National Rural Health Strategy

"Every citizen in Canada should have equal access to health care regardless of where they live."

- Mr. Justice Emmet Hall

There are many health care challenges for Canadians, but none are any greater than the challenge of providing care for those who live in remote and sparsely populated regions of this country. In 2005, 21% of the Canada's population lives in rural communities of less than 10,000 population and only 9.4% of the physicians live and work in these communities. The rural physicians' workforce comprised of 16% of family physicians and 2% of specialists.

Health status decreases as one travels to more rural and remote regions and this is reflected in a comparison of rural and urban morbidity and mortality rates. It is particularly true in Aboriginal communities where there are substantially higher rates of diabetes, respiratory and infectious diseases, and violence related deaths. The biggest discrepancies in rural-urban death rates are seen among young people – rural Canadians less than 45 years of age have about a 30 percent higher mortality rate than urban dwellers of the same age.[1] Ultimately, the most isolated rural Canadians live three years less than their urban counterparts.[2]

The ability to become pregnant is evenly distributed throughout the population but providers of maternity care are not. Rural women are finding it increasingly difficult to deliver their babies in their own communities, even if there is still a hospital. Access to maternity services in southern Ontario is decreasing[3] and in Northern Ontario the reported number of community hospitals that have closed their maternity wards has increased 5 fold since 1981. The distances that women have to travel are increasing.[1,5,4]

Studies in the United States[5,6,7] and Norway[8] consistently document significantly poorer outcomes for communities that lack maternity services, even when the referral centre is of an excellent calibre. Children of women who are forced to travel have greater rates of perinatal death and prematurity and incur double the health care costs (from travel and prematurity).

Of necessity, solutions to rural maternity care are being devised. In the absence of sufficient volume to attract specialist midwives or obstetricians, rural physicians have developed mechanisms that transcend urban classifications of primary and secondary care. An obstetrically trained GP,[9] with a GP anesthetist and trained nursing staff are able to provide local obstetric care for over 98% of women with results equal to that of the city.[10]

Roy Romanow, in the Commission on the Future of Health Care, chronicles how Canadians living in rural and remote communities spoke directly about their serious concerns. They spoke of the need for good health and good access to health care "not only because it is essential to sustain their own quality of life, but also the quality of life in their communities." He recommended targeting $1.5 Billion for a Rural and Remote Access Fund to address serious challenges in health care in rural and remote areas of Canada. Not a penny has been spent and challenges persist.

Rural Canada has a highly diverse economy and society, from the coastal regions to the agrarian heartland. Canada's rural natural resources provide employment, forest products, minerals, oil and gas, food, tax revenue and much of our foreign exchange.

It was noted that “People’s choice of whether or not to live in smaller communities is affected by whether or not they can get reasonable access to health care.” That view was echoed by rural physicians who said “geography is a determinant of health.” Sustaining and improving rural health care is important in ensuring that people will be willing to live and companies will be willing to develop industry in rural areas. In a time of increasing global competitiveness, the federal government cannot afford to ignore the link between health care and economic sustainability and growth in rural Canada: the primarily rural based, natural resource sector accounts for approximately 40% of total national exports.[11]

Geographically rural Canada comprised of 99.8% of Canada. Its mean rural population density of one person per square kilometre creates unique and special requirements for the delivery of health care. Acute, time based and life saving care standards such as the "golden hour" for trauma, and 30 minutes for caesarean section are dependent on short distances to health facilities, regardless of the population density.

Research shows that training experience in rural medicine is important and that rural origin applicants are the most likely to practice in rural settings.[12,13,14,15] Medical schools preferentially select people from urban neighbourhoods with an average income of over $80,000,[16] train them in an urban environment that promotes and emphasizes subspecialisation, research and academia, far removed from the considerations of the larger community. Graduates of the educational system are thus increasingly interested in subspecialisation and urban practice. Family medicine training positions are increasingly unfilled,[17] and even those that fill do not train to the skill level needed for rural practice. A 2004 study found that only seven percent[18] of current medical graduates choose to practice in rural areas, down from eleven percent of current medical school graduates back in the 1990’s.[19] They also appear to be ill prepared to live and work there as they tend to stay only a few years. The largest group of physicians who leave rural Canada are under 35 years of age. Attrition rates remain high. Quite consistently across provinces an average of 21% of previously rural GP/FP's respondents reported a move to the city in the previous two years. It has been said that any system is perfectly designed to produce the effects that it does. It is thus not surprising that access to care in rural Canada suffers from our medical system - including the government, medical bodies, training system and para-medical organisations - being organised in a highly centralised manner, best suited to countries with dense populations and short distances.

Comparatively low levels of funding can produce significant results. The Australian success in employing a national rural health strategy has increased the number of doctors practising in rural and remote areas in Australia from around 5,400 in 1995-96 to over 6,200 in 1999-2000.[20] Surely we can do as well.

Many have called for such a pan Canadian solution. The rationale for a united approach to physician distribution was argued in 1999 by consultants to the federal and provincial health ministers, Barer and Stoddart: *“It seems important to reinforce the idea that such a restructuring would need to be pan-Canadian if it is to be expected to provide an effective remedy to the problems of rural and remote communities. Absent such cross-country*

agreement, provinces and territories would likely be faced with whipsawing and increased migration between jurisdictions."[21]

The issue of servicing the health care needs of the rural population is a difficult issue with a long history. This is an issue of fundamental justice and equality that the provinces have wrestled with, probably to the limit of their ability, on an individual basis. Hospital closures and technology are not the solution. People are needed and primary care reform will help only if done properly with an understanding of rural realities. There is an opportunity for the federal government, together with the provinces and territories, to achieve further improvement as has been done in Australia. This is especially true with reform of the medical education system, which is best done nation wide. To do this the federal government has to have the bureaucratic structures in place to develop, promote and enact a national rural health strategy in conjunction with the provinces and territories.

> *"On his own skill, knowledge, resourcefulness, the welfare of his patient altogether depends. The rural district is therefore entitled to the best trained physician that can be induced to go there."*
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> *-Dr. Abraham Flexner 1910 in "Advancement of Teaching Medical Education in the United States and Canada"*

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