Impact of Bill 20 on Health and Social Services in Region 18

Bill 20: *An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*

Committee on Health and Social Services
National Assembly
March 18, 2015

Presented by:

Mrs. Bella Moses-Petawabano, Chair
Cree Board of Health and Social Services of James Bay

Dr. Darlene Kitty, President
Council of Physicians, Dentists and Pharmacists of Region 18

Cree Board of Health and Social Services of James Bay

Conseil Cri de la santé et des services sociaux de la Baie James
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Cree Board of Health and Social Services of James Bay

March 2015

Foreword

The impact of Bill 20 is an important issue that will have serious impact on the CBHSSJB and its medical workforce, and especially the Cree and non-Cree population of Region 18. The Board of Directors and the Council of Physicians, Dentists and Pharmacists (CPDP) of the Cree Board of Health and Social Services of James Bay (CBHSSJB) have assessed this important issue and will now advocate in the best interests of the Cree Nation of Eeyou Istchee. Letters to the Minister of Health and Social Services were written and sent by the Chair of the CBHSSJB and the President of the CPDP respectively. In addition, this brief was mandated to and prepared by a committee, whose members include:

- Darlene Kitty, Family Physician Chisasib Hospital, President CPDP Region 18, Clinical Representative on CBHSSJB Board of Directors
- Jill Elaine Torrie, Assistant Director, Public Health Department
- Toby Fainsilber, Family Physician, Waswanipi CMC
- Justin Ross, Family Physician, Mistissini CMC
- Pierre Lejeune, Surveillance Officer, Public Health Department
- Carole Laforest, Chief of Medicine, Family Physician, Mistissini CMC
- Robert Carlin, Director (interim) and physician, Public Health Department
- Anne Foro, Director of Planning and Programming
- Marcellin Gangbè, Surveillance Officer, Public Health Department

They were assisted by:

- Eloi Courchesne, Strategic Communications consultant (advice and translation)
- Katya Petrov, Communications Services (layout and editing)

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Executive summary

a. The Cree Nation is an Aboriginal people of more than 18,000 most of whom live in nine communities in Eeyou Istchee (James Bay), a remote Northern region of Québec (shown on Figure 1) of around 350,000 square kilometres, two-thirds the size of France. Distances are vast, climatic conditions are severe and costs are high. The Cree face severe health and social challenges, including high rates of diabetes and respiratory disease, overcrowded housing and related social stresses.

b. The Cree Board of Health and Social Services of James Bay (CBHSSJB) is a unique institution of Aboriginal governance in health and social services. It was established pursuant to Section 14 of the James Bay and Northern Québec Agreement of 1975 (JBNQA), a treaty protected by the Constitution Act, 1982. The Cree Health Board is the only health and social services institution in Québec governed by its own statute, the Act respecting health services and social services for Cree Native persons.

c. The Cree have special treaty rights to health and social services under the JBNQA. Section 14 explicitly requires Québec to recognize and take account of the exceptional difficulties of providing health and social services in the North. This undertaking requires measures to facilitate recruiting and retaining staff by ensuring working conditions and benefits sufficiently attractive to encourage personnel from outside Region 18 to accept posts for extended periods.

d. In 2005 and again in 2012, the Cree Health Board concluded an Agreement with Québec to resolve certain issues concerning Section 14 of the JBNQA. This Agreement requires the implementation of the Board's Strategic Regional Plan and provides a multi-year Funding Framework to do so. This Strategic Plan focuses on the delivery of first-line health services, including family medicine, and social services in the Cree communities.

e. The unique cultural, geographic, political and legal factors of Eeyou Istchee and the CBHSSJB are crucial to understanding how health and social services must be organized and delivered. Since the health status of the Cree is one of the worst in Quebec, our family physicians and other staff provides accessible, high quality care for the population of the region that aims to improve this in this context.

f. The Cree Health Board faces enormous challenges in recruiting and retaining qualified medical personnel in the Cree communities. These challenges include high staff turnover, related largely to difficulties associated with the Nordic conditions, isolation and distance.

g. Despite these challenges, the Cree Health Board has made important progress in recent years in recruiting and retaining physicians through a combination of full-time, part time and temporary positions. This has made possible the improvement of first-line services in the Cree communities.

h. The CBHSSJB and the CPDP of Region 18 oppose Bill 20 In its current form, as this legislation would reverse these gains. Although intended to improve access to family medicine, Bill 20 would have the opposite effect in Region 18. Its requirements regarding minimum caseload and working weeks do not take account of the special challenges of Region 18, which relies on a large complement of part-time and temporary physicians, some from outside Québec.

i. Bill 20 will cause many physicians to leave Region 18, reducing access to family physicians. Such a result is unacceptable in a remote region like Eeyou Istchee that is already facing severe challenges both in health conditions and in recruiting and retaining physicians. It will also necessitate sending Cree patients to the South, at much greater cost, for services no longer available in the Cree communities.

j. Any measures having such adverse effects would be contrary to Québec's treaty obligations toward the Cree in Section 14 of the JBNQA. They would also be inconsistent with Québec's undertakings in the Cree-Québec Health Agreement of 2012. Given these effects, Québec is under a constitutional duty to consult and accommodate the Cree regarding the measures proposed by Bill 20. No such consultation has taken place.

k. The Cree Health Board wishes to find solutions for these issues. It is prepared to discuss amendments of Bill 20 in order to reflect Northern realties, correct the lack of medical personnel in Region 18, and respect Cree treaty rights under the JBNQA. In the absence of such solutions, Region 18 and the physicians who work there should be excluded from the application of Bill 20.

1. Introduction

The Eeyou Nation of Eeyou Istchee, with the guidance of Tsheymendo, is committed to developing responsible, healthy communities in such a way as to result in:

- Individuals who are well-balanced emotionally, spiritually, mentally and physically,
- Families that live in harmony and contribute to healthy communities,
- Communities that are supportive, responsive and accountable, and
- A healthy environment that will continue to produce traditional resources

in the context of a strong national Eeyou government that: exercises complete jurisdiction and control over the delivery of quality comprehensive, integrated, inter-agency health and social services; that promotes Cree human resources development; and that applies adequate resources to address our needs with a strong expression of the Cree values of respect, honesty, loving, caring and sharing[1].

The Cree Board of Health and Social Services of James Bay (CBHSSJB) has jurisdiction under Section 14 of the JBNQA for health and social services in Region 18, serving a population of almost 17,000 resident Cree, and a small minority of non-Cree, across nine remote communities. Its facilities include the regional hospital in Chisasibi and nine Community Miyupimaatisiiun Centres (CMCs, similar to CLSCs).

Interventions by health professionals aim to treat and improve the significantly worse issues, such as diabetes, obesity, hypertension and mental health issues as shown in the section describing health status and social issues. Aboriginal health and social issues are unfortunately more prevalent than in the general population across Canada, requiring a culturally safe approach to care[2] [3].

The medical care is given by a team of family physicians and specialists in collaboration with nurses and other health care team members. Given our organization and structure of medical services here, we know that Bill 20 will severely and negatively affect our ability to provide medical services, and this will affect access and quality of care.

The recent tabling of Bill 20 has raised serious concerns for the Board of Directors of the CBHSSJB and the Council of Physicians, Dentists and Pharmacists of Region 18 because its obligations will lead to a major and unacceptable loss of family physicians from our Region. The impact of Bill 20 on health care services, physician workforce and particularly on family physicians are detailed here so that our context, realities and challenges can be appreciated in light of the tabling of Bill 20 and the preparation of its regulations. The CBHSSJB and CPDP of Region 18 oppose Bill 20 in its current form. An exemption or adjustments to accomodate our Region is requested so that we can continue to give accessible, quality care.

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[1] CBHSSJB. Guide for intervenors and users of the patways to Miuupimaatisiiun services hereby referred to as Code of Ethics. Approved by the Board of Directors March 19, 2009. Accessed March 16, 2015 at: http://www.creehealth.org/sites/default/files/Code%20of%20Ethics_0.pdf

[2] http://www.nccah-ccnsa.ca/368/Cultural_Safety_in_Healthcare.nccah.

[3] Kitty, D. 2014. Indigenous Cultures and Health In Canada: A Primer For Rural Physicians And Health Care Professionals (Chapter 1.3.4). In WONCA Rural Medical Education Guidebook, Section 1.3 Gender and Cultural Considerations in Rural Practice. Retrieved September 8, 2014 from: http://www.globalfamilydoctor.com/groups/WorkingParties/RuralPractice/ruralguidebook.aspx

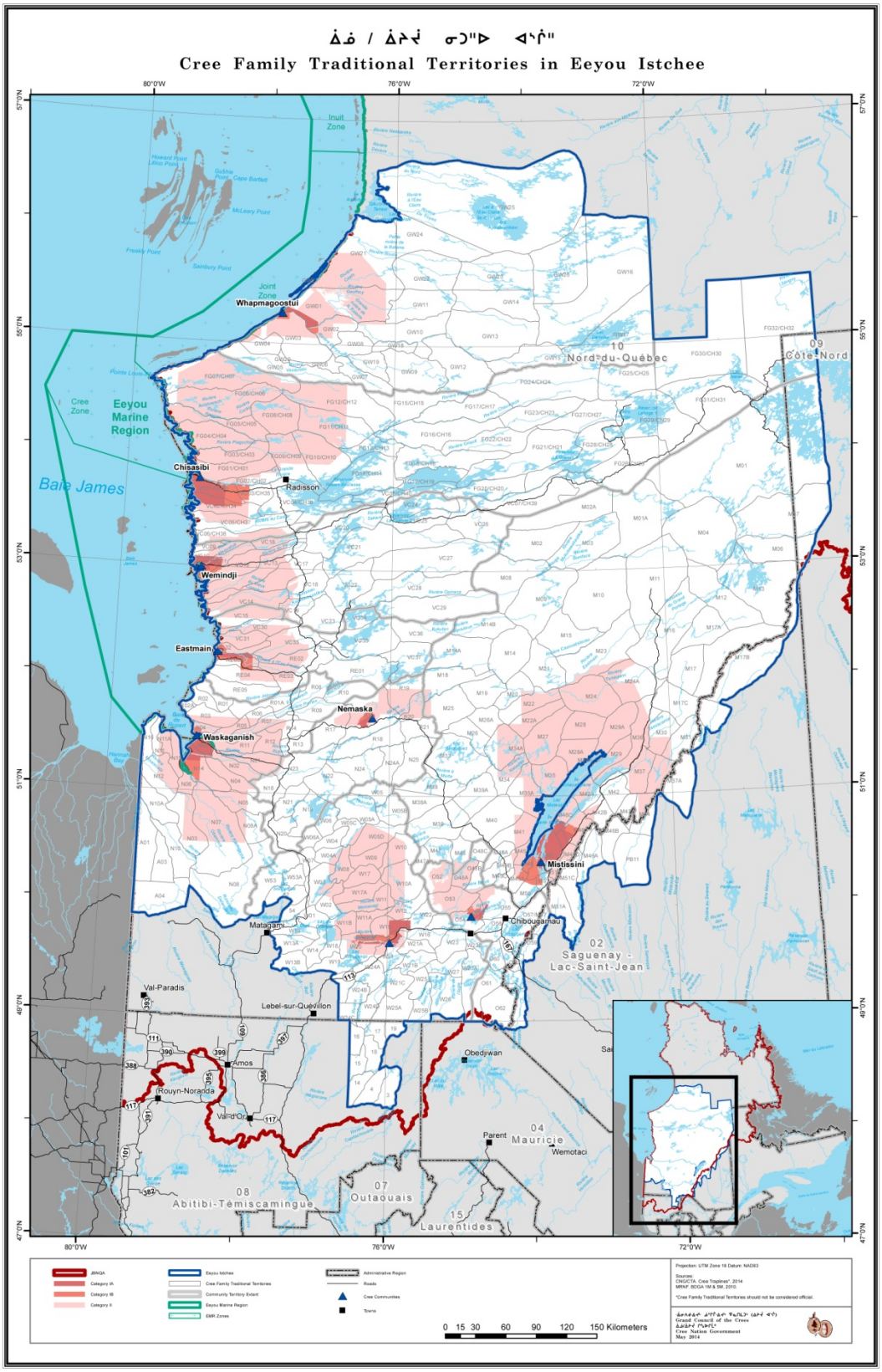
2. The Crees of Eeyou Istchee

2.1 Background

Known in Cree as Eeyou Istchee ('the land of the people'), the Cree Territory of James Bay has been inhabited for more than 5,000 years. The immediate ancestors of today's Cree have been living in the territory during the past two millennia[4], providing for their families through hunting, fishing and trapping. As soon as industrial interests targeted the region's lands for mining, hydro development and forestry, almost overnight most Cree families went from living nine months of the year on territories they controlled into a largely sedentary lifestyle in permanent communities. This rapid southern intrusion had the effect of changing many of the social factors which determine and underlie the health of the Cree, which today does not compare favourably with that of Quebec.

[4] Girard R et coll. 2012. Les Cris d'Eeyou Istchee avant le XVIIe siècle. In, Histoire du Nord-du-Québec. Québec: Presses de l'Université Laval, pp. 101-139.

Figure 1. The territory of Eeyou Istchee



2.2 Geographic challenges

The territory of Eeyou Istchee covers the major watersheds in Northern Québec which drain into James Bay and southeastern Hudson Bay. Its 350,000 square kilometer, between the 49th and 55th parallels, are the traditional Cree territory recognized in the James Bay and Northern Quebec Agreement, a treaty protected by the Constitution. Today, the territory is administered through the Cree Nation Government (Category II lands) and the newly created Eeyou Istchee James Bay Regional Government (Category III lands), which is controlled jointly by the Cree and Jamésian administrations. In addition, nine Cree First Nations and four Jamésien municipalities exercise local jurisdiction. With Nunavik, this area comprises the Nord du Québec Administrative Region 10. There are two Quebec health and social services regions in Eeyou Istchee: the Nord-du-Québec (Region 10) and the CBHSSJB (Region 18). Region 18 comprises the Category I and II lands of the nine Cree communities, which exist inside the boundaries of the enormous health Region 10.

The Cree communities are all accessible by road except Whapmagoostui, on the Hudson Bay coast, which has no road access but is accessible by air or for four months each year, by sea.

Table 1. Population of Cree communities and distances to referral centres

Community	Population (mid-2014)	Distance to (km)		
		LG** or Chib†	Val d'Or	Montreal
Whapmagoostui (fly-in)	934 Cree (+800 Inuit)	214 to LG	796 (flight)	1,124 (flight)
Chisasibi	4,391	97 to LG	934	1,466
Wemindji	1,452	158 to LG	862	1,394
Eastmain	747	n/a	700	1,232
Nemaska	794	n/a	641	1,033
Waskaganish	2,242	n/a	598	1,130
Waswanipi	1,811	135 to Chib	270	820
Oujé-Bougoumou	818	47 to Chib	402	732
Mistissini	3,618	90 to Chib	495	795

*all communities have road access except Whapmagoostui

** La Grande Airport †Chibougoumau n/a means these communities do not use LG or Chib in transferring patients

Referral centres are hospitals in Chibougamau, Val d'Or, and Montreal. Each community is served by Air Creebec via Chibougamau, Val d'Or and Montreal, while Air Inuit also connects through Whapmagoostui, La Grande and Montreal. Delivery of health and social services is circumscribed by this geography and the vast distances between points of service.

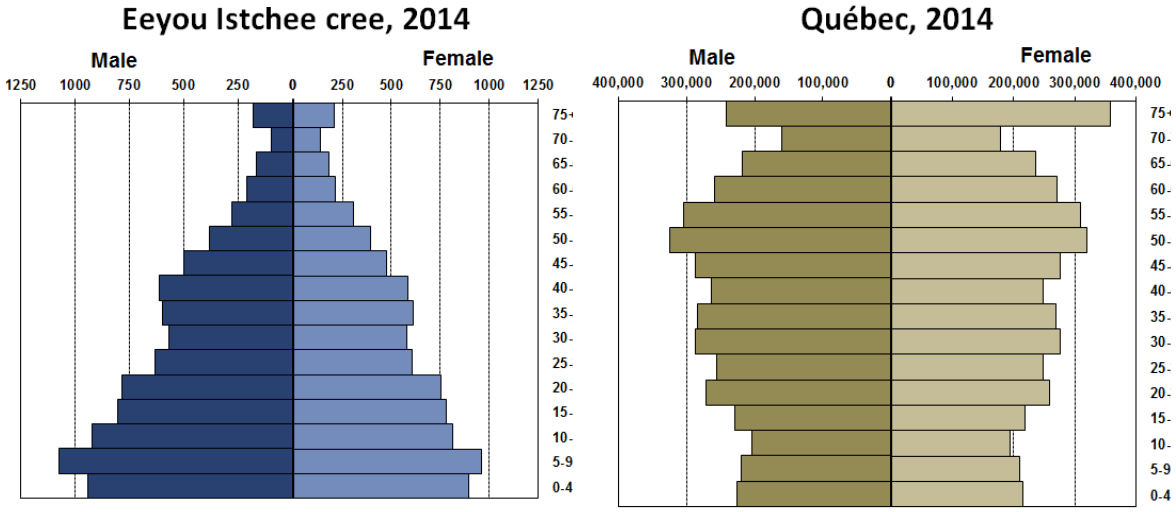
When patients are sent to a referral centre, either, emergently, urgently or routinely, to see a specialist, have surgery, for diagnostic tests, or for other reasons, the time, distance and mode of transportation (regular flight, driving or medivac plane) has to be taken into consideration by the physician and the health care team.

2.3 Population profile

In mid-2014, the official population of Cree Beneficiaries of the James Bay and Northern Québec Agreement who were resident in Eeyou Istchee was 16,807, with almost 60% living in the five coastal communities and just over 40% in the four inland ones. Up to 2014, the five-year average rate of growth of the beneficiary population was 2.22% per year. A baby boy born in Eeyou Istchee between 2009 and 2013 is expected to live 76.4 years (Quebec 80.0); for a baby girl, life expectancy is 78.3 years (Quebec 84.0). Female life expectancy has declined compared to previous periods. Cree men continue to outnumber Cree women.

The Cree population is young and, in general, comparable to the First Nations population in Canada[5]. Individuals aged 0 to 14 comprise 30.5% of the region's Aboriginal population[6], while those aged 65 and over comprise 5.8% (Quebec, 15.9% for each). Within the communities of Eeyou Istchee, around 50% of the population is under the age of 25 and the educational levels of those no longer in school is low. This means that there is a very high ratio of those who are dependent compared to other adults (90.1%), and limited opportunities for an important group who should have become independent but who lack effective education and training. This demographic profile has a great deal to do with the social challenges faced in the communities.

Figure 2. Population Profile of the Crees of Eeyou Istchee



Note: Eeyou Istchee's underdeclaration of the 0-4 years was corrected using the MSSS birth figures

Sources: -MSSS, JBNQ agreement Cree beneficiary list, July 1, 2014
-MSSS, population projections produced by the ISQ, January 2010

[5] http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm

[6] Due to late registration of those aged 0 to 3, this proportion might be closer to 33%.

3. Political and legal context

The *James Bay and Northern Quebec Agreement* (JBNQA) treaty of 1975 and *An Act respecting health services and social services for Cree Native persons,* CLQR chapter S-5, together constitute the treaty and legal framework for the Cree Board of Health and Social Services of James Bay (CBHSSJB).

Under Section 14 of the JBNQA, the CBHSSJB is responsible for the administration of health and social services on the Category I and II lands of Eeyou Istchee, James Bay, Quebec (Region 18). Under the Cree-Quebec Health Agreements of 2005 and 2012, the CBHSSJB carries out this responsibility in accordance with its Strategic Regional Plan, vision and orientations. In consequence, the CBHSSJB addresses and prioritizes the state of health and the needs of the population and gives its services accordingly.

The Board of Directors of the CBHSSJB takes advice on clinical matters through the Clinical Representative on the Board and the Council of Physicians, Dentists and Pharmacists (CPDP) of the CBHSSJB (Region 18). The explanation and impact of Bill 20 as tabled in its current form, were presented to the Board of Directors at a Special Board of Directors meeting on January 30, 2015.

Therefore, the CBHSSJB intends to advocate in the best interests of the Cree, to protect the health care resources and support the family physicians who work in Eeyou Istchee (Region 18). The Cree have special treaty rights to health and social services under the JBNQA. Section 14 explicitly requires Québec to recognize and take account of the exceptional difficulties of providing health and social services in the North. This undertaking requires measures to facilitate recruiting and retaining staff by ensuring working conditions and benefits sufficiently attractive to encourage personnel from outside Region 18 to accept posts for extended periods.

In 2005 and again in 2012 the Cree Health Board concluded an Agreement with Québec to resolve certain issues concerning Section 14 of the JBNQA. This Agreement requires the implementation of the Board's Strategic Regional Plan and provides a multi-year Funding Framework to do so. This Strategic Plan focuses on the delivery of first-line health services, including family medicine, and social services in the Cree communities.

Any measures having such adverse effects would be contrary to Québec's treaty obligations toward the Cree in Section 14 of the JBNQA. They would also be inconsistent with Québec's undertakings in the Cree-Québec Health Agreement of 2012. Given these effects, Québec is under a constitutional duty to consult and accommodate the Cree regarding the measures proposed by Bill 20. No such consultation has taken place.

4. Concerns of the Council of Physicians, Dentists and Pharmacists (CPDP) of Region 18

The CPDP of the CBHSSJB, in carrying out its functions, must take into account the necessity of providing adequate services to the Cree beneficiaries and non-Cree residents, the organization of the institution and the resources available in the institution.

Therefore, in order to comply with its legal obligations as enumerated in the Act, as well as in its by-laws to address the quality of care and services given to the population served by its members, the CPDP, through its Executive Committee, must review and address the serious concerns raised by Bill 20. The result of the Executive Committee's review and deliberation on the impact of Bill 20 was presented to the Board of Directors at a special meeting on January 30, 2015.

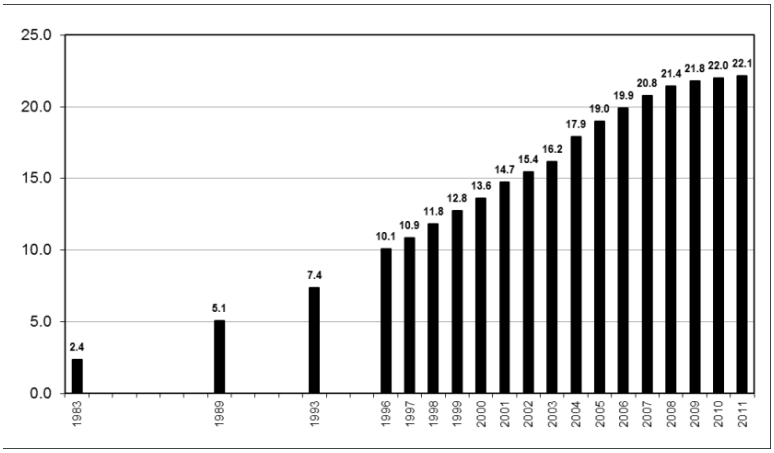
Subsequently, the impact of Bill 20 on medical services for Region 18 was reviewed at a Regular General Assembly of the CPDP which was held on March 3, 2015. Following this discussion, the CPDP members unanimously opposed, by resolution, Bill 20 in its current version. The resolution also directed that a letter be sent to the Minister of Health and Social Services to express the CPDP concerns, to request an exemption and to advocate for the preservation of medical service delivery to the population living in Region 18. The Board and CPDP of the CBHSSJB agreed to prepare this brief to be presented to the Health and Social Services Committee of the National Assembly.

5. Health and social issues affecting the population

With a few exceptions, such as cancer and vaccination rates, the health status of the Cree population does not compare favourably with that of Quebec. These differences create greater demands on the health care system in general and on family physicians who are responsible for care, while making the delivery of that care more complex. The population's poor health status manifests in the demands on clinical services especially for: diabetes and other chronic diseases; dependency issues, along with the traumas (including residential school experiences) and psychosocial sequelae associated with them. New social tensions now exist within a community which was previously homogenous and financially poor but is now living with growing social and economic inequalities.

The change in health status of the Cree, and its current decline in some areas, has been part of the transformations which have taken place in Eeyou Istchee within only two generations and which now show up as population-level trends and as individuals under care by family physicians. Diabetes rates have been doubling every ten years since the 1980s and in 2011, the raw rates were at 22.1%. In 2008-2009, the standardised rate was 3.4 times higher than Quebec's. Between 2009 and 2013, Cree mortality from endocrine and metabolic diseases was 2.3 times higher than Quebec's. There is some regional variation apparent, as higher rates of diabetes occur in Cree communities that are closer to southern centres.

Figure 3. Crude prevalence (%) of diabetes among Crees aged 20 years and over, Eeyou Istchee, 1983 to 2011



Note: 1983, 1989 and 1993 rates were initially reported for 15 years and over. The rates presented here were corrected to 20+.
Sources:- 1983 data from Thouez et al. (1990).
- 1989 data from Brassard et al. (1993).
- 1993 data from Véronneau and Robinson (1993).
- 1996 to 2011: CDIS, 2012-05-18 extraction + multiple correction reports
- MSSS, James Bay Agreement beneficiary list, estimates for December 31st of each year

In 2012, the Cree crude birth rate was double that of Quebec's, and the total fertility index up to 2012 was almost double. Diabetes adds great complexity to pregnancy care in the region. In 1981, 1% of pregnant women had diabetes but by 2011, it had climbed to 14.8%. Gestational diabetes rose from 12.8% of pregnancies in 1999, to 27.5% in 2010 and 2011. One consequence of this is that over 40% of pregnancies require that the family doctor treats diabetes as part of the maternal care.

The challenge of diabetes is very long-term. In 2011, clinics were working with 2,095 diagnosed cases with around 100 new patients being diagnosed each year. In 2011, 11% of those with

diabetes had been diagnosed more than twenty years making them at risk of other complications. The average age of people with diabetes was only 51.5 years, and the age of diagnosis was down to 39.8 years of age, from 48 years in 1989. Glycated haemoglobin tests in 2010 or 2011 showed one-third of people with diabetes had maintained target levels of control, another third had elevated levels, and the final third had very high levels (> 9.0%).

Table 2: Chronic diseases and risk factors

Item	Region 18	Quebec	Source
Metabolic syndrome			
Diabetes (prevalence)	28.4%*[7]	7.6%	Plante et coll. 2012. *Surveillance of Diabetes in Eeyou Istchee (taux ajustés selon l'âge)*
Dialysis and predialysis treatments (number of events, Chisasibi Hospital only)	2964	ND	CBH, *Annual Report 2011-2012*
Adjusted mortality rates – Circulatory system, 2005-2008	207 per 100 000 persons	192 per 100 000 persons	INSPQ. 2011, *Portrait de santé du Québec et de ses régions*
Respiratory system			
Adjusted mortality rates – Respiratory system, 2005-2008	119* per 100 000 persons	64 per 100 000 persons	INSPQ. 2011, *Portrait de santé du Québec et de ses régions*
Smoking, 12 years and +, 2003	45.7%*	25.9%	INSPQ. 2006, *Portrait de santé du Québec et de ses régions*
Osteoarticular system			
Arthritis or rheumatism, 12 years and +, 2003	6.5%*	14.0%	INSPQ. 2006, *Portrait de santé du Québec et de ses régions*
Backaches other than fibromyalgia and arthritis, 12 years and +, 2003	10.4%*	16.9%	INSPQ. 2006, *Portrait de santé du Québec et de ses régions*
Mental health			
Population that does not consider itself to be in good mental health, 12 years and +, 2003	8.1%*	3.6%	INSPQ. 2006, *Portrait de santé du Québec et de ses régions*
Population reporting high alcohol consumption 12 times a year or more, 12 years and +, 2003	28.4%*	16.7%	INSPQ. 2006, *Portrait de santé du Québec et de ses régions*
Data from only one of Region 18's communities[8]			
Substance abuse: alcohol, marijuana or cocaine	42.4%		Medical files: 2009-2011
Mental disorders	36.5%		Medical files: 2009-2011

[7] *: significant difference with Quebec

[8] This data, based on only one community in the region, has not been compared with provincial data.

Table 3: Hospitalisations, 2006-2009

Item	Region 18	Quebec
	Adjusted rates per 10,000 persons	Adjusted rates per 10,000 persons
Cancer	55	61
Digestive system diseases	203 (+[9])	81
Traumas	123 (+)	63
Cardiovascular system diseases	257 (+)	120
Osteoarticular system diseases	76 (+)	37
Respiratory system diseases	250 (+)	77
Genitourinary system diseases	88 (+)	42
All causes	1,780 (+)	792

Source: INSPQ 2011, *Portrait de santé du Québec et de ses régions 2013*

The most prevalent complication among Cree with diabetes is kidney disease, with roughly half of all patients with diabetes having kidney disease and patients with diabetes making up roughly half of all patients with kidney disease in the region. In November 2014, family physicians in the region were caring for 293 patients in the pre-dialysis program. They were also caring for 53 patients receiving haemodialysis and five patients receiving peritoneal dialysis, along with 19 who were receiving haemodialysis in Chibougamau but living in their communities.

Diabetes also compounds the rates of other chronic diseases such as cardiovascular disease (CVD). Now the second cause of mortality among men, hospitalisations for CVD were 2.1 times the Quebec rate (standardised) up to 2013, almost double the rate up to 2003.

Dependency issues, along with the traumas and psychosocial sequelae associated with them, place great demands upon family physicians because the cases are often highly complex and appropriate integrated programs are just being developed. There are two dependency issues: demographic and problematic use of alcohol and drugs. Half the population is under the age of 25. One in five babies is born to a teenage mother. Concomitant are low levels of education, which, in the clinic, mean that mean that 37.9% of mothers have less than 11 years of schooling (7.5% for Quebec). This is considered a risk factor for optimum maternal and infant health.

Problematic use of alcohol and drugs shows up dramatically in hospitalization for self-harm in young females. In the period up to 2013, rates were 4.2 times higher than in Quebec (standardised) and increasing. Similarly, in the period up to 2013, hospitalisations following an assault were 14 times higher than in Quebec, having doubled over ten years. It must be realized that since the CBHSSJB does not have electronic administrative records except for Chisasibi Hospital, these rates only reflect the most serious cases requiring transfer to 2nd and 3rd line services while the majority of cases are being dealt with in the local walk-in clinics by family physicians.

New social tensions within a community which has and is experiencing rapid change will be seen in various guises in the clinic, and are behind the well-known, although poorly documented observation, that a great deal of clinical work in the region is dealing with underlying mental health issues. Many children are involved with Youth Protection Services (YPS). In 2012-2013, YPS dealt with 1,827 cases and retained 74%. That same year, a total of 697 children were

[9] +: regional value is significantly higher than that in the rest of Quebec, p-value at 0.01.

waiting to be evaluated, 544 of them because they were from familial situations of neglect. In a 2007-2008 study of 506 adults, 57% had a history of depression, 51% of anxiety, 31% of violent behaviour, and 17% of suicide attempts. Of this group, 47% reported having experienced physical abuse and 30% reported being sexually abused in their lifetime. These underlying issues often or eventually manifest and impact the clinical care of our patients in Eeyou Istchee.

6. Health care services in Eeyou Istchee

Medical services are given primarily by family physicians working at the regional hospital in Chisasibi and in Community Miyupimaatisiiun Centres (CMCs) in each community[10].

The CMC's offer the same services as CLSC's elsewhere in Quebec, as well as dentistry, pharmacy and Non-Insured Health Benefits. Patients can access acute, urgent and emergent care (frequently involving a social issue) on a walk-in basis in the community CMCs and in Chisasibi Hospital. Pre-hospital emergency services are provided by the First Responders team in all communities and medical personnel respond to civil security emergencies such as major accidents and forest fires more frequently than in the south.

Chisasibi Hospital is a 29-bed regional hospital, comprised of 22 acute beds (including 2 pediatric and lodging beds) and 7 chronic beds, with an occupancy rate of 68%[11]. The hospital provides haemodialysis, digital radiology services, a laboratory and pharmacy, while telehealth services are being established now. The Mistissini CMC functions as a day hospital with haemodialysis and laboratory services, while telehealth and radiology services are being initiated.

When a patient requires secondary or tertiary services not available in the region, they travel by road, regular plane (if routine or less urgent) or medivac (if condition urgent or emergent) to these southern centres.

Corridors of care have been established with Val d'Or, Choubougamau and Montreal, depending on the secondary or tertiary service needed. Our family physicians respect these corridors and aim to attain these services at our designated referral centres, considering the patient's medical condition, urgency, and required procedures, diagnostic tests or treatments.

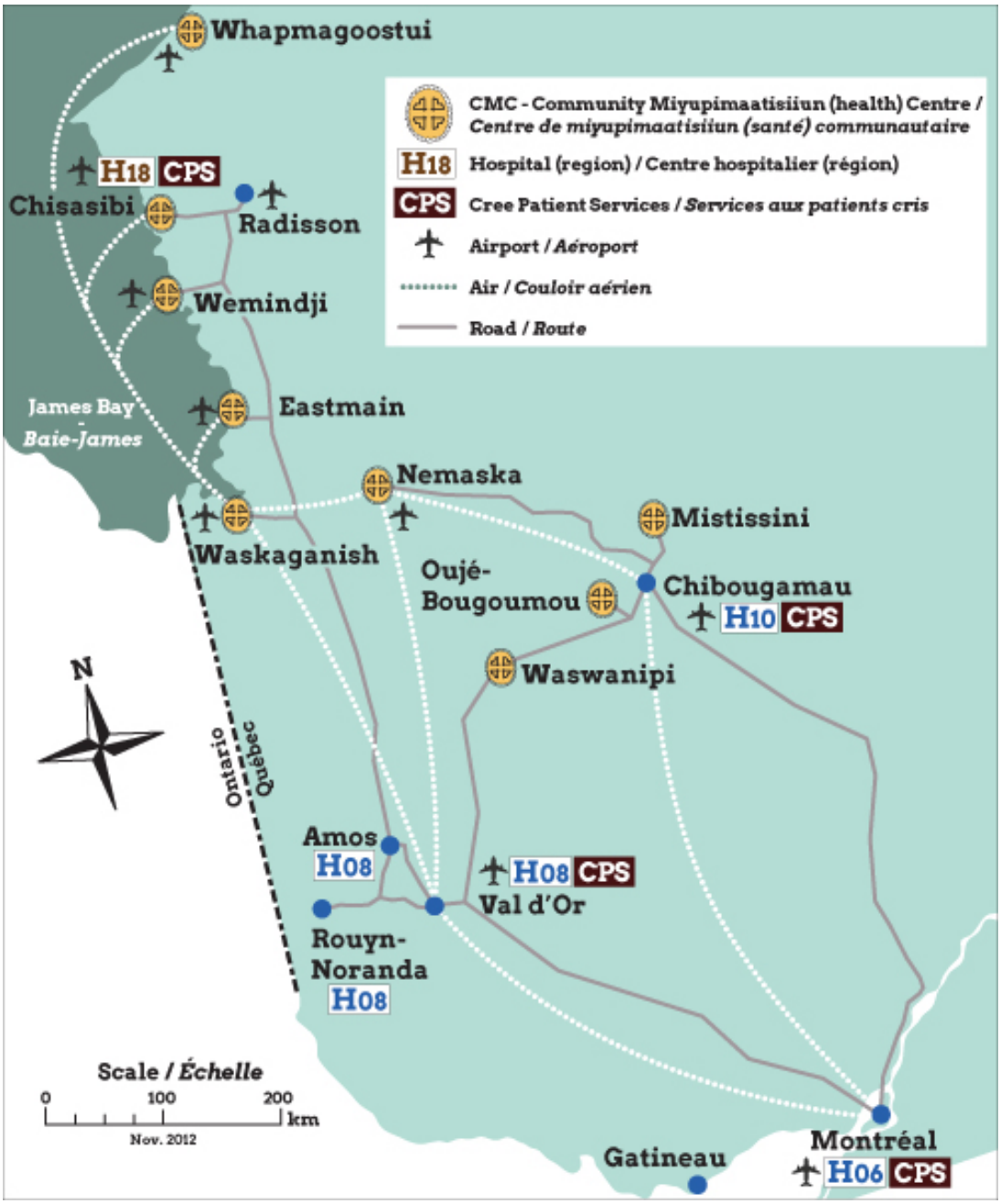
Referral Centres:

1. Chibougamau Hospital – primary centre, receives transfers from Waswanipi, Mistissini, Oujé-Bougoumou, and occasionally Nemaska
2. Val d'Or Hospital – secondary centre, receives transfers from coastal villages and Nemaska, as well as Chibougamau Hospital
3. Montreal hospitals – tertiary centres (MGH, RVH, MCH, Ste-Justine), receive transfers from all Cree communities and secondary centres

[10] Miyupimaatisiium refers to the state of having physical, spiritual and mental health that makes it possible to carry out daily tasks, appreciate the benefits of nature and maintain good relations with close and extended family and with friends

[11] One acute care bed is occupied permanetly for respite care.

Figure 4. Map of Region 18, Cree Communities, CBHSSJB Clinics and Referral Centres



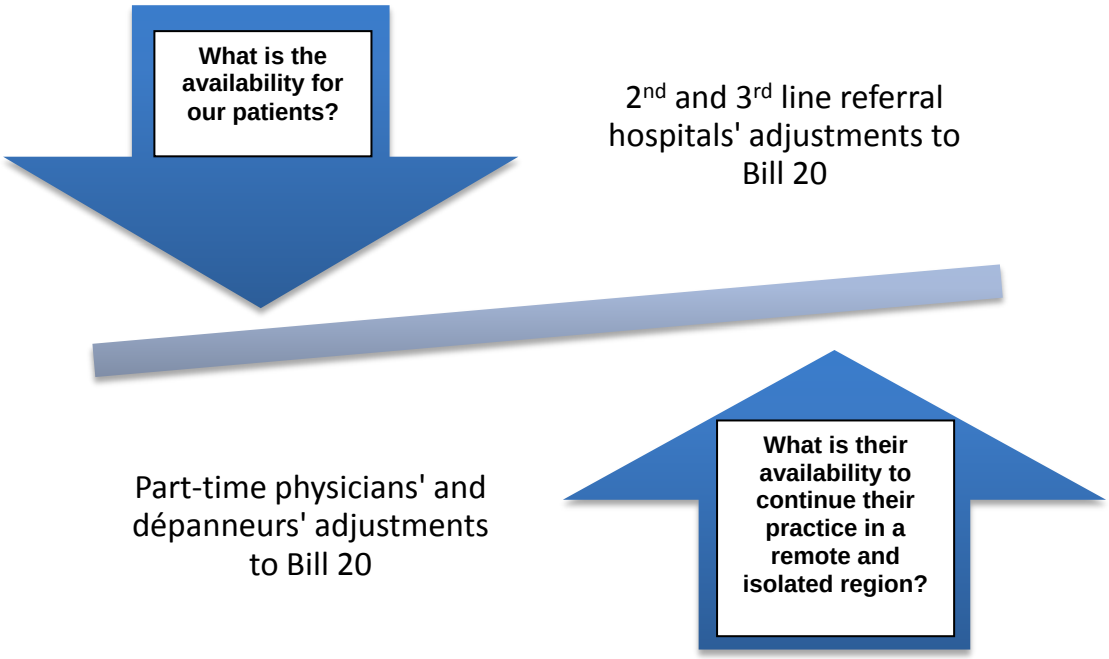
Visiting specialists come to Region 18 to see patients in consultation or follow-up and, depending on the specialty, do minor procedures. They may arrange for diagnostic tests that are not available in Region 18, surgeries and follow-up appointments in the secondary or tertiary centres.

7. Impact of Bill 20 on health care services

In Region 18, Bill 20 is expected to have a direct impact on health care services for patients since there will be reduced non-urgent services, particularly chronic disease and preventive care (described below). The loss of family physicians is also highly likely and is further explained in the last section. Region 18 is also expected to suffer indirectly from the impact of the Bill on the secondary and tertiary care centres which make up our corridor of services.

As stated in correspondence addressed to the MSSS, basic medical services in Region 18 are in a fragile state[12].2). The following diagram illustrates the double pressure that Bill 20 would exert on this already fragile state. On the one hand, for hospitals receiving patients from our region, physicians adapting to Bill 20 are likely to opt for less complex patients, thereby increasing their caseload. On the other hand, part-time and dépanneur physicians will seek to practice in regions with less constraints, related both to the geographical characteristics of our region and the requirements of Bill 20.

Figure 5. Impact of Bill 20 on the Corridors of Care of the Remote, isolated northern regions



7.1 Chronic disease management and preventative medicine will have lower priority

With fewer doctors working in Region 18, the CBHSSJB will have to ensure coverage for essential services (walk-in clinic, emergencies, inpatient care and haemodialysis) as a priority. Chronic disease management and preventive medicine would be significantly reduced or eliminated from the physician's schedule because the remaining physicians must ensure coverage of all the essential services. This will negatively impact care of patients with diabetes, high risk pregnancies, other medical conditions and mental health issues that require close monitoring

[12] Boulanger, N. et Marcoux, L. (2015). Administrative correspondence no X to Dr. Groulx. Analyse des implications de la *Loi 20* pour les régions nordiques et isolées (pp. 3). Québec : DRAMU région 17 et DMSA, DRAMU région 18.

for complications and treatment. This longitudinal follow-up would no longer be possible for our already isolated and vulnerable patient population of Region 18.

7.2 Cree Non-Insured Health Benefits costs will increase as a result

A significant aspect of health care for the Cree is covered under agreements made with the MSSS and Québec for non-insured health benefits (NIHB). This includes medications, medical transport, vision care, hearing aids, dental care and repatriation of the deceased. In particular, medical transport and medications entail the highest costs, as well as accommodations and escorts for patients when they are sent down south for their medical appointments. Family physicians prescribe most of these non-insured health benefits and they recognize that it entails significant costs. However, considering that the population is increasing, that health and social issues remain very significant and that there are unavoidable costs such as medivacs, these costs will continue to rise. If Bill 20 is implemented in its current form, the drastic loss of physicians, the impact on health services in Region 18 and the increased need for secondary and tertiary care will necessarily drive NIHB costs higher.

7.3 Culturally-safe care will be compromised

One of the exceptional aspects of medical practice in Eeyou Istchee is the cross-cultural component and the challenges in providing health services for the Cree population. Family physicians and other health professionals working in Region 18 and elsewhere must learn and give culturally safe care, which engages the Aboriginal patient as an active participant of their care, considering the historical, political and social contexts of their lives, family and community. Family physicians and the health care team must appreciate these contexts and Cree traditions to give culturally safe and effective care[13].

First, among all residents of the region, Cree and non-Cree, the Cree language is the mother tongue of 90%, and it is the language used in 86.7% of all households. Most people over 60 years and children too young to have started school speak neither English, nor French. For those who do speak English or French as a second language, competencies vary. Family physicians have to work with a Cree interpreter or learn some Cree to communicate with these patients. They also have to contend with major temporal, organizational, and cultural differences from the rest of Quebec. On the other hand, it is the Cree culture that provides a complementary adjunct to care for our Cree patients.

Specifically, the experience and commitment of our family physicians and their interest in Aboriginal health has contributed in building our medical team and retention efforts, as well as addressing the needs of the Cree population which has the worst health status in Quebec. This expertise will certainly be lost if family physicians leave the Region, as detailed below.

[13] National Aboriginal Health Organization. 2008. Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators. Ottawa.

8. Physician workforce in Region 18

8.1 Department of medicine

The Department of medicine is responsible for providing users with consistent, quality services which result in services which are medically integrated, culturally safe, effective and accessible to the whole population, while maintaining a medical presence in the communities (service points) that meets the needs. The Department emphasizes a philosophy that appeals to the versatility of each family doctor and specialist which, through their varying expertise, addresses the needs of the population.

We hope to preserve this diversity of knowledge and skills, including culturally safe practices. The following paragraphs outline the various aspects of the family physicians' work, as well as the impact of Bill 20 on professional and personal motivation, and most importantly, the access and quality of care for our patients, families and communities in Region 18.

8.2 Roles and schedules of family physicians

Family physicians are responsible for the delivery of health care in all nine Cree communities and are the sole physicians responsible for:

1. Emergency care
2. On-call coverage - onsite and by phone (for communities without a physician)
3. Medivacs - by air or land ambulance transfers to primary, secondary and tertiary centres
4. Hospital admissions and inpatient care in Chisasibi
5. Haemodialysis - in Chisasibi and Mistissini, concurrent with the MGH Nephrology team
6. Outpatient clinics, including community health (CLSC/CMC), external (walk-in) clinics
7. Home Care
8. Palliative Care
9. Collaborative case discussion and treatment with nurses
    a) Local (physician present)
    b) Other Community - Patients in another community without a physician are covered by Chisasibi and Mistissini physicians on-call
10. Teaching medical students and family medicine residents
11. Research to better life for the Cree people.

First-line care exists in each community 24 hours/day, 7 days/week, 365 days/year. Every community has a deputy chief family physician who is responsible for scheduling both permanent and dépanneur physicians to accommodate for the needs and medical care of patients. This includes chronic disease management, prenatal care, well-baby and well-child care, mental health, youth care and emergencies. Physicians share coverage of patients in a "GMF" style, which contributes to access to care. Our family physicians focus on caring for the patient as a whole, addressing patients' multiple physical and psychosocial problems. Physicians working in the territory supervise the care of nurses with the expanded role, whose scope of practice is directed by our therapeutic guide and collective prescriptions, which nurses consult to treat basic medical conditions, and discuss with the physician as needed.

When there is a shortage of family physicians in the community and territory, emergency care is given highest priority. Chisasibi Hospital requires at least five physicians to cover the emergency room, inpatient care and haemodialysis, whereas Mistissini Clinic needs at least 4 physicians to cover the emergency room and haemodialysis. There are two physicians on-call at all times in Chisasibi and Mistissini, the two largest communities. A shortage of physicians has the

immediate impact of closing the CMC/CLSC clinics in the communities for programs such as diabetes and mental health, leaving no physician coverage in the smaller communities; reducing the amount and quality of teaching students and residents.

Although it has taken many years of active recruiting strategies to hire family physicians and these efforts have helped to build our medical team. However, Bill 20 and its requirements can be expected to negatively impact our current medical workforce. This will likely cause a major shortage of family physicians, which will lead to reduced access and quality of care for patients with acute conditions and chronic diseases, and a negative effect on recruitment and research.

8.3 Specialist coverage needs consideration

Since there are no specialized medical staffing plan assignements (PEMS) except for one psychiatrist position and two community health positions assigned to Region 18, we are preoccupied by specialist coverage. In recent years, we have been experiencing significantly reduced specialist coverage and this is very difficult to resolve.

Some specialists do visit the Cree communities one to four times a year, to do consultations, give clinical care and follow-up to our patients. These specialists also provide collaborative advice in person or by phone, to our family physicians. In working with specialists, our family physicians help to coordinate these consultations, give concurrent care and do associated administrative work and telephone calls, which is time-consuming but necessary.

During periods when certain specialists are not on the territory, some second- and third-line services are provided by family doctors, to a limited extent, such as management of psychiatric patients (adults and pediatric), care of hospitalized patients, trauma and monitoring of haemodialysis patients, high-risk prenatal care, complex diabetes management, Internal medicine and geriatric issues.

Recently, telehealth services have begun to be developed, and may in future, contribute to reducing the need to send patients south. However, currently, there is a need for increased medical resources, that is family physicians, to coordinate specialist care through an integrated, collaborative approach along the corridors of care. For those specialists who provide care to patients from the Cree communities, consideration must be given regarding the timeliness to consult on a patient in the emergency department within two hours, as required in Bill 20. This is not possible given the time needed for transfers by land or air ambulance to the hospital in the south. Also, if Bill 20 is passed into law in its current form, how their work in the south impacts that aspect of their practice will also affect their ability to provide specialist coverage for Region 18.

8.4 Public Health physicians will be affected

Some of our part-time family physicians also work in public health along with two community health specialists. Their experience working in Eeyou Istchee as primary care physicians helps in adapting our public health programs and services to the distinctive clinical organization and cultural realities of the region. They contribute to public health work that:

- Ensures that traditional culture and foods are promoted
- Provides oversight so that water is safe to drink
- Encourages physical activity
- Organizes and delivers vaccination programs, and
- Performs many other clinical public health prevention and health promotion activities.

They are involved in research into culturally appropriate preventive care and manage health crises. Region 18 has already been impacted by Bill 10 despite being "exempt" from it. A Public Health Department cannot work in isolation and hence, it involves working regionally and locally, but also with provincial partners. What influence can the Quebec public health network exert on issues such as tobacco when human and financial resources are eroded? The challenges in our region demand a strong and vibrant public health approach and network. Bill 20 risks further limiting recruitment for part-time public health work in the Region where recruitment and retention of physicians with the necessary qualifications has always been a challenge.

8.5 Loss of physicians anticipated

Currently, there are a total of 140 family physicians coming to region 18 to serve our population. Of those, 21 are permanent full-time, 28 are part-time and 79 are dépanneurs (replacement physicians)[14]. Many of the part-time physicians are former full-time physicians who could not continue as full time physicians, for reasons explained in the next section. Many dépanneurs work in one community, but some work in two or more communities. Dépanneurs contribute 250-300 weeks of work in Region 18, helping us to cover much needed medical services in the communities.

While our medical team has stabilized in the last year, we anticipate that we will lose family physicians and specialists if Bill 20 is adopted in its current form. Timely access to care will be compromised if family physicians leave the Region. The broad scope of family practice will become more limited to walk-in and emergencies, hence other less urgent services such as CMC/CLSC clinic work may be not provided.

[14] Department of Medical Services and Affairs. 2015. Master Professional File.

9. Impact of Bill 20 on Region 18 family physicians

Since Bill 20 was tabled, the Department of Medicine and the Council of Physicians, Dentists and Pharmacists have studied its requirements and considered the implications that will seriously affect our staffing, composition of our medical team and scope of practice. The following points explain these concerns in light of the specific and unique context of Region 18, and especially related to patient care.

9.1 Departure of part-time physicians and dépanneurs

Full and part-time permanent physicians work in Region 18, as well as dépanneurs, because they prefer a practice model that suits their professional interests, schedule and personal lives. Many of our part-time physicians and dépanneurs work in hospitals, clinics and emergency departments in southern Quebec. Similarly, some of these physicians live and work in other provinces. With the passing of Bill 20, Quebec physicians would be forced to work outside of Region 18, in order to meet their patient quotas and their minimum number of work weeks. Physicians who come from other provinces are unlikely to be able to commit to work in Quebec and would not return to work in Region 18 for professional and personal reasons.

This is the most serious concern of the CPDP, given that the majority (119/140 or 85%) of our medical workforce is composed of part-time and dépanneur physicians. If we lose these physicians, the medical services will be severely reduced.

9.2 Full-time physicians will be affected

The loss of part-time and dépanneur physicians will cause a greatly increased workload for those remaining physicians, especially full-time physicians who also carry more responsibilities above and beyond clinical care. Minimal but necessary medical services will be given, but other non-urgent (but needed) clinics may not be conducted. Our full-time medical staff may also decide to leave the Region because of family reasons, such as caring for their aging parents and/or children attending school in the south. Hence, the departure of some full-time physicians is also foreseen if Bill 20 were implemented in Region 18.

9.3 Flexibility in scope of practice will be reduced

Region 18 offers family physicians the opportunity to practice virtually all aspects of family medicine in a challenging and culturally unique region. Our physicians commit to this stimulating work environment while still maintaining flexibility in their work scheduling. Physician recruitment in the rural and isolated communities of Region 18 is based on Indigenous health, northern practice and professional flexibility. Enforcing rules and regulations that stipulate patient quotas and minimum weeks-worked-per-year immediately jeopardize the interests and attraction of physicians who choose to practice here in the Cree communities. The proposed requirements of Bill 20 do not fit our model and variety of medical services that our physicians prefer and the Cree patients appreciate.

9.4 Linkages to academic institutions will be jeopardized

Many family physicians who work in Region 18 are involved in academic activities in both research and medical education. Medical students and family medicine residents come to Chisasibi, Mistissini and some smaller communities to do clinical rotations and learn about Indigenous health and social issues firsthand. These experiences that also help us recruit them later in their career, to work in Region 18 as family physicians. If Bill 20 is implemented in

Region 18, there will be less time for teaching and negative effects, such as loss of physicians, may result in our teaching status being reduced. Our partnerships with medical schools, residency programs and other health organizations will then become vulnerable.

9.5 Personal appeal to work in Region 18 will decrease

Working in an isolated, remote setting such as Region 18 offers many personal challenges and indeed, our medical staff make many personal sacrifices to come and work here. The logistics of living and working in Region 18 include:

- Isolation from one's parents, children, immediate and extended family is often felt by our physicians, which is reduced by returning south between scheduled work times. This isolation is certainly a factor in some physicians' decision to scale back their work from full-time, to part-time, to dépannage.
- Geographical factors such as distance and weather may influence where and when physicians work in the territory.
- Lifestyle and interests in outdoor sports and leisure and Cree culture are attractive aspects of working in Region 18.
- Full-time and part-time physicians are provided housing by the CBHSSJB and cannot purchase a home and settle permanent with their family in a Cree community, because they are not Cree beneficiaries.
- Some doctors are unable to move their partners to the region due to the lack of opportunity for spousal employment, starting a family, or their children are going to school in the south.
- Some physicians work in Region 18, but their partner lives and cares for their children who go to school in the south.
- Physicians with very young children live and work in the region until their children begin kindergarten.
- Physicians require essential personal and professional services for themselves and their family, such as their own family physician, specialist, dentists, (since non-Cree have no access to dental services), accountants and other needs that are not available to them up north.

While our physicians do consider the appeal of working in Region 18 for various reasons previously mentioned, this is weighed against these logistics. The flexibility and freedom to tailor and balance their work and personal responsibilities is valued by our family physicians and greatly enhances the retention over the long term. This contributes to the establishment of our medical team that is composed of many family physicians who gain or already have much experience working in our Cree communities, committed to give the best health care offered to our patients.

The personal factors that play a role in our family physicians' decision and commitment to practice in the region will be magnified if Bill 20 is implemented. Their family and personal needs will obviously become their priority. Despite the rewarding work that they do in the Cree communities, ultimately most may reduce their time or leave the region completely.

9.6 Recruitment and retention will decline significantly

Many of our medical staff have been recruited to work in Region 18 after coming here to do a family medicine rotation as a medical student or resident. Currently, Chisasibi, Mistissini and

some smaller communities are our designated teaching sites. Training opportunities for these medical trainees are incorporated into the physician schedules, where they work alongside attending physicians and become active members of the health care team. The flexibility and variety of family practice roles here is an attractive incentive for trainees to return here later in their career. They are also welcomed into the community and consequently appreciate the culture and lifestyle in Eeyou Istchee.

Medical students enjoy their clinical experience here and some choose to enter family medicine residency. Some family medicine residents return to work here as permanent or dépanneur physicians. However, the strict obligations of Bill 20 will deter students from becoming family physicians, and will likely lead many to do family medicine residency and later work in another province. Family medicine residents now training in Quebec may choose to leave the province after completing their residency. As a result, this important pool of potential recruits will dramatically decrease and this will be compounded by the anticipated loss of part-time and dépanneur physicians from our region.

Retention of family physicians working in Region 18 is obviously important to maintain medical service. However, as previously mentioned, these physicians will likely reduce or stop their work because of family or other reasons (e.g. having children/starting a family, caring for aging parents, nearing retirement, research interest etc), should Bill 20 be implemented. Increased workload, the required number of weeks, less flexibility and scope of practice will negatively influence their intent to stay in Region 18, which will inevitably lead to reduced continuity, quality and access to care.

9.7 Less experience and increased turnover will affect care

Part-time physicians and regular dépanneurs gain knowledge and expertise as they practice in remote and isolated settings, which benefits our patients, medical trainees and enhance the collegiality of our medical team. This experience comes into play when there is an emergency. The familiarity with community-specific resources for clinical care and medivac could be the difference in saving a patient's life. Length of time working in Region 18 and stability of our medical team are factors that positively contribute to improve care. A physician who is present in Region 18 for a longer period of time is better familiar with the limitations of its resources and the complex pathology of their community's patients.

If Bill 20 is implemented in Region 18 and we lose some of our medical staff, then physicians with little or no rural or remote experience may come to work in the region. This may well lead to negative outcomes for patients, either in emergencies or non-urgent care.

9.8 Number of physicians will regress to an unsustainable number

Recently, we have seen a significant increase in our physician coverage because of our recruitment efforts and retention efforts, yet we still have to use several recruitment strategies since physician turnover is continuing. Our medical staffing has expanded significantly, and this obviously helps us to increase our availability to see patients.

Medical staff

Year	Full-time	Part-time	Dépanneurs
2011	11	7	81
2015	21	28	91

If we lose physicians, especially the part-time and dépanneur physicians, the current medical services will regress to being severely under-staffed, as we experienced before and are still trying to recover from until recently. The CBHSSJB is already losing one permanent part-time physician who will move and practice in another province. In 2001, four permanent family physicians left Chisasibi for various reasons around the same time, which led to the closing of our Obstetrics service as the Department of Medicine was then solely reliant on dépanneurs physicians. Even losing a physician for one day or one week results in a significant deficit in clinical care for that time. Our many vulnerable patients will be at risk of worsening health as we will be unable to provide medical services to meet the needs of the population.

9.9 Family physicians in primary care in Quebec at risk

Family physicians form the mainstay of primary care in the health care system here in Québec and across Canada, and should be recognized for the various roles they undertake in their practice. The burden of access to care should not only be placed on family physicians and specialists, but also the MSSS and Québec. Other non-coercive means to increase access to care should be solicited, such as investing in telemedicine, health promotion, training more physicians and collaborative, multi-disciplinary strategies tailored to each region.

We support the concerns of these family physicians which echo the loss of physicians, autonomy, scope of practice and similar issues as discussed above. We deserve respect as the essential practitioner sustaining primary care and coordinating services by specialists, hospitals, diagnostic imaging and paraprofessionals. The lack of consideration for family physicians, in the context of Bill 20 will likely lead to a health care system in worse jeopardy, which will detrimentally affect quality of care.

10. Conclusion

The Cree Board of Health and Social Services of James Bay and the Council of Physicians, Dentists and Pharmacists of Region 18 are gravely concerned about the implications of Bill 20 as tabled and the severe consequences that will occur in this region if it is implemented in its current form. Many important issues were presented in this brief to inform the Committee of the unique, specific and common impacts on health services and medical workforce that will be felt here.

First, Eeyou Istchee, as a unique, remote region and Nation, must be considered in the context of the JBNQA, health agreements and strategic regional plan of the CBHSSJB. Any measures having such adverse effects would be contrary to Québec's treaty obligations toward the Cree in Section 14 of the James Bay and Northern Québec Agreement. They would also be inconsistent with Québec's undertakings in the Cree-Québec Health Agreement of 2012.

Since the health and social issues that affect the Cree show significant disparities compared to the general population of Québec, access to primary care and quality services in Region 18 must be preserved and improved. Currently, this is ongoing and integrated services are being developed. Our medical team is working collaboratively with other health professionals towards its full implementation. Bill 20 will set back years of effort in planning and initiating these programs, as well as establishing our medical team, which only recently is beginning to fulfill the health care needs of Eeyou Istchee. It will also likely lead to health care costs increasing, such as non-insured health benefits.

The obligations of Bill 20 as currently tabled will have a severe impact on our medical workforce, and particularly our family physicians, which will lead to a relapse in our recruitment and retention efforts. This will cause significant reductions in medical staffing as physicians leave the region, medical training of students and residents, administrative and clinical work. Most importantly, access to and quality of patient care will be detrimentally affected.

In addition, the autonomy, scope of practice, career choices and personal lives of family physicians in Region 18 and the rest of Québec are endangered. It is these aspects that determine the commitment, diversity and caliber of family physicians who work in this region. This balance of full-time, part-time and dépanneur family physicians and our visiting specialists offer the best and safest possible care for the patients of Region 18. Although intended to improve access to family medicine, Bill 20 would have the opposite effect in Region 18. Its requirements regarding minimum caseload and working weeks do not take account of the special challenges of Region 18, which relies on a large complement of part-time and temporary physicians, some from outside Québec.

The Cree Health Board wishes to find solutions for these issues. It is prepared to discuss amendments of Bill 20 in order to reflect Northern realties, correct the lack of medical personnel in Region 18, and respect Cree treaty rights under the JBNQA. In the absence of such solutions, Region 18 and the physicians who work there should be excluded from the application of Bill 20.