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## Canada's Health Care Challenge: Recognizing and Addressing the Health Needs of Rural Canadians

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Canada's universal health care system is among the best around the globe, and encompasses the basic, yet profound principle of "health for all" (Kozier et al, 2000). However, even in our seemingly flawless approach, a disparity exists, whereby the state of rural healthcare is in such contrast to its urban counterpart, that the health of rural Canadians has evidently reached a lower status (Public Health Agency of Canada, (PHAC), 2006). This paper will examine how rural Canadians differ in health status from their urban counterparts, and explore, specifically, epidemiological differences. Health determinants, specific to rural Canadians, will be discussed and factors affecting access to health care will be explored. The concept of primary health care will be articulated and potential factors contributing to Canada's struggle to maintain health equality will be identified. Finally, possible strategies and solutions that may bridge the gap for Canada's health disparity will be

presented.

## Rural vs. Urban

### What is Rural Canada?

The definition of “rural” or “rural community” has evolved to incorporate a more comprehensive view of what “rural” has come to constitute. However, developing a definition of “rural”, without undermining the work and skill of those who live in such communities, but still establishing a common identity has presented a challenge (Troughton, 1999). Rural does not simply mean “not urban”. Rural communities are unique in the characteristics and values they embody. Similarly, with emphasis on community, the land, land utilization, and cultural aspects that build on rural tradition (Troughton, 1999). Rural economies are diverse and while many share common themes regarding employment (i.e. agriculture, oil and gas, forestry, mining, tourism), economic status and growth remain inconsistent factors for many rural communities (PHAC, 2003, & Government of Canada – Depository Services Program (DSP), 2004).

Approximately 95% of Canada's land mass is rural (PHAC, 2006), and comprise all areas outside major urban centres (PHAC, 2003). While Canada's northern territory represents half of this figure, it is still estimated that almost 30% of the Canadian population lived in rural communities in 2001 (PHAC, 2003). This relatively high figure is due to common trends emerging in rural areas: large populations of aging Canadians that tend to settle in rural settings upon retirement (DSP, 2004), and high proportions of young children as a result of large young families in rural communities (PHAC, 2003). The direct result of such trends produces “relatively small populations of people of working age” (PHAC, 2003), creating unequal age-distribution populations.

### Health of Rural Canadians

In general, people who live in rural communities tend to present with poorer health than that of their urban counterparts (DSP, 2004, PHAC, 2006, & PHAC, 2003). Overall, rural residents have been shown to: exhibit less healthy behaviors, such as smoking and less-healthy dietary practices; were less likely to be physically active; have shorter life expectancies for both females and males; have higher mortality rates from cardiovascular and respiratory disease, diabetes, motor vehicle accidents and suicide; and have higher infant mortality rates, as well (PHAC, 2006). However, rural residents exhibit slight advantages over urban-dwellers with lower cancer incidences, are less likely to report high stress levels, and report a greater sense of community belonging (PHAC, 2006).

### Why the Disparity?

#### Rural Realities and Health Needs

The one determinant of health that specifically illustrates the underlying difference in rural health is that of socio-economic status (PHAC, 2006 & PHAC, 2003). While rural residents are more likely to have lower personal incomes, lower educational attainment and higher unemployment rates (PHAC, 2006 & PHAC, 2003), socio-economic factors (i.e. income, employment and working conditions, education, personal health practices and the environment) form a dynamic, collective integration that influence rural health outcomes. Rural Canadians differ from their urban counterparts in disease and illness as a result of apparent differences in rural realities and therefore, health needs (DSP, 2004). Such needs may be particular to occupation and the environment, changing demographics of the population, or common health needs that are present only in rural environment (DSP, 2004). Rural healthcare requires emphasis on factors such as age, gender, occupation and environmental health – in acknowledging such aspects of the rural population, insight into the health services that are specific to rural communities can be developed. Due to the diversity and inconsistency of health needs in rural areas however, “information suggests that the health care needs of certain groups are often not met, nor are they always understood, in rural environments” (DSP, 2004, p.5).

## Access to Health Care

Disparity in health status of rural Canadian communities is directly functional to their distance from urban centres – ultimately hindering access to available health care (PHAC, 2003). Results from the pan-Canadian study “How Healthy Are Rural Canadians” (PHAC, 2006), suggest that “living in areas with population density and low flow of commuters to an urban core is associated with special health risks” (p. 9). Place of residence or geography, ultimately contributes to the health of rural Canadians, “above and beyond socio-economic factors” (PHAC, 2006, p. 9). Despite the statistics of disease and illness common to rural residents, the “inability to obtain health services in a timely fashion” (PHAC, 2003, p. 1), is the underlying concern. The distance in which rural people must travel to reach appropriate and adequate health services, is a realistic problem expressed by many rural residents (PHAC, 2003). Health researchers are finding that the “distance to health care providers and facilities is increasing for rural residents” (DSP, 2004), and according to recent studies more than two-thirds of residents in remote northern regions live more than 100 kilometers from a physician (DSP, 2004 & PHAC, 2003). The discrepancy between the proportion of people living in rural areas – along with the health care needs of such people – and the availability of health care services is substantial and demands change.

## Primary Health Care... ?

### The Intent

The philosophy underlying primary health care (PHC) is what embodies and perpetuates Canada's healthcare system. The ideal of primary health care was

adopted by Canada and adapted to meet the changing health needs of its citizens.

In 1978, the World Health Organization coined the term “primary health care” and resolved that such an approach would be the “basis for effective delivery of health services” (Canadian Nurses Association, CNA, 2002, p. 2). Primary health care was not only a new means for addressing health issues, but became a global incentive, emphasizing “health or well-being as a fundamental right and a world wide social goal” (Kozier et al, 2000, p. 266). The concept of health was now intended to go “beyond... to include economic, social, psychological and environmental responsibilities of communities” (Kozier et al, 2000, p. 148).

Canada's response to WHO's original intent of “Health for All by Year 2000” was initiated in 1986, and the Minister of Health, Jake Epp, issued the Epp Report, which outlined challenges, promotion mechanisms and implementation strategies in promoting the health of all Canadians (Kozier et al, 2000). The principles of PHC – such as accessibility to health services, use of appropriate technology, individual and community participation, increased health promotion and disease prevention, and intersectoral cooperation – were to provide a framework upon which reform of the health system could occur (College & Association of Registered Nurses of Alberta, CARNA, 2005). The idea seemed probable; the goal, attainable. And while the system has been successful to a certain degree, extending the concept to account for and address the diversity in needs of all Canadian people, specifically those in rural communities, has been a challenge.

## The Struggle

While the concept of PHC is encompassing, the delivery of such a model is lacking in regard to rural health care. A multitude of factors collectively contribute to the underlying problem of rural healthcare delivery and include geographic maldistribution of physicians, inequitable access to primary care services, underserved areas, and overworked physicians in rural and remote communities (Barer, Wood, & Schneider, 1999).

The current health status of rural Canadians is then the result of emerging trends in the medical arena: The well-known fact of chronic and often critical shortages of physicians and nurses in rural areas (Society of Rural Physicians of Canada, SRPC, 2001) contributes to the challenge; it is estimated that while approximately 30% of Canadians live in rural areas, only 17% of family physicians practice in such areas (SRPC, 2001). Furthermore, research indicates that the training and recruiting of physicians is taking on an “urban centric educational paradigm” (SRPC, 2001); medical schools preferentially select students and train them in an urban environment which promotes specialization and research, instilling a mindset for urban practice alone (DSP, 2004 & SRPC, 2001).

The problem of increasing centralization also contributes to the health disparity between rural and urban. Difficulty accessing services, as well as lack of community-based care is often the result of healthcare restructuring (PHAC, 2003 & SRPC, 2001). This trend can also be extrapolated to women's health, as providers of maternity care are also not evenly distributed, ultimately contributing to "greater rates of perinatal death and prematurity, and directly incurring higher health care costs" (SRPC, 2001).

From this perspective, the disparity in health outcomes between rural and urban is definitely not without cause, and will only continue to increase.

## Possible Solutions

### Re-Defining Rural Canada

First and foremost, if the Canadian government is to change its approach regarding the delivery of healthcare for its rural citizens, then the development of a common definition of what constitutes "rural" must be the first step. In recognizing that accurate statistics are essential to providing a comprehensive picture of rural healthcare needs, a common definition would allow for consistent and reliable research gathering (Kozier et al, 2000). Furthermore, "a common definition would facilitate (1) the description of the healthcare needs of rural and remote residents, and (2) the development of political coalitions to address common problems" (Kozier et al, 2000, p. 292). As stated by Troughton (1999), "the new model for rural Canada must be centered on the ideal of rural sustainability" (p. 37). The focus here, being on developing a definition that integrates the values and positive attributes of a rural community, together with sustainable rural systems to provide a framework in which to understand the dynamic of rural health care needs (Troughton, 1999).

### Community Based Solutions

Healthy communities can be defined as "those that provide a safe environment, encourage community involvement, and have diverse economies, sustainable ecosystems and accessible health services" (PHAC, 2003, p. 2). Building on the aspect of community would be an approach that "involves strengthening the capacity of local citizens so they are able to identify health challenges, set priorities and take action" (PHAC, 2003, p. 2). While most rural communities are often limited in regard to available resources and infrastructure, the government of Canada is proposing the development of "rural health innovation centres" to enable rural communities in terms of health care (PHAC, 2003). Such innovation centres would focus on community development in order to promote and foster community-health research and community-based training (PHAC, 2003). Implementation of such a concept would require "integration into existing provincial structures" (PHAC, 2003, p. 2).

## Rural Incentive Plans

To improve rural access to health services, one option is to begin with those who provide such services – physicians and nurses. Recruiting and retaining such professionals to rural settings is a challenge that many provinces face. While monetary incentives provide some balance, the issue needs to be addressed at the education level and initial training (DSP, 2004, SRPC, 2001). Rural-oriented education programs and clinical experience for both medical and nursing students are being recognized as an effective means of training and retaining graduates in rural areas (DSP, 2004).

## Telehealth

Telehealth refers to “the use of information and communications technologies in the field of health care” (DSP, 2004, p. 11) and has the “potential to improve both the health and the health care of people living in rural Canada” (PHAC, 2003, p. 3). The goal of telehealth is to share health-related information among health care providers in order to deliver effective health services over large and small distance (DSP, 2004 & PHAC, 2003). The purpose is to supplement the skills and abilities of existing rural health care workers, which could contribute to improving the health care resources available to rural residents (SRPC, 2001 & DSP, 2004).

## Federal Action and National Policies

The federal government of Canada denotes that it does work to protect, promote and support rural health systems and maintains that several interconnected factors influence the extent of its role in rural healthcare (DSP, 2000). In other words, its constitutional authority can be seen as the extent of funding awarded to provincial governments. Nevertheless, the Canada Health Act is in place to set national standards regarding financial contributions to support the healthcare system (DSP, 2000). However, the government's approach to health is, of course, from a population health and health promotion perspective. Therefore, it is a concern that focus on socio-economic determinants and not necessarily access to healthcare, will divert attention away from the fact that health inequalities do exist for rural Canadians (DSP, 2000). Many rural health experts suggest that the federal government take on “a leadership role in the areas of research, technology, education and coordination of provincial initiatives” (DSP, 2004, p. 12). Such involvement would provide a cohesive approach across the country, as well as introduce a federal/provincial partnership that could focus on diminishing the existing disparity between rural and urban residents, ultimately improving the health of all Canadians.

## Conclusion

The purpose of this paper was to discuss the disparity in health for rural

Canadians when compared to their urban counterparts. It examined why such a discrepancy exists by highlighting how differing determinants of health ultimately produce different health needs; as well as identified limited access to health care services as the key contributor to health disparity for rural Canadians. This paper examined how the primary health care model essentially lacks effective healthcare delivery for rural residents, by articulating unfavorable trends occurring in the medical arena. Finally, possible solutions that may bridge the health-status gap of Canadians were outlined. The residents of rural Canada are dealing with an unnecessary challenge that demands coordinated effort and change. The concept of "health for all" is the underlying strength in Canada's healthcare system – reminder of such a fact has never been more relevant.

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