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CREE BOARD OF HEALTH AND SOCIAL SERVICES OF JAMES BAY

STRATEGIC REGIONAL PLAN

TO

IMPROVE HEALTH AND SOCIAL SERVICES

"MIYUPIMAATISIIUN"

"BUILDING A STRONG AND HEALTHY CREE NATION "

SEPTEMBER 2004

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Introduction

This strategic regional plan is the result of a collaborative effort between the Grand Council of the Crees (Eeyou Istchee)/Cree Regional Authority ("Grand Council") and the Cree Board of Health and Social Services of James Bay ("Cree Health Board" or "CBHSSJB"). It is intended to respond to the needs of the Cree population of Eeyou Istchee (James Bay, Quebec) regarding health and social services.

The process of developing this strategic regional plan has its origin in two distinct, but complementary, sources.

The first is the James Bay and Northern Quebec Agreement ("JBNQA"), signed in November 1975 by, among others, the Crees, the Inuit, the Government of Quebec and the Government of Canada. Section 14 of the JBNQA deals with Cree Health and Social Services. It grants the Cree Health Board jurisdiction over the administration of health and social services for the Crees of Eeyou Istchee. Section 14 vests the Cree Health Board with the powers and functions of a regional health council, as well as those of existing and future health and social service establishments in Region 18. It also provides for the obligations of the Government of Quebec to fund health and social services for the Crees. As the "Cree Native Party" for the purposes of the JBNQA, the Grand Council has the mandate to negotiate matters concerning Section 14.

Second, on 10 November 1999, Madame Pauline Marois, then Minister of State for Health and Social Services, and Mr. Bertie Wapachee, Chairman of the Board of Directors of the Cree Health Board, signed an agreement establishing a process to define the parameters, priorities, results to be achieved and funding framework for health and social services for the Crees. On 26 August 2002, Mr. François Legault, then Minister of State for Health and Social Services, undertook to work with the Grand Council and the Cree Health Board on an accelerated process to resolve questions relating to Section 14 of the JBNQA, specifically with respect to funding parameters for Cree health and social services. This process was further confirmed by letter of 28 March 2003 from Mr. Pierre Gabrièle, then Deputy Minister of Health and Social Services, setting forth a number of orientations and general objectives agreed with the Crees. These are to serve as a basis for continuing work leading to a formal agreement on health and social services for the Crees, as contemplated in the New Relationship Agreement ("Paix des Braves") signed between the Government of Quebec and the Crees of Eeyou Istchee on 7 February 2002.

It is useful to recall that the Act respecting health services and social services for Cree Native persons, R.S.Q., c. S-5 ("S-5"), provides part of the context for this process. Section 3 of the Act states:

> **3.** The Minister shall exercise the powers that this Act confers upon him in order to:

(*a*) *improve* the state of the *health of the population*, the state of the social environment in which they live and the social conditions of individuals, families and groups;

(*b*) *make accessible to every person*, continuously and throughout his lifetime, the *complete range of health services and social services*, including prevention and rehabilitation, to meet the needs of individuals, families and groups from a physical, mental and social standpoint;

(*c*) *encourage the population* and the groups, which compose it *to participate* in the founding, administration and *development of institutions* so as to ensure their vital growth and renewal;

(*d*) *better adapt the health services and social services to the needs of the population, taking into account regional characteristics, including the geographical, linguistic, sociocultural and socioeconomic characteristics of the region*, and apportion among such services the human and financial resources in the most equitable and rational manner possible;

(*d*.1) *promote*, for the members of the various *cultural communities* of Québec, *access* to health services and social services *in their own language*;

(*e*) *promote* recourse to *modern methods of organization and management* to make the services offered to the population more effective;

(*f*) *promote* research and teaching.

[Emphasis added]

Moreover, section 18 of S-5sets forth certain functions of the Cree Health Board:

(*a*) to *encourage the participation of the population in defining its own needs* in health services and social services and in the administration and operation of the institutions providing such services;

(*b*) to ensure sustained communication between the public, the Minister and such institutions;

[…]

(*d*) to advise and *assist the institutions in the preparation of their programs to develop and operate health services and social services* and to assume the duties that the Minister entrusts it with to carry out such programs;

> (*e*) to promote the exchange, the elimination of duplication and the *better distribution of services* in the region and the setting up of common services for several institutions;
>
> […]
>
> (*f*) to send the Minister, at least once a year, *its recommendations* to ensure *adequate apportionment* in its territory of the resources devoted to health services and social services and the best possible use of the available resources; […]
>
> [Emphasis added]

Elsewhere in Quebec, regional boards are required, under section 346.1 of the *Act respecting health services and social services*, R.S.Q., c. S-4.2 ("S-4.2"), to prepare a triennial strategic plan defining priorities for the health and welfare of their respective populations. This plan is to be developed taking into account both broad Ministry objectives and the realities specific to each region.

The development of a strategic regional plan for the Cree Health Board has provided the first opportunity, since the creation of the Board, to review in a systematic way the specific health and social service needs, characteristics and objectives of the Cree population and the Cree region.

This strategic regional plan is, first and foremost, a tool for integrating visions, programs and services. It aims to:

Improve the coverage, access and continuity of services for the Cree population.

Ensure better coordination among different stakeholders and funding of services adequate to respond to the needs.

Mobilize the human resources, and to address deficiencies in material, technological and information resources.

Finally, this strategic regional plan provides the opportunity for the Cree Health Board to begin a process to integrate traditional approaches to health and wellness. We wish to venture beyond well-trodden paths and to deliver culturally adapted services to the Cree. This necessarily entails providing a real place for specific traditional healing approaches, which have proved themselves to the Crees throughout their history. The objective is that those persons who want to choose specific traditional healing methods may do so in an informed way.

Vision Statement

The Cree Special General Assembly on Health and Social Services held in Oujé-Bougoumou on 16-19 February 1999 developed and approved the following Eeyou Nation of Eeyou Istchee Vision Statement regarding the development of community wellness:

Holistic Approach: Health and social development touch on all program areas.

Nation Building: As opposed to simple decentralization of services that affect us in common.

Capacity Building: Improving our ability to solve our health and social problems ourselves.

Traditional Values and Practices: Moving beyond the Western medical model, incorporating traditional healing and care-giving practices, basing programming on Cree family and cultural values.

Economic Viability: Adequate resources must be available to sustain the system.

Sustainability: Promote a healthy environment that supports the continued reliance on renewable resources that is key to our social and economic well-being.

Balance: Crees need to be balanced "Mentally, Spiritually, Physically, Emotionally,"

Control and Empowerment: Crees need to take charge of their social welfare and health, exercising total jurisdiction as a nation.

Responsibility and Accountability: Cree agencies will be responsible and accountable to a strong Cree Nation government. [1]

Orientations

The following orientations are intended to provide the framework for the means to be advanced in order to improve the health, the social services and the general wellness of the Cree population. These orientations are based on, among other things, the views expressed by the Cree communities themselves including he Special General Assembly on Health and Social Services held in Oujé-Bougoumou in February 1999 as well as of the "Conference on Future Directions" held in Chisasibi in June 2001.

The result sought for the Eeyou Nation of Eeyou Istchee is to have a society where:

Individuals are well balanced emotionally, spiritually, mentally and physically;

Families live in harmony and contribute to healthy communities;

Communities are supportive, responsible and accountable;

A healthy environment will continue to produce traditional resources.

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1 Based on CBHSSJB "Final Report of Special General Assembly on Health and Social Services held in Oujé-Bougoumou on 16-19 February 1999", p. 17.

The result to be achieved within a context of a strong national Eeyou government is to exercise complete jurisdiction and control over the:

Delivery of quality comprehensive, integrated, inter-agency health and social services

Promotion of Cree human resource development

Provision of adequate resources to address Cree needs with a strong expression of the Cree values of respect, honesty, loving, caring and sharing.

In order to achieve the desired results, the orientations, which will guide our actions over the coming years, are set forth below. These will be validated in close consultation with the Cree communities, and, in particular, with the Cree Elders, women and youth.

Orientation 1 Indicators for health and social wellness for the Cree population should be at least equal to those observed or sought for the general population of Quebec. This dictates urgent catch-up measures.

Orientation 2 Regular access to local health and social services in the Cree communities should be provided at least 80 hours per week. If regular access to local health and social services for the general population of Quebec is extended beyond 80 hours per week, it shall be extended accordingly for the Cree communities.

Orientation 3 Provide the human, material, technological and financial resources necessary to meet the needs of the Cree population, taking into account, among other things, the development delays experienced to date and the special Northern conditions.

Orientation 4 All services should be provided in accordance with the cultural values and realities of the Crees.

Orientation 5 Ensure that the Crees shall exercise jurisdiction and control over the health and social service organization. To this end, revise, update and amend existing legislation to reflect responsibility, authority and power of the Cree Board of Health and Social Services of James Bay.

Orientation 6 Develop a model for the integrated delivery of health and social services in the Cree communities, taking into account the special requirements of each.

Orientation 7 Develop a Cree social policy and consolidate social services of type, quality and quantity responsive to the needs of the Cree population.

Orientation 8 Provide integration for traditional approaches to medicine and social services (Cree Helping Methods)

Orientation 9 Prepare the future by training Crees to assume responsibility for the positions of physicians, nurses, social workers, other professionals, technicians, managers and other health and social service employees.

Orientation 10 Create the incentives necessary to attract and retain the required personnel so that the Cree communities are perceived as attractive places to live and work.

These ten orientations will guide and shape the means to be used to achieve the objective desired for the Cree communities: ‘‘Building a Strong and Healthy Cree Nation’’.

Context

Introduction

For Crees, the notion of health and wellness are inseparable from the phrase *Miyupimaatisiiun*. This expression, loosely translated as ‘‘to be alive and well and in good health’’, means a way of being that allows one to:

Care for and nourish his or her family;

Enjoy life and to participate actively within the community;

Be sufficiently strong to make a good living by hunting in the frigid regions of the north, meaning, ‘‘being alive well’’ (Adelson).

This chapter presents the status of health and wellness of the Cree population from diverse sources, [2] and from health indicators which, while the best available, are

2 The main sources used here are the following:
Torrie, Jill, *How Healthy Are The Eeyouch In 2002: An Update*, Public Health Department of James Bay Cree Territory, December 2002.
Groupe de travail sur la création d’un département de santé publique cri, Plan d’organisation de la santé publique crie, juin 2001.
Pageau, M., R. Choinière, et al., Le portrait de santé le Québec et ses régions. Québec City, Institut national de santé publique du Québec, 2001: 442.

uneven. This picture colours and gives perspective to the needs described in later chapters.

Cree Demography

In 1999, the total resident population of the Cree region was 13,594. This population comprised 11,900 Cree residents, or 95% of the total resident population, and 1,604 non-Cree residents.

For the purposes of this discussion of Cree demography, this section focuses exclusively on the Cree population. It should be noted, however, that, as indicated above, the total resident population of Region 18, comprising both Crees and non-Crees, is higher than the numbers discussed below for the Cree population alone.

The Cree population of Region 18 has more than doubled over the past 23 years: from 5,000 in 1976 to 11,900 in 1999. Assuming an annual growth of 2.5% from 2000, the Cree population will more than double again by 2028, to reach 25,000.

The following table summarizes the evolution of the Cree population since 1976, and shows demographic projections until 2028.

Year	***Number of Cree Residents***
1976	5,000
1996	10,160
1999	11,900
2002	13,638
2020	20,000
2028	25,000

The Cree population is growing at a rapid rate, 11.5% between 1996 and 2001, compared to 1.5% for all Quebec for the same period. This rapid growth is reflected in an elevated youth dependency ratio, 56%, compared to 28% for all Quebec. Conversely, the elder dependency ratio is lower than elsewhere in Quebec (6% vs. 17%).

The main demographic characteristics of the Cree population are the following:

Daveluy, C., C. Lavallée, M. Clarkson, E. Robinson, A Health Profile of the Cree: Report of the Santé Quebec Health Survey of the James Bay Cree 1991, Gouvernement du Québec, 1994. Schnarch, B., E. Robinson, J. Torrie, Health and What Affects It in the Cree Communities of Eeyou Istchee: A Compilation of Recent Statistics: CD-ROM and binder. Chisasibi, Cree Board of Health and Social Services of James Bay, Public Health Module Cree Region of James Bay, 2001: 121.

Adelson, Naomi, 'Being Alive Well', Health and the Politics of Cree Well-Being, University of Toronto Press, 2000.

A very young population: 34% of the people are under 15 years of age, compared to 19% for all Quebec. 66% of the Crees are under 30 years old compared to 33 % for Quebeckers as a whole.

Relatively few older people: 4% aged 65 years old and over, compared to 12% for Quebeckers as a whole

The crude birth rate is more than double the general Quebec rate, 23.9/1000 vs. 10.0/1000.

About 96% of aboriginal residents in Region 18 speak Cree as their mother tongue, 90% speak Cree at home and 98% can speak the language.

English is spoken by 77% and French by 29%. 26% speak both and 20% speak neither.

The types of health and social problems experienced by the population are affected by, among other things, its age distribution. Accordingly, the health and social services to be made available must, if they are to be efficient, reflect the age distribution and its associated problems.

Health

Lower Life Expectancy

Life expectancy among the Crees of Eeyou Istchee is significantly lower than that of the general population of Quebec: on average, about 73 years for men and women alike. Elsewhere in Quebec, life expectancy is about 75 years for men and 81 years for women. Almost all age groups among the Crees show a higher rate of mortality than the general Quebec population. This discrepancy is particularly marked for the very young (0-4 years: 290% the Quebec average) and the elderly (65-74 years: 160% the Quebec average).

Infant mortality is significantly higher than the Quebec average. This occurs mostly between the end of the first month and the end of the twelfth month (post-natal mortality rate 560% the all-Quebec rate). Two genetically transmitted diseases, Cree leuco-encephalopathy and Cree leukoencephalitis are largely the cause of this high mortality. Other causes must also be considered. One is the relatively low level of schooling among mothers (60% have less than 11 years of school, compared to 15% for all Quebec). Another is the youth of Cree mothers: the adolescent gestational rate is 8.1% among girls 18 years old or less, compared to 1.3% for all Quebec. The rate among Crees 20 years old or less is 23%, compared to 4.7% for Quebec as a whole. In general, the Public Health Department expects that one baby in every four or five will have a teenage mother.

Cree elders, people 65 years of age and older, comprise only about 4% of the total Cree population, as opposed to 12% for all Quebec. This age group has experienced a drastic decline, about 22%, among the Crees between 1991 and 1996, as opposed to

an increase of 11 % for all Quebec. Cree elders show a rate of mortality (3,700/100,000), about 60% higher than for the same age group in the general Quebec population (2,320/100,000).

Obesity: Rate High and Growing

Nutrition and diet are one of the most important health issues in Eeyou Istchee, as they contribute to the high rates of diabetes, children's overweight and obesity and infant anemia observed in the region.

In 1991, the prevalence of obesity was 57% for Cree women and 38% for Cree men, compared to 13% for both sexes in Quebec. The situation does not seem to have improved since then. In two communities in 2000, of those aged 20 and over, about 20% were overweight and 57% were obese.

In 2000-2001, 22% of the population were still making their living from hunting and fishing and were enrolled in the Income Security Program for Cree Hunters and Trappers, with the age profile skewed to young and old adults only. However, the protective effects of a traditional lifestyle are on the decline. There is a marked trend towards a sedentary lifestyle, due to the decline of the traditional way of life and an increasing disparity between a rapidly increasing workforce and the creation of new jobs. Crees are eating more supermarket goods. Communities lack infrastructure for exercise and sports and other recreational activities.

The region has the lowest rate in Quebec of infants weighing less than 2,500 grams at birth. [3] However, the number of births over 4,500 grams is increasing, posing a problem of high birth weight. Gestational diabetes, the rate of which is high in the region, increases the rates of high birth weight. Birth weight over 4,500 grams in the region is associated with increased neonatal morbidity. Of those babies, 17% had birth trauma injury, while only 3% of babies weighing less than 4,500 grams had such trauma. In the region, Rodrigues *et al* first reported a rate of gestational diabetes mellitus (GDM) of 12.8% for 1995-96, noting that such a rate was twice the rate in the North American population as a whole and the second highest reported in any aboriginal group worldwide. [4] A longer data set developed by Trevors, who incorporated the Rodrigues *et al* data, found a rate of 16.6%. [5]

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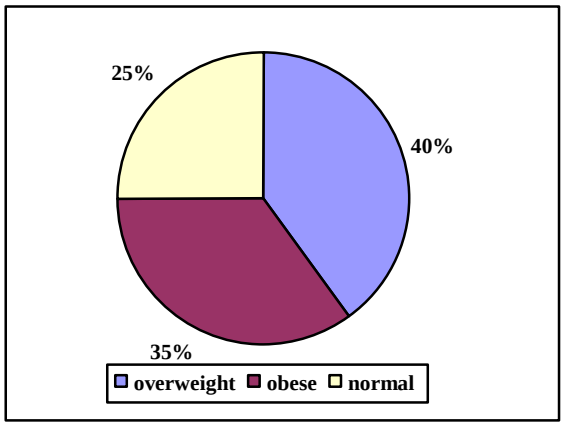
3 In the region, 1.3% of infants weighed less than 2,500 grams at birth. The 2nd lowest rate for a region was 5.3%. Nord du Québec had the highest rate at 9.4%. Naissances selon le poids de nouveau-né et la région de résidence de la mère, Québec 1998. Http://www.msss.gouv.qc.ca/statistics

4 Rodrigues, S, E. Robertson, K. Gray-Donald, ''Prevalence of Gestational Diabetes Mellitus Among James Bay Cree Women in Northern Quebec'', *Canadian Medical Association Journal* 160 (9): 1293-1297, May 4, 1999.

5 Trevors, T., *Consequences of Infant Macrosomia Among the Cree*. School of Nutrition and Human Dietetics. Montreal, McGill University, 2001.

The problem of overweight and obesity among elementary schoolchildren is as epidemic as diabetes among adults. This may be a greater public health problem than any other in the region. Large-scale public health interventions to reduce population-wide obesity are only just beginning, and interventions will be seriously hampered by the fact that the population does not necessarily consider children's overweight to be undesirable.



In the pie chart above, over-weight is defined as a body mass index (BMI) for age between the 85% and 95% percentile of the reference National Center for Health Statistics (NCHS) 2000 BMI standard. Obesity is defined as a BMI for age greater than the 95 percentile. The majority of children are either overweight or obese. A surprising point is that, in many age groups, obese children outnumber those merely overweight: children are either of normal weight or obese.

Diabetes – An Epidemic [6]

Prevalence

The presence of diabetes amongst the Cree of Eeyou Istchee (Eastern James Bay) is a relatively new phenomenon, having emerged only within the last two decades. Prior to the first observed case in 1978, there were no documented cases among the Cree population. Since that time, there has been a rapid progression of the incidence and prevalence of the disease. In 1989, a study conducted by Brassard et al. (1993), documented a prevalence rate of 5.2% for the James Bay Cree population over twenty years of age (equivalent to 4.1% for the population over 15 years). In 1991, the rate had risen almost by another 2% (Santé Québec, 1994; Verronneau & Robinson, 1993). Data from the Cree Diabetes Registry demonstrates that this rate had increased to 12.5% of the population over the age of 15 (or 15% of the population over age 20 by the year 2002).

6 Cree Board of Health and Social Services of James Bay, Diabetes Working Group of the Eeyou Istchee, Action Plan for the Prevention and Control of Diabetes in the Eeyou Istchee, June, 2001.

This crude prevalence is three times higher than the age adjusted prevalence of 4.7% of Quebec residents over the age of 20 years old. Thus, the total number of persons over 15 years of age diagnosed with diabetes increased almost five times between 1989 and 2002, with the crude prevalence rising from 4.1% to 12.5%, respectively (Table 1).

Table 4.3.3 -- Prevalence of Diagnosed Cases of Diabetes in Eeyou Istchee (Age 15 and older)

Year	Number of cases of diabetes	Crude Prevalence Rate (%)	Age-Adjusted prevalence rate (%)*
2002	1065	12.5%	N/A
2001	975	N/A	N/A
2000	886	11.0%	15.2
1999	817	10.4%	14.5
1998	720	9.4%	13.3
1997	607	8.2%	11.8
1993†	410	6.2%	9.7
1989†	230	4.1%	N/A

Source: CBHSSJB Diabetes Registry published data, 2002.
† Statistics from studies before the CBHSSJB diabetes strategy began in 1996
 Rates are age-adjusted to the 1991 Canadian population

Early Onset – Major Complications

Diabetes is affecting Eeyouch at much younger ages, with 25% of cases under the age of 40. This is a major health concern for the Cree Health Board, as these individuals will have to live significantly longer with their diabetes. Moreover, they will require clinical services longer in diabetes complications. The alternative is that they may live significant diabetes complications for a long time period.

Age (years)	10 -19	20 - 29	30 - 39	49 - 49	50 - 59	60 - 69	80 or more
Number with diabetes	10	72	186	243	275	173	117
Percent with diabetes	0.4%	3%	9%	20%	35%	39%	31%

By way of comparison, the prevalence of diabetes in the rest of Canada, according to 1997 data, is 0.5% for ages 12-34, 3.2% for ages 35-64, and 10.4% for ages 65 and over.

A high proportion of those living with diabetes in the Cree region are already affected by early complications of the disease. For example, in 2002, 58% of individuals with diabetes had some form of nephropathy (kidney damage), 11% had retinopathy (eye damage), 12% had neuropathy (nerve damage), and 13% had macrovascular disease (blood vessel damage). Furthermore, 68% were unable to maintain their blood sugar levels within a healthy range (HbA1c < 115% normal), which puts them at increased risk of progression of their complications or development of new complication (*Cree Diabetes Registry*, 2002).

The burden of the morbidity of diabetes will likely significantly increase over the next five to ten years. This is due to the fact that almost half of the Cree living with diabetes in Eeyou Istchee have only been diagnosed in the last five years, and 70% in the past ten years.

Most of the serious complications of diabetes only progress after ten to 20 years from diagnosis. Diabetic complications are irreversible, making secondary prevention of major importance for the Cree Health Board.

Duration of diabetes	Total
< 5 years	451
5 – 10 years	281
10 – 15 years	185
15 – 20 years	124
> 20 years	34

Based on the CBHSSJB 2002 diabetes registry

The dialysis centers where the Cree people are likely to be treated were surveyed in 2002. The results showed 8 cases of diabetic end stage renal diseases (ESRD) in the Chibougamau dialysis center, 10 cases in Chisasibi and 3 in Val d'Or. Montreal region was not surveyed.

There are few published long-term studies looking prospectively at progression of type 2 diabetes from diagnosis to development of ESRD and dialysis. As well, there are several important *modifiable* risk factors to the development of ESRD in patients with diabetes, making prediction of the long-term risk of dialysis difficult. These modifiable risk factors include glycemic control, blood pressure control and the use of angiotensin receptor blockers and/or angiotensin converting enzyme inhibitors.

The risk of diabetic nephropathy appears to be significantly higher in Aboriginal individuals (a rate 12 times higher has been documented in Manitoba Aboriginal vs. non-Aboriginal diabetic populations), with rates ranging from 25 – 60% of Aboriginal

people with diabetes developing diabetic nephropathy after 15 – 20 years with diabetes.[7]

The CBHSSJB diabetes registry has documented that about 60% of Cree currently living with diabetes, have some degree of nephropathy.[8]

The Manitoba data has shown that the risk of ESRD is about four times higher in Aboriginal individuals, and more than half of this ESRD is caused by diabetes. In addition, among Aboriginal people with ESRD, the relative risk of undergoing dialysis is 6.5 times that of a non-Aboriginal patient. In Manitoba, there has been an increase in dialysis starts of more than 400% since 1987.[9]

A recent morbidity and mortality weekly report (MMWR) documented a 1996 incidence of 584 new dialysis cases per 100,000 cases of diabetes in Alaskan and American Indians.[10] If one considers that there are currently 1,065 cases of diabetes diagnosed in Eeyou Istchee in 2002, one can expect 5 – 6 new cases of dialysis per year.

Coronary Artery Disease and Other Macrovascular Complications

Cardiovascular disease is the most frequent cause of morbidity and death in patients with diabetes. Data from Status Aboriginals in Manitoba, showed almost 60% of hospitalizations for heart disease and approximately half of the hospitalizations for stroke occurred among people with diabetes. In Kahnawake, half of those with diabetes had suffered a heart attack or coronary bypass surgery.[11]

Cerebrovascular disease leading to stroke was found in 13% of people with diabetes in Kahnawake, as opposed to just 3% of a comparable group of people without diabetes in the same community.[12]

Lower Extremity Amputations

The risk of lower extremity amputations following diagnosis of diabetes is 6% at 20 years and 11% at 30 years. Lower limb amputations are usually related to a diabetic nephropathy leading to a sensory deficit and increased risk of injury. The injury does not heal properly and becomes infected and gangrenous due to an associated arterial

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7 *Ibid.*

8 *Ibid.*

9 *Ibid.*

10 *Ibid.*

11 *Ibid.*

12 *Ibid*

insufficiency to the extremity. There is significant morbidity and increased mortality following amputations, with one study showing a 5-year survival rate after first amputation was only 40% in Oklahoma Native Americants.[13] The risk of lower extremity amputation can be decreased by 50% with aggressive screening and treatment programs.

Retinopathy

Diabetes can lead to increased rates of cataracts, glaucoma and retinopathy. The National Institutes of Health in the United States indicates that approximately half those with diabetes have some form of eye disease, and just over 10% report serious retinal disease. This same rate was found in Kahnawake, where retinopathy was found in 50% of diabetic patients after 10 to 15 years of the disease.

To summarize, diabetes is growing at an alarming and epidemic rate in the Cree region. Implementation of an action plan developed by the CBHSSJB and approved and funded by the MSSSQ has started. However, as long as the disease has not been brought under control, the human and financial burden, although difficult to evaluate with precision, will clearly continue to grow. The risk of a cost explosion is very real: elsewhere in Canada, it is estimated that the annual cost of treating people suffering from diabetes and its complications is at least $9 billion.

Dental Decay

Prevalence: 400% Greater for Five Year Olds

Compared to 25% in all Quebec, the prevalence of dental decay is 100% for five year olds in Chisasibi. The table below shows the prevalence and defs for each age group, and illustrates visually the "rhythm" of the progress of the disease in James Bay. Caries in early childhood reach a peak just before the loss of primary teeth and then start decay in the permanent teeth. This cycle is key to understanding how to implement preventive measures prior to the beginning of these problems.

The current waiting period is on average 11 months for basic dental treatment and 12 months for preventive treatment in the Cree region. A "normal waiting time" in the rest of Quebec is two to four weeks. Obviously, significant catch-up is required.

Overview of Dental Decay – Clientele, Prevalence and defs/DMFS (Decayed+Missing+Filled Teeth Surface)

Age group	Prevalence of Caries	Defs/DMFS	
		Per dentition (Cree children)	Comparison factors with Quebec
12-24 months	30.4%	Primary: 1.34	8 times higher

13 *Ibid*

4–5 years	86.3%	Primary:	18.67	5 times higher
7-8 years	98%	Both:	24.47	4 times higher
11-12 years	92.8%	Permanent:	7.86	3 times higher

Other Health Issues

Sexually Transmitted Diseases

The prevalence of sexually transmitted diseases (STDs) is much higher than elsewhere in Quebec. In particular, the rate of chlamydia is ten times the rate of Quebec as a whole. Data are not available concerning HIV, but it is known that HIV is a hundred times more infectious in the presence of STDs. The combination of a young population, an elevated rate of STDs, a high rate of mobility of people and problematic consummation of alcohol and drugs, considerably increases the risk of HIV infection in the population.

Rates of Chlamydia and Gonorrhea per 100 000 population from 1992 – 2000, James Bay Cree Region and Quebec [14]

Year	Chlamydia		Gonorrhea	
	James Bay	**Quebec**	**James Bay**	**Quebec**
2000	728	115	24	9
1999	1022	106	12	8
1998	1642	97	121	6.5
1997	922	87	72	7.5
1996	1070	90	60	6.5
1995	1309	96	106	8
1994	1195	109	117	10
1993	1044	145	0	11
1992	1164	170	48	14

Trauma: Twice the Quebec Rate

A 1991 Santé Québec survey indicates that the majority of Crees were then using cars, boats and snowmobiles, and a smaller proportion use ATVs, reflecting the northern lifestyle. However, many were not using available protective equipment, such as seat belts, helmets and flotation devices. Since 1991, there have not been any large-scale campaigns to encourage the use of protective devices. Hence, the results of the 1991 survey may still be relevant today. It should be noted that the rate of non-intentional trauma in 1991 was more than twice as high as the Quebec average (adjusted rates for years of life lost 1,668/100,000 for Cree, compared to 685/100,000 for all Quebec).

14 MSSSQ, *Analyse des cas d'infection génitale 1996-2000*.

Tobacco: Heavy Use by Youth

Based on the same 1991 Santé Québec survey, 77 % of Cree youth, aged 15 to 24 years, were regular or occasional smokers. In the communities, children as young as eight years old were observed smoking. More recent data, from 2001, show that 8 out of 10 pregnant women smoke. Among all Eeyouch 15 years of age and over, 53% smoke. This is more than twice the general Quebec rate of 24%.

Alcohol and Drug Abuse

Intoxication rates related to alcohol, cocaine and other drugs are about 125% higher than in Quebec generally. Consumption of alcoholic beverages, cocaine, heroin and others drugs manifests itself in numerous social problems (violence, sexual abuse, accidents, etc.). Although 22.5% of Cree are occasional drinkers and 27% are regular drinkers, the majority of Crees consume five or more drinks when they do drink. 24% of both males and females reported problems related to alcohol consumption, such as violence, injury, accident or warnings related to drinking and driving. This has unavoidable repercussions on personal security and social peace in the communities.

Drug trafficking seems to be on the rise although the phenomenon is largely hidden. No study exists of cocaine and heroin consumption of, but it is well known in the communities that is an emerging reality, especially among young people. Local police have confirmed this prevailing problem.

Mercury and Lead: Risk Factors

High levels of mercury in the Cree population of James Bay have been a cause of concern for many years. From 1988 to 1994, changes of mercury levels in the Cree population were studied. The level of intervention was defined at 15 mg/kg of mercury in hair for women of childbearing age, and 30 mg/kg for all other people. The proportion of the Cree population with mercury levels in excess of 15.0 mg/kg declined from 14.2% in 1988 to 2.7% in 1993/94.

In a study done in 2000 on infant anemia, [15] the prevalence of elevated blood lead concentrations (>0.48 µmol/L) [16] was 2.7 % (95% CI 0.36 – 5.0). Aboriginal populations who hunt are at risk for elevated blood lead levels due to the consumption of game with lead tissue intoxication and/or ingestion of lead pellets lodged in game. Among western James Bay Cree, adults have elevated dentine lead levels, evidence of a body lead

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15 Willows, N.D. (2000). *Anemia in James Bay Cree Infants of Northern Quebec*: A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Doctor of Philosophy, School of Dietetics and Human Nutrition, McGill University, Montreal.

16 Center for Disease Control, Atlanta: Blood lead levels 0.48 µmol/L (10 µg/dL) in children to be elevated, based on known adverse health effects at this threshold, including neurotoxic effects. Recent studies show blood lead concentrations in children <0.48 µmol/L are associated with cognitive deficits that point out that no safe level for lead may exist.

burden. In the same population, cord and maternal blood lead are correlated with maternal consumption of traditional food. The radioisotopes of lead found in Inuit cord blood matches that of lead found in the pellets used to shoot game, suggesting trans-placental transmission of lead to the foetus.

Although the mercury and lead data show some improvement, a risk remains, specifically related to the consumption of contaminated fish and game. Careful attention will be devoted over the next years to these contaminants and their impacts on the health of the population.

Iron Deficiency: Rate in Cree Babies Eight Times Quebec Average

In Region 18, most babies are breast-fed, especially in the coastal communities. There are anecdotal reports that the duration of breast-feeding has declined in all communities. Eight per cent of Cree babies have iron deficiency (hemoglobinemia 100g/l or less), compared to 1.1 % for non-native Canadians babies. Infants who were formula-fed had the lowest prevalence of iron deficiency and anaemia, likely because the formula was iron-fortified, while infants who consumed cow's milk had a high prevalence of anaemia. Breast-fed infants also had a high prevalence of anaemia and iron deficiency.

Infections are the main possible consequences of iron deficiency among Cree babies. More than one-half of infants (53.1%) were reported to have had an infection in the previous two weeks: colds (43.7%), ear infections (20.2%), multiple infections (17.5%), fever or unspecified infection (15.2%), and diarrhoea or skin infections (3.4%). However, the causes of this iron deficiency are not yet well understood. Further research is necessary to determine the precise factors and articulate an action plan to improve the situation.

Over-Crowded and Poor Housing

Recently, in Chisasibi, it has been reported that there is a high prevalence of mould and fungus, mainly in old houses. Some clinical syndromes have been described. In a survey of 417 heads of households from Chisasibi, [17] 42% reported the presence of mould in their house, although the survey did not include a measure of severity. More than half of the houses did not have air exchangers and, among these houses, 77% reported mould problems. Over-crowding is clearly a problem, with an average of 7.2 persons living in each house, compared to 4 in all other aboriginal communities elsewhere in Canada.

In 1996, about one house in four needed major renovations in Eeyou Istchee compared to one in twelve in all Quebec. The 1996 census data reported that the average number

17 Harris-Giraldo, R., Soares K., Hebert A., Matowahom J. (2001). The effect of housing conditions on health in the Cree community of Chisasibi, Eeyou Istchee, Northern Quebec, Canada: a qualitative study, Cree Board of Health and Social Services of James Bay and First Nation of Chisasibi**:** 2002.

of persons per room was double the rate for Quebec (0.8 vs. 0.4).[18] While only 1% of occupied dwellings in Quebec had more than one person per room, fully a quarter of houses in Eeyou Istchee exceeded this threshold.[19] Each Cree First Nation establishes annually the number of new houses needed. The most recent needs assessment demonstrated the urgent requirement for 1,400 units in the nine Cree communities.[20] Since the early 1980s, housing subsidies have met only one-half of the need for new housing units associated with the formation of new families. In sum, the current housing stock of 2687 units would have to be doubled in order to eliminate the backlog of housing demand in the Cree Nation and to replace substandard housing units.

The literature demonstrates that poor housing conditions are causally associated with poor health outcomes. More specifically, moulds and dampness are linked to respiratory diseases such as asthma, persistent coughing and bronchitis.

Housing, while an important determinant of health, does not fall under the jurisdiction of the Cree Health Board. However, as an interested partner, particularly from the point of view of public health, the Cree Health Board supports the efforts of the Cree authorities in dealing with this critical issue.

Dust

The Cree communities are concerned with the possibility of pulmonary problems caused by dust. The dust is a direct consequence of the unpaved streets and roads in and around many of the Cree communities. This is a source of many and recurrent complaints from the people in the region.

Social Wellness

Introduction

As with most other Aboriginal peoples in Canada and around the world, the Cree of James Bay have faced many changes that have caused disruption in all aspects of their life and culture as it was situated before European contact. Many adaptations had to be accommodated from the effects of Government policies and efforts to assimilate the Cree by religion, education and economic institutions. The impacts of these policies were compounded by the rapid encroachment of hydro, forestry, mining and other forms of natural resource exploitation on the traditional lands. Adaptations were necessary in order for the Cree to survive as a people, but the changes and experiences have displaced the people from their traditional cultural setting, their system of social

18 *Ibid.*

19 *Ibid.*

20 *Ibid.*

organization, their traditional ecological knowledge and their relationship with the animals and environment.

The accumulated impact of these matters has created dysfunctional survivalist behaviours among the Cree and the manifestation of many socially destructive situations in the communities. Three generations of institutionalization of Cree children in residential schools have brought on serious issues such as sexual abuse, intergenerational abuse, and behavioural problems of youth, conjugal violence, suicide and para-suicide, alcohol and drug abuse and mental health problems, among others.

Considering that the source of the problems originated from outside of the known traditional culture of the Cree, this disruption of the aboriginal spirit, mind and body has been identified as ‘‘Ethno-stress’’. This term relates to the impact of the experience from the roots of the Cree aboriginal identity.

The Situation

There is difficulty in endorsing a different cultural paradigm such as the way of life based on competition and productivity of the non-native civilization. This is well documented in the high rate of dropouts in Eeyou schools. From the figures we have in 1996, 35% of those over 15 had less than grade 9 educations and only 2% of the aboriginal population has a university degree, compared to 12% for Quebec as a whole. A program based on Cree culture recently implemented in the Cree School Board intends to alleviate this problem.

Unemployment is a direct consequence of the critical situation related to education and reaches 17% in Eeyou Istchee compared to 8.4% in Quebec today. However, this number does not include the Cree trappers and hunters who, as seasonal workers, benefit from the income security program.

Parental neglect, abuse and conjugal violence, though often unexpressed and therefore, not dealt with, are also cause for concern. The Santé Québec survey revealed that the majority of Cree (70 %) perceive public fights, neglect of children by their parents (68 %) and domestic violence (64 %) as serious problems. The loss of cultural identity, accentuated by the forced stay of several generations in residential schools, is generally acknowledged as the cause of these domestic problems.

The destruction of structures that once governed social interaction in Cree communities and families took away more than just relationships. It removed accountability and honour and left shame. Today’s generation of Cree can be described as:

Having a higher likelihood of a history of alcohol usage within the family

Having a higher likelihood of conjugal violence

Having a higher likelihood of children being placed in foster homes

Having a higher likelihood of first pregnancy as adolescent

Having a higher likelihood of three generations living within the household

Having a history of oppression, generational grief, depression, anxiety and shame

Most of the socials problems of the Cree region are summarized in the following lines:

Post-Traumatic Disorder: A Societal Task

Post-Traumatic Stress Disorder is evident in today's Cree society brought on by the Residential School. A societal strategy by different entities and individuals is required to face the many issues that were brought on by the devastating impact of this experience. At least three generations of James Bay Cree have been directly traumatized and many still carry repressed issues and denial. The secondary impacts of these are felt by family and friends. If not dealt with positively and in the right manner, this Post-Traumatic Stress Disorder raises the danger of becoming the dysfunctional norm for subsequent generations.

Ethno-Stress: A Symptom of Post-Colonialism

Ethno-stress occurs as a result of post-colonial trauma. It is the negative experience that happens when cultural beliefs, values, identity and traditions are devalued and disrupted. The Cree, like all nations that have been invaded in their homeland, suffer from ethno-stress. Ethno-stress can translate to feelings of powerlessness and hopelessness, which ultimately work against balance and harmony. In less than thirty years, the Cree have been subjected to the onslaught of change. To accommodate this change, bureaucratic and technocratic institutions have been established in an attempt to rectify the imbalance created. More often than not, these institutions are not value-based but rather legally based, in total contrast to the Cree culture.

The Cree communities are torn between a past that is rich in traditional values and a present, which offers the promise of a better future but no real guidance. The search for balance in life is very difficult for the Cree communities, especially in the crucial area of raising children.

Residential School: An Intergenerational Breakdown

Several generations of Cree parents were raised in residential schools. Children were taken from their homes to be ‘‘civilized’’ under the assumption that, given enough education, they would no longer consider themselves Indian. The schools offered food, clothing, shelter, education and hope, but unfortunately the disadvantages far outweighed the advantages. Students never had the opportunity to experience or embrace a traditional family environment or experience: what it was like to hear the stories of the elders or socialize with siblings or extended family members. They were not taught their responsibility within the family unit. The void that occurred was quickly absorbed in destructive and unhealthily habits.

A great number of today's adults were sent to residential schools. At the time students were punished for infractions of speaking their Native language or practicing their traditional beliefs. Common experiences for children in residential schools included:

Harsh and cruel punishment for inappropriate behaviours for children who were scared and/or frightened

Infrequent contact with families for months

Punishment for using their Native Cree language

Limitations placed on amount of food and clothing they received

A great number of today's adults who attended the residential schools, were deprived of parental lov e and guidance. As a result, the children who suffered this injustice lost the opportunity to learn how to parent and subsequently, how to pass on what had been given to their parents. The isolation from the family and community explains the general feelings of being ill prepared to take on the parenting role.

Sexual Abuse: Amplified by Residential School

Among other factors that have driven to the cases of sexual abuse in the Cree society, the residential school system has amplified the problem since the majority of the perpetuators have attended residential schools. It is imperative to acknowledge that the children who were sent to residential schools experienced or were witness to mental, emotional and sexual abuse. The scars left from this experience leaves them vulnerable to frustration and the traps of internalizing the violence to their own family circles.

Intergenerational Abuse: A Growing Reality

In total contrast to the traditional role of the elder in the family and community, older Cree people today now live the consequences of residential schools. At times, the same parents who were forced to send their children away are the same ones who are now neglected and abused by their own children and/or their grandchildren. The pain of yesterday continues to live within the family circle.

In the absence of family support, these old people suffer in isolation and can only rely on institutional care and social services. The challenges of dealing with this sensitive issue rest with the Cree. The Elders can regain their rightful place in Cree society only through the resurgence of traditional values, belief systems and Cree helping methods. The ultimate goal is to incorporate these values and beliefs into our institutions.

Youth Realities: A Heightened Level of Youth Under Youth Protection

Cree youth represent approximately 43% of the overall Cree population. During the year 2001-02, 19 % of the youth population had an active file under Youth Protection. However, this does not indicate that they were all under situations of neglect or

behavioural problems. These numbers also do not provide an accurate picture, as some clients can appear more than once depending on the number of times they are removed from a home and place in foster care.

Due to lack of resources, the entry door for services is often Youth Protection, which helps to explain that a majority of the 'signalements' are retained each year. During the same year, 88% of the signalements (630 out of 712) were retained, primarily for neglect and behavioural problems. Sadly, the Youth Protection workers do not have the time to work on the proper evaluation and assessment required for each case since there is a longer waiting period and placement of youth is the only option available to prevent further risk or if their safety is compromised. This applies in most cases for a term of twenty-four hours to five days. Others may require longer terms up to the maximum allowed by law.

According to recent statistics, the caseload has increased from the previous year. The active caseload numbers also includes the adoption and intervention done under Chapter S-5, the Youth Protection Act and the Young Offenders Act. The actual number of signalements received includes emergencies relating to adults and elders during the after-hours and weekend periods.

Reflective of the annual reports in the past decade, each year approximately 50% of the youth population experience placement (foster care or residential care). Youth Protection and emergency workers usually have few or no alternatives when the protection of a child is at stake. When a family is in crisis and a child needs to be protected, the worker is usually left with the single choice of applying the law, which often requires the removal of children from the home.

Conjugal Violence: An Obstacle to Community Healing

Conjugal violence is another problem that thrives in the communities. In the largest community of the Cree Nation, there are an average of nine cases every month, totaling approximately 108 cases a year. About 12% of the women between the ages of 20 to 65 have been involved in the judicial system for such violence. Almost all cases are associated with alcohol and drug abuse.

It is important to note that there is an absence of support for victims who report conjugal violence. Currently there is no shelter for the victims and their children in the Cree territory. Breaking the silence from this type of abuse is still socially unacceptable. Another important factor to recognize is that in the Cree territory, almost all house leases are in the male's name. So women who decide to leave are left without any support, no place to live and usually have to leave the territory. This could explain the reason why so many women still live in silence with violence and wait a long time before reporting to the police.

Mental Health Problems: An Emerging Reality

A documentary review of the 2002/2003 report indicated that the two main forms of chronic mental illness are schizophrenia and chronic depression. The review also illustrates that the Cree people have experienced post-traumatic stress disorder from past and present events and substance abuse. Many of the other existing problems include personality disorder, attention deficit disorder, bipolar disorder, anxiety, suicide attempts etc. There is only one psychiatrist who comes to the Territory, and his visits are limited to two inland communities. Consequently there is no access to the services of a psychiatrist for the coastal communities. The visiting psychiatrist has a caseload of approximately 105 adults. Additionally there are seven psychologists who visit the territory seven times a year. On average, they have a caseload of 35 individuals, 68.9% of whom are adult females. There were of 1,618 interventions done by the psychologists during the past year.

Suicide and Para-Suicide: A Growing Reality Among Youth

According to a 10-year study done between 1982 – 1992 on the Cree communities, on average about one person per year committed suicide in all of the Cree communities. This is about the same rate as for the general population of Canada. The majority of the people who committed suicide were males between 25 and 39 years old. Most of the victims had serious family, marriage or other personal problems and, at the time they committed suicide, they had consumed alcohol.

On the other hand, there were eight times more cases of attempted suicide. Of the total hospitalizations for para-suicide, 60% were female. Most were between 15 and 29 years old. 77% of the males and 47 % of the females were reported to be intoxicated when the incident occurred. About 10% were chronic alcohol abusers. It is also reported that 25 % of victims had made a previous suicide attempt.

Many people who attempted suicide were noted to have long-standing problems. The most frequent were difficult home situations, serious personal problems, feelings of rejection or disapproval, chronic misunderstandings and alcoholism. 18% were depressed.

In addition to chronic problems, an acute problem was often the "last straw". For females, an argument, moving away from family and other separations and being a victim of violence were the most frequent "last straws".

It has to be noted that there was an increase of 70% in para-suicides during the second five years of the study. The most important change was the increase in incidents involving firearms among young adult males. Part, but not all, of this increase may be due to the increase in the number of young Cree who are at highest risk of suicide and para-suicide.

Gambling: A Rapidly Emerging Problem

With the proliferation of gambling devices around the Cree region and their easy access, more youth and adults go gambling. Among them, many develop a pathological gambling behaviour. This problem is not well documented yet, but it is perceived as a rapidly emerging problem. The Public Health Department is mandated to study the problem over the next year and develop an action plan to provide promotional, preventive, interactive materials and strategies to effectively combat the problem.

Limited Resources: A Need to Adapt and Consolidate the Way Social Services Are Organized

Workers are often brought in to intervene in crisis situations. The chronic absence of resources, which would allow for intervention upstream, can doubtless explain why workers must intervene immediately, at the wrong time, and in crisis situations. There are no resources in the schools such as special educators or psychologists. There are few, if any, community resources and usually only two CLSC Community Workers per community (medium and small size) for all clienteles and all programs put together. Moreover, access to specialized resources such as psychologists and psychiatrists, in particular, is very difficult and access mechanisms are extremely complex.

Workers are frequently put in an extremely difficult situation when they have to assess a case of sexual abuse or to remove a child from the home of a friend, a neighbour or even a relative. Added to this difficulty is the fact that, for many workers, the cases in which they are asked to intervene stir up memories of their own personal histories of abuse, violence and drug and alcohol problems. It has to be noted that the Emergency Workers are the ones with a lesser amount of experience and skills. Some of them have limited educational background and were hired on the basis of their natural helping skills. In the context where problems are getting more and more complex, this is an inappropriate solution.

Furthermore, the Community Workers often lack, support, guidance and training. Workers receive basic training to deal with specific problem areas, and the existing undergraduate program in social services has allowed some workers to obtain their bachelor degree in social work. However, the majority of the workers do not have the academic background required for their work. There is a critical need to develop adequate culturally oriented and sensitive programs and intervention tools as well as continuing education programs in order to better equip and support them.

Conclusion

This picture is clearly incomplete. One priority is to develop a systematic *Miyupimaatisiiun* surveillance and health survey program in Eeyou Istchee. However, the overall tendencies outlined here are sufficiently obvious to compel immediate action in the desirable direction. The emphasis must be on education and modification of the social environment that will eventually return people to healthy nutrition, optimal physical activity, self-esteem as persons and as a nation, and a healthy sexuality to

prevent STDs and HIV. While waiting for this new paradigm, it is essential to guarantee that all necessary curative and preventive services work together to reduce actual and potential harms.

Objectives

Introduction

The first Orientation guiding this strategic plan, as set forth in Chapter 3, is the following:

> Indicators for health and social wellness for the Cree population should be at least equal to those observed or sought for the general population of Quebec.

This Orientation in fact constitutes a prime long-term objective of *results* of the Cree Health Board. Clearly, this orientation will take more than five years to achieve, the horizon that is the focus of this strategic plan. A more realistic target would be to secure the specific objectives within a period of ten years, that is, from 2004 to 2014. Certain objectives of results can only be achieved in partnership between the Cree Health Board and other competent authorities. At the same time, immediate action is required to implement over the next five years, from 2004 to 2009, the *means* required to secure these results. This discussion of specific objectives therefore distinguishes between objectives of *results*, to be achieved over the period 2004 to 2014, and objectives of *means*, to be achieved over the period 2004 to 2009.

Specific Result Objectives– 2004-2014

The specific objectives aim precise and measurable results over a 10-year period. These objectives are multi-facetted; all comprise preventive, health and social aspects. Hence, the attainment of these objectives requires a global, multidisciplinary approach. Such an approach challenges the Cree Health Board as a whole and each of its departments individually to intervene at the right time and with the appropriate means in order to achieve these specific objectives.

Recognized that health and social wellness are inextricably interrelated, key specific objectives under each rubric are presented here for ease of reference.

Health

Life Expectancy: Increase life expectancy in good health among women by at least eight years and among men by at least two years so as to match that of the general population of Quebec.

Obesity: Reduce prevalence by at least 420% for women and 300% for men so as not to exceed current general Quebec prevalence.

Diabetes: Reduce prevalence by at least 500% so as not to exceed current general Quebec prevalence.

Mental Health: Reduce prevalence to level not exceeding that of general Quebec population.

Dental Health: Improve dental health of the population

Reduce dental diseases (reduce prevalence of dental decay among five year olds by 400%, gum disease, dental infection, malocclusion, etc,) to a comparable provincial level.

Improve the access to dental services from present 12 months waiting period to a comparable provincial waiting period (2 to 4 weeks)

Sexually Transmitted Diseases (STD): Reduce prevalence of Chlamydia by at least 1000% so as not to exceed current general Quebec prevalence.

Trauma: Reduce the rate of injury and death caused by accidents by at least 200% so as not to exceed current general Quebec rate.

Environment Health: Reduce the risk on the health of environmental problems:

Poor Housing: Improve the number and condition of housing in order to address problems of overcrowding and related serious health and social problems.

Dust: Pave roads within communities in order to reduce dust and air-borne contaminants and associated health complaints.

Mercury and Lead: Reduce relatively high levels of mercury and lead among Cree population.

Tobacco Use: Reduce the rate of tobacco use among Cree youth so as not to exceed current general Quebec rate for youth.

Iron Deficiency: Finalize the research on the cause of the phenomenon and find solutions to reduce the prevalence.

Social Wellness

Post-Residential School Trauma: Heal the multi-facetted trauma associated with past attendance at residential schools, including:

Post-traumatic disorder;
Physical, psychological and sexual abuse;
Intergenerational breakdown.

Ethno-stress: Study the consequences of the problem and address this symptom of post-colonialism.

Abuse and Violence: Zero-Tolerance

Intergenerational abuse
Conjugal violence

Suicide: Address root causes of suicide and para-suicide and seek to eliminate.

Youth protection: Reduce the level of youth under youth protection and placement.

Youth Readaptation: Implement the action plan adopted by the Cree Health Board in November 2002.

Alcohol and Drugs: Reduce the negative consequences of the alcohol and drugs abuse.

Gambling: Raise the awareness of the population related to negative consequences of habitual gambling and reduce such consequences.

Specific Means Objectives – 2004-2009

The Cree Health Board has identified the following specific objectives of means for the period 2004-2009, each of which is discussed in greater detail below:

Public Health and Prevention: Invest heavily in public health and prevention to address present and emergent problems (diabetes, dental health, etc.).

Access to Local Services: Improve access to all possible services that can be provided in each community in the Cree Integrated Health and Social Services Centres.

Access to Specialized Services: Ensure access to specialized and ultra-specialized services at the right place and at the right time.

Youth Services
Addiction services (Healing Lodge)
Chisasibi Hospital services and Mistissini Integrated Clinic

Funding: Obtain the financial resources needed:

Catch-up budget to provide adequate resources for current operations
Development budget to improve services for the Cree population
Funding rules to ensure stability and predictability of resources
Capital budget (facilities, office space, housing, equipment)
Management systems

Human Resources: Ensure the recruitment and retention of appropriate numbers of qualified staff and the development of Cree human resources.

Public Health: A Population-Wide Perspective of Miyupimaatisiiun

Miyupimaatisiiun: Invest in surveillance, promotion, prevention, protection, research, training and policy-making in order to address all determinants of *Miyupimaatisiiun*, including the following measures:

Introduce traditional Cree approach in all public health activities.

Introduce Cree language as the main working language in all public health activities.

Public Health: Adapt and implement the *Programme National de Santé Publique 2002-2012* at regional and local levels in collaboration with relevant departments and with Cree First Nations. Special attention shall be addressed to the following public health objectives for the period 2004-2009:

Diabetes and Obesity: Reduce the prevalence of obesity and the incidence of diabetes (focusing on gestational diabetes).

Leukoencephalitis: Introduce genetic counselling and services in order to prevent leukoencephalitis and leukoencephalopathy.

Dental Health: Research and implement integrated and adapted dental health prevention programs.

Infectious Diseases: Control infectious diseases by immunization, health education, environmental interventions and improved surveillance.

Sexually Transmitted Diseases: Implement sexual education and addictions control in order to reduce the rate of sexually transmitted infections at least to the general Quebec rate with a view to preventing the introduction of HIV infection in the region:

Tobacco: Adapt and implement tobacco cessation activities.

Gambling and Substance Abuse: Educate and carry out socio-environmental interventions to prevent pathological gambling, drinking and drug abuse.

Family Support: Adapt and implement an integrated program to empower young and vulnerable mothers and fathers, and support families with babies and young children.

Surveillance: Reinforce surveillance, knowledge and research, and implement a comprehensive and regular survey of population Miyupimaatisiiun.

Networking: Public health national and international networking with other First Nations.

Prevention: Support preventive interventions in clinical settings.

Trauma: Educate, regulate and undertake activities to prevent trauma.

Environmental Health: Implement a comprehensive environmental health program, including:

Mercury program
Environmental health impact assessment of large development projects
Evaluation and recommendations for outdoors and indoors air quality

Surveillance of water quality
Implementation of Healthy Communities Program

Emergency Preparedness: Prepare and implement an emergency preparedness plan for each Cree community.

Cancer Screening: Implement breast cancer screening program (PQDCS) and integrated strategy against cancer.

Mental Health: Protection and improvement of mental health

Suicide prevention
Violence prevention

Senior Integration: Reintegration of seniors in community and social life.

Occupational Health: Adapt and implement occupational health programs

Cree Integrated Health and Social Services Centres

In order to improve access to local health and social services, the Cree Health Board has developed, and will implement, a model for the integrated delivery of health and social services in the Cree communities, taking into account the special requirements of each. The general concept of the ‘‘Cree Integrated Health and Social Services Centres’’, or, for brevity, ‘‘Cree Integrated Centres’’ (CIC), is based on five principles:

Local Services. The maximum of services is to be provided close to the population, in each community. The CIC will provide on a community basis, as illustrated in figure 5.2.2.2, the following services:

First-line services usually available in a CLSC
Emergency services and acute health care
Preventive services relating to the Programme national de santé publique 2002-2012
Services planned for the ‘‘Multi-Service Centre Phases I and II’’
Services for Youth and Families (Readaptation, Young Offender, Youth Protection, Adoption)
Services provided with Traditional Approaches
Outpatient rehabilitation services (e.g. hospital, private service models)
Pre-hospital services (ambulance services, first responders)

The corollary is that regional programs or services, for which no possibility or advantage for the clients exists of decentralization, will be maintained at a regional level of delivery. Such regional services could include, for example, group homes for youth, a reception centre and a regional hospital.

Integrated Services. Services are to be organized primarily for the people on the basis of their needs. This requires an integrated vision of the range, quantity, quality and continuity of services to be delivered.

Access. Access to services for the population shall be ensured during a convenient and extended regular operating schedule of at least 80 hours per week. In addition to this regular schedule, an emergency, on-call mechanism shall provide services around the clock in each community.

Regional Network. Each CIC is to form part of a Cree network of health and social services and shall be closely linked to the regional level of programs and services and to the CBHSSJB head office.

Flexibility. While the model is of a "one-stop" service centre integrating all local services under one roof, circumstances in certain communities may require that services be made available in more than one facility.

This chapter outlines in concrete terms certain specific objectives concerning services to be made available in each Cree community. These objectives should be viewed keeping in mind the following preliminary observations:

This approach of a Cree Integrated Service Unit is to be implemented by means of an integrated vision of the work organization and the development of versatile, multi-disciplinary work teams and professionals (having due regard for their respective competencies), that are able to provide the variety of services needed by the population. Over-specialization should be avoided.

Prioritize promotion, prevention, health and psychosocial services for 0-5 and 6-11 year olds due to the demographic youth profile.

Services must be provided that may extend beyond the strict notion of first line services (i.e. minor surgery, specialized clinical dental services, haemodialysis), taking into account the distance of other health services.

The Cree Integrated Centre approach does not necessarily imply that all services are to be provided at all levels and in all communities. The suggested distribution of services between local, regional and extra-regional levels is indicated in Table 5.1.1.

General (First-Line) Services

Improving access to general (first line) services implies the development in the Cree communities (both at the Chisasibi Hospital and at the Cree Integrated Centres) of a better-adapted response to the needs of the Cree population. This enhanced and adapted response should allow on-site treatment (in the region) for all possible health and social service problems, treated within the technical capabilities of a small hospital or CIC's. The Cree Health Board will have the capacity to treat all people within the region, thereby avoiding painful and stressful trips, wasted time, anxiety and separation from their closest relatives. The cost related to these trips is also considerable.

General (first-line) services will include, among others, the following.

Reception

General Health Services

- Medical Services
- Nursing Services
- Clinical Dental Services
- Psychosocial Services

In addition to all the responsibilities of managing and operating a regional health and social services organization, the Cree Health Board faces the challenge of providing services within the context of the socio-cultural characteristics of the Cree people of James Bay. One such challenge to establish a proper definition of the nature and magnitude of the "social" problems of the Crees of Eeyou Istchee. Another is to develop and establish a model of social and mental health services delivery that is consistent with traditional values in the face of shifting policies of various governments with different ideologies.

This effort will yield several benefits. First, it will shed light on the myriad of medical problems that actually stem from social origins. Second, it will emphasize the importance of maintaining a healthy lifestyle based on traditional Cree knowledge and identity. Third, it will integrate best "Western" practices in equal balance with Cree helping methods, allowing individuals a real choice in the treatment process. For this system of service to be stable, it is imperative that the resources allocated to it be recurrent and predictable as part of the overall operations of the Cree Health Board organization. It is also necessary that the relevant legal framework for various activities be reviewed and, if necessary, adapted to ensure congruence with the proposed model.

Psychosocial Services

- Psychosocial Reception
- Intervention in Situations of Emotional Crisis or Social Emergency
- Mental Health Services

Youth and Family Services

- Pre- and Post-Natal Services for Children 0-5 Years Old and Their Parents
- Services for Children 6-11 Years Old and Their Parents
- Services for Youth 12-24 Years Old and Their Parents

Other General (**First**-Line) Services

- Home Care Services
- Foster Home Services (elderly and disabled)

Specific Services

- Services for Youth and Families
- Rehabilitation Services (Hospital, Private-Services Type)
- Multi-Service Centres –Phases I
- Services for Elderly
- Services for Physically Handicapped
- Services for Intellectually and Mentally Challenged
- Residential Services Centres (Multi Services Centres Phase II)
- Healing Lodge
- Women Shelter (Community Organism Support)
- Meal Assistance Services
- Pre-Hospital Services (Ambulance Services, First Responders)

Cree Helping Methods

Cree Helping Methods are to be introduced to provide a choice to the Cree population. This will involve a consultation process with the membership in the nine Cree communities, and, more specifically, with the elders to define traditional and cultural based helping methods used to treat and help individuals, families and the community. The participatory research project will determine the future direction and orientation of this department, including the following:

- The organizational structure
- The development of programming and services for the organization and for the Cree population
- The cultural integration of Cree values and beliefs into the delivery and management of health and social services

Access to Specialized and Ultra-Specialized Services

Implement the Re-adaptation Action Plan Adopted in November 2002

While young people aged 0 to 17 years represent 22% of the overall population of Québec, this group represents 37% of the total Cree population in this region. According to the Lebon Committee report, released in 2001, the Cree region shows many indicators of great needs among the youth population. These indicators are the followings:

- A high number of births (18%) involved teenagers
- A fairly high number of children are victims of sexual abuse
- Several children have alcohol and drug abuse problems
- Due to the lack of activities and opportunities, there is a general idleness among young people, which leads to behavioural problems and acting out (vandalism, sniffing)

- Some children spend the night from place to place due to the lack of parental guidance and to presence of deviant behaviour in the home such as domestic violence or alcohol abuse.

Other findings have been pointed out by Lebon's committee. These findings are the following:

- A large proportion of young people are under the care of social services and youth protection
- A large proportion of children whose cases are being monitored are removed from their families and placed in a foster family
- Even in the absence of indicators based on rigorous measurements, it may be said that the incidence of high-risk cases among is definitively and significantly higher in the Cree community
- The resources-per-population ratios generally applied elsewhere in Quebec cannot be applied in Cree territory

An action plan has been developed to improve the overall situation of the youth. This action plan proposes the following goals:

- To develop a complete framework for the regional circle of services of youth and their families
- To realize a continuum of services options for troubled youth and families in Readaptation services
- To have an effective care management system in Readaptation services
- To have appropriate facilities for residential programs
- To help staff to possess the skills, knowledge and ability necessary to offer effective child care services
- To develop appropriate administrative structures for Readaptation services

Implement the Healing Addictions Program Adopted in July 2002

The Healing Lodge program aim to enhance the healing process of individuals who seek help and support by offering culturally oriented approach with respect the values and beliefs of the individuals.

The goals of the Healing Lodge program are the following:

- To foster a community supportive network for individuals and families who are encountering social crisis, related to alcohol or drug addiction
- To promote the revival of community ownership and responsibility of the well being of individuals and families
- To empower individuals to take ownership of their own personal issues through the Medicine Wheel teachings and the twelve (12) steps of the A.A. Program
- To commit to the healing journey of individuals who seek help and guidance in their personal lives.

Improve Access to Hospital Services (Basic, Specialized, and Ultra-Specialized)

- Expand the range of services available at the Chisasibi Hospital. This entails consolidating all general and specialized medical services and developing minor surgical activities that a 32-bed hospital can provide in accordance with applicable provincial standards for its patients.
- Resolve all safety issues related to the existing building.
- Improve the computerization of the hospital.
- Establish a capacity for minor surgery, services that would be offered by visiting surgical teams. Renovate the operating room to make it functional. (The nature and the volume of these minor surgeries will be determined in a complementary study).
- Provide appropriate specialized medical equipment.
- Dedicate certain of the total of 32 beds to intensive care.
- Consolidate haemodialysis services and develop facilities for patients from outside Chisasibi.
- Consolidate (considering the experience of Chisasibi Hospital with Sherbrooke University Hospital) a telemedicine system that includes full support for high-speed digital exchange of diagnostic data, video conferencing with all Cree clinics and other hospitals and videophone.
- Improve emergency room facilities.
- Optimize the hospital services in accordance with best practices.

Establish Certain Hospital-Type Services at Mistissini Integrated Health and Social Services Centre.

The three southern communities accounted for 68.2% of the 14,500 medical transports in 2001/02. Mistissini, the largest of these, accounted for 40.1% of the regional total. The southern district's reliance on external hospital services is also disproportionately high. Over five years (1996/97 to 2000/01) the southern district Med-Echo hospitalization rate fluctuated between 20,000 and 25,000 per 100,000 population. This equates to an extremely high annual rate, with a large number of southern district residents receiving hospital services.

Much of this traffic is for access to "light hospital services", which could be realistically offered in augmented southern district clinics. There is also strong potential for reducing the need for hospital services through preventive measures. To improve the southern district services and reduce the need for avoidable trips, the following measures would be implemented:

- Establish a radiology service with a capacity for general X-rays and specialized X-rays, ultrasound, and NST (non-stress tests) for pregnant women. This to include training for the General Practitioner (GP) to read X-rays, as already being done in Chisasibi, and full implementation of telemedicine to assist GPs for verification of X-rays and ultrasounds.

- Establish a basic laboratory, particularly for treatment of infections and for haemodialysis services (water filtration system, sterilization, etc.). This laboratory will focus on the diagnostics for the procedures that will be available locally.
- Establish a Paediatrics Outreach Programme, from Chisasibi Hospital Centre. This will be an intensified version of the one currently in place in Chisasibi, which makes use of short-term beds in Mistissini and has strong linkages with specialists, particularly from Chibougamau.
- Establish a light surgical station, so that resident general practitioners and visiting specialists will have an adequate work area.
- Establish an 8-bed acute ward with a nursing station. Six beds will be designated adult and two Paediatrics, although the spaces will be multi-purpose if necessary. Of these, one bed will usable for secure observation of psychiatric cases; one will be usable for isolation; and four will be equipped for ICU.

Partnerships with External Hospitals

The Cree Health Board is critically aware of the need of its main partners – Chibougamau and Val d' Or Hospitals – to maintain viable surgical and specialist teams that can serve both their own service populations, and the Cree region population where this role makes sense. These hospitals are also particularly well positioned to provide direct and indirect support to the three southern Cree clinics.

Formal contractual links are required between the Cree Health Board, on the one hand, and the Regional Health Boards of Chibougamau, Abitibi-Temiscamingue and Montreal, on the other. These links will provide rotating surgical teams and specialists necessary for Eeyou Istchee northern and southern districts to offer a range of "basic hospital" and "light hospital" services.

These contractual links will provide not just in-region support for basic and specialized services, but streamlined access to the specialized and ultra-specialized services found in designated special-role facilities.

In connection with these contractual links and with improvements in regional services, a clear, enforced policy will govern the transportation of patients from Cree communities to the appropriate centre for treatment.

Finally, these contractual links will provide administrative solutions to long-standing questions of geographic responsibility, such as who should provide ambulance and Medivac services under various circumstances, and where these transports should be directed.

FIGURE 5.1.1

CREE INTEGRATED HEALTH AND SOCIAL SERVICES CENTRES

PREVENTION	**Reception** **Interpreter Services**	**PSYCHO SOCIAL** **General Psychosocial Services** **Mental health** **Youth and Family**
HEALTH SERVICES **Medical** **Nursing** **Minor surgery** **Blood test** **Wound care** **Dental services** **Pre-Hospital services**	**REHABILITATION** **Rehabilitation services** **O.T.-P.T.-S.T**	**SPECIFIC SERVICES LINKED WITH REGIONAL PROGRAMS** **Woman shelter** **Adapted transport** **Community organisms** **Readaptation for youth and family** **Addiction Healing services** **Info-Health/social**
		MULTI SERVICES DAY CENTRES FOR ELDERLY AND DISABLE
HOME CARE **Home care services** **Meal assistance** **Foster families for elderly and disable**	**CREE HELPING METHODS**	**RESIDENTIAL SERVICES FOR ELDERLY AND DISABLE**

Legislation

Introduction

More than a quarter century has passed since the adoption of the *Act to amend the Act respecting health services and social services*. [21] This statute was enacted by the National Assembly in order to implement the provisions of Section 14 of the JBNQA respecting health services and social services for the Crees of Eeyou Istchee. The statute empowered the Government to delineate Region 10B (now 18) and to establish there a regional health and social services council. [22] This council was to fulfill the functions, duties and powers of a regional council while maintaining a public establishment belonging to the classes of a hospital center, a local community service center, a social service center and a reception center. The Cree Health Board and Region 10B were formally established by Order in Council 1213-78 on 20 April 1978.

This hybrid status of the Cree Health Board is unique in Quebec. The dual function of the Cree Health Board has never been easily accommodated in the general legislative framework for health and social services in Quebec. The role and functions of the Cree Health Board as a regional council have been under-funded, since scarce personnel and resources have, of necessity, been focused on acute service needs. In short, the strategic, planning and organizational functions of the Board have been underdeveloped. In the result, the Board has been burdened with structural deficiencies, which have made it difficult for it to discharge its statutory functions towards its population and to secure its fair share of resources for the development and delivery of services.

The mismatch between the legislative framework governing the Cree Health Board and that governing regional boards elsewhere in Quebec has increased since the enactment of the Act respecting health services and social services, R.S.Q., c. S-4.2. This Act provides for new functions and institutional organization for regional health boards. While the Crees rejected certain aspects of Chapter S-4.2, particularly its emphasis on centralization of decision-making, the fact remains that the Board has found itself even more marginalized within a health and social service network entirely premised on S-4.2 as an institutional framework.

The Cree Health Board considers necessary a critical reassessment of its current legislative framework in the context of the aspirations and needs of the Crees of Eeyou Istchee regarding health and social services; the underlying principles of Section 14 of the JBNQA; and a comparison between the functions, powers and organizational structures expressed in Chapters S-5 and S-4.2.

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21 S.Q. 1977, c. 48, now incorporated into the *Act respecting health services and social services for Cree Native persons*, R.S.Q., c. S-5.

22 *Ibid.*, s. 38*j*.

The time may have come to consider modernizing, where appropriate, the provisions of Section 14 of the JBNQA and of its legislative framework, Chapter S-5. Any such initiative must be led by the Crees and carried out in full respect of Cree rights under the JBNQA. Given the sensitive and long-term nature of any such initiative, which could culminate in amendment of Section 14 of the JBNQA by way of Complementary Agreement, it will require careful analysis and consultation with potentially affected stakeholders. A more comprehensive consideration of these issues is recommended as part of the implementation plan.

Principles

At the outset, it is worth recalling certain basic principles governing health and social services for the Crees of Eeyou Istchee as expressed in Section 14 of the JBNQA:

Section 14 establishes a special regime for the Crees of Eeyou Istchee regarding health and social services, and creates a unique relationship between the Crees and Quebec in this regard.

The rights and benefits of the Crees under the JBNQA may not be amended without their consent.

Section 14 creates the Cree Health Board as a Cree entity, under Cree control.

The Cree Health Board is to have the powers and functions of a regional council under the Act respecting health services and social services (now Chapter S-5).

In addition, the Cree Health Board is to have authority over a public establishment belonging to the classes of a local community service center, a hospital center, a social service center and a reception center.

Objectives

From the above principles flow certain objectives relating to the legislative framework of the Cree Health Board:

The legislative integrity of the rights and benefits of the Crees under Section 14 of the JBNQA must be protected from erosion or interference.

Legislation potentially affecting the rights, benefits and interests of the Crees under Section 14 of the JBNQA s hould not be presented for enactment without the prior consent of the Crees.

The Cree Health Board must be provided with the resources required to fulfill the full range of its powers, functions and duties under Section 14 of the JBNQA and Chapter S-5.

The Crees of Eeyou Istchee must have the opportunity to consider the adequacy and responsiveness of Section 14 of the JBNQA and Chapter S-5 to current health and

social service requirements, including financial, operational and institutional arrangements, and, where appropriate, to propose changes.

Jurisdiction

The Cree Health Board exercises jurisdiction in health and social service matters over Cree Category IA, IB and II lands, now designated administratively as Region 18. [23] The Board is responsible for the administration of appropriate health and social services for all persons normally resident or temporarily present in Region 18. Although not formally recognized in the legislation, the Cree Health Board also provides certain support services outside Region 18 to Cree patients who require treatment or services that can only be secured, at present, elsewhere.

Consideration should be given to formalizing the jurisdiction of the Cree Health Board over selected health and social services for Crees outside Region 18. Moreover, given the likely acceleration of resource development in Eeyou Istchee resulting from the New Relationship Agreement of February 2002, it may also be appropriate to consider enabling the Cree Health Board, at its option and subject to receipt of the required resources, to provide health and social services in the James Bay Territory outside Region 18 or to changing the boundaries of Region 18 to this end.

Functions

Section 18 of Chapter S-5 requires the Cree Health Board, in its capacity as a regional council:

> (*a*) to encourage the participation of the population in defining its own needs in health services and social services and in the administration and operation of the institutions providing such services;
>
> (*b*) to ensure sustained communication between the public, the Minister and such institutions;
>
> […]
>
> (*d*) to advise and assist the institutions in the preparation of their programs to develop and operate health services and social services and to assume the duties that the Minister entrusts it with to carry out such programs;
>
> (*e*) to promote the exchange, the elimination of duplication and the better distribution of services in the region and the setting up of common services for several institutions;
>
> […]

23 JBNQA par. 14.0.5; S-5 s. 51; Order-in-Council 1213-78.

> (*f*) to send the Minister, at least once a year, its recommendations to ensure adequate apportionment in its territory of the resources devoted to health services and social services and the best possible use of the available resources; […]

The problem here is not so much the statutory definition of the functions of the Cree Health Board as the provision of resources adequate to permit it to discharge them. This issue is addressed in Chapter 10.

Planning and Priorities

Currently, under Chapter S-5, the Cree Health Board must submit a regional medical and dental staffing plan to the Minister for approval, with or without amendments. [24] The planning and priority functions under Chapter S-4.2 are considerably more detailed. Consideration should be given to incorporating these planning and priority functions explicitly into Chapter S-5, while adapting them to the special circumstances of the Crees and the underlying principles of Section 14 of the JBNQA.

Three-Year Plan

S-4.2 provides that regional boards must prepare a three-year strategic service organization plan (Thee-Year Plan). Section 346.1 of Chapter S-4.2 requires that the Three-Year Plan must indicate the financial implications of the measures it contains and take into account the financial resources at the disposal of the regional board.

Human Resources Development Plans

Regional boards must draw up a regional resources development plan based on the orientations and policies established by the Minister and in cooperation with the institutions and organizations concerned. The regional board is responsible for the implementation of this plan, and must coordinate personnel development activities within the scope of the regional service organization plans and for the members of the boards of directors of institutions and assist community organizations with regard to resource development activities for their members.

Regional Medical Staffing Plan

This plan is prepared by a regional board based on the organization plans submitted to it and on the Minister's expansion or reduction objectives, the number of physicians required to perform certain specific activities, the recommendations of the regional medical commission, and the recommendations of the regional department of general medicine.

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24 S-5, s. 70.0.2

Regional Service Organization Plans

Regional boards under Chapter S-4.2 must develop regional service organization plans in accordance with the Three-Year Plan and in cooperation with the institutions and community organizations in the region. The service organization plans identify the services required to respond to the needs of the population in the region, taking into account, in particular, the health and social resources in the region, the mission of the centers operated by the institutions of the region, the financial resources identified for such purposes, and the social, cultural and linguistic characteristics of the population of the region. [25]

Under Chapter S-4.2, the regional service organization plans must be consistent with the orientations determined and policies established by the Minister who may, subject to the rights of third persons, cancel a decision made by a regional board pursuant to a service organization plan that is inconsistent with the Minister's orientations and policies. [26]

Here, the model of the regional service organization plan would require some modification. Given the principle of Cree jurisdiction and control over health and social services set forth in Section 14 of the JBNQA, the orientations and policies underlying the definition of the Cree Health Board's regional service organization plan would be determined by the Cree Health Board itself in consultation with the Cree First Nations and other affected stakeholders.

Governance

Representation

Section 54 of Chapter S-5 essentially reproduces Section 14.0.11 JBNQA regarding the composition of the board of directors of the Cree Health Board. The board of directors consists of elected representatives of the Cree communities, clinical staff and non-clinical staff, as well as a representative appointed by the Cree Regional Authority, the Director of Public Health and the Executive Director of the public institution. This composition serves better the principles of Cree control and autonomy than the largely appointed boards of regional health boards subject to S-4.2.

Chairperson

Given the time commitment required by this position during the development of the Cree Health Board, which will continue for the foreseeable future, consideration should also be given to providing a regular salary for the Chairperson. Mechanisms to enhancing the independence and accountability of this key position should also be considered.

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25 S-4.2, s. 347.

26 S-4.2, s. 347.

Complaints

Chapter S-4.2 sets out a detailed complaints procedure for users of health and social services. This procedure functions on a number of levels. At the institutional level, every institution's board of directors must establish a complaint examination procedure [27] and appoint a "local service quality commissioner". [28] A medical examiner and a review committee must also be appointed by every institution to handle complaints regarding physicians, dentists and pharmacists. [29]

Certain complaints may be addressed directly to the regional board. [30] The board of directors of the regional board must also establish a complaint examination procedure [31] and appoint a regional service quality commissioner. The institution submits an annual report regarding complaints to the regional board. [32] With a view to enhancing client responsiveness and accountability, consideration could be given to adapting certain of these elements for the Cree context.

Management Systems

The Cree Health Board is a unique and complex organization with a multidisciplinary triple mission.

- Provide direct health and social services to the population.
- Plan, organize, coordinate, budget and evaluate health and social services of the region. This is the mission of a "Regional Board of Health and Social Services".
- Provide public health programs and services.

These three missions make more complex the management of the organization and the northern conditions add to this inherent complexity.

The purpose of establishing sound management systems is to allow the Cree Health Board organization to operate with good management, transparency, confidentiality and security for patients and workers and to meet the required accountability in all respects.

The Cree Health Board's priorities in this regard are the following:

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27 S-4.2, s. 29. Section 34 sets out the minimum content of a complaint examination procedure.

28 S-4.2, s. 30.

29 S-4.2, s. 42, s. 51.

30 S-4.2, s. 60 (e.g. by persons residing in a nursing home, persons requiring pre-hospitalization emergency services, services or subsidies that the complainant ought to be receiving, etc.)

31 S-4.2, s. 62

32 S-4.2, s.76.10

Organizational Structure

In addition to the organizational and legal elements discussed in Chapter 6, the Cree Health Board would implement the following organizational priorities:

Adjust the organization chart to include a position for the purpose of the ‘‘Cree Helping Methods’’.

Develop and implement a Planning and Evaluation Department under the responsibility of the Executive Director. This Department will develop and operate the information systems needed as a basis for the strategic planning, decision-making and policy-making processes. This Department will be responsible for producing regular feedback (balanced score cards) to evaluate the achieved results and outcomes

Develop a Corporate Office with the following functions:

- Consolidate a Corporate Secretary position;
- Establish an effective and efficient CBHSSJB Communications Department responsible for the following functions:
- Ensure that employees are aware of the Cree Health Board’s mission, objectives and activities;
- Keep the employees informed as to the Cree Health Board’s policies, norms and procedures;
- Promote inter-personal, departmental, and inter-departmental communications;
- Ensure that the Eeyou nation receives the relevant and appropriate information regarding health and social services as well as the activities, policies and procedures of the Cree Health Board;
- Promote communications mechanisms to update the Board of Directors regarding the activities of the organization;
- Translation Service
- Retain a Cree translator for translating French and English documents into Cree for the use of Cree clients.
- Documentation Service
- A full review of the documentation centre is necessary in terms of reorganization and implementation purposes. This will promote access to all research documents and CBHSSJB publications. The services in the past included: acquisitions, medical library, lending and borrowing of acquisitions, reference section.
- There is a need to develop and establish a centralized and standardized filing and archival system for the administrative office of the Cree Health Board. Training on filing and retrieval system will be provided to all secretaries and administrative technicians.

Strengthen the links between the Cree Health Board and each community.

Decentralize decision-making to the lowest possible level of managers while reserving strategic decisions and key elements of control and evaluation to the board of directors and senior management.

Develop and maintain formal links with the MSSSQ and other regional health boards in order to be connected to the latest information and program developments.

Management Information Systems

The Cree Health Board is well aware of the need to develop and establish an integrated and decentralized Management Information System. The system will provide to managers the specific data they need to make sound decisions. The system will also permit managers to evaluate current activities and take corrective measures if necessary. To implement such a system, the following elements are needed:

Improve the Financial System:

> The goal is to have a reliable, up-to-date and integrated Financial System. The System will be based on a thorough needs assessment in order to meet all the requirements to provide the information as needed by the Board of Directors, managers, external auditors and the MSSSQ. It will connect all the independent components (e.g. NIHB, dental services) to the main accounting system. It will have the following characteristics:

- Core accounting system
- Rectifiable (cost recovery) components
- Patient transportation - insured and non-insured (all Cree Patient Services)
- Drugs (medications)
- NIHB

Implement the Personnel Information System.

Improve the Social Services Information System.

Clinical Information System

A Clinical Information System will be developed and implemented with the following characteristics:

Implement the patient/client information system: The goal is to have a system that provides the right information according to the norms of archives

Continue to install and improve medical technology systems based on information and communication technology

- Tele-Medicine
- Diagnosis support systems
- Computerized patient chart

The objective is to make the systems available and easy to use for the managers to help them to meet the objectives of the Cree Health Board. All information systems and sub systems are to be connected with the Planning and Evaluation Department.

To summarize, the Cree Health Board will develop the infrastructure for management system required to manage and operate the organization with efficiency for the benefit of the entire community and to be fully accountable for its activities and administration.

Personnel

Introduction

The Cree Health Board faces exceptional challenges in obtaining and retaining qualified and competent personnel for the current level of services and to prepare the ground for the future catch-up and development of human resources that is essential.

The organization experiences high staff turnover at all levels, related largely to the high stress work environment and difficult living and working conditions. Most of these difficulties are related to the Nordic conditions, isolation, distance, and a chronic shortage of local trained human resources.

This chapter identifies those issues directly related to personnel and establishes the main challenges facing the Cree Health Board in this regard.

First Challenge: Elevate Cree Representation in the Organization (Capacity Building)

After more than a quarter-century, the expectation of a primarily Cree-staffed regional board remains unfulfilled. This goal can be reasonably met, according to a realistic schedule, if the following measures are implemented:

- Structure a regional organization in which a Cree-controlled, predominantly Cree professional force delivers services to a predominantly Cree population.
- Set Cree hiring targets, by program and by department, so that all stakeholders work consistently towards achieving the desired levels of Cree representation.
- Develop a Cree Replacement Program to replace non-Cree staff by Crees.
- Improve the partnership with the Cree School Board in order to identify and support Cree students who want to become health and social services professionals.
- Carry out concrete measures to encourage, groom, and support Cree students through the long educational journey towards the health and social technical professions.
- Examine job descriptions with a view towards eliminating unreasonably high qualifications that limit Cree employment in the organization; without reducing employee quality (adaptation of the job definitions to the realities of the region).
- Develop a new strategy for reaching potential Cree recruits which emphasizes both the challenges, and the rewards, of public service within the Cree Health Board; the goal should be quality before numbers.

Second Challenge: Obtaining and keeping Qualified and Competent Personnel

The Board faces all of the usual ‘‘southern’’ recruitment challenges, greatly amplified by the northern context.

Develop a long-term human resource plan

- The Board must move towards long-term human resource planning, which includes all categories, including physicians, and which takes into account the progressive replacement of non-Cree staff by Crees.
- The human resource plan will take into account the staff needed, which is closely connected to the strategic regional plan.
- The human resource plan will pinpoint the key jobs to fill and set priorities.

Develop a recruitment and retention policy

- Develop a single vision for recruiting in accordance with the values and objectives of the Cree Health Board and based on standards of professional skills, cultural sensitivity, and overall interest for northern regions for the new personnel.
- Carry out aggressive programs of advertising in the Native media, within Quebec and outside Quebec.
- Revise the time-consuming system for conducting interviews; in particular, make use of efficient technologies, such as video conferencing.
- Devote a website devoted to recruiting and retention.
- Ensure that no one is hired until the applicant’s references, and previous employers, have been personally contacted.
- Develop or use all the useful tools to evaluate each candidate through the recruitment process.
- Extend recruitment, including advertisements and job fairs, beyond Quebec; this will ensure a sufficiently large pool of applicants, and it will reach Cree and other Natives who might apply.
- Develop a plan for the recruitment and retention of doctors, nurses, dentists, pharmacists and other key jobs. Involve the communities in the development and implementation of this plan.
- Issue all new personnel with an introductory kit including information on: the JBNQA treaty; the history of the Cree Health Board; the cultural and geographic milieu; and practical information such as how to have an enjoyable stay.

Improve the **training** strategies

- Carry out high quality routine training on three levels (orientation, basic, and advanced). We must move away from a system where some staff gets no training or training is infrequent or discontinuous.

Target some special training activities for workers in direct contact with the clientele to develop their cultural awareness, sensitivity and skills to help and support them to deal with the specific realities of the Cree population.

Allow for special training of non-unionized personnel including managers, physicians, and dentists.

Recognize and enforce the non-optional nature of training and development activities among all categories of personnel.

Train all personnel to replace, for short periods, their immediate supervisor.

Allocate a budget for the training and development activities.

Support **professional** development

Improve monitoring and evaluation of personnel. Use employee performance evaluations as a tool for support and development.

Simplify and shorten job descriptions.

Involve the managers and the Human Resources specialist in what will become a joint process of professional development.

Recognize that the best training is apprenticeship, and support managers in providing staff with constant opportunities to learn new functions through hands-on experience.

Designate for every manager a successor in the event of his/her absence, even for a short period.

Give time to employees for self-improvement.

Provide cultural leave.

Familiarize persons identified as ‘‘acting’’ managers, on a routine basis, with the issues and files of the manager whom they will have to replace.

Provide **employees** with support to meet and maintain professional standards

Ensure the development of professional and ethical standards.

Ensure the development of intervention protocols.

Ensure the development of policies and procedures.

Support and monitor the professional activities.

Ensure a multidisciplinary protocol approach.

Establish a user committee.

Define program standards

Develop effective programs that are culturally sensitive and measurable.

Ensure appropriate consultative methods in the process of developing programs.

Ensure that all programs are systematically and periodically evaluate.

Third Challenge: Repositioning and Enriching the Role, Status and Responsibilities of Managerial Personnel

Decentralize budget planning and control to managers.

Introduce performance measurements, recognition systems and support to manage the current activities and changes.
Provide a career mobility and opportunity inside the organization.
Provide managers with the key job tools (i.e. computers, management information systems, on line job descriptions, policies and procedures score cards) that are needed to effectively meet set goals.

Fourth Challenge: Provide Fair and Attractive Working Conditions and Personnel Support

The Board faces serious challenges both in terms of its ability to maintain the support needed for personnel retention, and in terms of the mutual obligations of personnel and organization:

Define working conditions, obligations, and union agreements and help employees to meet them.
Implement innovative measures to reduce effort spent on CSST administration, and to reduce an elevated, systemic tendency to use benefits of the CSST program.
Reduce the number of employees burned-out by reducing workloads through additional front-line personnel and through greater efficiencies at all levels.
Revisit the Housing Policy in light of the fact that a major program of new housing investments makes certain aspects of the policy counter-productive.
Develop a program (Employee Assistance Program) that assists employees with unresolved issues that may possibly affect work performance.
Develop employee recognition programs,
Require applicants for positions, which involve counselling, or therapy to take the standard psychological tests that are required elsewhere.
Make available for managers instant access to personnel statistics including: sickness, days spent in transit, overtime worked, and staff availability.
Make managers and staff accountable for performance and for results. This will promotes responsibility, reaching objectives, and job satisfaction.

Capital Issues

Introduction

Capital issues are among the most important concerns for the Cree Health Board. Many reasons explain these concerns, including the following:

The evident lack of functional space in the facilities in most communities to deliver health and social services to the population;

The lack of adequate housing for the current personnel, comprising both those already hired and working, and those who cannot be hired due to lack of housing. Indeed, in certain program areas such as diabetes and public health, the Cree Health Board has

already received the development budget but is unable to implement the programs due to a lack of housing for essential employees;

The lack of adequate housing for personnel to be hired shortly in the context of future development budgets to be negotiated. The housing issue must be addressed along with the development budgets;

The lack of administrative space and administrative equipment, particularly in the head office, makes it difficult to meet management and administrative requirements;

The lack of adequate operations, maintenance, repair and renovation funds for buildings and facilities, combined with the harsh climatic conditions of the region, accelerate wear and tear to the facilities and require additional investment in order to replace such facilities;

The need to address deficiencies in the current inventory of medical equipment in order to optimize the delivery of health services; and

A management information system that is completely inadequate, which requires extensive reconfiguration, upgrading, and expansion.

The Cree Health Board has 130 buildings and residential units distributed among the nine communities. These existing facilities need, in many cases, repair or reconstruction. Notwithstanding future needs, the present level of activities requires an increase in new space for services as well as for offices and lodging. The development of services envisaged in this Strategic Regional Plan implies an additional demand of space for services, offices and lodging.

The following sections outline:

the inventory of existing buildings, facilities and residential units arranged by the Corporation d'hébergement du Quebec;

new buildings and facilities needed pursuant to the Strategic Regional Plan;

capital needs regarding specialized medical equipment; and

information technology capital requirements.

Buildings and Facilities

Corporation d'Hébergement du Québec (CHQ) Capital Inventory – Existing Facilities

In the course of developing this Strategic Regional Plan, architectural assessments of all CBHSSJB residential and service facilities were undertaken, between December 2002 and February 2003, through a joint inventory project with the Corporation d'hébergement du Québec. Three architectural engineering firms inspected the

facilities, reviewed previous structural assessments, and provided a large and co-coordinated set of physical assessments. The firms were required to follow a Protocol of Capital Inventory and a Protocol of Building Audit provided by the CHQ. All the facilities, including houses, were assessed. A comprehensive report resulted from this process, comprising one volume for each community. The capital inventory describes the physical condition of the buildings and identifies which of the assets need to be repaired.

Asset repair is the work needed to maintain a building in a such condition as to be suitable to its function, and be in compliance with building codes and the applicable norms, specifically for the security of the occupants and users. Asset repair does not include the work that would be needed to improve the functionality nor the regular maintenance works needed for the building. [33] It should be noted that the CHQ assessments did not consider functional suitability; i.e., the size and architectural considerations that relate to the number of occupants and the volume of clients served. Rather, the assessment optic was engineering in nature. Therefore, questions such as the number of housing units required, and whether a facility needs rebuilding or replacement in light of non-engineering factors, are addressed elsewhere in this chapter.

Major Capital Requirements

The principal capital projects [34], comprising new construction, reconstruction or rehabilitation, to be undertaken by the CBHSSJB in the Cree communities are as follows:

New Cree Integrated Health and Social Services Centres (CIC) which will replace the old clinics and allow the Cree Health Board to provide a full range of services. This will involve expanding the recently built clinics, some of which are inadequate for existing needs and all of which fail to meet the new integrated needs.

Certain Regional Facilities to be provided in Chisasibi, in light of the needs to concentrate certain specializations for reasons of control, efficiency, and economics.

New Residential Service Centres (RSC) *i.e*. Phase 2 of the Multi-Service Centres will be discussed as set out in the Agreement.

Renting of Housing Units

New Housing Units are required -- both houses and transit units – to allow funded but vacant positions to be filled (*e.g.* diabetes, public health), to accommodate the new staff

33 Corporation d'hébergement du Québec. Inventaire et évaluation technique des immeubles de la région 18. Février 2003.

34 From the report " Cree Board of Health and Social Services - Overall Capital Plan – New Facilities for the Cree Communities" – Revised global capital needs June 30, 04, GBB Town Planners

that will be working in the above facilities under newly developed programs, as well as the travelling staff from the Head Office, and also to replace the unsuitable units now being used (e.g. temporary trailers).

The CBHSS will be renting the housing units rather than building them. [35]

This option is interesting in that:

It will reduce the overall amount of capital investment required;

The rent will become part of the yearly operating budget;

This will facilitate the policy of gradually hiring local individuals for CBHSSJB positions;

This will provide the greatest economic benefit to the local communities. Local administrations, or local businesspersons, could construct the units and rent them to the Cree Health Board under long-term lease agreements;

This ‘‘rental’’ approach allows the Cree Health Board to concentrate on delivering core health and social services, without the distraction of what amounts to running a hotel chain and a system of housing developments.

Major Medical Equipment

An inventory of the major medical equipment, including directly relevant architectural improvements, was made at the Chisasibi Hospital in January 2003. In summary, the hospital has a total purchased value of $2.9M in medical equipment. However, to perform minor surgical procedures an additional investment of $942,000 in general and special surgical equipment, ward care equipment and radiology mobile facility is needed. [36] This inventory will be a starting point for establishing a surgical capacity, taking into account the appropriate configuration to meet local and northern district surgical needs.

To improve the health services in the southern district of the region, it is proposed to develop the diagnostic and haemodialysis services in the Mistissini Health and Social Services Centre. A majority of consultations and transportations outside the region, from the southern district, are related to diagnostic purposes. With the appropriate equipment, it would be possible to provide diagnostic services closer to the people and, in doing so, avoid discomforting and costly trips outside the region. The investment required in specialized medical equipment is between $0.8M to $1M.

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35 Under this agreement, it is decided that the CBHSSJB will provide a 10% down payment on each unit and the yearly rents will include provision for maintenance, heating and insurance and possibly a yearly administration fee. Financing costs for this option will be calculated assuming the current interest rate over a 25-year period.

36 Retfalvi, Stephen A. *Chisasibi Hospital. Minor Surgery Inventory. Final Report*. February 7, 2003.

Information and Communications Technology

Management Information System

The Cree Health Board urgently needs a *Management Information System* (MIS). The present system cannot deliver the pertinent information, at the right time, in the required format. Budget control, accountability, and the supervision of management activities, coupled with the geographic distance and multiple users, require an integrated information system. This system will produce, on demand, current reports as well as streamline the paper trail. Up to date adapted equipment and applications will support the management activities and improve the global results of the organization.

The development and implantation of a *Management Information System* have the main following characteristics:

One local area network (LAN) per community, or one per facility when facilities are isolated (e.g., CPS offices). These LANs are connected in a Wide Area Network (WAN) through RTSS and have online access to the corporate applications and data warehouse.

The LANs have a high degree of autonomy so that local disruptions (i.e., electricity supply, communication lines, server failure) have only local impacts.

The new Management Information System is to be phased in over a period of three years.

The vital areas for Year 1 are Core and NIHB accounting and finance, which are closely linked. For the first year, a basic but functional system and the equipment able to provide at very short term the information to control the activities and the expenses of the whole organization is needed.

Make maximum use of existing infrastructure, including the MSSSQ's telecommunications network (RTSS).

Clinical Information System

The clinical information system permits gains in both productivity and quality of services. The clinical information system has a wide range of applications such as:

Management of patient registration, scheduling and care planning in hospital, in Integrated Health and Social Services Centres and in other services of the organization;

Patient Index System allows the integration of different systems and the implementation of a unified interface for all clinical staff. One of the main features of this system is a

data warehouse that stores pertinent information to establish the cost per treatment, service or case. This system would be extended to all communities and facilities, including CPS offices.

Integrated pharmacy system to support the medication administration to the patients and the medicine inventory keeping in all locations

Other clinical information systems and clinical data warehouses

Picture Archiving Communications System (PACS)
Radiology Information System (RIS)
Laboratory
Blood Bank (SIATH)
Public Health Information Network
Cree Patients Services
Telemedicine

In other respects, Cree Health Board has begun an information system planning process. A strategic information plan that notably includes the corporate vision on information needs and functional and technical assessments of existing systems will be released later this year. However, for a first approximation of the required investment, the information and support system investments in other organizations, such as Montreal hospitals and CLSC's, have been examined. The size, the number of employees, the number of locations, the budget and the complexity of the CBHSSJB structure have been considered in order to assess the required equipment and applications needed. Including Nordic costs, the required investment for information systems would be approximately $4M. An investment of $1.5M is proposed for the first year, followed by a phase investment of the balance of $2.5M over the next two years. These figures may require adjustment upon completion of the information strategic plan.

Financial Aspects

Nordic Costs

Identification

The isolated, northern location of the Cree territory has a direct impact on the cost of delivering health and social services to the Cree population. Transportation of patients and personnel to and from the South, delivery of goods and services, as well as difficulties in recruitment are all factors contributing to the high costs of health and social services. Moreover, Section 14 of the *James Bay and Northern Quebec Agreement* provides for specific entitlements and cost elements. One example is the Non-Insured Health Benefits programs, which gives rise to significant costs. All these additional costs will be referred to, in the following discussion, as Nordic Costs.

Labour Costs

In order to facilitate recruitment, the collective agreements signed with the MSSSQ in 2000 provide special clauses to attract and retain personnel in the region. These clauses are identified as ‘‘Regional Disparities’’; they contribute a large part of the Nordic Costs in health and social services. A list of some of these labour costs follows:

Nurses

Retention premium:	$7,000 to $8,000 per year
Attraction premium:	± $14,000 per year
Food transport:	*ca*. 750 kg/person/year @ $2/kg
Sorties:	4 plane tickets per year (for each nurse, with a spouse and dependents)
Lodging:	$8,600 per eligible employee (excluding rent, depreciation and interest)
Isolated stations**:**	$145 per week
Integration:	15 to 30 days
Moving and storage expenses:	$504,058 (all eligible employees)

Other Employees

Retention premium:	
Attraction premium:	
Food transport:	*ca*. 750 kg/person/year @ $2/kg
Special allocation:	66% of cost for food transport
Sorties:	4 plane tickets per year
Lodging:	$8,600 per eligible employee (excluding rent, depreciation and interest)
Moving expenses:	see above

Nurses – **Other Conditions** (impact on continuity of care delivery)

Possibility to accumulate 12 statutory holidays
After one year, possibilities to request a one-month leave without pay

Other Costs (Section 14 JBNQA)

Under Section 14 JBNQA, other requirements and entitlements of the Crees must be respected:

Reimbursement of travelling expenses and loss of revenues for Board members

Training to provide access to employment for the Cree population

Sufficient budget to provide for exceptional costs due to geographical location

Adequate funding for Non-Insured Health Benefits

Budget adjustments to cover demographic changes, costs for specifics services, and evolution of provincial health programs

Community Health Representatives

Conversion Factor

The purpose of identifying Nordic Costs is primarily to generate a ‘‘conversion factor’’, permitting one to determine how much a dollar spent on goods and services in the health sector in the south would purchase in the Cree region. In other words, how much is a southern dollar worth in the North?

A study commissioned by the MSSSQ in May 1997, [37] provides cost data indicating a conversion factor of about 2:1 for Nordic Costs (including NIHB) in the Cree Region during fiscal year 1995-96. In other words, Nordic Costs were about equal to ‘‘normalized’’ operating costs for the Cree Health Board for that year. Even these ‘‘normalized costs’’, the study states, were overestimated and could not be used for purposes of budgetary or statistical comparisons or analyses with other regions, given that many cost elements were difficult to quantify. A variety of factors, the study states, reduced the amounts actually available to deliver services. Among these factors, the following were mentioned:

Harsh climate; reduced accessibility to points of service; costs of maintenance, repair and replacement of facilities and equipment specific to the region; and the market monopoly enjoyed by certain businesses in the region;

Different working languages (with resulting translation requirements); need to train and develop Native work force;

Consequences of high turn-over rate of professional and medical staff, including discontinuity in service plans, demobilization of personnel, inexperience of available staff and lack of sense of ‘‘belonging’’ vis-à-vis region;

Large area of service region, with small population centres (and a portion of the population pursuing traditional activities outside the communities for part of the year), long distances between points of service, and obligation to maintain, simultaneously and at all times, minimum services in various sectors and different localities;

Lack of resources to provide basic services and absence of specialized services for various health and social service programs.

In order to evaluate the true costs of existing and future services, a conversion factor has been established based on actual data for the year 2001-2002. The methodology used is the following:

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37 MSSSQ, *L’Équité interrégionale et les régions Nord-du-Québec (10), Nunavik (17) et Terres-Cries-de-la-Baie-James (18)*, pp. 80-81, 147.

Identify the hourly paid rate, without Northern premiums.

Deduct all NIHB costs.

Estimate allocation of costs based on general distribution in the South (80% salaries, 20% other expenses) to obtain theoretical value of other expenses, excluding Nordic Costs.

Calculate global conversion factor.

The following table summarizes certain Nordic Costs for the Cree Health Board for fiscal year 2001-02. [38] The actual hourly salary rate (including Northern premiums) was $36.03 in 2001-02, compared to a rate of $27.47 in the South. In other words, general labour costs were 31% higher per paid hour in the North than in the South. In short, Nordic Costs represented about $6M in additional salary costs for the Cree Health Board in 2001-02.

The following table shows that, due to Nordic conditions, other expenses represented 37% of the Board's total expenditures for 2001-02 (compared to a theoretical norm of 20% in the South). Lodging, transportation, and energy costs contribute to this situation. Such other costs are proportionately three (3) times higher in the Cree Region than in the South, representing additional costs of more than $10M for the Board.

The table shows that, of total expenditures of $41M (excluding NIHB), $16M was spent to cover Nordic Costs (i.e. the difference, $16M, between the total actual expenditures of the Board, $41M, and total expenditures of a theoretical Southern establishment, $24.5M, to provide comparable services).

38 It should be noted that the table presents an estimate of Northern Costs based on information currently available; certain elements are incomplete and others are subject to revision.

CONVERSION RATE

BASED ON 2001-2002 FIGURES

Excluding Non Insured Health Benefits

		Actual		South	
Hourly rate (WORKED)		19.43 $		19.43 $	
PREMIUMS (NORDIC)		6.52 $		- $	
PREMIUMS (ON CALL, NIGHT SHIFT, ETC)		1.47 $		1.47 $	
		27.42 $		20.91 $	
Social benefits	21.24%	5.82 $		4.44 $	
		33.24 $		25.35 $	
Employer's contributions	8.39%	2.79 $		2.13 $	
Hourly rate (PAID)		**36.03 $**		**27.47 $**	
Conversion rate Paid hour / Worked hour		1.85		1.41	
Conversion rate salaries (north / south)			**1.31**		
36.03$ / 27.47 $					

	Actual		South (estimated)	
Salaries	25 687 448 $	1.31	19 584 296 $	80%
Other expenses (20% ratio in the South)	15 221 407 $		4 896 074 $	20%
	40 908 855 $		24 480 370 $	
Conversion rate other expenses (actual/estimated)		**3.11**		
15 221 407$ / 4 896 074$				
Global conversion rate		**1.67**		
40 908 855$/24 480 370$				

In summary, based on the conversion factors discussed above, it is more than reasonable to assert that $1.00 of services in the South will cost between $1.67 and $2.00 in the Cree Region.

Catch-Up and Development Budget

The catch-up and development budget sets forth the financial resources needed, in addition to the actual budget, in order to improve the range, quantity, quality and continuity of services to be delivered. It has already been noted that the level of the Cree health and social welfare is considerably below that observed for the rest of the population of Quebec. Urgent catch-up measures are required in order to bring the Cree indicators of health and social welfare into line with those observed or sought for the rest of the population.

Certain elements, specific to the Cree context, have a direct bearing on the cost of delivering services. These special elements make impossible comparisons of cost and productivity data between the Cree and other regions. The Nordic reality imposes an additional burden on the delivery of the services. It is more costly to do the same than in the other regions of Quebec. The distance, the isolation, the absence of critical mass, among others things make the normal southern benchmarks useless to appreciate the situation in the Cree region.

Second, the CBHSSJB has never been provided with the same resources as other regional health boards (régies régionales). In fact, the CBHSSJB has never been provided with the resources necessary to develop strategic plans for programs and services, to implement reforms or to coordinate and to evaluate the services delivered.

The development budget is based on a service delivery model named ‘‘Cree Integrated Services Unit’’ for each of the nine Cree communities. This model implies the principle of devolution, under which all services, which it is professionally and economically feasible to provide at a community level, will be so provided. This model implies that the ‘‘Cree Integrated Health and Social Services Centres ’’, a kind of ‘‘One-Stop Services Centre’’, will provide:

First-line CLSC services similar to those provided by other CLSC’s in Quebec;

Services for Youth and Families provided elsewhere by the ‘‘Centres Jeunesse’’)

Addiction program services provided elsewhere by the ‘‘Centres de réadaptation pour alcooliques et toxicomanes’’;

The catch-up and development budget also includes the public health programs and a special diabetes program required in view of the alarming situation among the Cree population. The model will include the day care services for elderly, disable and handicapped (‘‘MOU Multi-Service Centres’’) provided elsewhere by the ‘‘Centres d’hébergement et soins de longue durée’’ and the ‘‘Centre de réadaptation en

déficience physique et intellectuelle". Hence, the Cree Integrated Health and Social Services Centres should be considered as the integration of six different kinds of organization, whereas, in the rest of Quebec, such services continue to be provided by separate organizations.

The development budget also includes regional components for the addiction healing programs and Readaptation for Youth and Families.

The CBHSSJB wants to provide an increasing space for the Cree helping methods. Among others, it's one of the best ways to adapt the health and social services to the culture and the reality of the Cree population. To this end, some of the development budget may be used in the different programs and services to provide these services.

The development budget is summarized in the following table.

CATCH UP AND DEVELOPMENT BUDGET

FINANCIAL SUMMARY

DESCRIPTION	FY-1	FY-2	FY-3	FY-4	FY-5	STRATEGIC PLAN FIVE-YEARS
	2004-05	2005-06	2006-07	2007-08	2008-09	2004-2009
	$	$	$	$	$	$
Cree Integrated Services	3,016,864	5,156,094	5,156,094	4,305,888	4,305,888	21,940,828
Multi-Service Day Center	1,170,674	2,000,788	2,000,788	1,670,871	1,670,871	8,513,993
Youth Healing Services	397,812	679,898	679,897	567,787	567,787	2,893,181
Healing Lodge (Addiction)	260,150	444,620	444,620	371,305	371,303	1,891,998
Public Health Reg. Prog.	104,500	178,600	178,600	149,150	149,150	760,000

General Administration	550,000	940,000	940,000	785,000	785,000	4,000,000
TOTAL	**5,500,000**	**9,400,000**	**9,400,000**	**7,850,000**	**7,850,000**	**40,000,000**

Given the Nordic Cost conversion factor previously discussed, the $40M development budget requested here for the Cree Region is in fact equivalent to a $20M to $24M development budget in southern Quebec.

This development budget is established in 2004 dollars. The budget for subsequent years (2004 to 2009) will have to be readjusted on the basis of agreed indicators.

Funding Rules

The funding rules intent to establish stable and automatic budget adjustments for specific items. We propose three categories of funding rules. The categories are the followings:

Allocations for operations funding
Allocations for capital investment
Rules for medical doctors and dentists

These funding rules intend to stabilize the operating budget of the CBHSSJB over the next years. The health problems or services aimed by these funding rules are still in progression and could have a serious impact on the capability of the CBHSSJB to maintain a balanced budget over the years. For instance, the diabetes problem is at an epidemic stage in the Cree region and the possible consequences on the services needed and the related costs of the disease may jeopardize or the quality of services if they are not available at the right time, or the balanced budget, or both. A budget stabilizer or other specific budget adjustments are needed to face these emergent and not yet controlled health problems.

Implementation

The development of the Regional Strategic Plan has been an involved exercise, which has been fed by all levels of the Cree Health Board. It has attempted to capture all the required elements that would contribute to the catch-up and development of health and social services for the people of Region 18. The exercise involved the Board, the managers and many professionals in various departments as well as external consultants. The information that was generated was shared with the Ministry counter-parts at the Cree-MSSSQ Table at different draft stages. Once the final discussions have been completed with the Ministry, the crucial matter of implementation of the Strategic Plan will have to be addressed.

Implementation is a crucial part of a strategic plan. It will transform the strategy to reality, put a static plan into motion. It will also make it possible to reach the objectives planned and the desirable results sought.

However, implementation is a complex operation that requires a series of different tasks. It is complex because implementation involves most, if not all, the employees of the organization, other Cree and non-Cree organizations, board members, stakeholders, community leaders, patients or clients and the population in general. It is also complex because it implies many changes at all levels of the organization. These changes have to be well planned, explained and managed. Implementation of a strategic plan is a collective, multidimensional and demanding effort within an organization. It is very important to make a connection between what has been conceived as a Strategic Plan and the Implementation Process. The connection is a defined strategy in itself as to how best to implement the new resources that have been identified.

Successful implementation of the strategic plan depends on a well-conceived and adapted approach that suits the CBHSSJB. Five key issues have to be addressed in the implementation phase [39]:

- Understanding the strategic plan.

Everyone affected by or involved in carrying out the strategy must understand:

- What is to be achieved, and why;
- How the strategy is to be accomplished and within what timetable;
- What specific changes in activities, behavior and attitudes are required of each person involved.
- Commitment (initial and ongoing) of relevant managers and employees to implementing the strategy successfully and to do this in balance with the on going existing and retained “effective practices” of the organization.
- Resources required to implement the strategy (funds, tools, skills, training, staff and time).
- Process for tracking implementation progress and for making mid-course corrections.
- Accountability by managers and involved employees throughout the implementation period.

In addition to the five issues above, the Cree Health Board needs an approach that could take into account the complexity of the work to do, the cultural characteristics of the region, the workload of the managers and employees involved, the timetable of the overall operation and finally the impacts in the Cree communities. Because the Regional Strategic Plan has many and varied components, it will be important to especially focus on the areas that have been addressed and results known from the negotiations of the MSSSQ-Cree Table. The approach of the Cree Health Board should be based on a clear priority order, an efficient implementation process and different mechanisms to

39 Judson, Arnold S.: Making Strategy Happen. Basil Blackwell, 1990

follow the progress done. To keep all players who work in different sectors coordinated during the implementation process, a communication plan will be required.

Order of Priority

The implementation of the strategic plan requires the classification of priorities in order of relative urgency and determination of what are the results expected over the short, medium and long term. This order of priority is a starting point, with the Board periodically revising it according to changing circumstances of the health and social situation and organizational patterns.

Health and Social Priorities

Health and social priorities are described in Chapter 5 under Specific Results Objectives – 2003-2013. Each of these priorities has been formulated to achieve a clear result. The following are given as examples:

Obesity: Reduce prevalence by at least 420% for women and 300% for men so as not to exceed current general Quebec prevalence.
Diabetes: Reduce prevalence by at least 500% so as not to exceed current general Quebec prevalence.

All health and social priorities are part of the implementation process

Structural and Capital Priorities

Structural and capital priorities are mostly described in Chapter 5 – Objectives and Chapter 9 – Capital Issues. These priorities are called structural and capital because they constitute among others some important means to realize and achieve the health and social priorities. Infrastructures, facilities, space, information systems are needed to deliver the proper services. These following priorities are given as examples**:**

Deliver the nine Multi Services Centres
Implement in each community the "Cree Integrated Health and Social Services Centres".
Management Priorities

Management priorities are taken primarily from Chapter 7- Management Systems and Chapter 8- Personnel. These priorities focus on the administrative or professional support needed to plan, provide and assess the services to the population. These following priorities are given as examples**:**

Development of a financial and statistical system Become a model of excellent management in all aspects
Implement a Management Information System

Each priority requires the determination of the results to deliver; the main activities to be done in order to achieve the results; the manager to be responsible for that priority; the

staff involved; the external partners involved; the schedule; the resources needed; the indicators of results or of progress.

Implementation Process

Form an implementation team at the regional level to:

- Supervise the progression of the implementation process.
- Determine the activities required for each priority and approve the action plans.
- Adapt and adjust the activities according to the actual reality.
- Solve any implementation problems as they occur.
- Prepare the communication material for the employees and the general population and set a schedule for various aspects of communication for the organization, population and outside agencies such as the Grand Council and the Government.
- Prepare monthly status report for the Executive Director and the Chair and propose to them any issues that need to be decided by the Board.

This team would be composed by 5 to 10 key involved managers and staff. It reviews the progress of implementation of the Strategic Regional Plan regularly (weekly or every second week).

Form a steering team in each community

Set up a steering team in each community to:

- Inform itself of the progression of the implementation in each community.
- Adapt the Strategic Regional Plan to the reality of each community.
- Inform the population of the community.
- Keep in touch with the local representatives and channel their comments.
- Periodically review the priority order and recommend any changes according to the community needs.

The composition of the local steering team must be open enough to take into consideration the useful mechanisms in place already in each community. Hence, the local team could vary from community to the other.

Adopt a project management approach

Project management is the process of planning, organizing, and managing tasks and resources to accomplish a well defined objective, within constraints on time, resources and cost. The project management approach consists in dividing the whole implementation required work into different delimited projects. The project management approach, contrary to current management practice, is characterized by the fact that projects have a beginning and an end. This approach helps to focus on the tasks to perform to implement each part of the Strategic Regional Plan and on the specific results to achieve. For example, in a project management approach, each priority will

become a specific project with its own schedule, a team to work on it, resources to work with, and results sought. This approach helps to determine how many priorities it is possible to implement at the same time with the available resources.

Follow-up Mechanisms

Action Plans and Implementation Plan

A useful way to plan and follow the progress of the implementation of the priorities is to write down, as already noted, an Action Plan of all the required activities, manager responsible, the staff involved, the external partners involved, the schedule, the resources needed, the indicators of results or of progress.

Review and Evaluation Sessions

Periodically, organize review sessions with regional and local implementation teams, managers, union representatives, and community representatives. These review sessions would be at the head office level and in each community. These review sessions could be organized by the Board at every second month or so.

Mid-Course Adjustments Process

The Cree Health Board should develop a decision-making mechanism to make mid-course adjustments to the Strategic Regional Plan, to deal with the problems that will come up related to the many changes and their impacts in the organization, the resources needed, etc. The board could plan in the agenda of regular board meetings a section specifically dedicated to the implementation process.

The implementation phase needs to be carefully planned and methodically executed. The success of the implementation depends on multiple factors, but one of the most important is the overall management of the operation and keeping a close association between the plan and the implementation itself.

CONCLUSION

This Strategic Regional Plan presents a global picture of the situation, the problems that the Cree population face everyday and the solutions needed to improve the health and social wellness in the Cree region. One of the main objectives of the Cree Health Board is to raise sharply the health and the social wellness of the Cree population and catch up with the rest of the population of Quebec in term of health and social indicators. All the others objectives of the Strategic Plan follow from that main goal, of paramount importance. It is a challenge, it is a race against the clock and, in many cases, and it is a matter of life or premature death. Access to a range of preventive, first-line, specialized and ultra-specialized services are among the solutions needed to achieve this crucial objective. It is urgent to act.

Making the Strategic Plan a reality will require the continued goodwill, resolve, and partnership that have developed between the Crees and the Ministry of Health and Social Services. Certain facilitating conditions will help to reach the results sought. First, the quick resolution of the negotiation process, that implies rapid access to human, financial and capital resources needed to implement the Strategic Plan. Second, a budget horizon of three years to be able to implement the different measures of the plan optimally. Finally, the strong partnership and deep involvement of the authorities of each community, MSSSQ, GCCEI/CRA, Cree School Board and Cree Health Board to make it happen.