Reminder: palliative care *is* a rural medicine issue

Valorie A. Crooks, PhD
Department of Geography, Simon Fraser University, Burnaby, BC

Nadine Schuurman, PhD
Department of Geography, Simon Fraser University, Burnaby, BC

Correspondence to:
Dr. Valorie Crooks, RCB 7125, 8888 University Dr., Burnaby BC V5A 1S6;
crooks@sfu.ca

This article has not been peer reviewed.

Canada's aging population is on the rise, resulting in a greater demand for palliative care services.[1,2] This is particularly pronounced in rural communities. Specifically, demographic trends such as the increasing number of people relocating to rural areas upon retirement[3] and the process of aging-in-place in such communities[4] are amplifying the need for palliative care in these settings. At the same time, defining elements of health service provision in Canada, including the lack of tertiary and some forms of secondary care in rural settings,[5] has decreased the capacity to provide quality palliative care in nonurban areas.[6] Thus, as we emphatically state in our title, palliative care *is* a rural medicine issue.

Of course, the problem we have outlined above is not a surprise to *CJRM* readers. This is especially true of those in clinical practice in places where the trend of an increasing demand for palliative care in rural communities is most pronounced. We know that primary care practitioners in rural communities take primary responsibility for delivering palliative care in such areas[7] — something for which they have often not received specialty training.[8] For example, the Canadian Institute for Health Information reports that the smaller the community size, the greater the likelihood that a general practitioner (GP) will be involved in delivering palliative care; the national average indicates that 38.8% of GPs report practising palliative care, while up to 56.6% of rural and small-town family doctors report doing the same.[9] Our concern is that those "in the trenches" providing front-line health services to residents of rural communities are highly aware of the pressing need to address this service gap while, at the same time, this issue has yet to make it onto the agendas of most health care researchers and policy-makers.

Consider 2 recent policy initiatives that illustrate our previous point. First, British Columbia's Ministry of Health recently released its framework for palliative and end-of-life care. It is stated at the outset that "it is clear that the time is right to enhance end-of-life care."[10] Second, this call is also echoed in Health Canada's Canadian Strategy on Palliative and End-of-Life Care, which outlines that more knowledge regarding access to and the availability of palliative care is essential for shaping a national strategy.[11] Of note, neither document reviews (or even mentions) the unique nature of palliative care provision in rural communities. Furthermore, Wilson and colleagues[5] contend that there is minimal evidence about the availability and effectiveness of nonurban palliative care in Canada. These publications assist us in making our point that palliative care in rural areas is simply not on the agenda.

To move this agenda forward, or to even get this pressing issue onto the agenda, we must urge researchers and policy-makers to move beyond simply calling for different models of palliative care designed with rural areas in mind and actually create them. It is well-documented that health service delivery must be developed to meet the unique health care demands of

nonurban communities.[12] We know that relocating palliative care recipients to urban areas is inconsistent with the wishes of most dying individuals and their families,[13] and so is not a viable solution to this health service problem. Other solutions designed to address this service need vary widely, both within and between countries (see the systematic reviews undertaken by Evans and colleagues[8] and Wilson and coauthors[5]). Because of our current need to address this pressing problem, Canada has the potential to become a world leader at developing palliative care models designed specifically to meet the needs of rural communities.

Revisiting the title of our commentary, what is it that we must consider about the unique nature of palliative care medicine in rural and remote Canada? Such consideration must move beyond the demographic factors we have alluded to (but not outlined in full) above. We suggest that initiatives such as service centralization,[7] integrated team practice and information systems,[10] and the shift toward providing care in the community[14] are shaping the ways in which we can effectively deliver quality health care, including palliative care, in rural areas and thus must be considered. Factors further influencing the delivery of palliative care, specifically in rural areas, include the presence or absence of existing infrastructure, qualified medical practitioners, funding and user volume. Such factors shape the ability to deliver palliative care and are important to consider. It must also be considered that while most people prefer to die at home,[15] more than 70% of Canadians spend their final days in inpatient settings.[16] However, home deaths are more common in rural areas than in urban centres.[5] We suggest that these issues must — at least partially — guide our thinking about how best to deliver palliative care in rural Canada.

Certainly, other important issues need to be brought to the fore. The clinical, research and policy-making communities each play a central role in identifying factors that must be considered in developing models of palliative care for rural Canadian communities. The task is that we must now remind ourselves and others to address this issue before the service need becomes so overwhelming that it places undue stress on those practising rural medicine and compromises the quality of life/death of palliative care patients and their families.

Competing interests: None declared.

References

1. Carstairs S. Still not there — quality end-of-life care: a progress report. Available: http://sen.parl.gc.ca/scarstairs/PalliativeCare/Still%20Not%20There%20June%2020 05.pdf. 2005 (accessed 2006 Aug 6).
2. Canadian Hospice Palliative Care Association (CHPCA). Still not there — inequities still face Canadians accessing hospice palliative care [press release]. June 2, 2005. Available: www.chpca.net/public_policy_advocacy/QELC_still-notthere- report/CHPCA_Still_Not_There_Press_Release_EN.pdf (accessed 2006 June 4).
3. Bryant C, Joseph AE. Canada's rural population: trends in space and implications in place. *Can Geogr* 2001;45:132-8.
4. Hanlon N, Halseth G. The greying of resource communities in northern British Columbia: implications for health care delivery in already-underserviced communities. *Can Geogr* 2005;49:1-24.
5. Wilson DM, Justice C, Sheps S, et al. Planning and providing end-of-life care in rural areas. *J Rural Health* 2006;22:174-81.
6. BC Ministry of Health Services. Discussion paper on a provincial strategy for end-of-life care in British Columbia. Victoria (BC): Home and Community Care Branch, The Ministry; 2002.
7. Pereira G.J. Palliative care in the hinterlands: a description of existing services and doctors' attitudes. *Aust J Rural Health* 2005;13:343-7.
8. Evans R, Stone D, Elwyn G. Organizing palliative care for rural populations: a systematic review of the evidence. *Fam Pract* 2003;20:304-10.
9. Pong R, Pitblado R. Geographic distribution of physicians in Canada: beyond how many and where. Ottawa (ON): The Canadian Institue for Health Information; 2005.
10. BC Ministry of Health. A provincial framework for end-of-life care. Victoria (BC): The Ministry; 2006.
11. Health Canada. Canadian strategy on palliative and end-of-life care: progress report of the coordinating committee. Available: www.hcsc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-strateg-palli-at/2005-strategpalliat_ e.pdf (accessed 2007 Aug 6).
12. Larsen Soles TM. A strategic plan for eliminating rural hospital services through the process of regionalization. *CJRM* 2005;10:107-8.
13. Gilbar O, Steiner M. When death comes: Where should people die? *Hosp J* 1996;11:31-49.
14. James AM. Closing rural hospitals in Saskatchewan: On the road to wellness? *Soc Sci Med* 1999;49:1021-34.
15. Brazil K, Howell D, Bedard M, et al. Preferences for place of care and place of death among informal caregivers of the terminally ill. *Palliat Med* 2005;19:492-9.
16. Heyland DK, Lavery JV, Tranmer J, et al. Dying in Canada: Is it an institutionalized, technologically supported experience? *J Palliat Care* 2000;16(suppl):S10-6.