Honourable Allan Rock
Minister of Health
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Rock,

It is my pleasure to submit the preliminary report and recommendations of the National Liberal Rural Caucus, *Toward Development of a National Rural Health Strategy*.

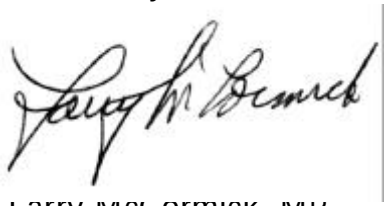
This document results from our discussion at National Liberal Rural Caucus on March 9 and your invitation to Members to contribute to the development of a national rural health strategy. Specifically, we were asked:

- To identify tools required by Members in order to conduct information gathering forums and other dialogues with Canadians;
- To identify innovative initiatives and proposals for involving rural Canadians and communities in development of a national rural health strategy;
- To identify key services, outcomes and health status issues that require accountability mechanisms; and
- To identify and prioritize major issues in rural Canada and suggestions to address the challenges.

The overall objective is to provide information and innovative suggestions toward a national rural health strategy.

Between March 9 and April 30, Members of Rural Caucus drew on their experience and conversations with constituents in order to develop these initial comments and suggestions. We appreciate the opportunity to influence the framework for a dialogue with rural Canadians.

Yours truly,



Larry McCormick, MP
Chair, National Liberal Rural Caucus

Second printing, revised
(see p. 6)
May 12, 1999

National Rural Health Strategy
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Mandate

The Honourable Allan Rock, Minister of Health, and Dr. John Wootton, Executive Director of Rural Health, Health Canada, attended National Liberal Rural Caucus on March 9 and extended an invitation to Rural Caucus to participate in the development of a national rural health strategy. The Minister sought advice on the following points.

1. *Identify* tools required by Members in order to conduct information gathering forums and other dialogues with Canadians;
2. *Identify* innovative initiatives and proposals for involving rural Canadians and communities in development of a national rural health strategy;
3. *Identify* key services, outcomes and health status issues that require accountability mechanisms; and
4. *Identify* and prioritize major issues in rural Canada and suggestions to address the challenges.

Overall, Rural Caucus will provide the Minister with information and innovative suggestions toward a national rural health strategy.

Process

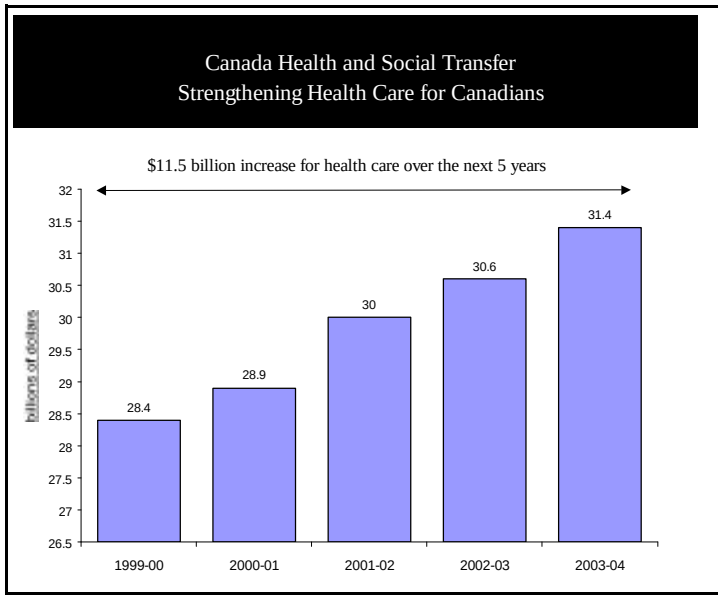
Phase 1: The initial report to the Minister will create a framework for moving toward the development of a National Rural Health Strategy.

Phase II: A follow-up report will be prepared during the fall of 1999, after Members have had an opportunity to consult with constituents.

Background

Budget '99

The 1999 federal Budget provided $11.5 billion to address immediate concerns about waiting lists, crowded emergency rooms, and shortages of diagnostic services. This is the largest investment this government has ever made. [1] The funds are being distributed on an equal per-capita basis – the same amount for each Canadian in every province.[2] Of these funds, $8 billion will be provided through future increases in the Canada Health and Social Transfer (CHST).



The 1999 Budget invests close to $1.4 billion in other initiatives to improve the health of Canadians. These include funds to improve information systems and to promote health-related research and innovation. Of this commitment, $190 million will go toward improving First Nations and Inuit health services and prevention of health problems through outreach and research.[3]

Throughout the 1990s, a "profound transformation" has occurred in health care in Canada. "More and more services are being provided in the community and in the home rather than in hospitals." This means that providers are increasingly diverse, "including doctors, nurses, midwives, physiotherapists, home care workers, pharmacists, practitioners of alternative medicines and informal caregivers." Besides a more complex arrangement of players, health care interventions are being expanded through new technologies and medical treatments.[4]

The 1999 Budget committed $115 million toward information technology. This means that "telehealth" and "telehomecare" initiatives will go a long way toward ensuring that distance is not a barrier to health care services. The technology will improve quality of life, eliminating the negative impact that occurs when patients are separated from their family and friends.

[1] *The Budget Speech 1999*, p.

[2] *Briefing Book: Budget 1999*, p. 142

[3] *The Budget Plan 1999*, p. 77, and Health Canada Fact Sheet, February 1999

[4] Ibid, p. 79

The Liberal government recognizes the unique problems facing Canadians living in rural and remote areas. "This Budget provides $50 million over the next three years to continue developing with the provinces promising strategies for rural and community health."[5]

Three final areas bear noting. First, the 1999 Budget specified $240 million over two years to create the Canadian Institutes of Health Research. Second, it anticipates a much larger role for nurses – "in the community, in clinics, in hospitals, and in the home." Third, the Budget allocated $287 million over the next three years for illness prevention initiatives.[6]

The 1999 Budget was clearly a health budget, providing numerous opportunities to improve the health and well-being of Canadians.

Recommendation

- **That the funds allocated in the 1999 Budget for health care be viewed through the Rural Lens.**

Rural Lens

On February 9, 1998, the federal Cabinet endorsed an impact test to measure the effects on rural residents of policies, programs and services of all federal departments and agencies. The process provides a mechanism for viewing government's work from a rural perspective.[7]

Rural Caucus congratulates the Minister of Health for his initiative in appointing the first Executive Director of Rural Health, whose mandate it is "to ensure that a rural health perspective is considered in the formulation and implementation of departmental policies, programs and services. He will report on rural health care and population health issues, identify areas for further research and represent the department on government-wide committees examining rural issues."[8]

Briefing Book: Budget 1999, p. 15

Briefing Book: Budget 1999, p. 15-16

Agriculture and Agri-Food Canada news release, 9 February 1998

Health Canada news release, 15 September 1998

Recommendations

- **Rural Caucus urges the Minister to ensure that the Executive Director and the Office of Rural Health complete a profile, by province and territory, of departmental policies, programs and services indicating their accessibility to, and impact on, rural residents; and**
- **Rural Caucus also looks forward to the Executive Director's report and identification of rural issues.**

Securing Our Future Together (1997 campaign)

Liberal commitments made in 1997 in the area of health care include:

- an expansion of the Canadian Breast Cancer Initiative;
- the development of a national strategy for the creation of a Canadian Health Information Network;
- tax credit for caregivers in providing home care to infirm family members, including seniors;
- support for emerging health issues such as home care and community care;
- establishment of a Health Transition Fund as recommended by the National Forum on Health to help the provinces test new approaches to primary care delivery;
- extension of the National AIDS Strategy at current funding levels for an additional five years;
- establishment of an independent National Population Health Institute, as recommended by the National Forum on Health, to report to the public on the national health status and the performance of the health system;
- together with our provincial, territorial, private sector, and service provider partners, the pursuit of a strategy toward universal public coverage for medically necessary prescription drugs; and
- a commitment to double the funding for the Tobacco Demand Reduction Strategy to promote the health and well-being of Canadian children and youth.

Recommendation

That the Minister of Health view each of these commitments through the Rural Lens and provide Caucus with an update of our progress as we approach the mid-point of our mandate.

Federal role in health care

Canada Health Act

Canadians consistently support the five principles of the *Canada Health Act*:

1. universality
2. accessibility
3. comprehensiveness
4. portability
5. public administration/non-profit by public authority

- The *Canada Health Act* provides the legislative framework and authority under which federal transfers are made to the provinces in support of health service delivery. The primary mechanism is the Canada Health and Social Transfer (CHST). The Act ensures that provincial health insurance plans comply with the five principles, noted above. With few exceptions, the Act governs only the provision of medically necessary physicians, hospital, and surgical-dental services.

- The federal government has well-established roles in health – from providing health services to First Nations, to funding health research, to ensuring the safety of food and controlling toxic substances. As well, the federal government administers health surveillance and protection; health promotion; regulation of drugs and devices; pilots innovations and provides leadership.

- The provinces and territories design, deliver, and administer health services, including licensing of physicians and other health care providers, hospital and institutional care, and some aspects of prescription medication.

Rural Canada

Rural is defined variously. Census divisions in Canada use a population-based definition that includes towns and villages of fewer than 10,000 people. The population-based indicator provides researchers and others with reliable and accessible data following each census, as captured on the table that follows[9]:

Urban and Rural Population Distribution in Canada, the Provinces, and Territories, 1996

Place	Urban	% Urban	Rural*	% Rural	Total
Canada	20,105,914	69.7%	8,740,847	30.3%	28,846,761
Newfoundland	197,434	35.8%	354,358	64.2%	551,792
P.E.I.	51,515	38.3%	83,042	61.7%	134,557
Nova Scotia	406,825	44.7%	502,457	55.3%	909,282
New Brunswick	261,698	35.5%	476,435	64.5%	738,133
Quebec	5,073,374	71.1%	2,065,421	28.9%	7,138,795
Ontario	8,244,216	76.7%	2,509,357	23.3%	10,753,573
Manitoba	688,524	61.8%	425,374	38.2%	1,113,898
Saskatchewan	508,963	51.4%	481,274	48.6%	990,237
Alberta	1,822,330	67.6%	874,496	32.4%	2,696,826
British Columbia	2,819,812	75.7%	904,688	24.3%	3,724,500
Yukon	17,196	55.9%	13,570	44.1%	30,766
N.W.T.	14,027	21.8%	50,375	78.2%	64,402

* Rural areas and urban areas with less than 10,000 population.

Source: Statistics Canada, *Census 1996, Population and Dwelling Counts*. (No. 93-357-XPB), Ministry of Industry, Ottawa, 1997.

Rural Caucus is concerned that the recent amalgamations in Ontario may affect future census reports. For example, when a town with a population of 5,000 amalgamates with two townships, each with a population of 3,500, the new entity would boast a population of 12,000. This "greater community" would shift the data from a rural census district to an urban one without any change in the distribution of the population – the same number of people would live in the town and the same number in the countryside. The end result would suggest that fewer people live in rural Canada, but in fact, no change would have occurred.

While the census district model provides important comparative information, it does have limitations. For example, Rural Caucus considers communities of more than 10,000 people to be rural when their economic foundation is based on primary production and processing activities, or when their economy is based on rural culture and nature tourism. This includes places such as Leamington, Ontario, and Brooks, Alberta; the vineyard and orchard areas of Niagara and the Okanagan; and tourism areas such as Lunenburg County, Quebec's Eastern Townships, and Muskoka.

[9] Source: "Notes on Rural Health updated Figures, Parliamentary Research Branch 8 April 1999, p. 2. Other important indicators used to describe rural include geographic and economic descriptors. Plea refer to *Think Rural!* Report of the Standing Committee on Natural Resources, Marc 1997, p. 7-9

Physicians in rural Canada:

According to the 1996 Census, 30.3 percent of Canadians live in rural communities. However, only 14.3 percent of generalist physicians and 2.9 percent of specialists serve the 9 million people living in rural Canada.[10]

In recent years, the number of generalist physicians, as a percentage of the population, has declined in both rural and urban Canada, but the decline has been sharper in small towns and the countryside. "Between 1994 and 1998, the number of rural generalist physicians fell by 15 percent, while the number of urban physicians fell by about 4 percent." During the same period, "the number of rural specialists fell by 17 percent, while the number of urban specialists increased by 2 percent[11]

Statistics tell us that Canadians living in smaller communities have farther to travel to see a physician than do city dwellers. For Canadians living in low-income areas in rural Canada, "the longer distance to doctors may be compounded by a lack of transportation and by limited public transportation." This problem is compounded in the north "where nearly two-thirds of the population was 100 or more km from the nearest doctor."[12]

Recommendations

1. We know that the rural population is a vulnerable one because of occupational risks, for example, of fishing and farming. We also know that seniors, single mothers and their children, and others who lack mobility are vulnerable, too often because of the dual impact of poverty and isolation. A search through publications reveals little research has been undertaken that examines these circumstances and the health care services available to address them in rural Canada.

Research is required:

- ***To re-examine occupational risks in rural Canada in order to evaluate the level of health services across the country to ensure access to appropriate health care in a rural context (please see p. 12, below), as well as to identify opportunities to promote preventative measures; and***
- ***To identify the links between quality of life issues and health and to develop mechanisms to address the needs of rural Canadians in ways appropriate to their rural context.***

continued

Ibid, p. 2, citing the Society of Rural Physicians of Canada

Ibid, p. 2, citing the Society of Rural Physicians of Canada

Ibid, p. 4, citing *Health Reports* (E. Ng, et al), Vol. 8, No. 4, Spring 1997, p. 19-31

Recommendations

2. Research in Australia reveals that "some health problems, such as mental illness, youth suicide, injuries, road trauma, alcohol and substance abuse, are most acute in rural areas."[13] In Canada, research has focused on the health problems of First Nations' populations and the resulting low life expectancy.[14] However, the challenges confronting other rural populations are less clear.

Research is required:

- ***To collate the data on First Nations' people and to identify any gaps in our response to the health needs of this population; and***
- ***To identify the specific health problems faced by other rural Canadians, to be followed by actions appropriate to the rural context.***

3. Once the needs assessments, as noted in the two preceding points, have been completed and actions have been undertaken, we need to:

- ***Ensure that evaluation mechanisms are in place to monitor the success of the interventions; and***
- ***Ensure that the five principles of the Canada Health Act apply, paying particular attention to universality and equitable access.***

Tools for effective information gathering

In order to conduct forums and other outreach activities in our ridings that will result in information useful to the Minister of Health and the Executive Director of Rural Health, Rural Caucus has identified a need for the following tools:

1. Members' guide
   - To be comprised of a profile, describing the federal role in health care and a description of areas within provincial jurisdiction;
   - To include a list of projects, actions, and programs initiated and/or supported by Health Canada.

Recommendation

That Health Canada compile the profile and the list.

[13] *National Rural Health Strategy*, Department of Human Service and Health (Australia), March 1994, p. 5

[14] Life expectancy rates are provided below, see p. 13

2. Video
   - To feature the Minister of Health and the Executive Director of Rural Health. This vehicle will introduce participants at riding activities to the topic, identify objectives, and outline how the information gathered will be used to develop the National Rural Health Strategy.

Recommendation

That National Liberal Research Bureau communications personnel produce the video.

3. Workbook
   - To provide a framework and articulate the questions in order that results of the forums and other outreach activities in the ridings will be comparable, useful, and inform the recommendations to be made in Phase II of the Rural Caucus report, Toward a National Rural Health Strategy.
   - To provide a mechanism for individuals and groups to complete on their own and return to their MP.

Recommendation

That the Office of Rural Health create the workbook based on the recommendation in this report and the needs of the Minister.

4. CD-ROM and Overheads
   - Create a CD-ROM to be used by individuals and groups to provide a technology option; and
   - Produce overheads, based on the Member's guide and the workbook, to facilitate and focus group discussions.

Recommendation

That the Office of Rural Health create optional overheads and CD -ROM based on the presentation video and workbook in order to facilitate outreach initiatives.

Involving rural Canadians

One of the suggestions coming out of the Rural Dialogue (1998) was that rural Canadians want to be involved early on in the development of new initiatives. This government listened. This rural outreach initiative provides a unique opportunity for Canadians to influence a National Rural Health Strategy, and Rural Caucus has identified ideas for just such involvment of rural Canadians and communities in the process of developing a National Rural Health Strategy.

Ideas and initiatives

1. Roundtable/forum, by invitation

   Suggested groups

   - Health care interest groups (e.g., medical associations, VON, hospital boards and auxiliaries, local health units)
   - Community-based interest groups (e.g., Meals on Wheels, homecare providers, "rural vitality" groups)
   - General interest groups (e.g., Federation of Agriculture, Women's Institute, seniors groups, service clubs)
   - Students (e.g., secondary schools and community colleges), municipal councils, local fair boards and so on)

2. Forum/panel, open to the public
3. Workbook, distributed through constituency offices in hard copy or by CD-ROM, as well as on the Health Canada website
4. Communication
   - Local radio stations (e.g., conversation with the host or call-in shows)
   - Video(s) to the community cable station (these can be produced by Liberal Research Bureau)
   - Interviews with the local newspapers

Recommendation

That the Minister of Health and the Executive Director of Rural Health provide support as required by Members. This could involve, for example, participation in the production of a Member's video and/or guest participation at a constituency function.

Accountability mechanisms

Rural Caucus recognizes the importance of identifying key services, outcomes and health status issues that require accountability mechanisms, and of identifying and developing the necessary tools to this end. This is a primary goal of the consultation process. It is important to stress that Rural Caucus supports the principle of openness and transparency, as noted in the Report of the National Liberal Caucus Committee on Health Priorities.[15]

Recommendations

- **That suggestions leading to evaluation tools or accountability mechanisms be included in a section of the workbook for Members;**
- **That specific suggestions regarding accountability mechanisms be included in Phase II, pending completion of consultations with constituents.**

[15] Report of the National Liberal Caucus Committee on Health Priorities, November 1998, p. 5

Preliminary identification of major issues

Appropriate rural health care in a rural context

Rural Canadians want access to equitable health services in their communities. Universality and accessibility are two of the most important principles under the *Canada Health Act* when dealing with the issues in rural health care in a rural context, particularly given the restructuring of institutional care across the provinces. The Society of Rural Physicians of Canada notes, "As acute care facilities in urban centres shrink, the need for improved ability to keep rural patients in their home hospitals is rising."[16] In addition to the strictly medical dimension, there are also quality-of-life factors, including suggestions that healing occurs more quickly when patients have the support of family and friends, a critical issue when people cannot obtain health care in their home communities.

Farmers

Between 1990 and 1996, "813 people died and 4,553 people were hospitalized for farm-related injuries,"[17] from a Census population (1996) of 485, 605 Canadians. "In particular, older farmers are at risk - 15 percent of the farming population is over 65, but that group has 30 percent of the fatal injuries. About 20 percent of fatal farm injuries are in children."[18]

One of the causes of farm accidents is stress. A Farm Safety Association study reports that farmers face stressful pressures, which "range from financial problems, to bad weather, to simply too much work." Over time, stress leads to physical weakness and fatigue. It becomes "difficult to concentrate [leading to] poor management decisions. Because of weariness and lack of concentration, you also will become much more accident-prone."[19] Another recent study noted that "those who reported a very high stress level also were the most likely to have been seriously injured in the previous year (18 percent); those who reported no stress were the least likely to have been injured (6 percent)."[20] This research supports a 1993 study by the Senate, which notes, "People are the cornerstone of any sustainable development in agriculture and the health of these people must be preserved. The present level of stress reported by farm communities is unacceptable. The recognition that stress creates ill health and contributes to injury, accidental death and illness makes it a serious concern of national significance."[21]

First Nations

[16] Society of Rura Physicians of Canada website (http:// www.srpc.ca/ rcc.htm)

[17] "Notes on Rura Health - Update Figures," Parliamentary Research Branch 8 April 1999, p. 5, citing the Canadian Agricultural Injury Surveillance Program (CAISP

[18] Ibid, p. 5, citing *Medical Post* (D. Driver), 24 November 1998, p. 28

[19] Farm Safety Association, "Dealing with stress," Fact She No. F-001, July 1996 (http:/ www.fsai.on.ca/ CC01_01A. HTM)

[20] Health Canada, *Farm Family HEALTH*, "Far family study sheds more light on farm accidents" Vol. 5, No. 1, Spring 1997 (http:// hwcweb.hwc. ca/hpb/lcdc/ publicat/farmfar ff5-1d_e.html)

[21] Standing Senate Committee on Agriculture and Forestry, "Farm Stress: Its economic dimension, its human consequences," Interim Report, 20:6, June 1993

Aboriginal Canadians comprise 3.8 percent of Canada's population with slightly more than half of all Aboriginal people living off reserve. "The difference in life expectancy of First Nations people and other Canadians in 1990 was seven years" (66.9 years for First Nations men and 74 years for women versus 74.6 and 80.9 years respectively for all Canadians). Life expectancy is lowest for Registered Indians living on reserves: 62 years for men and 69.6 years for women. Suicide rates for Registered Indian youth are eight times the national rate for females and five times the national rate for males. Infant mortality rates fell from 28 to 11 per 1,000 live births between 1979 and 1993, while the national rate fell from 11 to 6 in the same period. Whereas the rate of HIV/AIDS in the general population has levelled off, it is rising among Aboriginal people; it has gone from 1.4 percent in 1984-1990 to 4.4 percent in 1993-1995.[22]

Fishers, Atlantic

Commercial fishing is Canada's most dangerous job category. The death rate among Atlantic fishers "ranged from 30.2 per 100,000 for those aged 55 to 74 to 55.7 per 100,000 for those aged 15 to 34." For each 100,000 people, the fatality rate for fishers is 48.5, for farmers it is 24.7. The average for all occupational categories is 9 per 100,000. In addition to accidental deaths, fishers are also prone to certain types of cancers, partially attributed to diet.[23]

HIV/AIDS

There are unique problems when dealing with HIV/AIDS in rural Canada. The first is attitudinal - rural Canadians are less apt to acknowledge the potential for infection; the second is a concern over privacy when treating HIV/AIDS in small communities.[24] Despite popular perception, risk and rate of infection is the same in semi-rural areas as in large cities.[25] For HIV/AIDS data on Canada's Aboriginal population, see First Nations, above.

Home care

In 1998, the National Forum on Health explored the challenges of protecting and

Ibid, p. 6 citing DIAND (http://www.inac.gc.ca/strength/socio.html)

Ibid, p. 6, citing *Medical Post* (D. Driver), 24 November 1998, p. 28, and Occupational Injuries data, HRDC

Ibid, p. 4, citing *Canadian AIDS News* (C. Donovan), Vol. VIII, No. 4, Spring 1996, p. 2

Ibid, p. 4, citing a Health Canada study reported in *Medical Post* (R. Carlson), 15 September 1998, p. 53

promoting the well-being of family caregivers. Currently, the health care system is moving away from caring for the ill in institutions and toward community integration. This is resulting in "enormous pressures...being placed on families to render practical care and emotional support and to identify and orchestrate community services on behalf of family members who suffer from chronic illnesses, disabilities or age-related declines in functioning." The demands on caregivers are intense and complex, and these unpaid family caregivers pay a price through the loss of stamina, which compromises both their physical and psychological health.[26] Following publication of the five-volume report of the National Forum on Health, the Health Transition Fund was established by the federal government to provide information on four priority areas: home care; pharmacare; primary care reform; and integrated service delivery.[27]

In March 1998, Statistics Canada reported that "with cutbacks in formal health care services, Canadians have become increasingly concerned about issues such as care for seniors." Approximately 3.7 million Canadians are providing unpaid care to seniors. There is evidence that home care is a gender issue.[28]

More than three million Canadians require care in their homes and "family caregivers are providing more than 80 percent of Canada's home care." Today in Canada, "home care is an idiosyncratic patchwork" and to transform it into a system that is "accessible, affordable and recognizable" will require "a major shift in funding philosophy, perhaps a fundamental rethinking of medicare itself." To create a continuum of care or an integrated system will require "knocking down traditional barriers and hierarchies." Without a continuum, we find varying standards, a lack of monitoring, and different services across the country, resulting in the fact that not everyone who needs professional assistance is receiving it. Transferring health care to the home is effectively transferring the "financial burden from the state to the individual." It interrupts careers, with ensuing economic costs, and often creates stress on individuals and their families, with ensuing social costs. "Transforming home care from an afterthought into a priority will take standards, monitoring and political will."[29]

Women's health

The launch of Canada's Women's Health Strategy marked International Women's Day

[26] *National Forum on Health* (B.H. Gottlieb), Vol. 3, 1998, p. 115-118

[27] The fund provides $30 million to national level projects and $120 million to provincial and territorial projects allocated on a per-capita basis

[28] Statistics Canada, *The Daily*, March 17, 1998, p. 18

[29] *Globe and Mail* Homecare: four part series (A. Picard), 20, 22, 27, and 29 March 1999

(March 8, 1999).[30] The Strategy includes six initiatives:

- *Canadian Breast Cancer Initiative* - renewal of stable funding of $7 million per year
- *Clinical Trials Policy* - to ensure that clinical trials consider the effects of new drugs on women at all stages of life
- *Canadian Heart Initiative* - for women of all ages, 39 percent of deaths are attributable to cardiovascular disease, compared to 36 percent of men's deaths. This initiative supports an integrated approach to reducing and preventing deaths
- *Canadian Institutes of Health Research* - to ensure pan-Canadian integrated data-gathering and information exchange to ensure health care dollars are spent wisely, and to improve understanding of factors that contribute to good health, including the health of Canadian women
- *Canadian Strategy on HIV/AIDS* - includes national programs and research focused on the prevention of HIV in women, and the care and treatment of affected women
- *NURSE Fund (Nurses Using Research and Evaluation)* - a 10-year research program to find solutions to the challenges inherent in the changing roles and needs of nursing.

Women's Health Strategy builds on the work already undertaken by our five Centres of Excellence for Women's Health and support for the Canadian Women's Health Network. It echoes the Platform for Action adopted at the Fourth United Nations World Conference on Women (September 1995) and responds to the final report of the National Forum on Health (1997); Health Canada news release 1999-43

Recommendation

That the identification of issues and priorities be included in Phase II, pending completion of consultations with constituents.

Next steps

1. Between late May and early September of 1999, Members from rural constituencies will be consulting with rural residents across Canada – in their home constituencies and in their "twin" ridings.
2. In mid-September, Members will deliver their reflections on the process along with completed workbooks to the Chairman of Rural Caucus. This information will form the substance for Phase II.
3. Rural Caucus has decided that World Food Day, October 16, is an appropriate date to present their findings and recommendations to the Minister of Health and the Executive Director of Rural Health.

Conclusion

In the Report of the National Liberal Caucus Committee on Health Priorities (November 1998), Members noted, "Health care has evolved significantly over the past four decades. As the modernization of health care continues, so too will the strains new approaches put on an old system."[31]

Rural Caucus concurs with the National Liberal Caucus Committee on Health Priorities that "Canadians from coast to coast to coast want reliable health care."[32]

National Liberal Rural Caucus urges the Minister of Health to work with his provincial and territorial counterparts to identify ways of working co-operatively in order to facilitate constructive change to the health care system so that together we can provide the best health care possible to Canadians.

[31] Report of the National Liberal Caucus Committee on Health Priorities, November 1998 p. 4

[32] Ibid, p. 10

Members of National Liberal Rural Caucus

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Hastings, Frontenac, Lennox & Addington

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