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Recognizing First Nations Jurisdiction and Authority over Public Health for the Sioux Lookout First Nations Health Authority

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Abstract

Health outcomes for First Nations people living in community are challenged by the impacts of ongoing colonial laws, practices, and structures. First Nations control over developing community-led solutions is vital to improve overall wellbeing of First Nations people and communities. The Sioux Lookout First Nations Health Authority (SLFNHA) was established to develop health policy for the Sioux Lookout region, and to administer and oversee health services regionally. In 2016, SLFNHA implemented a First Nations-developed public health system, founded on traditional teachings and practices, called Approaches to Community Wellbeing. However, federal and provincial legal systems fail to recognize First Nations sovereignty over health and fail to address long-standing jurisdictional ambiguities.

The COVID-19 pandemic has demonstrated the strength and resilience of the communities served by SLFNHA and their use of community-developed protocols and decision-making structures to keep their communities safe. SLFNHA supported the management of the COVID-19 pandemic within the communities it serves, despite not having access to the same tools, resources, information, and authority as the provincial health units. The pandemic also highlighted the public health inequities faced by First Nations in Ontario and failure of existing processes to recognize First Nations jurisdiction thereby continuing to impede the full implementation of a self-determined public health system as envisioned by First Nations leadership.

Les résultats en matière de santé pour les membres des Premières Nations vivant dans la communauté sont affaiblis par les répercussions des lois, pratiques et structures coloniales en cours. Le contrôle des Premières Nations sur le développement de solutions communautaires est essentiel pour améliorer le bien-être général des peuples et des communautés des Premières Nations. La Sioux Lookout First Nations Health Authority (SLFNHA) *a été créée pour élaborer une politique de santé pour la région de Sioux Lookout et pour administrer et superviser les services de santé à l'échelle régionale. En 2016, la SLFNHA a mis en place un système de santé publique développé par les Premières Nations, fondé sur les enseignements et pratiques traditionnels, appelé Approaches to Community Wellbeing. Cependant, les systèmes juridiques fédéral et provinciaux ne reconnaissent pas la souveraineté des Premières Nations sur la santé et ne clarifient pas les ambiguïtés de compétence qui ont existé de longue date.*

La pandémie de COVID-19 a démontré la force et la résilience des communautés desservies par la SLFNHA et leur utilisation de protocoles et de structures décisionnelles développés par la communauté pour assurer la sécurité de leurs communautés. La SLFNHA a soutenu la gestion de la pandémie de COVID-19 au sein des communautés qu'elle dessert, bien qu'elle n'ait pas accès aux mêmes outils, ressources, informations et autorité que les bureaux de santé provinciaux. La pandémie a aussi mis en évidence les inégalités en matière de santé

publique auxquelles sont confrontées les Premières Nations en Ontario et l'incapacité des processus existants à reconnaître la compétence des Premières Nations, continuant ainsi d'entraver la mise en œuvre complète d'un système de santé publique autodéterminé tel qu'envisagé par les dirigeants des Premières Nations.

Key Messages

- Public health service delivery to communities has historically failed to meet health needs, in part due to ambiguous service delivery and inadequate legislation.
- Federal and provincial legislation has long oppressed First Nations by either limiting health services First Nations people can access, or disregarding First Nation developed, governed, and implemented systems.
- Health laws, practices, and protocols have existed at the community-level, and must be reclaimed and recognized in current legislation, as outlined in Section 35(1) of the *Constitution Act, 1982* and article 3 of the United Nations Declaration on the Rights of Indigenous Peoples.
- Public health re-organization for First Nations must include true Nation-to-Nation relationships, and recognize First Nations rights and authorities.

Messages-clés

- *La prestation de services de santé publique aux communautés n'a jamais réussi à répondre aux besoins de santé, en partie à cause d'une prestation de services ambiguë et d'une législation inadéquate.*
- *La législation fédérale et provinciale opprime depuis longtemps les Premières Nations soit en limitant les services de santé auxquels les Premières Nations peuvent accéder, soit en ignorant les systèmes développés, gouvernés et mis en œuvre par les Premières Nations.*
- *Les lois, pratiques et protocoles de santé ont existé au niveau communautaire et doivent être réclamés et reconnus dans la législation actuelle, comme indiqué à l'article 35 (1) de la Loi constitutionnelle de 1982 et à l'article 3 de la Déclaration des Nations Unies sur les droits des peuples autochtones.*
- *La réorganisation de la santé publique pour les Premières Nations doit inclure de véritables relations de Nation-à-Nation et reconnaître les droits et les pouvoirs des Premières Nations.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In 2010, the Chiefs in Assembly of the Sioux Lookout First Nations Health Authority (SLFNHA) passed Resolution 10-06, mandating the development and integration of a First Nations developed, integrated, and governed public health model (Sioux Lookout First Nations Health Authority, 2010). This Resolution led to the development of the Approaches to Community Wellbeing (ACW) model: a community-owned approach for community wellness, founded on traditional teachings and practices of the Anishinabe. Each community[1] can adapt and implement the ACW model (Figure 1) to meet their unique needs, though the model broadly aims to: integrate holistic, sustainable, and proactive approaches to community wellbeing; increase community ownership over health and health systems; support community members committed to healthy and safe community initiatives; provide reliable and relevant health education; support healthy communities and environments for children; and increase connection to the teachings of the Anishinabe. Since 2016, this model provides the foundations to deliver health promotion and education to 31 First Nations communities.

Since the development and implementation of ACW, SLFNHA has advocated for recognition as a self-determined public health system – a measure that would resolve the long-standing jurisdictional issues and provide equitable health services at the direction of the communities. This requires the development of a unique governance model that would be based upon First Nations sovereignty and recognition, and respect for First Nations laws, protocols, and decision-making concerning the health and wellbeing of their citizens.

At the beginning of the COVID-19 pandemic, the long-standing jurisdictional ambiguities and lack of legal authority over public health significantly impacted SLFNHA's ability to respond to the pandemic. Without legal recognition of the First Nations governed system, ACW cannot operate effectively within the provincial public health system; SLFNHA must work with the provincial health units, including all work related to data ownership and control, health care providers, education, and public health order enforcement. The COVID-19 pandemic highlighted strengths of the First Nations supported by SLFNHA, though it also amplified the challenges of the existing public health system. The result has been an ongoing process of indirect access and requests for permissions, resulting in a complex series of workarounds that add delay, fragmented service delivery, and negate the intention of a Nation-to-Nation relationship with recognition of First Nations inherent rights and authorities (UN General Assembly 2007).

[1]"Community" is used in lieu of "reserves" (Indian Act 1985) to more accurately describe the population SLFNHA supports. Regardless of current habituation, SLFNHA uses terms like "community," "in community," and "community members" to indicate they provide care, support, and advocacy to its inherent population.

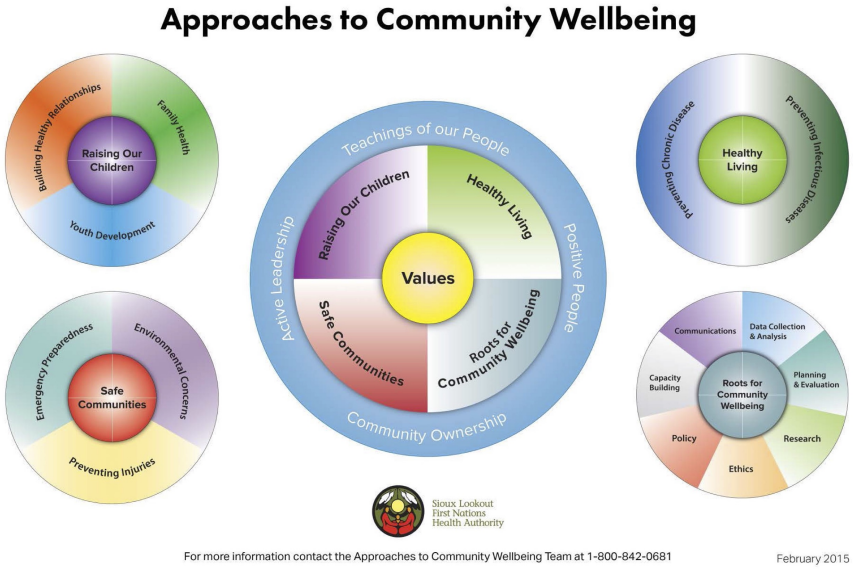

Figure 1: Approaches to Community Wellbeing model developed by SLFNHA (2016).

2 HISTORY AND CONTEXT

Health outcomes for First Nations people living in community are challenged by the impacts of ongoing colonial laws, practices, and structures, as exemplified by determinants of health such as insufficient infrastructure, poor living conditions, overcrowding, poor water quality, and others. Health promotion and education intended to prevent diseases and injury through positive physical and mental health for First Nations must therefore consider the circumstances, environments, structures, systems, and institutions that influence wellbeing (Public Health Agency of Canada 2020; Reading and Wien 2009).

The First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada provides health services to First Nation communities (Berthiaume et al. 2018). Public health service delivery to communities, however, has historically failed to meet health needs (Richmond and Cook 2016), in part due to ambiguous service delivery and inadequate legislation, which has been described as a patchwork of policies (Lavoie et al. 2011).

2.1 Jurisdictional ambiguity over public health

Jurisdictional ambiguity surrounding First Nations health care arises from the 1867 *British North America Act* (BNA). The BNA created a division of powers which defines the provinces being responsible for health services (s.92) and the federal government being

responsible for "Indians" (s.91). Further, the *Canada Health Act* outlines the responsibilities of provinces and territories to deliver health services, though is inexplicit regarding First Nations. This has led to jurisdictional uncertainty regarding which government is responsible for the provision of health to First Nations (Lavoie et al. 2011).

Public health jurisdiction generates an additional layer of ambiguity. In Ontario, public health units deliver legislatively mandated health programs and services across the province. Each health unit is responsible for a designated geographic area and must comply with the regulations and provisions outlined in the Health Protection and Promotion Act (HPPA).

The majority of public health units in Ontario have First Nations communities listed in their catchment (Berthiaume et al. 2018) and as such, they are included in the broader health surveillance system; however, health units typically do not provide services to First Nations people living on reserve.[2] For remote fly-in communities, barriers to access services are even greater, as neither the provincial nor federal government provide the travel dollars required to access provincial public health services.

Indigenous Services Canada (ISC) provides public health funding and services as a matter of practice and policy rather than a matter of legal obligation (Adelson 2005) arising from Constitution or Treaty obligations. As such, the role of federal government is not grounded in legislation to provide clear roles and authorities. Additionally, the practical applications of the HPPA remain ambiguous as the legislation fails to adequately recognize First Nations governance, and fails to recognize the role of ISC in the provision of public health services.

Regardless, the application of authorities from within the HPPA would be an intrusion on First Nations rights to self-determination and community-based decision making, and would create concern regarding the erosion of Treaty rights to health, as well as the federal fiduciary responsibility for First Nations. However, the current alternative of partial application of the HPPA results in a jurisdictional vacuum that perpetuates ongoing barriers to accessing equitable public health for First Nations people in Ontario.

2.2 Nation-to-Nation relationships

Prior to colonization, First Nations had their own traditional legal practices and systems to maintain community safety. First Nations have tended to their own collective health from time immemorial, as well as implemented laws to govern commerce, punishment, enforcement, dispute resolution, education, and many other matters (Borrows 2008).

While this authority and sovereignty is inherent, given that Indigenous Peoples were once independent, self-governing entities in possession of most of the land now making up Canada (Slattery 1982), the recognition of these rights in Canadian and international

[2] Although s.50 of the HPPA provides an option for First Nations to enter into agreements with their local health unit to contract services, these administrative agreements fail to recognize First Nations governance systems. For the First Nations served by SLFNHA, a s.50 agreement would not support a regional First Nations system and protection of Treaty and inherent rights.

law helps protect these rights and affirm their existence. Treaties and Indigenous inherent rights are constitutionally entrenched and protected, therefore carrying the highest power in Canadian law. In fact, Indigenous and Treaty rights are constitutionally protected under Section 35 of the *Constitution Act, 1982*: "[t]he existing aboriginal and Treaty rights of the aboriginal people of Canada are hereby recognized and affirmed."

The communities served by SLFNHA have always asserted their Treaty right to health as Treaties 3, 5, and 9 were written with the understanding that they contained a promise to health care. In her analysis of the Treaty right to health, Boyer (2011) states that the attacks on the health of First Nations were an impetus to entering into Treaty negotiations to alleviate their suffering. Boyer's analysis details that Treaty 9 negotiations included evidence of a verbal commitment to health services, and that Treaty 3 and 5 negotiations contained an implied commitment, given the expressed commitment to ensure wellness and safeguard against diseases, as well as the commitment to non-interference with existing ways of life (Boyer 2011; Craft and Lebihan 2021). Ancestors that negotiated Treaties and subsequent adhesions did so to establish a relationship of peaceful co-existence with settlers. Being forced to adapt the laws and systems of others was not what was intended when Treaty negotiations with the Crown began.

More recently, article 3 of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) specifically recognizes Indigenous Peoples' authority as sovereign nations to protect and promote the health and welfare of citizens using methods most relevant for their communities, stating that "Indigenous [P]eoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development" (UN General Assembly 2007, 8). This includes the right to plan and govern health services and the right to delegate authority to a representative organization, such as SLFNHA.

As a Declaration, the UNDRIP represents statements that are globally agreed-upon standards, unspecific to the Canadian context and existing legislation, most notably the protection of Indigenous and Treaty rights in the Constitution (Isaac and Hoekstra 2018). Implementing UNDRIP would require new laws, policies, institutions, structures, and patterns of relations, which could have transformative influence on the health status of Indigenous Peoples in Canada (Wilson-Raybould 2019). In Canada, the UNDRIP was first endorsed in 2010 but not ratified until 2016. In 2017, the federal government released ten principles on Respecting the Government of Canada's Relationship with Indigenous Peoples (also referred to as the UNDRIP Principles), and finally, in June 2021, Canada enacted the *United Nations Declaration on the Rights of Indigenous Peoples Act* to help guide a cooperative working relationship between the federal government and Indigenous Peoples. While helping to ensure that federal laws are consistent with the UNDRIP (Department of Justice Canada 2021), this Act provides a roadmap for the federal government and Indigenous Peoples to work together to implement the Declaration based on reconciliation, healing, and cooperative relations (Department of Justice Canada 2023). Additionally, the Act requires an action plan be developed no later than two years after enactment, meaning

completion by June 2023.

While this process unfolds, SLFNHA has been managing a public health pandemic since 2020 and has aligned services to support the communities it serves from within a colonial and oppressive structure with ambiguous roles and responsibilities between government partners.

2.3 SLFNHA: First Nations developed and governed

SLFNHA was established to develop health policy for the Sioux Lookout region, and to administer and oversee health services regionally (Scott-McKay-Bain Health Panel 1989). Leadership from its 31 member First Nations communities meet annually to determine SLFNHA mandates and direction. Ongoing oversight is provided by the Sioux Lookout area Chiefs Council on Health and SLFNHA Board of Directors (comprised of representatives from each Tribal Council and independent communities, two Elders, and one ex-officio medical representative).

In 2006, the Chiefs in Assembly mandated the establishment and implementation of a regionally developed and governed public health system (Resolution 10-06). SLFNHA completed the Public Health System Project (2012-2015) to determine community needs, objectives, and visions for a public health department. This project included an environmental scan, community engagement sessions, and brainstorming on how to incorporate traditional teachings and knowledge into a public health model. The resulting ACW model was presented and approved by the SLFNHA Chiefs in Assembly through Resolution 15-03.

Although it was envisioned that SLFNHA would develop health policy, the organization has had to work within prescribed government models and authorities and has been largely limited: "For decades now, we've had access to the money for health care, and have been given prescribed activities to design and provide health services. But we've never had the control we need to create an Anishinabe health system for our people." James Morris, CEO and President (Sioux Lookout First Nations Health Authority 2022).

3 THE POLICY-MAKING PROCESS

The relationship between self-governance and health status is well documented (Berthiaume et al. 2018; Dussault and Erasmus 1996; Gracey and King 2009; Truth and Reconciliation Commission of Canada 2015; Waldram et al. 2006). Indigenous models of health service delivery can improve access to health care, respond well to local needs, support effective use of resources, and often emphasize population wellness over individual health (Lemchuk-Favel and Jock 2004). Although the right to self-determination is entrenched in the Canadian Constitution and the UNDRIP, Canada's inadequate implementation of structural change throughout its existing legal systems has resulted in a failure to support the reclamation of Indigenous systems. First Nations people require a decolonized approach to public health

that integrates traditional knowledge and teachings and addresses their determinants of health.

The ACW model and department within SLFNHA has had enormous value and benefit during the COVID-19 pandemic, and it is difficult to imagine what the situation would have looked like if the model was not well established and able to support COVID-19 response. Prior to the pandemic, an external review was conducted for the ACW department, finding that the department "has established a solid foundation for public health in the region" (Goss Gilroy Inc. 2020, 32) and noted the following key accomplishments:

- strengthened First Nations governance for public health;
- increased capacity for public health planning;
- helped prevent harm associated with addiction;
- increased community capacity for mental health programs;
- increased youth engagement in promoting wellbeing; and
- created health status reports.

The evaluation highlighted significant advances by introducing "new ways of conceptualizing public health that respects traditional teachings and practices while making use of western medicine" (Goss Gilroy Inc. 2020, 3). The evaluation concluded that improving the public health profile in the communities served by SLFNHA must include public health interventions that are conceived and implemented based on First Nations approaches, and that are specific to community needs and circumstances. Further, since program sustainability depends on "renewed funding to ensure continuity in program staffing, capacity and momentum," ongoing funding for the ACW department is warranted for greater stability and flexibility to "adapt to local conditions" (Goss Gilroy Inc. 2020, 4).

Sustainable and meaningful solutions require fundamental structural change and a new jurisdictional model that recognizes First Nations sovereignty and rights. SLFNHA is currently seeking commitment from both levels of government to explore and support these options, and to evolve together in a true Nation-to-Nation relationship that provides equitable access to the provincial system while fully protecting Treaty rights and corresponding obligations of the Crown.

3.1 Reform process

As SLFNHA continues to pursue a Nation-to-Nation process to achieve a self-determined public health system, there are several reform processes that SLFNHA may leverage to achieve their ultimate vision of a self-determined public health system.

Health transformation

The Charter of Relationship Principles Governing Health System Transformation in the Nishnawbe Aski Nation Territory (2017) outlines a trilateral commitment to a Nation-

to-Nation and collaborative approach to health planning. The Charter acknowledges the historical context and need for a renewed health plan, specifying guiding principles that include First Nations governance, management, and approaches. This included a commitment to consider legislative changes, and "removing barriers caused by jurisdictional, funding, policy, cultural and structural issues that negatively impact First Nations ability to plan, design, manage and deliver quality health care services in their communities and for their members" (Charter of Relationship Principles for Nishnawbe Aski Nation Territory 2017, s. 4(6)). SLFNHA has worked closely with Nishnawbe Aski Nation in this transformative change process, which includes work regarding the development of an Indigenous health law, and a review of the existing federal and provincial health laws.

Ontario public health modernization

In 2019, the Ontario Ministry of Health committed to modernizing the provincial approach to public health through consultation that would evolve existing health systems (Ontario Ministry of Health 2019). Engagement with Indigenous communities was highlighted as necessary to improve access to culturally relevant initiatives and programming (Ontario Ministry of Health 2019), with suggestions to strengthen Indigenous representation and decision making, focused on Indigenous inclusion in existing systems and models (Association of Local Public Health Agencies 2020). This process was paused during the pandemic; however, SLFNHA hopes that any legislative reform will take into consideration and recognize the unique public health system for the First Nations it serves.

Federal Indigenous health legislation and the UNDRIP Act

In 2021, the federal government committed to working with Indigenous organizations to co-develop Indigenous health legislations that would improve access to quality and culturally relevant health services (Indigenous Services Canada 2021). Mandated by the Minister of Indigenous Services, the federal government is committed "to address the social determinants of health and advance self-determination in alignment with the UNDRIP" (Indigenous Services Canada 2021). This commitment explicitly supports the transformation of health service delivery to Indigenous-led organizations (Indigenous Services Canada 2021), and generates potential for organizations like SLFNHA to achieve formal recognition for the legitimacy of the ACW model to operate as equally as provincial health units. The proposed federal legislation is anticipated to include a legal recognition of First Nations' inherent authority over the health of their people and will resolve the long-standing jurisdictional issues by establishing clear legal obligations and fiscal relationships to fund and support health in First Nations communities. Additionally, the action plan arising from the UNDRIP Act is anticipated to create processes to ensure that Canada's laws recognize Indigenous law and jurisdiction.

4 IMPLEMENTATION AND EVALUATION

Recognition of self-determination requires real and meaningful systemic change and a transformation of laws, policies, processes, and structures. This includes policy and legislative changes that reflect the recognition and implementation of title, rights, and fiscal relationships to fulfill Treaty rights and obligations. Legislative reform that would recognize Indigenous laws and jurisdiction must create processes for First Nations to fully implement their own structures and systems to look after the health and wellbeing of their community based on specific customs, traditions, and values. Additionally, provincial systems would provide access to the tools, resources, and supports required to achieve public health equity for the communities served by SLFNHA. Through negotiations between First Nations leadership, the Ministry of Health and Long-Term Care, the FNIHB, and with support of the two local Health Units (Thunder Bay District Health Unit and Northwestern Health Unit) an interim solution for public health governance was developed, whereby the Public Health Physician is seconded from Thunder Bay District Health Unit to SLFNHA. This interim solution, however, represents a series of complicated work arounds that do not address the long-standing structural or jurisdictional issues. Through this arrangement, the Health Units continue to act as gatekeepers to the provincial system, while SLFNHA remains on the outside of the provincial public health system without the tools, access, resources, or authority required to operate their own public health system.

SLFNHA's response to the COVID-19 pandemic illustrated that First Nations have the capacity to operate a public health system and to develop strategies and measures that maintain community safety. However, it also highlighted the resulting challenges from a complicated system based on patchwork solutions and workaround measures. The insufficient nature of the current arrangement of workarounds was dreadfully apparent during the COVID-19 pandemic as SLFNHA and the communities it serves repeatedly encountered delays accessing information, and failures of provincial systems to recognize the unique circumstances and conditions of remote First Nations in pandemic planning.

4.1 The challenge with colonial public health models: COVID-19 response

The ability of SLFNHA to support the communities it serves throughout the COVID-19 pandemic was limited by ongoing reliance on provincial partners to receive access to the provincial public health system, manifesting in three major barriers. Firstly, SLFNHA had to access data and information through indirect means, often creating delays and communication challenges for the communities they support. Without timely and accurate information, communities were often, and felt, at risk. The communities and SLFNHA were constantly adapting to challenges posed by public health system processes and procedures that do not consider the realities of living in a First Nations community.

Secondly, the SLFNHA Public Health Physician is limited in their role as they are

not recognized as having powers equivalent to a Medical Officer of Health, creating issues especially around public health enforcement. While SLFNHA operates on the recognition of community sovereignty in decision making regarding public health restrictions in their community, the communities and SLFNHA cannot work in isolation. Failure of external systems to recognize First Nations sovereignty meant that community leadership was unable to seek support from police, the justice system, and other entities to assist with enforcement.

Thirdly, funding mechanisms in place for SLFNHA are largely limited to proposal-based funding within a fixed-pot funding environment. This is drastically different from provincial health units that have long-term sustainable funding sources, and the ability to trigger additional funding and surge capacity based on needs and circumstances.

These experiences highlight some of the ongoing structural violence resulting from jurisdictional ambiguity and legislative void around First Nations health (Farmer et al. 2006). The failure of federal and provincial legal systems to recognize First Nations sovereignty has resulted in a First Nations developed and governed public health department that has no legal authority to carry out critical functions of a public health system.

5 CONCLUSION

Control over services and developing community-led solutions is vital to improve the overall health and well-being of First Nations people and communities. The communities served by SLFNHA have a right to a fully functioning public health system with equitable access to tools, resources, and funding. While SLFNHA has made incredible gains by navigating and working within the current patchwork arrangement made up of complex workarounds, an urgent need for fundamental change and a new Nation-to-Nation jurisdictional model persists to achieve comprehensive and sustainable solutions.

Federal and provincial governments must generate space for multiple legal traditions to operate in harmony, and ultimately decolonize legal and political frameworks by recognizing First Nations jurisdiction in their self-determination processes. A trilateral process is required to uphold the Crown's commitment to the Treaty right to health while ensuring that First Nations people receive public health equity through meaningful participation in the provincial public health system.

Provincial and federal health care reform processes have an opportunity to learn from the COVID-19 experience and to demonstrate reconciliation by supporting First Nations jurisdiction over public health through recognition of SLFNHA's public health model, ACW. First Nations developed and governed models are essential to provide equitable access to tools and resources comparable to provincial health units, ultimately respecting the laws, protocols, and decisions that community leadership generate for community safety and overall wellbeing.

	Medical Officer of Health (MOH)	**Current Arrangement for SLFNHA Public Health Physician**
Diseases of public health significance	**Direct Access and Communication** • Direct access to labs; health care providers share personal health information directly with MOH. • MOH can directly communicate with Ministry of Health and Public Health Ontario for technical support. • MOH is notified of changes to policies and procedures.	**Indirect Access and Communication** • Access to information, support and policy and procedural change through health unit • Results in delay, confusion, miscommunication, etc. • Inability to issue and enforce public health measures.
Surveillance system	Has the authority to direct others to provide required information: • hospitals, health care providers, and partners; and • data and information required to develop surveillance systems.	• Can request participation but not guaranteed; has no legal authority to participate. • When/if granted, often must negotiate data sharing agreements or memorandum of understanding, resulting in delays.
Health hazard: environmental	• Obligated to investigate health hazard and be provided with environmental (chemical) testing results. • Direct access to information. • Authority to issue order to stop health hazard from occurring.	• No authority to request information – must access through the health unit. • Indirect access to information • No authority to investigate • Request health unit to issue order
Health hazard: food	• Can require investigation of a restaurant or food provider. • Can issue direction for changes to be made at the restaurant.	• Must work through the health unit to issue enforcement orders.
Health status reports	• Considered a Health Information Custodian and can request data from provincial databases. • Has direct access to databases.	• Must submit a data research request. • If approved, not guaranteed access to full data set.

Table 1: Summary of differences between a health unit MOH and adaptation assumed by SLFNHA Public Health Physician.

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