Rural and remote community health care in Canada: beyond the Kirby Panel Report, the Romanow Report and the federal budget of 2003

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Dr. John Wootton, former Executive Director of the Office of Rural Health and now a special advisor on rural health in the Population Health and Public Health Branch of Health Canada, has said that "If there is a two-tiered medicine in Canada, it's not rich and poor, it's urban versus rural."[1] This dramatic statement emphasizes the extent of the current health care gap between urban and rural areas of Canada, a problem that was addressed in the Kirby Panel Report[2] and the more recently released Romanow Commission Report.[3]

In this paper I discuss how these 2 bodies approached the problem and, how the federal government budget of 2003[4] dealt with the issue and the need to go beyond the current situation in order to address the rural and remote health care issues.

The Kirby Panel Report

The portion of the Kirby Panel Report[2] devoted to a discussion of rural health (volume 2, chapter 10) starts by pointing out some stark statistics about the dimensions of the rural health problem. It notes that about 95% of Canada's territory is rural and about 30% of Canada's population (approximately 9 million people) lives in rural and remote areas.

Defining characteristics of rural

The Kirby Panel Report points to the following as the defining characteristics of rural Canada, paraphrased from the report:

- Rural Canada includes not only rural and remote communities but also small towns outside major urban areas.
- Rural populations are declining as young people leave, looking for better opportunities and seniors leave looking for better long-term care facilities.
- Rural populations near urban centres or in recreational areas are increasing.
- Across Canada, more than half of the Aboriginal peoples live in rural and remote areas.
- Ontario and British Columbia have the lowest percentage of rural residents, and almost 50% of the population in Atlantic Canada lives in rural areas.
- Seniors, children and youth under the age of 20 years are over-represented in rural areas.
- Rural areas have populations that suffer higher unemployment levels and lower educational levels than populations in the rest of the country.
- Rural people living in the Prairie provinces have lower unemployment than people living in rural Atlantic Canada.[1]

In terms of the health status of the rural population, the Report notes that compared with urban areas, life expectancy in rural areas is shorter, and infant death rates are higher. Overall, the health of rural residents is worse

than their urban counterparts.

The health and health care needs of the rural population are also different, given the environment, demographics, occupations and ethnic composition.

Access issues

The most serious problem for residents of rural and remote areas is access to health care. The report rightly quotes the *Canada Health Act* (CHA) provision that reasonable access to insured health services be provided to all Canadians under uniform terms and conditions. The Report points out, however, that in the real world, CHA notwithstanding, rural and remote area residents can have access only to a small range of service providers, and if they have to seek more specialized care they must travel long distances and incur additional expenses, which are not fully reimbursed. During some parts of the year, travel may be impossible due to weather conditions, leading to poor health outcomes.

Recently, there has been widespread closure of rural hospitals in some provinces, such as Saskatchewan, with serious consequences to the local residents. A telling observation found in the Report is that the 1993 closure of 53 rural hospitals in Saskatchewan was followed by an increase in the perinatal death rate in affected areas. Even if one may not directly have caused the other, the Report notes that this finding "is concerning."[1]

Recruitment and retention

Related to the access problem is the issue of recruitment and retention of health care personnel. The Report notes that the lack of access to physicians is a particularly severe problem, one that has been persistent and is expected to continue. Strategies involving financial incentives have not worked, since the determinants of physician location include many personal factors such as lifestyle, access to schools for children, and opportunities for spousal employment among others. Of course, as the Report notes, these problems are not unique to Canada. The United States, Australia and New Zealand also report similar difficulties.

Telehealth

What can be done in view of the severe shortage of personnel and forbidding geographical barriers faced by the rural and remote communities in gaining access to health services? The Report mentions telehealth as a possible solution. The upside of this technology is to act as a supplement to "the skills and abilities of existing rural health care workers to deal with problems that would otherwise require patients to travel out of the community to access needed care."[1] The risk, however, is that this technology could lead to a situation that "needed care can be accessed only from outside sources."[1]

Government response

The federal government responded by creating an Office of Rural Health within Health Canada. The Report also mentions the allocation of $50 million over 3 years, starting in 1999, to support pilot projects under the Innovations in Rural and Remote Community Initiative. In July 2001, the federal government established a Ministerial Advisory Committee on Rural Health "to provide advice to the federal Minister of Health on how the federal government can improve the health of rural communities and individuals."[1]

Witnesses who appeared before the committee emphasized the need for a "federal presence in areas such as funding, immigration, planning, evaluation, information-sharing and co-ordination, technology, facilitating consensus, promoting innovative solutions to rural health issues, and an expansion of the mandate of Health Canada's Office of Rural Health."[1] The Report concludes the discussion on rural health by expressing the hope that the Ministerial Advisory Committee on Rural Health "will lead to concrete policies and programs that will effectively contribute to enhancing the health of rural Canadians."[1]

The final report of the Kirby Panel, released in October 2002,[2] contains its recommendations for action. Despite noting the serious problem facing rural Canadians in the area of health care, there are only 2 recommendations of specific concern to the health care of rural and remote communities.

Relevant recommendations

The Report (chapter 11) calls for the establishment of The National Coordinating Committee for Health Human Resources. Part of its mandate is to recommend "strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in

under-serviced regions, particularly the rural and remote areas of the country."[2] This recommendation suggests that health care training institutions should make an attempt to recruit students from the under-represented groups. Presumably, the graduating students from these groups will go back to where they came from and serve their communities. There is evidence suggesting rural students have a better chance of going back to the rural areas to practise medicine upon graduation than their urban counterparts.[5] However, this is a long-term solution and will not provide immediate relief to the health care human resource shortage in rural and remote communities.

Since most Aboriginal peoples live in rural and remote communities, these recommendations (dealt with in chapter 12 of the Report) are important.[2] The Report recommends that the federal government "provide additional funding to CIHR [Canadian Institutes for Health Research] in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians."[2] The Report also recommends that the federal government "provide additional resources to expand its research capacity and to strengthen the research translation capacity in the field of Aboriginal health."[2]

These are valuable recommendations. However, no dollar figures are attached to them, so they are more exhortations than policy recommendations that can be implemented and monitored.

The Romanow Commission Report

Like the Kirby Panel Report, the Romanow Commission Report[3] devotes a whole chapter (chapter 7) to health care issues in rural and remote communities. It begins by recommending the establishment of a new rural and remote access fund "to support new approaches for delivering health care services and improve the health of people in rural and remote communities."[3] It also recommends using part of the fund to address the demand for health care providers in these communities and to expand telehealth to improve access.

Geography determines health

The Report then makes its case for the change, noting the vastness of the Canadian landscape and the large number of people living in rural and remote communities. These factors make it difficult to "ensure that all our citizens have access to health care services regardless of where they live."[3] The Report echoes the views of rural physicians that "geography is a determinant of health."[3]

Rural–urban disparities

The Report also recognizes the disparities in health status between urban and rural Canadians and identifies access to health care in rural and remote communities as a problem due to the distances and the struggle to recruit and retain health care personnel.

The Romanow Report delves deeper into the characteristics of the rural and remote communities and makes the point that rural and remote communities are "not a single, homogeneous population."[3] They are diverse just as are urban areas. As a result, health needs, and the way in which health care needs to be delivered, vary widely. The Report recognizes that there is no "one size fits all" solution. It also recognizes that issues specific to rural and remote areas overlap with Aboriginal health care issues.

Location versus health

Another troubling observation made in the Report is that the "health of the community also appears to be inversely related to the remoteness of its location."[3] That is, there is a gradient in terms of health status, depending on how far away a community is from an urban metropolitan area. The farther away the community, the worse is the health status of the population. Despite the efforts to improve access in the 1990s in the wake of centralization and consolidation, the Report notes there is an "inverse care law" in effect.[3] That is, while the health status of this population is lower and access to primary care is worse, the rural communities are not as well served as their urban counterparts.

Human resources

Like the Kirby Panel Report, the most serious problem identified in the Romanow Commission Report is the shortage of health human resource personnel in the rural and remote areas. The Report notes that there are no physicians living north of 70° latitude yet there are 3000 people living in that region. They have to travel more than 100 km, often in rough weather, to see a physician. It is safe to assume that the many who are unable

to undertake the necessary travel suffer the health consequences.

Issues facing rural and remote communities

The Report highlights the fact that there is no coherent national approach to address the issues of rural communities. Instead, provinces and territories are developing their own approaches in isolation. Briefly, the Report identifies the following as important issues dealing with health care in rural and remote communities:

- Identifying what "adequate access" should include.
- The need for effective linkages with larger centres.
- The special challenges faced in serving the smallest and the most remote communities where the numbers are too small even to sustain basic services.
- Focus on availability of health care services and not on the "health deficit."
- The predominance of urban approaches to rural communities.
- The lack of research and gathering of evidence for improving health and health care in smaller communities.

Developing a vision

After identifying the issues, the Report calls for development of a vision "where Canadians residing in rural and remote regions and communities are as healthy as people living in metropolitan and other urban centres."[3] The Report does not elaborate on such a vision in any detail, but provides a moving quote from Jose Amaujaq Kusugak who said during a public hearing in Montreal: "I believe that … the success of our Health Care System as a whole will be judged not by the quality or service available in the best urban facilities, but by the equality of service Canada can provide to its remote and northern communities."[3]

The Report considers this as the vision guiding "all rural health initiatives, including policy development, program planning, clinical practice, research and health human resources development."[3] It lists a series of principles to support the vision, which essentially states that rural and remote areas need solutions that address their unique features in the Canadian landscape.

The Report recognizes that provinces and territories are constitutionally responsible for delivering health care services, but the federal government could play a "coordinating and facilitating role by working closely with the provinces and territories and other stakeholders."[3]

Recommendations

Having set the stage, the Report articulates the recommendations (paraphrased) as follows:

- Recommendation 30: The Rural and Remote Access Fund should be used to attract and retain health care providers.
- Recommendation 31: A portion of the Rural and Remote Access Fund should be used to support innovative ways of expanding rural experiences for physicians, nurses and other health care providers as part of their education and training.
- Recommendation 32: The Rural and Remote Access Fund should be used to support the expansion of telehealth approaches.
- Recommendation 33: The Rural and Remote Access Fund should be used to support innovative ways of delivering health care services to smaller communities and to improve the health of people in these communities.

The Report elaborates on the rationale of these recommendations and expresses the hope that in the long term "it means the disparities between the health status of people in smaller communities and the rest of the Canadian population can be considerably reduced."[3]

Other chapters in the Report contain related recommendations. For example, chapter 3 contains the following recommendation:

- Recommendation 14: Steps should be taken to bridge current knowledge gaps in applied policy areas, including rural and remote health, health human resources, health promotion, and pharmaceutical policy.

And in chapter 4, we find the following recommendation:

- Recommendation 15: A portion of the proposed Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer, and the Home Care Transfer should be used to improve the supply and distribution of health care providers, encourage changes to their scopes and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers.

Budget proposal

In addition to its recommendations, the Romanow Report proposed the provision of a budget for these initiatives. The proposed budget figures are itemized in Table 1.

The Report urged that these funds be set up as soon as possible. One problem with these funding proposals is that, while the aggregate allocations are spelled out, the budget is not broken down by programs envisaged within these proposed funding envelopes. It is not clear, for example, how much should be spent on Recommendations 30, 31 and 32 that pertain to the Rural and Remote Access Fund.

Despite ignoring suballocations, the Report has done better than the Kirby Panel Report, which did not specifically allocate any funds to be provided to the rural and remote communities. The Kirby Panel Report was satisfied with simply identifying the problems and urging action to ameliorate them. In this sense, the Romanow Commission Report can be considered an improvement over the Kirby Panel Report.

The 2003 Federal Budget

A recent editorial[6] in the *Canadian Medical Association Journal* referred to the 2003 health care budget as adding items to a shopping cart. Although many items from the Romanow Commission Report made it into the shopping cart, the Rural and Remote Access Fund was definitely not one of them even though all the other items in Table 1 did. It is not clear why this was the case.

Territorial leaders frustrated

The 3 territorial leaders, Paul Okalik (Nunavut), Stephen Kakfwi (Northwest Territories) and Dennis Fentie (Yukon), attempted to draw attention to the special health care needs of the North during the meeting of the premiers and territorial leaders in February 2003 to reach an agreement on health care funding, but their views were side-stepped. They were offered, respectively, about $11 million, $15.6 million and $12 million.[7] They argued that these amounts do not meet the special health care needs of the territorial residents. It costs, for example, $10 000 per patient for a helicopter transfer to Vancouver from some of the remote communities. Despite their efforts, the *per capita* funding formula was retained. As the result, the frustrated territorial leaders refrained from signing the final deal.

After the February 2003 meeting, however, the 3 territorial leaders met with the Prime Minister and the Minister for Health privately and were able to gain a promise of separate floor funding of "at least" $60 million in short-term funding.[8] It was, of course, only a beginning, with the promise of more to come. With this agreement, the dispute seems to have been resolved.[9] This separate funding for the territories, over and above the per capita funding, has set a precedent. It remains to be seen whether this practice will continue.

The verdict

The problems and concerns of the rural and remote communities were well-recognized by both the Kirby Panel and the Romanow Commission. The Romanow Commission went so far as to recommend an immediate transfer of $1.5 billion to a Rural and Remote Access Fund to be used to grapple with the problems of recruiting and retaining health care personnel, exposing students to rural and remote areas during their education and training and expanding telehealth initiatives. These proposals, however, did not find room in the 2003 federal

Table 1. One Time Bridge Funding to the Canada Health Transfer ($Billions)

	2003/04	2004/05	Cumulative targeted 2003/04 to 2004/05	Additional Cash Investment 2005/06
Diagnostic Services	1.5		1.5	
Rural and Remote Access	1.5		1.5	
Primary Health Care Transfer	1.0	1.5	2.5	**6.5**
Home Care Transfer	1.0	1.0	2.0	
Catastrophic Drug Transfer	–	1.0	1.0	
Total cash base for Canada Health Transfer				**15.32**

Source: "*Building on Values: the Future of Health Care in Canada.*" Table 2.3 found on page 71, (c.2002). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2004, and courtesy of the Privy Council Office.

budget for health care. Therefore, much work remains to be done, not only to put these issues into the shopping cart but to make sure they get to the checkout counter.

A VISION FOR THE HEALTH CARE OF RURAL AND REMOTE RESIDENTS

The first requirement is to bring the special health care needs for residents of rural and remote areas back onto the public agenda. Given the provisions of the CHA, the emphasis made in the Kirby Panel and Romanow reports and the support Canadians have expressed for Medicare, this situation is not just unacceptable; it is untenable.

If the overall health status of Canadians needs to be improved, as seems to be the objective of the 2003 budget, it cannot be done if the health care of roughly one-third of Canadians is ignored. It is a truism that if one wants to raise the average, the status of those below average must be raised above average to have any impact. It is common knowledge that the health status of rural and remote area residents is below average compared with that of other Canadians, so it is imperative that this segment of the population be given special attention. A vision for a healthier Canada has to include a new vision for healthier rural and remote area residents.

"Rural Health in Rural Hands"

Health Canada does not have to look far to find this new vision. Most of what is needed is already contained in a report submitted to the federal Minister of Health,[10] This report is appropriately entitled *Rural Health in Rural Hands*. It contains important strategic directions that should be taken to deal with the special health and health care needs of the rural, remote, northern and Aboriginal communities.

The Report's overarching vision is "Healthy people living in healthy rural, remote, northern and Aboriginal communities." To bring this vision to fruition, the Report points to some strategic directions and makes a number of policy recommendations.

Strategic directions

The strategic directions extend to the following areas:

- Building healthy communities.
- Infrastructure for community capacity-building.
- Intersectoral collaboration.
- Rural health research.
- Health information technology.
- Health human resources.
- Aboriginal health.

Recommendations

The list of recommendations is long and can be found in Appendix A of the Report. The following are some of the key policy recommendations, paraphrased:

- Health Canada recognizes that rural, remote, northern and Aboriginal communities are different from urban communities; it supports the development and implementation of the health communities models and promotes them among the stakeholders.
- Health Canada works with stakeholders to sponsor the rural health innovation centre model.
- Health Canada works with the Conference of Deputy Ministers of Health to establish a focal point for developing policies, programs and action plans for common rural health care issues.
- Make rural health research a high priority and make long-term investment in the CIHR strategic initiative in rural and northern health research and in the CHIR's Institute on Aboriginal Peoples' Health.
- Health Canada seizes the opportunities provided by broadband network to reach and respond to the needs of the rural and remote communities; this means protecting the investments already made in telehealth programs such as the Health Infostructure Support Progamme, the Canada Health Infostructure Partnership Programme and the Canadian Network for the Advancement of Research, Industry and Education, Inc. until a sustainable strategy for a nationwide rural telehealth initiative is identified.
- The Minister of Health develops a nationwide health human resource strategy, with particular emphasis on recruitment and retention issues for rural, remote, northern and Aboriginal communities.
- Health Canada strengthens community-based health promotion and disease prevention programs developed and delivered by and for Aboriginal people and provides sufficient funding for First Nations and Inuit health services.

These recommendations are well thought out and will go a long way toward addressing the health and

health care needs of the rural, remote, northern and Aboriginal communities. The recommendations call for a coherent national approach, instead of the current "crazy quilt" of policies and programs. That is the reason for involving Health Canada in a facilitating and coordinating role, as found in these strategic directions and policy recommendations.

Another important point is that these recommendations are interrelated in many ways. For example, the success of the recruitment and retention policies depends on access to broadband technology and telehealth initiatives, because one of the most serious problems besetting health care personnel in rural and remote areas is isolation, some of which can be alleviated by access to telehealth facilities. Telehealth can be used not only for clinical purposes but also for consultations, continuing medical education, patient education and administrative meetings.

Conclusions

The Kirby Panel and the Romanow Commission reports both recognize the special nature of the health and health care problems faced by rural and remote communities in Canada. The Romanow Commission Report even recommended an immediate infusion of $1.5 billion for a Rural and Remote Access Fund. The federal budget of 2003, however, did not adopt this recommendation.

Lack of funding in rural health puts the health and health care needs of almost one-third of the Canadian population at risk. The current state of "benign neglect" goes against the spirit of the CHA. It is time to put the health care needs of rural and remote communities back on the national agenda and follow the vision and policy recommendations articulated by the Ministerial Advisory Council on Rural Health. A good starting point is to institute the Rural and Remote Access Fund as recommended by the Romanow Commission at the next available opportunity and build from there. The residents of rural, remote, northern and Aboriginal communities deserve no less.

Competing interests: None declared.

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