

A POLITICAL ECONOMIC HISTORY OF MEDICAL AND DENTAL CARE IN NUNAVUT, CANADA

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ABSTRACT

Objectives. To describe the historical development of medical and dental care in the territory of Nunavut, Canada.

Study design. Ethnographic case study using political economy as a mode of explanation.

Methods. Participant observations, document reviews and stakeholder interviews, conducted over a four-year period.

Results. There is a clear and now long-term movement from state and professionally controlled health care delivery to Indigenous control over care.

Conclusions. Indigenous groups increasingly hold control over health care delivery through a complex form of management that straddles both public and private organisational spheres.

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INTRODUCTION

At present, the Inuit of Canada continue to experience significant health disparities in comparison to the general population (e.g., lower life expectancy, higher rates of infant mortality, infectious and chronic disease, accident and suicide) (1,2). It is readily recognised that the factors which create and maintain these health problems result from a complex set of processes (3,4). For oral health, these factors range from the bacterial environment

in the mouth and personal care habits, to the social norms that establish such habits and the dynamics of the system meant to treat oral disease.

Analyses of the macro social environments that impact Indigenous health have generally tied such populations to the dynamics of colonial imposition and the social resistances to it (i.e., understanding cultural self-determination and efforts at self-government and control over the social redistribution of health resources). In characterising poor health in this fashion,

the determinants of health become political and economic in scope. It is important to understand such factors, as they are known to impact care by decreasing quality, diminishing access, and creating poor conditions for health-promoting behaviours (3,4).

This two-part article outlines the political economic history of medical and dental care in Nunavut, an Indigenous self-governing territory comprised of 3 regions: Baffin, Kivalliq (formerly known as Keewatin) and Kitikmeot (Figure 1). The regions contain 26 communities with an approximated 27 000 people.

Determining health and disease in Inuit populations

Substantial reviews exist that consider the various health challenges faced by the Inuit of Nunavut (1,2). Here we concentrate on oral health and disease.

Archaeological findings in Thule and Inuit skeletal remains indicate few instances of dental dystrophy and a very low incidence of dental caries (5-8). Considerable wear of the dentition is noted, explained in terms of the incorporation of sand into food, and the use of the teeth for softening animal skins. Early

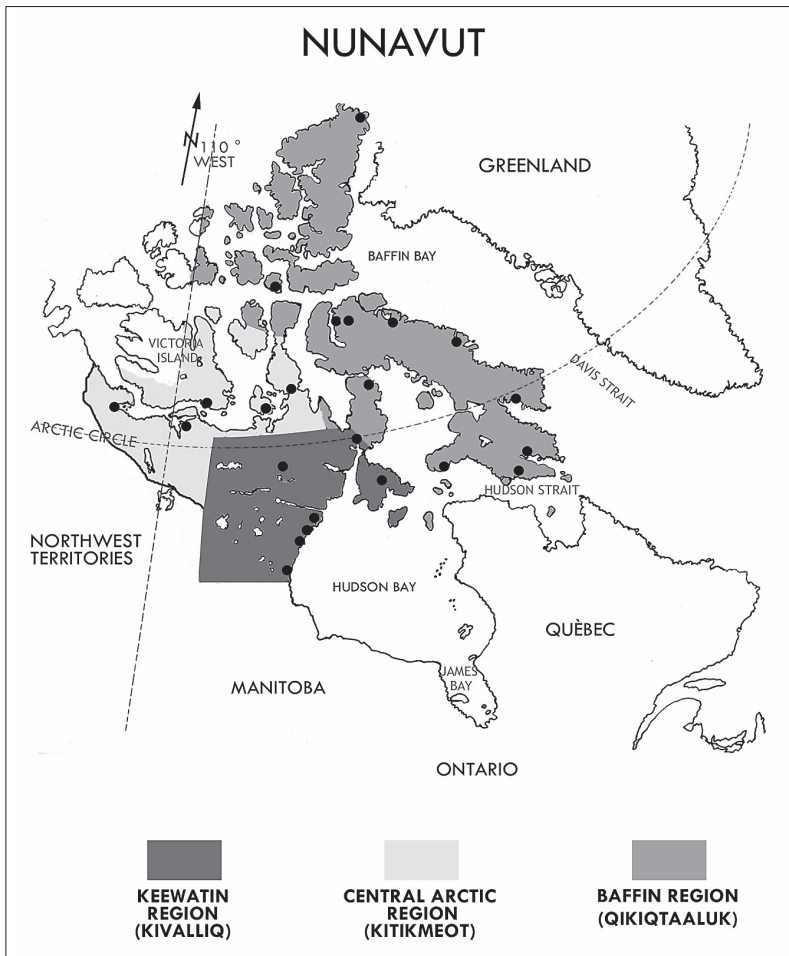


Figure 1. Map detailing the Nunavut territory in northern Canada.

researchers hypothesised that this could lead to the formation of abscesses, the end result of a process referred to in dentistry as occlusal traumatism. Further noted in the skeletal record are osteomyelitis, osteoperiosteitis, and sinusitis, providing evidence that pathologic conditions were present in early populations.

Like other diseases, the patterns and causes of dental disease have undergone change over the course of Arctic history, wherein dental surveys of communities over time reveal a pattern of epidemiologic transition (9,10). Surveys conducted in Alaska, Canada and Greenland in the early 1900s present traditional lifestyles resulting in minimal caries and little tooth loss, even into old age, and as southern cariogenic foods were brought north, diets changed, contributing to increased levels of disease. Recent work in other Arctic and Indigenous populations confirm this pattern (11-17). The Maori in New Zealand, Aborigines in Australia, Sami in northern Scandinavia, and Indigenous groups in Central and South America and East Asia, all report a significant decline in oral health sustained post-colonisation.

Most of this research has linked oral health states to diet and personal practices, yet this is only part of the picture. Although no data exist for the Inuit of Nunavut, socio-economic factors that influence oral health may be described for Canada as a whole. Only 53% of Canadians are covered by dental health insurance, with high-income persons (those least likely to need care) being 7 times more likely to have insurance than persons with low income (those most likely to need care)(18). Insured Canadians are 2.7 times more likely to report a dental visit within a one-year period, with 78% of those in the high-income bracket and 41% of

those in the low-income bracket reporting such a visit (18). Household income and insurance coverage are thus powerful determinants of the ability to acquire dental care.

Locker (19) has noted that further studies demonstrating inequalities in oral health are redundant, and prompts us to identify the factors involved in generating and maintaining such inequalities, and to analyse their implications in terms of policy and service delivery. Thus, we can venture that policy and service delivery, which exist within political and economic environments, generate and maintain inequalities in health.

Political economy as explanation

In attempting to account for the implications of policy and service delivery on health, this history relies on the theory of political economy. Herein, political economy is defined as an approach that views “economy as socially and politically embedded and as structured by power relations” (20). In this regard, I have previously argued that four political economic factors delimit the development of dental care in Nunavut: geography and disease burden; Indigenous self-determination; State/Indigenous relations; and dental practice and philosophy (21,22). I propose that the same holds for medical care, where people’s illnesses are counterposed amongst attempts to make isolated and inherently expensive health systems more accountable and responsive to constituents, all uniquely playing out in relations between Indigenous governments, professional groups and the Canadian State (23-25). It is with this theoretical and analytical base that I attempt to describe and account for the development of medical and dental care in Nunavut.

PART I: THE CASE OF MEDICINE

Religious missions and mining companies initially tended to the health needs of Inuit on behalf of the State and, by 1943, of the Northwest Territory's (NWT) eleven hospitals, all but two were owned and operated by churches and/or industry (2). In 1946, the health responsibilities of the federal Department of Mines and Resources were brought under the newly formed Department of National Health and Welfare. Known as the Indian Health Service, the Northern Health Service, and/or the Indian and Northern Health Service, religious and private institutions were administratively replaced, eventually acting more as operating contractors than as managers. By 1956, federal authorities were "operating 18 hospitals (growing to 22 by 1960), 33 nursing stations (37 by 1960), 52 health centres containing dispensaries, and 13 other health centres employing full-time physicians or nurses (83 health centres by 1960)" (2). In 1962, the Indian and Northern Health Service was eliminated and amalgamated to the new Medical Services Branch of Health and Welfare Canada.

A discrete Indigenous health service was now observable in the midst of a developing Canadian health care system. For example, the Hospital Insurance and Diagnostic Services Act of 1956 and the Medical Care Act of 1967 established the social redistribution of health resources along the range of insured and uninsured service (or non-commercial and commercial social good). This was applied to Indigenous care, further concretising the federal responsibility over Indigenous groups.

By the late 1960s, the poor living conditions of Indigenous Canadians gave rise to

an ethnonationalist movement (which may be characterised as an organised political movement of cultural self-determination and control over a group's social life). This was spurred on by a federal White Paper on Indigenous affairs, proposing to repeal major federal legislation, terminating the Ministry of Indian and Northern Affairs, and shifting responsibility of Indigenous populations to provincial and territorial authorities (26). Firm social pressure from Indigenous groups and their non-Indigenous supporters resulted in the movement away from this policy position, representing an early shift in the relations of power between Indigenous Canadians and the State.

Major improvements in northern health care occurred in the 1970s. In many communities, equipped health centres now provided outpatient primary care services through nurse practitioners and itinerant physicians, and referrals to secondary and tertiary care in the south (23). A growing, federally supported economy and culture was developing, providing employment and significant budgets within territorial governments and Indigenous communities (27). A professional economy slowly opened for health care providers, particularly those associated with universities, who historically became increasingly involved in the servicing of contracts for care to Indigenous populations across all of Canada. Providers adopted a philosophy of primary health care, which recognised the importance of local involvement in service delivery. In turn, the Community Health Representative and the Community Health Committee were introduced to place a modicum of control at the local level (24).

The social environment of this time gave rise to unique challenges. A salient example

may be found in debates concerning the evacuation of women for pregnancy and birthing purposes (28). Here, a dominant biomedical authority, advising travel of pregnant women to larger centres to mitigate risk, was challenged by northern women and ethnonational groups, who attempted to regain control over care as represented through the location of birth. This was particularly relevant for what would become Nunavut, as Inuit were one of the earliest groups formally involved in such political struggles, ultimately aiming to establish not only relevant health policy, but also self-governing regions (29).

In response to the ethnonational pressure, federal authority then attempted to clarify a position on Indigenous health services, stating that delivery was a matter of policy, rather than a statutory obligation (30). In 1978, attempts at placing limits on uninsured medical and dental services, now known as the Non-Insured Health Benefits (the NIHBs), were also met with significant resistance (31). Authorities responded with the Report of the Advisory Commission on Indian and Inuit Health Consultation, and with the Indian Health Policy. The advisory commission “recommended that Inuit and Indian health be addressed separately, given the vastly different traditions and problems faced by the two groups” (32). The Indian Health Policy withdrew the proposed guidelines for uninsured medical and dental benefits, and situated Canadian Indigenous health policy on three pillars: community development; the traditional State/Indigenous relationship; and their mutual roles within the provincially and territorially entrenched Canadian health care system (33). In time, Indian issues did nonetheless overlap enough with Inuit, such that

the policy came to heavily inform developments for both groups.

The movement towards local and ethnonational control continued in the 1980s. For example, the Inuit Tapirisat of Canada (the central Inuit ethnonational organisation, now the Inuit Tapiriit Kanatami) passed a resolution supporting the devolution of health services (34). O’Neil documented “Gjoa Haven Gambit”, a community’s push for control over their nursing station, and described efforts in the Baffin region that ultimately led to health board devolution (24,34). O’Neil attempted to forecast what the creation of an Inuit territory (Nunavut) might do to the northern health system, warning that governance structures would potentially be challenged by ethnic tensions and professional dominance (24). Weller also provided an analysis of devolution, prognosticating that, in Nunavut, local control could be made difficult by the regulatory system developed by the territorial board, or by physicians being able to exercise greater power in a decentralised system (35). Weller and Manga also discussed the trend towards the re-privatisation of health services in North America, suggesting an impact on the circumpolar north (36,37).

Such an impact would not materialise until the mid 1990s, as Canadian governments became increasingly concerned with trends in health and social services expenditures. While northern health services had observed substantial increases in financing throughout the 1970s and 1980s, federal transfer payments to provinces and territories would slow (2,25), with such efforts at cost control resulting in some of the most tenuous times in northern health service history.

Tester (25) documented such difficulties in his analysis of the Keewatin region's health board, and its controversial involvement with the private sector. The health board initially advanced the idea of a P3 plan, or "private-public partnerships", meant to alleviate some of the economic struggles that, by the mid 1990s, had become severe. Decreased transfers as a result of the Canada Health and Social Transfers Act of 1995 forced health boards to search out revenue. In the Baffin region a \$25 million dollar offer was made by the region's ethnonational organisation for the building of a new hospital (25,38). Noting privatisation as an issue, the Baffin board declined the offer (38). Despite this, all three regional Inuit organisations eventually entered into contracts to build, and in some cases to lease back, new health facilities in their respective regions (39-41).

Privatisation of the health care sector was clearly seen as an option. This is understandable in an environment where a significant amount of service provision is based on the federal and territorial tendering of health contracts for insured and uninsured health services (or non-commercial and commercial social goods). Contracting occurred historically (through Church and Industry), and in the quest for modern provisory amenities, came to tie southern contractors to northern contracts. Primarily meeting this need were private and public institutions, the former constituted by sole-proprietors, or human health resource agencies, the latter by health professional faculties. Examples of private-for-profit firms include Med-Emerge International Incorporated, a large health resource agency that provides health professional services and consultative support to northern communities.

The majority of firms were not so expansive and include those corporations owned and operated by sole-proprietors who delivered services either by themselves, or through a relatively small selection of colleagues. Academically based firms can be found at most universities across Canada. The contractor position was, by this time, fundamentally entrenched in the daily activity of delivering care.

In this environment, the possibilities for business and fiscal opportunity (and passive privatisation) increased. For example, Tester (25) described a local non-Inuit conglomerate of real estate firms (with ties to individuals in government) that began to play a role in health services by owning shares in a professional health service corporation. He documents how this conglomerate utilized policy that favoured northern business interests, and then came to include private Inuit interests, utilizing policy that favoured Indigenous business interests. Questions are raised "about whether money budgeted for health should be generating profits for corporations, diverting resources that would otherwise be available for services to a corporate entity" (25). More recently, there is the case of a company owned by the same conglomerate that attempted to build a private for-profit mammography-imaging clinic in the Keewatin region, raising questions regarding adherence with the Canada Health Act (42). As Tester aptly notes, a "complete history of northern health services might be entitled: Prayerful, Public and Private Provision" (25).

By 1999, the self-governing territory of Nunavut was a reality, yet control of health services was not explicitly outlined in the Nunavut Land Claims Agreement (43). The inaugural Inuk Premier abolished regional

health boards and established a single Department of Health and Social Services (25). In turn, the Nunavut government announced that it would seek input and advice from the Nunavut Social Development Council, set under article 32 of the Nunavut Agreement, in the making of health policy. Although the council's mandate was arguably unclear, it was to approximate a health authority for the public self-government of Nunavut. Like other ethnonational organisations, it was to be consulted on matters of mutual interest, yet the Council was ultimately dissolved amid concerns about its effectiveness (44,45).

For Nunavut, the idea of Indigenous self-government holds consequences for health services. Tester (25) notes that the boundaries between institutions have become blurred, whereby Indigenous rights, as represented in ethnonational organisations, are sometimes conflated with public governance, and where debates surrounding such rights are now possibly swallowed up in debates about governance. This blurring and blending of institutional realities also extends to social and economic development policy. Consider that social improvement through economic development has historical roots as the mainstay of federal attempts to alleviate inequalities in Indigenous Canada (46). Whittington's descriptions of ethnonationalist capitalist organisations and/or native economic development corporations as governance, as vehicles for self-determination, and as capitalist efforts, are a testimony to such a reality (47). While many of Nunavut's ethnonationals are highly focused private sector operations, their roles and actions link closely to Nunavut's public governance. Ultimately, the question remains as to what exactly will

be the role for ethnonationalist institutions in health and social services? Will they be contractors? Policy makers? Public and/or private managers?

Irrespective of the unclear institutional dynamic, efforts aimed at Inuit control are now effectively built into Nunavut governance. Key examples include the formal incorporation of Inuit Qaujimagatuqangit (traditional knowledge), the enactment of the Nangminiqatunik Ikajuti Policy (policy promoting Inuit business interests), and attempts to constitute all human resource sectors as representative of the population (roughly 85% Inuit, 15% non-Inuit) (48-50). In medical care specifically, there are positive efforts currently underway in relation to newly funded Community Health Councils, and a general increase in social and financial support for Community Health Representatives and northern nursing (48-51). Inuit ethnonationals have also been effective in finding their way to negotiation tables that were often only set for First Nations and federal authorities. Over the last decade, Inuit organisations have developed their health portfolios, formed health committees, and have substantially increased and improved their health lobby efforts, aiming to establish an Inuit-specific secretariat at the now First Nations and Inuit Health Branch of Health Canada (52-56).

Recent debate has nonetheless moved away from a strong ethnonational effort at control, and increasingly settled at the level of improving, managing and funding the health system. A jointly run public and self-government Inuit Home and Community Care Program has been created, and developments continue in the collection of health

data and its use in public health surveillance, through the Inuit Health Information Initiative (54-56). However, guaranteeing stable and adequate fiscal support for such programs remains a most onerous challenge. As noted by Tester: "By 1999, the budget of the Baffin regional board was \$42 423 369 for approximately 13 000 people. 20% of this budget was being spent on medical travel. By comparison, the Nunavik region of Arctic Quebec was getting \$37.5M to serve 8000 people, about \$1400 more per capita" (25).

Significantly, there are increasingly divergent opinions between northern governments (ethnonational and territorial) and the federal authority over program policy and responsibilities. This is observed for NIHBs; territorial authorities take the position that they are no longer interested in administering and/or acting as the primary contractor for the program (57). They state that the federal government is responsible for the program, as they are structured around federal fiduciary responsibilities for Indigenous Canadians, rather than territorial responsibilities for Indigenous citizenry. Coupled with this are the ethnonational organisations and private corporations interested in the management and service delivery of this program, as there is the potential to generate revenues in the private markets surrounding health care. In this sense, there has been a subtle shift away from devolution, towards a desire to evolve some programming back to federal authorities, or possibly a lateral pass to ethnonational groups and their cadre of market players interested in governmental contracting. Federal authority appears to be accommodating such efforts through bodies like the Northern Secretariat (a structure meant to consolidate the admin-

istration of federally funded programs within the territories) (56), and through policy aimed at involving local, regional and Indigenous business in the transfer of control over health programs (22,25).

PART II: THE CASE OF DENTISTRY

According to Gullet (58), the first recorded dentist in the Canadian Arctic was W.P. Millar, who, in 1922, spent six months in the far northwest on behalf of the Hudson's Bay Company. In addition, C.H.M. Williams, R.W. Leigh and C.S McEuen all ventured north on federal supply ships, or through their involvement with the military (5,8,58). Further archival evidence places dentists in the Arctic in and around the 1930s (59,60). Between 1948 and 1956, British dentist Terrence Hunt photographically documented much of his experience while working for the Department of National Health and Welfare (61). Apart from this sparse clinical care, there was little, if any, sustained activity.

The 1960s then came to represent the golden age of dentistry, wherein the profession took on the modern aspect of a commercial social good, characterised as a market-based, often employer-insured service, delivered in private practices. Significant advances in dental public health (i.e., municipal water fluoridation) occurred alongside industry-marketed dental education and a growing dental health culture, all associating straight white teeth with health and wealth. Welfarism's right to health movement also moulded dentistry in this time to accommodate the public insuring of particular socially and geographically marginalised populations (e.g., children, refugees, some

institutionalised populations, First Nations and Inuit). This involved the governments in the direct and indirect delivery of dental care to such groups. In the Indigenous context, dentistry became incorporated within the federal government's conception of the uninsured medical and dental benefits that it delivered out of policy to Indigenous Canadians (i.e., the NIHBs).

By the early 1970s, when nursing stations were delivering a full complement of services, the infrastructure for dental care remained lacking. "Government salaries were too low to attract good personnel, and dentists were far too busy in their private practices to have any interest in providing more than emergency care to Indian patients" (62). In 1971, to combat this lack of care, federal authorities contracted the University of Toronto to develop and operate The National School of Dental Therapy (NSDT) (62,63). This concept was influenced by the New Zealand Dental Nurses Program, given impetus by need and existing dental health policy that mandated the availability of care for those deemed socially in need. Dental therapists provide curative care to children and preventative care to communities in places where dentists do not often practice. Nonetheless, the organised profession has resisted this model of care, questioning knowledge and technical capacity, and mounting successful efforts to limit its practice.

As regional centres became larger places of social and economic activity, economies of scale promoted the establishment of dental practices. In 1973, the Hay River Dental Clinic became one of the first private practices in the NWT, with others eventually seeking a similar opportunity in other

regional centres (64). As resident providers, these practitioners were almost immediately contracted by federal authorities to deliver services to outlying communities.

Contracting for dental services through resident dentists became an obvious answer to fulfil need. As discussed for medical care, contracting was the historical answer, with many providers employed in the academic and/or governmental sector as interns, professors, administrators and providers. Combined with the directly employed dental therapists, contracts with resident and non-resident dentists, and with their academic institutional relations, established the general structure of dental care delivery in the Canadian North. Recall that in response to ethnonational pressure, the federal government attempted to clarify a position on uninsured medical and dental care in this decade, stating that delivery was a matter of policy, rather than a statutory obligation.

By the 1980s, the dental profession "began to experience a surplus of dentists and were becoming less busy, so the dental community became more interested in treating Native people" (62). With no clear policy to describe specific responsibilities for Indigenous dental care, federal authorities once again entrenched the contractor position. Across Canada, dental service contracts for Indigenous communities began forming a recognisable part (however small) of the general dental economy. Here the typology of provider becomes more complicated, including the resident private for-profit corporation, the non-resident for-profit corporation, and the university-based public for-profit corporation. While residency of provider allows for regional centres to enjoy a consistent and potentially long-term

relationship with one or several practitioners, all contractors deliver services to the most isolated communities in a similar fashion (i.e., itinerant care, provided in two to three week periods, often by different providers throughout the year).

Yet, despite an increasing number of contractors, services were still limited by the inability to recruit and retain individual providers. In response, special targeted dental treatment and public health programs, and more aggressive human resources recruitment strategies, were adopted. Clinical treatment programs took the form of paediatric operating room access (as in paediatric oral surgery for rampant caries), and access to the treatment modalities of orthodontists and oral surgeons. Dental public health services used educational material produced through dental therapy and nursing efforts at the federal, territorial and local levels. Meanwhile, recruitment and retention strategies focused on attracting international graduates. With a commitment to practice in the north, professionals were allowed to practice pending the requirement of passing a series of three exams to obtain their Canadian license. Dentists were registered under a special legislated category within the NWT's dental legislation, or Part III of the dental register, resulting in their descriptor as Part III dentists (65). These providers became associates of northern clinics, travelling to isolated communities and, in some cases establishing clinics of their own. Resident for-profit corporations eventually came to service most of the three regions of Nunavut, forming a specific cohort in northern dental services and in the competition for contracts.

In 1987, one resident practitioner (at one point a Part III dentist) established a practice in the Baffin region, with a subsequent clinic in the Keewatin region. As Tester (25) documents, the dentist claimed that having a viable practice required servicing outlying communities, and that doing so was in accordance with a government push towards privatisation. A member of the aforementioned real estate conglomerate then started a petition in the Keewatin Chamber of Commerce in support of this claim. When contracts were renewed, communities were consulted as to whom they would prefer, the university-based public for-profit provider (at that time a long-term contractor in the region), or the new resident for-profit provider. All preferred the former except two communities. The regional health board renewed its contract with the university excluding these two communities. Members of these communities held business interests in the conglomerate, and such interests would become part of a new dental corporation, one that utilized favourable contracting policies for both northern and Indigenous businesses.

By the 1990s, most northern dental programs now experienced patient and practitioner dissatisfaction, as well as administrative problems at the local, regional and national levels (66). Stakeholders ascribed their dissatisfaction to administrative difficulties within the NIHB program, the high turnover rate of dental personnel, the minimal length of dentist visits, and the lack of specialist care and support. As in medical care, these difficulties were underpinned by the significant federal cost-containment of the period.

P3 plans were seen as a way to finance capital health infrastructure within an environment of lessening fiscal transfers. These plans included dental care as well. In 1992, the Keewatin health board cancelled its contract with its university provider, deciding to contract with a new resident for-profit dental corporation created by those who, several years earlier, took possession of service provision in two communities. This corporation had two dentists as majority owners, and a single minority owner, a subsidiary of the real estate conglomerate. The dental corporation gained much legitimacy in terms of territorial contracting policies that favoured local, northern and Indigenous business interests.

This contractor came to deliver services in the Keewatin region for four years, using Part I and Part III dentists; the Kitikmeot region used services from another resident for-profit corporation (also owned by a shareholder of the newer corporation), delivering services in the same fashion. In the Baffin region, care continued through a clinic in the regional centre (owned by a shareholder of the newer corporation as well), and by university-based practitioners not under a university contract, but through their own separate arrangements, plus a number of other smaller private contractors.

By this time, NIHB costs had increased twelve-fold over a 15-year period and constituted roughly half of all federal Indigenous health expenditures (2). Federal authorities created national program directives and administrative procedures meant to immediately limit services to a published list, with eligibility subject to increasing scrutiny. All regions thus experienced major cutbacks and decreasing support for services they were in

the habit of providing. "By 1995, the NWT was running a deficit of more than \$50 million, and the federal budget of 1995-96 cut a further \$50 million from transfers to the NWT for health, education and welfare" (25).

In 1997, the Keewatin health board announced that the management of dental services would go to the newer (and by now five-year-old) corporation servicing the region, including those services delivered by dental therapists. The latter were in turn terminated, yet it remained unclear if they would in fact be hired back by the contractor. In short, this P3 plan would result in dental services being billed to care delivered by some dentists (a federally insured, private uninsured service for First Nations and Inuit), and not to the program delivered by dental therapists (a publicly insured public service delivered by territorial authority), thus directing service costs through federal remuneration activities with private contractors. This logic was further supported by the tendency to view the NIHBs as a federal responsibility in response to the pressures of decreasing funds and the historical State/Indigenous relationship.

Another important aspect of this P3 plan was the nature of the contractor's role. In subsuming the dental program, the contractor would have to lease space from community health centres, providing some revenue for territorial authorities. It was presumed that sub-contractors would then reimburse the contractor for the rented public space and for any administration. So, through what can be construed as a form of passive privatisation, governmental costs were perceived as decreasing, with a subsequent increase in the flow of capital and earning potential, all

possible through the contracting of a private sector health corporation. Arguably, such opportunities are more easily conceived relative to the nature of dental care as a commercial social good.

The health board decision was not easily accepted, and three communities took strong action against the plan. With support from the regional education board, the United Northern Workers Union, the regional Inuit organisation, and the NSDT, these communities rejected the removal of dental therapists (and by extension the handing over of service administration to the contractor). Conflict-of-interest allegations were then raised against one health board member regarding a perceived connection with the dental contractor through the complex ownership structure of the local real estate conglomerate. These communities ultimately came to request a separation from the health board, and the opportunity to manage their dental programs themselves.

Federal authorities reacted by stating that dental therapy monies would be removed from the current contribution agreement with the territorial government and applied to the contractor's billings if the P3 plan went forward. Federal officials denied reimbursement for fee-for-service billings submitted by the contractor during this period, raising concerns regarding "double billing", a breach of the Canada Health Act (67,68). Moreover, the social tumult and renewed interest from other contractors presented federal authorities with an opportunity of their own, allowing them to address regional dental fees, then seen as inflated with premiums historically used to attract clinicians. In 1998, fees in the northern territory were cut by as

much as 39%, and the previously existing 20% premium for working in the north was removed (69).

Complaints were openly raised about the quality of services provided by Part III dentists and the lack of services in general. In reviewing the basis for these and other complaints, the Hechter Report (68) concisely reflected the concerns of the time, observing two fundamental issues in the delivery of dental care in the regions: the geographic and political division of the NWT as per Nunavut in 1999; and "the fiscal realities of the funding envelope, which includes dental care, noting that increases to the envelope are essentially capped". The report also stated that "the government of the NWT is overtly attempting to discourage the employment of Part III dentists", and further confirmed previous discussion concerning dental care planning: "A somewhat uncharitable view is that the elimination of the dental therapists and their program is part of a corporate plan to increase revenue to a privileged few under the guise of responsible privatization".

Due to mounting pressure, the contractor stepped away from providing dental services to the region as a whole, and returned to previous activity in regional centres. New contracts were tendered, most assuming that the region would return to university-based care. Yet, university-based clinicians observed an opportunity in the outcome of the recent turmoil as well, forming a new cadre of for-profit dental corporations outside the historical programs of the university. In the end, only services in the Kitikmeot region remained with their long-term resident provider with university-based care only receiving a small contract to service

communities in the Baffin region. Services in the Keewatin region and in remaining Baffin communities were given to a new for-profit dental corporation stemming from stakeholders within the university environment. With the creation of Nunavut in 1999, the dental service environment quieted, remaining coordinated on a regional basis, feeding back to a central administrative authority within a new single Department of Health and Social Services. However, where this central administration would be located, and how it would be structured, remained unclear, expectations favoured a decentralised and Inuit representative structure. Contracts for dental service were then re-tendered in 2001, and all contractors were now more organised and serious in terms of their competitive approaches. By this time as well, an even newer cadre of dental corporations emerged, ones with Inuit ownership that held residency in Nunavut.

Article 24 of the Nunavut Land Claims Agreement directed the government to engage in “preferential contracting policies, procedures and approaches intended to maximise local, regional and northern employment and business opportunities, and implement measures that will increase participation of Inuit firms in business opportunities” (43). Article 24 also states that bid criteria should include “the existence and proximity of head offices, administrative offices, or other facilities, in Nunavut, as well as the employment of Inuit labour and the engagement of Inuit professional services” (43). This provision became formalised as the Nangminiqaqtunik Ikajuti Policy, with contractors reacting by building resident practices, even though their owner-dentists still resided in the south, or by

creating new corporations with Inuit partnerships, or ownership.

In the heated competition, contractors then claimed that they would aid or take over the administration and practices of dental public health services from the health department. This afforded the university provider (institutional and individual) some social power, as they represented the seat of this knowledge. In turn, stakeholders formed strategic partnerships that created larger, more expertise-rich corporations.

By mid 2002, after months of intense competition, contracts were awarded to two previously non-resident, but now resident for-profit corporations, and to one new resident for-profit corporation with no northern clinic, but with Inuit majority ownership and a university-based sub-contractor. All competitors now had some level of residency (either directly, or by proxy), employing local people and interacting more fully with the northern economy. They also held plans to offer dental public health services as a contract service, something historically observed as the purview of public programming, and an option that was not taken. This lends further credence to Tester’s (25) analysis of northern health services history as being one of prayerful, public and private provision. While there have been minor changes, this dental care services structure remains today.

Conclusions

This article has outlined the historical changes in the dynamic of control over programs and services in both medical and dental care. The trend developed away from an exclusive central and regional State authority coupled

with professional authority towards a model in which local and regional Indigenous authorities are now major players. All of this has occurred within the particular parameters and/or boundaries of a changing Canadian State, itself slowly moving towards some level of privatisation in the health care system. Indigenous governance over care has emerged as a corporate dynamic, whereby services are controlled through a complex form of public and private structures and interests. This has raised questions within Canadian health care ideology, which has traditionally held a negative view of corporate health care. Dentistry has tended to expand such ideological boundaries because of its nature as a socially uninsured health service, or as a commercial social good. Medicine and dentistry can in fact represent a yardstick for ascertaining what such limits can be; in this case, illuminated and made possible through the complexities of the State/Indigenous dynamic.

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