consensus decision-making); 3. Pilimmaksarniq (the concept of skills and knowledge acquisition); 4. Piliriqatigiingniq (the concept of collaborative relationships or working together for a common purpose); 5. Avatimik Kamattiarniq (the concept of environmental stewardship); and 6. Qanuqtuurunnarniq (the concept of being resourceful to solve problems).[87]

Despite this thorough ideation, a concept such as IQ is still difficult to enact, especially so when many decision makers are non-Inuit and the language of governmental use remains predominantly English. To this end, even though IQ is explicitly stated in the NDHSS mission statement and listed as a core value, some administrative stakeholders suggest that it has yet to fully realise any sort of consistent implementation.

Another way of incorporating IQ is to enact the role of a representative government, meaning that since roughly 85% of the population of Nunavut is Inuit, so should roughly 85% of the governmental workforce. Conceivably, a public service that is predominantly Inuit constitutes a predominantly Inuit-being, -thinking, and -feeling public government. For this administrative stakeholder, this was a difficult task, as there exists little Inuit-specific dental expertise that he could draw on. Only one Inuit employee had any clinical dental expertise, and was one of several others exiting towards the private dental market. This administrative stakeholder faced the problem of not being able to fulfil the government's responsibilities under Article 23 of the NLCA (rights and advantages regarding government employment).

This administrative stakeholder had to respond to Article 23 and the plethora of governmental outcomes meant to address it. There was the 'Priority Hiring Policy,' the 'Inuit Employment Plan' (IEP), 'Direct Appointments,' and 'Specialised Training Initiatives,' all of which created new responsibilities and potential change for his department. These programs (to some extent or another) stemmed from the Nunavut Unified Human Resources Development Strategy (NUHRDS):

> "The NUHRDS is directly responsible for much of the programming that prepared Inuit to assume many of the jobs within the Government of Nunavut departmental offices upon start up. The initiatives made a significant difference, and enabled the new Government of Nunavut to recruit Inuit from a greatly enhanced labour pool. Many of the NUHRDS initiatives were long term in nature and the Inuit employment benefits will only be seen in the future. Stay in School Initiatives are an example."[88]

The Priority Hiring Policy was a "part of the Government of Nunavut's commitment to create a public service that [is] representative of the population it serves."[89] This policy replaced the old NWT's 'Affirmative Action Policy,' the name essentially describing its relevance. "Based on a serious under-representation of beneficiaries in the Nunavut public service, beneficiaries who meet the qualifications are given priority over other applicants for all job competitions."[90]

The IEP set forth 42 initiatives designed to increase Inuit representation in the public service.[91] These initiatives are broad ranging and run the gamut of possibilities across departments, each department responsible for developing and proposing their own plan. Several government departments, including Human Resources, Education, Culture, Language, Elders and Youth, and Executive and Intergovernmental Affairs, were identified as having lead roles in the implementation plan.[92] Interdepartmental committees were established in 2001 to coordinate departmental plans. The IEP is listed as a critical issue of concern for the NDHSS.[93]

Due to its status as a premiere example of the government's work towards enacting 'self-government through public government,' results of the IEP are publicly available through quarterly reports named 'Towards a Representative Public Service.'[94] The day Nunavut was created, overall Inuit representation in the government was 45%. This representation decreased to 44% in March 2000 and to 43% in March 2001.[95] By early 2003, it stood at 41%.[96] The government's 'Occupational Gap Analysis' has consistently shown that Inuit representation in senior management, middle management and professional categories is well below any sort of ideal. In the NDHSS for example, while 50% of executive positions are Inuit, they only fill 16.7% of senior management, 10.2% of middle management, and 9.3% of professional positions.[97] Inuit involvement in governmental activities still concentrates at the administrative level, with Inuit constituting 81% of all administrative staff.[98] Departments have identified these higher-level groups as priority areas for education and training initiatives, and targeted them for 'mentoring' and 'succession planning' programs (these options associated with specific IEPs).[99]

'Direct Appointments' have also become a way to increase Inuit involvement at higher levels of bureaucratic decision-making. This process:

> "[I]s used by the Government of Nunavut in certain circumstances, to achieve a qualified and representative public service. Direct Appointments support fair and equitable career development and support the Priority Hiring Policy of the Government. Direct Appointments are also used in situations where the regular recruitment process has been unsuccessful with hard-to-staff positions. Cabinet approves all Direct Appointments."[100]

Since formal education levels in Nunavut lay below the Canadian average, and with the post-secondary education sector in Nunavut being limited, "the government is co-operating with Inuit organizations to find innovative ways of recognizing practical knowledge and skills that have been attained outside of the formal educational system

[...] [h]owever, improved education is the key to increasing long term Inuit representation in the Nunavut public service."[101]

Recognising education as the key to the success, 'Specialised Training Initiatives' have been and are being consistently developed. "[P]iloted in 2000-2001 [...] [s]pecialized training is intended to develop technical, job-specific competencies and address the unique learning needs of a department, division or position."[102] These training programs have come to include 'Education School Services Group Process Training,' 'Health & Social Services Community Health X-Ray Assistant,' 'Justice Leadership Training,' 'Nunavut Housing Corporation's Property Management Leasing Course,' amongst many others. Other significant initiatives include the 'Akitsiraq Law School,' the 'Teacher and Nursing Programs of Nunavut Arctic College,' and the 'Nunavut Senior Assignment Program' and the 'Public Service Career Training Program.' So if the 'dreams of Nunavut' are to be fulfilled, it will be through the development of increased capacity within its borders, now currently grounded in the establishment of opportunity in education and training.

b. Community Wellness Coordinators, Hamlet Health Subcommittees, Community Health Committees, Committees of Council, Community Health Representatives, Non-Governmental Organisations, and Volunteer Networks

This administrator also held questions about the yet unknown potential capacities and demands of the newer and/or reinvigorated older health stakeholder groups. New were the Community Wellness Coordinators (CWC), funded under a Territory-wide 'Wellness Initiative' either through Hamlets or RIOs, and the Hamlet Health Subcommittees struck

by some Hamlets in response to the historically ill-defined capacities and actions of CHCs. Reinvigorated health stakeholder groups include the Community Health Committee (CHC) (now officially known as 'Committees of Council') and the CHR. This administrative stakeholder would also have to respond to the increasing territorial, regional, and local involvement of Non-Governmental Organisations (NGOs) like ITK and Pauktutiit, and the emergence of local 'volunteer networks.'[103]

At Nunavut's six-month mark, the Standing Legislative Committee on Health was advised that:

> "[T]he Department is trying to take a lead role in coordinating the various funding initiatives from several departments that fall under the broad heading of "Wellness". In some communities, wellness coordinators work for the Hamlets and in the Baffin, they are part of the Regional Inuit Association. Members were advised that the community wellness coordinators will play a role in the community level health decision-making."[104]

Questions quickly developed as to how interactions with this new health stakeholder would constitute. To date, cooperation with CWCs has occurred through contact with dental therapists, most often concerning local need.

Hamlet Health Subcommittees were formed in response to CHCs that had not generally proven an effective avenue for change. These subcommittees also reflected the goal of some Hamlets seeking direct involvement in decision-making processes surrounding health. This would involve the NAM making regular recommendations concerning health, including enhancements to community alcohol education, properly funding alcohol education committees, reassessing the role of the CHR, establishing clarity as to patient rights associated with pharmacy dispensing, and resolving issues surrounding medical travel.[105]

The desire for municipal involvement was also expressed at a majority-Inuit Legislature, when early on, an option was introduced for CHRs to be incorporated as Hamlet employees and work in conjunction with CWCs:

> "Members were also advised that the [CHRs] will also play a role in the community level health decision making. [...] Members observe that at times, CHRs become secretaries, interpreters, liaison, and have very little time to do health promotion or prevention work. Members would like to see the role of the CHR clarified and they note that if the CHRs were under the Hamlet Councils, they could promote wellness in the community better. Members note that both the Community Wellness Coordinator and the CHR's could provide support to the Community Health Committees."[106]

Members of the Legislative Assembly also stated that:

> "[This Committee] requested a more explicit approach to [CHCs], and a stronger involvement of Hamlets, so that communities can play a more meaningful and effective role [...]. The Department has [...] also began the process of working with the Hamlets to create and support these committees and provided a modest $5,000 per committee per year. The Standing Committee [also] requested that more attention be paid to the [CHRs] in terms of ensuring these positions are filled in every community, clarifying their role to include more responsibility to work with local [CHCs], and providing more training. The Standing Committee heartily supports community involvement and wellness initiatives and more culturally appropriate services, through the use of Elders and [IQ]. However [...] it will be important that appropriate steps be taken to ensure that they do happen, or at least start to happen and are not simply good intentions or words on paper."[107]

New CHCs were in turn formed, now termed 'Committees of Council' (ostensibly still referred to as CHCs). While funding was an issue early on,[108] these committees have received funding increases as of 2003.[109] As per their early planning documents, they appear focused, having visions and goals that are well defined. Councils are composed of eight members, including, 'if possible (but deemed very important), a former Health and Social Services Board member, a Hamlet Councillor, other community members who are able and committed to participate, and a NDHSS representative or CHR (as a resource only and not a member).'[110] They are proposed to have involvement in such things as 'health and wellness promotion,' 'determining, monitoring and measuring program and service delivery with the people,' 'communications in our community with Hamlet Council,' 'setting direction for a significant part of the work of the Wellness Coordinator,' 'hiring of Health & Social Services staff,' amongst others.[111] Developing

'Community Wellness Plans' that address their local concerns,[112] potential funding is available through initiatives encompassed within the broad category of 'wellness.'[113] Time will tell if these councils will be involved in a repeat of the past, where little real support actuates. Further, the existence of these councils does not negate the existence of Hamlet Health Subcommittees, who will surely continue in some communities, potentially as a way of monitoring the progress of such councils. As before, for this administrative stakeholder, interactions were seen to be occurring through local contact with dental therapists. Recent stakeholder commentary suggests that Committees of Council are still too early in their process to be a regularly interacting stakeholder.

CHRs on the other hand are now ensconced in dental departmental interests through their role expansion, which added 'specialised functions' like 'dental health prevention,' 'maternity care,' 'public health,' and 'enhanced health promotion skills.'[114] The NDHSS continues to work in collaboration with Nunavut Arctic College and its CHR training program, recently certifying a series of 'Health Promotion programs.'[115] Linked CHR/hamlet staff training programs in wellness promotion are also in development.[116] As per recent stakeholder commentary, all of this programming includes oral health considerations.

This administrative stakeholder also had to answer to the pressure of NGOs and local community members who formed part of a larger voluntary Inuit/non-Inuit health advocacy stakeholder group. NGOs include the ITK Health Committee, Pauktutiit, NIICHRO, and other discrete local organisations. These organisations have found capacity at local, regional, territorial, federal (and international) levels, being able to push agendas in many areas of decision-making. NGOs have long held involvement in

community-level programming activities, only to further increase their profile in Nunavut's community-focussed environment. So much is this the case, that the most recent NDHSS report calls for the 'development of capacity' for NGO involvement in program funding opportunities, and the need "[t]o identify and work with NGOs and volunteer networks providing allied care in Nunavut communities."[117]

All of these groups have increasingly called attention to the tremendous suffering associated with oral disease, particularly amongst children. ITK has gathered these voices and has been politically effective at pushing the need for preventative programs and/or any strategy meant to address the issue.[118] This administrative stakeholder, already understanding the tremendous need for establishing preventive measures, now had to find ways to do just that under the current pressure. Some avenue was potentially found in the future work of CHRs, CWCs, and Committees of Council, but in terms of immediacy, coordination and planning extended from centralised authority.

A FNIHB developed national oral health disease prevention strategy (involving the application of topical fluoride to school age children through dental therapists) became adopted. With the proposed direction of concentrating on health promotion and illness prevention services, this initiative became listed as a 'critical issue' in the department's latest report.[119] The approval and implementation of an 'Oral Health Strategy' was sought for the fiscal year of 2003-2004.[120] It is increasingly clear that Indigenous self-determination and self-governmental practice shape the planning and delivery of dental and other health services. This is reflective of historical occurrences, where influence concentrates on health promotion and disease prevention activities rather than curative care.[121]

IV. The Nunavut Government's Health Financing and Health Structure

In attempting to adjust to the public processes and structures that are acting in Nunavut, this administrative stakeholder was still troubled mainly by one thing: the lack of funds by which 'to do what he had to do.'

> "Like all provinces and territories, the Government of Nunavut receives transfers from the federal government. Nunavut's major federal transfers are the Formula Financing Grant and the Canada Health and Social Transfer (CHST). As well, there are a number of other transfers related to the delivery of health care [*e.g.* NIHB, Canada Prenatal Nutrition Program, National Native Alcohol and Drug Abuse Program, amongst others] and justice support systems. Certain transfers are provided for specific purposes, with the amount based on spending undertaken by the territory in regard to a specific function. The majority of transfers are, however, not earmarked to a particular government function or responsibility. This allows Nunavut to make its own decisions regarding funding it provides to meet its responsibilities and priorities."[122]

This stakeholder felt it was the constraints of federal transfers and not his programs and planning that determined what he could do, regardless of whether he had the power 'to make his own decisions regarding funding.' Frustrated, he would reasonably argue that administering the dental NIHB was not his responsibility, since 'it was the responsibility of federal authorities.' This claim is supported by the fact that the NIHBs were 'by rule' a federal program (and not officially offered up in devolution/transfer initiatives), and by the fact that these services were offered in lieu of the 'special fiduciary relationship' between Inuit and the State. Yet this stakeholder was still fundamentally involved in their delivery, controlling some financing and service programming.

Financing Nunavut is an existent exploration into enacting (through resources) an Indigenously carved out territorial body within the domain of an historical (resource relevant) relationship between an Indigenous group and a modern State. Inuit share a direct historical relationship with the Federal Crown, separate and distinct from their relationship with the territorial government, this relationship constituting in part through the 'direct delivery' of some services. While this does not purely exist in practice, as

most services accessed in Nunavut stem from territorial interactions (funding ultimately from federal program transfers), this still provides (and allows for) much complexity in the way Nunavut is funded and the manner in which these services are delivered.

This stakeholder had a clear sense of this, partly recognising his duties as a Nunavut public servant in terms of federal authority. Many territorial programs are thought of in similar terms as, federal programs that are administered and delivered by territorial authorities on behalf of federal ones.[123] For example:

> "The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services for Inuit and First Nations."[124]

Stating that 'he couldn't do anything' since 'there wasn't enough money,' this stakeholder felt that the NIHBs 'weren't his responsibility anyway.' Partially resigning himself to this rationalisation, he nonetheless fervently debated at every opportunity in his attempts to secure more funds.

Much cynicism existed amongst stakeholders regarding the negotiations that occurred with federal authority. When one considers that 'negotiation' in recent years clearly established little possibility for any new significant increases in funds (aside from how well one 'negotiated' or 'pleaded' their case), centrally capped funds only allowed for certain possibilities. If any money did enter, it was a transfer of a discrete and particular federal contribution and/or grant, most often to address some specific and emergent issue and could not be counted upon regularly.[125]

This administrative stakeholder's inability to negotiate for more funds was a direct result of a basic political fact: little resources (whether material or ideological) mean little power. As it stood, this administrator held no ability to exert influence, the

Nunavut budget being primarily constituted through federal transfers (own source revenues totalling roughly only 9%). Federal authorities then truly hold ultimate decision-making power. As per Tester, this power means that Nunavut (and this administrator's department) is fundamentally tied to the funding movement of federal coffers, and is therefore permanently at risk.[126] Cuts to the CHST initiated in 1995 are an example of this vulnerability, immensely impacting the then government of the NWT 'to do what it had to do' in order to meet the needs of its citizens (*e.g.* P3 planning).[127]

'Formula financing' plays a significant role in any funding movement:

> "This grant is controlled by an agreement between Nunavut and the federal government which specifics the terms and conditions by which the grant is paid, as well, as how the annual entitlement to funds is determined. The grant is unconditional and is determined by means of a formula which takes into account: Nunavut's population growth relative to Canada; the growth in spending levels of provincial and local governments on public services capped by the growth in the Canadian economy as a whole; and the ability of Nunavut to raise it own revenue through taxes and fees."[128]

Nunavut's grant is determined with the following formula: Grant = Gross Expenditure Base (GEB) - Eligible Revenues (ER). The GEB establishes need, while the ER is measured by determining 'eligible revenues' (*e.g.* tax base, sustainable and non-sustainable resource capacity, amongst many others). This stakeholder often noted that the GEB is only an approximation of Nunavut's expenditure needs based on its share of historical expenditures in the former NWT. It is not equal to the government's actual expenditures or needs. Similarly, eligible revenues are an estimate of the territory's revenue-raising capacity, and not an accurate assessment of actual territorial revenue.

Officials also claim that the 'terms and conditions' for the 'annual entitlement to funds' from the formula financing grant are problematised. For instance, in an interview with a northern periodical, Nunavut's Health Minister stated:

> "While the federal government, in theory, pays the full cost of providing various benefits, in reality, Nunavut is short-changed. That's because what Health Canada pays out doesn't cover the full cost of offering the services. The territorial government isn't always fully reimbursed [...]. 'Either we're

> without the full billing or not at all' [...]. This means Nunavut is hit with a whack of additional expenses per year simply because it's providing Inuit with the health care they need."[129]

However, a recent audit conducted by the Auditor General of Canada demonstrated that roughly $30 million in statement claims to the federal government had not been sent, with no final payments transferred as no evidence confirming how the money was spent was provided (this included costs for insured hospital and physician services).[130]

The Nunavut Government recognises its basic political position:

> "A key element for Nunavut's future success is the reduction of dependence on the Government of Canada. Reducing our dependence will make Nunavut less vulnerable to factors out of our control and more responsive to changing needs within the territory."[131]

Moreover, "[since] [t]he main source of Nunavut's revenues, for the short to medium term future at least, will remain the Government of Canada [...] the federal government is our key partner in meeting Nunavut's financial need."[132]

a. The Nunavut Department of Health and Social Services

For the 2002-2003 NDHSS, revenues totalled $151,033,000. This amount is divided between five departmental sections: 1. Directorate; 2. Healthy Children, Families, and Communities; 3. Health Insurance Programs; 4. Health Protection; and 5. Treatment Programs (see Figure 10); and along six different 'lines of business:' 1. Directorate; 2. Population Health; 3. Social Services; 4. Health Protection; 5. Care and Treatment; 6. Health Insurance (see Figure 14).[133] The department's Healthy Children, Families, and Communities, Health Insurance Programs, and Treatment Programs consume 84% of expenditures, roughly equalling responsibilities in the lines of business population health, social services, care and treatment, and health insurance (86% of expenditures).

Figure 14. Breakdown of NDHSS 'Lines of Business' Expenditures

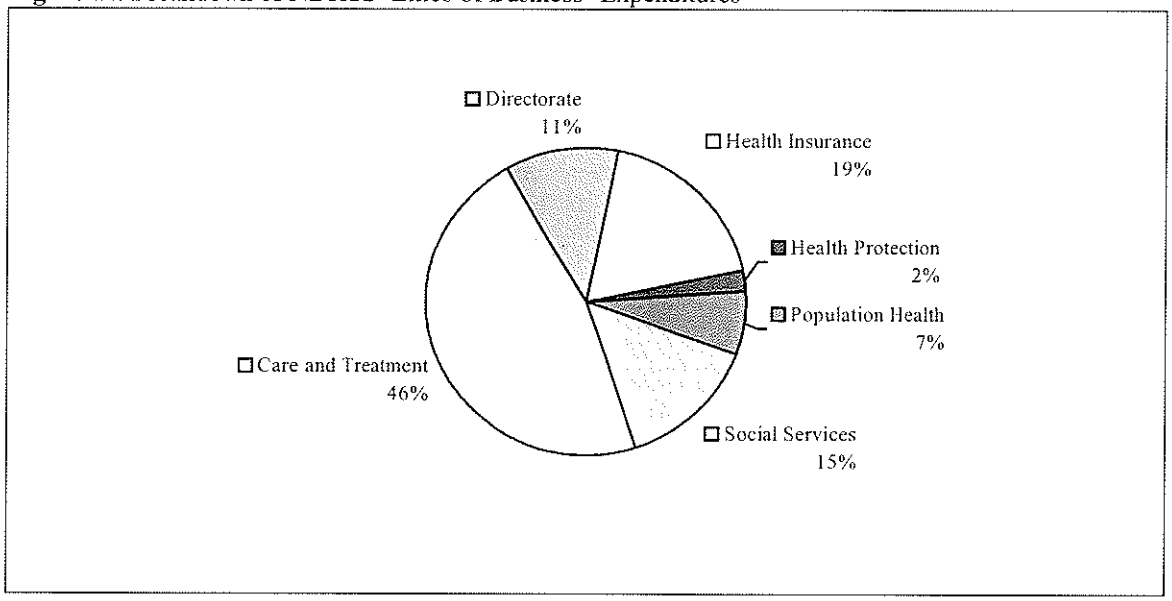


Table 7. NDHSS Departmental Sections Listing Activities and Responsibilities

NDHSS Sections	Activities and Responsibilities
Healthy Children, Families, and Communities	Activities include information and research, health promotion, social well-being and dental. Information and research collects, analyses and reports on legally mandated or otherwise significant indicators within health and social services. Health promotion and social well-being include CHRs, as well as social workers that work to enhance individual, family and community health, supporting the Bathurst Mandate. Dental activities include everything from promotion to treatment and aftercare for seniors.
Health Insurance Programs	Programs such as hospital services within Nunavut and other jurisdictions for Nunavut residents, including supplementary health benefits and non-insured health benefits.
Treatment Programs	Treatment Programs include services provided at health centres, the hospital and medical/client travel. This includes urgent medical evacuations, necessary referrals, and unavoidable social/family emergencies that require transport out of the community, or out of the territory. This Branch also includes the cost of physician services and social workers

In reviewing Tables 7 and 8, one finds fluid structural properties across departmental sections, different programs, responsibilities, and/or 'lines of business.' These structures clearly bleed into each other. So while these tables document what the Nunavut Government states is its structural activity, for dentistry, on the ground realities

speak to a dental administrative stakeholder that was the head of a 'dental division,' exclusively managing 'dental services' (*i.e.* insured hospital dental services, dental public health services, dental therapy services, non-insured dental services). The department managed the travel associated with insured and non-insured dental care, and managed other specific aspects of the dental NIHB (*e.g.* some claims processing, coordinating benefits).

Table 8. Activities and Responsibilities of NDHSS 'Lines of Business'

NDHSS 'lines of business'	Activities and Responsibilities
Population Health	The Department delivers several programs in cooperation with the federal government. Health Canada provides funding for the Department to manage and administer a number of programs for Inuit and registered Indians. Provides direction and leadership in public health support throughout Nunavut through a number of prevention and public education initiatives such as anti-smoking, mental health and suicide prevention.
Social Services	Provides a range of support services for children and vulnerable adults who may require protection, or other specialized services.
Care and Treatment	Treatment represents the most significant portion of the Department's expenditures. Included in these programs are urgent medical evacuations, necessary referrals, and emergency social/family interventions that may require transport out of a community, or out of Nunavut. Included are in-patient and outpatient services, public health, and chronic care and home care service delivery.
Health Insurance	Responsible for the management and administration of territorial Health Insurance Programs, such as hospital services within Nunavut and other jurisdictions for Nunavut residents, including supplementary health benefits and non-insured health benefits.

Another way of understanding Nunavut's health service structure is to relate it to service delivery or to function:

> "The DELIVERY MECHANISM category groups programs according to how those services and programs are delivered. The results indicate whether or not staff are directly involved in the provision of services, the role that contracting plays in the delivery of programs and the relative importance of grants and contributions in the government's expenditures. Three categories were developed for delivery mechanisms - Direct Service; Contracted Service; [and] Grant/Contribution. The FUNCTIONAL categories are somewhat generic in nature and could be used by any provincial or territorial government. Classification by functional category allows programs to be grouped by the

kind and type of role they perform for government rather than by the actual substance of the program. Four functional categories were developed – Advisory; Regulatory; Administrative; [and] Service or Product Provision."[134]

Even more clarity is gained when noting that like every jurisdiction in Canada, the Nunavut Government provides insured hospital and physician services to its citizens under the *Canada Health Act*. Funds associated with insured services stem from the CHST and from unconditional transfers. This is where Nunavut maintains most of its decision-making authority, as these transfers are not linked to any specific health program. With much less power, the Nunavut Government also manages funds that flow from transfers provided for specific purposes (*e.g.* administering and delivering the NIHBs on behalf of federal authorities).

b. NIHB Financing and Structural Debates

In 2001, the total 'negotiated' contribution for the NIHBs was $10,926,000.[135] For the 2002-2003 fiscal year, this amount rose to $12,926,000.[136] The increase of two million dollars was the result of consistent and active debate in the health care sector, and in the NIHB programs in particular. These contentions were aided through the formation of a Territorial power-block, with this 'coalition' being well supported by the Provinces and by professional medical groups.[137]

Again, the Nunavut Government did not see itself receiving a 'full transfer' relative to NIHB service expenditures and needs:

"[The Health Minister] says the amount of NIHB money spent in Nunavut doesn't meet the actual costs or needs of Nunavut's young and growing population. [...] [T]he NIHB pay-outs aren't keeping pace with Nunavut's rapidly increasing health costs. 'There's an escalator in the NIHB of 3 per cent, but my costs are increasing by 9 per cent,' [the Health Minister] said. [...] Some non-insurable benefits also have individual caps, too. These put a limit on the number of certain medical treatments an eligible person may receive in one year [which in turn the Nunavut Government sometimes provides]."[138]

Even more basic is the added consternation of financing health and social services on a per capita basis.[139] Nunavut officials believe this to be an extremely flawed and inappropriate funding mechanism relative to geographical and professional resource challenges (that immediately increase costs), and relative to treatment of one of Canada's sickest populations.

While each particular NIHB service have unique circumstances (a brief consideration is tackled in Chapter 6), all share similar complications, viz. that of little resource in the face of overwhelming need, where eligibility requirements and the available frequency of treatments and services are under increasing federal stricture. For example, much like dental care, vision care suffers from the challenges of finding professionals and service days beyond those that are covered. Broken eyeglasses are often sent to regional centres out of necessity, with complicated visual problems dictating travel to regional and/or southern centres. In answering the question of a lack of service days, the Nunavut Health Minister stated:

> "[T]hrough the contract of NIHB, the Federal Government that pays for these services tells us how many days we can get and it's based on the population. So for a smaller community, [...] it's for at least two visits a year of three days each. We are going to try, when that agreement comes up, to bring that total up so that the smaller communities and even the larger communities can get more service under that contract."[140]

The services associated with 'medical travel and lodging' have also caused worry and action amongst health based Inuit advocacy, ethnonationals, and government officials. For example, in tackling this NIHB, NAM states:

> "WHEREAS: Health & Social Services patients have to travel outside their home communities & Nunavut for medical purposes; and WHEREAS: Some patients have to be away from home for extended periods of time; and WHEREAS: Communication is very important for the patients and families to inform each other about community and family issues and also to update family members on the patient's conditions; THEREFORE BE IT RESOLVED THAT: The [NDHSS] provides a toll-free phone in each community and boarding homes outside of Nunavut to serve better communication for Nunavummiut. THEREFORE BE IT RESOLVED THAT: The [NAM] lobby the scheduled airlines in Nunavut to provide the same quality of service as is provided by airlines in the South."[141]

The Health and Social Services responsed to this and other previous complaints:

> "[We have] completed a RFP for Scheduled Medical Travel that included requirements for hot meals on flights over two hours as well as the provision of lavatory services. The issue of patient comfort during flights is a priority for the department. For the issue of equitable treatment under Aeroplan, the Department of Health and Social Services does not have jurisdiction over this issue."[142]

More recently, NIHBs have also come to fund a 'number of other incidental services.' To date, this includes mental health crisis counselling, audiology, and the payment of provincial health care premiums. This category has allowed previously uninsured health services to enter the NIHB envelope of coverage, some eventually being listed or thought about 'on their own' (*e.g.* audiology and mental health crisis intervention). Federal authorities speak little of these 'incidental services' for fear of having to adjust to newer additions in an already administratively unruly and burdened program. As is developed in Chapter 6, since this program relates to 'uninsured services,' coverage can potentially extend to many other services of this kind (*e.g.* physiotherapy services, occupational therapy services, speech pathology services, message therapy services, amongst others).

Ethnonationals place pressure on territorial/federal authorities to extend the breadth of the NIHBs, and have at times attempted to make cases for discrete health related adjuncts. For example, in another resolution of the NAM:

> "WHEREAS: The mobility of handicapped Nunavummiut is necessary for their health and well being; and WHEREAS: No department within the Nunavut Government will assist financially for the construction of mobility aids (ramps); and WHEREAS: The hamlets are not funded for the construction of mobility aids (ramps); THEREFORE BE IT RESOLVED THAT: The [NAM] lobby the Nunavut Government to assist the hamlets financially for the construction of mobility aids (ramps)."[143]

Other NIHBs that continuously receive much attention are medical travel and pharmacy benefits -- the two most costly NIHBs. In considering the former:

> "[G]eography causes the cost of providing essential programs and services to be very expensive. An example of this is the $15.4 million we must use to provide transportation for our people to access health services not readily available in our communities."[144]

By 2002, this cost had risen to $29,574,000, with yearly increases in the order of 7% to 14% per year.[145] A study was commissioned to consider options, exploring the possibility a 'main dispatching service' (which suggests that planning and coordination would occur in a more centralised fashion versus a decentralised one), and even the possibility of Nunavut owning its own fleet of aircraft.[146]

Medical travel is a key example in demonstrating the inequitable funding of services. For Nunavut, the NIHBs only cover a $250 co-payment for medical travel, a sum established in 1988 during the 'health devolution' that has not changed since that time. Unlike other regions, no funds are provided for escorts, with the Nunavut Government having to cover all costs. Again:

> "We believe there is a fiduciary responsibility of the federal government for aboriginal health care and we want the same deal the other jurisdictions are getting. If you're an aboriginal patient in Northern Quebec and are flown south for a treatment or in Labrador, or in Northern Alberta, the federal government certainly picks up more than the 250 dollar payment we get."[147]

Prescription drugs on the other hand are a significant issue relative to developments in, and the availability of, pharmaceuticals. A growing consideration for Canadian health care planners in general, the pressure of making costly life-saving drugs and drug regimens available has pushed the potential establishment of 'pharmacare' to the social forefront. Nunavut's Health Minister stated: "There have been major concerns every time I go to a federal/provincial health care meeting about how Health Canada picks and chooses what drugs are used under the Pharma Care Program."[148]

Unlike dental care, there is no financial limit to the amount of pharmaceutical treatments allowed under the NIHB program. Nevertheless, the Nunavut Government still functions relative to a fixed budget. Complaints are often made in relation to the

composition of NIHB 'formularies/drug schedules,' and in relation to the availability of certain drugs:

> "You know, each patient, each person reacts differently to different drugs and I think that's taken into consideration when prescribing. There are cases where you may have a normal drug that's prescribed to an individual for a certain reason [and the doctor] didn't want to give this one that is funded under the program because of the side effects and when they give the individual another one, that isn't covered. We don't have the luxury of having the volume of stock to pick and choose the perfect one, the perfect drug that is going to work for everybody that is covered under this plan."[149]

Significantly, the Nunavut Government has taken the argument of self-determination and attempted its manipulation in order to save costs. For instance, nurses often provide medications directly from health centre stock. Under this form of service delivery, the NDHSS uses unconditionally transferred monies (those not associated with conditional NIHB agreements/transfers) and stocks health centres with common medications, thereby acting as a direct provider. Pharmacists in regional centres also provide medications to Inuit populations, and provide certain medications to smaller communities (as per a medical doctor's prescription for drugs not commonly available in a health centre). Medications come in on flights, picked up by the patient at the local health centre, with the Nunavut Government's involvement being minimal, as pharmacists bill FNIHB/NIHB directly. As a result, the Nunavut Government believed it possible to set up a situation whereby patients would be given a 'choice' as to how they would receive medications: either from a nurse in a health centre or from a regional pharmacist. This programmatic effort, known as the 'patient's choice policy,' allowed the Nunavut Government to sidestep and/or decrease its involvement, as any time a regional pharmacist fills a prescription (as per a nurse 'recommending' to their patient that they 'choose' this option to fill their prescriptions), it is done so at the 'point of service' (directly billing FNIHB), and not at the 'point of residency' (as would be the

case when receiving medications from a health centre, directly billing the Nunavut Government, who then must seek recourse to recover the costs from federal authority).

This policy came under much criticism:

> "WHEREAS: The [NDHSS] have imposed the above program upon the people of Nunavut without consultation; and WHEREAS: It will create problems in Communities that have no pharmacy and very few air flights per week; and WHEREAS: The lack of prompt prescription delivery may have a negative impact on a person's health; THEREFORE BE IT RESOLVED THAT: The [NAM] lobby the [Nunavut Government] to rescind their recently imposed policy called Patient's Choice; and BE IT FURTHER RESOLVED THAT: The Nunavut Government be advised that the program title is misleading as patients were not given a choice as to whether they preferred to receive prescriptions from a pharmacy or their local Health Centre."[150]

This policy direction is an example of a Nunavut Government attempt to develop mechanisms by which to remove itself from its perceived 'middleman' position in the NIHBs, and logically (and in this case impractically) buttressed by the direct relationship that exists between Inuit beneficiaries and FNIHB.

The financing and structure of the NIHBs are thus a fundamental source of debate in the governance dynamic of Nunavut, with negotiations distilling to one construct.

> "[We have spent] the last three years negotiating with the federal government [...] [N]ot only was it not acceptable, it was an affront to us as a jurisdiction to have to cover those costs. We believe there is a fiduciary responsibility of the federal government for aboriginal health care [...] [T]he cabinet has agreed to [this] negotiating position [...] and we have been aggressive in that negotiating stance with the federal government."[151]

As is detailed in Chapter 6, suggestions have been made to involve NTI in these negotiations (as per their role in a self-governed Inuit public territory):

> "[T]he federal government have to look after the Aboriginal people and Non-Insured Health Benefits, so with that, wouldn't they listen to us better if NTI was to take over and negotiate with the federal government because NTI does not, we don't pay taxes to NTI so maybe it would be better for NTI to look after the health money for the Inuit people. Can we not simply say, in 1988, we were really stupid for accepting the responsibility of medical programming for Aboriginal people in the NWT and now we're grandfathering it in Nunavut and we want to renege on that and give it back to the federal government, or at least have an Aboriginal organisation like NTI contracted with the federal government because we simply can't afford it."[152]

So while the Nunavut Government responds to Inuit self-determination by changing process, it also uses it to negotiate with federal authorities as a result of the social power

provided for by the ideological space created by it. Yet in maintaining previous arguments and attempts to manoeuvre its social power, it must still respond to its current challenges (see Table 9).

Table 9. Present Challenges to Nunavut's Health System[153]

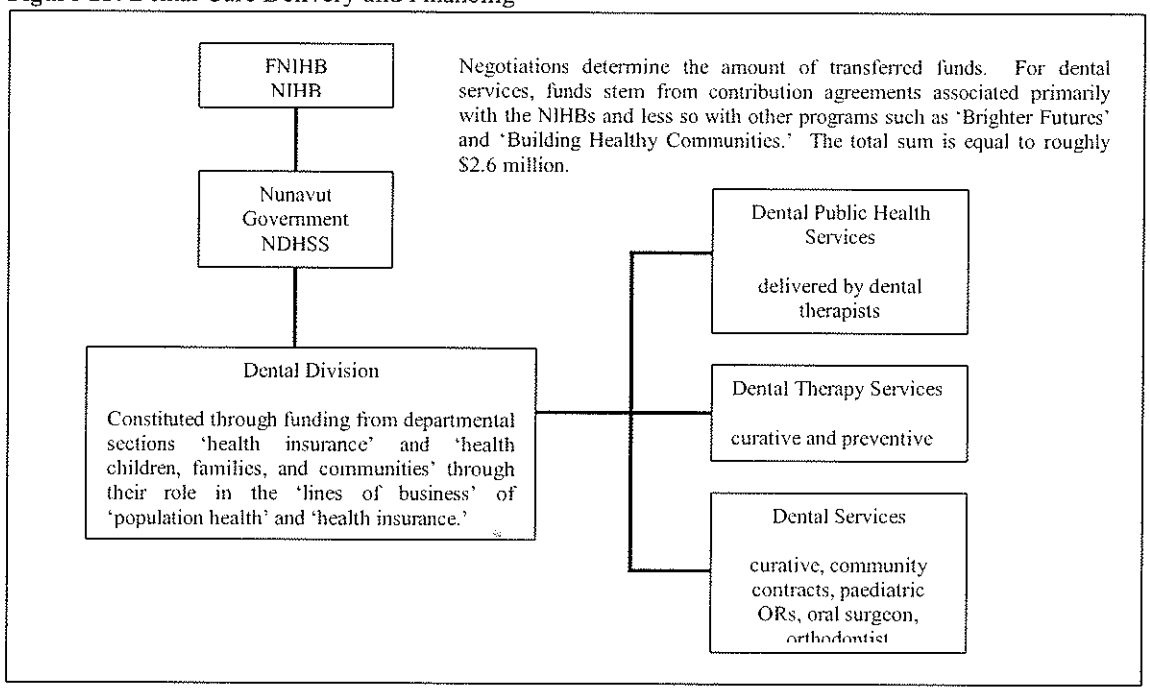
- The most expensive health care system in Canada with costs twice as high as those in the provinces
- Where $300 million a week is spent on health care
- Where federal transfers are made on a per capita basis, not on need, conditions, and by extension actual costs
- Where an increase of $4 billion dollars in Canadian federal health transfers results in only a $3 million increase for Nunavut
- Where $35 million per year are spent for medical travel in a budget of $151 million (approximately 20%)
- Where a medical evacuation from Iqaluit (a regional centre) to Ottawa can cost $8000 and the federal government only provides a co-payment $250 under the NIHB plan

c. Dental Care Delivery Structure and Financing

As discussed in Chapter 3, dental care in Nunavut is delivered through several channels: care provided by resident clinicians in regional centres; itinerant care in smaller communities by contracted dentists; and the direct delivery of services by dental therapists (*i.e.* curative care to children and preventative care to all age groups). In terms of how these channels structurally constitute, resident northern clinicians deliver services in resident clinics and bill the FNIHB/NIHB system directly at the 'point of service.' They have little contact with the Nunavut Government at the general administrative level (unless they also own contracts that deliver services to smaller communities). 'Point of service' billing also occurs with services delivered in smaller communities (as in filling out the Dent29 form described in Chapter 4), with care in such communities involving the notion of dental contracts, whereby a corporation is contracted by the Nunavut Government to find dentists for the deliver of services. While (curative) dental services are again billed to FNIHB/NIHB at a 'point of service,' this care now enters the purview of public management (as opposed to the private management of the dental market

indicative of regional centres and their resident clinicians and clinics). Again, this public management also encompasses all of the services delivered by dental therapists (regional centres included).

Figure 15. Dental Care Delivery and Financing



As separate from the private sphere, services come to be seen as flowing from two NDHSS departmental sections and from two 'lines of business:' Health Insurance, Healthy Children, Families, and Communities, and population health and health insurance. In reality however, a dental division manages all of these services, constituting, in part, the responsibilities associated with the aforementioned departmental sections and 'lines of business.' This means that care delivered in Nunavut communities is paid for in three distinct yet connected ways (ultimately stemming from FNIHB funding):

1. Through direct FNIHB/NIHB payments to resident clinicians in regional centres (from dental billings);

2. Through direct FNIHB/NIHB payments to the Nunavut Government for services delivered by contractors in smaller communities (from dental billings);
3. Through direct FNIHB/NIHB contribution agreements/transfers to the Nunavut Government for dental therapy services (from public funds).

This structure of financing is subtle and complex, and merits detailing (see Figure 15).

Dental care in Nunavut is funded out of the roughly $13 million transferred to the Nunavut Government for all NIHB services. In detail:

> "[U]nder the NIHB Agreement [...] we have 694 thousand 300 dollars for the following expenditures for dental treatment. Those include the travel, the accommodations, the meals, freight costs for dentists, for buildings and a fee for service basis through the dental claims processing system. The actual fees paid to the dentists are billed directly to Health Canada by the dentist and that's through [centralised authority]. These costs are not recorded on the financial records with the Government of Nunavut because they're billed directly to NIHB. The total cost of air transportation for eligible recipients of dental coverage is also covered under the NIHB Agreement. [And] [i]n the Baffin Region, we have nine dental therapists at a cost of 796 thousand dollars; in the Kitikmeot Region, 432 thousand dollars, and in the Kivalliq Region, 688 thousand dollars for a total of 23 dental therapists."[154]

Note that through two NDHSS departments and from two 'lines of business' (all essentially constituted through the actions of a dental division with regional subsidiaries), the NDHSS expends $1.92 million on services. However, if one adds what has been stated in the Legislative Assembly Hansard, actual costs are $2.61 million, resulting in a discrepancy of roughly 690 thousand dollars. This discrepancy is due to the fact that the Nunavut Government also receives monies from other non-NIHB related transfers that are partly used for dental programming (*i.e.* dental therapy curative and preventative care). These contribution agreements hold within them funds for the 'dental activities' of the departmental section Healthy Children, Families, and Communities (*e.g.* 'Brighter Futures, Building Healthy Communities,' 'Canada Prenatal Nutrition Program'). How this money is used is the decision of the Nunavut Government, but it generally flows to FNIHB supported or developed programs at the community level.[155]

Irrespective of the simplicity of FNIHB/NIHB funding the delivery of most if not all dental care, it does so in a very complex manner. As reviewed, curative services are contracted and have historically constituted in several ways, vacillating between fee for service arrangements and per diem ones, between simple arrangements with individual contractors or with corporations, and between small contracts compared to larger ones (relative to the number of communities 'owned' by contractors).[156] Questions on how to best structure the delivery of services have always been relevant.

Throughout the 1980s, there was little or no competition as there were few individual clinicians and contractors available. With more and more contractors developing interest (individual and corporate), there came a point when administrators were faced with a market of competition.[157] In the 1990s, competition allowed for two things. Federal authorities could comfortably and safely enact strong cost-cutting measures (relative to any professional blowback), since anyone who was not happy had full knowledge that there were other contractors that would gladly take their place.[158] Competition also allowed administrative stakeholders to weigh out the costs of establishing and fuelling a market of competition in northern dental services. Should regions only have one provider? Should they have many? In kind, should large contracts or small ones be given out? Should they be given to corporations or to individuals, with fee for service or per dium arrangements?

'Weighing out the costs' resulted in the adoption of a single delivery model across Nunavut. This model developed out of the Baffin region. As in the other regions, the total number of days where one could deliver services was set. Unlike other regional counterparts that were receiving per diems, however, Baffin had fee for service

arrangements. This became judged as 'the most effective way' to structure service delivery since it guaranteed productivity (with the implicit incentive in a fee for service structure) and also limited costs (by fixating the number of service days beyond which no transfer of monies would occur). As stakeholders comment, a completely 'social model' with per diem and/or salaried arrangements was not seen as positive, since experience had shown that dentists did not work as long or as hard under this model. Yet if a completely open and private model was adopted, dentists and/or corporations, if they so chose, could be in communities all year 'round. Even though the chances of this were minimal, in a time of fervent cost cutting, this was not a logical choice. The Baffin model has, in administrative practice, developed as the most 'well-accepted' when taking both patient need and sustainability into consideration.

Of critical importance in the Baffin model was that fees billed by dentists were then 'revenue shared' between the Nunavut Government and the contractor, each taking a shared responsibility for the costs associated with freight, the salaries of the clerk-interpreter and assistants, accommodations, dentist travel, meals, and clinic maintenance (with this accounting for most of the aforementioned $694,300).[159] Whatever responsibilities each party adopted equalled the split in revenues. Historically, since most subcontracting dentists negotiate between 40 to 45 per cent of billed services, the Nunavut Government and contractor share 55 to 60 per cent to pay for costs. While valid, this is also not a completely accurate description of the redistribution of resources generated from the delivery of services.

More exact, the total amounts of costs for dental services delivered by dentists are already established throughout the region before any service is billed. This amount based

on historical precedence of devolved/transferred monies to the Nunavut Government (essentially capped since the mid to late 1990s). The relatively fixed flow of capital starts when a dentist bills for their services. Most contractors cover the costs associated with some freight, some accommodation, clerk-interpreter and assistant salaries, and travel, with the Nunavut Government covering the costs of some freight, some accommodation, and clinic maintenance. Billings are then processed at the federal level (claims verification, predetermination, claims processing and reimbursement) and then received by both the Nunavut Government and contractor (who then distributes to subcontractors). This distribution occurs along the previously noted 40/60 split, where the subcontracting dentists receives 40 to 45 per cent of billings, with the Nunavut Government and the contractor splitting the remainder.

Of this remainder, ethnographic discussion suggests that the split between the Nunavut Government and contractors is generally between 5-15 per cent/85-95 percent respectively (of the original 60 per cent). The Nunavut Government is then further reimbursed by FNIHB for dentist travel, accommodation, freight, and the clerk-interpreter salary. This is termed 'reciprocal billing,' whereby the Nunavut Government provides a claim for costs associated with the delivery of care provided by dentists and is then reimbursed (similar to the initial claim for dental care delivered).

Of import is the fact that dentists are sometimes not paid, as in when their claims are rejected because of mistakes (*e.g.* incorrect beneficiary number, lack of signatures, mistaken tooth numbering, amongst many others), when a 'treatment frequency' has been reached, or when the treatment delivered is not an 'eligible benefit.' This is significant, as when a claim is rejected, the Nunavut Government does not receive the 5 to 15 per

cent that it depends upon to cover some of its costs. For this administrative stakeholder, this was frustrating as 'it was not the responsibility of the Nunavut Government if dentists could not accurately complete their Dent29 forms' or 'if clinicians decided to do treatment that extends beyond a frequency or patient eligibility' (most often mistakenly, as it has been suggested that dentists often treat patients relative to a fee guide and not relative to their needs[160]).

This is why the clinicians passing through this administrative stakeholder's office were quickly given the task of correcting forms to try to collect on billings that had been rejected. Even though 'by rule' it was this administrators responsibility to make these corrections, in an environment where subcontractors and contractors are most often south, this responsibility is sometimes more effectively dealt with closer to home. Contractors are nonetheless also acutely aware of these rejected claims, as they are also not paid for these services, since it is considered good business practice to 'stay on top' of these rejected claims.

A critical detail lies here. In effectively arguing that the NIHB dental program was not his responsibility, this stakeholder also commented that the Nunavut Government was 'just another contractor.' For example, the Nunavut Government is reimbursed for its costs through 'reciprocal billing' (up to a designated amount as per negotiations for federal transfers), and further, 'revenue shares' relative to billed services. Less obviously then, the Nunavut Government (as other ethnonational organisations in Canada) can be considered a contractor for the coordination and administration of the NIHBs for a population that receives these services in the context of a special fiduciary relationship. As administrative stakeholders have commented, the Nunavut Government is the

'contractor,' then they 'subcontract' dental corporations, who then 'sub-subcontract' individual clinicians or other corporations.

Yet federal transfers also fund for service costs that are not billed in any privately oriented sense, viz. those transfers for publicly constituted dental therapy and dental public health services. So while wanting to remove itself as a 'contractor' of federally constituted NIHBs, the Nunavut Government must still 'publicly administer' aspects of dental care that have historically been part of 'insured services.' As a result, this administrator still very much held civic 'dental duties.'

Here then lies the subtle interplay between the public and private components of dental service delivery (in financing and structure), creating and blurring many lines: in the way dental care is thought about (*i.e.* the division of dental services to 'private dental services,' 'public dental therapy services,' and 'dental public health services'); the way it is financed (*i.e.* 'revenue sharing,' 'reciprocal billing,' and the 'public funding' of some services); and the way it is delivered (*i.e.* through 'publicly funded' dental therapy and dental public health programming for all communities, through 'purely private' dental offices in regional centres, through 'publicly and privately managed' contracted services to smaller communities, with both of these billing a system that publicly insures an uninsured service).

It is very evident that Indigenous self-determination in Nunavut acts as a factor in the development of all health services, both insured and uninsured. It continues to be the driving context for debates that fund the reality of sociopolitical change. These debates are essentially of the following nature: political (*e.g.* ethnonationalism and colonialism, self-government and public government); economic (*e.g.* the dynamic of corporate

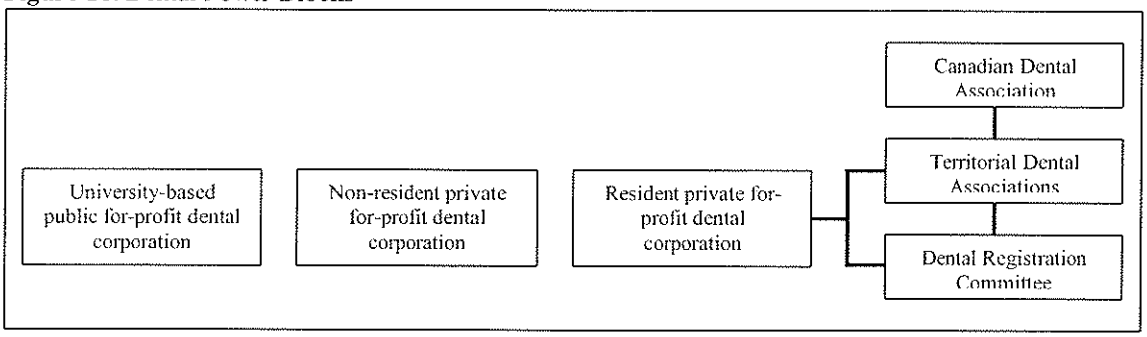
structures in Nunavut's self-governing ethnonational aspect, residency and ethnicity in northern contracting, the NNI); ideational (*e.g.* the idea of Indigenous control, IQ); processional (*e.g.* IQ, IEP, Committees of Council); and ultimately financial and structural (*e.g.* how to fund health and social services, specifically the NIHBs, relative to a fiduciary relationship). A premier example of such debates is found within the presentation of a composite case example surrounding events for the competition of dental contracts during the late 1990s and into recent years.

> ***Acting as a contractor for dental care in Nunavut, the Dean of this dental academy was under increasing pressure to respond to the possibility that the institution would be left out the current round of dental contracting. This pressure turned to frustration in the context of competition that no longer recognised his institution's authority in this endeavour, and its genuine and real capacity to enact change for the better. In his opinion, dental contracts were now too much like 'contracts in the market.'***
>
> ***'Whatever happened to the old days when governments only looked to the academy for meeting the needs of northern populations?' Those days were clearly over. Now, as one contractor among many, he was in an intense competition. Not only did he have to respond to the new 'shoo in' Inuit majority-owned resident private for-profit dental corporation (who by their very nature were perfectly placed to take a large portion of the pie), he had to respond to the insurgency of competition from within his own institution-- this from a private for-profit non-resident dental corporation (who was now achieving 'residency' by building a northern clinic) created by members within the faculty.***
>
> ***On the one hand, here was one corporation that he understood as being the future of northern dental care (relative to his support of community and human resource development), and on the other, one that was created in the vein of dental entrepreneurialism (something that he implicitly rejected as a community-minded/public health dentist). Both corporations were entrepreneurial and acted as source of competition, with both having a better shot at attaining contracts as per new policy.***
>
> ***He still maintained some power though. Not only was his institution well experienced in the delivery of care to areas of this sort, it was also a place where dental public health expertise could be found. This provided some legitimacy. In fact, he had been approached with the possibility of acting as a 'subcontracting partner' to the Inuit majority-owned dental corporation in order to support their contract bid. With several 'new' corporations perceived as 'lacking in experience,' this Dean had some options.***
>
> ***Overall, his decision to partner with the Inuit majority corporation constituted a way of maintaining a position in the northern contracting circle, concurrently supporting the ideographic implications of one contractor, and making his position clear on the ideographic positioning of another.***

V. The NNI Policy and the Competition for Dental Contracts

This Dean represented one of three distinct historical 'power-blocks' in northern dental contracting life (see Figure 16). These are: university-based care (university-based public for-profit dental corporations); corporations owned by members and/or affiliates of university-based care (non-resident private for-profit dental corporations); and corporations owned by long-term northern clinicians (resident private for-profit dental corporations).[161] This structure results from a history that saw the delivery of care to Nunavut regions first develop with those clinicians that travelled on behalf of federal authorities (rather than on behalf of corporations), with the eventual involvement of the academic sector, followed by the establishment of Part I (and Part III) resident northern clinicians and their corporations, then followed by competition from within the academic sector. The relations between these groups form much of the dynamic in this political economy, and the details of their constitution are relevant.

Figure 16. Dental Power-Blocks



As described, the notions of 'residency' and of 'public/private' form the central descriptors for these power-blocks, with residency relating to the contracting practice of rewarding a corporation that locates in the north, ideally locally, and with the public/private predicate essentially dividing corporations between university-based and completely private sector operations. It should nonetheless be understood (as will be

detailed in Chapter 7) that university-based care, while constituted as a publicly motivated corporation, still very much acts as a 'private' entity, in that part of its endeavour reflects the modern need of dental academic institutions to generate revenues for operating purposes (even if at worse, those revenues only cover the costs of 'outreach programs,' or at best, provide revenue to be used in other areas of institutional need).

So by the mid 1990s, after 'taking contracts' from university-based care in the Keewatin region, long-term northern clinicians found themselves wanting to get out of dental contracting. These clinicians expressed an interest to remove themselves from providing care to smaller communities, wishing instead to concentrate on resident practices in regional centres. Less obviously, with increased difficulties in 'making money' relative to federal cost containment measures, and with then current tumult associated with these corporations and P3 restructuring, these contractors saw their control over contracts disappear.[162]

By the late 1990s, new contractors entered the scene: university-based clinicians (some private practice dentists, others community/public health dentists) creating corporations to take advantage of the vacuum left by the northern resident clinicians. Previous practice had seen these clinicians deliver services through academic institutions, but also independently, most often relative to contracts for individual trips and/or in response to the emergent needs of one or two communities. So with previous independent contractual relationships with pre-Nunavut authorities and administrators, and with the new opportunities, they created their own for-profit dental corporations. These university-based clinicians (who now owned non-resident private for-profit dental corporations) were successful in their contract bids, also 'taking contracts' from

university-based care, which appeared to be the obvious choice of contractor at the time. Seen as a major coup, this would fuel the increased competitive nature of future contract tenders.

By the end of 1999, with the Nunavut Government soon to be releasing the next RFP for dental contracts, knowledge came of plans to create a new Inuit majority-owned resident for-profit dental corporation (the first ever in Nunavut, created by one of the administrative stakeholder's Inuit employees and a university-affiliated dentist). While Inuit minority-owned resident dental corporations had existed in the pre-Nunavut regions (*e.g.* Kiguti Dental Services Ltd.), majority ownership was even more legitimising. All power-blocks became acutely aware of the potential for such a corporation to alter the balance of power in the 'ownership' of communities, with the consequences for all power-blocks not being the same.

By this time, resident northern clinicians were no longer seen as interested and were not believed to be in preparation to meet the RFP. In terms of contract competition, the new Inuit majority corporation did not present any immediate threat to this stakeholder group as no contracts exist for regional centres. It is also important to note that regardless of whether they compete for contracts now, this does not mean that resident northern clinicians will not do so in the future. It is also incorrect to assume that because they do not compete today, they do not influence northern dental cultural life. In fact, it is these resident northern clinicians that constitute northern (Nunavut/NWT/Yukon) dental associations and their political activity, representing clinicians in fee guide negotiations and in the issue of the problematised NIHBs. This power-block also constitutes the Nunavut dental licensing authority or the 'Dental

Registration Committee' under Nunavut's *Dental Profession Act*. For this stakeholder group, the impact of the new Inuit majority-owned dental corporation came in relation to the new clinics that would soon to be built in regional centres as part of the heated contract competition.

For all other power-blocks, the impact of this new dental corporation meant a keen awareness of the new NNI policy. Their weaknesses relative to this same policy became more obvious as well. This policy shaped and forced corporate manoeuvrings, with this Dean becoming involved in an intense period of competitive behaviour and positioning, rife with accusations of competitor weaknesses and contradictions.

Contractors now had several options: partner with Inuit majority- or minority-ownership, hire local Inuit labour, and/or provide some form of northern corporate or personal residency. Corporations owned by members/affiliates of university-based care in turn began to build dental clinics in regional centres in order to satisfy the residency bias of the NNI policy (the building of these new clinics strategically involving Inuit labour and contractors wherever possible). As a result, many private for-profit dental corporations, which had previously been non-resident, were now resident.

The creation of such clinics became the most significant impact on already resident northern clinicians. Yet these clinicians are still seen as having 'more residency,' as new dental clinics were built to satisfy northern business residency, and not northern personal residency. As it stands, all contractors who built clinics remain 'non-resident' in that they hire clinicians to provide services in their clinics (although some do provide services in these clinics on an itinerant basis).[163]

For this Dean, the option of opening a northern dental clinic was not taken. Instead, a positioning of power came in the form of pressure placed on the corporation stemming from within his institution. This was an attempt to cease this competitor's activities insofar as these activities constituted a perceived conflict of interest. The question was this: Can a faculty member engage in direct competition with their academic employer? An answer to this question was not clear and came to involve legal manoeuvrings by both parties. The detailed relevance of this dynamic (whereby community/public health dentists within dental academies can form private for-profit dental corporations) is very important and is developed in Chapter 7 to further depict the dual nature of dentistry in Canada. Reflecting and grounding the proposed influence of a philosophical split between public health dentistry and private practice dentistry, this Dean (a community/public health dentist) quickly took an uncharitable view of the more private approach taken by faculty members (some community/public health dentists and some private practice dentists) to northern contracting.

Other stakeholders perceived this differently, inadvertently grouping themselves relative to their 'public' or 'private' inclinations. For example, while some stakeholders viewed the university-based clinicians with corporate interests as being in conflict, some viewed university-based care in conflict as well: the former as they were thought to be acting unethically in their use of academic contacts to provide services, and in their preponderance to flow dental expertise to Nunavut regions through their corporations (as opposed to through their role as a representative and promoter of their academic institution's interests in this region); the latter relative to the question of whether a public educational institution should be gaining from publicly tendered market-based (private)

contract opportunities and functions (*e.g.* delivering dental care to Nunavut communities).

Irrespective of public/private inclinations, critiques, and/or being community-minded or not, dental public health expertise was recognised by all as important. So in an environment of heated competition, dental public health expertise / modalities / technologies became itemised as a service that contractors offered in order improve their bids and the status of their corporations (something that had never taken on such an explicit characterisation in contracting before). Competitors began to offer assistance to the Nunavut Government in this regard, and even expressed the possibility that the administration and practices of public health services could be taken on as a contractual obligation. Some discussion even developed as to the potential of a 'dental public health' RFP. This displays two interesting things.

First, with heated competition, the provision of dental public health efforts became a competitor-perceived contractual service need for the Nunavut Government. A service easily offered since both university-based care and other corporations had community/public health dentists as leaders, or attained dental public health knowledge through partnerships. Second, this placed dental public health modalities as a market health service, something that, while displayed as positive and easily achievable through current market players and mechanisms, was still very new. This provides yet another example of the inclination towards the privatisation of services in northern health care.

So without a northern clinic and any form of 'residency points,' and without significant 'Inuit content,' this Dean readily perceived his institutions weaknesses. Irrespective of whether they constituted the most 'historically stable' form of care, this

would not be enough. This Dean then decided it would be a positive benefit to partner with the new Inuit majority-owned resident private for-profit dental corporation.

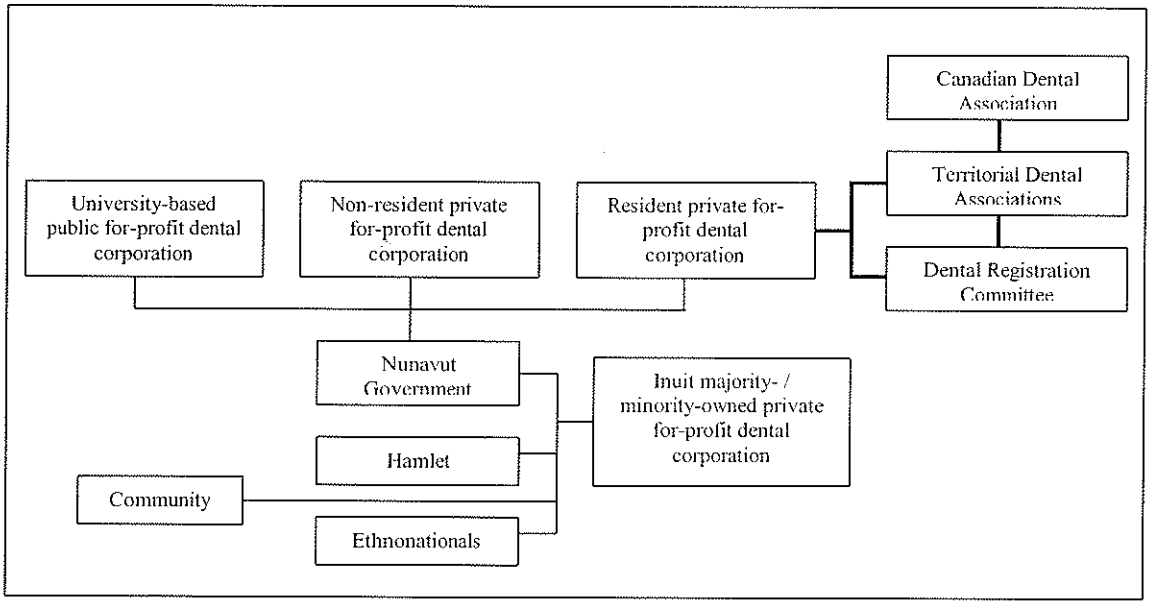
In their partnership, both parties would gain. The new corporation would acquire the stability of a long-term contractor's experience and expertise, and this academic institution would maintain its involvement. In particular, this Dean saw positive benefits in several things. His institution would maintain some position in servicing Nunavut and benefit from the potential fiscal gains. As a clear ideological statement on the support of increased Inuit involvement in northern health care, and as an ideological statement against his internal competition, it made the Inuit-majority corporation much more powerful and a significant competitor versus that internal competition. This would also create the possibility of involving students in more diverse 'externships/outreach activities' as part this institution's increased commitment to 'service-based learning, and would provide a potential environment for research as per the increased interest in 'Aboriginal health research.'

As early as July 2001, and more recently by mid 2002, a 'decision/steering committee' composed of the senior dental administrator, the NDHSS assistant deputy minister, the directors of medical affairs, population health, corporate affairs, community services, the executive directors of all regions, and representatives from the RIOs and NTI, have all awarded contracts to a non-resident/resident for-profit corporations, and the new resident for-profit corporations (one with Inuit-majority ownership and university support, one with Inuit-minority involvement). It is very clear that Indigenous self-determination continues to play a delimiting role in the development of dental services in Nunavut.

a. The Consequences and Problems with Competition

In impacting the development of dental care in Nunavut, Inuit self-determination has also played other, less obvious roles in delimiting northern dental services. As some stakeholders comment, such vigorous competitive activity allowed federal authorities to slow their negotiations with the Nunavut Government relative to federal transfers, pointing to the need for both the Nunavut Government to settle disputes concerning the application of the NNI, and for contractors to settle their own disputes. In doing so, federal authorities were able to 'save money' as little services occurred within the context of RFP delays.

Figure 17. Dental Power-Blocks and New Competition



With the focus being on placing some dental care services in the hands of an Inuit-majority owner, this action was seen as paralleling an increased Inuit control and capacity (see Figure 17). This new corporation meant that Inuit were hired and that a more direct connection now potentially existed between communities and a managing contractor, since an Inuit owner would potentially be more approachable and more

conducive to community contact. Yet it still remained that only a few Inuit and non-Inuit stakeholders gained from such contracts.

In the spirit of Piruqsaijit Ltd., a completely private corporate entrepreneurial endeavour became discussed as some type of community development vehicle, aligning successful corporate activity with the advancement of a global Inuit interest. This notion ultimately tied to the complex Nunavut governance/ethnonational structural existence that at once creates and blurs lines relative to types of Indigenous control over services (*e.g.* public ethnonational control, quasi-public ethnonational control, private ethnonational control), and relative to the already complex 'public/private' nature of the services to be controlled (*e.g.* the potential for complete privatisation in the delivery of a publicly insured uninsured service containing both curative and preventative elements).

With the heated competition, much pressure was placed on officials to respond to this corporation and its life under the NNI. In fact, stakeholders overlooked the fact that this corporation was not even supposed to exist under Nunavut law. The Nunavut *Dental Profession Act* states: "all of the issued shares of the corporation belongs to one or more licensees."[164] This means that corporations owned in part by non-licensees are in breech of the Act (*e.g.* Kiguti, the new Inuit majority-owned dental corporation). The Act goes further and states that cancellation of registration can occur if "a person who is not a licensee has exercised voting rights in respect of any shares in the corporation."[165] Irrespective of this possibly unknown (or ignored) fact, some stakeholders did raise questions as to the idea of a dental therapist owning and running a dental corporation.

In lieu of these and other problematisations, FNIHB appears to be taking more control over the administration of the dental NIHB (through the Northern Secretariat),

trying to mitigate current and future risks. FNIHB may also be moving towards forms of service delivery that minimise the role of the 'dental human resource corporation.' As recent administrative stakeholder interactions suggest, newer RFPs may attempt to encourage the contracting of northern clinicians themselves in an effort to minimise costs, and may also attempt to re-establish the more 'traditional' contracting of northern providers, who through their corporations own contracts following a private practice corporate model as opposed to the human resource and management firm. Yet since 'dental human resource corporations' (managed by individuals who are non-resident) now own resident northern clinics, tradition may still conclude in appearance.

Of final and ultimate importance: competition for contracts was so fierce, that the goal of finding successful ways to improve dental services and dental health in northern Inuit communities was completely lost by all parties. Almost anything was said and promised that could potentially mean success. While the perceived 'university / community partnership' with an Inuit owned corporation ended in small success (in the market sense), this new dynamic cannot be confused with any proposed action of this corporation as a vehicle for community development, as only a few select people benefited. For maximum community development, stakeholders must be working together, rather than competing for revenue sources amongst alliances that do not result in any significant health improvements, since it has been seem that community control can increase health at the individual and population level. Sadly, dental services in Nunavut may currently be more about competition and administrative debates, rather than about a cohesive vision aimed at relieving the suffering associated with dental disease.

VI. Conclusions

This chapter presented the argument that Indigenous self-determination does very much the same thing as geography and disease burden: it delimits the delivery of dental care in Nunavut communities. As determined, this structure impacts both the developments of health services in general and the NIHBs in particular, as well as the modern competition for dental contracts. Yet one reality resonates more than any other: in all of its years, the Nunavut Government received almost all revenues from federal transfers. This economic fact continues to render the Territory highly vulnerable to the actions of centralised authority. No amount of ideological, cultural or social power will mend this fact-- only control over economic spaces will. So until Nunavut can create an economic base to support 'economies of scale' (ideally with a supply Inuit providers), centralised economic/political control will continue.

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[1] Indigenous self-determination is understood herein as any Indigenously associated action that aims to advance the wellness of an Indigenous person and/or population (regardless if it does so or not). Self-determination, or the idea of controlling and improving one's life and future, and that of the lives and future of one's children (especially in the context of lives that have been disrupted through external rule), is the very reason why there exists both Inuit ethnonationalism and the notion of Inuit self-governance (as represented in Nunavut). Inuit self-determination should also be understood relative to the specific and particular 'fiduciary relationship' shared between Inuit and the Federal Crown. In short, Inuit self-determination (in the context of a specific historical/political relationship) is the raison d'être for the sociopolitical change under discussion.

[2] IQ is represented as 'traditional Inuit knowledge' and believed to be necessary at all levels of Nunavut governance.

[3] The NNI policy enshrines Article 24 of the NLCA, supporting the practice of preferential contracting towards northern, local and Inuit business. The NNI policy is showcased as an example of the 'ideal of Nunavut,' whereby both ethnonational and public authority enact 'self-government through public government.'

[4] As quoted in: **Inuit Tapiriit Kanatami** (2000) Summary Report: Inuit Health Policy Forum. Ottawa: ITK.

[5] **Dacks G** (1981) A Choice of Futures: Politics in the Canadian North. Toronto: Methuen Publishers.

[6] **Ibid.**

[7] **George B Cuff & Associates Ltd** (2001) Report on the NWT Health and Social Services System. Yellowknife: Government of the Northwest Territories.

[8] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[9] Consequently, Nunavut remains acutely vulnerable to federal pressures and fiscal cutbacks. This was well represented through the Tester's recent work, and through O'Neil's 'fourth world.' Surely then, a colonialist history can still be seen as feeding the political struggles between Canada's North and South, between Nation State and Indigenous Territory, and between Territorial and Federal Governments. See **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia. **O'Neil JD** (1986) "The politics of health in the Fourth World: A Northern Canadian example." Human Organisation 45(2): 119-127.

[10] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[11] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[12] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[13] **Weaver SM** (1981) Making the Canadian Indian Policy: The Hidden Agenda, 1968-1970. Toronto: University of Toronto Press.

[14] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[15] **O'Neil JD, Lemchuk-Favel L, Allard Y, Postl BD** (1999) "Community Healing and Aboriginal Self-Government: Is the Circle Closing?" in Hylton JH (Ed.) Aboriginal Self-Government in Canada. Saskatoon: Purich Publishing.

[16] **Inuit Tapiriit Kanatami** (2000) Our History. Ottawa: ITC Communications Department.

[17] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[18] **Ibid.**

[19] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[20] The formation of TFN is significant, as it became the main ethnonational institution for Inuit of the proposed Nunavut Settlement Area (which eventually becomes NTI, the parallel ethnonational entity associated with governing the public self-government of Nunavut).

[21] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA; **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62; **Dickerson M** (1992) Who's

North? Political Change, Political Development and Self-Government in the Northwest Territories. Vancouver: UBC Press and Arctic Institute of North America; **Duffy R** (1988) The Road to Nunavut: Progress of the Eastern Arctic Inuit Since the Second World War. Kingston: McGill University Press.

[22] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[23] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[24] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA; **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[25] **Légaré A** (1993) "Le Projet Nunavut: Bilan des Revendications des Inuit des Territoires-du-Nord-Ouest." Études/Inuit/Studies 17(2): 29-62.

[26] **Hicks J and White G** (2000) "Nunavut: Inuit self-determination through land claims and public government?" In Dahl J, Hicks J, Jull P (Eds.) Nunavut: Inuit Regain Control of Their Lands and Their Lives pp. 30-117. Copenhagen: IWGIA.

[27] **Ibid.**

[28] **Ibid.**

[29] **Ibid.**

[30] **Government of Nunavut** (1999) The Bathurst Mandate. Iqaluit: Government of Nunavut.

[31] **Ibid.**

[32] **Ibid.**

[33] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[34] **Whittington M** (1986) Native Economic Development Corporations: Political and Economic Change in Canada's North. Ottawa: Canadian Arctic Resources Committee.

[35] Tester ultimately grounds his analysis in a consideration of the establishment and developing class structure in modern Aboriginal Canadian life, finding connections between public sector influence and class based Indigenous structures. Tester also finds analytical support in **Mitchell M** (1996) From Talking Chiefs to a Native Corporate Elite. Montreal: McGill-Queen's University Press, which argued that the northern cooperative movement, while drawing upon Inuit collective cultural traditions, established an Inuit elite, that now, for all intents and purposes, acts as a ruling class.

[36] As presented in Chapter 3, from the early 1980s and throughout the 1990s, substantial work went into 'regionalising' and 'making more accountable' the health structures in the old NWT. Regional health boards and other more 'local' ethnonational structures were supported in this regard (e.g. CHC, CHRs). Yet as mentioned, the Inuit 'A team' was considered more fundamental to the establishment of an Inuit self-governing territory.

[37] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[38] **Ibid.**

[39] **Quiñonez CR** (2003) "Dentistry in Nunavut: Inuit Self-Determination and the Politics of Health." In Oakes J, Riewe R, Wilde K, Edmunds A, Dubois A (Eds.) Native Voices in Research. Winnipeg: Aboriginal Issues Press.

[40] **Government of Nunavut** (2001). Department of Health and Social Services 2001-2002 Main Estimates. Iqaluit: Government of Nunavut.

[41] The NAM is increasingly becoming an important voice in Nunavut governance, as is evident through the relevance of its discourse. See for example **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM. Herein, the NAM makes clear critiques through resolutions that call for needed action on such diverse issues as 'Search and Rescue Funding,' 'Vocational Training Centres,' 'Suicide Prevention Studies,' 'Economic Opportunities for Non-Decentralized Communities,' 'Aboriginal Rural Funding,' 'Food Price Monitoring,' 'Inuit Senior Citizen Care Homes,' 'Diabetes,' 'Government of Nunavut Contracts,' amongst many others. The municipal form of directed and focused political activity is increasing in Nunavut. This is not surprising, as 'community autonomy' is one often-noted nature of Indigenous ideology. Local Hamlets can in one sense be considered another core of Nunavut governance. The Nunavut Government paralleling this belief through its move towards a decentralised governmental structure (whereby communities become more important centres of cultural and economic activity). More fundamentally still is the fact that each community and hamlet has long lived with the fact that territorial, federal and ethnonational realities often impact local occurrence. For example, organisational structures in communities (e.g. health centres) constitute through federal, territorial, ethnonational, and municipal concerns (whether through funding and/or programming).

[42] See for example **Bell J** (2002) "ITK president blasts Inuit health-care standards." Nunatsiaq News April 05; **Inuit Tapiriit Kanatami** (2002) Inuit Nipingat Qanuinngittiarnirmut (A Voice for Inuit Health) – Inuit Health Information Initiative, Aboriginal Health Infostructure, Telehealth, Health Research. Ottawa: ITK; **Government of Nunavut** (2001) Home Care Presentation to Inuit Tapirisat of Canada Health Committee. Iqaluit: Government of Nunavut Department of Health and Social Services; **Inuit Tapirisat of Canada** (2000) Mandate/Purpose of ITC Health Committee. Discussion Paper. Ottawa: ITC.

[43] Researchers/health professionals who study and/or practice in northern regions initially established the CSCH and ISCH. Their mandate was to create a community of northern researchers and institutions that would promote circumpolar health research and debates (and often acts as a voice of advocacy relative to the inequality experience by the populations under study). Over time, as the relations of power between researcher and research subject began to shift, ethnonational structures assumed positions of power in these professional societies. This often in relation to ethnonationalist efforts within academic sectors for more stringent ethical considerations as applied to the study of Indigenous populations, with a subsequent rise of research methods in this regard (e.g. Participatory Action Research, community development approaches, et cetera).

[44] **Government of Canada, Department of Indian Affairs and Northern Development and Tunngavik Federation of Nunavut.** (1993) Agreement Between the Inuit of the Nunavut Settlement Area and Her Majesty the Queen in Right of Canada (Nunavut Land Claims Agreement). Ottawa: Government of Canada.

[45] **Wilman M** (2001) "GN Must Involve Inuit in NIHB Decisions." Nunatsiaq News. Letter to the Editor March 09.

[46] **Author Unknown** (2003) "Inuit still not tapping into healing fund." CBC North August 13.

[47] **Author Unknown** (2002) "NTI takes back social development responsibility." CBC North March 06.

[48] **Nunavut Tunngavik Incorporated** (2002) "Nunavut Social Development Council to be Restructured to Deal with Nunavut's Social Crisis." Press Release March 5.

[49] **Ibid.**

[50] **Nunavut Tunngavik Incorporated** (2002) " Nunavut Tunngavik Takes Control of Nunavut Social Development Council – Dismisses Council Members." Press Release March 22.

[51] **Ibid.**

[52] **The GN/NTI Contracting Working Group** (2000) Nunavummi Nangminiqaqtunik Ikajuuti. Iqaluit: Government of Nunavut.

[53] **Ibid.**

[54] **Rideout D** (2001) "GN, NTI in stand-off over contracting policy: sides can't agree on how appeals board should work." Nunatsiaq News June 22.

[55] **Ibid.**

[56] **Rideout D** (2001) "Inuit firm stuck waiting for appeal: GN, NTI feud leaves Nunasi in limbo." Nunatsiaq News June 29.

[57] **Author Unknown** (2002) "Why NTI is fighting the GN." Nunatsiaq News June 14.

[58] **Ibid.**

[59] **Bell J** (2002) "GN-NTI dogfight moves to the courthouse." Nunatsiaq News June 14.

[60] **Author Unknown** (2002) "Business policy fight settled in Nunavut." CBC North July 31.

[61] **D'Souza P** (2002) "GN gives non-Inuit firms one-year NNI extension." Nunatsiaq News April 12.

[62] **Ibid.**

[63] They are described as 'Kivalliq Partners in Development.' This makes sense in the context of historical practices that have seen northern social and economic development policy aim to promote local Indigenous business, the NNI policy being the latest example. Northern businesses respond by attempting to form Inuit-minority and more effectively, Inuit-majority owned corporations.

[64] As will be further developed in Chapter 6, this appears to be the case for many Aboriginal communities in Canada, whereby control and involvement in 'health and social services' through the activities of public and private markets is a substantial portion of ethnonational discourse and practice. This makes sense in an environment where 'health and social services' form a substantial portion of local economies. For example, health centres often constitute a significant number of potential jobs in a community. In fact, health and social services funding often constitutes some of the largest budgets in communities (relative to anything else, private industry included). Regardless of whether these economies constitute a large portion of local opportunity, the fact remains that these local economies do not constitute independently (insofar as federal transfers constitute a great majority of infused infrastructure, capital and wages). These economies in turn remain susceptible to cuts and/or cost-control measures enacted by federal authorities.

[65] Both businesses are listed as late as 2003 in the NNI Business Registry as Approved Nunavut Businesses offering these services (amongst others related to health and social services).

[66] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[67] The KIA purported to be in preparation to establish an NIHB 'pilot project.' **Kivalliq Inuit Association** (1997) Annual Report. Rankin Inlet: KIA.

[68] This series of points presents an interesting reality for Nunavut, viz. that 'devolution/transfer' can mean three things: devolvement to the Nunavut Government; devolvement to ethnonational structures; or devolvement to the ideal of Nunavut governance (e.g. a 'public self-governed' situation whereby the NSDC could have acted in relation to both NTI and the Nunavut Government in an NIHB administrative capacity).

[69] **Government of Nunavut** (2002) Building Nunavut Through Decentralization: Evaluation Report. Iqaluit: Prepared under contract to the Evaluation and Statistics Division, Department of Executive and Intergovernmental Affairs, Government of Nunavut.

[70] **Bell J** (2003) "GN moves 23 jobs to Pangnirtung." Nunatsiaq News July 04.

[71] **Government of Nunavut** (2002) Building Nunavut Through Decentralization: Evaluation Report. Iqaluit: Prepared under contract to the Evaluation and Statistics Division, Department of Executive and Intergovernmental Affairs, Government of Nunavut.

[72] **Bell J** (2003) "GN moves 23 jobs to Pangnirtung." Nunatsiaq News July 04.

[73] **Government of Nunavut** (2002) Budget Address. Sixth Session of the First Legislative Assembly of Nunavut. Iqaluit: Government of Nunavut.

[74] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[75] NAM has reported on the increasing disparity between decentralised and non-decentralised communities, and in this regard, has called for the need to create and support economic opportunities in decentralised communities. **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM.

[76] This researcher chooses to characterise IQ in this regard, as IQ, while defined relative to traditional knowledge, cannot only constitute as such. Clearly, while historical cultural understandings are relevant to define, aid, and provide for pride, health and success, it appears naïve to only contextualise IQ in this way. Surely, change is a constant. Consider comments made by Jaypetee Arnakak in a Northern periodical: "To many people, the 'traditional knowledge' aspect of IQ is often the only side that is seen, but that describes only one half of it. IQ, [...] is really about 'healthy, sustainable communities' regaining their rights to a say in the governance of their lives using principles and values they regard as integral to who and what they are." **Arnakak J.** (2001) "What is Inuit Qaujimajatuqangit? Using Inuit family and kinship relationships to apply Inuit Qaujimajatuqangit." Canku Ota (Many Paths) An Online Newsletter Celebrating Native America Issue Issue 27 January 13.

[77] **Government of Nunavut** (2000) Joint Report of the Standing Committees of the Legislative Assembly of Nunavut on the 2000-2001 Budget and Departmental Business Plans of the Government of Nunavut. Iqaluit: Government of Nunavut; **Government of Nunavut** (1999) Report on the Review of Draft Departmental Business Plans and Preliminary Information on the 1999/2000 Main Estimates. Iqaluit: Government of Nunavut; **Government of Nunavut** (1999) Report on the Six-Month Departmental

Progress Update - Departments of Culture, Languages, Elders and Youth; Education; Health and Social Services. Iqaluit: Government of Nunavut.

[78] **Government of Nunavut** (1999) Report on the Six-Month Departmental Progress Update - Departments of Culture, Languages, Elders and Youth; Education; Health and Social Services. Iqaluit: Government of Nunavut.

[79] **Ibid.**

[80] To see Inuit self-determination represented in public health discourse is not new. Recall O'Neil, Weller, and Tester's arguments, all recognising a dynamic between Inuit polity who, most often than not, pushed a public health agenda relative to biomedical practitioners and administrators who, most often than not, maintained and funded a curative mode of care (these biomedical practitioners and administrators also having to respond to the same Inuit polity that, while pushing a public health agenda, also maintained firm pressure regarding availability and access to curative services).

[81] **Government of Nunavut** (2001) Department of Health and Social Services 2001-2002 Main Estimates. Iqaluit: Government of Nunavut.

[82] **The Agora Group** (2002) "Inuit Qaujimajatuqangit: A lesson for all?" Import - A Weekly Review of Developments in Health and Human Services 2(27): 6-7.

[83] **Arnatsiaq S** (2002) "Government focuses on Inuit Qaujimajatuqangit: Department coordinators, elders council to help GN implement IQ." Nunatsiaq News September 06.

[84] **Rideout D** (2001) "Nunavut's Inuit Qaujimajatuqangit group get started." Nunatsiaq News February 02.

[85] **Government of Nunavut** (2003) "Inuit Qaujimajatuqangit Katimajiit Established." Press Release September 08.

[86] Interestingly, early Inuit policy planners claimed that: "Taking cue from the lessons learned from the Government of the NWT Traditional Knowledge Policy [...] [we] deliberately tried to keep IQ from becoming an official policy, knowing that separating IQ from the contemporary realities renders something that is profound, enriching and alive into something that meaningless, sterile, and awkwardly exclusionary." **Arnakak J** (2001) "What is Inuit Qaujimajatuqangit? Using Inuit family and kinship relationships to apply Inuit Qaujimajatuqangit." Canku Ota (Many Paths) An Online Newsletter Celebrating Native America Issue Issue 27 January 13.

[87] **Ibid.**

[88] **Government of Nunavut** (2000) Inuit Employment Plan. Iqaluit: Department of Human Resources Government of Nunavut.

[89] **Government of Nunavut** (2001) Combined 1999-2000 and 2000-2001 Public Service Annual Report. Iqaluit: Department of Human Resources Government of Nunavut.

[90] **Ibid.**

[91] **Ibid.**

[92] **Ibid.**

[93] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[94] **Ibid.**

[95] **Government of Nunavut** (2001) Combined 1999-2000 and 2000-2001 Public Service Annual Report. Iqaluit: Department of Human Resources Government of Nunavut.

[96] **Government of Nunavut** (2003) Towards a Representative Public Service – Statistics as of March 31st 2003. Iqaluit: Training and Development Division Department of Human Resources Government of Nunavut.

[97] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[98] **Government of Nunavut** (2003) Towards a Representative Public Service – Statistics as of March 31st 2003. Iqaluit: Training and Development Division Department of Human Resources Government of Nunavut.

[99] **Government of Nunavut** (2001) Combined 1999-2000 and 2000-2001 Public Service Annual Report. Iqaluit: Department of Human Resources Government of Nunavut.

[100] **Ibid.**

[101] **Ibid.**

[102] **Ibid.**

[103] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut; **Government of Nunavut** (2000) Joint Report of the Standing Committees of the Legislative Assembly of Nunavut on the 2000-2001 Budget and Departmental Business Plans of the Government of Nunavut. Iqaluit: Government of Nunavut; **Government of Nunavut** (1999) Report on the Review of Draft Departmental Business Plans and Preliminary Information on the 1999/2000 Main Estimates. Iqaluit: Government of Nunavut; **Government of Nunavut** (1999) Report on the Six-Month Departmental Progress Update - Departments of Culture, Languages, Elders and Youth; Education; Health and Social Services. Iqaluit: Government of Nunavut.

[104] **Government of Nunavut** (1999) Report on the Six-Month Departmental Progress Update - Departments of Culture, Languages, Elders and Youth; Education; Health and Social Services. Iqaluit: Government of Nunavut.

[105] **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM.

[106] **Government of Nunavut** (1999) Report on the Six-Month Departmental Progress Update - Departments of Culture, Languages, Elders and Youth; Education; Health and Social Services. Iqaluit: Government of Nunavut.

[107] **Government of Nunavut** (2000) Joint Report of the Standing Committees of the Legislative Assembly of Nunavut on the 2000-2001 Budget and Departmental Business Plans of the Government of Nunavut. Iqaluit: Government of Nunavut.

[108] **Author Unknown** (2001) "Health committee funding plans under fire in Nunavut." CBC North November 26.

[109] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[110] **Gjoa Haven** (2001) Committee of Council Phase I: Strategic Planning Document. Gjoa Haven: SolutionsNorth; **Kugaaruk** (2001) Committee of Council Phase I: Strategic Planning Document. Kugaaruk: SolutionsNorth; **Taloyoak** (2001) Committee of Council Phase I: Strategic Planning Document. Taloyoak: SolutionsNorth.

[111] **Ibid.**

[112] **Ibid.**

[113] **Government of Nunavut** (2000) Joint Report of the Standing Committees of the Legislative Assembly of Nunavut on the 2000-2001 Budget and Departmental Business Plans of the Government of Nunavut. Iqaluit: Government of Nunavut.

[114] **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM.

[115] **Government of Nunavut** (2003) Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[116] **Ibid.**

[117] **Ibid.**

[118] **Inuit Tapiriit Kanatami Health Committee** (2003) Presentation made to Federal Legislative Standing Committee on Health regarding Inuit oral health issues. April 30. As is developed in Chapter 6, ITK is now part of a partnering block (with other national Aboriginal organisations like Assembly of First Nations and with professional organisations like the CDA) that routinely takes aim at the policies and processes they see as problematic.

[119] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[120] **Ibid.**

[121] The social space of public health has allowed Inuit self-determination practices to mandate power in the delivery of services (both curative and preventative). This makes sense when Inuit constitute a minimal proportion of clinicians/administrators (who play a significant role in establishing policy and planning). Education initiatives in professional nursing, education, and law (and possibly one day in medicine and dentistry) all aim to correct this imbalance.

[122] **Government of Nunavut** (2001) "Budget Address." Sixth Session of the First Legislative Assembly of Nunavut. Iqaluit: Government of Nunavut.

[123] These programs are described as 'stacked contribution agreement funding' in the NDHSS 2002-2003 Main Estimates, and include 'Brighter Futures, Building Healthy Communities, Mental Health Crisis Management, Solvent Abuse Program and Home Nursing, Canada Prenatal Nutrition Program, National Native Alcohol and Drug Abuse Program, Treatment and Training, Home and Community Care, Fetal Alcohol Syndrome Program, and Program Management.' **Government of Nunavut** (2002) Department of Health and Social Services 2002-2003 Main Estimates. Iqaluit: Government of Nunavut.

[124] **Government of Canada** (2002) Canada Health Act Annual Report 2001-2002 (Chapter 3 Nunavut). Ottawa: Government of Canada.

[125] An example of this would be the infusion of funds for an oral health prevention effort as a direct response to pressure from ITK, other ethnonationals, all in cooperation with professional authorities. As

reviewed in Chapter 3 and developed in Chapter 6, this prevention effort was a direct response to efficient pressure from the aforementioned groups, who demanded that any new funds come from outside current budgets. So when money was received, it stemmed from a new contribution and/or grant.

[126] **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[127] This capital shortage allowed the P3 (private, public, partnership) policy to develop and provide a context for meeting the services needs of Nunavummiut (to date constituted by ethnonational involvement in capital projects). This allowing for the development of private sector interests in northern health care. **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia.

[128] **Government of Nunavut** (2001) Budget Address. Sixth Session of the First Legislative Assembly of Nunavut. Iqaluit: Government of Nunavut.

[129] **George J** (2001) "Picco says he'll press Ottawa for more NIHB money: Health minister says Nunavut isn't getting its fair share of aboriginal health funds from Ottawa." Nunatsiaq News February 23.

[130] **Author Unknown** (2002) "Nunavut not billing Ottawa, millions owed." CBC North December 4

[131] **Government of Nunavut** (2001) "Budget Address." Sixth Session of the First Legislative Assembly of Nunavut. Iqaluit: Government of Nunavut.

[132] **Ibid.**

[133] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[134] **Ibid.**

[135] **Legislative Assembly of Nunavut** (2001) "Oral Questions." Hansard of the Fifth Session of the Legislative Assembly. Iqaluit: March 28.

[136] **Government of Nunavut** (2003). Department of Health and Social Services Business Plan 2003-2004. Iqaluit: Government of Nunavut.

[137] **Author Unknown** (2003) "Northern premiers to sign co-operative pact." CBC North September 03; **Author Unknown** (2003) "Premiers win new funding for health." CBC North February 20; **Author Unknown** (2003) "Pressure mounts on feds for northern health deal." CBC North February 07; **Author Unknown** (2003) "North rejects national health accord." CBC North February 06; **Author Unknown** (2003) "Premiers stand on health lauded in North." CBC North February 06.

[138] **George J** (2001) "Picco says he'll press Ottawa for more NIHB money: Health minister says Nunavut isn't getting its fair share of aboriginal health funds from Ottawa." Nunatsiaq News February 23.

[139] **D'Souza P** (2003) "Territories could receive extra money for health care - Premiers agree per capita funding not enough for northern regions." Nunatsiaq News January 31; **Government of Nunavut** (2002) "Premier, Minister endorse call for 'urgent attention' to rural and remote health care." Press Release November 28.

[140] **Legislative Assembly of Nunavut** (2000) "Oral Questions." Hansard of the Third Session of the Legislative Assembly. Iqaluit: February 29.

[141] **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM.

[142] **Ibid.**

[143] **Ibid.**

[144] **Legislative Assembly of Nunavut** (1999) "Budget Address." Hansard of the First Session of the Legislative Assembly.

[145] **Legislative Assembly of Nunavut** (2002) "Oral Questions." Hansard of the Sixth Session of the Legislative Assembly. Iqaluit: May 09.

[146] **Ibid.**

[147] **Ibid.**

[148] **Legislative Assembly of Nunavut** (2001) "Oral Questions." Hansard of the Fourth Session of the Legislative Assembly. Iqaluit: March 28.

[149] **Ibid.**

[150] **Nunavut Association of Municipalities** (2003) Action-Based Resolutions. Annual General meeting. Cambridge Bay: NAM.

[151] **Legislative Assembly of Nunavut** (2002) "Oral Questions." Hansard of the Sixth Session of the Legislative Assembly. Iqaluit: May 09.

[152] **Ibid.**

[153] **Canadian Health Coalition** (2003) A Canadian Health Coalition Report on Health Care in Northern Territories. Ottawa: Canadian Health Coalition (Northern Territories Federation of Labour, Public Service Alliance of Canada – North, Alternatives North, Union of Northern Workers Yukon Federation of Labour, Yukon Employees Union, Union of Northern Workers – Local 11, Canadian Labour Congress). This situation has been described as a crisis by the Coalition, which has become very active in lieu of the most recent Canadian Royal Commission on Health Services (the 'Romanow Report'). As per their estimation, the Nunavut health care budget needs approximately $30 million more per year.

[154] **Legislative Assembly of Nunavut** (2002) "Oral Questions." Hansard of the Sixth Session of the Legislative Assembly. Iqaluit: May 09.

[155] Another detail of relevance here is the stated number of dental therapists. The notion that there are a total of 23 dental therapists is questionable. As per ethnographic observation, there appears to be roughly 6 to 8 dental therapists in the region. As presented in the case study, this administrative stakeholder often commented on his inability to attract dental therapists. Moreover, in the context of a decline in dental therapy graduates from the NSDT, the notion that the Nunavut Government employs this many dental therapists is highly suspect.

[156] As will be developed in Chapter 7, this vacillation occurs relative to the practice philosophy inclinations of those dentists that administer services. Some seeing fee for service structures and competition as an ideal context (more often than not private practice dentists), others preferring per diem arrangements stressing more governmental involvement in services, such as in concentrating on prevention (more often than not public health dentists).

[157] This did not mean that there were too many practitioners, as there is still a struggle to find human resource capital. With contractors (who find clinicians for service provision) becoming a force in contracting life (as opposed to the historical power held by the single practitioner with a northern clinic), this simply meant that subcontracting clinicians had increased choices as to whom they wanted to work for.

[158] Competition was intense enough that while in the 1980s dentists were receiving an estimated 120% of every procedure. By the late 1990s, contractors were willing to deliver services for less than 100%.

[159] The Nunavut Government also covers the costs associated with patient travel to regional centres for more complex dental care (e.g. paediatric OR, oral surgery, orthodontics), again, with only a $250 co-payment for a ticket that can range between $600 - $1200 dollars. Consider that if all children that are purported to be on the waiting list are seen (roughly 300 children as per stakeholder commentary), the costs could range anywhere from $180 thousand to $360 thousand (an expense that when mentioned to administrators, was often laughed at and said to be 'impossible'). With roughly $2.3 million to work with, this administrative stakeholder often stated that he needed double this amount to do any sort of effective job. Interestingly, this administrative stakeholder stated that the money would really only be used to provide more dental days (curative care). As was discussed in Chapter 4, this answer is common, whereby the immediate response to answer need comes in the form of curative care to ease an acute situation. Again, this with undeniable evidence and professional knowledge that preventative care in combination with curative care appears to be a more rational answer to solve the 'problem of oral health.'

[160] **Treasury Board of Canada** (1997) Description of Dental Program Redesign Initiative for Health Canada. Ottawa: Treasury Board of Canada; **Hechter FJ** (1997) Review of the Delivery of Dental Care Funded through the Non-Insured Health Benefit (NIHB) Dental Program in the Northwest Territories. Ottawa: Medical Services Branch.

[161] The question can be posed as to the non-inclusion of corporations owned by non-members/non-affiliates of university-based care (i.e. power-blocks constituted through non-resident clinicians with no affiliation to any university). While there have been non-university affiliated clinicians with small individual contracts with regional health boards, these individuals never moved to form corporations that were to have any lasting power in the modern contract circle.

[162] **McCluskey K** (2000) "Stalemate continues: Dentists and feds still far apart." News/North July 10; **Pastori C** (1998) "Crisis in dental recruitment (letter to the editor)." Nunatsiaq News November 06; **George J** (1998) "KRHB rebuilding health care system in the Kivalliq – The Keewatin regional health board is ready to strike a new deal with the University of Manitoba, and plans to re-hire dental therapists and restore dental services." Nunatsiaq News July 24; **Bourgeois A** (1998) "Ottawa cuts take big bite out of dentists' fees." Nunatsiaq News April 30; **Bell J** (1997) "Ottawa says no to Keewatin dental deal: Health Canada officials say they won't honour fee-for-service billings submitted by dentists working for Kiguti Dental Services in the Keewatin." Nunatsiaq News September 26. The desire to not compete for dental contracts may not be entirely accurate. As some stakeholders comment, there was enough negativity in the Federal/old NWT Dental Association negotiations over fee guide reductions and new predetermination processes, that both clinicians and federal authorities saw no opportunity for successful bids.

[163] Of additional significance, administration now takes place in both northern and southern locations, whereas before it would only occur in the south. This can be seen as one positive effect of this new dynamic. These clinics further provide a place of employment for local persons, and also become part of a regional centre's economy. Moreover, the establishment of these clinics provides the health consumer with increased choices.

[164] **Annual Volumes of the Statutes of the Northwest Territories** (1988) Dental Profession Act (as appropriated by the Nunavut Court of Justice). Yellowknife: Government of the Northwest Territories.

[165] **Ibid.**

Chapter 6. State/Indigenous Relations

I. Introduction

Inuit control over Nunavut's health services is tethered to debates surrounding Indigenous governance, funding for Indigenous services, and the proposed claim of 'fiduciary' and/or 'aboriginal' rights to health and health care. Immediately grounding in the unclear and unsettled 'rights and responsibilities' between both groups, this is how the previous chapter's administrator buttressed his arguments that some of the delivery of dental care in Nunavut is not NDHSS responsibility. The bases for such arguments are more finely understood relative to the larger general dynamic that the State shares with all Indigenous groups, that which includes and impacts the Inuit of Nunavut but also occurs outside of their jurisdiction.[1] This chapter will consider this more 'macro' social space and its unique delimiting capacity.

Beginning with a brief review of the current direction of Canada's Aboriginal health policy and system (demonstrating the existence of a discrete 'Aboriginal Health System' of which Nunavut is a part), it then turns to a detailed analysis of the NIHBs. Being an NIHB, dental care in Nunavut is part of a modern complex of market-based health services, which in combination with today's Indigenous governance dynamic, is now forming part of an 'Aboriginal Health Economy' (of which Nunavut is a part). These developments critically intersect with the unclear 'rights and responsibilities' and 'historical conflations' of the State/Indigenous relationship, and in an environment of subtle and shifting governmental controls and responsibilities (and of increased private interests), the unresolved nature of such debates now holds significant power to shape the health and health care of all Indigenous groups.

II. A Brief Review of Canada's Aboriginal Health Policy and System

Indigenous groups have their own unique contexts and ways of mitigating their relationship with the State. Yet they also coexist in the general environment of centralised/federal policy developments. The resultant administration and service provision of this policy has historically held Inuit as separate from 'Indians,'[2] but as all Aboriginal groups increasingly control their services, the mechanisms that govern and guide this process have congealed.

What was described as 'health board devolution' in the pre-Nunavut regions is now very similar to First Nations 'health transfer' (as per a 'health transfer policy'): all groups sign 'stacked contribution agreements' (now increasingly pro forma agreements); the same programs exist in such agreements (e.g. Nursing, CHRs, National Native Alcohol and Drug Abuse Program, Brighter Futures, Building Healthy Communities); and per capita expenditures are linked to those that do and do not hold some form of Indigenous status (e.g. an Inuit 'beneficiary' or a 'status Indian'). So while 'transfer' in the provinces did not originally constitute 'devolution' in the territories (as territorial governments and not individual Aboriginal communities and/or ethnonational organisations accept transferred health programs and funds), both observed the same essential transfer of monies and control, and came to share many concerns (e.g. appropriate funding, cultural and geographic relevance, federal 'off-loading').

Differences are minimised when observing the Nunavut Government as an ethnonational, and the attempts of Inuit ethnonationals to acquire programmatic activity through 'transfer' continues further, such as with KIA and the NIHB program in the mid

1990s, and more recently through NTI and QIA with public health and social programming.[3] The enactment of a fully (Inuit and First Nations) integrated and devolved/transferred system has also become one focus of policy for federal and Indigenous authority.[4] So in the 30 years of 'passing control' (either through comprehensive land claims or specific agreements), the policy that supported and guided the concept(s) of 'devolution/transfer' became predominantly equal for all groups. When stakeholders discuss 'The Indian Health Policy,' 'The Health Transfer Policy,' 'The Inherent Rights Policy,' 'Devolution,' and/or 'Transfers North of 60,' they all refer to the same movement of increased Indigenous control over culturally relevant (most often public health) programs.

Ultimately, when MSB was renamed FNIHB to note (in part) the differences between Inuit and First Nations, it still adopted a singular mission and vision:

> "[Mission] To establish a renewed relationship with First Nations and Inuit that is based on the transfer of direct health services and a refocused federal role, and that seeks to improve health status of First Nations and Inuit. [Vision] First Nations and Inuit people will have the autonomy and control of their health programs and resources within a time frame to be determined in consultations with First Nations and Inuit people."[5]

Yet how to enact and achieve these laudable goals continues with significant political disagreements. Disagreements where inequity is readily recognised, where Indigenous people are seen as developing their 'control over services and self-governing capacity,' where State administrative and bureaucratic concerns concentrate on cost-containment, and where the 'rights of Indigenousness'[6] are still debated.

Specifically, Aboriginal health policy in Canada has now fixated on three constructs, or three 'new pillars:' inequity, control, and costs. Note the absence of any construct to ensconce the notion of rights. This is well reflected in comments made by a senior FNIHB official:

> "MSB has identified three broad strategic directions which inform the work of the Branch: 1. The development of sustainable health systems that are well-integrated into the Canadian health system. 2. The reduction of health inequalities experienced by First Nations and Inuit. 3. Strong partnerships with First Nations and Inuit to create the needed and desired changes in the health system. These goals are pursued within the overarching vision of control and autonomy of health services by First Nations and Inuit. Also, the goals are responsive to fiscal realities and pressures."[7]

Or, as was more directly stated:

> "First Nations and Inuit Health Branch priorities: To manage the cost-effective delivery of health services within the fiscal limits of the First Nations and Inuit health envelope. To facilitate First Nations and Inuit in developing the capacity (infrastructure and processes) to foster and maintain healthy communities. To support action on health status inequalities affecting First Nations and Inuit communities, according to their identified priorities."[8]

So with the federal need to contain costs perceived as most imminent:

> "[P]rogram expenditures [were] required to be managed within a fixed financial envelope. Annual growth rates have been set at 6 percent in 1995-96, 3 percent in both 1996-97 and 1997-98, and approximately 1 percent in 1998-99 [roughly 3% into today]. The Department has established regional envelopes, and there is flexibility for each region to move resources among programs within its allocation."[9]

Capping budgets ushered in the 'envelope environment,' where freedoms to structure and redefine programming were introduced as per the exigencies of the 'self-government environment' (giving the sense of an enhanced decision-making capacity), yet any decisions only occurring within the confines of a 'fixed financial envelope.'[10]

In time, cost-containment became observed as equalling the federal agenda, with the politicisation of Canada's 'Aboriginal health system' now further entrenched. A summary of this situation is well represented in an Auditor General's report:

> "The provincial and territorial governments are primarily responsible for the delivery of health care [...]. [They] consider that the federal government should accept full responsibility for [Aboriginal populations]. The federal government views health care as primarily a [provincial and territorial] responsibility [maintaining] that the federal government's provision of health services to status Indians and Inuit is based on policy and not on treaty or other legal obligations. Most [Aboriginal groups] generally consider that all necessary health services must be provided to them under Aboriginal and treaty rights and, as such, represent a fiduciary obligation owed by the Crown."[11]

Desperate to move forward, groups now discuss their contentions relative to 'sustainability' and 'fiscal responsibility,' and 'renewed relationships' or 'health renewal.'

Apart from the politicised and charged relations that still result from such disingenuous and unclear policy, Canada's 'Aboriginal health services' have developed into a readily recognisable structure, functioning separately from and intimately with the provincially/territorially based system (almost all recognising its heavy or full constitution of territorial systems). As Lavoie states: "[S]eparate systems are here to stay."[12] 'Ottawa and the regions' is now a centralised mandate engine that feeds into the peripheral authority of FNIHB regional departments and their intersection with the modern complex of ethnonational organisations enacting 'self-government' through a mix of governmental and service delivery duties.

Lavoie provides a useful description of this separate structure by applying the 'three sector model' for the delivery of non-commercial social goods, with her example being primary health care services. The government is the first sector (or the 'payer'), the capitalist market the second, and non-profit NGOs the third (or the 'providers'). Lavoie describes the existence of a developing 'fourth sector' in the Canadian, Australian, and New Zealand general health systems.[13]

> "A fourth sector has now emerged, with distinctive features. It includes indigenous, and for the most part, primary health care services, funded with public dollars to provide services to an indigenous constituency that is invariably considered high risk as a result of colonial policies and socio-economic marginalisation. Like the third sector, indigenous services are involved in the delivery of non-commercial social goods. In addition, indigenous health services are often tied to an indigenous governance structure, are primarily designed by indigenous groups to serve the needs of that group, and to promote their political aspirations involving a renegotiation of their relationship with the nation-state."[14]

Paralleling Lavoie's analysis, this researcher places clear emphasis on the existence of the same phenomena, as established by the term 'Aboriginal Health System.' This researcher affirms that these organisations are tied to an Indigenous governance structure (Nunavut and northern ethnonationals being one case example), and adds to Lavoie's work by stressing the following details: unlike the 'non-governmental' third

sector, fourth sector organisations are 'governmental;' and unlike the third sector, fourth sector organisations are not always 'non-profit.'

As described in Chapter 5, it is not always clear whether ethnonationals involved in the delivery of 'non-commercial social goods' are strictly 'non-commercial,' as they are also involved in the development of purely corporate structures so as to economically develop the delivery of 'commercial goods.' In this fourth sector, the delivery of primary health care services (funded with public dollars) is also coupled with the delivery of 'commercial social goods' such as the NIHBs (funded with public dollars). Canada's fourth sector is possibly best described as incorporated ethnonational organisations that extend a range of statuses themselves, defined through governmental, non-governmental, and market-oriented forms.

Describing this as a 'range' is also not wholly accurate, as Indigenous governmental entities can at once be 'governmental' and/or 'market-oriented.' Ethnonationals involve themselves in 'acts of governance' simply by taking on the delivery of health and social services through public and private means. Moreover, as any other government, the management of services is attempted in a fiscally efficient manner, ethnonationals perceiving the ability to 'economically develop' through keeping 'saved' administrative funds, and/or through the intake of a 'fee' for the management of services.

What was originally a complex horizontal/vertical structure of 'federal regions and head office' has come to hinge on community/ethnonational bodies currently enacting 'self-government' *qua* 'contracts' (e.g. 'contribution, transfer, and self-government agreements,' memorandums of understanding, the private markets of

governmental contracting). This situation is also aptly characterised by Lavoie as 'Governed by contracts,'[15] or as taken further by this researcher, 'Governing by contracts.' All of this is made possible through the historical conflation of 'self-government, economic and social development, and control over services.'

So as communities, organisations, and governments are being asked to sign agreements that have the potential to homogenise them under the context of 'health renewal,' as stated, maintaining and/or sustaining what exists today has become the most pressing challenge. Transfer and devolution policies now come under regular criticism and administrative review (by all parties), some suggesting that the federal government may be moving away from current arrangements, viz. it may be 'taking back' programs as centralised/regional authority believes that 'they can do it cheaper.' In Nunavut for example, this is being achieved through the increased capacities of the Northern Secretariat. While some groups are satisfied with 'returning programs,' as they are not manageable under current constraints, others are 'fighting for their lives.'

Taking or giving programs back may not be met without significant political/social barriers. It may simply not be possible after roughly 30 years of passing control. For example, both the long-standing federal 'Comprehensive Claims Policy' and the 1993 policy guide on the 'Inherent Right to Self-Government' support the 'full transfer of control.'[16] Any movement in an opposing direction may be constituted as a significant breach of current policy and a potential squandering of any positive developments to date.

Whether or not FNIHB can 'do it cheaper' is also yet unknown, and is in fact highly suspect. Some suggest that programs managed by Indigenous communities,

governments, and organisations are generally 'under budget' as much as they are 'over budget,' as they were when FNIHB was sole authority. Over budget programs are oft criticised while under budget ones may not be 'strategically' recognised. In fact, any savings are increasingly re-appropriated by FNIHB to offset regional deficits, which openly contravenes current 'contracts.' Programs that were 'financially unruly' prior to First Nations and Inuit control appear to still be.

On a national level, settling such differences is currently mitigated by the interactions of an increasing cadre of 'joint task forces and working groups.' These structures officially recognise the involvement and representation of federal, regional, and ethnonational authority, and include representation from provincial, territorial, and professional authorities (as well as technical complementation). With problematised policy and uncomfortably unclear constructs guiding State/Indigenous relations, ethnonational cooperation is now represented in the developing relationships and common interests of these groups (as enforced within 'joint initiatives').[17] This modern dynamic of policy and practice, and its impact on dental services in Nunavut, is well represented through the details of a composite case study involving a series of ethnonational, governmental, and professional stakeholders, attempting to resolve the current crises in NIHB programming.

It was a meeting of stakeholders to discuss recent and older contentions concerning health services in Indigenous regions. At the table were Ethnonational and State delegates, of import here being members of ITK, the Assembly of First Nations (AFN), and the Nunavut Government. As was the trend recently, they were there to discuss the sustainability of current programming in the face of such funding shortages, and as always, the many issues surrounding the NIHBs.

This negotiation table was actually not unlike many previous ones, except that now, they were considered a 'joint committee,' enacting the ideal of 'partnership' and 'renewal' between the State and Indigenous groups (and less obviously between ethnonationals as well). As one stakeholder commented, 'sustainability' and 'health renewal' was just another way of making cost containment more palatable.

Expected (yet not appreciated to its fullest by federal authority) was the power found within the joint manoeuvrings of ITK, AFN, and the Nunavut Government. Here were three ethnonationals,

one a public government, all supporting a mutual agenda (to improve funding and management), all accommodating each others' specific needs and wants (of import here being the needs and wants of the Nunavut Government northern ethnonationals). To say the least, federal authority was surprised at the coordinated fashion in which discussion developed. While the notion of a pan-Indigenous context and solution to the current crisis had become accommodated (at one point criticised for its homogenising effects), it was now here represented as a pan-Indigenous attack on centralised administration.

The highly contentious assail of comments focussed around the new 'informed consent initiative.' This initiative had actually started to better track pharmaceutical misuse, observed by centralised authority as an improvement to the system. Ethnonationals did not agree, pointing to breached aboriginal, treaty, and/or fiduciary responsibilities, and placing the initiative as yet another example of paternalism. ITK, AFN and the Nunavut Government were in agreement: the initiative had to go.

Such unified statements allowed communal entry into historical complaints about the NIHBs in general (e.g. poor management, poor access, poor services), with ITK and the Nunavut Government taking specific measures to show that they were interested in changes to the program in their region. The Nunavut Government, as it has done repeatedly, commented on its desire to remove itself from NIHB service and management duties, believing this program a federal not a territorial responsibility. ITK quickly moved to represent the expressed interest of NTI and RIOs in adopting NIHB programming, pointing to examples in the south for possible models of development.

Federal authority was reticent, as NIHB 'transfer pilots' had initially stalled (due to long-term internal NIHB management problems), and were now taking a direction that was creating significant tension with some professional groups. Northern ethnonationals nevertheless observed the potential economic and social benefits associated with NIHB control, and ITK did not waiver on the demand. To be sure, it was their right; it was their program.

III. The NIHB Program

The NIHBs have come to represent one of the most problematic aspects of the Aboriginal Health System, and have long been a source of controversy for those involved. Chapters 4 and 5 are a clear representation of this at the clinical, administrative, and contractor levels. So prior to this negotiation table, the Nunavut Government had long experienced the NIHBs as problematic, and are ready to disassociate from them if and when an opportunity presents. An opportunity has now presented, with some northern ethnonationals prepared to adopt some control over the program, advancing their social rights to self-government as established by FNIHB policy. Northern ethnonationals were involved in early discussions for this type of 'health transfer,' but their projects never materialised (this is detailed shortly). Interest did not significantly wane though, and

control over the NIHBs is generally seen as a positive development amongst northern ethnonational stakeholders (both public and private).

One reason for this positive outlook has to do with the nature of the program, viz. the NIHBs represent 'commercial social goods' that provide potential opportunity for economic development. Seeking opportunity in the markets associated with the NIHBs is actually quite socially complex, in that while being possible, potential economic gains intersect with three things: the ever-present problematisation of Indigenous rights; with Canadian values surrounding health; and with the power dynamics of professionally dominated economies. Passing control of the NIHBs, for example, from the Nunavut Government to northern ethnonationals, quickly becomes mired by such a complex nature, and less obviously, by what it may actually mean to control these services.

For example, apart from the basic question of whether the NIHBs represent a specific Indigenous social right, it is unclear what is being 'transferred,' as it is unclear if the NIHBs constitute a 'governmental health program' or a 'governmental health insurance plan.'[18] To fully develop these ideas, a consideration of this program's historical development and current structure is necessary. It is also necessary to use examples from southern Canada and its Indigenous communities, since 'NIHB transfer' did not develop for northern ethnonationals. As has been noted, while differences exist between north and south, and between Inuit and First Nations, enough similarity and partnership has developed such that occurrences for First Nations groups have now become potentialities for Inuit (and *vice versa*). As a result, the current dynamic of 'NIHB transfer' holds much potential for future developments within Nunavut.

a. Historical Development

The first time a tooth was 'pulled out' by a nurse, or medication given by a travelling doctor, a 'NIHB' was being delivered. This is not entirely accurate though, as there was nothing known as a 'non-insured health benefit' early on. What constituted an 'insured health benefit' remained unclear as well, since not until the post-war years did Canada begin to define (in earnest) what it insured or did not insure through its provision of health services in a developing national health system.

In referring to the historical development of the NIHBs, the Auditor General describes them as "evolving gradually."[19] It appears that the programmatic activity constituting these services did not acquire the aspect of 'non insured health benefits' until the late 1970s. In the 1960s, these services were described as 'medically necessary uninsured medical and dental benefits,'[20] and before this, were simply conceived as activities within larger programs (*e.g.* the medical equipment, supplies, transportation, and pharmaceuticals, provided by nursing and physician services) or discrete activities themselves (*e.g.* dental services). Such delivery was based in the historical relationship between Aboriginal people and the State, and effectively existed only as a by-product of attempting to answer the medical requirements that arose out of need (*i.e.* medical transportation, prescription drugs, medical equipment and medical supplies, dental care, and vision care). There really appeared no focussed and/or directed development in 'NIHB services' until quite recently in the history of Indigenous health services.

More broadly, the concretisation of these 'medical requirements and needs' into a program termed the 'NIHBs' arises out of a link to the development of Canada's general system. As both hospital and physician services became part of the publicly insured

system, over time, services either became listed as 'insured' or 'uninsured.' Social groups and each of the early modern health professions had a role in establishing this status (*e.g.* unions, industry, nurses, physicians, dentists, pharmacists), and through the period 1920 - 1960, as social groups were active in promoting the idea of insured hospital and physician care, neither the medical profession nor the insurance industry mounted any serious objection to the establishment of 'socialised medicine.'[21] The dental profession on the other hand was 'neither for nor against' the development of 'insured dental services' in Canada, long turning to its historical policy advice and programmatic solutions for the delivery of services to the greatest number of people (to be detailed in Chapter 7).[22]

By the 1960s, with hospital care now nationally insured, both the medical profession and the insurance industry had become involved in developing an economy around the 'private insuring' of health states and health risks (*i.e.* 'life and health insurance').[23] The insurance industry further developed this economy by entering into the dynamic of employer-employee contracts that insured for 'supplementary medical and dental benefits' (*e.g.* eyeglasses, pharmaceuticals, orthodontics). So when Medicare passed in 1967, the medical profession and the insurance industry (and even some Provinces) were not supportive of the new 'social medicine' ideal, preferring the development of care within the purview of the modern market economy (time nonetheless demonstrating the effective adjustments of these groups).[24]

The social details of how the early 'market-based health professions' (*i.e.* dentistry, pharmacy and optometry) came to be excluded from insured care generally remains critically unexplored. Yet with long-term professional and/or social separations

between physicians and these groups, it is not frivolous to say that they were already viewed as 'different,' and/or as providing services that were 'less medically necessary.' By the mid 1960s (when physician services were beginning their final foray into their publicly insurable form), governmental authorities were already aware of the fiscal challenges of publicly insured services (as hospital based insurance had been in place for slightly less than a decade). So the addition of more than just physician services may have been shied away from, let alone promoted for inclusion.

Some provincial and municipal authorities nevertheless began to insure some 'less medically necessary' services (*e.g.* dental care), as part of 'welfare/social assistance,' or through targeted funding (*e.g.* public clinics, services delivered to children in schools, services delivered by institutions such as the Red Cross and the United Way). By the early 1970s, the general Canadian was either 'self-insured' (as in payment 'out of pocket'), insured through employer-employee contracts, or insured through municipal/provincial mechanisms,[25] of particular importance here being the form of 'insurance' (for 'uninsured services') developed by federal authorities to provide care to Aboriginal populations: the NIHB program.

As is often stressed by federal authority, the provision of uninsured services was only ever observed so as to 'match' provincial forms of coverage for these same services (*i.e.* for the socioeconomically depressed). Since Aboriginal populations experience much inequity, coupled with the fact that isolation (and federal jurisdiction) precluded provincial intervention, they naturally 'matched' for similar services. 'Program principles' limiting services relative to inequity and isolation are noted as far back as 1958, then apparently reaffirmed in 1974, when MSB attempted to limit benefits "to

needy First Nations and Inuit individuals living on reserve or within federal jurisdiction."[26]

Scarcity meant that services were still generally provided as needed or when available, and as noted in an administrative manual, "recipients were expected to contribute towards the costs of benefits to the extent they were financially able."[27] By 1975, with the increasing role of ethnonationalism and its push to gain clarity as to the exact nature of these services, MSB stated that:

> "It is a matter of policy rather than statutory or treaty obligation that the federal government has provided certain health services to Indians. Parliament is asked each year through appropriation acts for the authority and resources to provide these services. The policy has been, and is, for the federal government to do what is necessary to ensure that Indians have access to adequate health services in order to achieve a standard of health comparable to that of other Canadians."[28]

Then in 1978, the federal government followed by introducing 'Guidelines for Uninsured Medical and Dental Benefits' so as to "standardize practices across the country and set limits on benefits."[29] These guidelines continued the historical agenda of limiting 'eligibility' by only covering services for those who live within federal jurisdiction, and for those who met the 'criteria of a financial means test.'[30]

Faced with intense opposition from the Aboriginal community, the Minister of National Health and Welfare declared a six-month moratorium on the guidelines, and in the interim:

> '[Withdrew] the Guidelines for Uninsured Medical and Dental Benefits and establish[ed] the level of service during the moratorium as the norm for budgetary purposes; establish[ed] professional medical or dental judgment or other fair and comparable Canadian standards as the criteria for health service delivery; reaffirm[ed] the historical role of the federal government and the provinces in the provision of health services; and promote[d] consultation and participation in the administration and delivery of health programs."[31]

Establishing the 'level of service during the moratorium' as 'the norm for budgetary purposes' was a crucial step in the development of the NIHB program. It established regional NIHB budgets (just as capped envelope funding did in later years for

the global FNIHB program), and since then, budgetary increases have only occurred through supplemental appropriations based on historical expenditures. This has given rise to stakeholder complaints of inequitable funding from region to region, especially in the face of actual costs and needs.

Attempting to further address the intense opposition (and carefully not committing to any additional health responsibilities), the 1979 Indian Health Policy reaffirmed previous principles, "re-establish[ing] non-insured health benefits as an open-ended program [yet] requirements for a means test and on-reserve residency were dropped."[32] The 'non insured health benefits' (as they had now come to be known) were "from then on to be provided on the basis of professional medical and dental judgement, or other fair and comparable Canadian standards."[33]

Establishing the NIHBs as a service delivered at a level 'comparable [to] Canadian standards' further reaffirmed this historical condition. Considering this closely, one observes that the 'fair and comparable Canadian standard' for access to 'non insured services' is really none. Unless one is 'self insured,' insured through employer-employee contracts, or insured through municipal/provincial mechanisms for the socioeconomically depressed, there exists no clearly associated 'social right' for a 'non-insured service.' Following this logic, the NIHBs are provided to Aboriginal populations primarily due to socioeconomic deprivation (yet also due to the lesser-stressed reasons of jurisdiction and historical relations).

Providing the NIHBs on the basis of 'professional medical and dental judgement' continued the intimate involvement of the health professions in establishing NIHB programmatic activity and direction. Medical, dental, and other health professionals have

always existed at the MSB administration level in committee membership, in service provision, and in contracting (with individuals holding positions across several domains simultaneously, or at different points in their professional careers). This relational involvement has done much to define the practices and policies of the NIHB program (to be demonstrated shortly and further detailed for dentistry in Chapter 7).

By the early 1980s, in 'practice and policy,' the NIHBs had come to be listed as:

- prescription drugs, medical supplies, and medical equipment;
- transportation for medical reasons;
- vision care services (such as eye glasses); and
- dental care.[34]

With southern and northern health markets developing, the majority of NIHB service providers were now beginning to play a role in improving access, and more plainly, were increasing their economic interests in Aboriginal populations. These providers included dentists, pharmacists, optometrists, mental health counselling, podiatry, physiotherapy, chiropractic, acupuncture, and occupational therapy, amongst others. Regional program directors were increasingly faced with requests from patients/clients, and from market-based providers, all seeking approvals for the services, medical equipment, and/or medical supplies needed. Coupled with demographic and legislative factors, by the late 1980s, NIHB program expenditures had ballooned to $400 million, up from $36 million in 1979.[35]

'In practice,' the NIHBs had come to include more and more listed pharmaceuticals, medical supplies, medical equipment, and administratively acceptable reasons to provide medical travel and allied health services. The term 'in practice' is relevant here, as centralised authority did not officially view all of the services provided

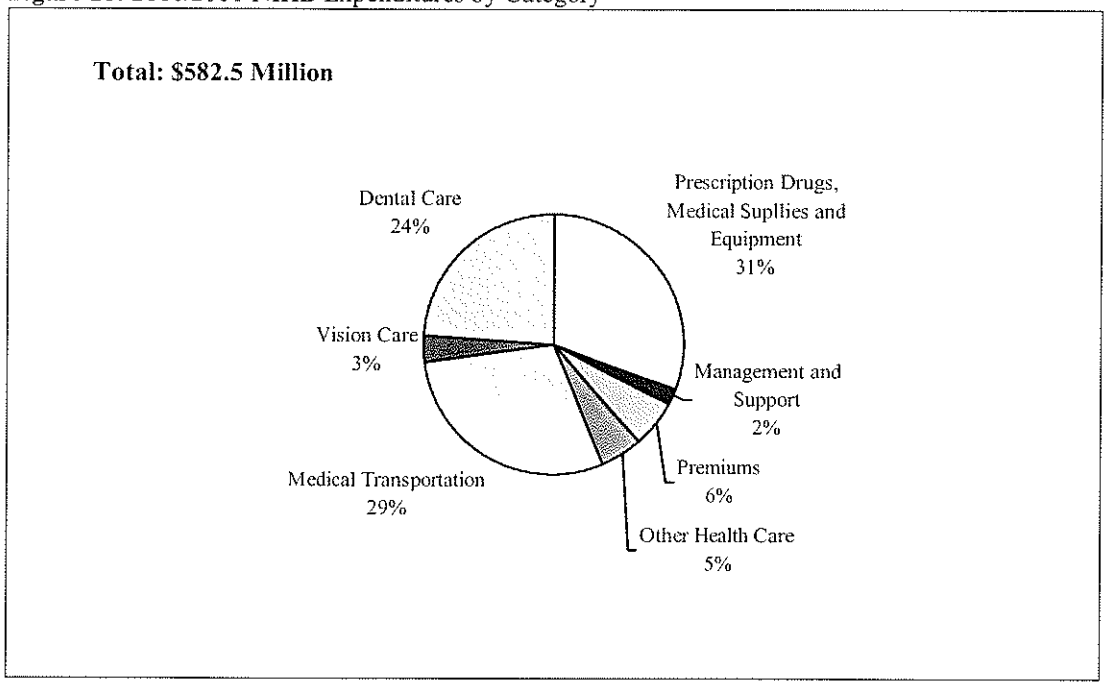
by the regions as 'eligible benefits.' Only under 'extraordinary circumstances' were these services to be provided (essentially on a case by case basis).[36]

Regional administrations were still nonetheless faced with having to respond to the specific and increased needs of disease-burdened populations, who, on a daily basis, were developing and enacting their social rights as 'Inuit and First Nations patients/clients/beneficiaries.' In parallel was the increasing employment (and advancement) of Indigenous individuals across the Aboriginal Health System, either through devolution/transfer, or through governmental educational and hiring initiatives (*e.g.* CHRs, Aboriginal nurses, health technicians and other health practitioners, Aboriginal administration). As a result, the regional administration that authorised the provision and payment for 'certain benefits' was more sympathetic to the realities of those receiving care than at any other time in MSB history. Both Aboriginal and non-Aboriginal administrators have pointed to the moral difficulties associated with denying services to people they see themselves as meaning to help, the NIHBs becoming a sink for extra health expenditures, with 'medical necessity' an easily expanded category. As succinctly stated by the Auditor General: "[There are] deficiencies in expenditure control processes."[37]

Politically, an ever-expanding envelope of services was problematic as well. As more services became added, newer services could (and often did) become ensconced within debates concerning the 'rights' (human, fiduciary, aboriginal, treaty, citizenry) of Indigenous individuals and populations. So by the early 1990s, regardless of program policy, past definitions, and efforts to contain services, the NIHBs were now generally listed as:

- drugs, medical supplies and medical equipment;
- medical transportation;
- dental care;
- vision care; and
- other health care services.[38]

Figure 18. 2000/2001 NIHB Expenditures by Category[39]



With a category like 'other health care services,' it was clear that centralised mechanisms of control were needed. As reported:

> "The auditors estimated that failure to effectively implement the principle of last resort [...] resulted in annual expenditures of $45 million that would not otherwise have been incurred. The auditors also found that [...] expenditures of the non-insured health benefits program included $40 million for goods and services not specified as benefits in the national Program Directives and related policies. The program [also] lacks the information systems and capabilities necessary to analyze [and control] expenditure patterns at the national and regional levels."[40]

Health Canada in turn began a sustained administrative effort at observing and enforcing particular aspects of its original 1979 policy (*i.e.* only providing 'eligible benefits' and applying the 'payer of last resort' principle), and established centralised mechanisms by which to do so (*i.e.* National Program Directives and Administrative Procedures,

developing a centralised claims processing system and increased information systems capacities).

The centrally mandated regional enforcement of particular policies is apparent by their titles: benefits are to be limited to only 'eligible ones,' and NIHB is to be the insurance 'payer of last resort' (relative to self-insurance, 3rd party coverage, or provincial coverage). The framework for their enactment came through National Program Directives and Administrative Procedures, which "replaced the [individualised] Regional Guidelines followed in administering the NIHB program."[41] More essentially, they were an "effort to focus on defining and limiting the benefits available."[42] As stated in an administrative manual:

> "The following changes are being made to administrative procedures and management practices: [1] the eligibility criteria and the medical necessity criteria for the program are being applied more consistently to provide fair and equal client access and to improve the Department of Health and Welfare's accountability for the expenditure of public funds; [2] the scope of the program is more clearly defined to offer a consistent level of service, regardless of place of residence, and to avoid the duplication of service with other health care programs."[43]

With these rationalisations, the 'eligibility criteria and medical necessity criteria' were 'defined and limited' through a whole array of generalised and benefit specific mechanisms (see Appendix D).

Common to all the NIHBs was the need for a centralised way of electronically tracking and controlling expenditures. As it stood, 'information systems and capabilities' were lacking:

> "In July 1987, the federal government entered into a two-year contract [...] with a private sector firm for the development and operation of a claims processing system for dental accounts. In December 1988, [...] the Department decided to tender for the development and operation of a similar automated claims processing system for all benefits. In March 1990, a second five-year contract was awarded, on a competitive basis, to the same firm for $42 million, and work on the development of the pharmacy claims portion of the contract was initiated. [...] Original plans called for the entire system to be implemented by December 1992. However, it was not until July 1993 that pharmacy accounts were processed in all regions. [...] As of September 1993, the Department had not prepared detailed systems requirements for vision care and medical transportation benefits."[44]

While 'all benefits' were to be part of the electronic system, in the end, only "[c]laims for dental services, drugs and medical supplies and equipment [came to be] processed through [what is now] the national Health Information and Claims Processing System (HICPS)."[45]

By 1997, with problems well recognised across many levels, a 'renewed mandate' for the NIHB Program was approved within the continuing negotiations of federal authorities and ethnonational polity. The renewed agenda included:

- An updated definition of program objectives, principles, client eligibility and benefits;
- The authority to transfer NIHB to First Nations and Inuit control subject to Treasury Board approval;
- A benefits management strategy to ensure a fiscally sustainable approach to managing the NIHB Program.[46]

'Defining program objectives, principles, client eligibility and benefits' (in order to limit costs) was now an administrative constant, at this point roughly into its second decade of application. NIHB 'Joint Working Groups / Sub-Groups / Technical Groups / Committees / Task Forces' all undertaking the working actualities of politically establishing what NIHB criterion would be (see Table 10).

Table 10. Joint Initiatives Involving the NIHBs[47]

NIHB Transitional Transfer Framework: • The Department developed and is seeking approval of a time-limited transitional NIHB transfer framework based on completed framework documents jointly developed by a First Nations / Inuit / FNIHB working group.
NIHB Joint Management: • FNIHB established a joint First Nations/Inuit/FNIHB Steering Committee to explore and expand national NIHB co-management opportunities • Overseeing the evaluations of NIHB pilot projects, providing coordination to First Nations/Inuit participation in various benefit management committees (*e.g.* Dental Care Advisory Committee), national review of medical transportation and prescription drug misuse.

So 'in partnership,' the attempted realisation of a 'benefits management strategy' that encouraged 'sustainability' largely included the refinement of efforts developed over NIHB history. In other words, cost containment measures were maintained and improved whenever possible, these being: renegotiated and/or unilateral implementation of new

benefit grids (*i.e.* fee schedules); the predetermination/preauthorisation of benefits; conducting provider audits; program re-structuring (*e.g.* switching from 'frequency-based' to 'needs-based' approaches relative to eligibility criteria); and consistent reviews of programmatic activity to make them more 'efficient and cost-effective.'

The long history of consistent NIHB cost-control measures and problematised administration had also resulted in tensions between the State and professional and non-professional service providers. This impacted communities as they became 'caught in the middle,' but also due to their increasing role as service providers. For example, with the early contracting of medical transportation services to Aboriginal communities / organisations / companies, cost containment was readily perceived as degrading the development of ethnonationally governed and provided care, and less obviously, expected economic gains. So taking aim at NIHB cost-control measures became commonplace, now represented in the strong and active combined ethnonational and professional lobby to maintain and improve services, if not expand them.[48]

Such concerns (as expressed at this negotiation table), while rooted in the politics and history of the NIHB program, are more so based in the obscure nature of the program, viz. it has no legislative base, it heavily involves the private sector, and it is unclear whether it is a 'program' or an 'insurance scheme.' A consideration of these structural weaknesses follows.

b. Structural Considerations

The need to control benefits and costs, along with a challenged NIHB administration, were recognised as early as 1982. At this time, the Auditor General indicated that a high

staff turnover, and the absence of both nationally established service standards and administrative guidelines, all resulted in inconsistent and problematised services.[49] With subsequent reports in 1988, 1993, 1997, and 2000, the Auditor General continued to stress the need for significant centralised/regional management efforts in order to ameliorate the fact that the program was still being delivered "without agreement on its exact nature, without complete information on its costs, and without an effective management control framework."[50]

Of significant value in the 1993 Auditor General Report was the recognition of the program's subtle and unclear nature:

> "The 1979 Indian Health Policy states that the federal government's 'legal and traditional responsibilities to Indians' flow from 'constitutional and statutory provisions, treaties and customary practice.' In spite of this historic relationship between the government and Canada's native population, there is no specific federal legislation recognizing non-insured health benefits. The absence of specific enabling legislation has left a gap in the definitions of purpose, expected results and outcomes of the non-insured health benefits program. With no legislative starting point for policy and program development, there is still, after almost fifteen years, no consensus in the Department as to the exact nature of the program."[51]

Lacking clarity, the provision of NIHBs within the context of the market-based health services generally resulted in the program being more readily conceived of as a 'health insurance plan' rather than a 'health program.' As noted by the Auditor General:

> "So whereas a health program might have objectives defined in terms of improving health status, a health insurance plan would have as its objective to provide coverage, up to pre-determined limits, for specified medically required services and products. The auditors found that, in practice, the program is managed more as an insurance plan. As such, it covers the cost of providing supplementary health benefits to qualified individuals. Program performance is judged on whether the specified benefits were provided within the set limits. Although the premiums, deductibles and co-payment provisions commonly found in health insurance plans are absent in this program."[52]

As such, the NIHB program is a publicly financed private health insurance carrier of a population, which currently has little or no recourse to premiums, deductibles and co-payments. The consequences for a sustainable public program are aptly expressed in one stakeholder's explanation of NIHB realities:

"Look, [NIHB] is one of the only programs that you fund. You bill it but you fund as well, so the more you bill the more you fund. And insurance companies aren't like that. Insurance companies will levy a premium if they haven't got enough money, they'll up the premium so everyone pays more the next year anyway. That's the message we have to get through, that's a hard message to get through because [stakeholders] don't want to hear it."[53]

With this fundamental logic (and/or flaw), FNIHB/NIHB administration, 'in conjunction with Inuit and First Nations populations,' attempts to sustain a program that as an 'insurance mechanism,' is to act in the economic market and grow relative to the hedging of risk (*i.e.* the intake of more insurance premiums than services rendered), yet its growth ultimately deterred or made impossible through the lack of premiums, deductibles and co-payments, or more fundamentally, through cost-containment measures and a historical expenditure ceiling. As a result, the NIHB economy has ineffectively structured services under a capitalist frame, where contracted providers are sought at every level of organisation and management (from provision to reimbursement), each contractor aiming to produce volume so as to increase earnings, even when containing the economy is the major impetus for programmatic success (in contradistinction to the goals of capitalist markets). As stated in the previous comments, this is a hard reality and often ignored by all stakeholders.

So the structure often noted as problematised (possibly inherently as per its dual logic), is a complex admixture of public programming and private sector articulations. This as per the nature of the services delivered, viz. market based non-insured commercial social goods. This results in an economy that is very much alive, yet very much controlled.

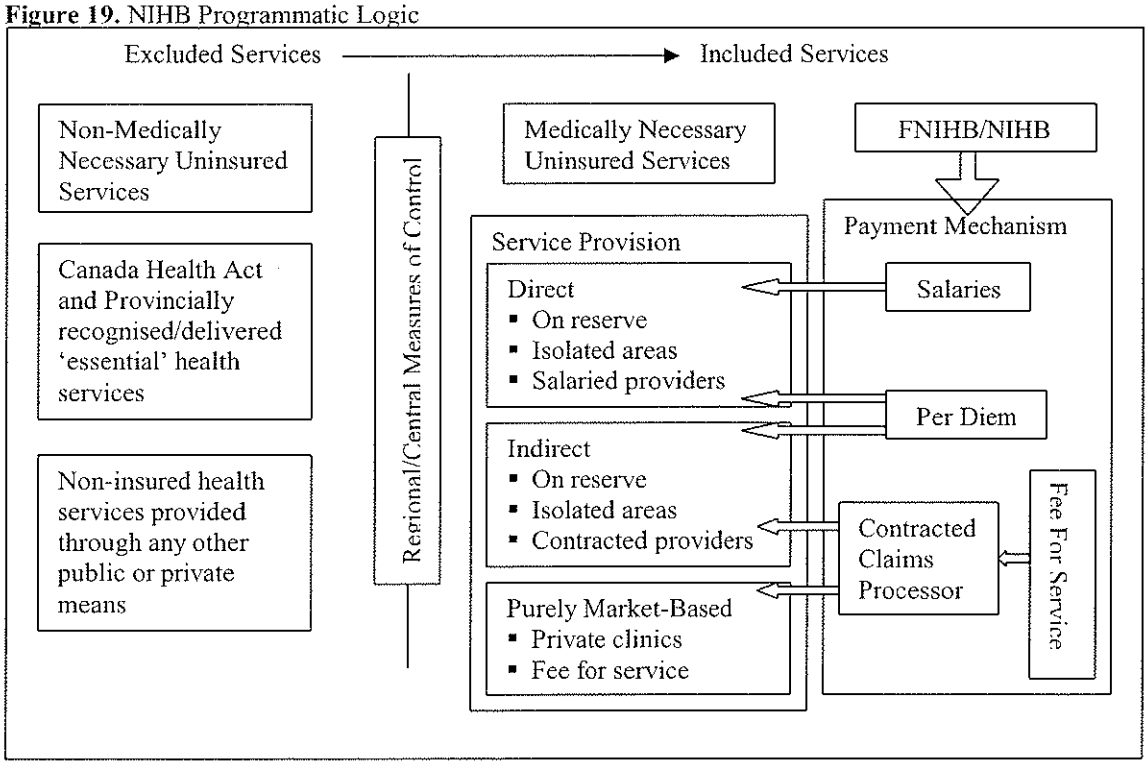
The complexity of this program in constituting the large part of an 'Aboriginal Health Economy' is well reflected in its delivery structures and mechanisms, control measures, debates, and the respective importance of each benefit category (*i.e.* describing

direct or indirect delivery, how benefits are limited, the way Aboriginal business and governance representation is involved, the level and nature of involvement with professional and non-professional groups, the influence of Aboriginal service providers, its function in the Aboriginal Health System and Economy). For example, the provision of pharmacy benefits, medical supplies and equipment constitute some of the most costly services, and also represent the greatest potential for economic growth relative to their intersection with an aging population, with the home and community care industry, and with modern health contractors and retail chains. As the provision of dental services has observed some of the most well focussed critiques as per Aboriginal professional service provider involvement, contentions demonstrate that not all Aboriginal/Professional relations are meant to advance common agendas (like improving health and health services), and can sometimes involve direct economic competition and encroachments on professional dominance (*e.g.* pharmacy and dental chains). In limiting medical travel through authorising field nurses, clerks, or by an authority that 'administers medical transportation benefits on behalf of government through contribution agreements,' also involved are the series of largely Aboriginal coordination providers (*e.g.* patient referral services), medical transportation corporations (*e.g.* multi-passenger van services), and community organisations (*e.g.* local taxi companies, individuals employed by health centre) that gain from such activity. Appendix D attempts to frame the NIHBs in this way by providing a glimpse into each of the benefit categories, and their existence and connections as part of this publicly financed private health insurance program.

Through the NIHBs, a complex set of events now constitutes a discrete system for the delivery of uninsured health services to Aboriginal populations (of which Nunavut is

a part). This portion of the Aboriginal Health System is situated within and articulates with Canada's larger '3rd party insurance plans,' whether publicly financed, publicly and privately financed, or privately financed. As an Aboriginal Health Economy, this involve the State as the primary funder/payer (increasingly less so as a provider), and the market as a provider (through the 'second, third, and fourth' sectors), servicing Aboriginal population through a complex admixture of public/private means, involving mechanisms to determine and enhance 'the rights of beneficiaries' (*i.e.* what an Indigenous person is entitled to and who should be delivering the services to them).

Figure 19. NIHB Programmatic Logic



So inextricably linked to a system "funded with public dollars to provide services to an indigenous constituency [...] tied to an indigenous governance structure [...] involving a renegotiation of their relationship with the nation-state,"[54] the growth of this fully State-supported economy and the social rights associated with its services have been placed beside economically achieving and/or representing collective aspirations to self-

determination and self-government. Equally, through the potential control over services and associated market economies (both aimed at expanding provision and fiscal gain), individual social rights over health have become intricately connected to the collective rights associated with Indigenousness and Nationhood. An elaboration of this subtle and complex set of relations is detailed later.

In short, due to the 'spending ceiling' beyond which FNIHB has to seek 'supplemental appropriations,' annual budgetary requests are now a regular feature of the program. Much criticism and debate results whenever FNIHB/NIHB officials appear in front of the Canadian Treasury Board and Parliamentary Committees concerning Aboriginal health and fiscal issues. As federal stakeholders comment, while the program is 'simple enough to discuss,' it is difficult to truly conceive 'how it could work,' or even be 'controlled,' due to its 'exact nature,' viz. it is a private insurance scheme functioning within public management and controls. This negotiation table did not address this tremendous subtlety, and in only referring to the problematic nature of the program, reacted to its complexity, and not to the root causes of many problems. Clear example of this are observed in the debates surrounding the 'new informed consent initiative,' and in the events surrounding the newer and older NIHB 'transfer pilots,' a discussion of which now follows.

c. The Informed Consent Initiative

NIHB weaknesses in information systems capacities were well recognised by the mid 1980s, with early prototypes of automated claims processing systems (now HICPS) developed soon after. In order to collect more accurate and systematic information on

Aboriginal populations and services, HICPS claimed to increase patient/client safety, but more readily controlled programs and costs. With improvements made over time, the goal has become to increase coordination with all mechanisms providing health surveillance on Aboriginal individuals and populations (*e.g.* Federal Hospital Files, Federal Nursing Stations and Health Centres Files, First Nations and Inuit Health Information Systems, Methylmercury Levels in Canadian First Nations and Inuit Peoples Database, Status Verification System, Canadian Tuberculosis Reporting System[55]).

As in all jurisdictions in Canada, this goal means to electronically database, track, and link as many health systems as possible (regionally and by sector). The generalised initiative is termed the 'Canada Health Info Highway' or 'Canada's e-Health strategy.' As part of an overall investment in electronic systems infrastructure development (through industry and research), this is seen as establishing an administrative decision-making structure that is more effective, efficient, controllable, reliable, evidence- and outcome-based, and publicly accountable.[56]

These new electronic technologies (now tracking and accounting for services and people) intersected with larger social discussions concerning personal privacy. Modern governments in turn began collateral developments in policy aimed at the social protection of personal privacy rights:

> "[T]here are many existing, pending and proposed laws in Canada that have their purpose to protect the right to privacy. [L]egislative texts [that] vest individuals with that fundamental right includes the *Canadian Charter of Rights and Freedoms*, Federal and Provincial *Privacy Acts*, the *Personal Information Protection ad Electronic Documents Act* of 1999, the *Model Code for the Protection of Personal Information*."[57]

Through a new policy practice, the concept-complex of 'personal health information' has developed. For example, there are clear guidelines as to what constitutes 'personal health information.' The mechanisms for the 'collection' and 'use

and disclosure' of this information in both the public and private sectors are increasingly delineated. Access to clinical records and registries for research purposes has also observed evaluation, with further considerations including the development of concepts in 'informed consent' and 'substitute decision making,' along with the 'safeguarding, retention and destruction' of information across public and private sectors.

Paralleling this was the developing discursive actions surrounding the 'rights of the research subject,' of import here being Indigenous communities and their increasing demands for ethical practice of governmental and university-based research within their borders. Kaufert and others provide a discussion of the political and cultural mediation in establishing 'informed consent' within clinical interactions involving Aboriginal patients.[58] They also document the developments surrounding a negotiated consensus on the academic / community / ethnonational mechanisms by which to accomplish ethical and consensual research practices.[59]

In regards to 'public health practice,' O'Neil and others have provided an analysis of current developments relative to the collection of health information and public health surveillance.[60] As noted:

> "Historically, health surveillance in First Nations communities has posed logistic difficulties, which are compounded by jurisdictional uncertainties. Most notifiable disease systems are funded and maintained by provincial governments. [...] However, data collection and public health interventions have generally been the responsibility of the federal government and more recently of First Nations themselves. The situation can lead to a disconnect between surveillance and public health practice, and quality control in surveillance systems can be compromised. The transfer of health services to the control of First Nations could further complicate these relationships unless concerted efforts are made to promote collaboration between federal and provincial public health agencies and First Nations."[61]

So like most State/Indigenous situated realities, the development of health information systems and its research uses became linked to jurisdiction, human resource and infrastructure capacity, and to political/historical relations. The Inuit of Nunavut have experienced similar challenges, yet collecting their information has developed in an

environment where collecting practices are not so problematised, as they recognise themselves as citizens of a territory, which has historically collected information and continues to do so.

So through efforts in the ethnonationalist process, both Inuit and First Nations populations have developed capacities in mediating the activity of academic/governmental research, and have established their own health surveillance systems and social technologies (mandating both their practice and use). The term 'OCAP' (ownership, control, access, and possession) has come to represent this agenda. In partnership with governmental and university-based stakeholders, 'joint initiatives' using targeted funding (*e.g.* the e-Health strategy, the Health Transition Fund) have all advanced the ideal of OCAP, developing some of Canada's most significant health information systems and technological capacities (*e.g.* the community-based First Nations and Inuit Health Information System, the First Nations and Inuit Health Survey, the Aboriginal Peoples Survey).

Apart from ideals, the FNIHB administrative need for automated systems lay in the risks associated with the NIHB program. For example:

> "[S]ome doctors may overprescribe medications to patients, using program resources; the costs of the program may escalate to an unsustainable level; some clients may access excessive levels of benefits; some clients may abuse or misuse prescription drugs; some dentists may overservice clients; and some providers may overbill for services provided to clients."[62]

Early on, insufficiently developed systems were the major reason for an inability to control these events. FNIHB was then pressed further into action by increasing public awareness of its pharmacy program.

> "Between 1986 and 1996, there were numerous reports of prescription drug addiction and prescription-drug- related deaths of First Nations individuals in several provinces. In Alberta, for example, [...] regional office identified a total of 42 prescription-drug-related deaths in First Nations communities during 1986-88."[63]

HICPS was still not in full operation until July 1993. Yet "as the system was designed mainly to process claims, some Branch regional officers noted their repeated frustration that the NIHB program had been able only to pay bills rather than to help provide solutions to the prescription drug abuse problem."[64]

In 1997, the Auditor General called for further "comprehensive solutions in an attempt to address program weaknesses"[65] (*i.e.* enhance patient safety, curtail patient and provider abuse, control costs). This resulted in the development and testing of a 'point-of-service system' that would act as "a key mechanism to control drug use and administer benefits."[66]

> "In such a network, when a pharmacist enters the details of a prescription on an in-store computer, the information is transmitted electronically to a central system that assesses, the system will provide a set of system-generated messages and warning codes. It will also provide the dates of the last three prescriptions of the NIHB client. Pharmacists are expected to make dispensing decisions in response to warning messages, and the system will allow overrides."[67]

Importantly, it was also recognised that:

> "[A] point-of-service system will not in itself solve prescription drug misuse problems. Tightening up controls is only one aspect. Health Canada needs to examine the implications and resource requirements for community health programs with respect to treatment, community education and prevention of prescription drug addiction in [Aboriginal] communities."[68]

Administrative attention also turned to the imminent need to fall within the compliance of newer Canadian personal privacy standards (and as will be presented, possibly failed to recognise compliance with Aboriginal resistances associated with information collection practices and with perceived rights to health and health services). Relative to the NIHBs, compliance was needed to collect, use, and disclose personal health information within both the public and private sectors. For FNIHB/NIHB, the major complication associated with its 'point-of-service' system (and any other personal health information collection practice) is its status as an unlegislated programmatic activity. For example, a legislated program can collect and use more personal health

information when compared to an unlegislated one, as it necessarily needs this information to monitor a program that is legislatively/publicly funded (placing this information within the public sphere). Yet since the NIHB program is not legislated, and since part of the collection and use of information takes place within private domains (*e.g.* the processing and tracking of claims data occurring within the auspices of a federally contracted claims processor), it is a subtler situation that establishes more stringent criteria as per newer legislation. So while in the provinces, legislated pharmacy programs and their automated systems can generate "warning messages such as drug-to-drug interactions, overmedication, visits to several doctors and pharmacy shopping [...] also provid[ing] a full profile of all recent medications dispensed to an individual,"[69] the FNIHB system remained limited. Health Canada was then directed to explore "with various jurisdictions the possibility of having access-to-information and privacy legislation amended in order to allow its point-of-service system to provide more information on recent prescriptions."[70]

With minimal possibility or power to alter current legislation, FNIHB/NIHB would have to obtain clear statutory authority, or establish a mechanism to obtain client consent (for the collection and use of the personal health information). While logistically complicated, the latter was still an obvious choice for administrators, since to legislate a problematised program immersed in historical debates could prove a dangerous political step (if not wanting to legislate the federal responsibility over such services). The 'consent initiative' was in turn introduced as a measure to enhance both patient safety and provider accountability, and less so as a further means to improve the shortcomings of NIHB management processes (specifically in relation to continuing cost control efforts).

The initiative was initially presented in early 2000 to the NIHB 'National Joint Steering Committee.'[71] With some initial misgivings, the matter was then presented to the NIHB 'Joint Technical Working Group,' who decided to consider the matter through the creation of a 'subcommittee.'[72] Looking for practical solutions, in mid 2000, a 'Joint AFN/ITC/FNIHB Consent Advisory Sub-Committee' was formed.

By mid 2001, legal authorities and privacy consultants were part of a heated debate concerning State surveillance and personal privacy, quickly spilling into debates concerning aboriginal/treaty/fiduciary rights, the quality of the NIHB program, and its transfer/devolvement. All of this necessitated the formation of another 'Joint Consent Advisory Committee' attached to the original NIHB 'National Joint Steering Committee' (both composed of senior political authorities).[73] First Nations and Inuit polity came to increasingly observe the consent as 'just another cost control measure' and a further derogation of their rights.

The structure of the consent form became criticised on many fronts. It was noted that on the consent, personal information was filled out before the person came to the terms of their disclosure, essentially giving the information before consenting. Repetition and undefined terms were also noted as problematic. The ability to truly obtain 'informed consent' was questioned relative to the consent's intelligibility, and to the general language, cultural, and educational disconnects between patient/clients and their service providers. Questions were then raised as to the 'breadth and vagueness' of the consent as a whole, and came to include the intimation of 'conspiracy theories' surrounding 'State control and surveillance.' All concerns mingled with historical critiques on paternalism and with the 'moral guidelines that govern the Health

Canada/First Nations relationship.'[74] Ethnonational legal council and membership came to predominantly resist the form for its potential use as a facilitator of budgetary and programmatic decision-making aimed at cost containing, and in its capacity to aid in the derogation of federal duties and beneficiary rights. After several regional and national stakeholder gatherings convened to discuss this and other pressing issues, and after pre-testing the consent in three regions,[75] and even after developing several iterations of the form in consultation between 2001 and 2003, many Aboriginal authorities simply advised against signing the consent.

Critiques also developed as to the use of Aboriginal populations for the purposes of State/Professional battles. For example, using information for the purposes of a provider audit without legal recourse to collect that information definitively places the prosecutorial strength of that information under question. So as the consent form allowed FNIHB to legally track services and continue the policing of provider abuse in an effective manner, Aboriginal polity pointed to being 'caught in the middle' once again. In the context of State/Professional battles and an Ethnonational/Professional lobby, professional authorities began to claim that clinicians were increasingly placed in a compromising situation by being 'left with the responsibility' of seeking a signature for an unpopular and potentially constitutionally problematised consent.

To not expect resistance could be conceived as naïve. First, FNIHB had introduced the consent initiative with little or no ethnonational involvement in terms of conception and early development (irrespective of its introduction to the NIHB Joint Steering Committee). Second, FNIHB introduced the initiative with caveats to deter refusals in signing the consent, which themselves acted as a cost control measure. For

example, not signing the consent would result in immediate and direct difficulties accessing services, viz. pre-payment for services by the patient/client would now be required, with reimbursement possible through a future administrative process initiated by the patient/client. This hard federal stance was quickly interpreted as: 'if you did not sign, you do not receive services.' With a largely socioeconomically depressed population, the ability to pay was clearly problematic. Almost farcically, if someone could indeed pay, to then access the reimbursement option would require the signing of the consent form. It is not that surprising that First Nations and Inuit reacted with resistance. So what began as an effort to improve the NIHB system (by bringing it line with current legislation largely to control prescription misuse), ended in the heightening and re-highlighting of historical contentions.

This negotiation table ended up debating long-term issues through the spark provided by a substantial endeavour that, while not enacted effectively by federal authority, was still needed, and even demonstrated some federal goodwill (by its introduction and mitigation in the NIHB joint committee). Of significant interest to this study is the unified voice of ethnonationals, particularly the partnership between the Nunavut Government and northern ethnonationals (further demonstrating the cooperation and partnership needed for the 'dream of Nunavut' to see fruition).[76] Nonetheless, responding so fervently to such particularity did not address the root cause for the existence of such a problem in the first place, viz. the NIHBs remain ill defined as per a lack of legislation.

All complaints were finally raised (in a sophisticated and coordinated fashion) at a 2003 meeting of the Federal Parliamentary Standing Committee on Health, then dealing

with the problem of 'First Nations and Inuit Dental Health.'[77] In the course of several hours, through the strong voices of ethnonational representation and Aboriginal and non-Aboriginal professional providers, the consent initiative increasingly shaped into a failed administrative endeavour. By early 2004, FNIHB claimed that it was "altering its approach to the consent initiative,"[78] essentially meaning it had withdrawn it.

d. Pilot Projects and the Transfer of Control

At this negotiation table, discussions had previously occurred between the Nunavut Government and northern ethnonationals (here represented by ITK) relative to the 'transfer' of NIHB management and service duties. The Nunavut Government was expressing keen interest in passing their responsibilities to interested northern ethnonationals. This would not be without complications though, as the current dynamics of 'NIHB transfer' held its own set of problematisations, making any northern transfer a challenge. Due to the unclear nature of the NIHB program, NIHB transfer had been slow to begin with, some jurisdictions simply not interested in acquiring such risks.

Interest from ethnonationals has existed for some time:

> "In 1994, Health Canada received a five-year authority to proceed with [NIHB] pilot projects with interested First Nations and Inuit communities. The primary objectives were to test various management and delivery options, to improve the program's efficiency and effectiveness, and to facilitate First Nations and Inuit involvement in, and control of, the program. The pilot projects were to operate for two years with an optional third year. An interim evaluation of each pilot was required after the first year, and a final evaluation when each project ended."[79]

The 'transfer of control' over the NIHBs was initially slowed by Auditor General recommendations calling for significant improvements in NIHB administrative processes prior to any 'transfer pilot.' As recommended, any transfer of the NIHBs "must recognize the weaknesses identified and assign responsibility for fixing them."[80] By 1995, FNIHB had planned the implementation of 30 pilot projects over a two-year

period, "with 22 proposals receiving a negotiating mandate but few approved for pilot implementation [with] only one pilot under way."[81]

In 1997, as FNIHB/NIHB mitigated internal and external pressures with modest improvements in management and expenditure control (supported by the pillars of cost, control, and inequity), a 'renewed mandate' re-established authority for the transfer of the NIHBs. The 'benefits made available for pilot transfer' were medical transportation, vision care, and medical supplies and equipment. Shortly after, possibilities for control over drug and dental benefits were also 'made available.'

Discussions around an Inuit proposal did occur at this time, with the Keewatin RIO at the forefront of interest.[82] Yet due to the developing dynamic within the Keewatin health board in the mid 1990s (*i.e.* the 'P3 plan' and its privatising efforts in the midst of damning conflict of interest charges, prohibited billing practices, and poorly rationalised dismissal of regional dental therapists), it was not believed to be a stable enough environment for such an experiment. As stakeholders further suggest, the Nunavut Implementation Commission did not believe RIOs sufficiently prepared to undertake such a challenge, preferring that 'control' become a Nunavut Government responsibility (which it subsequently did). With the Keewatin health board dynamic reaching its zenith in 1997 (as 'NIHB transfers' were finally developing in southern Canada), and as focus turned on the creation of Nunavut and its responsibilities over all health services, a pure ethnonational 'control' fell out of favour.

Though Nunavut was in part an ethnonational, and contradictorily, while 'transfer pilots' made services 'available,' most benefits had already been, in one form or another, a component of the general FNIHB 'passing of control' (in this case the 'devolution' to

pre-Nunavut regions). Managing discrete administrative aspects of the NIHBs were a long-standing part of contribution agreements for community health program transfer/devolution (*i.e.* territorial governments and southern communities taking part in managing medical transportation, and/or involved in choosing and coordinating professionals and itinerant services). Still, the 'first three NIHB pilot projects' to assess 'full control' were not reported as commencing until 1996, followed by three more in 1997, and then ten more in 1998, for a total of 16 'initial pilot projects.' Of the 16 'newer' pilot projects approved, most involved medical transportation benefits, but also covered a select few pharmacy, dental, and vision initiatives.[83]

Criticisms then resurfaced in 2000, when the Auditor General noted that only five pilot sites had been evaluated since their renewed mandate in 1997. As it stood, during the interim, 'evaluating' pilot sites had slowed by disagreements at the NIHB Joint Steering Committee level. By 1998, only 'an evaluation framework' had been drafted (even though the pilots were mandated four years prior). With only four 'draft evaluation reports' received by mid 2000 (all under review by the NIHB 'Pilot Evaluation Sub Committee'), there had still been 'no overall evaluation of the effectiveness of the pilot exercise.'[84]

Even without a definitive framework for evaluation, the then 'current round of pilot projects' were still expected to meet the following criteria:

> "[A]ssume all benefit areas; manage the current national benefit levels; serve all members regardless of residency; and obtain a completed Consent Form from each eligible recipient covered under the funding arrangement."[85]

The last of these expectations was clearly problematised. Less obviously, the others were as well.

To not 'assume all benefits' meant that some NIHB management remains with FNIHB. Stakeholders commented that FNIHB 'did not enter' into the transfer of a problematised program in order to 'only transfer certain benefits.' This created two lines of administration for one program, and also added to the line already policing the ethnonationally/community-assumed NIHB. In contraposition, ethnonationals and communities do not always pursue significant control over particular benefit areas, with some areas perceived as 'high risk.' A commonly voiced example of this deals with pharmacy benefits: 'if one assumes control over the pharmacy budget,' and then 'someone in the community gets HIV/AIDS,' what happens to a budget that 'all of a sudden' is much less resilient (this relative to a single case that has the definitive potential to consume an inordinate amount of budgetary funds). Some communities interested in NIHB 'pilot transfers' simply did not have the capacity, in that they lack the economies of scale and/or population needed for maintaining the activities of such programs.

Not 'managing to the current national benefit levels' provided other problems. For example, some communities wish to change the very structure of the NIHBs to suit their needs, potentially (and almost inherently) not meeting this expectation. Some communities find themselves in a position where budgets become strained (without recourse to 'supplemental appropriations'), and not being able to 'manage to current national benefit levels.'

'Serving all members regardless of residency' has also become a problem, as some communities have taken up the responsibility of offering services to individuals of other communities or to those without Indigenous status. With little recourse to regain

the costs associated with delivering these services, this puts strain on all budgets, again without the ability to seek 'supplemental appropriations.' With all of the former complications, by 2002, many communities had foregone their 'transfer pilots,' reverting back to old practices. Of the 16 'newer pilot projects' funded in 1997, "one pilot went into self-government, eleven have reverted to contribution agreements, and one joined with a larger pilot,"[86] with the remaining three still in their approval phase.

Apart from this, confusion remains as to what exactly constitutes a 'pilot project.' Every initiative to assess the development of First Nations and Inuit control could be considered, in early phases, 'a pilot project.' For the NIHBs, medical transportation, medical supplies and equipment, and drug and dental benefits were all 'piloted' in community health program transfers/devolution, with some discrete administrative control over NIHB services occurring even though, by rule, the NIHB program was not available for transfer until 1997. There were differences though.

Stressed in older 'transfer pilots' was the incorporation, management, and coordination of NIHB providers and their services into the dynamic of 'community health programming,' as directly controlled by the health leadership of a community (*e.g.* communities that receive funds for, and control decision-making over, the dentists they hire, the pharmacists they hire, *et cetera*). So:

> "Although the [new pilot] transfer of NIHB to First Nations and Inuit control will follow a similar process to community health transfers, there are four key differences: 1. Unlike community health programs, the costs of providing benefits to community members are influenced to a much greater extent by pressures such as client utilization and market increases. 2. The provision of benefits is dependent on private sector providers and markets. 3. Unlike services such as nursing, which most communities already have expertise in, providing benefits requires expertise in health benefit management which may not already exist at the community level. 4. Provision of community health programs is generally restricted to members living on-reserve [while] [p]rovision of benefits through the NIHB Program is not restricted to those members living on-reserve."[87]

This meant that an exploration into new mechanisms by which to 'pass control' were underway (other than traditional community health transfer/devolution). Initially:

> "Preliminary Proposals [were] accepted from: a. Individual First Nations or Inuit communities; b. A grouping of several First Nations or Inuit communities; c. Provincial Territorial Organizations; d. Tribal Councils; e. Other First Nations or Inuit Organizations; f. Existing Pilot Projects wanting to renew their pilot agreements under the new terms and conditions."[88]

These groups were to submit a 'business plan' that "explain[ed] a community's plans for the management of the many complex organizational and financial aspects of delivering the various non-insured health benefits."[89] This 'business plan' would ideally provide:

> "[A] community or group of communities with business opportunities to reduce the costs of benefits and thereby have funds to put towards other health programs. Examples of ways in which communities can reduce the costs of benefits include: taking action to improve the health status of its members, e.g., hiring a salaried pharmacist who would educate clients as drugs are dispensed; reducing medical transportation costs by hiring a salaried physician and/or dentist to work within the community."[90]

While reflecting the logic of older pilot projects in directly hiring providers, these 'various management and delivery options' more often than not centred on 'business opportunities,' such as community/ethnonational 'health management corporations' (that approximate regional health authorities), or community/ethnonational corporations aiming to act as 'economic development vehicles' through their 'control over services.' Essentially, ethnonational structures that held economic advantage in the delivery of NIHBs services (all of course to advance 'self-government').

An example of a 'health management corporation' includes Anishinaabe Mino-Ayaawin Incorporated. Created in 1996 by a Regional Tribal Council, this organisation states to be 'a non-profit apolitical health management corporation' using a 'primary health care philosophy.'[91] This corporation's existence was nonetheless seen as an enactment of a political reality, and more importantly, as a mechanism by which to build health governance capacity (human, social, and economic). Any 'saved' funds (as per its

'business opportunities to reduce the costs of benefits') are reinvested into the corporation to further develop capacity, and along with the management fee claimed for administering services, seen as part of the increasing fiscal wealth of its member communities. In representing seven member communities (and some non-member ones), this corporation acts as a centralised authority, having responsibilities across community health programming (*e.g.* nursing services, environmental health services), in addition to the NIHBs. This NIHB pilot project spans the control of commercial and non-commercial social health goods, in turn ensconcing all domains of modern health service delivery.

An example of an 'economic development vehicle' is found within this and other health management corporations, and in newer individual community/ethnonational initiatives. Both involve the proposed 'management and delivery option' of providing care to community members through control over NIHB provider structures, viz. ownership of ethnonational third-party managed pharmacies and dental clinics, which constitute a form of ethnonationally-specific managed care. In attempting to 'reduce the costs of benefits through business opportunity,' the pilot projects aim to reduce 'per unit' costs through the development of service supply structures. Through these structures (that provide services to Aboriginal members and non-members), pharmacists and dentists could be hired on salary, disbursing care possibly through capitation or at reduced fees. Any saved funds (or revenues) could be put towards other health programs, or into other non-health related activities.

For example, 'Founder's Pharmacy' was:

> "[A]n offshoot of a $23-million, three-year pilot project [called] Anishinaabe Mino-Ayaawin Inc., [...] charged with finding more cost-effective and 'member-sensitive' ways to deliver and pay for quality healthcare under the problem-plagued federal NIHB program. Founder's Pharmacy will operate one

> store on a reserve and two more in other areas of the province. About 15,000 native persons [will be serviced]. There are plans to franchise Founder's Pharmacy so it can be sold to First Nations throughout Canada."[92]

This situation was not unique, with similar examples existing in four other provinces, not all proving successful. In Ontario:

> "Pharma Plus Drugmarts closed its First Nations Pharmacy, citing poor performance. The pharmacy, founded by MediTrust Healthcare Services Inc. in November 1998, was originally planned to be the first of a national native-owned pharmacy chain."[93]

Relative to an individual community-based initiative:

> "'We've taken control of our NIHB program and now collect monthly data on everything from pharmaceuticals to podiatry and chiropractic services.' [...] His band receives $420,000 per year from the federal government to administer a pharmacy program for 2,500 individuals; about 1,300 on the reserve and 1,200 in other parts of Canada. When pharmacists bill First Canadian Health Management Corp. - the Toronto claims processor for the NIHB - First Canadian in turn submits a bill to the [X] Nation (or one of the other First Nations bands, as applicable)."[94]

As it stood, pharmacy pilot projects were not well received by their professional organisational parallel. In creating such health service delivery structures, they impacted individual pharmacists and their professionally controlled monopolies (*i.e.* governmental contracts and other pharmacy markets). For example, "[X] owner of a pharmacy says he could lose as much as half of his business if a First Nations pharmacy opened [in his area],"[95] and since "about 100 of the province's 365 licensed pharmacies do substantial business with NIHB, which accounted for $26.7 million in total pharmacy services in 1997-98,"[96] these Aboriginally controlled corporations hold definitive economic impact.

Some pharmacy organisations openly opposed these initiatives:

> "Similar pilot projects have been attempted and have failed, leaving pharmacies with unpaid claims. The [X] NIHB Pilot Project may prove to be very successful, however [this professional pharmacy association] wants to limit the risk to [provincial] pharmacies. Health Canada has been asked to guarantee payment in the event the [X] NIHB Pilot Project does not make payment for legitimate claims. There are a variety of other outstanding concerns with respect to contractual language, and administrative issues (payment cycles, prior approvals, etc.). In addition pharmacists are concerned that this Pilot Project will limit first nations accessibility to medications. Accessibility is, of course, one of the Principles of the *Canada Health Act*. At this time, [this organisation] is recommending to members that [they not sign any contract] if they are approached by representatives of the [X] NIHB Pilot Project, they are best served to direct them back to our office so that we may centrally address outstanding issues."[97]

Interactions eventually became negative:

> "I am writing with respect to the document titled "Notice To All Pharmacies" that has been circulated by [X organisation]. It is disappointing to see that [X organisation] has decided to proceed at this time, without first addressing the many concerns raised by the [professional pharmacy association]. The current contract pharmacies are being asked to sign contains errors in contractual language, unreasonable contractual terms, and does not address the issue of certainty of payment. Pharmacies are not being asked to enter into a contract with [another] Pilot Project, but rather a separate corporation which has only recently been created. This newly created corporation has no track record, no credit history, and no experience administering drug claims. Obviously pharmacies are going to be reluctant to enter into contracts given the inherent risk involved. [This association] has met with your organization on several occasions and has documented many of our concerns in our correspondence to you. We are now told by pharmacies that one of your representatives is telling pharmacy owners that [this association] approves of the contract they are being asked to sign. This assertion is entirely wrong. It is more efficient for you to deal directly with [this association], the organization that is charged with the mandate to represent pharmacists' interests in this area, than for you to try to mislead pharmacies into entering this unreasonable agreement. I suggest you are wasting valuable time by failing to deal with our concerns centrally."[98]

Significantly, these newer pilot project corporations challenge modern professional notions on how to best structure the delivery of care to patients, challenges that, when supported by federal authority, are observed to be a serious breech of Professional/State relations and their legislated partnerships in professionally controlled service delivery. These pilot projects were viewed as forms of managed care, and were quickly criticised as such: "I don't see how you could use a PPO [preferred provider organisation] without really restricting the access to pharmacy services [contravening the *Canada Health Act*]."[99]

While pilot projects continue for pharmacy, they never 'took off' for dental services. With professional dentistry's social power being more than that of pharmacy, this possibility was quickly and quietly addressed, making any enactment a difficult political reality. Nevertheless, because the NIHBs (and the professional groups that deliver them) are part of the more private side of Canadian health care, they remain open to 'non-professional' competition or derogation of their State supported monopolies (developed in Chapter 7 for the dental profession). In this sense, "[t]his is a free country,

[i]f we want to open a chain of drugstores, we are completely within our rights [in a capitalist economy]."[100]

The 'purest' capitalist NIHB pilot project was not considered as such: it was a business endeavour supported by a State-funded market-based mechanism attempting to reflect Aboriginal business in government contracting surrounding Aboriginal populations. In 1997, through the 'Procurement Strategy for Aboriginal Businesses' (PSAB), the Department of Indian and Northern Affairs was given the task of administering 3% of the $14 billion in goods and services that the federal government contracts every year.[101] PSAB requires that companies bidding on any contract worth more than $5,000 that serves a primarily (80%) aboriginal population must have at least 51% aboriginal ownership and one-third aboriginal employees to qualify under the 'set-aside provision.'[102] As the NNI in Nunavut, this policy aids the social and economic development of Aboriginal populations in their increasing control over the relational activity that constitutes their governmental services (assumedly in relation to increasing capacities in self-governance).

The PSAB tender of relevance here is the federal contract for NIHB claims processing, awarded to First Canadian Health, a corporation created by the Tribal Councils Investment Group of Manitoba Limited and Aetna Health Management Canada Incorporated.[103] The $250-million contract continued the private management of claims processing that began in the late 1980s (through the contracting of a non-Aboriginal insurance firm), and continued the incorporation of mechanisms for Aboriginal control.

> "Although a separate issue from the set-aside provision, there is definitely a link between the government granting the contract to a native-owned company and its plan to transfer control of health programs to natives. Giving natives control of the claims process is one way to encourage aboriginal business development that will bring revenue and jobs to native communities, says [...] the NIHB office in Ottawa. And, with aboriginal groups controlling their own health programs, [NIHB] believes

> steps could be taken at the community level, through such measures as coordination of benefits and using local dealers as preferred providers, to reduce healthcare costs. [The investment group] leaders also see a link between acquiring the contract and the move towards gaining control of their own healthcare programs. [Representation] says that understanding the gaps and problems in healthcare for native people - over-prescribing of drugs and higher than average rates of diabetes, for instance - is important for developing a health management approach for natives."[104]

So through a purely capitalist (clinically/medically removed) service provider, a very clear connection is made between the private control of discrete aspects in health service delivery, more effective and cheaper health services, and the realities of an Indigenous constituency (inevitably considered high risk) trying to renegotiate their relationship with the State. Further, through the ethnonational for-profit corporate delivery of commercial social health goods (to enact and promote a self-governing capacity), Indigenous groups are involved in a very modern process: the neo-liberal privatisation of health services in Canada (to be considered shortly).

Since Aboriginal self-government in Canada is conceived of in relation to independent and self-governing communities/regions, the claims processing contract included a clause such that "Aboriginal groups [could choose] to handle their own benefit plans [and] partner with anyone they wish."[105] "Aboriginal groups shut out of the claims contract do have the option of carving their benefits out of the NIHB Program altogether [and moving towards their own self-government efforts]."[106] In fact, it was this consideration that kept other health insurance market players from bidding: "It's been estimated that half of the bands in Canada could carve out [of the NIHB program] over the nine-year contract, so there was a real possibility the $250-million contract would diminish over time."[107]

Yet as one coordinated aspect of a larger movement in Aboriginal sectoral control and self-government, First Canadian Health is well aware of its capacities in adjusting to the needs and rights of Aboriginal communities. In its contract bid, the organisation

stated that it "would help those groups that want to carve out their chunk of the business, [and] provide processing and adjudication [of benefits claims] at a cheaper rate to groups that need assistance to make it possible for them."[108] In the context of a future Aboriginal Health System and Economy potentially driven by the privatisation of services, this health management firm is further "recruiting other aboriginal organizations across the country to develop the company, and is scoping the native benefits scene for other benefits and healthcare ventures."[109]

The connections between the NIHBs and privatised mechanisms of payments for uninsured health services are even more intricate. Consider that some communities purchase 3rd party coverage (through market-based carriers like Aetna Health Management Canada Incorporated) to provide services to their employees (not to the population at large). At one point, this ability involved some overlap with funding from the NIHBs. As reported by a provincial Aboriginal authority:

> "In 2003, FNIHB unilaterally imposed a policy change with regards to the NIHB program. Effective June 1, the current wrap-around policy which allowed First Nations employers to fund benefits over and above those covered by the NIHB Program will be dissolved."[110]

Some have suggested that FNIHB fund communities/ethnonational organisations, who would then purchase coverage through a '3rd party plan,' dissolving the NIHBs altogether. While intriguing, this assumes that the economies of scale exist in Aboriginal communities such that these populations could support private clinics (and experience reasonable access). This would also appear improbable in today's climate of unsettled claims regarding Aboriginal rights and the unclear modes of control over service delivery that constitute current self-government initiatives.

As a mode of control, situating the enactment of self-government in the private sphere simply followed the increasing management of the NIHBs as an insurance

mechanism over the late 1980s and 1990s. This makes it clearer why current 'transfers of control' settled in business opportunities within the health marketplace. Still, a marketplace fundamentally thwarted as economic actors aim for fiscal gain in an environment of limited (and increasingly shrinking) capital.

To date, modes of service delivery control have now been defined through the limits of 'community health transfers' and through NIHB 'transfer pilots.' These transfers of control can be said to equal influence over each pole of the insured/uninsured structure of Canadian health care. So with increased control over the planning and delivery of commercial and non-commercial social health goods, the claim of a separate Aboriginal Health System and Economy is further confirmed. Surely, this is a system and economy increasingly composed of Aboriginal governmental health authorities that centralise services for geographical groupings of communities (*e.g.* Anishinaabe Mino-Ayaawin Incorporated, Aboriginal health boards, NDHSS regions), paralleled by Aboriginal market actors that support the mechanisms of delivery in the centralisation of these services (*e.g.* pharmacy chains, First Canadian Health, 'multi-passenger van services'). All entities, naturally, are fundamentally tied to the reality of Aboriginal self-government in Canada today.

In this milieu, the role of Inuit in 'NIHB transfer' remains undecided, as Inuit interest in NIHB transfer has resurfaced. With the creation of a 'social policy department' within the Baffin RIO, a call was made for transfer of the NIHB program to this Inuit authority.[111] Stakeholders suggest that discussions between NTI and the Nunavut Government have touched upon the potential for NTI itself to be involved in

NIHB management. Recent commentary in the Nunavut Legislative Assembly points to repeated discussion:

> "[T]here have been meetings with NTI as well as our department on the negotiating with NIHB. The former Assistant Deputy Minister of the department now with Community Government and Transportation, Richard O'Brien had meetings with NTI and as I said earlier NSDC [...]."[112]

These interests mingle in the Nunavut Government agenda of removing itself from NIHB management and the ethnonational push for social and economic development opportunity.

So while all northern parties are interested to play their role in passing and/or acquiring control, current NIHB dynamics may not allow for any significant developments. As the Inuit of Nunavut observe the same opportunities that southern ethnonationals have, they are sure to keep pushing in this direction. NTI, RIOs, and organisations such as Piruqsaijit Ltd. and Nunavut Business Initiatives Ltd., all have or are currently developing capacities in the management, provision, and supplying of NIHB services.[113] Piruqsaijit Ltd. is even supported by Sodexho Inc., a multi-national corporation that provides many tertiary services for health care facilities, readily admitting its interest in private for profit health care opportunities.[114] Yet as was apparent at this negotiation table, strictly pushing for control over the NIHBs does not address the fact that any movement in this direction will less obviously necessitate definitive (and not contentious) discussion around what it means to control this program, how the Nunavut Government will maintain its necessary involvement, and the significant planning and mitigation needed for the inevitable professional challenge to such endeavours.

IV. Unclear Rights and Responsibilities, Historical Conflations, and Privatisation

At this negotiation table, and within these debates, one observes that unanswered historical contentions and uncritical conflations remain, fundamentally complicating any movement towards the future. How can ethnonational authority gain meaningful control over programs, it can be asked, when the rights associated with those programs remain ill defined (let alone the programs themselves)? How can meaningful control become established when it is even unclear whether the current Indigenous governance dynamic actually equates to governance? One would truly find it difficult to establish a clear answer to the question: 'What constitutes self-government?' In such logical frailty, the uncritical 'passing of control' continues.

Scholarly analysis of this social movement has always maintained that 'self-government and control over services' can improve the health status and health outcomes of Indigenous Canadians and their communities. For roughly 20 years, this logical yet under-supported assumption has been the modus by which the politically negotiated State/Indigenous relationship surrounding health has advanced. If one follows current federal rubric, Aboriginal groups are:

> "[A]ttaining autonomy and control of their health programs and resources within a time-frame to be determined in consultation with First Nations and Inuit people. First Nations and Inuit communities and organizations have expended $112 million to further their vision, and enhance their capacity to manage and administer their health services based on their community needs and priorities [one of these needs and priorities being control over services and governing the mechanisms of their development through self-rule]."[115]

Yet after the signing of numerous comprehensive land claims agreements and many discrete and individualised agreements, both federal and ethnonational authorities may now be degrading any positive developments. This as a result of an over-politicised environment that is openly confused relative to the terms it uses, and for the most part, critically unaware of the simple problematisations that it enacts and the potential

consequences it creates, as it continues to conflate intricately connected yet very separate constructs (all in the name of self-determination and self-government). So as federal and ethnonational governmental publications comment that Aboriginal communities are in a 'transition to self-government' or may have even achieved it through structures such as Nunavut, there still appears no clear consensus as to how this occurs, or what this may actually mean (even though it is agreed that 'control over services through self-government' is a positive thing).[116] So as newer evidence much more strongly supports the notion that 'self-government and control' can indeed improve Indigenous individual[117] and social health,[118] the current dynamic may be doing more to harm any potential rather than to foster it.

a. Unclear Rights and Responsibilities

An analysis of the unclear rights and responsibilities associated with the State/Indigenous relationship extends well beyond this study (with any substantial considerations ultimately necessitating juridical analysis and social intervention, possibly internationally based). Yet some discussion surrounding its constitution in health is useful. For example, a good way of observing the unclear rights and responsibilities surrounding health is by plotting what rights and responsibilities are established within and enacted through the players of the Aboriginal Health System and Economy. These are 'payer rights and responsibilities,' 'provider rights and responsibilities,' and 'client rights and responsibilities' (see Table).

From this table, it is clear that the complexities surrounding 'health and health services' essentially ground in two contentions: that of 'Nationhood' and that of

'collective and individual rights.'[119] The contention of Nationhood will be considered in the next section. Of relevance now is the contention of collective and individual rights to health and health services.

Table 11. Payer, Provider, and Client 'Rights and Responsibilities' Concerning 'Health and Health Services'

	Rights	**Responsibilities**	**Unclear Right/Responsibility**
Payer Governmental Federal	▪ Nationhood ▪ Representation of greater Canadian populations	▪ Nationhood ▪ Funding ▪ Base level service support (*e.g.* infrastructure) ▪ 'Trust-like' fiduciary responsibility ▪ Fulfilling the Canada Health Act	▪ 'Are the NIHBs an aboriginal / treaty / fiduciary right?' ▪ 'Is health an aboriginal / treaty / fiduciary right?' ▪ 'Are federal authorities obligated to provide services?'
Provider Governmental Federal and Ethnonational	▪ Nationhood ▪ Representation of specific Canadian populations	▪ Nationhood ▪ Service ▪ Management ▪ Patient/Client Protection	▪ 'Is control over services equal to self-government (*i.e.* enacting Nationhood)?'
Provider Corporate Ethnonational	▪ The right to service populations ▪ Some more formally than others as through State-supported preferential contracting (*e.g.* Economic Development Corporations) ▪ Nationhood?	▪ Service ▪ Management ▪ Patient/Client Protection ▪ Nationhood?	▪ 'Is corporately oriented service- provision congruous with enacting Nationhood?'
Provider Professional	▪ The right to service populations ▪ Some more formally than others through State-supported monopolies (*e.g.* dentistry versus allied health providers)	▪ Service ▪ Management ▪ Patient/Client Protection	▪ 'Can providers turn patients away relative to problematised NIHB insurance coverage?' ▪ Can providers ask patients to pay for services themselves so as sidestep the problematised NIHB coverage?'
Patient/Client First Nations and Inuit	▪ Protected by the *Canada Health Act* ▪ Access to services?	▪ Not abusing services ▪ Accessing services ▪ In market-based health insurance economies the client is made responsible for some of the costs	▪ 'Are the NIHBs an aboriginal / treaty / fiduciary right?' ▪ 'Should NIHB clients provide co-payments or premiums?' ▪ 'Is health an aboriginal / treaty / fiduciary right?'

Establishing a social claim to the NIHBs is grounded in the ethnonational position that 'health and access to health services' constitute collectively based individual rights as per their historical relationship with the Canadian State. For example, during the Royal Commission on Aboriginal Peoples, a social attack on the claim of a treaty/aboriginal/fiduciary right to health care resulted in this motion by the AFN:

> "SUBJECT: First Nation Treaty Right to Health; WHEREAS the Treaty First Nations entered into Treaties with the Crown [...]; and WHEREAS in exchange [...] the Crown in Right of agreed to provide certain types of compensation and benefits [...] among them Health Care; and WHEREAS section 35 of the Canadian Constitution, 1982 recognizes and affirms the existing Aboriginal and Treaty Rights of the Aboriginal People of Canada; [...] and WHEREAS the Reform Party is launching a public campaign calling for the termination of the Treaty Right to Health Care for First Nations; [...] BE IT FURTHER RESOLVED THAT all Treaty First Nations take action to protect the Treaty Right to Health Care and negate the campaign [...] against Treaty and Aboriginal Rights."[120]

This logic is based on the 'medicine chest clause' of Treaty 6:

> "That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents will grant the Indians assistance of such character and to such extent as her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity that shall have befallen them. [...] That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of Indians at the direction of such agent."[121]

This is the only treaty that contains specific written reference to 'health care.' However, records of negotiations clearly indicate that 'health' was discussed as part of treaties 8, 10 and 11.[122] Some further suggest that 'health promises' should be read into all historical negotiations, as treaties were conceived of as socially similar.[123]

Federal legal opinion is nonetheless clear:

> "In summary, the following information can be derived from [...] treaty material: (1) health care was not, at least by the government, considered a main feature of the numbered treaties; (2) in response to Indian fears with respect to great sickness [...] officials promised discretionary assistance from time to time. Always it was emphasized that such assistance would not be part of the everyday life; (3) nor would medical assistance for day to day sickness [be provided] except as or when a general opportunity arose and then on a discretionary basis, for example, when medical officers accompanied the Treaty Commissioners; (4) the only commitment Government appears to have made was that a medicine chest would be left at various locations containing medical supplies to be provided free of charge to those Indians who might require them. Given the limitations stated above, and given that these supplies were provided to an individual untrained in medicine, i.e. the local Indian Agent, and given that such provision of supplies would appear to have been with in his discretion, from a historical perspective, it would not be entirely frivolous to authorize what was promised to the Treaty Indians to a supply of first aid materials. The "medicine chest" clause has come before the Courts for

> Interpretation on a number of occasions. Aside from [one judgment], the Courts have almost unanimously given to the words of the treaty the plain and ordinary meaning. [...] Even looked at today in fair, large and liberal way, Canada likely has very limited health related legal obligations flowing from Treaty. [...] Provision of health care then, as now, was to the greatest extent a matter of policy and not a treaty protected right."[124]

As a result, 'health' is not often 'allowed on the treaty table.' Yet the contention of collective rights to health and health services can still be considered an open one, and still deeply embedded within the problematised historical claims of both groups.

Initially, an analysis of this contention need not be complicated. To begin, Aboriginal people (just as everyone else in Canada) are guaranteed access to hospital and physician services under the *Canada Health Act* (irrespective of difficulties in geographical and social limitations). Aboriginal groups do have very clear collectively based rights to 'health and health services.' As far as this idea, then, there is really no contention.

While it may be naïve to state this, the problems of jurisdiction, of a specific Indigenous right to health and health services, plus the continued social problematisations between both groups, have resulted in an effective degradation in service provision to all Indigenous Canadians. Simple claims for improvements in basic health services immediately become linked to historically problematised and politically charged debates. The collective rights grounded in the *Canada Health Act* are largely (and incorrectly) absorbed into debates concerning the separate social rights inherent to Indigenous Canadians. So while the former of these social rights are clear, they have become less so in the context of additional claims to health and health services.

This contention comes into better focus when considering the NIHBs. It is here where a right to health and health services is more effectively debated, viz. do Aboriginal people have access to services that are otherwise not a Canadian social right as per their

status as the original Nations/Peoples of this land? To date, these services have been provided 'out of policy' and 'to match' for those similar services provided by provincial/municipal governments (for the socioeconomically depressed). Yet Indigenous leadership makes strong claims for the constitutional and socially contractual basis of such service provision.

Most interestingly, the medicine chest clause may apply more directly to the NIHBs than to any other health service, as it is not frivolous to constitute a medicine chest as filled with 'medical supplies.' In fact, the broadest interpretation offered by the courts reads:

> "The clause might unquestionably be more explicit but, as I have said, I take it to mean that all medicines, drugs or medical supplies which might be required by the Indians [...] were to be supplied free of charge."[125]

Here, the notion of the medicine chest and the NIHBs more clearly intersect. All of this strengthening the contention of an Indigenous right to the NIHBs, let alone a federal responsibility.

If this were to ultimately become a broader Canadian social debate (necessitating juridical intervention), Indigenous groups may encounter difficulty in establishing such a claim. As it stands, representing the NIHBs as supplementary health benefits within the context of the Canadian social response to socioeconomic deprivation (as per a capitalist welfare State) is not overtly challenging. Yet in the context of Canadian social sensibilities regarding the fundamental (universal, comprehensive, portable, accessible, and publicly administered) rights of Canadians to health and health services, a claim based on historicicity and cultural separateness may prove less effective.

So how can the responsibilities of programs be transferred/devolved when the true nature of the rights associated with such responsibility remains open for interpretation?

Reflecting the common uncritical conflations associated with this political economy, here human rights to health and health services have intersected with the 'rights/benefits' associated with Indigenous historical and modern claims (*e.g.* land rights, hunting rights, self-government, control over the delivery of noncommercial and commercial social goods). Going further, commercial social rights (*e.g.* the ability of the open market to provide commercial social goods) increasingly blend with notions of Indigenous collective rights over the control of service delivery (and markets) associated with self-governing mechanisms (that mitigate the market-based delivery of commercial social goods). The relevance of this subtlety is now reviewed.

b. Historical Conflations: Self-Government, Control Over Services, Social and Economic Development

Establishing equality (or at least not recognising the difference) between self-government, control over services, and social and economic development, has ultimately defined a discernible aspect of Indigenous health services in Canada. The predominantly corporate (and partially corporately enacting) Indigenous self-government structure in Canada today bears clear witness to this fact. Nevertheless, can self-government, control over services, and social and economic development really be considered that different, let alone in isolation from each other? Do they not logically constitute the effort towards self-rule? While there are obvious and clear connections between all three, this researcher contends that not observing them as separate has done much to degrade the development of Indigenous health services.

The logic flows thus: Sections 25 and 35 of the *Constitution Act* serve to recognise aboriginal/treaty/fiduciary rights as part of the national consensus in the patriation of Canada. Yet as the Constitution recognises these rights, it does not observe them in any detail. A particular concern to Indigenous Nations remains the right to self-government.

In a series of special constitutional conferences held for the purpose of discussing Aboriginal concerns between 1982 and 1986, self-government was the most prominent subject.[126] Consensus on a constitutional agreement remained elusive, especially since territorial leaders did not hold an official seat at the negotiation table.[127] The 1987 'Meech Lake Accord' further failed in this regard. Attempts to deal with the Federal/Quebec relationship and bypass Aboriginal and northern concerns resulted in the singular opposition of Elijah Harper in the Manitoba Provincial Legislative Assembly that halted patriation. The 'Charlottetown Accord' of 1992 would then have recognised self-government as a constitutionally protected Aboriginal right, but this accord was swallowed up by continued Federal/Quebec disagreements and became rejected in a general referendum.

The 'third order' of government insisted upon by ethnonational leadership at this time was still denied *carte blanche* by federal and provincial representation.[128] The Federal Government then proposed in 1994 that instead of amending the constitution to explicitly recognise the inherent right of self-government, it would negotiate self-government agreements on the understanding that the inherent right of self-government is an existing right already recognised in section 35 of the *Constitution Act* (even though it is not in print). In 1995, the federal government released its policy guide, 'Aboriginal

Self-Government - The Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government,' often referred to as the 'inherent right policy.' This outlines the federal government's present approach to the inherent right to self-government, which at one level, is no approach at all since the major contention of Indigenous sovereign power remains.

The contention of Nationhood is also very much open, with the question of 'How is a Nation(s) within a Nation to look?' very much alive. Through historical conflations, what has resulted is the development of a corporate Indigenous regime, enacting self-government through acts of political, social and economic development, and attempting to control service delivery across all sectors. One can observe the subtly intricate connections and conflations that have led to this situation within an Auditor General report:

> "Economic Development of First Nations Communities. [...] In this context, institutional arrangements consist of the following: Organizations or structures [which] include political bodies (the chief and council of a First Nation), governmental bodies (economic development departments), business management organizations (development corporations), and less formal structures such as partnerships or negotiating forums. Rules [that] include treaties, agreements, laws, regulations, and policies. Practices and procedures [that] include staffing or planning procedures, and the outputs of procedures—strategies, plans, and certifications. These institutional arrangements set the framework for economic development. They are also interrelated. Organizations develop laws and procedures, rules establish what kinds of organizations and procedures are created, and practices describe how organizations are run and how rules are implemented."[129]

While very logical, the problems associated with such an environment are now being recognised.

For example, Cornell and Kalt recently discussed the question of Nationhood in an analysis titled: 'Alaska Native Self-Government and Service Delivery: What Works?'[130] They too describe a situation whereby "[s]elf-government and service delivery are not the same thing and need not be organized the same way."[131] So negotiating the organisation of 'control over services' as equal to the negotiation of the

organisation of 'self-government' is clearly incorrect, yet is something that routinely and uncritically persists.

As part of a larger program on the investigation of modern American Indigenous economic development, Cornell and Kalt also note the necessity for separation between political processes and management ones.[132] They further explain the need for a change in development ideology from 'job building' to 'Nation building.' For example, Alaskan Tribes that are building successful economies tend to share certain 'Nation building' features of governance. These include: stable political institutions and policies that bring predictability to process (a prerequisite for capital investment); a judicial system independent of political influence (which allows for the reliable resolution of disputes); firewalls between the management of enterprises and tribal governance (which leads to more profitable and sustainable enterprise); competent, professional bureaucracies (required to administer the complexities of governance); and governing institutions that reflect the cultural traditions of the tribe (or face the consequences of losing legitimacy). In short, these authors approach development as primarily a political problem, not an economic one.

This logic is reflected in another Auditor General Report:

> "The [communities] we visited recognized that politics, government administration, and business management must have a degree of insulation from each other to provide the necessary stability for economic development. [...] Achieving appropriate separations among business, administration, and politics is a particular challenge for [communities] because they often have a limited leadership pool due to their small population, and because they often pursue economic opportunity through collective means, such as community-owned businesses. The [communities] we talked to have developed a range of mechanisms that establish such separation. For example [there exist] [d]ocumented roles and responsibilities that separate strategic and political roles from day-to-day government administration and business management; [p]rocedures to identify and manage possible conflicts of interest; [p]rocedures to hire and promote staff based on merit and qualifications; [a]greements to keep existing management in place for several years when purchasing businesses; [b]oards that include members other than [political leaders]."[133]

In Canada's Aboriginal Health System and Economy, one can say that the development of an incorporated Aboriginal (approximating) regional health authority like Anishinaabe Mino-Ayaawin Incorporated may constitute movement in this direction. In the context of today's environment, there still appears cynicism as to the reality that this health management corporation is 'apolitical' and 'non-profit.' The close work that would have to take place to achieve such a system between a Nunavut public government and self-government may buffer such critiques. Yet with policy that conflates such critical constructs, finding clarity in any direction may prove difficult.

c. Privatisation

Here lies a crucial aspect of this analysis and of the current milieu. Are there in fact clear demarcations between a for-profit or non-profit status in today's Indigenous cadre of self-government corporations? As it stands, they constitute a complex admixture of both.

For Cornell and Kalt:

> "Self-governing communities may freely choose not to provide services themselves but to contract those services out to other entities that have administrative or economic advantages in delivery. Examples of effective service provision of this sort are legion, ranging from tribal consortia for the delivery of welfare services to intertribal health programs to tribes that contract for fire protection with nearby cities and cities that contract with tribes for such services as water treatment or solid waste disposal."[134]

'Examples of effective service provision' are clearly legion and seen as such in the United States, where the privatisation of services is a clear mode of socially acceptable control. In Canada, this may not directly translate, but the movement towards a neo-liberalist State has played a role in accommodating such developments.

With the general government retrenchment of the 1980s and 90s, the use of 'health' as an economic vehicle for capitalist development (simply to meet the needs of those delivering services) has become a pressing reality (hence the rise of the 'public

private partnership'). Many scholars have conceived this as problematic, some establishing the administrative and fiscal inefficacies associated with more private systems, and the negative effects they hold for the health of individuals and populations.[135] In the case of Indigenous populations, uncritically observing historical conflations has doubly worsened this approach, as privatised health service delivery, while becoming observed as a modus for pure economic development, has also come to potentially function as a perceived form of governance or enactment of self-governing practice.

At one level, this is understandable when one considers that these health and social services budgets are fundamentally important in socioeconomically depressed communities. Not only do they provide services where there might otherwise be none, they also constitute some of the largest inflow of capital into a community, create jobs, and in turn form an economy that comes to sustain real people. Yet in time, as the State (at first in conjunction with the Church, mining companies, and military, and then with a non-Indigenous academic and capitalist sector) began creating an economy of contracts around the delivery of health and social services to such populations, ethnonational pressure eventually turned to capture some of the opportunity.

It is here where unclear lines may become too crossed. For example, in heavily involving the private ethnonational sector, what possible outcomes will this form of passive privatisation produce? If in the open market, could the non-Indigenous Canadian access these services? In an increasingly class-based modern Indigenous society,[136] are the current mechanisms that lead to social inequity in the broader Canadian society useful

in their reproduction? Ultimately, in the context of a severely constrained economy (both socially and economically), is pure capitalist economic development even possible?

For Cornell and Kalt, such concerns are not pressing:

> "One of the unfortunate developments at the national level has been a pattern of adding language to national program legislation restricting funding in Alaska to regional non-profit organizations. [...] While many regional programs are both innovative and first-class, these restrictions have made it more difficult for tribes or other, non-regional associations of communities to develop innovative solutions to service problems. By excluding non-regional organizations from direct funding and mandating regionally organized service delivery, policymakers effectively limit the range of possible [capitalist] solutions and reduce the likelihood that—in a complex and diverse [capitalist] environment—the problems at hand actually will be solved."[137]

In this case, neo-liberalism may not prove so negative for Indigenous populations as is commonly proposed. As long as economies are legislated to grow, these developments could actually prove positive. Yet growth does not appear to be the funder/payer's intent.

V. Conclusions

Irrespective of diversity, Inuit populations and their dental services are now part of certain singular realities in a developing health system and economy, realities that now hold power over Inuit, their health, and their health services. Unfortunately, in attempting to improve this health, this system continues its oft-quoted 'ad hoc' development under unclear social statuses, rights, and responsibilities, all supporting the maintenance of problematised historical conflations that are now charting new territory before effectively mapping what has already been settled. This seems an ineffective manner to structure and develop health care services that are from the very beginning more costly, and from all accounts, also more difficult to deliver as per geographical and social organisation.

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[1] Surely, this is a necessary analytical step when knowing that in the historical and modern colonial relationship, activity outside of Nunavut often has an over-determined capacity to influence developments in the region.

[2] Early on, a 1939 Supreme Court decision defined Inuit as administratively equal to 'Indians' (confirming that Inuit were a federal responsibility and bringing 'Northern Affairs' closer to 'Indian Affairs'), yet the administrative mechanisms that governed them remained separate. For example, an Inuit registry was never created paralleling the 'Indian register' of the Indian Act, although Inuit did have a 'disc' system, whereby a leather or hard plastic disc with a number (the size of a large coin) was given to them for State purposes. Importantly, the signing of the NLCA was equal to the signing of a modern treaty, the registry designating Nunavut 'beneficiary status' paralleling the Indian Act's historical register, holding similar implications (e.g. different 'statuses,' 'losing status' through administrative rules, 'classes of citizens' in Canadian Indigenous societies).

[3] **Nunavut Tunngavik Inc** (2004) "Transition to new NTI department complete." Press Release January 16; **Nunavut Tunngavik Inc** (2003) "NTI Makes Important Advances in Social and Cultural Development Department." Press Release November 05; **Nunavut Tunngavik Inc** (2003) "Nunavut Tunngavik Inc. to explore building a drug and alcohol treatment centre for Inuit." Press Release Novermber 04; **Nunavut Tunngavik Inc** (2003) "NTI Initiates Pilot Beneficiaries with Disabilities Program." Press Release July 21; **Bell J** (2002) "QIA launches social policy department." Nunatsiaq News October 11; **Kivalliq Inuit Association** (1997) Annual Report. Rankin Inlet: KIA

[4] **Dion Stout** M (2002) Turning to a Sustainable and System-wide Approach: Improving Access and Quality of Health Care Services for First Nations and Inuit. Ottawa: Joint Working Group on First Nations and Inuit Health Renewal; **Gaspe Tarbell Associates** (2002) Control of Programs and Services - A Discussion Paper for the Joint Working Group First Nations and Inuit Health Renewal. Ottawa: Joint Working Group on First Nations and Inuit Health Renewal; **Jamieson L** (2002) Improving Health Status and Outcomes for First Nations and Inuit. Ottawa: Joint Working Group on First Nations and Inuit Health Renewal; **Lemchuk-Favel L** (2000) First Nations and Inuit Health System Renewal: A situational analysis. Ottawa: FAV COM; **Lemchuk-Favel L** (1999) Financing a First Nations and Inuit Integrated Health System. Ottawa: FAV COM.

[5] **Health Canada** (1997) Health Canada Estimates: A Report on Plans and Priorities. Ottawa: Government of Canada.

[6] A major strategy of centralised authority has always been to control costs by limiting who can access services under a recognised Indigenous status.

[7] **Inuit Tapiriit Kanatami** (2000) Summary Report: Inuit Health Policy Forum. Ottawa: ITK.

[8] **Ibid.**

[9] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[10] With a swift fixation of what could be spent, federal planners were addressing their awareness of Canada's Indigenous demography (which demonstrated a very young and growing population. See **Four Directions Consulting Group** (1997) First Nations Demography. Ottawa: Department of Indian Affairs and Northern Development Research and Analysis Directorate.

[11] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[12] **Lavoie JG** (2003) "The Value and Challenges of Separate Services: First Nation in Canada" In Healy J. and McKee M. (Eds.) Health Care: Responding to Diversity. Oxford: Oxford University Press.

[13] **Ibid.**

[14] **Ibid.**

[15] **Lavoie JG** (2003) "Governed by contracts: the development of Indigenous primary health services in Canada, Australia and New Zealand." NAHO Journal of Aboriginal Health (forthcoming).

[16] **Dion Stout M** (2002) Turning to a Sustainable and System-wide Approach: Improving Access and Quality of Health Care Services for First Nations and Inuit. Ottawa: Joint Working Group on First Nations and Inuit Health Renewal.

[17] See for example **Assembly of First Nations, Inuit Tapiriit Kanatami, Metis National Council** (2002) "Aboriginal Leaders Must Participate in First Ministers Meeting on Health." Media Release January 09.

[18] **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[19] **Ibid.**

[20] **Ibid.**

[21] **Taylor MG, Stevenson MH, Williams P** (1984) Medical Perspectives on Canadian Medicare. Toronto: York University; **Gelber SM** (1966) "The Path To Health Insurance." Canadian Public Administration Vol. 9:211-20; **Hastings JEF and Mosley W** (1964) "Introduction: The Evolution of Organised Community Health Services in Canada." Royal Commission on Health Services. Ottawa: Government of Canada.

[22] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press.

[23] **Ibid.**

[24] **Taylor MG, Stevenson MH, Williams P** (1984) Medical Perspectives on Canadian Medicare. Toronto: York University; **Gelber SM** (1966) "The Path To Health Insurance." Canadian Public Administration Vol. 9:211-20.

[25] This results in the now infamous 'gap' of the attempted equitable insuring of services such as dental care, whereby both those insured through employment and those receiving social assistance, have access to services, yet those with low-income jobs do not, as their jobs generally do not provide for insurance, let alone the financial means by which to purchase one's own insurance or to pay directly 'out of pocket.'

[26] **Assembly of First Nations** (2003) Background to the Non-Insured Health Benefits. Ottawa: AFN.

[27] **Medical Service Branch** (1989) NIHB Administrative Manual. Ottawa: MSB.

[28] **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[29] **Ibid.**

[30] **Ibid.**

[31] **Ibid.**

[32] **Ibid.**

[33] **Ibid.**

[34] **Ibid.**

[35] Apart from increased access and utilisation, NIHB expenditures also grew relative to the young and growing Aboriginal population, and to federal legislation that granted many Indigenous Canadians Indigenous status under the Indian Act. **Waldram J, Herring D, Young T.** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[36] **Medical Service Branch** (1989) NIHB Administrative Manual. Ottawa: MSB.

[37] **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[38] **Ibid.** NIHB also began to cover health insurance premiums, this being an example of the strong regional character of FNIHB/NIHB administration, whereby unique historical practice (in British Columbia and Alberta) saw the NIHB program establish payment for these premiums.

[39] **Ibid.**

[40] **Ibid.**

[41] **Ibid.**

[42] **Ibid.**

[43] **Medical Service Branch** (1989) NIHB Administrative Manual. Ottawa: MSB.

[44] **Auditor General of Canada** (1993) Chapter 19: Department of National Health and Welfare: Non-Insured Health Benefits. Ottawa: Auditor General of Canada.

[45] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[46] **Ibid.**

[47] As described and summarised from the FNIHB web site. www.hc-sc.gc.ca/fnihb-dgspni/fnihb

[48] **Canadian Dental Association** (2001) "CDA Adopts New NIHB Strategy." Communiqué March/April. Ottawa: CDA; **Canadian Dental Association** (2001) "NIHB Dominates Discussions with MPs." Communiqué May/June. Ottawa: CDA; **Canadian Dental Association** (1999) "Efforts to Improve NIHB Continue." Communiqué July/August. Ottawa: CDA.

[49] As per **Waldram J, Herring D, Young TK** (1995) Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

[50] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[51] **Ibid.**

[52] **Ibid.**

[53] **Peter Cooney** (2002) Personal Interview. Montreal, Quebec. May 26.

[54] **Lavoie JG** (2003) "Governed by contracts: the development of Indigenous primary health services in Canada, Australia and New Zealand." NAHO Journal of Aboriginal Health (forthcoming).

[55] These constitute the 'Personal Health Information Banks' containing information on Aboriginal people as listed by Health Canada.

[56] There is debate whether current trends in this regard equal social equity, or only a mechanism to further the centralisation and control of power in modern capitalism. **Mykhalovskiy E** (2001) "Towards a Sociology of Knowledge in Health Care: Exploring Health Services Research as Active Discourse." In Armstrong P, Armstrong H, Coburn D (Eds.) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. Oxford: Oxford University Press.

[57] **Government of Canada** (2002) A Compendium of Policy for the Protection of Personal Privacy in Health Research. Ottawa: Government of Canada.

[58] **Kaufert JM and O'Neil JD** (1989) "Biomedical Rituals and Informed Consent: Native Canadians and the Negotiation of Clinical Trust." In Weisz G (Ed.) Social Science Perspectives on Medical Ethics. Kluwer Academic Publishers; **Kaufert JM, O'Neil JD, Koolage WW** (1985) "Brokerage and Advocacy in Urban Hospitals: The Impact of Native Language Interpreters." Sante Culture Health 3(2): 3-9.

[59] **Kaufert JM, Commanda L, Elias B, Grey R, Young TK, Mazumi B** (1999) "Evolving Participation of Aboriginal Communities in Health Research Ethics Review: The Impact of The Inuvik Workshop. International Journal of Circumpolar Health 58: 134-44; **O'Neil JD, Kaufert JM, Kaufert PL, Koolage WW** (1993) "Political Considerations in Health Related Participatory Research in Northern Canada." In Dyck N and Waldram JB (Eds.) Anthropology, Public Policy and Native Peoples in Canada. Montreal: McGill-Queen's University Press.

[60] **O'Neil JD, Blanchard J** (2001) Considerations for the Development of Public Health Surveillance in First Nations Communities. Winnipeg: Centre for Aboriginal Health Research; **O'Neil JD** (2001) Critical Issues in Health Information and Surveillance in First Nations Communities. A Report Prepared for the First Nations and Inuit Health Branch, Health Canada; **O'Neil JD, Reading J, Leader A** (1998) "Changing the Relations of Surveillance: The Development of a Discourse of Resistance in Aboriginal Epidemiology." Human Organisation 57(2): 230-7

[61] **O'Neil JD, Blanchard J** (2001) Considerations for the Development of Public Health Surveillance in First Nations Communities. Winnipeg: Centre for Aboriginal Health Research.

[62] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[63] **Ibid.**

[64] **Ibid.**

[65] **Ibid.**

[66] **Ibid.**

[67] **Ibid.**

[68] **Ibid.**

[69] **Ibid.**

[70] **Ibid.**

[71] **Joint AFN/ITC/FNIHB Consent Advisory Sub-Committee** (2001) Client Consent Stakeholder Presentations. Ottawa: FNIHB.

[72] **Ibid.**

[73] **Ibid.**

[74] **Ibid.**

[75] **Ibid.**

[76] **Nunavut Tunngavik Inc and Government of Nunavut** (2003) "Consultation Crucial on Non-Insured Health Benefits Consent Plan." Joint Press Release July 29.

[77] **Parliamentary Standing Committee on Health** (2003) First Nations and Inuit Dental Health. Ottawa. April 30.

[78] **First Nations and Inuit Health Branch** (2004) "Changes to Consent Initiative." Press Release. February 26.

[79] **First Nation and Inuit Health Branch** (2001) 2001-2002 Annual Report. Ottawa: FNIHB.

[80] **Auditor General of Canada** (1997) Chapter 13: Health Canada – First Nations Health. Ottawa: Auditor General of Canada.

[81] **Ibid.**

[82] **Author Unknown** (1997) "Poor Start on Unity Issue." Nunatsiaq News Editorial December 12; **Kivalliq Inuit Association** (1997) Annual Report. Rankin Inlet: KIA.

[83] **First Nation and Inuit Health Branch** (2001) 2001-2002 Annual Report. Ottawa: FNIHB.

[84] **Ibid.**

[85] **Ibid.**

[86] **Ibid.**

[87] **Health Canada** (2001) Non-Insured Health Benefits Handbook for Pilot Projects. Ottawa: Public Works and Government Services.

[88] **Ibid.**

[89] **Ibid.**

[90] **Ibid.**

[91] **Anishinaabe Mino-Ayaawin Incorporated** (2001) Administrative Dental Manual. Winnipeg: AMA.

[92] **Square D** (1999) "NIHB funds First Nation pharmacies." Pharmacy Connects. November Issue.

[93] **Ibid.**

[94] **Ibid.**

[95] **Ibid.**

[96] **Mendenhall M** (1999) "SphA, NIHB Partner for pilot." Pharmacy Connects. November Issue.

[97] **Manitoba Society of Pharmacists** (2003) "Non Insured Health Benefits (NIHB) Pilot Project." MSP Member Update 1(15): October 17.

[98] **Manitoba Society of Pharmacists** (2003) "Letter written to Southeast Non Insured Health Benefits." Winnipeg: Manitoba Society of Pharmacists.

[99] **McLaren S** (1998) "Closed for Business?" Canadian Pharmaceutical Journal. October 1998.

[100] **Square D** (1999) "NIHB funds First Nation pharmacies." Pharmacy Connects. November Issue.

[101] **Department of Indian and Northern Affairs** (2003) Procurement Strategy for Aboriginal Businesses Initiative. Ottawa: DIAND.

[102] **Ibid.**

[103] **Felix S** (1997) "Bidding For a Healthy Future." Benefits Canada. Maclean Hunter Publishing Limited.

[104] **Ibid.**

[105] **Square D** (1999) "NIHB funds First Nation pharmacies." Pharmacy Connects. November Issue.

[106] **Ibid.**

[107] **Ibid.**

[108] **Ibid.**

[109] **Ibid.**

[110] **Assembly of Manitoba Chiefs** (2002) 2002 Annual Health Report. Winnipeg: Assembly of Manitoba Chiefs.

[111] **Bell J** (2002) "QIA launches social policy department." Nunatsiaq News October 11

[112] **Legislative Assembly of Nunavut** (2002) "Oral Questions." Hansard of the Sixth Session of the Legislative Assembly. Iqaluit: May 09.

[113] **Nunavut Tunngavik Inc** (2004) "Transition to new NTI department complete." Press Release January 16; **Nunavut Tunngavik Inc** (2003) "NTI Makes Important Advances in Social and Cultural Development Department." Press Release November 05; **Nunavut Tunngavik Inc** (2003) "Nunavut Tunngavik Inc. to explore building a drug and alcohol treatment centre for Inuit." Press Release Novermber 04; **Nunavut Tunngavik Inc** (2003) "NTI Initiates Pilot Beneficiaries with Disabilities Program." Press Release July 21; **Bell J** (2002) "QIA launches social policy department." Nunatsiaq News October 11; **Piruqsaijiit Ltd.** (2002) Business Information NNI Policy Registry Approved Nunavut Businesses. Iqaluit: NTI; **Nunavut Business Initiatives Ltd.** (2000) Business Information NNI Policy Registry Approved Nunavut Businesses. Iqaluit: NTI; **Kivalliq Inuit Association** (1997) Annual Report. Rankin Inlet: KIA.

[114] **Petrie C** (2003) "Rankin Inlet firm joins forces with service-industry giant." Nunatsiaq News April 18; **Canadian Union of Postal Employees** (2003) Inventory of Major Privatisation Initiatives in the Canadian Health Care System after 2003 First Canadian Minister's Meeting on Health Care" Ottawa: CUPE.

[115] **First Nations and Inuit Health Branch** (2004) Ten Years of First Nations and Inuit Control. Ottawa: FNIHB.

[116] **Auditor General of Canada** (2003) Chapter 8 Indian and Northern Affairs Canada – Transferring Responsibility to the North. Ottawa: Government of Canada; **Auditor General of Canada** (2001) Chapter 12 Indian and Northern Affairs – Comprehensive Land Claims. Ottawa: Government of Canada; **Newhouse DR and Belanger YD** (2001) Aboriginal Self-Government in Canada: A Review of Literature Since 1960. Department of Native Studies, Trent University; **Auditor General of Canada** (1999) Chapter 10 Indian and Northern Affairs Follow-up. Ottawa: Government of Canada; **Auditor General of Canada** (1998) Chapter 14 Indian and Northern Affairs Canada – Comprehensive Land Claims. Ottawa: Government of Canada.

[117] **Chandler MJ, Lalonde CE, Sokol B** (2000) "Continuities of Selfhood in the Face of Radical Developmental and Cultural Change." In Nucci L, Saxe E, Turriel E (Eds.) Culture, Thought, and Development. New Jersey: Lawrence Erlbaum Associates; **Chandler MJ and Lalonde CE** (1998) "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations." Transcultural Psychiatry 35(2): 193-211. Here, six markers of cultural continuity (loosely interpreted as self-identity) were found to be associated with a reduction in the rate of youth suicide. The marker with the greatest protective value was 'self-government' (others include education services, police and fire services, health services, and cultural facilities).

[118] **Cornell S and Kalt JP** (2003) Sovereignty and Nation-Building: The Development Challenge in Indian Country Today. Boston: Harvard Project on American Indian Development; **Cornell and Kalt JP** (2003) Alaska Native Self-Government: What Works? Boston: Harvard Project on American Indian Development. Here, the greater the political development of a community, the greater their economic health.

[119] While grounded in juridical difference, Indigenous groups increasingly conflate the social details of 'treaty,' 'aboriginal,' and 'fiduciary' rights, so that what is considered one right, is inevitably constituted as equal to the others. For example, Inuit never signed historical treaties, thus they do not hold 'treaty rights' (although it can be said that the NLCA represents a modern treaty, thus they do hold treaty rights in this sense), yet Inuit see themselves as holding the similar if not equal rights as their First Nation counterparts as per their shared Indigenous status. A significant occurrence of this is found in the claim to a 'right to health,' so while the First Nations speak of a 'treaty right to health,' Inuit speak of a congruous 'aboriginal right to health.' Both Inuit and First Nations groups observe access to health services as a fiduciary responsibility held by the State (and thus their common fiduciary right).

[120] **Assembly of First Nations** (1994) Special Chiefs Assembly Resolution on First Nations Treaty Right to Health. Ottawa: AFN.

[121] As quoted in **Laforest M** (1994) The Treaty Right To Health Legal Opinion for National Health and Welfare. Ottawa: Counsel Native Law Section Department of Justice.

[122] **Ibid.**

[123] **Ibid.**

[124] **Ibid.**

[125] **Ibid.**

[126] **Boldt M** (1993) Surviving as Indians: The Challenge of Self Government. Toronto: University of Toronto Press.

[127] **Dickerson M** (1992) Who's North? Political Change, Political Development and Self-Government in the Northwest Territories. Vancouver: UBC Press and Arctic Institute of North America.

[128] **Boldt M** (1993) Surviving as Indians: The Challenge of Self Government. Toronto: University of Toronto Press.

[129] **Auditor General of Canada** (2003) Chapter 9 Economic Development of First Nations Communities. Ottawa: Government of Canada (bolding in original).

[130] **Cornell and Kalt JP** (2003) Alaska Native Self-Government: What Works? Boston: Harvard Project on American Indian Development.

[131] **Ibid.**

[132] **Cornell S and Kalt JP** (2003) Sovereignty and Nation-Building: The Development Challenge in Indian Country Today. Boston: Harvard Project on American Indian Development

[133] **Auditor General of Canada** (2003) Chapter 9 Economic Development of First Nations Communities. Ottawa: Government of Canada.

[134] **Cornell and Kalt JP** (2003) Alaska Native Self-Government: What Works? Boston: Harvard Project on American Indian Development.

[135] See for example the works in **Armstrong P, Armstrong H, Coburn D.** (2001) Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. New York: Oxford University Press

[136] **Newhouse DR and Belanger YD** (2001) Aboriginal Self-Government in Canada: A Review of Literature Since 1960. Department of Native Studies, Trent University; **Tester FJ** (n.d.) The Evolution of Health and Social Services for Nunavut: Class, ethnicity and public versus private provision. School of Social Work and Family Studies and the Institute for Resources and Environment, University of British Columbia; **Mitchell M.** (1996) From Talking Chiefs to a Native Corporate Elite. Montreal: McGill-Queen's University Press.

[137] **Cornell and Kalt JP** (2003) Alaska Native Self-Government: What Works? Boston: Harvard Project on American Indian Development.

Chapter 7. Dental Practice and Philosophy

I. Introduction

The previous chapters demonstrated how dentistry behaves in Nunavut: Chapter 4 representing its clinical realities; Chapter 5 its administrative processes and competitive behaviours within the market-based health service/NIHB contract environment; Chapter 6 being a more 'macro' contextualisation of the immediate milieu. It is now necessary to consider dentistry in itself: dentistry as an institution, not just in the north, but also in Canadian society (*i.e.* another more 'macro' space that delimits on-goings in Nunavut but occurs outside of it). For example, in theorising the social basis for dental practice, Davis recognised that:

> "Aside from [varied] economic interest[s] [...] there is the impact of dentistry itself. Within the broad confines of social structure and political tradition [in this case involving a capitalist welfare state and its intersection with Indigenous groups and their socially particular historical/political relationship], the delivery system and its detailed functioning reflect a treatment philosophy, occupational ideology and a pattern of work organisation that is almost entirely of the dental profession's own making."[1]

As per this understanding, this chapter will detail how (in and of itself) Canadian dental practice and philosophy delimits the development of dental care in Nunavut. It will outline the major dimensions of how dentistry (as a profession) behaves in its relations concerning service delivery to the socio-geographically marginalised.

In this regard, the dental NIHB now constitutes the most significant 'public' programmatic activity within Canada's general system of dental care. By 1999, the NIHB represented roughly one quarter of all public dental expenditures, in some regions reaching as high as two thirds (for some dental practices, 'NIHB insurance' corresponds to the vast majority or even the full compliment of billings).[2] The dental NIHB is now

the definitive social space where the larger professional/social debates concerning oral health inequality, and the adequacy of the current structure of care, largely reside.

II. Dental Care in Canada

That oral health inequality (in all populations, not just Indigenous ones) is tied to a structure of care is undeniable. Yet while recognised as inadequate to fulfil the needs of all populations, are there really any other policy and practice options in light of the modern realities of oral health and care? Can there be a limited universal public insuring of treatment for diseases that are (for the most part) wholly and easily personally preventable? Disease that for large portions of the population (most likely the individuals who can pay for treatment) does not represent a significant health problem, and that (through medicalisation and other cultural mediation) has become a very modern complex of aesthetic concerns along with medically necessary ones?

Accurately reflecting today's mitigating factors, these questions also hold the unneeded capacity of lessening the social impact (and response) of knowing that many people still do suffer from 'cavities and toothaches' (and all the basic traumas that result).[3] How dental care in Canada has come to organise in this modern dynamic of need and its epidemiological context, is funded by a practical and philosophical structure that reflects a complex and subtle response to this situation. The details of this are now reviewed, demonstrating how the subsequent financing and rationing of dental care (from the very outset) delimits the practice of dentistry in Nunavut.

a. The Structure of Practice and Philosophy

Apart from the general lack of analytic focus on this structure,[4] agreed upon is the basic characterisation of dental practice in Canada under its organisation into private practices (*i.e.* sole-proprietorships, partnerships, groups, corporate or franchised) and its general foundation within the private health services sector.[5] For example, in Manitoba (a province with a higher than average public insurance rate), roughly 85% of all clinicians are part of the private sector, with the remainder linked to the more 'public activities' of education and salaried positions.[6] This under-represents the amount of 'private' provision, in that some 'private' clinicians hold academic and/or governmental responsibilities, and some 'public' clinicians involve themselves in 'private' activities (*e.g.* as private practice owners or associates, locum activity, federal or provincial contracting on a fee for service basis, managing dental health service corporations). As such, another (perhaps more accurate) characterisation of dental practice is the public/private nature of this system (see Figures 2 and 20).

Such a characterisation is informed by this investigator's bias, viz. that when referring to dentistry's practice and philosophy, they are generally viewed from experiences and discussions concerning the treatment of socio-geographically marginalised populations. This characterisation of dental practice does not claim to subsume a totalised description of dental care Canada. Rather, it is a description of the larger dental profession's relations surrounding the treatment of such populations.

Important to these relations is that in the overwhelmingly private dynamic of Canadian dentistry, the public dental care sector, as primarily defined through its interest in the treatment of the socio-geographically marginalised, draws its social strength from

such interests (partly through the inherent moral dynamic). With the powerful role of governmental provision and support for this care, and with the use of dental education as a service provider and ideological supporter of such provision, some balance of power is altered here. So while representing only a small portion of the dental care system (organisationally and financially), the public profession holds significant authority within the dental culture in terms of the care to such populations, and relative to the profession's interactions with government. As cynically recognised by one stakeholder:

> "If you look at total dental expenditures on an annual basis in Canada, they're between six and seven billion. NIHB last year spent just under a hundred and twenty-million dollars, fee-for-service was a hundred million, that is about one to one-and-a-half percent of total dental expenditures in Canada in any one given year. My question to the CDA is why are they not worried about the other 98.5% of services. It is a very unusual interest that they have."[7]

More accurately, substantial interest lay in both the private and public profession, reflected in a healthy professional tension between polarised camps, between the public ideas that challenge private dominance. Yet due to the long-term mingling of varied public and private interests, what exists today is a public/private admixture of ideas that (like the historical State/Indigenous and NIHB dynamic) blurs and blends lines. This has the result of informing a culture where (what would otherwise be mutually exclusive) categories congeal to allow practices that subsume the power inherent in both contrasting ideologies. This is termed the 'dyad of dental culture.'

For example, as presented through Figures 2 and 24, this researcher observes the dental profession as structured along a dynamic where the community's interests (as represented in the actions and experiences of all stakeholders) are mitigated through market forces, with both public and private entities involved in a complex rationing of preventative and curative care (public programs being overwhelmingly resource small yet proving a substantial ideological challenge to the private market health service). Being a

professional culture that blurs and blends constructs, these figures are only static representations of a system that is actually quite fluid. In Figure 2, it is possible and valid to completely constitute one side of the dynamic with the other (by flipping every descriptor). In taking the public side to the private side (where fee for service would switch with per diem and salary, and where private insurance switched with NIHB, *et cetera*), one would observe an accurate representation of dentistry in Canada, since private practitioners often treat NIHB populations (fee for service) in private dental practices. It is also possible to see the same private practitioner under a salaried or per diem arrangement (although much less common) delivering services within a northern Aboriginal community clinic or within an urban publicly oriented community clinic. On the reverse, there also exist situations where academic institutions and/or a non-governmental service provider bill fee-for-service from public and private 3rd party plans.

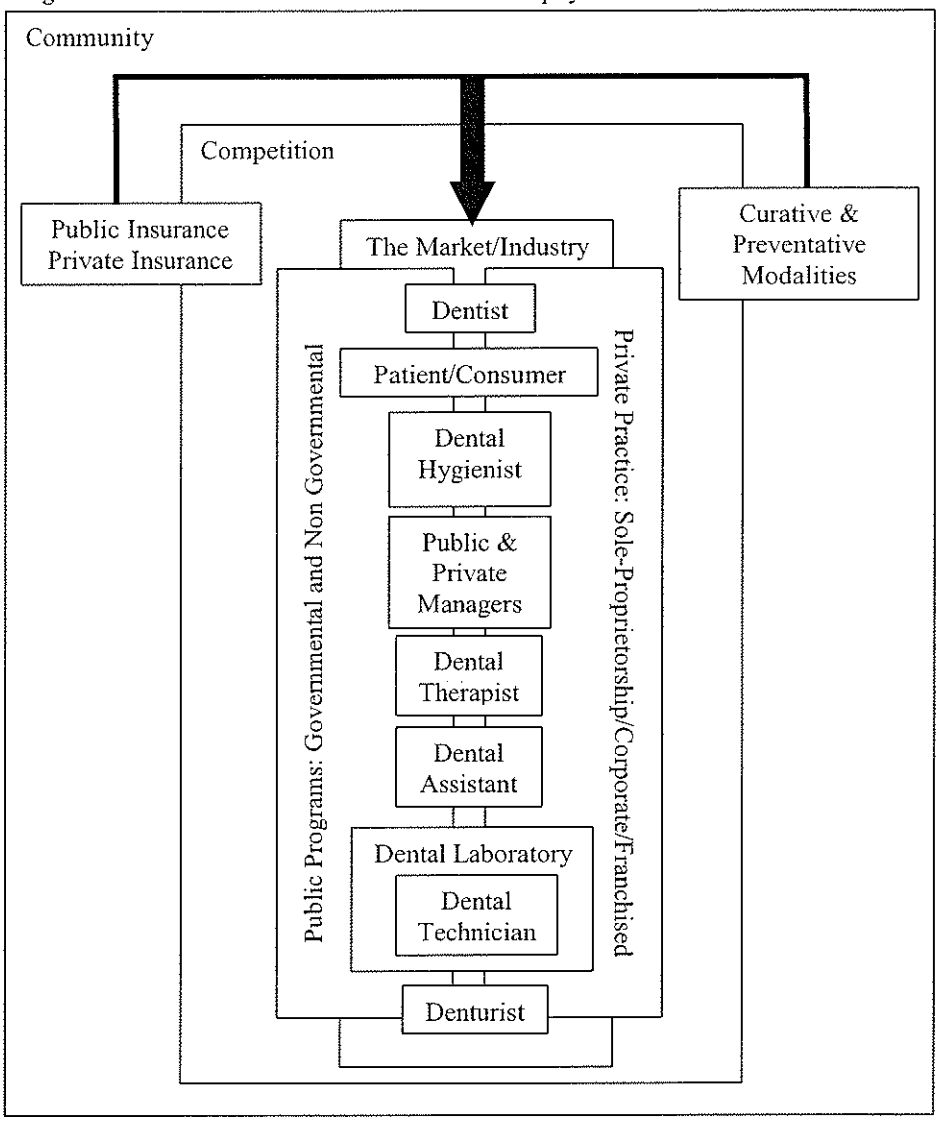
In no other profession can one observe the long-term mutual rise of privatised and medically modelled forms of care in parallel with such behaviouristic, population, and preventatively based approaches to that same care. For example, "influenced by the dentists' own emphasis on prevention and control,"[8] dentistry was conceivably more inclined to develop a 'socialised' system that emphasised public forms of treatment and prevention (this so as to maintain its market based predominantly sole-proprietor form of practice). This argumentum was perhaps best summarised at the 1943 annual meeting of the CDA:

> "Let it be stated emphatically that organised dentistry is *not* supporting legislation to merely set up large scale systems of treatment *but is proposing a definite plan of approach toward the controlling of dental disease in Canada.* The former is retrograde for dentistry, the latter is not" (italics original).[9]

There were actually three times--the first in 1906, the second in 1938, and here in 1943--where organised dentistry organisationally rejected clinical services at a population level,

instead advising governments to concentrate efforts on prevention and clinical control of disease at younger age groups or for those who "could not pay for themselves."[10] This policy agenda continues to this day.

Figure 20. The Structure of Practice and Philosophy



So what is now the example found in the professional promotion of industry-marketed treatment seeking behaviours (and insurance schedules and payments), whereby the individual is to seek (and is insured for) periodic, regular, maintenance care, itself preventatively based (*i.e.* 'see your dentists every six months'), is conceivably a historical outcome of an early structural admixture of contrasting yet complimenting ideas. Of

particular relevance to this study is how this structure supports (and is well represented by) the actions of dental educational public institutions, whereby non-profit institutional corporations are increasingly observed as a mode by which to generate revenue to support the preventative, educational, research, professional, and moral obligations of the institution (to be detailed later). This dyadic understanding of the dental culture also further contextualises how dental public health knowledge and its interventions easily became a market deliverable in the competition for northern dental contracts. Surely, the professional policy recommendations of health education and preventative measures as a better plan of action when addressing the needs of an entire population, and only treating children or the socially marginalised through public means – with both of these employed as a strategy by which to maintain professional dominance -- is the definitive example of this subtlety and complexity. Perhaps Canada's system of dental care is more accurately described as a structure where 'public and private' are not "polar opposites, but mediated reciprocally in one another."[11]

Underlying this admixture of normative standards is a utilitarian liberalist ideology. Utilitarian liberalism (attempting to achieve the greatest good and requiring a guaranteed social minimum) represents a movement out of *laissez faire* capitalism and into modes of social policy that, while requiring the fundamental involvement of economic markets, also believe that the greatest good is achieved with State intervention, thereby guaranteeing a social minimum. For dentistry, which is considered a less medically necessary service as per Canadian health values, this is reflected in State support for private market-based access (*e.g.* non-taxation of employee/employer dental benefits), and when necessary to 'guarantee a social minimum,' through the ensuring

public mechanisms of access. This 'public mechanism' involving the market, but also resulting in the production of publicly based care.

This ideological base is contiguous with societal and professional beliefs concerning individual and social responsibilities over health. Here, since oral health is 'less medically necessary,' the available options for seeking care largely sit in the health marketplace, with relatively little governmental intrusion (as long as one has the means socially and geographically). Seeking care is observed as the responsibility of the individual--as long as that individual is cognitively capable of making such decisions--whereby 'choosing one's practitioner' is sacrosanct to the profession.[12] Of great significance is the observation that the mitigation of oral health and disease lay primarily with the individual. Surely, this is what society has concluded when not providing for such care in its universal system, viz. 'there is only so much society can do for you when you fail to brush your teeth,' but always with the presence of some social mitigation to meet a perceived social minimum. So in philosophy as it is in practice, 'public and private' are not mutually exclusive but mitigated through one another (*i.e.* the dyad of dental culture).

b. Financing and Rationing Dental Care

Out of this philosophical and practical character comes the financing and rationing of dental care in Canada. In the first half of the 20th century, financing and rationing care was predominantly mitigated by an individual seeking treatment from a dentist of their choice, paying a fee for the services directly 'out of pocket,' inc which one could access service if one had the means. In the middle years of the century, with the movement

towards welfarism and publicly insured health services, governments increased their interest in easing the burden of direct payment for care, coming to insure dental services delivered in hospitals, and further identifying mechanisms for the financing and rationing of public care not necessitating hospitalisation. With long-term reasonable policy advice from the organised profession, this generally resulted in the support for municipal water fluoridation, educationally based preventative measures, and the public insuring of clinical care for the socio-geographically marginalised.

The public insuring of specific services for specific populations either meant receiving care in public or private settings, with both private and publicly based clinicians paid by salary, on a sessional basis, or fee for service. Over time, as governments grouped relative to two modes of payment -- publicly funded third party payment versus publicly based salaried providers, with both of these easing the direct burden of payment for targeted populations -- professional and social movements pushed for the publicly funded fee for service third party form of payment. This was a result of several considerations.

Firstly, care in public and salaried environments often represented a challenge to professional dominance, with any portion of the public market almost always guided towards care in private settings through private professional policy advice. Secondly, with an increasing lack of commitment by some governments (especially in the context of fiscal and professional pressures), some programs became co-managed by professional authorities, with some jurisdictions even observing the parallel management of publicly funded, but professionally managed and organised programs (all inevitably ignoring any form of remuneration other than fee for service).[13] Thirdly, the establishment and great

expansion of privately funded fee for service third party payment did much to create an environment where this form of financing and rationing came to dominate as the perceived (and sought after) norm.

In 1966, the first Canadian non-government sponsored dental plan was organised in British Columbia by the 'Sheetmetal Workers' International Association' and the 'Credit Unions and Cooperatives Health Service Society:'

> "Under the terms of the contract, all eligible workers and their dependants were able to obtain basic dental services from the dentist of their choice and to have the bulk of the fee paid by [the Credit Unions and Cooperatives Health Service Society]. The program was financed by monthly premiums. [...] It was not novel, in that the premium financing method had already been widely employed [...] through commercial insurance companies [and] medical profession-sponsored or approved plans [for other health services]."[14]

Costing premiums became an issue of examining the programs performance, and more often than not, the risk associated with the dental program proved minimal. As underwriters economically gained, the program came to influence many others in Canada, with the 1970s and early 1980s observing a significant rise in this form of dental care. Private sector spending increased by roughly 10 times, public sector by a factor of 129 times.[15] While the growth is dramatic in public expenditures, they still paled in comparison to private ones: $1.2M versus $108M in 1960 and $176M versus $1.1B in 1980 respectively.[16]

Contributing to the general expansion of the dental care market, this trend eventually stabilised, ultimately reversing for public care under the fiscal pressures of governmental health rationing, and as per beliefs concerning the epidemiology of dental disease and dentistry as a private health market. Public dental expenditures (out of total dental expenditures) have dropped from roughly 20% in 1982, to 9% in 1990, down to 5.8% by 1999.[17]

In the context of disappearing funds (most often for public clinical programs), and with the general shaping of public programs by the dominance of the private profession, whatever programmatic activity remained came to further parallel private administrative and management mechanisms. These private mechanisms of administration and provider remuneration are numerous, with some reviewed in previous chapters (*e.g.* the predetermination of benefits, the review of claims over a specified amount by practitioners, provider profiling or the review of treatment and billing patterns, the examination of patient).

With these mechanisms for 'doing business,' in time, some groups sought to finance and ration plans themselves (*i.e.* an employer or union that could bear the financial risk, allowing one to control large sums of money that, for even short periods, can earn considerable returns). Yet as underwriters, they were still presented with the need for significant business administration and management expertise, coming to develop relationships with past carriers (*i.e.* insurance companies), requesting their 'Administrative Services Only.' In turn, 'ASOs,' or businesses known as 'Third-Party Administrators' developed to fill a new market niche. First Canadian Health can be said to act as a third party administrator (*i.e.* 'the claims processor') for the NIHB program.

This complex set of processes, whereby the tendency has been for public dental care to structure relative to developments in the private dental care market, provides a good example of the power of professional practice and philosophy. Moreover, it represents the subtlety involved in society's views on health (or the mitigation of it), and its impact on the financing and rationing of dental care. As is now demonstrated, this

milieu (in and of itself) has definitively problematised the NIHB environment, which has been one of 'dental insurance' for the socio-geographically marginalised.

c. Nunavut and NIHB Considerations

That the structure of dental care in Canada often proves in disjuncture to the needs of a population such as Nunavut's is well recognised by many stakeholders:

> ***"I think that the biggest problem is [...] having a private practice mentality is not going to impact the oral health of the population. Expecting the client to seek treatment, to know best when to seek treatment, in a high caries population, is not the best way."***[18]

> ***"Any program that's treating Aboriginal people tends to be treatment focussed because that's how dentists are remunerated [...] It doesn't work. I think one of the most important things is that people in Nunavut need to take ownership, they have to take some responsibility for their, for their oral health care as people shou... [sudden pause] you know, everywhere are expected to."***[19]

Sometimes implicitly observed (as in the second commentary), to continue to enact a 'private practice' for two to three week periods, holding prime responsibility on the individual, and still expect anything other than the alleviation of pain and the meeting of very basic needs, is naïve.

Furthermore, when the dental NIHB is observed as a form of 'third party insurance,' and developed (through political, social, professional, and economic pressures) to approximate private mechanisms of insuring for care, the system inherently resists change trying to concurrently act as a 'public' program. For example, how does a public program finance care when the cost utility and success of many treatments remain in question, but are structured as the norm (and expected by providers) within the system one is trying to approximate (*e.g.* examining a patient every six months, chair-side oral health instruction as a billable service)? This, in the face of financing that, unlike a regular insurance mechanism, has no recourse to premiums or co-payments (not having

the luxury to finance care that does not prove cost-effective and -useful), and one that is not really meant to develop in capital (yet is increasingly pushing in that direction as per stakeholder activity).

Any forward developments in the NIHB program as a 'public' mechanism of care (*e.g.* allied provider service provision, routing funds to prevention, salaried providers) are now quickly stifled due to the NIHB accommodation of the perceived professional necessity for a private insurance scheme. All stakeholders readily ignore the complexity of the NIHB public/private dynamic (as observed in Chapter 6), not addressing the complicated movements in programmatic efforts, and inevitably construing what are normally conceived of as reasonable public demands (*i.e.* cost-utility, cost-effectiveness), as unreasonable ones, resulting in further negativity and contention.

Then there is the reality of business: as reviewed in Chapter 6, through the creation of service delivery structures that attempt to structure care in alternative ways (*e.g.* preferred provider organisations, managed care), current NIHB transfers have come to present a challenge to professional dominance. If there is to be any movement within Nunavut in this regard (through ethnonational adoption of an NIHB transfer), it will surely have to face the difficulties of changing the status quo. Interestingly though, some forms of adopting control need not breed such contention.

As stated, First Canadian Health currently acts as an ASO for FNIHB/NIHB in that in only processes claims and does not bear the risk of financing the program. Partially observed as a governmental component of Indigenous self-rule, commentary has given the appearance that assuming control of funds (not just third party management duties) is one possibility for this company (and any other group that chooses to 'carve

out' their benefits). So the question begs asking, will groups (through the transfer of funds) come to hold the risk for providing services so as to control these potential investment funds? Further, in attempting to advance and expand an economy, will ethnonationals come to seek premiums or co-payments (to support what is otherwise shaping into an unsupportable program)? With ethnonational and professional efforts at seeing the NIHB program develop as per their wants (*i.e.* improved coverage, increased awareness and utilisation amongst patient/clients), the private profession would surely accommodate the further development of the NIHB program as a 3rd party insurer (as long as it limits its challenges to professional dominance and continues the growth of the program).

The broader basis of Canada's dental culture clearly delimits any future developments for dental care in Nunavut. With significant clinical and administrative complications, many are left trying to recreate the expectations and functions of a private practice (and its associated economic modes of production) within a system that, in critical part, is not meant to behave in this capacity. To this end:

> "Private practice [...] is well-suited for the healthy, employed, dental conscious, middle-class patient who rarely has a problem with accessibility to private care, who can generally afford necessary treatment and who practices good oral hygiene. [...] But not every dental patient, or prospective patient [...] fits the category just described. [...] Private practice is never likely to fit the needs of these groups."[20]

III. Public Health Dentistry, Academic Dentistry, Care to Socio-Geographically Marginalised Populations, and the Politics of Profession

With a strained awareness of the inherent and subtle complications of this form of care, the system nonetheless resists change. Yet as private dominance is powerful in its ability to sway the dental NIHB towards practices that fall within its established norms, it is not

the only dynamic that limits developments. In considering dentistry in itself (and in reflecting this researcher's bias), there comes a need to critique community/public health dentistry and its specific milieu.

'The public health dentists' sat there, listening to the long list of criticisms being read out by 'the private practice dentist's' representation, a sampling of which included the laborious NIHB administrative processes, the poor remuneration, the highly contentious review procedures, the informed consent initiative, the confusion concerning the direction of NIHB pilots, the lack of preventative care for patients/clients, amongst others. In their defence, the 'public stakeholders' saw administrative contentions as a necessary part of dealing with what was otherwise a public system of care, regardless if it was mistakenly perceived by private stakeholders as simply '3rd party insurance.' What dug deep were criticisms regarding their preventive efforts (or lack thereof). This was a particularly 'sore bone to pick' as public stakeholders once provided significant efforts, and perceived the historical private professional derogation of these efforts (as represented by a faltering dental therapy program) as the main reason why prevention had become so problematised (and the program as well for that matter). They were further critical of the private practice belief that prevention qua 'telling someone to brush their teeth' actually works, let alone representing a billable service. Yet as colleagues attempting to improve current social complications and a history of significant inequity, they would congenially and convivially recognise their difficulties, never really getting to the 'meat of the issue.'

Present as well were representation from 'the dental hygienists,' 'the dental therapists,' 'the First Nations and Inuit,' 'the territorial, provincial, and federal governments,' 'the contractors,' and a mix of other 'non-governmental' stakeholders that were involved in service provision to the socio-geographically marginalised. Stakeholders loosely represented two broad interests. Some were advocates of private care, fighting battles for those who chose to constitute their practices within such populations and within the limitations of public modes of financing. Some were advocates of public care, specifically through their role as administrators, as academics, and as public providers (some at times private providers as well).

In representing contrasting ideals, some wore different hats simultaneously. This produced subtler forms of advocacy. So there were those that supported public care, yet sought similar economic gains as private providers due to their institutional and individual activities. Some used the context of such care provision to advance their group's interests in the general professional culture.

In its complexity, contradictions were expressed as normal behaviour, even expected. As such, there were the private stakeholders, discussing inequity, yet attempting to maintain a system that is structured inequitably, often taking the lead role in constraining efforts meant to ease this inequity (other than those not observed as a derogation of private professional dominance). There were the public stakeholders, 'in partnership' with ethnonationals, also discussing inequity, yet acting 'against them' in their role as bureaucrats and constrainers of Indigenous governmental and economic advancements (as per ethnonational interests in developing the Aboriginal Health System and Economy). Private stakeholders were also 'in partnership' with ethnonationals, equally discussing inequity, jointly attempting to quash bureaucratic initiatives and seeking an expansion of the current financial envelope, yet concurrently in competition with ethnonationals relative to their advancements in this economy. Then there were the public stakeholders, always discussing inequity, yet attempting to maintain or expand a system that, while not functioning under their direction and leadership, was beneficial to them as per their particular economic and professional interests. In essence, all were involved in attempting to control an economy, or those resources that surround the care delivered to the socio-geographically marginalised.

a. The Rise of Public Health Dentistry and Academic Dentistry

Early on, the community oriented actions of individual dentists and charitable organisations constituted the very loose organisational structure surrounding this ideological pillar of dentistry. In the late 19th century, J.G Adams, the father of this discipline in Canada,' in a very early example of future professional rubric, felt that the "proper emphasis [...] was to preclude the need for artificial dentures by preventing diseases of the teeth among children." He also founded a 'free dental hospital for poor children' where he produced educative literature, representing a place where one could access care if one 'could not pay for themselves.'[21] In time, this 'publicly oriented' institution of care established itself as a recognised specialty and formal part of the Canadian dental culture:

> "Dental Public Health (Community or Social Dentistry) is an expanding organised health activity. It has official status in all major health agencies and ever increasing scope on the curricula of dental schools and schools of public health. It has an active role in the organisation and work of dental associations and in government departments of health in Canada since about 1950."[22]

With the social reconsiderations of the 1960s, several professionally and governmentally supported projects then became funded in order to further develop the 'social side' of dentistry.[23] Coupled with then generous increases in funding for dental education, the creation of community dentistry departments became a part of a general ideological and infrastructural expansion.[24]

"[E]ncouraging the development of departments of community dentistry, particularly on the part of the public, appears to have been the rising egalitarian view of health care as a right."[25] Yet as part of the professional body politic, these departments were not always viewed as a positive development:

> "I feel that this survey is slanted so as to favor a Universal Denticare program. This I oppose and have hence refused to answer certain questions. The whole questionnaire seems to me to be a politician's way of obtaining statistics which he can then twist to support his desire for Denticare."[26]

> "How about including in the Dental curriculum the latest scientific and technological advances in addition to all this sociological garbage."[27]

Other significant milestones include the establishment of the Canadian Association of Public Health Dentistry in 1966, and the creation of the NSDT in 1971, and the establishment of the 'dental nursing' program in Saskatchewan in 1972. All were established with the support of dental education and the now unified cadre of professional community/dental public health expertise. Thus continued the particular and significant relationship between community/public health dentists, the academic sector, and federal/provincial/territorial authorities, eventually becoming dominated by contractual obligations for the care delivered to the socio-geographically marginalised.

Since 'public health' is a discipline unto itself, other dental stakeholders (particularly the dental hygienist, but including the dental therapist, the dental assistant, and the dental manager) developed interests in the administrative, academic and professional statuses associated with this discipline. Although only a dentist can be a 'public health dentist,' these individuals have also become an indistinguishable part of public health dentistry, holding positions of authority and power.

To support this discipline's interests, public stakeholders began to establish an ideological base for their endeavours. The notion of 'Primary Dental Care'[28] and/or POHC was advanced in this regard.[29] Paralleling the rubric of PHC:

> "[POHC] is the diagnosis and prevention of oral diseases using as much as possible of available local technology based on full co-operation and participation of the community, and the provision of emergency oral health services, within the community, aimed at relief of pain and maintenance of good oral health."[30]

As a model of public care:

> "It is regarded as first contact line in oral health care delivery. Principally, it is divisible into two broad bases namely: (A) Preventive Oral Health Care Services and (B) Emergency Oral Health Care Services."[31]

This represents the modus of operation for many non-governmentally, governmentally and/or academically based clinics, where public health interventions are stressed more so than they are practiced, and where individuals with no recourse to pay for treatment are provided emergency care at little or not cost. Yet in time, non-governmental and academically based care also began to collect on the public and private insurance available to individuals who sought care in their clinics (*i.e.* social assistance payments, NIHB).

This detail links POHC and its educational/governmental base to the internal and external social dynamics of the profession: the market reorientation of the late 1970s and 1980s realised the incorporation of practice management and aesthetic dentistry into the dental curricula, with a balance sought through similar efforts in ethics, the behavioural and population health sciences (*i.e.* POHC), and in the increased involvement of students in community dentistry endeavours (as per their perceived humanising influences and the possible recruitment of new graduates for the specialty practice).[32] While involving students in 'outreach activity' through 'community externships' had been a part of community dentistry curricula since their inception, over time, this involvement became an important rationalisation for academic interests in the opportunities of publicly financed dental care (especially when facing tremendous government cut backs).[33]

The logic is thus: by definition, dental education is a form of service provision; dental students simply need patients. Treatment has traditionally occurred in large centralised 'main clinics,' offering care at reduced rates, allowing access to academic specialists (that would otherwise be completely cost-prohibitive). These clinics consistently operate on a loss, and represent the greatest costs to the institution. So by the

mid 1990s, with major cutbacks to their funding, changes in dental education came to partly focus on alleviating the burden of inherently costly activities (particularly educating in main clinics). An obvious choice was to minimise the amount of clinical education that occurred within the walls of the institution, and community dental departments and their 'outreach activity' provided significant opportunities. Some universities established longer terms for their community externships, a few even leaving the 'main clinic model' altogether, completely constituting their educational activity in hospitals, community clinics, and through private practitioners offering opportunity in their private practices. Intersecting with this was the observation (made many years earlier) that, at times, 'outreach programs' (often staffed by salaried community/public health dentists and interns) were able to provide a modest profit for the faculty running them. So while initially conceived as a way to provide students with experiences in these clinical environments and to increase interest in public health dentistry as a career choice, then conceived as a way to alleviate fiscal stress, these programs are now part of a general movement in dental education to actively search out revenue.

There in turn appeared a general rise in discourse surrounding 'outreach units' and their role in 'meeting the needs of under-serviced populations.'[34] Within the professional body politic, discussions around this new 'role for dental education' have produced contention.[35] The general profession can have misgivings about 'dental education as service provision,' especially when public health dentistry acts as the historical antagonist to the private profession. Many ask: Is it the role of an academic institution to compete for service contracts? Is it appropriate for these institutions to be involved this directly in the treatment of populations when they are so intimately

involved in governing and policing such treatment? Should dental schools be able set up clinics in direct competition with local (traditionally modelled) clinics? It is too early to tell whether there will be a general professional acceptance of this newer 'outreach/community clinic.'[36]

b. Care to The Socio-Geographically Marginalised and The Politics of Profession

Important to this discussion is the awareness that competition in this economy is subtle, constituting in the intersection of (and control over) many separate spaces (*e.g.* private dental practice, public dental practice, urban practice, rural practice, institutional and non institutional for-profit corporations, not-for-profit institutions, professional ideologies, control over the organisation of work and modes of production). This case study represents a unique example of the many stakeholders coming together to outline their positions within this political economy. Here represented are the two broad categories of the dental dyadic structure, each advancing opinions on 'how to make the system work,' concurrently (and additionally) representing all of the particular subsections and/or combinations produced in this milieu. All groups pursued (in a complex dynamic) their specific interests (in turn impacting the delivery of care to populations such as Nunavut).

Initial complexities associated with the problems of administration[37] and with trying to meet overwhelming need, quickly dissolved into the political and economic concerns of the many particular subsections. So often choosing to focus contentions in the historical debate of private professional dominance and its derogation of public care, public stakeholders did not readily discuss their discrete influences on care. For example, since the administration and management of the NSDT was undertaken by the

Saskatchewan Indian Federated College (as a PSAB tender), the profession of dental therapy has suffered. A review of the roughly $9M dollar contract in 1999 concluded:

> "[I]t was evident that the first two years an a half years of [Saskatchewan Indian Federated College] operation of the NSDT was completely un-acceptable. It resulted in staff and student discontent and confusion, alienated many dental therapists in the field and was generally harmful to the credibility of the NSDT and dental therapy."[38]

Further complicating the NSDT issue is the recent interest of dentists to hire dental therapists (as they do other dental auxiliary to maximise practice output). Resulting in recruitment difficulties for traditional employers (federal, provincial, and territorial governments), some private stakeholders may now want the practice maintained, as governmental perception that the current dynamic may not be meeting their goals builds. As some stakeholders have suggested, this ideologically weakens the program, making it more susceptible to fervent centralised cost-cutting efforts.

Public stakeholders are also attempting to shape the structure of care relative to their institutional and personal wants. As established decision-makers, contractors, and service providers, some stakeholders consistently steer care (in regions such as Nunavut) to maintain their interests (*i.e.* giving policy advice that stresses the services and expertise that they can offer).[39] Aside from the Deans of dental schools and the Heads of community dentistry departments, public stakeholders (within and outside of dental education) have long advanced the idea of independent corporate and professional activities. The efforts of dental hygiene and dental therapy as organised groups represent the most current example.

With dental therapy now diminished in organisational capacity, dental hygiene has stepped forward to represent this stakeholder's goals and interests (in line with their own). Advancing their position through the power afforded by employment in the public

governmental and non-governmental sector, these stakeholders have been able to access institutional opportunities to advance their agenda of independent practice and economic control over their modes of production.[40] Dental hygiene has buttressed its actions with a very active lobby (that holds sophisticated capacities), effectively representing its agenda through their role in advocating for the 'public' interests of increased access to care, and the need to service populations that are otherwise ignored by the 'private' profession (this of course through independent dental hygiene and therapy practice that would be more cost-reasonable when compared to dentist fees).[41] Their inclinations are to shape the current system of care to their ends, to see themselves as independent practitioners of POHC, and therefore 'the first contact' for someone's dental problems. The inherent play at some market control is evident here, firmly supporting the notion that public stakeholders themselves limit the potential developments of regions such as Nunavut.

Due to this complexity, there results a subtle and intricate social dance between stakeholders, whereby the private side advances certain notions, and the public side others (all sometimes in concert or against each other's interests). So as the private profession advances the notion of expanded awareness and expanded coverage in private settings (as do ethnonationals), the public profession advances equity and alternative forms of service delivery (as do ethnonationals). While the profession resists any developments that challenge its dominance (such as ethnonationals and auxiliary professional groups involved in challenging it), ethnonationals resist any derogation of their control over the current public system (such as private and public professionals involved in challenging this). To be sure, in their dependence on the fiscal and professional advantages associated with delivering care to such populations, public

stakeholders (in concert with their own and others' private interests) may now possibly limit much needed improvements.

IV. Conclusions

With the impacts of dental practice and philosophy (in and through the private and public spheres), one can observe social actors engaging in a manner that is expected of them. Society has made certain things 'normal' for dentistry, viz. it is acceptable to observe the development of care for socio-geographically marginalised populations within the context of market dynamics (relative to ideas of responsibility over the mitigation of oral health, how one accesses services, and how those services come to be structured so as to meet the needs of such groups). Stakeholders are now competing for resources that are ever diminishing, in an environment already complicated by the problems of isolation and sickness, of cultural self-determination, and of the many confines of Indigenous rights, non-insured health services, and professional control over a means of production. As a result, services are simply unable to develop in a reasonable and controlled manner.

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[1] **Davis P** (1980) The Social Context of Dentistry. London: Croom Helm Ltd.

[2] **Baldota KK and Leake JL** (2004) "A Macroeconomic Review of Dentistry in Canada in the 1990s." Journal of the Canadian Dental Association (forthcoming); **Peter Cooney** (2002) Personal Interview. Montreal, Quebec. May 26.

[3] This is further complicated by the current status of modern welfare state health economics, where health care expenditures continue their dramatic increases, making the addition of oral health needs a hard priority, especially in the face of other developing health needs like pharmacare and homecare.

[4] Good examples include: **Adams TL** (2003) "Professionalisation, Gender and Female-Dominated Professions: Dental Hygiene in Ontario." Canadian Review of Sociology and Anthropology 40(3): 265-89; **Lynch M and Calnan M** (2002) "The changing public/private mix in dentistry in the UK – a supply-side perspective." Health Economics 12: 309-21; **Manga P** (2002) The Political Economy of Dental Hygiene in Canada. Ottawa: Canadian Dental Hygienists Association; **Grytten J and Sorensen R** (2000) "Competition and Dental Services." Health Economics 9: 447-61; **Adams TL** (1998) "Gender and women's employment in the male-dominated profession of dentistry: 1867-1917." The Canadian Review of Sociology and Anthropology 35(1): 1-13; **PJ and Hu T** (1996) "A multi-equation model of payments and

public access to services: the case of dentistry." Applied Economics 28: 1359-68; **Kress GC** (1995) "Dental Education in Transition." In Cohen LK and Gift HC (Eds.) Disease Prevention and Oral Health Promotion. Munksgaard: Copehagen; **Nash D A** (1994) "A tension between two cultures ... dentistry as a profession and dentistry as proprietary." Journal of Dental Education 58(4): 301-6; **Burt BA and Eklund SA** (1992) Dentistry, Dental Practice, and the Community 4th Ed. Philadelphia: WB Saunders Company; **Lewis DW** (1992) "The Provision of Dental Care in Canada." In Burt BA and Eklund SA Dentistry, Dental Practice, and the Community 4th Ed. Philadelphia: WB Saunders Company; **Boyd MA** (1993) "Curriculum Focus: Traditional Dental Education Confronts The New Biology and Social Responsibility." Journal of Dental Education 57(5): 340-2; **Nettleton S** (1989) "Power and Pain: The Location of Pain and Fear in Dentistry and the Creation of the Dental Subject." Social Science and Medicine 29: 1183-90; **Nettleton S** (1988) "Protecting a Vulnerable Margin: Towards and Analysis of How the Mouth Came to Be Separated from the Body." Sociology of Health and Illness 10(2): 156-69; **Fraundorf KC** (1984) "Organised Dentistry and the Pursuit of Entry Control." Journal of Health Politics, Policy and Law 8(4): 759-81; **Gluck GM, Aroskar MA, Nezu A** (1983) "Cost Containment in Dentistry and its Impact on the Distribution of Services." Theoretical Medicine 4: 207-14; **Rovin S and Nash J** (1982) "Traditional and Emerging Forms of Dental Practice: Cost, Accessibility, and Quality Factors." American Journal of Public Health 72(7): 656-62; **Scheffler RM, Foreman SE, Feldstein Lipscomb J and Douglass CW** (1982) "A Political Economic Theory of the Dental Care Market." American Journal of Public Health 72(7): 665-75; **Davis P** (1980) The Social Context of Dentistry. London: Croom Helm Ltd; **O'Shea RM** (1971) "Dentistry as an Organization and Institution." Milbank Memorial Fund Quarterly / Health and Society 49(3): 13-28; **Cole RB and Cohen LK** (1971) "Dental Manpower: Estimating Resources and Requirements." The Milbank Memorial Fund Quarterly XLIX(3): 29-62.

[5] **Ibid.**

[6] **Manitoba Dental Association** (2004) Dental Economics Quarterly. Spring. Winnipeg: MDA.

[7] **Anonymous** (2002) Personal Interview. Montreal, Quebec. May 26.

[8] **Gullet DW.** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press.

[9] **Ibid.**

[10] **Ibid.**

[11] **Adorno T** (1998) Aesthetic Theory. Minneapolis: University of Minnesota Press.

[12] **Davis P** (1980) The Social Context of Dentistry. London: Croom Helm Ltd.

[13] **Stamm JW, Waller M, Lewis DW, and Stoddart GL** (1986) Dental Programs in Canada: Historical Development, Current Status and Future Directions. Ottawa: Health and Welfare Canada.

[14] **Ibid.**

[15] **Ibid.**

[16] **Leake JL** (1984) "Expenditures on dental services in Canada, Canadian Provinces and Territories, 1960-80." Journal of the Canadian Dental Association 50(5): 362-8.

[17] **Baldota KK and Leake JL** (Forthcoming) "A Macroeconomic Review of Dentistry in Canada in the 1990s." Journal of the Canadian Dental Association; **Leake JL** (1993) "A Macroeconomic Review of Dentistry in the 1980s." Journal of the Canadian Dental Association 59(3): 281-87; **Leake JL** (1984) "Expenditures on dental services in Canada, Canadian Provinces and Territories, 1960-80." Journal of the Canadian Dental Association 50(5): 362-8.

[18] **Past Provider, Past Private Administrator, Present Public Administrator** (2001) Personal Interview. Toronto, Ontario. December 12.

[19] **Present Provider, Present Private Administrator** (2002) Telephone Interview. Winnipeg, Manitoba. July 28.

[20] **Burt BA and Eklund SA** (1992) Dentistry, Dental Practice, and the Community 4th Ed. Philadelphia: WB Saunders Company.

[21] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press.

[22] **Faculty of Dentistry University of British Columbia** (1969) A Survey of Opinions on Public Dental Programs (Nature, Relationships and Outlook). Federal Health Grant Project 609-7-189. Ottawa: Government of Canada.

[23] **Faculty of Dentistry University of British Columbia** (1969) A Survey of Opinions on Public Dental Programs (Nature, Relationships and Outlook). Federal Health Grant Project 609-7-189. Ottawa: Government of Canada; **Faculty of Dentistry University of British Columbia** (1967) A Survey of Dental Public Health Within the Dental Profession and Within Public Health Agencies Including Those of Government. Federal Health Grant Project 609-7-148. Ottawa: Government of Canada; **Faculty of Dentistry University of British Columbia** (1966) What is the Nature of Dental Public Health – Its Objective? Federal Health Grant Project 609-7-99. Ottawa: Government of Canada.

[24] **Gullet DW** (1971) A History of Dentistry in Canada. Toronto: University of Toronto Press.

[25] **Faculty of Dentistry University of British Columbia** (1969) A Survey of Opinions on Public Dental Programs (Nature, Relationships and Outlook). Federal Health Grant Project 609-7-189. Ottawa: Government of Canada.

[26] **Ibid.**

[27] **Ibid.**

[28] **Loupe MJ** (1978) "Defining primary dental care." Journal of Public Health Dentistry 38(3): 207-11; **Martin JL** (1977) "Primary dental care: a conceptual model." Virginia Dental Journal 54(1): 7-10; **Martin JL** (1976) "Primary dental care: an educational methodology for dental hygiene students." Educational Directions for Dental Auxiliaries 1(3): 25-7.

[29] **Jeboda SO** (1991) "Developing a model for primary oral health care practice." Odontostomatol Trop 13(4): 121-2; **Jeboda SO and Eriksen HM** (1988) "Primary oral health care. The concept and suggestions for practical approach." Odontostomatol Trop 11(4): 121-6.

[30] **Ibid.**

[31] **Ibid.**

[32] **Ireland RS and Dawber S** (1999) "Introducing undergraduate dental students to the wider role of the primary care team." Journal of Dental Education 3: 145-7; **Romer M, Dougherty N, and Amores-Lafleur E** (1999) "Predoctoral education in special care dentistry: Paving the way to better access?" Journal of Dentistry for Children March-April: 132-5.

[33] **Bailit H, Beazoglou T, Formicola AJ** (2004) "The Dental Curriculum and The Cost of Dental Education." Public Presentation. Hawaii: International Association of Dental Research; **Albino JEN** (1998) "Who will lead dental education in the future?" American Dental Education Association 75th Anneversary Summit Conference Discussion Papers and Proceedings; **Hardigan JE, Reed MJ** (1998) "The cost of

Academic Dentistry: how will we pay the bill?" American Dental Education Association 75th Anneversary Summit Conference Discussion Papers and Proceedings.

[34] **Elkind A** (2002) "Outreach teaching: is this the future for dental education?" British Dental Journal 193(2): 111-2; **Levine N, Sigal MJ, Munroe CO** (1986) "Outreach Dental Programs: A Viable Adjunct to Dental Faculty Education." Journal of the Canadian Dental Association 8: 709-13; **Formicola AJ, McIntosh J, Marshall S, Albert D, Mitchell-Lewis D, Zabos GP, Garfield R** (1999) "Population-Based Primary Care and Dental Education: A New Role for Dental Schools." Journal of Dental Education 63(4): 331-37; **The Future of Dental Public Health Report** (1994) "Preparing Dental Public Health to Meet the Challenges and Opportunities of the 21st Century." Journal of Public Health Dentistry 54(2): 80-91; **Ismail AI** (1996) "Dental Education and the Primary Oral Health Care Clinic Model." Journal of Dental Education 60(6): 520-23.

[35] **Isman R** (1994) "Implications for State and Local Dental Programs and Relationships Between Public and Private Dental Practice." Journal of Dental Education 58(4): 307-12.

[36] Of interest is the recommendation made to the Romanow Commission by the CDA for support of dental faculties in their role as service providers. Specifically, "The Canadian Dental Association recommends that the federal government take action to help financially support the dental schools on the basis of their provision of dental care, which offers affordable services to many low-income individuals and families." Again, it is unclear as to what form of support this CDA means, support for 'main clinics' or for the 'outreach' activities of faculties.

[37] Of which only a few stakeholders readily admitted awareness to, never really getting to the 'meat of the issue.'

[38] **Hardwick F and Schwartz A** (1999) External Review of the Dental Therapy Program of the Saskatchewan Indian Federated College National School of Dental Therapy. Ottawa: Health Canada Medical Services Branch.

[39] For example, for many years considered a strong contractor, and now arguably weaker relative to recent dynamics necessitating regional residency and/or Indigenous involvement, academic structures are now providing support for NIHB transfers that may be less so about enhancing Indigenous control (and challenging private dominance), and more about maintaining a role in this economy.

[40] See for example: **Adams TL** (2004) "Inter-professional conflict and professionalisation: dentistry and dental hygiene in Ontario." Social Science and Medicine 58: 2243-52; **Canadian Dental Hygienists Association** (2003) Access Angst: A CDHA Position Paper on Access to Oral Health Services. Ottawa: CDHA; **Canadian Dental Hygienists Association** (2003) Dental Hygiene Research Agenda. Ottawa: CDHA; **Canadian Dental Hygienists Association** (2003) First Nations and Inuit Oral Health: Oral presentation to the House of Commons Standing Committee on Health. Ottawa: CDHA; **Canadian Dental Hygienists Association** (2003) Financing Canada's Oral Health System: Oral presentation to the House of Commons Standing Committee on Finance. Ottawa: CDHA; **Canadian Dental Hygienists Association** (2000) Policy Framework for Dental Hygiene Education in Canada 2005. Ottawa: CDHA.

[41] **Ibid.**

Chapter 8. Conclusions and Recommendations

I. Conclusions

Four factors mitigate the development of dental care in Nunavut communities. They are: 1) Geography and Disease Burden; 2) Indigenous Self-Determination; 3) State/Indigenous Relations; and 4) Dental Practice and Philosophy. To defend this claim, and to make concluding remarks about it, the 'problem of oral health and structural inequity' is reviewed, and the story of the 'political economy of dentistry in Nunavut' told one last time.

a. The Problem of Oral Health and Structural Inequity

Archaeological, clinical, and oral histories describe a picture of good oral health in early Inuit populations. With traditional diets consisting of animal products and little or no carbohydrate, caries were uncommon. But as Inuit experienced great social change, they adopted southern diets, high in processed sugars, poorly buffered in the context of traditional oral hygiene techniques that stressed flossing meat out of in between your teeth, rather than brushing away sticky starchy foods.

Discussed as 'an epidemiologic transition' from low to high disease, the state of oral health in Nunavut communities is now described as a hidden epidemic. Such rates of disease hold significant consequence for those that experience them. From the excruciating pain and acute psychic tension of a toothache, to nutritional and cognitive impacts, the 'problem of oral health' is a serious one.

Consider one stakeholder's comments:

> ***"[W]hen you come into a community, you're there for two to three weeks and your working [...]12 days, with [inadequate] equipment [...] you're not going to see all the people. [...] You're not going***

> ***to finish all their treatment [...] they have 13, 14, 15, 16 cavities or fillings or extractions [...] you don't want to spend all your time on one person because [the government] won't pay for it [...] you spend one day on one person, you're going to see 12 people."***[1]

So in addition to the tremendous need, the problem of oral health includes a weak infrastructure and poor access, now more pressed than ever in an environment of increasingly tighter budgets and politicised stakeholder relations.

Creating and maintaining the problem oral health results from a complex set of processes, or 'factors that mitigate it.' From the bugs in one's mouth, to the dynamics of the dental care system, a range of things influence oral health status. Effectively, things that exist from 'micro to macro.'

Analysis of the macro social environments that impact Indigenous health has generally tied such populations to the dynamics of colonial imposition and the social resistances against it (*i.e.* understanding efforts at self-government and control over the social redistribution of health and social services). Characterising the problem of oral health this way, the factors that mitigate it become imminently political and economic in scope. These more macro political economic factors are important to understand, as they are known to impact care by decreasing quality, diminishing access, and creating poor conditions for health promoting behaviours.

Effectively accessing the nature of these factors (*i.e.* what they may be) depends on a research approach that views "the economy as socially and politically embedded and as structured by power relations."[2] It follows then that the social redistribution of dental care resources in this region is socially and politically embedded, and structured by the power relations of stakeholders. These 'structural interrelations' influence, shape, delimit, and/or constrain the actions of stakeholders as they attempt to deliver care in such environments.

A powerful and commonly presented example of what is meant (*i.e.* 'structural inequity' or the social and political interrelations that impact health), describes the situation of a woman in a northern community that can drink 500mL of milk for roughly $5 to $6, or can drink a soda pop for roughly $1 to $2. What is reasonable to an unemployed single mother with four kids, living in a two-bedroom house with ten other people? While extreme (and a definitive experience for many), most would argue that something is not right here, and less obviously, things become even more intricate.

What if that woman is a shareholder in an investment firm (managed by her political representation) that owned the factory that bottled the soda pop? What if this business control (of bottling the soda pop that one's population drinks) is effectively seen as an aspect of self-government? Political economic factors are often complex and subtle: to understand their influence, the story of dentistry in Nunavut is now presented.

b. The Story of Dentistry in Nunavut

According to the dental historian Gullet, 1922 represents the first recorded dentist in the Canadian Arctic. Scientific papers of this period also describe the activities of dentists that ventured north on federal ships or through their involvement with the military. Archival evidence then places dentists in the Arctic in and around the 1930s, with activity increasing from 1948 thru to 1956. There was little governmentally sustained dental treatment available, yet it is naïve to assume that no dental care occurred, as traditional care involved oral care, and when asked, now retired nurses recall that a priest, a local person, or themselves often had to take on this responsibility (often an extraction).

The 1950s and 1960s represent the rudimentary beginnings of what can reasonably be described as a dental care system for Inuit populations. Within the purview of federal jurisdiction and power, Inuit were part of a larger effort by the Indian and Northern Health Service to meet the health needs of Aboriginal populations. Limited by geography, the goal was to regularly include physicians and dentists on yearly supply and medical ships, and follow with the creation of a series of nursing stations as a front line, routing patients south for more complex care. But nursing stations did not often contain dedicated dental clinics, with the federal government concentrating its efforts on the care delivered by directly employed or contracted clinicians, all travelling to these regions, most using portable equipment.

In 1962, a government reorganisation saw the elimination of the INHS and the creation of the Medical Services Branch of Health and Welfare Canada, which took control of service provision. In trying to develop these services, an important aspect of this political economy is revealed, viz. that early on, much of the development of dental services to these regions was intimately tied to the institution of community and/or public health dentistry, and also to that of academic dentistry. It was in these stakeholders that interest was found in delivering such care, for it was community-minded dentists, or more formally trained public health dentists, that worked for governments and academic institutions, directly involved in establishing programs, concurrently delivering care through the service provision efforts of both institutions.

Another early and significant aspect of this political economy, is that while services became available to Aboriginal populations because of need and the interests of public stakeholders, from a policy point of view, they did so, only because of then

provincial and municipal efforts at providing access to uninsured health services like dentistry. Dental services never became part of Canada's universal health care system, and only became available as a governmentally sponsored social benefit for those receiving social assistance (lest a few other institutionalised populations). Since Aboriginal groups experienced socioeconomic inequity, and since they were a federal responsibility, in policy, federal authorities 'only matched' for services now provided by other governments, again concentrating efforts on the care delivered by publicly employed or contracted dentists.

Dentistry was also beginning its foray into the federal programmatic activity that would become known as the 'Non Insured Health Benefits.' These services were initially described as 'medically necessary uninsured medical and dental benefits,' and grouped certain uninsured health services. Now including pharmaceuticals, medical transportation, medical equipment, and other allied health services, when established as medically necessary by federal authority, services become provided out of need, and again, to 'only match' other Canadian norms.

The early dynamic of this social environment, whereby MSB was increasingly developing a discrete Aboriginal health system (of which dentistry was a part), then became politically charged in 1969 with the federal government's release of a new vision for an Aboriginal social policy. The policy proved unacceptable to the Aboriginal community, and essentially launched the 'rise of ethnonationalism,' where Aboriginal groups across Canada began a process of systematic resistance aiming to regain control over the processes that governed them. Inuit leaders created the Inuit Tapirisat of Canada, now the Inuit Tapiriit Kanatami.

All the major aspects of this political economy are now set. Early dental care for Inuit populations is clearly observed as the challenge of distance (*i.e.* geography). Part of the developing NIHBs, dental care is delivered out of need (*i.e.* disease burden), predominantly through the actions of publicly oriented stakeholders (*i.e.* dental practice and philosophy). Delivery is based in the historical and political relationship between Inuit and the State (*i.e.* Indigenous self-determination and State/Indigenous relations).

So by the 1970s, as nursing stations delivered a full complement of services, the infrastructure for dental care was still lacking, "government salaries [...] too low to attract [...] personnel" and "dentists [...] far too busy in their private practices to have any interest in providing more than emergency care." This time was not a boom in terms of human resources, but did see infrastructure develop, and became a time for laying down the fundamental practices of dental care in Canada's North.

For example, in 1971, MSB and the University of Toronto partnered to develop The National School of Dental Therapy, striking a vision to train an adjunct practitioner for work in isolated Aboriginal communities. Given impetus by need, political power by public stakeholders, and accommodated by then current professional dental health policy (which maintained that curative and preventative dental care should be offered to children through public means), professional dominance nonetheless resisted this new service provider. With dental therapy coming to experience a period of great success, in time, it did succumb to the effective degradation of the larger profession.

By the mid-seventies, the economies of scale were present for dentists to establish private practices in the pre-Nunavut regions. Few dentists took this opportunity, but there were some. Contracting these few resident private practice dentists became a quick

and obvious step to fill need, supplementing the work of already established public stakeholders. With the first wave of dental therapists now working across the Arctic, a system was indeed developing.

This time also represent the further ideological and politicised struggles between Indigenous groups and the State. Inuit continued to develop their interests in achieving control over their lands, advancing their vision of reclaiming a self-governing status. The political dynamic around health partly focussed on the NIHBs, where in 1975, federal authorities defined their responsibilities over these services as a matter of policy and not obligation. In limiting care based on need, Indigenous groups concurrently developed the argument that services were not delivered in this capacity, but relative to their rights as Indigenous Canadians. It was indeed a matter of obligation, and a further right to govern such care. In the pre-Nunavut regions, this was reflected in the calls of ITC and some communities for the devolution of control over health services.

Claiming an Indigenous social right to health, to health services, and to control over services, disputes eventually led to the tabling of the 1979 federal Indian Health Policy (which now guides Canadian Inuit health policy). A statement on the necessary involvement of Indigenous groups in their services, and in the one-day potential control over them, this contextualised such control and involvement in community development and the traditional relationship between Indigenous groups and the State. Here is an early expression of another important aspect of this political economy, viz. that social and economic development (or community development) became very closely linked to control over services and self-government. So still observing geography limit care, and need drive a system to include the dental practice and philosophy of public and private

stakeholders, Indigenous self-determination and State/Indigenous relations were now increasing their influence.

By the early 1980s, dental markets were saturated in the south. This increased professional interest in Aboriginal populations, and with disputes over policy to describe federal responsibilities and Indigenous rights, governmental authorities responded by entrenching the contracting form of service delivery. Regardless of the contractor, each provided services in a similar fashion: itinerant care to isolated communities, provided in two to three week periods, often by different providers throughout the year, overwhelmingly consisting of acute care, several weeks simply not allowing any comprehensive treatment, or for any sort of concerted dental public health effort.

With the option of several providers, all with similar approaches to care, services were still limited by the inability to recruit and retain personnel (even with saturated southern dental markets). Special targeted dental treatment and public health programs were adopted to focus efforts, and more aggressive human resources recruitment strategies used, both aiming to improve the limited system. Targeted treatment programs took the form of operating room access (as in paediatric oral surgery for rampant caries), and access to treatment by orthodontists and oral surgeons. Advancements in dental public health services took the form of dental therapy efforts. Much of this work produced in the then current 'hay days of dental therapy.'

Recruitment and retention strategies aimed to attract foreign dental graduates. Known as Part III dentists (as per their registration in the territorial dental act), these providers became associates of northern resident clinics, travelling to isolated communities, some eventually establishing their own clinics. These practitioners are

important as they form a specific cohort in northern dental services and the competition for dental contracts.

By the late eighties, important changes were beginning to take place in the pre-regions of Nunavut in this regard. A resident foreign-trained northern practitioner had established a practice in a regional centre, quickly expanding into a second regional centre, immediately impressing influence in such a sparse northern dynamic. Demands continued for the devolution of control over health services, and this resulted in the creation of regional health boards, who quickly engaged the notion of 'P3 plans,' or 'public, private partnerships,' where the involvement of the private sector (like the new resident foreign-trained provider) was encouraged to alleviate increasingly challenged budgets.

These tighter budgets were in part, a result the ballooning fiscal environment of the NIHBs, which by the late 1980s, reached $400 million, up from only $36 million ten years earlier. With increasingly little money, territorial administrators looked to the idea of the 'P3 plan' for dentistry. When contracts were renewed, all communities were consulted as to whom they would prefer: an academically based provider (by then the long-term contractor in the region), or the new foreign-trained resident clinician (who had intentions of privately managing dental care, alleviating the health board of this responsibility as per the P3 plan).

The idea was not popular, and the board renewed its contract with academic dentistry, excluding two communities, where less obviously, the business interests of the region resided. These private interests would eventually become part of a new dental corporation, one that would take advantage of favourable contracting policies for

northern residency and Aboriginal business. This would become possible due to developing ideas in the State/Indigenous relationship surrounding the opportunities to control services.

Advancements in this regard were now also linked to the efforts of the Tunngavik Federation of Nunavut, created to represent Inuit in their efforts at gaining a self-governed territory. TFN was important as it represents an 'ethnonationalist capitalist organisation' or a 'native economic development corporation.' Here again is a reflection of a social and economic development policy closely linked to the business actions of corporations, and the self-government aspirations of the people they represent.

By the early 1990s, northern programs were described as wrought with patient and practitioner dissatisfaction, and steeped in administrative problems. As before, stakeholders explained problems relative to the high turnover rate of personnel, the minimal length of clinical visits, the lack of specialised care and support, but now concentrated almost exclusively on NIHB administration. These contentions developed as federal and territorial managers shaped the mechanisms of the NIHBs to better fit the uninsured health service marketplace in which the were delivered.

To partly buffer the claims of Indigenous groups that these services were a right and publicly insured for them, NIHB structured as a third party payer for dental care, undertaking many of the processes of private insurers, even though it was more a public program than an insurance carrier. Administrative mechanisms met with much disapproval, especially since they were often more stringent and laborious than their private counterparts as per the accountability demands of the public purse. This complexity frustrated administrators as well, as their private mechanisms for public

budgetary control were simultaneously incongruous with the market context of the NIHBs, and the public context of their funding and governance.

For example, resources were challenged in an environment, where unlike a private insurer, the NIHBs held no recourse to premiums or co-payments, so as demands grew, there was no financial base to support it. In paraphrasing one administrator: 'the more we insure, the more we fund, and insurance doesn't work that way.' The Auditor General of Canada pointed to this lack of clarity in the NIHBs, especially noting its impact on any transfers of control, as it was unclear what was being controlled, a health program or an insurance scheme.

Through these problematised administrative mechanisms, federal authority continued its cost containment efforts. In devolving programs that were resource starved and not easily managed, centralised authority inadvertently burgeoned continued support of the dental P3 plan. Effective spring of 1992, one health board cancelled its contract with an academically based provider, and in moving towards the private sector, awarded the contract to the resident clinician that had earlier taken possession of two communities. This contractor had since partnered with Inuit business interests, creating much legitimacy as per contracting policies favouring local and Aboriginal business. Representing a tremendous coup, academic dentistry's role in this political economy was no longer a given (as it had been for roughly 20 years).

Further cost cutting equalled more P3 planning. In early 1997, the health board announced that the management of all dental services would now be handed over to the northern and Aboriginally based private practice. Already servicing the whole region, this corporation would now also subsume the administration and care of dental therapists.

Seen as a measure to save money, dental therapists were let go, and were not hired by the northern contractor (some thinking that they would be), as more money could be made if dentists delivered the same services. Here is an example of the professional degradation of dental therapy, and the attempted privatisation of what are otherwise public dental services.

As a management mechanism, federal, territorial, ethnonational, and academic authorities all rejected it. MSB officials moved to not honour this contractor's billings, portraying their efforts as a breech of the *Canada Health Act*. These events presented with much controversy, and MSB (soon to be called the First Nations and Inuit Health Branch of Health Canada) opportunely took advantage.

For much of northern dental history, little competition meant that dental fees were inflated with special premiums to attract clinicians. As competition slowly developed (between public and private stakeholders), and with the major professional players now marred by controversy, inflated fees were cut by as much as 39%, with the introduction of even newer and more contentious administrative mechanisms. Such tumult also highlighted complaints about Part III dentists, with authorities quickly terminating this recruitment practice to ease tensions. Dental therapists were reinstated but most were working elsewhere.

A commissioned review of the events effectively characterised many of these problems as politically and economically based, and the result of power dynamics between private motives and the public good. This review also noted the now long-term observance that preventative care was almost non-existent, and that funds were essentially capped at the federal level. Any improvement would have to occur within a

fixed financial envelope, in an environment that was by now very politicised and mired in unclear historical relationships.

Wanting to move forward, contracts were re-tendered in mid 1997, many expecting academic dentistry to return to its former status. But this was not case, as other academically based stakeholders also observed opportunity, creating their own dental resource firms, offering services themselves and through their academic contacts, separate from their employers. With historical involvement, power and legitimacy, these new contractors entered the competition circle, taking the place of a now defunct northern P3 contractor, pushing academic dentistry into more remote regions. With the new mix of providers, attention turned to the creation of Nunavut.

The creation of a Nunavut territory in the spring of 1999 impacted the daily acts of administration for all stakeholders. For northern dental departments, services became coordinated on a regional basis, feeding into a single health department (which replaced regional health boards). Where this central administration would be, and how it would look, remained unclear, all expecting changes as per 'the dream of Nunavut,' which called for a 'decentralised' and 'Inuit representative' government. Dental departments were never moved, and Inuit representation has evolved in several ways, including the hiring of more local people, and the attempted incorporation of traditional knowledge into public dental policy, planning, and delivery (and as detailed shortly, through opportunity in the market of dental contracts).

As stakeholders settled into new administrative routines, the problematised NIHBs remained the major concern. Coordinated critiques on federal and territorial administration came from the joint efforts of dental regulatory authorities and

ethnonationals. These stakeholders called for expanded services and the immediate enactment of preventative care at both the Nunavut Government and FNIHB level. Governments did respond with improvements in administration, and by establishing plans for a focussed preventative effort.

The Nunavut Government was itself focussing its own critique, one based on the knowledge that devolved monies were not able to meet need, and that while controlling certain aspects of the NIHBs, these services were really a federal responsibility (as per the State's historical relationship with Inuit). So at one point adopting the program to bring it closer to Inuit control, the Nunavut Government now wants to return or 'evolve' its responsibilities. Part of this strategy depends on the interest of Nunavut ethnonationals in assuming control over these services, interest expressed since the mid 1990s, but not developed due to the turmoil of P3 planning. Based on the experiences of southern First Nations, NIHB transfers present with unique economic opportunities, something desperately needed in such environments.

Several years into the experimental control of the NIHBs, some southern ethnonationals were involved in significant business ventures. In being able to control pharmaceutical disbursement, medical transportation, and/or the delivery or management of NIHB services, the possibility of financial gain was present, as ethnonationals could create pharmacies, health human resource firms, and any other historical structure that held fiscal advantage in this environment. Those that would control the NIHBs are 'ethnonationalist capitalist organisations,' which in Nunavut concurrently represent the self-government and financial interests of Inuit beneficiaries.

Characterised as 'self-government through public government,' Nunavut creates an environment where the lines between institutions becomes blurred, where social and economic development policy, self-government, public and private control over services, and Indigenous rights, all closely intermingle. This creates situations that challenge current Canadian social norms about who can control health services, and how that control can look. In Nunavut, corporations that attempt self-governmental control through private mechanisms of influence are common. Major legitimated governmental ethnonationals (all corporate entities) now control aspects of hospital and health centre construction and management, and also deliver some health and social services programming.

Corporations falling outside any formal recognition in the 'self-government through public government' of Nunavut still find social support in their self-characterisation as economic and social development vehicles: who through success in the marketplace, advance the Inuit interest. An example of this is found in the private Inuit interests that partnered with the resident dental contractor in the mid 1990s, which have since involved themselves in the supplying of medical equipment and human health resources, and advanced plans that were interpreted as violating the *Canada Health Act* (*i.e.* attempting to build a private for profit mammography clinic using equipment not yet licensed in Canada). So still maintaining unclear rights to services (as it is still unknown whether health or self-government are truly aboriginal rights), Indigenous groups now attempt to enforce these rights through a complex quasi-private and quasi-public self-governmental corporate structure, created as per the confusions and limits of governmental policy.

This was the case in the competition for dental contracts occurring post-Nunavut, where an even newer cadre of dental corporations emerged. Reacting to the rights and advantages of Inuit and northern business interests (as guaranteed in a new Nunavut territory), stakeholders quickly moved to establish corporations that were Inuit majority or Inuit minority owned, or that somehow held residency in Nunavut. Some built new northern practices, some pointed to their role in community, economic, and social development, and some suggested that choosing them meant the advancement of Inuit self-determination and self-government.

In the heated competition, corporations further claimed that they would aid or take over the administration and practices of dental public health services (a service easily offered by academically based care and other corporations that have public health dentists as leaders or as subcontractors). The result of potentially privatising dental public health efforts should be noted here. This never occurred, but since every stakeholder knew that a board consisting of ethnonationals and public governmental officials would decide the outcome of this competition, attempts to meet governmental need became highly aggressive, some placing significant pressures on others to back away from contracts and the building of northern clinics, or imposing their will by forming strategic partnerships that created larger more powerful expertise-rich corporations. To date, all contractors manage to maintain some position in the contracting circle.

With upwards of two decades of cost control, and in the midst of consistent calls for renewed relationships, this geographically and socially challenged system of care continues its development in an environment of competition, unclear rights, unclear

responsibilities, barely sustaining the resources that it has, where goodwill struggles to answer the ever-present and overwhelming need. So in asking what influences dental care in Nunavut communities (using a political economic approach), this investigation demonstrates how four factors impact its development: geography and disease burden by complicating the practices associated with service delivery in remote communities to a population with a high prevalence of dental disease; Indigenous self-determination through the challenging social reorientations necessary when building Canada's first Inuit 'self-government through public government;' State/Indigenous relations by situating this service's development in a series of unsettled, unclear, and politicised debates, that compromise effective service delivery; and dental practice and philosophy by informing service delivery in a manner that is generally ill equipped to meet the needs of such a population, and by shifting attention from public to private interests.

II. Recommendations

The awareness that these four factors impact the development of care in Nunavut is not novel. Yet in their apparentness, the manner in which these factors play out has proven quite intricate and subtle. Here then lies the major difference between concluding that something is, and recommending a successful avenue for its positive change. So while it is obvious that renewal is needed, why this has proven unachievable represents the dilemma of such social complexity. It is no wonder why all stakeholders appreciate the limitations of these factors, yet daily re-enact problematised realities without directly addressing the root causes of such dramatics.

Initial suggestions for improvement often ground in the idea that increased funds, provider remuneration, alternative modes of service provision, and enhanced preventative activity hold answers to such challenges. More financial resources will always alleviate immediate needs: more dental days could become available; more education and prevention opportunities developed; better equipment and financial incentives would draw more clinicians to this care. Yet irrespective of this positive development, the historical reaction of answering the needs of pain and suffering through the expansion of curative services, will most likely still prove ineffectual (and the generally minimally advantageous preventative interventions undertaken as well). Further, as is the case for dental therapy, having more funds is still not enough in a human resources environment experiencing an acute lack of providers.

Considering alternative modes of service delivery remain linked to the events of Part III providers, and could still produce social tensions if reconsidered. It nonetheless remains a viable mode by which to alleviate immediate need. The Part III registration category of the territory's dental act was only nullified, and did not remove it from print, suggesting that this could become legislatively reactivated if considered necessary. With remaining Inuit specific contentions regarding these providers, this part of the register will likely remain dormant.

The expanded duties of dental therapists and dental hygienists must also be considered. An expansion of abilities in these groups, however problematised by professional polity, clearly represents a rational option for meeting need (irrespective of whether current attempts are failing). Even if able to mitigate the initial resistance, attempts would still require significant investment and expertise, and would somehow

have to strengthen the commitments made by graduates to work in the program's intended delivery environments.

Student delivered care does represent a significant and often ignored possibility, and necessitates the involvement of academic dentistry. In Nunavut, this practice has all but disappeared, yet this is an option worth exploring (as per the positive aspects of the immediate human resource increases, exposing students to such environments, and attracting graduates to such clinical opportunities). Community specific commentary demonstrates some misgivings about the practice for fear of receiving treatment from someone still under training (this perceived as a derogation of their care).

Another alternative mode of service delivery is simply constituted in attempts to readjust the current patterns of practice. Removing 'the private practice mentality' and enhancing 'prevention' (with many caveats) can do much to potentially address current challenges. Despite the increasing professional awareness of evidence-based care and its capacity to necessitate a reappraisal of clinical logic, care to the socio-geographically marginalised remains largely ill equipped (theoretically and practically) to answer such need. It is important to note that relatively little research discussion occurs as to the most demonstrably effective modus of delivering care in Nunavut (most discussion grounding in the exigencies of the political dynamic). Questions that bear great influence on the potential improvement of care remain unanswered. For example, if faced with one hundred individuals that required extensive care (which grossly underestimates presentation and need), is it better to attempt two procedures on many people, or attempt to complete care (within reason and clinical limits) on fewer? If so, who would those people be? How would they be chosen? It appears that aside from the inherent challenge

to the status quo, even considering changes to the current nature of care proves difficult in and of themselves.

Importantly, there is progress in just accepting the realities of distance, disease burden, and power dynamics (even if just for a moment), and observe the real opportunities in explorations of a new approach to care. For example, a team approach could prove very beneficial, care involving the direct governmental hire of dental providers (creating a team by salary), or the hiring of pre-formed teams (most likely involving current corporations who would now only collect a management fee, or if 'ethno-governmentally based,' negotiate control through mechanisms separate from its corporate service delivery activity). This would create an environment for the expanded delegation of tasks to dental hygienists, dental therapists, dental assistants, CHRs, and clerk-interpreters, such that dentists could provide more complex care, with many more people treated. This would in no way change the current pattern of dental days and community visits currently in place. Further, much more capacity and impetus is created for individualised and community health interventions in such an environment.

Aside from all of this, one must still contend with the simple fact that having poor oral health is inexorably linked to inequity that is of a sort much greater then the immediate dental problem (or the nature of culpability associated with individual experiencing that problem). While the dental problem appears so immediate and overwhelming in its acuteness, the idea of addressing larger social dynamics through the dental body politic quickly fades away into the problem's long-term social innocuousness (and this emphatically supporting the view that oral disease results in fundamental impacts to the individual and society). Yet in a sobering moment, one must recognise

that unless considered (and alleviated), not facing the direct implications of why people are so sick will continue to deter from any meaningful health improvements, further maintaining an ill equipped system meant to deal with such complicated and subtle health states. Of most significance in this regard, prevention may be best incorporated *qua* social legislation. For example, to have to drink soda pop since milk is cost-prohibitive or unavailable is not reasonable (*i.e.* food security legislation), let alone a glass of clean and non-infective water (*i.e.* environmental health legislation).

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[1] **Present Provider, Present Private Administrator** (2001) Personal Interview. Toronto, Ontario. April 16.

[2] **Sayer A.** (1995) Radical Political Economy: A Critique. Oxford: Blackwell.

Appendix A

Data Type	Retrospective		Prospective	
	'Private'	**'Public'**	**'Private'**	**'Public'**
Documentation	***Data Source:*** Stakeholders ***Examples:*** e-mails, business proposals, memoranda & other narrative records. ***Consent mechanism:*** The use of this data will be negotiated with the stakeholder; negotiation means showing the specific data to the relevant stakeholder and seeking permission for its use. Permission will be sought prior to, or at interview, where information regarding the study will be reviewed and consent forms will be signed.	***Data Source:*** Governmental & Non-governmental agencies, journalistic sources. ***Examples:*** 5yr Review-Implementation of the NLCA, Clyde River Protocol, Canadian Dental Association Communiqué ***No consent required***	***Data Source:*** Governmental & Non-governmental agencies, stakeholders. ***Examples:*** meetings of minutes, internal reports & memoranda, general notes. ***Consent mechanism:*** Data owned by governmental & non-governmental agencies will be sought through their formal request mechanisms; data owned by stakeholders will be sought prior to, and at interview, where information regarding the study will be reviewed and consent forms will be signed.	***Data Source:*** Governmental & Non-governmental agencies, journalistic sources, national and regional dental association publications. ***Examples:*** to be determined ***No consent required***
Archival Records	***Not applicable***	***Data Source:*** Governmental & Non-governmental agencies, Legislative Hansards. ***Examples:*** The Nunavut Land Claims Agreement, The Nunavut Act, Nunavut Dental Act, Departmental reports. ***No consent required***	***Data Source:*** Governmental & Non-governmental agencies. ***Examples:*** to be determined ***Consent mechanism:*** Data owned by governmental & non-governmental agencies will be sought through their formal request mechanisms.	***Data Source:*** Governmental & Non-governmental agencies, journalistic sources, national and regional dental association publications. ***Examples:*** to be determined ***No consent required***

Semi-structured open-ended interviews	*Not applicable*	***Data Source:*** The names of stakeholders have been collected by aggregating a list of individuals identified by stakeholders known to the researcher. ***Examples:*** Potential participants for this research study are part of a group of stakeholders involved in the provision of oral health care services in Nunavut. They can be grouped into the following categories (where one or more of the descriptors can apply to a single individual): 1. Inuit stakeholder, 2. past or present care provider, 3. past or present private administrator, 4. Past or present public administrator. ***Consent mechanism:*** Recruitment of study participants will be done via personal contact, initially through email and followed by hard copy. The email will introduce the researcher, provide information about the nature of the study and its goals, will give examples of potential questions for the interview, and formally request the participation of the stakeholder in the study. If contact is successful, a mutually acceptable time and location will be arranged for an interview to occur by telephone or in person. Participants will be asked to sign consent forms before the commencement of interviews, one for the interview itself, and a second for potential access to, and use of any documentation relevant to the study. If by telephone, the study information previously sent by e-mail and hard copy will be referenced, as well, consent forms will be faxed and received prior to conducting telephone interviews. With the participant's permission, telephone and in-person interviews will be recorded and transcribed verbatim.

Participant-observations	***Data Source:*** Clinical and ethnographic impressions in the form of narrative records, journal entries, letters. ***Examples:*** These data sources result in a kind of oral and written account of my experiences as a clinician in Nunavut for two years. ***Consent mechanism:*** Any data of this kind will be stripped of any direct and/or contextual descriptors before incorporation into the research text, and explicitly noted as the observer's impressions of events.	***Data Source:*** Ethnographic impressions in the form of narrative records. ***Examples:*** to be determined ***Consent mechanism:*** Ethical considerations with individual participants will ensure that informed consent is an ongoing process. Since case study methods sometimes involve casual and/or repeated conversation about the research topic, stakeholders will be advised that their comments may become anonymous data in the research study whenever these conversations occur. As such, consent will also be reviewed throughout the research process to endure that participants fully understand the components of the study and the voluntary nature of their involvement.

Appendix B

Consent Forms

Participant Information (Interview)

Factors Influencing the Development of Oral Health Care in Nunavut

Purpose of the Study
This is a thesis project in the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba. The purpose of the project is to learn about the factors that are influencing the development of oral health care in Nunavut. I will be interviewing roughly 15 to 20 stakeholders regarding this topic. The objective of this study is to provide information about the context in which dentistry has developed history of dentistry in Nunavut, as well as to examine dentistry in relation to Inuit self-government and self-determination. The results of this study will be used to provide information for the improvement of oral health care services in Nunavut.

Study Procedures
In this interview, I would like to ask you a number of questions regarding the development of oral health care in Nunavut. I would like to assure you that all information you provide in this interview will be kept strictly confidential and will only be used to create a general picture.

Your name and all personal identifiers will be kept separate from all data to ensure that you will not be identified in any way. Access to all information will be restricted to project personnel and secured electronically and physically from public access. This study will take place between October 2001 and February 2002.

Costs
This interview is conducted at no cost to you. As well, you will receive no payment or reimbursement for any expense related to taking part in this study.

Benefits
When the research is completed, it will help in understanding the history of the way dentistry is practiced and administered in Nunavut. Also, with your input, problematic areas may be addressed at the health service delivery level with the goal of improved dental care for Nunavut residents.

Confidentiality
Information gathered in this research study may be published or presented in public forums; however, your name will not be used or revealed unless otherwise noted by you. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed; your personal information may be disclosed if required by law. Organisations, such as the University of Manitoba Research Ethics Board, may inspect and/or copy your research records for quality assurance.

Voluntary Participation/Withdrawal from the Study
Your participation in this study is strictly voluntary. You may refuse to participate, you may refuse to answer any question, or you may withdraw from the study at any time.

Questions
You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study, contact the research team: Carlos R. Quiñonez, Centre for Community Oral Health, Faculty of Dentistry, University of Manitoba, (204) 789-33978.

For questions about your rights as a research participant, you may contact the University of Manitoba – Bannatyne Campus Research Ethics Board at (204) 789-3389.

Do not sign this consent unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent
I understand that I am being asked to take part in a study concerning oral health care services in Nunavut. The interviewer will ask me questions about what I think and understand about the development of dentistry in Nunavut. This interview will take roughly two hours. I have been given information about the purpose of the project, how my name was selected, and the risks and benefits of the study. I have been given the investigator's name and telephone number. I understand that I can ask any questions at any time.

I understand that information regarding my personal identity will be kept confidential, but that absolute confidentiality is not guaranteed. I understand that I can choose to take part, or not to take part in the study. I can stop the interview at any time. I understand that the tape recordings and any pertinent information concerning the interview will be kept in a locked place. I understand that all the information that pertains to me will be labeled with a number and not my name. As part of the study, the investigator may use my statements and will identify me as:

(Please choose those by which you want to be referred to in the study text)

? Past or present private administrator
? Past or present public administrator
? Past or present provider
? Inuit stakeholder
? Anonymous
? By name

I ? consent ? do not consent, to being contacted at a later time for more information. I authorize the inspection of my records that relate to this study by the University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Name: _____ Date: _____

Signature of Participant: _____ Date: _____

Signature of witness: _____ Date: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believed that the participant has understood and has knowingly given their consent.

Signature of Investigator: _____ Date: _____

Participant Information (Access To and Use of Information)

Purpose of the Study
The study of the 'Factors Influencing the Development of Oral Health Care in Nunavut' is a thesis project in the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba. The purpose of the project is to learn about the factors that are influencing the development of oral health care in Nunavut. I will be interviewing roughly 15 to 20 stakeholders regarding this topic. The objective of this study is to provide information about the context in which dentistry has developed history of dentistry in Nunavut, as well as to examine dentistry in relation to Inuit self-government and self-determination. The results of this study will be used to provide information for the improvement of oral health care services in Nunavut.

Study Procedures
As part of this study, I would like your permission to use private documents owned by you such as correspondence, emails, proposals, etc. This information will be analysed in a general way and will be used to illustrate the key themes that emerge from the research. I would like to assure you that all information you provide will be kept strictly confidential and will only be used to create a general picture.

Your name and all personal identifiers will be kept separate from all data to ensure that you will not be identified in any way. Access to all information will be restricted to project personnel and secured electronically and physically from public access. This study will take place between October 2001 and February 2002.

Costs
This data collection is conducted at no cost to you. As well, you will receive no payment or reimbursement for any expense related to taking part in this study.

Benefits
When the research is completed, it will help in understanding the history of the way dentistry is practiced and administered in Nunavut. Also, with your input, problematic areas may be addressed at the health service delivery level with the goal of improved dental care for Nunavut residents.

Confidentiality
Information gathered in this research study may be published or presented in public forums; however, your name will not be used or revealed unless otherwise noted by you. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed; your personal information may be disclosed if required by law. Organisations, such as the University of Manitoba Research Ethics Board, may inspect and/or copy your research records for quality assurance.

Voluntary Participation/Withdrawal from the Study
Your participation in this study is strictly voluntary. You may refuse to participate, you may refuse to allow access to and use of any information owned by you, and you may withdraw your information from the study at any time.

Questions
You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study, contact the research team: Carlos R. Quiñonez, Centre for Community Oral Health, Faculty of Dentistry, University of Manitoba, (204) 789-33978.

For questions about your rights as a research participant, you may contact the University of Manitoba – Bannatyne Campus Research Ethics Board at (204) 789-3389.
Do not sign this consent unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent
I understand that I am being asked to take part in a study concerning oral health care services in Nunavut. I have been given information about the purpose of the project, how my name was selected, and the risks and benefits of the study. I have been given the investigator's name and telephone number. I understand that I can ask any questions at any time.

I have seen all information presented by the researcher and understand that the information I am allowing ? access to ? giving to the researcher will be used for the purpose of the study. I understand that all the information that pertains to me will be labeled with a number and not my name.

I understand that information regarding my personal identity will be kept confidential, but that absolute confidentiality is not guaranteed. I understand that I can choose to take part, or not to take part in the study. As part of the study, the investigator may use my statements and will identify me as:

(Please choose those by which you want to be referred to in the study text)

? Past or present public administrator
? Past or present provider
? Inuit stakeholder
? Anonymous
? By name

Name: _____ Date: _____

Signature of Participant: _____ Date: _____

Signature of witness: _____ Date: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believed that the participant has understood and has knowingly given their consent.

Signature of Investigator: _____ Date: _____

Appendix C

Interview Schedule

COMMON QUESTIONS FOR ALL STAKEHOLDERS

- How long have you been involved in dental care in Nunavut? In what capacity?
- Do you think dental care is an important service for Nunavummiut? Why?
- Do you think dental services are good or bad in Nunavut? Why?
- What do you see as the major barriers to providing care in Nunavut?
- What do you think should change in dental care services in Nunavut?
- How do you think dental care can be improved?
- How would you set up dental care services in Nunavut?
- Do you think the creation of Nunavut has anything to do with dental care services?
- Has the creation of Nunavut impacted dentistry?
- Has Inuit self-government and self-determination impacted on dentistry?
- Do you think traditional knowledge should be part of dental care in Nunavut?
- How do you think Article 24 of the NLCA and the NNI policy have influenced the development of dental care services?
- Do you think the NIHB program is working in Nunavut? Why?
- What are the 'politics' like in the bidding process for contracts? Do they affect dental care in Nunavut?
- Can you describe in your own words, the types of people that have delivered dental services in Nunavut or the old NWT? Is everyone similar? Different?
- Why do you think people come to Nunavut?
- What do you think of dental CHR positions?
- What do you think is the best way to tackle the problem of the state of oral health of Nunavummiut?

INUIT STAKEHOLDER

- Why is it important for Inuit to control this health service?
- What do you bring to dental care services in Nunavut?
- Is it important to have communities involved in their dental care?
- Do you think NIHB should and can be controlled by Inuit?

PUBLIC ADMINISTRATOR

- Have there been any changes that you consider important in the administration and delivery of dental care services since or within your involvement?
- What problems do you face with the administration of dental services?
- Do you think other NIHB should be under the control of Inuit?

PRIVATE ADMINISTRATOR

- Have there been any changes that you consider important in the administration and delivery of dental care services since or within your involvement?
- What problems do you face with the administration of dental services?
- Is the administration of dental services a good clinical and/or business endeavour?
- Did you consider Article 24 and the NNI policy when attempting for contracts in Nunavut?

CARE PROVIDER

- Why do you work in Nunavut as a clinician?
- Do you do your job as a clinician the same as if you were down south?
- As a clinician, do you account for Inuit culture in the way you deliver care? How?
- Describe the dentistry that you do?

Appendix D

NIHB Delivery Structures and Mechanisms, Control Measures, Debates, and Role in Aboriginal Health System and Economy

These tables do not represent a thorough analysis of each category, yet do provide an entry point if this mode of understanding is to be further applied.

A. Vision Care

Delivery Structure and Mechanisms
- Indirect and direct provision through a combination of professional and allied provider care (*i.e.* optometrists, opticians, CHRs, clerks/technicians)
- Services most often involve eye exams, the delivery of glasses and their repair
- Contracts with clinicians on reserve and in isolated areas; indirect provision by urban providers
- "In view of the large volume of frames and lenses required, MSB will have in place contractual arrangements with a supplier of frames and lenses. Fitting rates will be negotiated with the [Province X] Optometric Society and the Ophthalmic Dispensers of [Province X]."

Control Measures
- Parity with provincial coverage, viz. stressing that "registered Indians and Inuit in [Province X] are eligible for the above mentioned insured services as are all [Province X members] and [Province X] is to be billed for these insured services."
- Medical criteria – "an initial prescription written for a beneficiary who has never before received glasses; or eye prosthesis as specified in Directive[s] and Administrative Procedure[s]; high index lenses; a new prescription following an eye examination where the change in refractive error is at least that outlined in Appendix A; when other characteristics of the lens or frame requirements have significantly changed; replacement eye glasses; repair."
- Eligibility criteria – based on need and frequency (*i.e.* limiting listed services)
- Pre-authorisation of benefits

Debates
- The problems associated with isolation and a lack of providers (*e.g.* waiting for repairs)
- The lack of choices relative to eye glass frames
- Frequency of benefits

Role in Aboriginal Health System and Economy
- Little published debate in vision care
- Few aboriginal professional providers, some Aboriginal allied service providers

B. Medical Transportation

Delivery structures and mechanisms
- Includes costs for travel, patient escorts, and lodging
- All medical transportation authorised by "MSB field nurses, authorised clerks, or an agent designated by MSB (provincial/territorial nurse), or an agent (band councillor, clerk or CHR) designated by an Indian Band that administers medical transportation benefits on behalf of MSB through contribution agreements."
- Involves contracting with coordination providers (*e.g.* 'patient referral services,' 'commercial establishments under contract'), largely Aboriginal medical transportation corporations (*e.g.* 'multi-passenger van services'), taxi companies, community organisations (*e.g.* local taxi companies, individuals employed by health centre or community using community vehicles, individuals using their own vehicles)
- Negotiated flat rates established with all contractors

Control measures
- Criteria exists for medical necessity, patient escorts, family member or care giver medical

transportation, transportation to alcohol and drug treatment centres, ambulance services, and meals and accommodation (private arrangement, commercial establishment under and not under contract, children's boarding homes)
- Some measure of control is provided by nurses and clerks assessing cases, with significant medical evacuations by air and/or water involving more coordination with regional and/or hospital authorities
- Certification of medical attendance
- Community and personal accountability measures

Debates
- Constitutes a significantly rising benefit and much debate
- Questions as to the nature of band-referrals and self-referrals (*e.g.* attending traditional healers and/or when there is disagreement about the need for medical travel)
- Community discourse and ethnographic observation speak to times when individuals such as elders and young persons have been left to wander at airports and/or hospitals with poor communication and support (*i.e.* 'Who will pick me up?' 'Where am I going?' 'What's going to happen?')
- Long term complaints about the minimal resources and contact with friends and family when having to travel for medical reasons, thus exclusion of coverage for the travel of family members and/or medical interpreters is often challenged.
- Questions as to the nature of 'eligibility,' viz. patients are referred relative to certain 'lines' of medical travel, all based on 'rights' to the service as per 'status' and/or membership in a band/community, necessitating several administrative routes involving federal, community, municipal and/or provincial coverage mechanisms.
- Provider compensation parity across regions (*i.e.* the 'regionality' issue)
- The increasingly limited transportation available for seeking other NIHB services
- Due to significant increases in costs and in debates, FNIHB attempted to remove this service from the NIHB envelope into Community Health Programs, but met with significant ethnonational resistance and did not move the program

Role in Aboriginal Health System and Economy
- One of the earliest transferred/devolved services
- Constitutes one of the earliest 'Joint Task Forces' aimed at improving services
- An early part of the developing health economy, as opportunity existed for entrepreneurialism and for intra-community contracting (*e.g.* community health authority contracts band/local company/local individuals) and inter-community contracting (*e.g.* an independent community contracts an ethnonational organisation or a larger Aboriginal corporate provider)
- Largely involves non-professional market actors
- Provides a substantial economy to ethnonationally-owned and managed boarding facilities, and/or larger hotel chains that own flat rate contracts with communities and/or federal authorities, both providing for lodging and meals
- Growth potential is large relative to the increased usage and necessity when achieving 'parity with Canadian standards'

C. Medical Supplies and Equipment

Delivery structures and mechanisms
- Provided relative to 'need on a continuing basis' as established by medical professionals; once the criteria of need is met, a 'standing offer' for services is issued with 'approval given by the authorising officer for a time period not to exceed one year'
- Direct and indirect forms of provision
- Providers include:
- community stakeholders (nurses, CHRs, clerks) providing supplies directly (*e.g.* contribution agreements, pilot projects)
- allied health service providers under contract in rural and isolated areas or in urban private practice providing supplies indirectly (*e.g.* physiotherapy, podiatry, audiology, chiropractic, amongst others)
- Suppliers include those corporations (ethnonational and non-ethnonational) that provide through bulk and wholesale arrangements

- Contracts with these suppliers established by transferred communities, devolved territorial authority, and federal authority
- Fundamental articulation with home and community care programs and industry
- Benefits include: wound dressing supplies, incontinence supplies for disabled adults and disabled children, catheter and toileting supplies, contraceptive aids, orthopaedic supplies (amongst many others)

Control measures

- Consistently stresses coverage under other governmental programs and/or 'third party plans'
- Periodic review through claims processing information systems to ensure 'abnormalities in supply issuance are corrected quickly.'
- Requisition authorities (*i.e.* 'many requisition forms')
- Regional/centralised medical equipment loans (direct provision)
- Equipment leasing
- Repair and replacement criteria for medical equipment
- Pre-authorisation of benefits
- Limiting listed services

Debates

- Imminent concerns relative to:
- the rise in diabetes (*e.g.* wound care or end stage renal failure)
- the development of Aboriginal nursing homes
- the reintroduction of homebound individuals and/or disabled children and adults into rural and urban Aboriginal communities (*i.e.* supplying 'home/community/palliative care' within communities)
- Has led to legal action by market actors on both federal and community authority relative to disputes concerning the termination of contracts and/or defaulting on payment

Role in Aboriginal Health System and Economy

- Significant potential for economic development relative to the rise of home and community care programmatic activity
- Involves the voice of Aboriginal biomedical professional and non-professional providers

D. Other Health Care Services

Delivery structures and mechanisms

- Includes mental health services, physiotherapy, audiology, chiropractic, occupational therapy, acupuncture, speech pathology, traditional healers
- Provided by contractors either through direct FNIHB and/or community/ethnonational (contribution agreement) delivery
- Indirect delivery through private clinics
- Some development of State/community/ethnonational involvement with university-based initiatives (*e.g.* physiotherapy and occupational therapy services)
- Categorised as 'other health services' with the knowledge that inclusion in the NIHB envelope requires significant administrative and political will in the face of capped expenditures
- One of the earliest inclusions was 'professional mental health treatment for communities in at risk, crisis situations,' nevertheless, this category can include all allied health service provision, some increasingly arguing for the inclusion of 'traditional healers and their services'

Control measures

- Consistently stresses coverage under other governmental programs and/or 'third party plans'
- While unique relationships with providers exist across Canada, most often, regional/centralised authority deals with claims on a case by case basis
- Keeping this category ill-defined (*i.e.* limiting benefits)

Debates

- Constituted by ethnonational polity in 'need' and in the attempt to match both the services and health experiences of non-Aboriginal Canadians
- The notion that health services are a treaty/aboriginal/fiduciary right applies, thus extending to these services
- Professional and ethnonational concerns about the increasingly stringent delivery criteria
- Due to the fact that this benefit category can include almost any allied health service (with

increasing pressures in this regard), FNIHB attempted to remove this service from the NIHB envelope into Community Health Programs, met with significant ethnonational resistance, and did not move the program

Role in Aboriginal Health System and Economy

- Has the potential to act as a category for the inclusion of innumerable uninsured health services
- Few Aboriginal providers, yet intersect with much First Nations and Inuit activity through contractual obligations with service providers, potentially developing greater relationships and thus the potential for agenda building and lobby partnering
- Involves the voice of Aboriginal biomedical professional and non-professional providers

E. Dental Care

Delivery structures and mechanisms

- Largely indirect provision through professional contractors and/or through private clinics
- Direct provision through the involvement of dental therapists, dentists, and university-based and/or affiliated providers on salary
- Involves preventative (dental therapists and public health dentists) and curative services (private practice and clinically active public health dentists)
- Includes diagnostic; cleanings; fillings; root canals; dentures; oral surgery; orthodontics; paediatric and particular adult operating room services
- Significant involvement of professional dental organisations
- Significant interaction between ethnonational organisations, professional organisations, and service providers (*e.g.* through political/lobby partnerships and service delivery contractual obligations)
- Benefit grids are established solely through State/Professional negotiations
- Involved in 'pilot projects,' transfer and/or devolvement

Control measures

- Consistently stresses coverage under other governmental programs and/or 'third party plans'
- 'Negotiated' fee guides (*i.e.* limiting benefits)
- Medical need criteria
- Setting the number of days services can be delivered through contractors
- Predetermination of benefits relative to dental professional judgement
- Frequency and needs based approaches to care (*i.e.* limiting listed services)
- Provider audits (electronic and on-site)

Debates

- The lack of answers to the 'problem of oral health'
- The lack of service providers and preventative endeavours
- Provider complaints concerning difficulties in claims processing and control measures
- Provider abuse and over billing
- Ethnonational complaint relative to access
- Professional concerns about regional parity

Role in Aboriginal Health System and Economy

- A significant example of the intimate involvement and play of State, professional, and increasingly, community/ethnonationals interests
- Involves the strong voice of Aboriginal dental professionals
- A significant point of articulation and bridging between ethnonational polity and professional organisations
- Provides the basis for larger professional debates concerning professional dominance over service delivery and the social rights associated with access to services

F. Pharmacy

Delivery structures and mechanisms

- Indirect provision through contractors and/or pharmacies (urban, on reserve, rural)
- Direct provision by nurses and/or staff in health centres
- Structured relative to prescription, over the counter, and proprietary medicines
- Significant involvement of professional pharmacy organisations
- Formulary negotiated with pharmacy professionals with input from medical profession

- Involved in 'pilot projects,' transfer and/or devolvement

Control measures

- Consistently stresses coverage under other governmental programs and/or 'third party plans'
- Prescriptions
- Pre-authorisation
- Audits of providers (electronic)
- Tracking of client abuse through electronic and electronic assisted means (*i.e.* information systems tracking and/or the ' point of service' system, whereby the dispensing pharmacist has electronic access to the record of a patient/client and can more accurately asses abuse)
- 'Negotiated' formularies (*i.e.* limiting listed pharmaceuticals)
- 'Lowest-cost alternative' policy for prescription drugs

Debates

- Professional concerns about regional parity, unilateral formulary changes and cutbacks
- The impact of the Romanow Commission and its call for pharmacare services
- Increased discontent between Aboriginal and Professional stakeholders regarding the creation of proprietary Aboriginal pharmacy chains

Role in Aboriginal Health System and Economy

- Constitutes a significantly rising benefit
- Has much potential to grow, both in use and in economic development considerations (*i.e.* pharmacy chains)
- Demonstrates that not all Aboriginal/Professional relations are meant to advance common agendas, and can involve direct competition