

# *Rural Health in Rural Hands*

Strategic Directions  
for Rural, Remote,  
Northern and Aboriginal  
Communities



*Rural Health in Rural Hands  
Directions for Rural, Remote,  
Northern and Aboriginal  
Communities*

The opinions expressed in this document are those of the Ministerial Advisory Council on Rural Health and do not necessarily reflect the official views of Health Canada.

Ce rapport est également publié en français sous le titre *La santé rurale aux mains des communautés rurales : Orientations stratégiques pour les communautés rurales, éloignées, nordiques et autochtones.*



# Message From the Chair

November 2002

*Rural Health in Rural Hands: Strategic Directions for Rural, Remote, Northern and Aboriginal Communities* was prepared by the Ministerial Advisory Council on Rural Health. This report is a first step toward building healthy rural communities and reducing the inequities in health status between rural and urban Canadians.

The Council was established in 2001 to provide independent advice to the federal Minister of Health on how the federal government can maintain and improve the health of rural individuals and communities. The 21 Council members from across the country represent a broad range of disciplines and expertise on diverse rural, remote, northern and Aboriginal concerns. At its inaugural meeting in October 2001, the Council identified four priority areas on which to focus its work – healthy communities, health information technology, health human resources and the health of Aboriginal people.

This report examines rural health challenges and recommends a course of action for improving the health and well-being of people living in rural, remote and northern areas of Canada. It articulates seven strategic directions for addressing these challenges and sets out specific recommendations.

The Council hopes this report will complement the findings of, and be a valuable addition to, the final report of the Romanow Commission on the Future of Health Care in Canada and the final report of the Senate Standing Committee on Social Affairs, Science and Technology on the state of the health care system in Canada.

The members of the Ministerial Advisory Council on Rural Health express their gratitude to the many individuals, policy makers and organizations who informed the Council's deliberations. As Chair of the Council, I wish to thank my fellow Council members for their hard work and dedication in preparing this report and for their commitment to improving the health of people living in Canada's rural, remote, northern and Aboriginal communities.

Respectfully submitted,



Colin Kinsley  
Chair  
Ministerial Advisory Council on Rural Health

# *Acknowledgments*

The Ministerial Advisory Council on Rural Health wishes to give special thanks to the communities of Vanderhoof and Prince George, British Columbia, and Thunder Bay, Ontario, where meetings of the Council were held this past year. During the meetings, community members and health care providers shared their insights and ideas on how best to meet the health needs of their communities.

The Council appreciated the opportunity to hear from policy makers, academics, representatives of national organizations and federal government officials who share an interest in the health and well-being of people living in rural, remote, northern and Aboriginal communities. The Council also benefitted greatly from hearing about the experiences of their community colleagues.

The Council wishes to acknowledge the dedication and hard work of the staff from the Office of Rural Health at Health Canada who provide Secretariat support to the Council.

---

# Table of Contents

Message from the Chair .....	i
Acknowledgments .....	ii
Table of Contents .....	iii
Executive Summary .....	1
<b>SECTION I: INTRODUCTION</b> .....	<b>7</b>
<b>SECTION II: CHALLENGES IN RURAL, REMOTE, NORTHERN AND ABORIGINAL COMMUNITIES</b> .....	<b>9</b>
<b>SECTION III: STRATEGIC DIRECTIONS</b>	
1. Building Healthy Communities .....	17
2. Infrastructure for Community Capacity-building .....	24
3. Intersectoral Collaboration .....	26
4. Rural Health Research .....	29
5. Health Information Technology .....	35
6. Health Human Resources .....	41
7. Aboriginal Health .....	48
Conclusion .....	53
Endnotes .....	54
<b>APPENDICES</b>	
Appendix A – List of Recommendations .....	59
Appendix B – List of Members of the Ministerial Advisory Council on Rural Health .....	66

# Executive Summary

## ***“Healthy people living in healthy rural, remote, northern and Aboriginal communities”***

The rural, remote, northern and Aboriginal communities which make up rural Canada have diverse social, geographic and economic characteristics.

People who live in these communities are tied to the land by historical and cultural traditions, by long-term economic investments and by their preference for living in small communities, closer to nature. Depending on which definition of rural is used, between 21 and 30 percent of the Canadian population lived in rural communities in 2001.

Most rural communities have large populations of older people and children, with relatively small populations of people of working age (those between 20 and 50 years old). This age distribution is a result of the aging of the rural population, the tendency of retirees to move to rural areas, large family sizes and the migration of rural youth to urban centres. The cultural and linguistic make-up of rural Canada includes official language minority communities, a small immigrant population and more than half of Canada’s 1.4 million Aboriginal people — First Nations, Inuit and Métis people.

Rural Canada comprises all territory outside of major urban centres and constitutes 95 percent of the country’s land mass; Canada’s north occupies half of that land mass. The breadth of geography includes prairies, mountains and tundra with extreme climate variations. Rural economies

are diverse, ranging from mixed-economy communities to single-industry communities that depend solely on agriculture, forestry, fishing, hunting and trapping, oil and gas, mining or tourism. In terms of economic status, there are prosperous communities located near urban centres and small, remote communities with high unemployment levels and few prospects for economic growth.

Generally, the health of people living in rural, remote, northern and Aboriginal communities is poorer than that of their urban counterparts; indeed, health status declines with distance from urban centres. Compared with urban residents, people living in rural communities have shorter life expectancies, higher death rates and higher infant mortality rates. Although the national averages indicate that the difference in life expectancy between urban and rural populations is about a year, life expectancy between regions varies by as much as 16 years. In 1996, infant mortality rates in rural areas were 30 percent higher than the national average, while death rates from all causes were 9 percent higher than the national average.

The poor health status in rural areas is linked to a broad range of personal, social, economic and environmental factors and conditions that influence health, such as income, employment and working conditions, education, personal health practices and the environment. Most rural

areas have lower personal incomes and higher unemployment rates than urban areas. As well, rural workplace conditions often pose serious health hazards. In the majority of rural communities, people have fewer years of formal education than their urban counterparts, and rates of smoking, heavy alcohol consumption, obesity and physical inactivity are higher than the national averages. Access to safe drinking water is also a concern in many rural areas.

Aboriginal people tend to have the poorest health status. The gap in life expectancy between Aboriginal people and the general Canadian population varies from 6 to 14 years. Moreover, the infant mortality rate for Aboriginal people is double that of the Canadian population overall. Aboriginal communities have a high prevalence of all major chronic diseases and high rates of suicide, fatal injuries, smoking and alcohol consumption. Low incomes, low levels of education, chronic unemployment, inadequate housing, exposure to environmental contaminants and the legacy of the residential school era have a strong influence on the health status of Aboriginal people.

Rural realities and rural health needs are different from those in urban areas, and people throughout rural Canada have expressed serious concerns about their inability to obtain the health services they need in a timely fashion and closer to home. A major problem for rural people is the distance they must travel to reach health services. More than two-thirds of residents in northern and remote regions live more than 100 kilometres from a physician. In the Arctic, people may have to travel up to six hours by plane for hospital-based services and harsh weather conditions often make travel dangerous or impossible for days.

There is a fundamental mismatch between the health care needs of people living in rural Canada and the availability of health care providers and health services. Physicians, nurses and other health care providers are concentrated in urban centres, where the healthiest people in the country live. In 2000, only 17 percent of family physicians, four percent of specialists, and 18 percent of registered nurses practised in rural, remote and northern communities, where up to 30 percent of Canadians lived.

With regard to rural health care services, there is an underdevelopment of health promotion programs, a lack of diagnostic services, poor access to emergency and acute care services, a lack of non-acute health care services and under-servicing of special-needs groups, like seniors and people with disabilities. As well, health care restructuring has centralized, reduced or eliminated hospital-based services without community-based services being enhanced.

“Healthy people living in healthy rural, remote, northern and Aboriginal communities” is the vision that guided the Ministerial Advisory Council on Rural Health in the preparation of this report. This report contains the Council’s advice to the federal Minister of Health on a variety of issues affecting the health and well-being of people living in rural Canada. The recommendations in this report are grounded in a health determinants approach that recognizes that economic, social and environmental factors have a significant collective influence on health. The recommendations are intended to stimulate thinking, support existing work and offer new solutions. This report sets out the following seven broad strategic directions to address rural health challenges.

## **1. BUILDING HEALTHY COMMUNITIES THROUGH MODEL DEVELOPMENT AND NATIONAL POLICIES**

Communities play a vital role in the health and well-being of their members. Vibrant, healthy rural communities are built and nurtured by the citizens who live there, the private and non-profit sectors and all levels of government. Community capacity-building, an approach referred to as “Healthy Communities”, involves strengthening the capacity of local citizens and communities so they are able to identify health challenges, set priorities, develop strategies and take action.

For Aboriginal communities, capacity-building also includes strengthening cultural identity and community life. Healthy communities are those that provide a safe environment, encourage community involvement, and have diverse economies, sustainable ecosystems and accessible health services.

Rural, remote and northern communities are ideally suited to improving health by building community capacity. The Council therefore recommends:

- developing programs and policies specific to rural, remote and northern communities;
- supporting the development of Healthy Communities models;
- establishing community capacity-building coalitions and networks;
- supporting opportunities for community capacity-building processes and coordination;
- establishing a nationwide Healthy Communities virtual library;
- disseminating the Healthy Communities approach;
- training health care providers in the Healthy Communities approach; and
- developing Aboriginal-specific Healthy Communities models.

## **2. BUILDING INFRASTRUCTURE TO ENABLE RURAL COMMUNITIES TO DEVELOP COMMUNITY-BASED SOLUTIONS TO HEALTH CHALLENGES**

Rural, remote and northern communities require resources and infrastructure to create their own solutions to their health challenges. The infrastructure capacity of most rural communities is generally limited, although there is considerable variation across communities.

The Council proposes developing a network of “rural health innovation centres” as the infrastructure for capacity building related to health care in rural communities. The rural health innovation centre model focuses on community development, facilitation and coordination and promotes the following elements: strengthening community capacity; fostering community health research; supporting generalist and community-based training; developing health information technology readiness and capacity; and devising recruitment and retention strategies.



It is important that the key elements of the rural health innovation centre model be integrated into existing provincial and territorial structures. Strong collaboration with provinces and territories is needed to advance the recommendation to:

- sponsor stakeholder workshops, integrate key elements of the rural health innovation centre model into existing structures, and, phase in the rural health innovation centres, establishing new structures where needed.

### **3. FOSTERING GREATER INTERSECTORAL COLLABORATION ON HEALTH ISSUES**

Strong intersectoral collaboration is necessary to address the complex factors and conditions that influence the health status of rural Canadians. This strategy calls for greater collaboration, both across sectors (e.g., housing and transportation) and across jurisdictions (i.e., federal, provincial, territorial and municipal).

Many stakeholders, including front-line health care providers, researchers, national Aboriginal organizations, municipalities and non-government organizations have an interest in the health of rural Canadians. These stakeholders need opportunities to network and collaborate to ensure comprehensive, integrated responses to the health challenges affecting rural, remote and northern communities.

The Council firmly believes in the need for greater collaboration on several fronts and recommends:

- fostering collaboration across jurisdictions and sectors;
- increasing collaboration among stakeholders; and
- establishing innovative jurisdictional partnerships for Aboriginal health services.

### **4. EXPANDING RURAL, REMOTE, NORTHERN AND ABORIGINAL HEALTH RESEARCH**

Rural health research is necessary to understand, forecast and positively influence the health of people living in rural, remote, northern and Aboriginal communities. Through research, health challenges can be examined and monitored, appropriate rural health policies can be developed, and the effectiveness of health programs and services can be evaluated. Rural health research helps communities and residents clarify health issues, take action and hold governments accountable for the health care they receive. Rural health research is also important because Canada is the second largest country in the world, with a sizeable rural land mass and population. It is important that Canada work toward becoming a global leader and innovator in rural health research.

The Council therefore recommends:

- enhancing national data collection and analysis on the health status of people living in rural, remote, northern and Aboriginal communities, and developing indicators on the health of rural communities;

- enhancing rural health research;
- building research capacity in rural and northern Canada;
- promoting community-based research;
- supporting research on Aboriginal health;
- developing, documenting and disseminating best practices and models of care; and
- supporting research on rural health models.

## **5. CREATING A NATIONWIDE TELEHEALTH AND DISTRIBUTED LEARNING NETWORK TO SERVE THE HEALTH AND HEALTH CARE NEEDS OF RURAL, REMOTE, NORTHERN AND ABORIGINAL COMMUNITIES**

Information and communication technologies have the potential to improve both the health and health care of people living in rural Canada. They can be used directly in patient care, or indirectly, as a means of information-sharing about success stories and best practices among rural, remote, northern and Aboriginal communities. The purpose of health information technology is to share health-related information among various health care providers and health care settings and to deliver health services over large and small distances. Telehealth can also support the recruitment and retention of health care providers in rural communities.

The Council therefore recommends:

- seizing opportunities provided by broadband;
- creating a nationwide rural telehealth initiative with dedicated funding;
- improving community readiness for telehealth;
- protecting existing investments through a bridging fund; and
- building the knowledge base on telehealth for future investments.

## **6. SUPPORTING THE TRAINING, RECRUITMENT AND RETENTION OF HEALTH HUMAN RESOURCES**

Health care providers make a significant contribution to the health and well-being of their communities. Rural health care providers need to be highly skilled generalists, rather than specialists, and practise in ways that are community-centered, team-oriented, innovative and flexible. Rural, remote and northern communities face an acute and persistent shortage of health care providers. Smaller communities across Canada report difficulties in recruiting and retaining physicians, nurses and other allied health care providers.

To address the health human resources issues facing rural Canada, the Council recommends:

- developing a nationwide rural health human resources strategy;
- supporting a survey of post-secondary health care training programs;
- promoting health careers to young people in rural, remote, northern and Aboriginal communities;
- improving post-secondary health education opportunities for rural, remote, northern and Aboriginal students;
- developing rural health and Aboriginal health curricula;

- increasing rural community-based learning opportunities;
- improving working conditions and support for rural health care providers;
- maximizing distance education and continuing professional development; and
- supporting community innovation.

These recommendations require extensive collaboration with provincial and territorial governments and other stakeholders.

## **7. PROMOTING ABORIGINAL-SPECIFIC HEALTHY COMMUNITY MODELS, NATIONAL POLICIES AND PROGRAMS THAT EMBRACE THE DISTINCTIVENESS OF ABORIGINAL CULTURES**

More than half of Canada's 1.4 million Aboriginal people — First Nations, Inuit and Métis people — reside in rural, remote and northern regions. Significant disparities exist between the health status of Aboriginal people and that of the general Canadian population.

To improve the health and well-being of all Aboriginal people, it is important to invest in and build on the strengths and capacities of First Nations, Inuit and Métis communities, in collaboration with provincial and territorial governments and Aboriginal partners. There is also a need to promote the rejuvenation of cultural and community life. Culturally sensitive and relevant programs and health

services are prerequisites for improving the health and well-being of First Nations, Inuit and Métis people.

The Council therefore recommends:

- integrating traditional knowledge, medicine and healing practices into existing Aboriginal health services for First Nations and Inuit people and working with provincial and territorial governments with respect to other Aboriginal people, including Métis and non-Status Indians;
- supporting the work to preserve traditional medicine;
- building on the strengths and capacities of Aboriginal communities;
- improving Aboriginal health care services;
- supporting cultural and community renewal; and
- enhancing parenting and family supports.

Building healthy communities and reducing inequities in health status is a challenge for all Canadians. The recommendations in this report provide an important and exciting opportunity to significantly improve the health and well-being of people living in rural Canada. Through their implementation, the Council hopes to realize the vision of healthy people living in healthy rural, remote, northern and Aboriginal communities.

# SECTION I: *Introduction*

The mission of Health Canada is to help Canadians maintain and improve their health. Canadians who live in rural, remote, northern and Aboriginal communities face significantly greater health challenges than those living in urban centres for reasons directly related to where they live, risks associated with their occupations and the level of access to timely health care. Rural Canadians believe that Health Canada needs to take a leadership role in facilitating and promoting change in the health care system. Health Canada must ensure that rural concerns are a priority on the federal government's agenda and that rural voices are heard in discussions about health care in Canada.

## **MINISTERIAL ADVISORY COUNCIL ON RURAL HEALTH**

The Ministerial Advisory Council on Rural Health was created to identify and champion current and emerging issues in rural health and to ensure that they are appropriately referred for action. The Council provides independent advice to the federal Minister of Health on how the federal government can maintain and improve the health of people who live in rural, remote, northern and Aboriginal communities. Its responsibilities include:

- creating a forum for innovative thinking to provide long-term direction to the Minister on rural health issues;
- participating in the ongoing development of a nationwide rural health strategy, including suggesting appropriate future activities and directions for the federal government and its partners;

- identifying issues of relevance in discussion with rural communities, defining the partnerships required for implementation and suggesting proposed approaches for addressing these issues;
- inviting collaboration and partnerships with key national organizations to address rural health issues and recommending specific strategies;
- proposing priorities for rural health research and being available as a resource to the Special Advisor to the President of the Canadian Institutes of Health Research on rural and northern health;
- engaging the services of researchers as necessary to fill gaps in knowledge about rural health to inform policy recommendations; and
- maintaining rural health as a national priority.

The Council has sought to be bold, creative, credible and sensitive to the uniqueness of rural Canada.

## **ESTABLISHING WORKING GROUPS**

Early in its deliberations, the Council established four Working Groups reflecting the four areas identified as priorities for its work: building healthy communities, health information technology, health human resources and Aboriginal health. The Council commissioned studies and consulted a broad range of policy makers, academics, federal government officials and representatives from national organizations. It established informal relations with two federal/provincial/territorial advisory committees reporting to the Conference of Deputy Ministers of Health. The studies commissioned for the Working Groups will be posted on Health Canada's web site at [www.hc-sc.gc.ca/english/ruralhealth/advisory.html](http://www.hc-sc.gc.ca/english/ruralhealth/advisory.html)

## EXPLORING DEFINITIONS OF RURAL

As a first step, the Council explored definitions of “rural”. The summary of definitions prepared for the Council can be found on Health Canada’s web site at [www.hc-sc.gc.ca/english/ruralhealth/advisory.html](http://www.hc-sc.gc.ca/english/ruralhealth/advisory.html)

Defining rural is problematic because no standard definition of rural is used in research, policy or planning. In Canada, many definitions are used, based on different criteria, levels of analysis and methodologies. The most common approach is that all territory not classified as “urban” is considered “rural”.<sup>1</sup>

How rural is defined is important because each definition produces different numbers, classifies different people as rural and identifies different characteristics of rural populations.<sup>2</sup> For example, based on the 2001 Census data, Statistics Canada’s rural and small town definition classified 21 percent of the Canadian population as rural, while the Organization for Economic Co-operation and Development (OECD) predominantly rural regions definition classified 30 percent of the Canadian population as rural.<sup>3</sup> These differences in definition in turn affect decisions on policies, programs, funding and service delivery.

A recent article by Statistics Canada and the Rural Secretariat, Agriculture and Agri-Food Canada outlines six definitions of rural used in Canada and recommends that policy analysts select the definition best suited to the question being addressed.<sup>4</sup> The Council supports this recommendation. To reflect the unique diversity of communities commonly referred to as rural, the Council will be using the terminology “rural, remote and northern”.

## ARTICULATING A VISION AND PRINCIPLES

The vision that guided the Council’s work was “healthy people living in healthy rural, remote, northern and Aboriginal communities”.

The following eight principles provide the framework for the recommendations in this report:

- the “healthy communities” approach, i.e., one that focuses on improving the social, economic and environmental factors influencing a community’s health and well-being;
- the “health determinants” approach, i.e., one that recognizes that the health of each person and of the population as a whole is determined by many factors, such as the physical environment, socio-economic conditions, personal health practices and accessibility of health care services;
- support of community capacity-building that focuses on solutions determined by the community, skills development and improved community infrastructure;
- support for the long-term sustainability and growth of rural, remote, northern and Aboriginal communities;
- promotion of a culture of intersectoral collaboration within and among jurisdictions, sectors and stakeholders;
- respect and recognition of the particular roles, responsibilities and interests of various stakeholders and levels of government (i.e., federal, provincial, territorial, municipal) with regards to health;
- working toward health care systems that are sensitive and responsive to the distinctive needs of rural, remote, northern and Aboriginal communities; and
- preservation of the vitality of official language minority communities in Canada.

## SECTION II: *Challenges in Rural, Remote, Northern and Aboriginal Communities*

The rural, remote, northern and Aboriginal communities that make up rural Canada have diverse social, geographic and economic characteristics. People are the foundation of these communities, tied to the land by historical and cultural traditions, by long-term economic investments in their communities and by their preference for living in small communities, closer to nature. The social fabric of rural Canada is characterized by linguistic and cultural diversity, strong informal support networks and close family bonds. Rural Canada is home to official language minority communities, pockets of immigrants who settled the land, towns made up of close-knit, intergenerational families, Atlantic outpost enclaves, as well as Métis settlements, First Nations reserves and isolated Inuit communities north of 60°.

Rural Canada includes all territory outside of major urban centres and constitutes more than 95 percent of the country's land mass. The territory extends roughly 5,300 kilometres from east to west and nearly 4,600 kilometres from north to south.<sup>5</sup> Canada's north — the area north of the southern limit of discontinuous permafrost — occupies about half the Canadian land mass and possesses two-thirds of the country's coastline. The breadth of rural geography includes prairie farmlands, mountainous terrain, the Canadian Shield and windswept tundra. Rural climate variations are extreme, ranging from areas with short, intense summers and long, cold winters to more temperate regions.

Economic development and activities in rural Canada span resource-based, agriculture, manufacturing and service industries. Rural economies are diverse, ranging from mixed-economy communities to single-industry communities that depend solely on agriculture, forestry, fishing, hunting and trapping, oil and gas, mining or tourism. There are remote hamlets with little economic growth and high unemployment, small towns with a few family-run businesses, communities that support giant resource industries such as tar sands operations and pulp mills, and prosperous bedroom communities near urban centres.

### **THE IMPORTANCE OF RURAL CANADA**

Rural Canada is rich in natural resources — forest products, oil and gas, minerals and fish. About 95 percent of Canada's natural resources are found in rural, remote and northern areas. The resource-based sector is of prime importance to the Canadian economy, representing 25 percent of Canada's Gross Domestic Product and 40 percent of its exports.<sup>6</sup> Rural Canada has a proven capacity to innovate. For example, the resource-based sector's productivity is 33 percent higher than the national average, and 35 percent of new small business start-ups occur in rural communities.<sup>7</sup>

Rural Canada is an important source of food security and provides recreational amenities for all Canadians. The beauty of rural, remote and

northern regions also makes Canada one of the most popular tourist destinations in the world, with a 2.9 percent share of the global international tourism travel market.<sup>8</sup> This beauty is an important part of Canadian identity and heritage and is central to how the world perceives Canada and, indeed, to how Canadians see themselves.

## **PORTRAIT OF THE RURAL, REMOTE, NORTHERN AND ABORIGINAL POPULATION**

### *Demographics*

Depending on which definition of rural is used, between 21 and 30 percent of Canada's population lives in rural, remote and northern areas.<sup>9</sup> About one percent of the Canadian population lives in the north.<sup>10</sup> Ontario and British Columbia have the lowest percentage of rural residents, whereas the territories and the Atlantic provinces have the highest. Almost half the population of Atlantic Canada lives in rural areas.

In absolute numbers, the rural population is growing, but because it is growing more slowly than in urban areas, the actual proportion of the Canadian population living in rural areas is declining relative to urban areas. The exceptions to this decline are Aboriginal communities, communities close to cities and communities in recreational areas that are rapidly expanding.<sup>11</sup>

Most rural communities have a high "dependency ratio," that is, large populations of children (19 years and younger) and seniors (older than 60 years) and relatively small populations of people of working age (those between 20 and 50 years). The age distribution is a result of a combination of

the aging of the rural population, the tendency of retirees to move to rural areas, large family sizes and the migration of rural youth to urban centres for further education and employment opportunities. Between 1991 and 1996, about 30 percent of teenagers aged 15 to 19 left rural communities.<sup>12</sup>

### *Linguistic and Cultural Characteristics*

The linguistic and cultural make-up of rural, remote and northern areas is varied. There are official language minority communities. For example, in 1996, New Brunswick, a province with a large rural population, was home to 33 percent of the entire francophone population living outside Quebec.<sup>13</sup>

In 1996, rural Canada had the lowest proportion of immigrants, including recent immigrants and visible minorities; urban centres had the highest proportion. Variation in the size of immigrant populations ranged from as low as 2 percent in rural Prince Edward Island to as high as 67 percent in the city of Richmond, British Columbia.<sup>14</sup>

More than half of the 1.4 million Aboriginal people<sup>15</sup>— First Nations, Inuit and Métis — live in rural, remote and northern communities. The Aboriginal population tends to be younger and is increasing more rapidly than the general population. In 1996, the average age of the Aboriginal population was 25.5 years, 10 years younger than the average age of the general population. Children under 15 years of age made up over one-third of all Aboriginal people, compared to 21 percent of Canada's total population.<sup>16</sup>

## **HEALTH STATUS OF PEOPLE IN RURAL, REMOTE AND NORTHERN CANADA**

### *1. Health Status Indicators*

Relative to people in most countries, Canadians enjoy a high standard of health. However, that high level of health is not equally shared by all Canadians. Generally, the health status of rural, remote and northern residents is lower than that of their urban counterparts, decreasing as one moves from areas bordering urban centres into extreme remote regions. Compared to urban residents, people living in rural, remote and northern communities have shorter life expectancies, higher death rates and higher infant mortality rates.

Overall, national averages of life expectancy indicate that people living in rural Canada live about one year less than their urban counterparts. Regional disparities are much more pronounced; for example, average life expectancy ranges from as low as 65.4 years in the remote northern region of Nunavik in Quebec, to as high as 81.2 years in Richmond, British Columbia — a gap of 16 years!<sup>17</sup>

Infant mortality rates and death rates are consistently higher in rural Canada than in urban Canada. For example, in 1996, rural death rates from all causes were 9 percent higher and rural infant mortality rates were 30 percent higher than the national averages.<sup>18</sup> In 1999, infant mortality rates were highest in Nunavut and Northwest Territories and lowest in the Yukon, British Columbia and Nova Scotia.<sup>19</sup>

### *2. Health Determinants*

The poorer health status of rural Canadians is not a result of a few specific causes. Rather, it is closely linked to a range of personal, social, economic and environmental factors and conditions that influence health, such as income, employment and working conditions, education, personal health practices and the physical environment.<sup>20</sup>

#### *A. Income and social status*

This is the single most important determinant of health. In 1995, most people in rural areas had personal incomes well below the national average of \$25,196. Personal income ranged from \$19,565 in rural New Brunswick to \$15,546 in rural Saskatchewan. In contrast, many people in urban areas had personal incomes well above the national average. Rural Canada, with the exception of some rural prairie regions, also received a high proportion of government transfer income (e.g., old-age pensions, unemployment insurance benefits, child tax benefits, and goods and services tax credits), which is another indicator of lower annual income.<sup>21</sup>

#### *B. Employment and working conditions*

Rural areas generally have higher unemployment rates than urban centres. In 2001, the average rural unemployment rate was 8.3 percent, while the national average was 7.2 percent. Rural unemployment ranged from high rates of 23.5 percent in Newfoundland and 17.1 percent in Prince Edward Island to low rates of 4.6 percent in Manitoba and 4.1 percent in Alberta.<sup>22</sup> Moreover, rural working conditions pose serious health and safety hazards for rural workers, especially farmers, fishers, foresters and miners.



In addition to the increased incidence of accidents related to the growing use of complex machinery, there is increased exposure to hazardous chemicals, noise, long working hours and temperature extremes.<sup>23</sup>

### *C. Education*

Health status tends to improve as educational level increases. In the majority of rural communities, people have lower levels of formal education than those living in urban centres. In 1996, 72 percent of Canada's population aged 25 to 29 had graduated from high school. Compared to most major urban centres, which had a high proportion of high school graduates, the percentage of high school graduates in remote northern areas ranged from a low of 29 percent in Nunavut to 68 percent in the Yukon.<sup>24</sup>

### *D. Personal health practices and coping skills*

In most rural communities, the rates of smoking, heavy alcohol consumption, obesity and physical inactivity are above the national averages. In 1996, Newfoundland, Nova Scotia, Quebec and the far northern regions had the highest rates of smoking. The highest rates of regular heavy drinking were found in Newfoundland and the far northern regions. As well, high rates of obesity and low rates of physical activity were common in rural areas. In comparison, urban areas had a lower proportion of smokers and heavy drinkers and people tended to be more physically active and less obese than rural residents.<sup>25</sup>

Individual health practices influence chronic conditions and disabilities. Smoking, inactivity and obesity are major risk factors for chronic conditions such as diabetes, arthritis and high blood pressure and can lead to disabilities.<sup>26</sup>

Statistics from 1996 show that people living in Canada's northern remote communities have the lowest average number of years free from disabilities in the country, compared to people living in large urban centres, who have the highest number of disability-free years.<sup>27</sup>

### *E. Physical environment*

Factors in the physical environment, such as water and air quality, are also key influences on health. Access to safe drinking water is of concern to many rural communities. Many people drink from untreated water sources, including streams, wells and dugouts, and are at risk for pathogenic microbes (viruses, bacteria and parasites), natural toxins (e.g., toxins from green algae) and chemicals (e.g., pesticides). The tragedy at Walkerton, Ontario, demonstrated the vulnerability of the rural water supply and drew national attention to the need to guarantee access to safe drinking water for all.<sup>28</sup>

Living in rural, remote and northern communities also has positive effects on health status. For example, housing is generally more affordable in rural regions; the rate of occurrence of high life stress is lowest among rural populations; and social support networks are stronger than those in urban areas.<sup>29</sup>

At the same time, it is important to recognize that the health conditions affecting people in rural, remote and northern areas are not homogeneous. For example, in 1996, the highest mortality rates from lung cancer were in remote northern areas, whereas lung cancer deaths were well below the national average in rural areas of the prairie provinces. Likewise, the rate of occurrence of high blood pressure was highest in rural Atlantic Canada, while the far north had one of the lowest rates.<sup>30</sup>

### 3. Health Status of Aboriginal People

Aboriginal people are in significantly poorer health than the general Canadian population, and have lower life expectancies, higher infant mortality rates and higher death rates. The gap in life expectancy between Aboriginal people and the general Canadian population ranges from 6 to 14 years. Moreover, infant mortality rates for Aboriginal communities are double the Canadian average. Aboriginal communities also experience high rates of fatal injuries and suicide. The suicide rate in the Aboriginal population for all age groups is about three times the national average; among Aboriginal youth, it is five to six times the national average.<sup>31</sup>

The prevalence of all major chronic diseases, including diabetes, heart problems, hypertension and arthritis/rheumatism is significantly higher in the Aboriginal population than in the general population and appears to be increasing. For example, diabetes is more than three times higher in Aboriginal communities than in non-Aboriginal communities. Smoking is more prevalent with 62 percent of people smoking in Inuit and First Nations communities. Alcohol, substance and solvent abuse is also common. Furthermore, about 75 percent of Aboriginal women and 40 percent of Aboriginal children have experienced family violence.<sup>32</sup>

Low incomes, low levels of education, chronic unemployment, inadequate housing, exposure to environmental contaminants and the legacy of the residential school era are some of the factors that contribute to the poor health of Aboriginal people.

### HEALTH SERVICES IN RURAL, REMOTE AND NORTHERN COMMUNITIES

*“If there is two-tiered medicine in Canada, it’s not rich and poor, it’s urban versus rural.”<sup>33</sup>*

Realities and health care needs in rural areas differ from those in urban areas and call for “rurally sensitive” responses.<sup>34</sup> Rural residents across the country have expressed serious concerns about their inability to obtain access to timely health services closer to home.<sup>35</sup> Rural residents tend to have low rates of contact with medical, dental and mental health providers. For example, in 2000–01, physician consultation rates in rural areas ranged from 48 percent in Nunavut to 80 percent in northern Manitoba.<sup>36</sup>

A major problem for people in rural, remote and northern communities is the distance they have to travel to reach medical services. Rural residents are on average about 10 kilometres away from a physician, compared to less than 2 kilometres for residents in larger urban areas. In northern and remote regions of Canada, over two-thirds of the population live more than 100 kilometres away from a physician.<sup>37</sup>

The need to travel imposes an increased financial burden in the form of transportation costs and hotels; it also means people are separated from their families and community supports. Travelling long distances for health services may also adversely affect health outcomes because of delays and the hazards of transport or inclement weather. This is the case for pregnant women. Studies have shown that in communities lacking maternity services there is an increased incidence of perinatal deaths and premature births.<sup>38</sup> The health of rural seniors is also linked to the availability of transportation so they can get to the local doctor’s office or travel to major centres for specialized health services.<sup>39</sup>

There is a fundamental mismatch between the health care needs of Canadians living in rural, remote and northern areas and the availability of health care providers and health services. The following demonstrates why it is hard for rural residents to obtain quality health care.

### 1. *Health Care Providers*

*A. Uneven distribution of physicians and nurses*  
Physicians and nurses are concentrated in urban locations, where the healthiest people in the country live. In 2000, only 17 percent of family physicians and 18 percent of registered nurses practiced in rural, remote and northern communities, where up to 30 percent of Canadians lived.<sup>40</sup>

*B. Lack of medical specialists*  
Only 4 percent of medical specialists worked in rural areas in 2000. This meant that many rural people had to travel long distances to receive specialized care.<sup>41</sup>

*C. Uneven distribution of other health care providers*  
Rural Canadians have fewer options for health care providers than their urban counterparts. Most rural areas have a serious shortage of mental health providers, physical and occupational therapists, social workers, and speech and language pathologists.<sup>42</sup>

*D. Lack of continuity of providers*  
Generally, physicians and specialists do not live in Canada's remote and northern communities; rather, they are flown into the communities to provide health care. Often, it is not the same physician going to the communities, making it difficult to establish good patient-physician rapport and continuity of care.

### 2. *Health Care Services*

*A. Underdevelopment of health promotion and lack of preventive, diagnostic services*  
Health promotion and health education services are underdeveloped in most rural communities. Rural children and youth would benefit from access to information on a variety of health topics, including healthy diets, healthy sexuality and fitness. Preventive services are also lacking in most rural communities; for example, mammography screening for breast cancer is used significantly less in the far northern regions and Atlantic Canada than it is in Canada as a whole.<sup>43</sup>

*B. Downsizing, closures and centralization of health services*  
Restructuring and health care reform in the provinces and territories have resulted in increasing centralization of services, downsizing and closures of rural hospitals and long-term care facilities. This restructuring has often occurred without enhancing community-based primary care services and has made it more difficult for people who live in rural areas to access services.

Moreover, hospital closures have had a negative economic impact on rural communities, since hospitals are not only major employers, they generate other economic spin-offs. It has been estimated that 14 to 20 percent of the total employment in rural regions can be attributed to the health sector, including direct and secondary services.<sup>44</sup>

*C. Lack of access to emergency and acute care services*

Although larger rural centres may have hospitals with basic services, people still have to travel to urban centres for specialized treatment. Furthermore, unlike people who live in cities, rural residents have no choice of hospital; this can be an issue if the only accessible hospital has decided not to provide certain services.<sup>45</sup>

*D. Lack of access to non-acute health care services*

Most people living in rural, remote and northern communities have limited or no access to a range of health care services commonly provided in urban centres. These services include rehabilitation, palliative care, home care, counselling, respite and long-term care. This means that people have to move to larger centres or travel long distances to receive the care they need.<sup>46</sup>

*E. Under-servicing of special needs groups*

Many people require special services in addition to basic health care. Acute (emergency) and long-term (chronic diseases) needs are not easily met in rural communities. People with unique health care needs include:

- seniors, who require a more supportive environment as they age;
- culturally diverse groups, such as official language minority communities, Aboriginal people and new immigrants, who require culturally sensitive health care providers and programs, as well as access to health services in their own languages; and
- people with disabilities, who need specialized services such as physiotherapy or dialysis, as well as standard services that are accessible.<sup>47</sup>

*F. Unique health services challenges for remote and northern regions*

Remote and northern communities face larger health challenges than rural communities closer to urban centres. Health care facilities in northern and remote areas are fewer and more dispersed. People from remote, northern communities may travel up to six hours by plane to obtain routine, hospital-based services. Harsh weather conditions that make air or road travel dangerous or impossible for days further compound the problem.<sup>48</sup>

## **HEALTH OF COMMUNITIES**

The health of people is closely linked to the health of the communities in which they live. This close link is not recognized by the current approach to health care, which is oriented toward individuals. A broader “health determinants” approach recognizes that many economic, social and environmental factors or conditions, often related to the communities in which people live, contribute to the health and well-being of individuals.

The overall health of rural, remote and northern communities is significantly poorer than urban communities, although there is considerable variation among rural communities. While some rural communities located near large urban centres may prosper, other rural communities are struggling to survive. The factors affecting community health include the migration of youth to cities; the aging of the population; chronic high unemployment; downturns in economic activity, often related to

mechanization of agriculture or over-exploitation of natural resources; and declining community infrastructure, including health care.<sup>49</sup> As well, many Aboriginal communities are experiencing both rapid population increases and stagnating employment. Community resources are insufficient to meet health needs, which further contributes to deteriorating social conditions and disempowerment. All these factors related to the communities in which people live have profound effects on the health and well-being of rural residents.

# SECTION III: *Strategic Directions*

To realize the vision of “healthy people living in healthy rural, remote, northern and Aboriginal communities” the Council has outlined seven broad strategic directions.

1. Building Healthy Communities
2. Infrastructure for Community Capacity-building
3. Intersectoral Collaboration
4. Rural Health Research
5. Health Information Technology
6. Health Human Resources
7. Aboriginal Health

Four strategic directions relate specifically to the work of the four Working Groups; the other three are cross-cutting themes identified by all the Working Groups. The Council believes that it is necessary to move forward in all areas to realize the vision.

## 1 BUILDING HEALTHY COMMUNITIES

### ***Strategic Direction: Building healthy communities through model development and national policies***

Communities play a vital role in the health and well-being of their members.<sup>50</sup> Although communities can be built on shared faith, perspective or profession, in this report the term refers to geographic communities. Each community has its own set of health care needs, which reflect its history, economic situation, geography, social structures and overall health of its residents. Each community also has a unique set of assets that it can mobilize to respond to its needs.

Healthy communities are ones that provide safe environments, meet the basic needs of all residents, support community involvement in local government and health initiatives, and celebrate their historical and cultural heritage. Healthy communities also have diverse and innovative economies, provide accessible health services, have sustainable ecosystems, and address health and development issues as a community.<sup>51</sup> Trevor Hancock, the founder of the “Healthy Communities” movement, defines the ideal community as having the following six characteristics: conviviality

(living harmoniously); equity (fairness and justice for all); prosperity (generating sufficient wealth); sustainability (environmentally responsible); viability (unpolluted environment); and livability (safe, pleasing environment).<sup>52</sup>

The Healthy Communities approach was pioneered in Canada in the 1980s.<sup>53</sup> It emphasizes collaboration, including citizen participation, to identify and take action on the social, economic and environmental factors that affect health and well-being. For example, a community could decide to take aim at poverty by setting up communal kitchens, meals-on-wheels services or youth centres. It may decide to plant trees to protect the environment. To increase employment, a community might sponsor economic development forums. A Healthy Communities approach often means rekindling a sense of belonging and pride in one's community. What most distinguishes this approach from others is its focus on bringing communities together to collaborate, set priorities and take action.

The key elements of the Healthy Communities approach are: a broad definition of health; an asset-based approach that identifies a community's strengths, resources and experiences; intersectoral collaboration among agencies and organizations so that problems are not dealt with in isolation; community participation in defining problems and priorities; and local action by volunteers, health care providers and community organizations. The Healthy Communities approach is supported by a significant body of research and offers practical tools for communities to use. In fact, the model developed in Canada has inspired the World Health Organization and many countries to advocate its use, especially for implementation in rural communities.<sup>54</sup>

## **DEVELOPING PROGRAMS AND POLICIES SPECIFIC TO RURAL, REMOTE AND NORTHERN COMMUNITIES**

In Canada, the dominant models for health policies, programs and services are "urban-centric," that is, they are based on urban populations, urban needs and urban systems. For example, specialization is the dominant model for organizing hospital medical care; it has little practical value in rural communities, where a generalist approach is more appropriate. Health promotion and disease prevention programs are also based on urban models. For example, rural areas do not have access to diverse specialists and expertise found in urban centres.

These urban-oriented models tend not to be easily transferable or adaptable to rural systems, and usually do not meet the needs of people living in rural areas. Moreover, rural issues are often overlooked in policy discussions, and the predominance of urban-oriented models prevents the development of models more appropriate to rural communities. An important first step for building healthy rural communities is to acknowledge that urban and rural realities are not the same and that Canada needs policies and programs that specifically address rural needs.

### ***Recommendation***

- 1.1** *That Health Canada recognize that rural, remote and northern communities are different than urban communities and that this be reflected in its policies and programs.*

## **SUPPORTING THE DEVELOPMENT OF HEALTHY COMMUNITIES MODELS**

Building healthy communities requires developing the capacity within each community to organize, set priorities and take action. Research has shown that the more capacity communities have, the healthier they are.<sup>55</sup> Most communities have some capacity on which they can begin to build.

Healthy, vibrant rural communities are built and nurtured by citizens living in the communities, private and non-profit sectors and all levels of government. Governments must build on existing community capacity and invest in developing the social capital and infrastructure of communities. Municipal governments can make a unique contribution because, as the level of government closest to the community, they have the most intimate understanding of living conditions, and they can contribute resources, including funding. Community capacity-building is also in line with current federal interests; for example, the Government of Canada recently announced a community capacity-building initiative as part of a broader strategy to help rural communities find local solutions to local challenges.<sup>56</sup>

The Healthy Communities model is ideally suited to rural, remote and northern communities. These communities are often highly motivated, and their strong sense of community identity favours a holistic approach to health. As well, the small size of rural communities makes them easier than urban centres to organize, reach consensus and coordinate a broad response.<sup>57</sup>

## **Recommendation**

**1.2** *That Health Canada, in partnership with provinces, territories and municipalities, support the development and implementation of Healthy Communities models in all rural, remote and northern communities, drawing on existing resources, expertise and networks.*

## **ESTABLISHING COMMUNITY CAPACITY-BUILDING COALITIONS AND NETWORKS**

To support community capacity-building, rural communities must have opportunities to organize, consult and agree on priorities, especially when using a broad definition of health and working with a range of partners. Experience from the Healthy Communities movement suggests that, for linguistic, cultural and socio-political reasons, coalitions and networks are most effective when they are organized at the provincial or territorial level (e.g., Quebec Network of Healthy Cities and Towns, Ontario Healthy Communities Coalition, Acadian Healthy Communities Movement). Funding from both federal and provincial governments has helped maintain these networks.<sup>58</sup>

Healthy Communities coalitions and networks are involved in many activities. These include:

- providing referral services (e.g., if a community wants to educate its members on the use of toxic products, the Healthy Communities network will refer the community to appropriate experts);
- providing advice to different government departments on programs (e.g., crime prevention programs);



- creating opportunities to celebrate and recognize local community contributions (e.g., hosting award programs);
- organizing conferences, establishing resource centres or publishing newsletters; and
- providing toolkits of community resources and “how to” advice.

It is necessary to devote personnel to such networks: the Ontario coalition has a provincial office that employs three full-time people, while the Quebec network employs four people. Furthermore, the community capacity-building process must be facilitated, and facilitation services need to be available close to home, either at the regional or the county level. In Quebec, each of the 150 local community services centres called *les Centres locaux de services communautaires* (CLSCs) employs professional community organizers. Trained, regionally based field workers must be available to support communities. Non-governmental organizations with a proven track record of facilitating community capacity-building could be contracted to provide this service.

In addition to facilitation services, technical assistance is needed to monitor community health (collect and interpret data); to evaluate projects, programs and services; and to develop research on rural Healthy Communities models.

Strong Healthy Communities networks exist in Quebec (more than 150 communities), in Ontario (79 communities) and in the Acadian communities of New Brunswick (18 communities). Key partners in these three networks include provincial, professional and non-governmental associations representing environmental, health and social interests. In Quebec, the CLSCs are also closely linked to the network. Manitoba has a small network, while Alberta has a few local Healthy Communities projects, but no provincial network. The British Columbia network no longer exists. Nova Scotia recently announced

plans to set up a provincial Healthy Communities network. There is no nationwide network.<sup>59</sup> At present, Healthy Communities networks are concentrated in central Canada, whereas very remote and northern areas (e.g., parts of the Atlantic provinces, the prairies and the territories) have little or no networking capacity for Healthy Communities.

The federal government has an important role to play in stimulating greater connections among rural, remote and northern communities. In partnership with provincial and territorial governments, Health Canada can facilitate the establishment of Healthy Communities coalitions and networks at the provincial and territorial level so that all rural, remote and northern communities can exchange information, learn from each other and work together to build healthy rural communities.

### **Recommendation**

#### **1.3 That Health Canada work with provincial, territorial and other partners to establish community capacity-building coalitions and networks.**

### **SUPPORTING OPPORTUNITIES FOR COMMUNITY CAPACITY-BUILDING PROCESSES AND COORDINATION**

Funding is required to support opportunities for community capacity-building processes to ensure that the initiative comes from the bottom up and that the community is willing to invest in and take action on identified priorities. Community capacity-building processes take time and require funding to launch them and see them through their early planning stages. Experience has shown that a single fiscal year of funding seldom produces lasting results and that financial support needs to

be on a multi-year basis. Furthermore, funding for carrying out community priorities should not come from the same source that provides funding for community capacity-building processes.<sup>60</sup> In many cases, the community can accomplish a great deal by using volunteers and by redirecting the existing financial resources. For large projects, communities will need access to other funding sources.

Another aspect of the collaborative approach is the need to coordinate efforts. Once communities are ready to proceed, they often discover that provincial and federal ministries are not. For example, a community may not be able to pursue a health program in schools if it is not consistent with provincial or federal priorities. Unfortunately, the lack of coordination happens across departments within the same level of government, as well as among different levels of government. Coordination is important to ensure that the demands on small communities are not overwhelming; for example, it can be taxing to small communities if each project or program requires that a voluntary community advisory group be established because it is usually the same volunteers who are involved.

### **Recommendation**

**1.4** *That Health Canada work with other federal departments and provincial and territorial partners to coordinate efforts and provide funding opportunities for community capacity-building processes and coordination.*

### **ESTABLISHING A NATIONWIDE HEALTHY COMMUNITIES VIRTUAL LIBRARY**

Communities learn from the successes of others. Anecdotal evidence of this kind, or success stories, can be more powerful in inspiring people to act than data from research studies.<sup>61</sup> Communities also need guidelines and ideas on how to organize and take action, as well as information about sources of funding and other resources.

A nationwide Healthy Communities virtual library needs to be established so that communities can readily exchange information and share their successes in developing community-based solutions to health challenges. This important networking tool would be facilitated through health information technology (see Strategic Direction 5). Information gathered from existing Healthy Communities libraries in Quebec, Ontario and the United States could serve as a starting point. To be effective, the virtual library would need to be able to screen information; offer information to both health care providers and the general public; and make materials available in plain language. One significant role for the virtual library would be to disseminate research on rural Healthy Communities models; another role would be to ensure that documents and tools are translated into both French and English. Technical support is critical to making the library accessible to as many people as possible.

### **Recommendation**

**1.5** *That Health Canada establish a nationwide virtual library of Healthy Communities resources specific to rural, remote and northern communities.*

## **DISSEMINATING THE HEALTHY COMMUNITIES APPROACH**

Over the 15-year history of the Healthy Communities movement in Canada, one of the most effective means of promoting the approach has been to bring communities together at conferences and workshops. For example, Healthy Communities networks in Ontario, Quebec and New Brunswick hold annual conferences. These forums serve many purposes: exchanging experiences and best practices; exploring broader issues and challenges; influencing policies at the community, provincial and federal levels; and developing effective models that cross disciplines and sectors. They are also vital to motivating community workers, showcasing the accomplishments of small communities and training people in the use of tools.

### **Recommendation**

**1.6** *That Health Canada, in collaboration with provincial, territorial and municipal governments, fund forums, conferences and consensus workshops for rural citizens, national health providers' associations and academic health centres to share Healthy Communities experiences and community tools.*

---

## **TRAINING HEALTH CARE PROVIDERS IN THE HEALTHY COMMUNITIES APPROACH**

Local health care providers can be a valuable resource in community capacity-building, particularly when they participate actively in community life. In addition to providing expertise in their respective professions, health care providers also tend to be influential in other ways. For example, many physicians and nurses become mayors, city councillors or chairs of community organizations.

The smaller the community, the more likely it is that health care providers will assume community leadership roles. In small rural or remote communities, health care providers commonly work in formal or informal collaboration with other professionals and community leaders. Teamwork among local professionals — both health care providers and others, across disciplines and sectors — helps ensure that solutions to the community's health challenges will be tailored to local conditions.

Health care providers need to become comfortable with the nature of the participatory and process-oriented Healthy Communities approach. They also need basic development of skills in such areas as team-building, leadership, strategic planning and evaluation. This training can be delivered at the post-secondary level and through ongoing training programs offered by existing networks and coalitions.

**Recommendation**

**1.7** *That Health Canada work with provincial, territorial and municipal governments to promote Healthy Communities concepts, principles and applications among health care providers.*

---

**DEVELOPING ABORIGINAL-SPECIFIC HEALTHY COMMUNITIES MODELS**

Healthy Communities models are well-suited to the cultures and way of life of Aboriginal communities. About 77 percent of First Nations and Inuit communities have populations of less than 1,000 people, many of which are isolated or remote.<sup>62</sup> According to Aboriginal traditions, a healthy community is a community in harmony at all levels — individual, family and community — people work together and take care of each other. A healthy community is one that provides a safe, clean environment, is free from addictions and violence, and has adequate health services.<sup>63</sup>

Communities need to be able to scope out their own health needs, identify solutions and then have easy access to the resources necessary to tackle social, economic and environmental causes of poor health status. Tapping into existing Aboriginal-specific Healthy Communities models and promoting and disseminating the models across the country can help Aboriginal people to address the challenges they face. For example, a Healthy Communities strategic process was developed for the Algonquin Nation as early as 1987 and is still being used as a framework for action by the Great Lake Victoria Reserve.<sup>64</sup>

**Recommendation**

**1.8** *That Health Canada, in partnership with Aboriginal communities, develop a strategy with new funding to implement Aboriginal-specific Healthy Communities models that promote healthy lifestyles, self-reliance and self-determination.*

---

## 2 INFRASTRUCTURE FOR COMMUNITY CAPACITY-BUILDING

**Strategic Direction: Building infrastructure to enable rural communities to develop community-based solutions to health challenges**

In addition to community action and public awareness of health issues, rural, remote and northern communities need the infrastructure in place to be able to set their own priorities and to develop community-based solutions to health challenges. Infrastructure refers to three types of resources:

- physical resources (transportation systems, communications networks and public facilities such as hospitals, clinics, etc.);
- human resources (health care providers and trained personnel, as well as community leaders); and
- organizational and administrative structures (policies, regulations and incentives).<sup>65</sup>

Disparity exists between urban and rural areas in basic infrastructure; for instance, many rural communities lack transportation systems and communications networks. Although many rural communities have strong bonds, close relationships and informal helping systems, their small populations and the ongoing migration of youth to urban areas have diminished the pool of human resources.

There is also considerable variation in health infrastructure from one rural community to the next. The north, for example, has considerably fewer resources than other parts of rural Canada. Some provinces and territories have established umbrella organizations to coordinate health activities on a provincial or territorial level, while others have not. For example, Quebec has a network of

local community services centres called *les Centres locaux de services communautaires* (CLSCs) across the province. Manitoba and Alberta have Regional Health Authorities as the coordinating structures. On the other hand, Ontario does not have a coordinating umbrella organization.

### ESTABLISHING “RURAL HEALTH INNOVATION CENTRES”

In 2000, the Australian government developed a new rural health model and established a network of Centres of Rural Health to respond to the unique needs of rural citizens and communities. The centres, under the direction of the Rural Clinical Schools Program of the Australian Department of Rural Health, are located in regional communities with populations of 20,000 to 60,000 people. Their primary role is to develop and support education and research related to rural and regional health. In just two years since this program was initiated, the centres have been built and staffed and are well under way.<sup>66</sup>

There is significant potential to adapt the Australian experience to the Canadian context, although it is important to keep in mind different jurisdictional roles and responsibilities with respect to health, and existing provincial and territorial infrastructure. Accordingly, the Canadian model proposed by Council, called “rural health innovation centres”, would focus on community development, facilitation and coordination; there would be no involvement in direct health service delivery.

The Canadian model would be based on the following five elements:

1. *Strengthening community development capacity and empowerment*, with a focus on building healthy communities and establishing strong rural health networks.
2. *Fostering health research at the community level*, by involving communities in setting the research agenda; developing and undertaking community-based research; and collaborating with researchers.
3. *Devising strategies for the recruitment and retention of health human resources* that reflect community needs and resources and draw on the innovative spirit of rural citizens.
4. *Developing health information technology capacity and readiness*, to enable communities to connect with regional, provincial and national organizations and governments. Technical assistance, including hardware, software and training programs, would also need to be provided to rural communities and providers to strengthen local health information technology systems.
5. *Developing and supporting generalist, community-based training*, to equip health care practitioners with the wide range of skills needed to work in rural, remote and northern communities.

The rural health innovation centre model offers a fresh approach to responding to rural health challenges and addressing the disparity in infrastructure that exists across the country. It is important that the five elements of the rural health innovation centre model be integrated into existing provincial and territorial infrastructures. For example, in Quebec some CLSCs are already active in recruitment and retention, research and community capacity-building, in partnership with regional boards. Those centres might give priority to introducing health information technology and developing generalist, community-based training.

Collaboration with the provinces and territories is necessary to explore how the rural health innovation centre model could be phased in. Given that each province and territory has a different approach and capacity, the rural health innovation centre model must be flexible. The goal for the first year would be to establish rural health innovation centres (or integrate their key elements into existing community health structures) at 13 sites across the country, one for each province and territory. Within three years, the rural health innovation centre concept would be expanded to 100 locations.

The Council is recommending a three-phase strategy: undertaking broad consultations with stakeholders; building on and strengthening existing infrastructure; and establishing new structures where needed.

### **Recommendation**

- 2.1** *That Health Canada work in partnership with provincial and territorial Ministries of Health to sponsor multi-stakeholder workshops on rural health innovation centres; integrate the key elements of the rural health innovation centre model into existing structures; and phase-in rural health innovation centres, establishing new structures where needed.*

### 3 INTERSECTORAL COLLABORATION

#### ***Strategic Direction: Fostering greater intersectoral collaboration on health issues with stakeholders***

Strong intersectional collaboration is required to address the complex factors and conditions that influence the health of people living in rural, remote, northern and Aboriginal communities. Essentially, intersectional collaboration means working together across sectors such as health, housing and transportation and across federal, provincial, territorial and municipal jurisdictions. The benefits of such collaboration include framing a comprehensive response, improving communication, making effective use of limited resources, and reducing duplication and gaps.<sup>67</sup>

#### **FOSTERING COLLABORATION ACROSS JURISDICTIONS**

##### *Canada's health system is a shared responsibility*

In Canada, jurisdiction over health is shared between the federal government and the provinces and territories, and each jurisdiction has been assigned distinct roles and responsibilities.

According to the Canadian Constitution, the federal government is responsible for:

- setting and administering national standards for the health care system through the *Canada Health Act*;
- helping finance provincial health care services through fiscal transfers;

- delivering direct health services to specific groups, including First Nations and Inuit people;
- promoting national research; and
- developing national health protection, disease prevention and health promotion policies and programs.<sup>68</sup>

Provincial and territorial governments are responsible for:

- managing and delivering health care services;
- planning, financing and evaluating hospital care, physician care and allied health care services; and
- managing some aspects of prescription care and public health.<sup>69</sup>

There is a well-developed and long-standing structure in place to coordinate policies and share information relating to health matters across federal, provincial and territorial jurisdictions. A revised structure has been recently approved and is in the process of being implemented. It is therefore timely to create a focal point within this revised structure on rural health issues.

### **Recommendation**

**3.1** *That Health Canada seek support from the Conference of Deputy Ministers of Health to establish a focal point within the revised federal/provincial/territorial structure for developing policies, programs and action plans for common rural health issues.*

### **ENHANCING COLLABORATION ACROSS SECTORS**

Sectors such as housing, transportation, employment, education, culture, recreation and economic development influence people's health. The factors that affect health are inter-related, and therefore, the most effective solutions are integrated, collaborative and multi-sectoral. At the federal level, potential for coordinated action is greatest in areas where interests are shared across departmental mandates; for example, in the area of health information technologies.

It is important to ensure that future collaborative federal initiatives and programs are developed using a "rural lens". A rural lens raises awareness of rural issues by encouraging federal government departments and agencies to assess the effect of proposed initiatives and programs on the health of rural communities and citizens. This would ensure that new federal initiatives would support the social and economic well-being of rural communities and strengthen their capacity to meet local challenges.<sup>70</sup> A rural lens would also ensure that rural issues are not an afterthought or appendage in discussions on health policy. All government activities should reflect the need for an uniquely rural approach.

### **Recommendation**

**3.2** *That Health Canada work with federal departments and agencies to assess the impact of proposed government initiatives and programs on the health of rural Canadians and communities, and to encourage action within respective mandates to support rural health.*

### **INCREASING COLLABORATION AMONG STAKEHOLDERS**

Municipalities, the voluntary sector and Aboriginal communities are instrumental in building healthy communities because they are closest to the people involved. For instance, the primary function of municipal governments is to develop safe, vibrant community environments.<sup>71</sup> The voluntary sector made up of local citizens and community organizations plays a critical role in communities. As well, Aboriginal communities across the nation are increasingly assuming responsibility for their own health services.

Front-line health care providers, national health care organizations, professional licensing bodies and researchers all have interests and responsibilities relating to rural health. Many are involved in identifying health issues and in designing and implementing responses to rural needs. These individuals and organizations along with municipalities, the voluntary sector and Aboriginal communities must develop stronger links with each other so they can exchange ideas and work together to effectively address the health needs of rural Canadians. The federal



government is well positioned to provide leadership and foster collaboration among these major stakeholders.

### **Recommendation**

**3.3** *That Health Canada promote partnerships, networking and collaboration among relevant stakeholders to address health issues affecting rural, remote northern and Aboriginal communities.*

### **ESTABLISHING INNOVATIVE JURISDICTIONAL PARTNERSHIPS FOR ABORIGINAL HEALTH SERVICES**

Health services are delivered to Aboriginal people through a complex array of federal, provincial, territorial and Aboriginal-run programs and services. Who delivers what to whom depends on status under the *Indian Act*, place of residence, community location, and whether Health Canada has transferred delivery of health services to a particular community. This situation often results in program fragmentation, gaps, overlaps and the inability to develop a holistic and integrated approach to health and wellness.<sup>72</sup>

Establishing jurisdictional partnerships for Aboriginal health services requires a certain amount of creativity. For example, when the Eskasoni Integrated Primary Health Project (funded through Health Canada's Health Transition Fund) integrated all aspects of health care, a new community centre was built consisting of two separate buildings with a shared wall to respect jurisdiction. One building, funded federally,

housed the community health programs; the other accommodated primary care services and was funded by the Eskasoni Band. Results from the project evaluation showed increased satisfaction by both patients and health care providers, improved coordination and reduced costs for patients (e.g., transportation costs) compared to the delivery of health services before the integrated approach.<sup>73</sup>

Another example of an innovative partnership is the Aboriginal Head Start Program in the remote northern region of Nunavik in Quebec. A strong alliance was formed among Health Canada, Human Resources Development Canada, the Government of Quebec, the Nunavik regional government and Inuit communities to ensure all pre-school children living in the area had access to the program. This partnership benefits communities by increasing children's school readiness and providing economic benefits. The Council fully endorses the establishment of innovative jurisdictional partnerships across the country to ensure better health care services for Aboriginal people.

### **Recommendation**

**3.4** *That Health Canada work with other federal departments, provincial and territorial governments and Aboriginal communities to establish innovative models for jurisdictional partnerships across the country.*

## 4 RURAL HEALTH RESEARCH

### ***Strategic Direction: Expanding rural, remote, northern and Aboriginal health research***

Rural health research is necessary to understand, forecast and positively influence rural health. Through research, health challenges can be examined and monitored, appropriate rural health policies can be developed, and the effectiveness of health programs and services can be evaluated. Rural health research helps communities and citizens clarify health issues, take action and hold governments accountable for the health care they receive. As part of the September 2000 Health Accord, First Ministers agreed to report regularly to Canadians on health status, health outcomes, the performance of publicly funded health services and the actions taken to improve these services.<sup>74</sup>

Rural health research is particularly important in Canada — the second largest country in the world — with its vast expanses of land and sizeable rural population. Other countries with large rural expanses, such as the United States and Australia, have made significant financial investments in developing their rural health research capacity. It is important that Canada work toward becoming a global leader and innovator in rural health research.

#### **ENHANCING NATIONAL DATA COLLECTION AND ANALYSIS ON PEOPLE LIVING IN RURAL, REMOTE, NORTHERN AND ABORIGINAL COMMUNITIES, AND DEVELOPING INDICATORS ON THE HEALTH OF COMMUNITIES**

Until recently, national data on the health status and key determinants of health for people living in rural, remote, northern and Aboriginal communities have been quite limited. Comprehensive national statistics were not available beyond some broad indicators of health, such as life expectancy, infant mortality and death rates. Most national surveys also did not capture the dynamics of rural, remote and northern communities. Sampling criteria sometimes excluded small population sizes; comparisons were difficult because of differences in data collection and methodologies; and urban-rural comparisons were simply not done on available data.

Federal departments (e.g., Statistics Canada) and other national research and health information organizations (e.g., the Canadian Institute for Health Information) are currently modifying research methodologies and introducing new surveys to improve information on rural regions. For example, data from the new *Canadian*

*Community Health Survey* is providing detailed information on the health of people living in rural, remote and northern regions.<sup>75</sup> In addition to geographically sensitive national surveys and surveillance systems, there is a need for consistent data collection and analysis within federal departments and organizations to help identify trends in rural health.

Appropriate indicators are also required to assess and monitor the health of communities. The little information available on communities has been estimated by grouping different health, demographic and socio-economic indicators together and applying them to a geographical area. This does not reflect the health of individual communities. Efforts are currently under way to measure information at a regional level to more accurately monitor the health of rural communities.

Furthermore, to be meaningful, profiles of rural communities must contain a broad-based, comprehensive set of both positive and negative indicators, including information on environmental quality, economic viability, social capital, community capacity and community governance. Quality of Life indexes, such as those developed by the Federation of Canadian Municipalities and the Canadian Policy Research Network, can also provide information that would be useful for monitoring the health of communities.

---

## **Recommendation**

**4.1** *That Health Canada work with other federal departments and research and health information organizations to ensure that national surveys and surveillance systems are sensitive to geography and are able to provide consistent data collection and analysis of the health of people living in rural, remote, northern and Aboriginal communities, and to ensure that indicators for monitoring the health of rural communities are developed.*

---

## **ENHANCING RURAL HEALTH RESEARCH**

Interest in rural health research is on the rise across Canada — at local, regional, provincial, territorial and national levels. But, while there is much progress, research is not being carried out in a systematic, coordinated manner. Researchers duplicate one another's efforts, gaps exist and poor dissemination of findings limits the practical application of the research.<sup>76</sup>

To build a solid foundation for rural, remote and northern research, federal departments and funding organizations and agencies need to make rural health research a priority. Federal departments such as Health Canada and Industry Canada, and research funding organizations and agencies (such

as the Canadian Institutes of Health Research, the Social Sciences and Humanities Research Council, the Canadian Foundation for Innovation and the Canadian Health Services Research Foundation) must fund research and evaluation initiatives that are relevant to rural Canadians.

Some funding organizations have already made a strong commitment to rural research. For example, in recognition of the importance of rural issues for its 13 institutes, the Canadian Institutes of Health Research (CIHR) appointed a Special Advisor to the President of the CIHR on rural and northern health in 2000. In 2002, the CIHR announced a \$1.5 million fund for rural and northern health research.<sup>77</sup>

The Rural Health Research Summit held in Prince George, British Columbia, in 1999 confirmed the importance of building partnerships, connecting researchers and disseminating information.<sup>78</sup> Today, some research funding organizations and agencies are attempting to enhance rural health research. For example, the CIHR established a working group for rural health research, knowledge translation and policy development involving key federal departments and research funding organizations and agencies. The Council firmly believes that Health Canada should play an active role in this working group.

Rural, remote and northern research needs to be enhanced by sustaining and increasing existing research expertise, training a new generation of researchers, increasing the amount of high-quality rural health research being done, and enhancing Canada's ability to contribute to rural research of national and international importance.

### **Recommendation**

**4.2** *That the Minister of Health make a long-term investment in the Canadian Institutes of Health Research's strategic initiative in rural and northern health research.*

### **Recommendation**

**4.3** *That the Minister of Health work with federal colleagues to make rural health research a high priority by designating funds for rural health research, strengthening rural health research capacities and networks, and ensuring that research is disseminated.*

## **BUILDING RESEARCH CAPACITY IN RURAL AND NORTHERN CANADA**

The research capacity of rural and northern Canada varies considerably. Most rural and northern universities and some colleges, such as the Nunavut Arctic College, are engaged in research activity. Some have specialized research institutes or centres, e.g., the Centre for Rural and Northern Health Research at Lakehead and Laurentian Universities.

However, compared with larger urban institutions, many rural and northern universities and colleges are not well positioned to undertake research. Many lack the capacity (both the research personnel and the infrastructure) to support research activities. This lack of research capacity makes it difficult for rural and northern institutions to obtain funding from the major granting organizations and agencies. For example, fifteen of the largest universities in Canada currently hold 77 percent of all federal research funding.<sup>79</sup>

Building research capacity in rural and northern institutions is vital to a better understanding of rural health issues. It is of particular importance to the north, which has seen a steep decline in research activity by governments and university researchers, primarily due to the high costs and complex logistics of northern research.<sup>80</sup> Strategies must be devised to support research capacity in rural and northern universities and colleges.

One strategy is to build research capacity through specially designed grants and targeted requests for proposals. Another is to designate funds to support the development of rural-urban research teams and to provide salary support for rural students, postdoctoral fellows, researchers and Chairs.<sup>81</sup>

---

### **Recommendation**

**4.4** *That the Minister of Health work with federal colleagues to stimulate research capacity in rural and northern institutions and communities through specially designed grants and targeted requests for proposals, demonstration projects and designated personnel awards for rural health researchers, including Chairs.*

---

### **PROMOTING COMMUNITY-BASED RESEARCH**

Community-based research is different than traditional academic research in that it takes place in community settings and involves local people and grassroots organizations in defining research questions, designing and implementing research projects, and reviewing outcomes. It builds community involvement because people are encouraged to have meaningful input into all stages of research. The benefit of this involvement is increased confidence in decision making and information sharing in the community. As well, the research is more likely to produce information that is directly applicable to the community in which it takes place. People also tend to take greater ownership for solving their health challenges when they participate in the creation and understanding of knowledge about themselves.

Most rural health research is not initiated or driven by rural communities. Rather, the bulk of research is undertaken by researchers and research institutions primarily located in urban centres. This limits opportunities for rural communities to set the research agenda, develop the capacity needed to do their own research or gain access to research funding.

Communities must be involved at every stage of the research process and participate in the design, implementation and evaluation of research activities. Two ways of promoting community-based research are: to strengthen partnerships between communities and academics; and to increase research capacity in rural, remote and northern communities.

Existing models for community-academic partnerships are the CIHR's Community Alliances for Health Research program and the Social Sciences and Humanities Research Council's Community University Research Alliances program.<sup>82</sup> Increasing research capacity in rural communities involves establishing research funding opportunities that communities can access, promoting research skills development for local citizens and providing ongoing research assistance to communities as needed. The "rural health innovation centres" proposed in Strategic Direction 2 would serve to facilitate community involvement in rural health research.

### **Recommendation**

**4.5** *That Health Canada promote community-based health research and evaluation with demonstrated community input and involvement in research activities funded through Health Canada and research funding organizations.*

### **SUPPORTING RESEARCH ON ABORIGINAL HEALTH**

Community-based research that is Aboriginal-directed and controlled is vital to improving the health status of Aboriginal people. Research on Aboriginal health must be culturally sensitive, fostering the principle that "all knowledge is spiritual knowledge".<sup>83</sup> Aboriginal research must also encourage the contribution of Aboriginal researchers and respect the differences among First Nations, Métis and Inuit people. The Aboriginal Women's Health Research Synthesis Project called for the "indigenisation" of the research process to develop strategies for collaboration among researchers and Aboriginal organizations, and to incorporate Aboriginal stories and experiences into research.<sup>84</sup>

Two organizations dedicated to Aboriginal health research and knowledge-sharing are the CIHR–Institute on Aboriginal Peoples' Health (CIHR-IAPH) and the National Aboriginal Health Organization (NAHO). The mandate of the CIHR-IAPH is to promote Aboriginal health research; one of its primary initiatives is to establish a network of Aboriginal research centres through the Aboriginal

Capacity and Development Research Environments (ACADRE) program. NAHO focuses on sharing knowledge, developing tools for exchanging information and fostering greater awareness of data, statistics and research. Both organizations require long-term funding to ensure that Aboriginal health remains a research priority.

### **Recommendation**

**4.6** *That the Minister of Health support long-term funding for Aboriginal health research and knowledge-sharing through the CIHR-Institute on Aboriginal Peoples' Health, the National Aboriginal Health Organization and other organizations.*

---

### **DEVELOPING, DOCUMENTING AND DISSEMINATING BEST PRACTICES AND MODELS OF CARE**

Best practices are concepts, structures or approaches proven to lead to the desired results, and have the potential to be replicated or adapted. Developing and sharing best practices can help rural, remote, northern and Aboriginal communities build community capacity. For Aboriginal communities, best practices must promote Aboriginal control; enhance integration of services; be built on partnerships; be sustainable; build capacity; ensure accountability; and provide culturally appropriate services.<sup>85</sup>

### **Recommendation**

**4.7** *That Health Canada work with national Aboriginal organizations to document and share on an ongoing basis best practices and models of care among Aboriginal communities.*

---

### **SUPPORTING RESEARCH ON RURAL HEALTH MODELS**

There are no well-defined models for delivery of rural health care appropriate for the majority of rural, remote and northern communities in Canada. While Ontario, British Columbia and Manitoba have developed frameworks for rural health, each province has taken a different approach.<sup>86</sup> Rural models of care and strategies of best practices need to be developed. Two areas that require immediate attention are research on rural health care services delivery models and rural Healthy Communities models.

### **Recommendation**

**4.8** *That Health Canada support research on rural health service delivery and rural Healthy Communities models and strategies of best practices.*

---

## 5 HEALTH INFORMATION TECHNOLOGY

### ***Strategic Direction: Creating a nationwide telehealth and distributed learning network to serve the health and healthcare needs of rural, remote, northern and Aboriginal communities***

Many people have described the condition of Canada's health care sector as "critical". Budget constraints and serious shortages of health care providers coexist with an increasing demand for health care services, driven in part by an aging population, new technologies and prescription drugs. The health sector is under close scrutiny, with growing demands for review and re-examination of the objectives of the health care system, ongoing reform and restructuring, improved management, accountability and a greater reliance on evidence-based health care and decision making.

In this context, rural, remote, northern and Aboriginal communities, which have traditionally been disadvantaged compared to their urban counterparts, are concerned about their ability to obtain access to timely health care services closer to home. The health status of rural populations is poorer than that of their urban counterparts, and many of the socio-economic conditions affecting their health are less than ideal.

Telehealth, or health information technology, offers a solution to address some of the health problems in rural Canada. Telehealth is about removing distance as a barrier to receiving care and, therefore, has greater relevance in meeting the needs of rural Canadians. However, it should be noted that telehealth is a vehicle to assist, complement and improve access to health care services and information, and is not a justification

for removing or diverting needed health care resources away from local communities.

The purpose of using telehealth in rural communities would be to improve the health of rural Canadians in two ways: by using technology as a tool in direct patient care; and by connecting rural communities with each other so that they can share best practices and success stories.

Telehealth permits delivery and exchange of health information, access to health care services, and sharing of expertise over distances using information and communication technologies such as the telephone, the Internet, videoconferencing, computer, world-wide web, wireless devices and satellite systems. It encompasses a spectrum of activities or applications. It means talking with a nurse by telephone for advice, connecting to a health care provider through e-mail, using the Internet and web sites to gather health and health care information, and talking with a health care provider by videoconference to resolve a health problem.

Telehealth also allows health care providers and teams to obtain relevant, up-to-date, reliable and valid patient health records (electronic health records), to acquire information on disease care, and to transmit information about laboratory results or medication, information or diagnostic images such as x-rays and pictures of skin or eye



conditions to remote sites for evaluation and assessment, through networks that guarantee privacy, confidentiality and security. Moreover, Internet and videoconferencing capability provides opportunities to maintain and enhance skills and knowledge without the need to travel to urban centres. It also permits direct discussion with colleagues or specialists for advice and support.

For patients and their caregivers, it means less travel and more timely access to health care providers and services. The need for timely access to health care closer to home was expressed time and time again in the rural dialogue involving 7,000 rural citizens from communities across the country.<sup>87</sup> For families, videoconferencing makes it possible for people in remote communities to visit their relatives in distant hospitals.

Telehealth is also about providing health information through Internet web sites. The Council feels that priority should be given to creating portals — or single-window entry sites and pathways that guide users through Internet web sites — for health promotion and information in appropriate languages and cultural contexts. Telehealth is also a means of responding to the needs of particular people such as official language minority groups, recent immigrants who do not speak either of Canada's two official languages and people with disabilities.

Strategic Direction 1, Building Healthy Communities, emphasizes how important it is to invest in community capacity-building and to promote networking so that communities can share experiences and learn from each other. Telehealth is a means of networking and exchanging information that can help rural, remote, northern and Aboriginal communities develop community-based solutions to shared challenges.

## **SEIZING OPPORTUNITIES PROVIDED BY BROADBAND**

In many ways, Canada is considered a world leader in telehealth. Federal, provincial and territorial governments and the private sector have made significant contributions to the development of telehealth, with considerable attention to the health care needs of rural, remote, northern and Aboriginal communities. However, at this time, development is concentrated on individual projects that have no connection to one another. To maximize telehealth's potential to eliminate distance and geographic barriers, it is essential for Canada to adopt a nationwide perspective and strategies that ensure that the country is not left with isolated, stand-alone networks unable to connect with or "talk to" one another.

Only communities connected by a suitable communications infrastructure can benefit from the potential of telehealth. The type of telehealth activity or application is determined by the available bandwidth, i.e., the capacity of the communications network or infrastructure to transmit information. Broadband refers generally to high bandwidth that will support a minimum of full-motion audio- and videoconferences.<sup>88</sup>

Unfortunately, there are significant disparities in the availability of high-speed communications infrastructure between Canada's northern and southern communities, a gap often referred to as the "digital divide". All urban areas with a population of 100,000 or more have broadband access, whereas 80 percent of rural communities in Canada do not have access to broadband. In fact, some remote northern communities are still without even the narrowband plain old telephone system (POTS).<sup>89</sup>

The National Broadband Task Force advocated for a broadband network connecting all communities in Canada. It underscored the importance of improving broadband access in rural, remote, northern and Aboriginal communities and recommended that the government ensure the development of infrastructure in communities where the private sector is unlikely to take the initiative.

The Council is encouraged by the federal government's recent commitment to accelerate the establishment of a broadband network in rural Canada by 2005, and by the inclusion of broadband as one of the five investment categories in the Canada Strategic Infrastructure Fund. The expansion of broadband networks in Canada will ensure that Canadians who live and work in rural communities have access to distance learning and telehealth services.

### **Recommendation**

**5.1** *That Health Canada seize the opportunities provided by the broadband network to reach and respond to the needs identified by rural, remote, northern and Aboriginal communities by developing appropriate distance learning packages and telehealth services that complement and support the rural health care delivery system with a view to providing equitable and timely access to essential health services close to home.*

### **USING TELEHEALTH AS A KEY LEVER FOR ADDRESSING CURRENT HEALTH CARE NEEDS**

The major objective of telehealth is to support the recruitment and retention of health care providers in rural, remote, northern and Aboriginal communities. (The shortage of health human resources in rural communities is discussed in Strategic Direction 6, Health Human Resources, of this report.)

The recruitment of health care providers to rural, remote, northern and Aboriginal communities must begin with educating students in their communities. Telehealth and telelearning technology make distance learning possible. Students introduced to this technology in the course of their education are likely to become users of telehealth. The Council applauds the decisions to develop a new northern medical school in Ontario and satellite training programs and campuses in northern communities. It has initiated discussions with the two emerging northern medical programs in Ontario and British Columbia to examine the potential of using telehealth and telelearning in a distributed learning model.

The Council firmly believes that building an environment and culture of collegiality is key to improving recruitment and retention of health care providers in rural communities. Strategies to support rural health care providers through the use of health information technology include:

- support for those providing patient care to reduce the sense of professional isolation;
- continuing education/continuing professional development in the workplace;
- tele-mentoring and tele-assistance programs to develop and support skills of rural health care providers;

- the exchange of information technology skills and health clinic case studies between rural practitioners and students;
- peer-to-peer interactions (e.g., nurses consulting nurses);
- frontline health care providers to specialist consultations (e.g., nurses consulting family physicians or family physicians consulting specialists); and
- the development of advanced telehealth applications of special interest to rural communities, (e.g., robotic surgery and robotic assists).

To promote and develop the use of telehealth in rural, remote, northern and Aboriginal communities, a nationwide rural telehealth initiative must be created. The nationwide rural telehealth initiative would need to: address timely access to essential health care services; support recruitment and retention of health care providers; develop innovative, rurally focused education programs, including northern medical schools; and address the special health needs of official language minority communities and Aboriginal communities. Dedicated funding sources are required for model implementation of a nationwide telehealth initiative to address rural health needs (e.g., tele-surgery, tele-pathology and tele-learning); health information technology training for health care providers; and the creation of portals for health promotion and information in appropriate languages and in the context of cultural sensitivity.

---

### **Recommendation**

**5.2** *That Health Canada, in collaboration with other federal departments, work with provincial and territorial governments and the private sector to create a nationwide rural telehealth initiative as a vehicle for improving the health status of Canadians living in rural, remote, northern and Aboriginal communities.*

*That Health Canada, in collaboration with other federal departments, work with provincial and territorial governments and the private sector to create adequate funding sources for model implementation of a nationwide telehealth initiative to address rural health needs.*

---

### **IMPROVING COMMUNITY READINESS**

Rural communities, particularly low-population, low-density communities, will need assistance to develop their community readiness, that is, the capacity needed to implement, manage and sustain activities related to health information and communications technologies. Strategies to promote community readiness in rural Canada, include:

- creating strategic community alliances (for instance, health, education, legal, industrial, commercial and municipal users) that will lead to an integrated, multi-user, networked community;
- preparing the community of health care providers to accept, adopt and use information technologies and to become active learners;
- building capacity among health care providers, managers and end-users to use technology;
- developing and maintaining technical support for networking needs; and
- creating “rural health innovation centres” as discussed in Strategic Direction 2, Infrastructure for Community Capacity-building.

#### **Recommendation**

**5.3** *That Health Canada work in partnership with such organizations as the Federation of Canadian Municipalities to assess and build community readiness and mobilize action to develop appropriate infrastructure to support information and communications technology applications and services.*

### **PROTECTING EXISTING INVESTMENTS**

Federal, provincial and territorial governments and their research funding organizations have already made significant telehealth investments through pilot, demonstration and proof-of-concept projects and their implementation. Although they have been successful, many projects will not be sustainable once funding ends. The Council believes that the investments made thus far should not be wasted and that telehealth projects should be eligible for bridging funds until they become self-sustaining.

#### **Recommendation**

**5.4** *That Health Canada invest in a rural telehealth bridging fund to protect the investments already made in telehealth through programs such as the Health Infostructure Support Program (HISP), Canada Health Infostructure Partnership Program (CHIPP) and CANARIE Inc. until a sustainable strategy for a nationwide rural telehealth initiative is identified.*

### **BUILDING THE KNOWLEDGE BASE FOR FUTURE INVESTMENTS**

In addition to implementing telehealth in rural communities, there is a critical need for funding devoted to research projects that address the unique health technology needs and issues of rural, remote, northern and Aboriginal communities. For a number of reasons, Canada's existing funding bodies have not been inclined to support telehealth as a research theme. Telelearning and telehealth are still relatively new and the benefits of using these technologies are not yet fully understood. Still, as in any field of scientific endeavour, research is required to develop a knowledge base that will help make effective use of investments in these new technologies.

Many questions need to be explored at the technical and infrastructure level, the operational level and the health service delivery level. Research is also needed to determine what is affordable, who is willing to pay and which models work best. Finally, research is required to evaluate the impact of these technologies on health care providers, voluntary caregivers and patients; on recruitment and retention; and on community health status.

### **Recommendation**

**5.5** *That Health Canada, in collaboration with other federal departments, create dedicated funding opportunities for competitive rural health research projects to develop a rigorous evaluation of telehealth projects to guide future development and investment and to support rural health trainees, researchers and institutions devoted to rural telehealth.*

---

## 6 HEALTH HUMAN RESOURCES

### *Strategic Direction: Supporting the training, recruitment and retention of health human resources*

Health care providers make a significant contribution to the health and well-being of their communities. The spectrum of health human resources includes formal health care providers, such as physicians and nurses; allied health providers like social workers, mental health counsellors, laboratory technicians, nursing assistants, midwives and therapists; and informal caregivers.<sup>90</sup>

Health care providers in rural, remote and northern communities need to be highly skilled generalists, as opposed to specialists. This calls for training that develops multiple skills needed to respond to diverse challenges associated with working in rural communities. Rural health care providers also need to practise in ways that are community-centered, team-oriented, innovative and flexible.

#### **DEVELOPING A NATIONWIDE RURAL HEALTH HUMAN RESOURCES STRATEGY**

Canada continues to face an acute and persistent shortage of health care providers, particularly in rural, remote and northern areas.<sup>91</sup> Rural communities have fewer physicians and nurses than urban areas, and the numbers continue to decline. In 2000, about 17 percent of family physicians, four percent of specialists and 18 percent of registered nurses practised in rural communities.<sup>92</sup> The shortage of qualified health care providers is also common in Aboriginal communities.<sup>93</sup>

Governments and communities have tried a variety of strategies to improve recruitment and retention of rural health care providers. They have enhanced continuous education opportunities, used telehealth consultations to reduce isolation, offered locums (replacements) for respite and vacations, and encouraged providers to get involved in community life and activities.<sup>94</sup> But these strategies have not been pursued in a systematic, coordinated manner and therefore have had limited effect.

Most recent reports on health care reform<sup>95</sup> focus on health human resources as one area that needs reform. A nationwide health human resources strategy, with specific investments for rural, remote, northern and Aboriginal communities, is urgently required. A major goal of such a strategy would be to develop a systematic, innovative approach for recruiting and retaining a variety of health care providers in rural communities. The “rural health innovation centres” described in Strategic Direction 2, Infrastructure for Community Capacity-building, would be ideally situated to pursue recruitment and retention strategies at the local level.

During its deliberations, the Council identified the following components of a nationwide rural health human resources strategy:

- conducting a survey of post-secondary health care training programs to identify existing opportunities and barriers for rural health and Aboriginal health training;

- promoting health care careers to young people in rural, remote, northern and Aboriginal communities;
- improving post-secondary health education opportunities for rural and Aboriginal students;
- developing rural health and Aboriginal health curricula;
- increasing rural community-based learning opportunities;
- improving working conditions and support for rural health care providers;
- maximizing distance education and continuing professional development; and
- encouraging community initiatives that address issues related to health human resources.

The Council believes the provinces and territories would be enthusiastic partners in a nationwide rural health human resources strategy, given that the recruitment and retention of health care providers was identified as a priority at the federal/provincial/territorial level.

### **Recommendation**

**6.1** *That the Minister of Health work with provincial and territorial colleagues to develop a nationwide health human resources strategy, with particular emphasis on recruitment and retention for rural, remote, northern and Aboriginal communities.*

### **CONDUCTING A SURVEY OF POST-SECONDARY HEALTH CARE TRAINING PROGRAMS**

A survey of post-secondary educational institutions is needed to identify existing opportunities and barriers for training in rural health and Aboriginal health. The rural component of the survey would need to focus on existing programs and opportunities for field training, as well as on barriers to recruiting and training rural students. The Aboriginal component would focus on the availability of programs, the number of Aboriginal students enrolled in and graduating from the programs, and the financial and personal supports available to students. The survey would serve as a benchmark to guide the development of new strategies to address issues related to training.

### **Recommendation**

**6.2** *That Health Canada support a survey of post-secondary educational institutions to identify academic and field training opportunities and barriers for rural health and Aboriginal health training to establish a benchmark and guide new strategies to address issues related to training rural health care providers.*

### **PROMOTING HEALTH CAREERS TO YOUNG PEOPLE IN RURAL, REMOTE, NORTHERN AND ABORIGINAL COMMUNITIES**

One recruitment strategy is to promote health careers to young people in rural, remote, northern and Aboriginal communities. For example, only 10.8 percent of medical students come from rural communities.<sup>96</sup> Encouraging students to consider health careers should start in primary and secondary schools when children begin to make career choices. Furthermore, research shows that rural recruitment efforts are more successful when directed at people living in rural areas because family ties and an appreciation for rural life make these recruits more likely to return to their home communities.<sup>97</sup>

#### **Recommendation**

**6.3** *That Health Canada work with provincial and territorial partners to develop a coordinated action plan to promote health careers to primary and secondary school students in rural, remote, northern and Aboriginal communities.*

### **IMPROVING POST-SECONDARY HEALTH EDUCATION OPPORTUNITIES FOR RURAL, REMOTE AND NORTHERN STUDENTS**

Another recruitment strategy is to improve opportunities by providing incentives to students from rural, remote and northern communities to train as health care providers. Some provinces have waived tuition fees or have forgiven student loans for health care providers who agree to work in

remote locations. For example, Ontario's Free Tuition Program offers grants of up to \$40,000 to medical students in exchange for a three- or four-year commitment to work in an under-serviced area.<sup>98</sup> Investment programs, such as Registered Education Savings Plans (RESPs), could also be promoted as a vehicle to encourage more students from rural, remote and northern areas to pursue health careers.

#### **Recommendation**

**6.4** *That Health Canada, together with other federal departments, work with provincial and territorial governments to improve post-secondary health education opportunities for rural students, by exploring strategies such as strengthening existing subsidy programs and promoting investment programs to encourage more rural students to train as health care providers.*

### **IMPROVING POST-SECONDARY HEALTH EDUCATION OPPORTUNITIES FOR ABORIGINAL STUDENTS**

In 1997–98, there were approximately 2,000 Aboriginal health care providers, including 800 nurses, 67 physicians and a range of other providers of health services such as lab technicians, dentists, optometrists, pharmacists and health administrators. Aboriginal people make up three percent of the Canadian population, yet Aboriginal nurses and physicians account for less than one percent of all registered nurses and physicians.<sup>99</sup>



The Indian and Inuit Health Careers Program of the First Nations and Inuit Health Branch of Health Canada was designed to encourage Aboriginal health training and help students overcome social and cultural barriers. The bursaries component of the program is administered through the National Aboriginal Achievement Foundation and awards about \$500,000 annually in bursaries and scholarships to Aboriginal students.<sup>100</sup>

Some post-secondary institutions have special-entry programs to prepare Aboriginal students to go into health professions; for example, the University of Manitoba ACCESS program provides opportunities for Aboriginal students to enter the faculties of medicine, dentistry, pharmacy and medical rehabilitation. Other academic institutions reserve spaces for Aboriginal students; for example, the University of Saskatchewan reserves two spaces for Aboriginal students in its Bachelor of Science in Nutrition program.

Even with these measures, the representation of Aboriginal health care providers is still relatively small compared to the size of the Aboriginal population. Post-secondary enrolment of Aboriginal students must be stimulated by supporting Aboriginal entry programs and ensuring that the necessary financial and personal supports are available to Aboriginal students.

---

### **Recommendation**

**6.5** *That Health Canada work with partners to increase the number of Aboriginal students in post-secondary health programs by augmenting the bursary envelope of the Health Canada Indian and Inuit Health Careers Program, maximizing the use of existing Aboriginal entry programs and spaces reserved for Aboriginal students across the country, and increasing opportunities if needed.*

---

### **DEVELOPING RURAL HEALTH AND ABORIGINAL HEALTH CURRICULA**

Post-secondary health curricula must address the unique health challenges facing people who live in rural, remote, northern and Aboriginal communities. Colleges, universities and other training centres across the country must offer curricula on rural health and Aboriginal health across all health disciplines. This strategy involves developing and piloting specialized curricula, as well as building on existing curricula. Specialized curricula on rural health and Aboriginal health would include Healthy Communities models, the rural context, the health status of rural and Aboriginal people, cultural sensitivity and traditional medicine. Specialized curricula are already offered in some post-secondary educational institutions; for example, the University of Regina offers a Certificate in Indian Health Studies that consists of courses in the sciences, Aboriginal language and Aboriginal health.

In addition to specialized courses, rural health and Aboriginal health should be an integral part of all health training programs, so that every health care provider has a basic appreciation of and sensitivity to the rural context and Aboriginal culture. For example, increased awareness would help specialists located in urban centres offer more appropriate support to rural physicians. Both specialized and integrated rural health and Aboriginal health curricula must be given priority.

### **Recommendation**

**6.6** *That Health Canada encourage provincial and territorial governments to build on existing curricula and develop new initiatives as needed so that curricula on rural health and Aboriginal health are available in colleges, universities and training centres across the country.*

### **INCREASING RURAL COMMUNITY-BASED LEARNING OPPORTUNITIES**

Health care students need to be trained locally so they develop the skills and relationships necessary to work in rural communities.<sup>101</sup> Northern and rural medical programs will promote local training. Health care students of all disciplines must also be given opportunities and financial support (e.g., travel allowances) to undertake field training in rural, remote, northern and Aboriginal communities. Field training not only gives students a genuine taste of rural environments, it may lead to a decision to work there.

### **Recommendation**

**6.7** *That Health Canada work with provincial and territorial governments and national professional organizations to encourage the creation of opportunities for rural community-based learning for students in the health professions.*

### **IMPROVING WORKING CONDITIONS AND SUPPORT FOR RURAL HEALTH CARE PROVIDERS**

Smaller communities have difficulty attracting and retaining health care providers because of heavy workloads, limited opportunities for professional development and professional isolation, along with lack of employment opportunities for spouses. Rapid staff turnover and high attrition rates reflect the difficult working conditions in rural, remote and northern communities.<sup>102</sup>

One strategy to improve recruitment and retention is to increase incentives by offering subsidized incomes, special grants or bonuses, travel allowances, money to help set up offices, ensured vacations and extra pay for living in isolated places.<sup>103</sup> Another strategy is to ensure appropriate facilities and supports are available to rural health care providers. The “rural health innovation centres” described in Strategic Direction 2, Infrastructure for Community Capacity-building, would be ideally situated to support rural health care providers.

### **Recommendation**

**6.8** *That Health Canada, in partnership with other federal departments and the provinces and territories, address the urgency of the health human resources shortage in rural, remote, northern and Aboriginal communities by providing appropriate incentives, facilities and supports for rural health care providers.*

### **MAXIMIZING DISTANCE EDUCATION AND CONTINUING PROFESSIONAL DEVELOPMENT**

Working conditions can also be improved by providing opportunities for continuing professional development. Such opportunities include funding to upgrade education and attend conferences or workshops, provision of in-service training and improved networking among health care providers.<sup>104</sup> Health information technologies will help improve professional development opportunities for health care providers who are isolated in remote and northern communities. However, to maximize distance education opportunities, provincial, territorial and federal governments must collaborate with universities, colleges and training centres.

### **Recommendation**

**6.9** *That Health Canada, in concert with federal departments and provincial and territorial partners, develop strategies to maximize distance education and continuing professional development opportunities for health care providers in rural, remote and northern communities.*

### **SUPPORTING COMMUNITY INNOVATION**

Innovation is at the heart of community strategies to address health human resources shortages. One innovation is to maximize the skills of existing health care providers so that, where there are shared competencies, work can be done by other health care providers. For example, in some rural communities, rehabilitation services have been improved by employing physiotherapy assistants to supplement physiotherapists. Health occupation legislation and regulations used to be quite rigid, but the old system is being replaced by an approach that allows more flexibility.<sup>105</sup> This development is particularly beneficial to rural communities where it makes sense to use existing health human resources to the fullest extent possible, as long as health and safety are not jeopardized. Skills development programs enable health care providers to be cross-trained so they have the capacity to perform multiple tasks.

Providing opportunities for informal caregivers to develop their skills is another idea that merits support. Studies have estimated that informal caregivers, who give voluntary care to others, provide more than 70 percent of all health care.<sup>106</sup> In rural communities, informal caregivers play an important role because of the shortage of health care providers and the lack of formal health services.

***Recommendation***

**6.10** *That Health Canada recognize the significant contribution that local health care providers and local citizens make to the health of their communities and work with provincial and territorial partners to provide opportunities for skills development.*

---

## 7 ABORIGINAL HEALTH

***Strategic Direction: Promoting Aboriginal-specific healthy community models, national policies and programs that embrace the distinctiveness of Aboriginal cultures***

Rural, remote and northern regions are home to more than 50 percent of Canada's 1.4 million Aboriginal people.<sup>107</sup> The term Aboriginal includes three distinct groups, with unique heritages, languages, cultural practices and spiritual beliefs: 1) Indians now commonly referred to as First Nations, Status and non-Status as determined by the *Indian Act*, living on reserve and off reserve; 2) Inuit people; and 3) Métis people.

There are more than 600 First Nations communities across the country, speaking over 50 languages. About 63 percent of these communities have fewer than 500 residents and 5 percent have more than 2,000. Inuit people share the same language, Inuktitut, but speak different dialects. Most Inuit settlements are located above the treeline in Nunavut, the Northwest Territories, northern Quebec and Labrador, and have on average fewer than 1,000 people per community. The Métis people are of mixed First Nations and European ancestry and have their own distinct language, known as Michif, which is a mixture of French, English, Cree and Ojibway. Métis people live mainly in Manitoba, Saskatchewan and Alberta; about 10 percent live on Métis settlement lands.<sup>108</sup>

All three groups of Aboriginal people — First Nations, Inuit and Métis people — have poorer health than the Canadian population as a whole. The disparities in health status between Aboriginal and non-Aboriginal people are significant and persistent.<sup>109</sup> Compared with the general population,

Aboriginal people have a lower life expectancy; higher infant mortality rates; higher rates of chronic illnesses (e.g., diabetes); and higher rates of injury, substance abuse, smoking, suicide and family violence. They also have less access to health care services than the general population because their communities tend to be small and located in remote areas. As well, the Aboriginal population is the fastest growing population in the country; it is increasing at twice the rate of the Canadian population and is younger on average.<sup>110</sup>

### **INTEGRATING TRADITIONAL KNOWLEDGE, MEDICINE AND HEALING PRACTICES**

Aboriginal cultures have a rich heritage of traditional medicine, which includes traditional knowledge, medicinal remedies and healing practices. Although First Nations, Inuit and Métis people have their own distinctive beliefs and practices, they share many similarities. To Aboriginal people, health means “a balance in the life-support systems that promote mental, emotional, physical and spiritual well being”.<sup>111</sup> Traditional medicine is based on a holistic approach that goes far beyond the western biomedical focus on physical health, and includes mental, emotional and spiritual well-being.<sup>112</sup> This view of health is a prototype for healthy communities in all rural, remote and northern communities.

Fundamental differences exist between traditional and western medicine. Western medicine is based on a disease model while traditional medicine is

based on wellness. Western medicine is a formalized health care and medical system with a scientific base, structured education and licensing, standardized care practices and documentation of knowledge. In contrast, traditional medicine is an informal health care and medical system with a metaphysical base, informal training system, no standardized care practices and oral transmission of knowledge.<sup>113</sup>

The provinces of Ontario, British Columbia and Manitoba have established Aboriginal health and wellness centres that combine traditional and western medicine in health care services for Aboriginal people. A preliminary scan identified 14 such centres currently in operation. The centres have annual budgets of between \$2 and \$4 million depending on the size of the community they serve. They are funded primarily by the provinces, with some federally funded programs, e.g., the Community Action Program for Children.

Aboriginal health and wellness centres offer primary health care services and community programs for chronic diseases, prenatal and postnatal child care, health care training and community capacity-building. They also offer a range of traditional services, including ceremonies, consultations with traditional healers, talking circles and community feasts. Typically, they employ a mix of physicians, nurse-practitioners, elders, nutritionists, mental health educators and health promotion staff to deliver both western and traditional medicine.<sup>114</sup>

The 1997 First Nations and Inuit Regional Health Survey funded by Health Canada found that 80 percent of respondents believed that a return to traditional ways was necessary to improve the health and well-being of Aboriginal people.<sup>115</sup>

Integrating traditional medicine into current health care services for Aboriginal people would help improve the quality of health care services in Aboriginal communities. It would address the needs of Aboriginal people in a holistic manner and preserve ancestral traditions of healing. There is also the potential to develop multiple models, including mobile centres that would travel to provide service to remote communities in the north.

Traditional medicine is included in some Health Canada programs offered through the First Nations and Inuit Health Branch. The mental health program supports ceremonies such as sweat lodges for use in addiction treatment. The Aboriginal Diabetes Initiative includes support for communities to incorporate traditional practices and beliefs into local diabetes prevention programs. The non-insured health benefits program covers transportation, meals and accommodation for eligible clients who must travel to consult a traditional healer.

The Council firmly believes that traditional medicine must be integrated into the current health care system so that all Aboriginal people — First Nations, Inuit and Métis people — have the choice of being able to obtain access to traditional medicine. Taking into consideration the different jurisdictions involved in the delivery of health care services to Aboriginal people, the federal government can initiate some actions in partnership with national First Nations and Inuit organizations, and in other instances, work collaboratively with the provinces, territories and all the national Aboriginal organizations, including those representing Métis people and non-Status Indians.

### **Recommendation**

**7.1** *That Health Canada work with First Nations and Inuit partners as part of the First Nations and Inuit Health System Renewal process, to fully integrate traditional medicine into the current health care system for First Nations and Inuit people and ensure new services embrace traditional and western medicine.*

### **Recommendation**

**7.2** *That the Minister of Health work with provincial and territorial colleagues and Aboriginal partners to establish Aboriginal health and wellness centres in their respective health care systems so that all Aboriginal people including Métis and non-status Indians can obtain access to traditional medicine.*

practices.<sup>116</sup> Weakening of traditional medicine began with the first missionary contact and continued with the dispossession of Aboriginal people from the land. The residential school system, with its policies of assimilation and displacement, led to further loss of traditions, lifestyles and culture.

Today there is an imminent danger of losing valuable knowledge. For example, among First Nations communities, the custom of elders passing on traditional knowledge to children has been weakened and, as elders die, valuable information is being lost. Elders play a pivotal role in transmitting knowledge, but many are reluctant to share information with strangers for fear that the medicines will be commercialized. Traditional medicine must be preserved for the benefit of future generations.<sup>117</sup> Although the federal government cannot control the transmission of traditional knowledge, it can influence the acceptance of traditional practices by recognizing and supporting organizations working to preserve traditional medicine.

### **Recommendation**

**7.3** *That Health Canada recognize the immediacy of the need to preserve traditional medicine, and ensure that efforts currently being undertaken by national Aboriginal organizations and research institutes are adequately funded.*

## **SUPPORTING THE WORK TO PRESERVE TRADITIONAL MEDICINE**

Many inequalities in the health status of First Nations, Inuit and Métis people can be attributed to the erosion of Aboriginal culture and the loss of traditional knowledge, medicine and healing

## **BUILDING ON THE STRENGTHS AND CAPACITIES OF ABORIGINAL COMMUNITIES**

Building on the strengths and capacities of First Nations, Inuit and Métis communities is necessary to promote healthy lifestyles, encourage self-reliance and self-determination, and build healthy communities. Current health initiatives tend to focus on individuals rather than on communities, leading to a fragmented approach to health and well-being.

Health Canada provides a broad range of community-based health promotion and disease prevention programs in the areas of community care, substance abuse, women's and children's health, chronic and infectious diseases, training and retention of health care providers, infrastructure, telehealth, environmental health and mental health. Some programs are directed specifically to First Nations people on reserves and Inuit people, while others are pan-Aboriginal and include Métis people and non-Status Indians. These programs could be strengthened by increased involvement of Aboriginal people in consultation processes and in the development and delivery of programs. It is also important that all programs be respectful of the differences among First Nations, Inuit and Métis people.

### **Recommendation**

**7.4** *That Health Canada strengthen its community-based health promotion and disease prevention programs by ensuring that specific initiatives are developed and delivered by Aboriginal people for Aboriginal people.*

## **IMPROVING ABORIGINAL HEALTH CARE SERVICES**

Health Canada provides direct primary care and emergency services in nearly 200 remote and isolated areas. There are currently 529 federal health facilities, including 77 nursing stations, 217 health centres, 121 health stations, 61 health offices and 4 hospitals. The federal government also provides non-insured health benefits to 706,000 First Nations (on and off reserve) and Inuit people. These benefits cover prescription drugs, medical transportation, dental and vision care, provincial premiums and medical devices.<sup>118</sup>

Since the mid-1980s, the federal government has been transferring control of health services to First Nations and Inuit communities and organizations. Each eligible Aboriginal community has decided whether to accept comprehensive or limited transfer of community-based health programs, environmental health, treatment and prevention health services, as well as the appropriate services from the First Nations and Inuit Health Branch. By 2000, 276 eligible communities (46 percent) had signed a Health Services Transfer Agreement.<sup>119</sup>

In partnership with the Assembly of First Nations and the Inuit Tapiriit Kanatami, Health Canada is currently engaged in a process of health system renewal in First Nations and Inuit communities. The renewal process acknowledges the need for constructive changes in First Nations and Inuit health.<sup>120</sup> It comes at an opportune time, as there is a growing perception among Aboriginal people that health care services have not kept pace with their needs and rapid increase in population. Many people consider that the current funding envelope is not sufficient and that services must be improved.



### **Recommendation**

**7.5** *That Health Canada provide sufficient funding for First Nations and Inuit health services, including non-insured benefits, taking into account the needs of the population and projected population increases.*

### **SUPPORTING CULTURAL AND COMMUNITY RENEWAL**

First Nations, Inuit and Métis people are engaging in a powerful process of renewal of their cultures and way of life. This rejuvenation is a vital component of the overall health and well-being of rural, remote and northern communities. As Aboriginal communities grow, it will be increasingly important to encourage future generations to participate constructively in this process. Many communities continue to struggle with the legacy of the residential school era — the loss of culture, languages, and parenting and family supports, as well as the impacts of addictions, abuse and family breakdown.<sup>121</sup>

In response to the recommendations by the Royal Commission on Aboriginal Peoples, the federal government established the Aboriginal Healing Foundation in 1998. The federal government committed \$350 million dollars over 10 years to support community-based healing initiatives for the First Nations, Inuit and Métis individuals, families and communities who were affected by the legacy of physical and sexual abuse in residential schools. The deadline for final project applications is February 2003. Although the Aboriginal Healing Foundation has funding for five more years to monitor and evaluate funded projects, there is no

comprehensive action plan or designated funding to address ongoing concerns.<sup>122</sup> Priority must be given to developing such an action plan.

### **Recommendation**

**7.6** *That Health Canada continue to work in partnership with Indian and Northern Affairs Canada, the Aboriginal Healing Foundation, religious institutions and Aboriginal communities to develop a comprehensive action plan with ongoing funding for programs that address the impact of residential schools on the health status of Aboriginal people.*

### **ENHANCING PARENTING AND FAMILY SUPPORTS**

Healthy child development and positive parenting, important factors for achieving successful health outcomes for children, are enhanced by the availability of parenting and family supports. The quality and availability of parenting and family supports is not consistent from one part of Canada to the next. First Nations, Inuit and Métis communities need equitable access to a full complement of supports.

### **Recommendation**

**7.7** *That Health Canada ensure parenting and family supports are available to all Aboriginal communities in rural, remote and northern areas.*

# Conclusion

Building healthy rural communities and reducing the inequities in health status between rural and urban people is a challenge for all Canadians. One of the most important ingredients for a successful outcome will be the ability to focus the energy and political will to improve the health status of rural citizens and to build vibrant, healthy rural, remote, northern and Aboriginal communities. The challenge is complex and much more work is needed.

This report by the Ministerial Advisory Council on Rural Health is just a first step. The Council has articulated a vision and outlined seven broad strategic directions to address rural health challenges — building healthy communities; enhancing community infrastructure; fostering greater intersectoral collaboration; expanding rural health research; creating a nationwide telehealth initiative; creating systemic and innovative approaches for health human resources; and promoting Aboriginal health.

The recommendations in this report offer an important opportunity to invest in the health and well-being of rural Canadians and contribute to rural sustainability. They are intended to stimulate thinking, support existing work and offer new solutions.

As an advisory council providing independent advice to the federal Minister of Health, the Council has directed all of its recommendations to the Minister of Health and Health Canada. However, just as the challenges facing rural Canadians are shared, creative solutions will have

to be generated in partnership with other levels of government, the private and voluntary sectors, professional organizations, Aboriginal organizations, researchers, health care providers and rural citizens themselves.

Improving the health status of rural Canadians and rural communities requires a combination of short- and long-term strategies. Some solutions can be realized within existing budgets; however, substantial new investments are required. The Council strongly urges the federal government to work with provincial and territorial governments to make long-term funding investments in rural Canada. It is Council's belief that such investments are needed to provide a solid foundation for improving the health status of rural Canadians and their communities, now and in the future.

The Council believes that this report should be used to promote comprehensive action to improve the health of Canadians in rural, remote, northern and Aboriginal communities. It calls for action to build on promising initiatives that have already been instituted by various levels of government. It also envisions a strong federal leadership role to ensure that rural health becomes a nationwide priority and that rural, remote, northern and Aboriginal communities have a healthy and sustainable future. The Council welcomes the response of the Minister of Health as the work continues toward the realization of the vision of "healthy people living in healthy rural, remote, northern and Aboriginal communities".

**ENDNOTES**

- <sup>1</sup> Troughton, M.J. (1999). "Redefining 'rural' for the twenty-first century". Health in rural settings: contexts for action, ed. Ramp, W., Kulig, J., Townshend, I., and McGowan, V. University of Lethbridge, Lethbridge, 21–38.
- <sup>2</sup> du Plessis, V., Beshiri, R., Bollman, R., and Clemenson, H. (November 2001). "Definitions of rural," Rural and Small Town Canada Analysis Bulletin, 3(3).
- <sup>3</sup> Statistics Canada (2001). Census of population.
- <sup>4</sup> du Plessis et al, op. cit.
- <sup>5</sup> Canadian Rural Partnership (2001). Annual report to Parliament 2000-2001. Government of Canada, Ottawa, at [www.rural.gc.ca/annualreport/2001/report\\_e.phtml](http://www.rural.gc.ca/annualreport/2001/report_e.phtml)
- <sup>6</sup> Statistics Canada (1999). CANSIM matrices, 1999. Statistics Canada, Ottawa.
- <sup>7</sup> Infometrica (2000). Estimates, 1986–2000. Infometrica, Durham, NH, USA; and Mendelson, R. (1999). "The composition of business establishments in smaller and larger communities in Canada," Rural and Small Town Canada Analysis Bulletin, 1(3).
- <sup>8</sup> Canadian Tourism Commission (2001). 2000 tourism performance. Canadian Tourism Commission, Ottawa.
- <sup>9</sup> Statistics Canada (2001). Census of population.
- <sup>10</sup> Task Force on Northern Research (2000). From crisis to opportunity: rebuilding Canada's role in northern research. Minister of Public Works and Government Services, Ottawa.
- <sup>11</sup> Canadian Rural Partnership, op. cit.
- <sup>12</sup> Statistics Canada (1996). Census of population; and Dupuy, R., Mayer, F., and Morissette, R. (2000). Rural youth: stayers, leavers and return migrants. Report submitted to the Rural Secretariat of Agriculture and Agrifood Canada and the Atlantic Canada Opportunities Agency. Canadian Rural Partnership, Ottawa.
- <sup>13</sup> Fédération des communautés francophones et acadienne du Canada (June 2001). Improving access to French-language health services. Fédération des communautés francophones et acadienne du Canada, Ottawa.
- <sup>14</sup> Statistics Canada and the Canadian Institute for Health Information (May 2002). Health indicators (82-221-XIE), vol. 2002, no. 1.
- <sup>15</sup> The number of ethnic Aboriginal people is 1.4 million, but the number of self-reported Aboriginal people is smaller (based on Census data).
- <sup>16</sup> Health Canada (November 1999). A second diagnostic on the health of First Nations and Inuit people in Canada. Health Canada, Ottawa.
- <sup>17</sup> Statistics Canada, Demography Division, unpublished data. In 1996, life expectancy for rural females was 80.82 years, as opposed to 81.31 years for urban females. The comparable figures for rural and urban males were 74.67 years and 75.67 years, respectively.
- <sup>18</sup> Special data tabulations on urban/rural statistics prepared by Statistics Canada, using 1991 and 1996 Census data (unpublished). In 1996, infant mortality rates were 7.3 per 1,000 births, while urban infant mortality rates were slightly lower (at 5.2 per 1,000 births) than the national average (at 5.6 per 1,000). Infant mortality rates in the three territories were more than twice the national average (at 14.1 per 1,000 births). Death rates are consistently higher in rural Canada. In 1996, the rural death, at 7.9 per 1,000, was slightly higher than the national average, at 7.2 per 1,000, while the urban death rate (at 7.0 per 1,000) was slightly lower than the national average.
- <sup>19</sup> Nunavut Department of Health and Social Services (September 2002). Report on comparable health indicators for Nunavut and Canada. Government of Nunavut, Iqaluit.
- <sup>20</sup> Federal, Provincial and Territorial Advisory Committee on Population Health (1999). Toward a healthy future: second report on the health of Canadians. Minister of Public Works and Government Services Canada, Ottawa.

- <sup>21</sup> Statistics Canada and the Canadian Institute for Health Information, op.cit.
- <sup>22</sup> Statistics Canada (2001). Labour force survey; United States Department of Agriculture, Rural conditions and trends, vol. 11, no. 2; and Statistics Canada (2002). CANSIM II Table 282-0066. Statistics Canada, Ottawa.
- <sup>23</sup> Standing Senate Committee on Social Affairs, Science and Technology (2002). The health of Canadians — the federal role: interim report. Vol. 2. Government of Canada, Ottawa.
- <sup>24</sup> Statistics Canada and the Canadian Institute for Health Information, op. cit.
- <sup>25</sup> Ibid.
- <sup>26</sup> Federal, Provincial and Territorial Advisory Committee on Population Health, op. cit.
- <sup>27</sup> Statistics Canada and the Canadian Institute for Health Information, op. cit.
- <sup>28</sup> Peterson, H. (2001). "A tale of two countries: the quality of rural versus urban drinking water in Canada," *Encompass Magazine*, at [www.suncoastdesigns.com/flash/drhans.pdf](http://www.suncoastdesigns.com/flash/drhans.pdf)
- <sup>29</sup> Statistics Canada and the Canadian Institute for Health Information, op. cit.
- <sup>30</sup> Ibid.
- <sup>31</sup> Health Canada, A second diagnostic, op. cit.; and Archibald, L., and Grey, R. (2000). Evaluation of models of health care delivery in Inuit regions. Inuit Tapirisat of Canada, Ottawa.
- <sup>32</sup> Health Canada, A second diagnostic, op. cit.
- <sup>33</sup> Health Canada, Health Protection Branch, Laboratory Centre for Disease Control (Spring 1999). "New office to focus on rural health issues," *Farm Family Health*, 7(1). Interview with Dr. John Wootton.
- <sup>34</sup> Health Canada (n.d.). Rural health frequently asked questions. Health Canada, Ottawa, at [www.hc-sc.gc.ca/english/ruralhealth/faq.html](http://www.hc-sc.gc.ca/english/ruralhealth/faq.html)
- <sup>35</sup> Canadian Rural Partnership (1998). Rural Canadians speak out: summary of rural dialogue input for the National Rural Workshop. Government of Canada, Ottawa, at [www.rural.gc.ca/discpaper\\_e.phtml](http://www.rural.gc.ca/discpaper_e.phtml)
- <sup>36</sup> Statistics Canada and the Canadian Institute for Health Information, op. cit.
- <sup>37</sup> Ng., E., Wilkins, R., Dole, J., and Adams, O.B. (March 1999). "How far to the nearest physician?" *Rural and Small Town Canada Analysis Bulletin*, 1(5).
- <sup>38</sup> Hutten-Czapski, P. (May 31, 2001). State of rural healthcare: presentation to the Standing Senate Committee on Social Affairs, Science and Technology. Society of Rural Physicians of Canada, Shawville, at [www.srpc.ca/librarydocs/Kirby\\_SRPC.htm](http://www.srpc.ca/librarydocs/Kirby_SRPC.htm)
- <sup>39</sup> National Advisory Council on Aging (January 1993). "Aging in rural communities and small towns," *Expression*, 9 (1).
- <sup>40</sup> Canadian Medical Association (2000). Physician resources data base, as cited in Hutten- Czapski, op. cit.; and the Canadian Institute of Health Information (2002). Supply and distribution of registered nurses in rural and small town Canada. Canadian Institute for Health Information, Ottawa.
- <sup>41</sup> Canadian Medical Association, Physician resources data base, as cited in Hutten-Czapski, op. cit.
- <sup>42</sup> Jennissen, T. (December 1992). Health issues in rural Canada (BP-325E). Government of Canada, Ottawa.
- <sup>43</sup> Ibid.
- <sup>44</sup> Hutten-Czapski, op. cit.; and Weatherill, J. and Coulson, D. (1999). Alternative models of health system delivery and access to core speciality services in rural Canada. Health Canada, Ottawa.
- <sup>45</sup> Jennissen, op. cit.
- <sup>46</sup> Kelley, M.L. (2002). Building a model for rural palliative care delivery. Unpublished paper.
- <sup>47</sup> Jennissen, op. cit.

- 48 Browne, A. (n.d.). Issues affecting access to health services in northern, rural and remote regions of Canada. University of Northern British Columbia, Prince George. Northern Articles Series, at [www.unbc.ca/northern/browne.htm](http://www.unbc.ca/northern/browne.htm)
- 49 Pitblado, R.J., Pong, R., Irvine, A., Nagarajan, K.V., Sahai, V., Zelmer, J., Dunikowski, L. and Pearson, D. (June 1999). Assessing rural health: toward developing health indicators for rural Canada. Health Canada, Ottawa.
- 50 Sherwood, D. (July 2002). Building healthy rural communities. Paper prepared for the Ministerial Advisory Council on Rural Health, Health Canada, Ottawa.
- 51 Ibid.
- 52 Ibid.
- 53 Ibid.
- 54 Ibid.
- 55 Ibid.
- 56 Government of Canada (2002). Government of Canada delivers on promise to provide economic development tools for rural communities. Government of Canada, Ottawa. News release, at [www.agr.gc.ca/cb/news/2002/n20626be.html](http://www.agr.gc.ca/cb/news/2002/n20626be.html)
- 57 Sherwood, op. cit.
- 58 Ibid.
- 59 Ibid.
- 60 Ibid.
- 61 Ibid.
- 62 Standing Senate Committee on Social Affairs, Science and Technology, op. cit.
- 63 Deiter, C., and Otway, L. (2001). Sharing our stories on promoting health and community healing: an Aboriginal women's health project. Prairie Women's Health Centre of Excellence, Winnipeg.
- 64 Kistabish, R., and Perron, J.M. (November 1987). Santé algonquine: document de réflexion. Unpublished paper.
- 65 World Health Organization (1998). Health promotion glossary. World Health Organization, Geneva.
- 66 World Organization of Family Doctors (WONCA) (2002). Working together: Communities, professionals and services, 5<sup>th</sup> Annual Conference, Melbourne, Australia (April 30 - May 3, 2002).
- 67 World Health Organization, op. cit.
- 68 Health Canada (n.d.). *Canada Health Act* — frequently asked questions. Health Canada, Ottawa, at [www.hc-sc.gc.ca/medicare/FAQ-e.htm](http://www.hc-sc.gc.ca/medicare/FAQ-e.htm)
- 69 Ibid.
- 70 Government of Canada (n.d.). Canadian Rural Partnership checklist of rural lens considerations, at [www.rural.gc.ca/checklist\\_e.phtml](http://www.rural.gc.ca/checklist_e.phtml)
- 71 Federation of Canadian Municipalities (August 8, 2002). A partnership for quality of life. Federation of Canadian Municipalities, Ottawa, at [www.fcm.ca](http://www.fcm.ca)
- 72 Standing Senate Committee on Social Affairs, Science and Technology, op. cit.
- 73 Dion Stout, M., and Kipling, G.D. (2002). Sharing the learning, The Health Transition Fund synthesis series: Aboriginal health. Health Canada, Ottawa, at [www.hc-sc.gc.ca/htf-fass/english/aboriginal\\_en.pdf](http://www.hc-sc.gc.ca/htf-fass/english/aboriginal_en.pdf)
- 74 Canadian Intergovernmental Conference Secretariat (September 11, 2000). First Ministers meeting communique on health. Canadian Intergovernmental Conference Secretariat, Ottawa. News release ref: 800-038/004.
- 75 Statistics Canada and the Canadian Institute for Health Information, op. cit.
- 76 Pong, R. (2000). "Rural health research in Canada: at the crossroads," *Australian Journal of Rural Health*, 8, 261–265.
- 77 Canadian Institute for Health Information (Dec. 5, 2000). Thirteen outstanding researchers to lead health institutes. Canadian Institutes of Health Research, Ottawa. Press release, at [www.cihr-irsc.gc.ca/news/press\\_releases/2000/pr0021\\_e.shtml](http://www.cihr-irsc.gc.ca/news/press_releases/2000/pr0021_e.shtml)

- <sup>78</sup> Watanabe, M., and Casebeer, A. (1999). Rural, remote and northern health research: the quest for equitable health status for all Canadians. Report of the Rural Health Research Summit, Prince George, British Columbia, 23–25 October 1999.
- <sup>79</sup> Frank, T. (April 2001). “Big-time research at small universities.” University Affairs, 10-11, 30-32. Association of Universities and Colleges of Canada, Ottawa.
- <sup>80</sup> Task Force on Northern Research, *op. cit.*
- <sup>81</sup> Rural health chairs would function as network nodes to develop capacity for rural health research. The chairs would play a key role in developing inter-institutional, inter-disciplinary and community-based linkages and partnerships that connect with rural health innovation centres and other key organizations to ensure overall connectivity and relevance of rural research.
- <sup>82</sup> Social Sciences and Humanities Research Council (n.d.). Community–university research alliances — a pilot program from SSHRC. Social Sciences and Humanities Research Council, Ottawa, at [www.sshrc.ca](http://www.sshrc.ca); and Canadian Institutes of Health Research (n.d.) Community alliances for health research (CAHRs) program. Canadian Institutes of Health Research, Ottawa, at [www.cihr-irsc.gc.ca](http://www.cihr-irsc.gc.ca)
- <sup>83</sup> Timmins, L. (Fall/winter 2001/2002). “Research as a spiritual contract,” Canadian Women’s Health Network, 4/5(4/1).
- <sup>84</sup> Stout Dion, M., Kipling, G, and Stout, R. (May 2001). Aboriginal women’s health research synthesis project: final report. Centres of Excellence for Women’s Health Program, Women’s Health Bureau, Health Canada, Ottawa.
- <sup>85</sup> Archibald, L., and Bird, P. (July 2001). Innovation in First Nations and Inuit health systems: models, structures and approaches. Discussion paper prepared for the First Nations and Inuit Health Branch, Health Canada, Ottawa.
- <sup>86</sup> Kelley, *op. cit.*
- <sup>87</sup> Canadian Rural Partnership, Rural Canadians speak out, *op. cit.*
- <sup>88</sup> See [www.broadband.gc.ca](http://www.broadband.gc.ca)
- <sup>89</sup> Industry Canada estimates, based on 1996 population data from Statistics Canada and confidential company information. See Simpson, R. (2001). Canada’s Broadband Strategy: the report of the National Broadband Taskforce. Presentation to the Joint WP TSP/IE Workshop. Organization for Economic Co-operation and Development, Paris, at [www.oecd.org/pdf/M00023000/M00023806.pdf](http://www.oecd.org/pdf/M00023000/M00023806.pdf)
- <sup>90</sup> Wanke, M.I., Sanders, L.D., Pong, R.W., and Church, W.J.B. (1995). Building a stronger foundation: health human resources in community-based health care: a review of the literature. Health Promotion and Programs Branch, Health Canada, Ottawa, at [www.hc-sc.gc.ca/hppb/healthcare/pubs/strongerpdf/health.pdf](http://www.hc-sc.gc.ca/hppb/healthcare/pubs/strongerpdf/health.pdf)
- <sup>91</sup> Commission on the Future of Health Care in Canada (2002). Health human resources in Canada’s healthcare system. Issue/survey paper prepared for the Commission on the Future of Health Care in Canada, Ottawa; and Pong, R. (2002). Health Transition Fund synthesis series — rural health/telehealth. Health Canada, Ottawa.
- <sup>92</sup> Canadian Medical Association, Physician resources data base, as cited in Hutten-Czapski, *op. cit.*
- <sup>93</sup> Health Canada, A second diagnostic, *op. cit.*
- <sup>94</sup> Barer, M.L., and Stoddart, G.L. (June 1999). Improving access to needed medical services in rural and remote Canadian communities: recruitment and retention revisited. Discussion paper prepared for the Federal/Provincial/Territorial Advisory Committee on Health Human Resources, Health Canada, Ottawa.
- <sup>95</sup> Commission on the Future of Health Care in Canada, *op. cit.*; Pong, Health Transition Fund, *op. cit.*; and Standing Senate Committee on Social Affairs, Science and Technology, *op. cit.*
- <sup>96</sup> Hutten-Czapski, P. (April 11, 2002). Rural health care – the chasm not crossed; presentation to the Commission on the Future of Health Care in Canada. Society of Rural Physicians of Canada, Shawville, at [www.srpc.ca/librarydocs/RomanowSudbury.pdf](http://www.srpc.ca/librarydocs/RomanowSudbury.pdf)

- <sup>97</sup> Standing Senate Committee on Social Affairs, Science and Technology, op. cit.; and Worley, P.S., Prideaux, D.J., Strasser, R.P., Silagy, C.A., and Margarey, J.A. (2000). "Why we should teach undergraduate medical students in rural communities," *Medical Journal of Australia*, 172(12), 615–617; and Wonca Working Party on Rural Practice (2002). Policy on quality and effectiveness of rural health care. Monash University School of Rural health, Traralgon, Vic.
- <sup>98</sup> Government of Ontario, Ministry of Health and Long-Term Care (2002). Free tuition program. Queen's Printer for Ontario, Toronto, at [www.gov.on.ca/MOH/english/ministry/recruit/tuition.html](http://www.gov.on.ca/MOH/english/ministry/recruit/tuition.html)
- <sup>99</sup> Health Canada, A second diagnostic, op. cit.
- <sup>100</sup> Health Canada, First Nations and Inuit Health Branch (n.d.). Meet the challenge: Indian and Inuit Health Careers Program Information. Health Canada, First Nations and Inuit Health Branch, The Publication Resource Centre, Ottawa; and National Aboriginal Achievement Foundation (n.d.). Education program, at [www.naaf.calfinancia.html](http://www.naaf.calfinancia.html)
- <sup>101</sup> Barer and Stoddart, op. cit.
- <sup>102</sup> Barer and Stoddart, op. cit.; Aboriginal Nurses Association (2000). Survey of nurses in isolated First Nations communities: recruitment and retention issues: final report. Aboriginal Nurses Association, Ottawa; and MacLeod, M. (August 1998). "We're it": the nature of nursing practice in very small rural and remote hospitals in northern British Columbia. University of Northern British Columbia, Prince George.
- <sup>103</sup> Barer and Stoddart, op. cit.
- <sup>104</sup> Aboriginal Nurses Association, op. cit.
- <sup>105</sup> Pong, Health Transition Fund, op. cit.
- <sup>106</sup> Ibid.
- <sup>107</sup> Statistics Canada (1996). Census of Population.
- <sup>108</sup> Standing Senate Committee on Social Affairs, Science and Technology, op. cit.
- <sup>109</sup> Royal Commission on Aboriginal Peoples (November 1996). Gathering strength, vol. 3. Department of Indian and Northern Affairs Canada, Ottawa.
- <sup>110</sup> Health Canada, A second diagnostic, op. cit.
- <sup>111</sup> Royal Commission on Aboriginal Peoples, op. cit., p. 109.
- <sup>112</sup> Letendre, A. (2002). "Aboriginal traditional medicine: where does it fit?" *Crossing Boundaries*, 1(2), 79–87.
- <sup>113</sup> Shestowsky, B. (1993). Traditional medicine and primary health care among Canadian Aboriginal people. Aboriginal Nurses Association of Canada, Ottawa.
- <sup>114</sup> Government of Ontario (2001). Aboriginal healing and wellness strategy: annual report, 2000/2001. Government of Ontario, Toronto.
- <sup>115</sup> First Nations and Inuit Regional Health Survey National Steering Committee (January 1999). First Nations and Inuit regional health survey. Health Canada, Ottawa.
- <sup>116</sup> Royal Commission on Aboriginal Peoples, op. cit.
- <sup>117</sup> Borins, M. (1995). "Native healing traditions must be protected and preserved for future generations," *Canadian Medical Association Journal*, 153(9), 1356-1357.
- <sup>118</sup> Health Canada (2001). Non-insured health benefits program: 2000-2001 annual report. First Nations and Inuit Health Branch, Non-Insured Health Benefits Directorate, Program Analysis Division, Health Canada, Ottawa, at [www.hc-sc.gc.ca/fnihb/nihb/annualreport/annualreport2000\\_2001.pdf](http://www.hc-sc.gc.ca/fnihb/nihb/annualreport/annualreport2000_2001.pdf)
- <sup>119</sup> Health Canada (1999-2000). First Nations and Inuit Control Annual Report, at [www.hc-sc.gc.ca/msb/pptsp/annual\\_e.htm#t3](http://www.hc-sc.gc.ca/msb/pptsp/annual_e.htm#t3)
- <sup>120</sup> Health Canada, First Nations and Inuit Health System Renewal (October 2001). Focus on fundamentals: a population health and community development approach. Health Canada, Ottawa.
- <sup>121</sup> Aboriginal Healing Foundation (May 2002). The healing has begun: an operational update from the Aboriginal Healing Foundation. Aboriginal Healing Foundation, Ottawa [www.ahf.ca/english-pdf/healing\\_has\\_begun.pdf](http://www.ahf.ca/english-pdf/healing_has_begun.pdf)
- <sup>122</sup> Ibid.

# APPENDIX A

## *List of Recommendations*

### 1 BUILDING HEALTHY COMMUNITIES

***Strategic Direction: Building healthy communities through model development and national policies***

- 1.1 That Health Canada recognize that rural, remote and northern communities are different from urban communities, and that this difference be reflected in its policies and programs.
- 1.2 That Health Canada, in partnership with the provinces, territories and municipalities, support the development and implementation of Healthy Communities models in all rural, remote and northern communities, drawing on existing resources, expertise and networks.
- 1.3 That Health Canada work with provincial, territorial and other partners to establish community capacity-building coalitions and networks.
- 1.4 That Health Canada work with other federal departments and provincial and territorial partners to coordinate efforts and provide funding opportunities for community capacity-building processes and coordination.
- 1.5 That Health Canada establish a nationwide virtual library of Healthy Communities resources specific to rural, remote and northern communities.
- 1.6 That Health Canada, in collaboration with provincial, territorial and municipal governments, fund forums, conferences and consensus workshops for rural citizens, national health providers' associations and academic health centres to share Healthy Communities experiences and community tools.
- 1.7 That Health Canada work with provincial, territorial and municipal governments to promote Healthy Communities concepts, principles and applications among health care providers.
- 1.8 That Health Canada, in partnership with Aboriginal communities, develop a strategy with new funding to implement Aboriginal-specific Healthy Communities models that promote healthy lifestyles, self-reliance and self-determination.



## 2 INFRASTRUCTURE FOR COMMUNITY CAPACITY-BUILDING

***Strategic Direction: Building infrastructure to enable rural communities to develop community-based solutions to health challenges***

- 2.1 That Health Canada work in partnership with provincial and territorial Ministries of Health to sponsor multi-stakeholder workshops on rural health innovation centres; integrate the key elements of the rural health innovation centre model into existing structures; and, phase-in rural health innovation centres, establishing new structures where needed.

## 3 INTERSECTORAL COLLABORATION

***Strategic Direction: Fostering greater intersectoral collaboration on health issues with stakeholders***

- 3.1 That Health Canada seek support from the Conference of Deputy Ministers of Health to establish a focal point within the revised federal/provincial/territorial structure for developing policies, programs and action plans for common rural health issues.
  - 3.2 That Health Canada work with federal departments and agencies to assess the impact of proposed government initiatives and programs on the health of rural Canadians and communities, and to encourage action within respective mandates to support rural health.
  - 3.3 That Health Canada promote partnerships, networking and collaboration among relevant stakeholders to address health issues affecting rural, remote, northern and Aboriginal communities.
  - 3.4 That Health Canada work with other federal departments, provincial and territorial governments and Aboriginal communities to establish innovative models for jurisdictional partnerships across the country.
-

## 4 RURAL HEALTH RESEARCH

### ***Strategic Direction: Expanding rural, remote, northern and Aboriginal health research***

- 4.1 That Health Canada work with other federal departments and research and health information organizations to ensure that national surveys and surveillance systems are sensitive to geography and are able to provide consistent data collection and analysis of the health of people living in rural, remote, northern and Aboriginal communities, and to ensure that indicators for monitoring the health of rural communities are developed.
- 4.2 That the Minister of Health make a long-term investment in the Canadian Institutes of Health Research's strategic initiative in rural and northern health research.
- 4.3 That the Minister of Health work with federal colleagues to make rural research a high priority by designating funds for rural health research, strengthening rural health research capacities and networks, and ensuring research is disseminated.
- 4.4 That the Minister of Health work with federal colleagues to stimulate research capacity in rural and northern institutions and communities through specially designed grants and targeted requests for proposals, demonstration projects and designated personnel awards for rural health researchers, including Chairs.
- 4.5 That Health Canada promote community-based health research and evaluation with demonstrated community input and involvement in research activities funded through Health Canada and research funding organizations.
- 4.6 That the Minister of Health support long-term funding for Aboriginal health research and knowledge-sharing through the CIHR-Institute on Aboriginal Peoples' Health, the National Aboriginal Health Organization and other organizations.
- 4.7 That Health Canada work with national Aboriginal organizations to document and share on an ongoing basis best practices and models of care among Aboriginal communities.
- 4.8 That Health Canada support research on rural health services delivery and rural Healthy Communities models and strategies of best practices.

## 5 HEALTH INFORMATION TECHNOLOGY

***Strategic Direction: Creating a nationwide telehealth and distributed learning network to serve the health and healthcare needs of rural, remote, northern and Aboriginal communities***

5.1 That Health Canada seize the opportunities provided by the broadband network to reach and respond to the needs identified by rural, remote, northern and Aboriginal communities by developing appropriate distance learning packages and telehealth services that complement and support the rural health care delivery system with a view to providing equitable and timely access to essential health services close to home.

5.2 That Health Canada, in collaboration with other federal departments, work with provincial and territorial governments and the private sector to create a nationwide rural telehealth initiative to promote and develop telehealth as a vehicle for improving the health status of Canadians living in rural, remote and northern communities.

That Health Canada, in collaboration with other federal departments, work with provincial and territorial governments and the private sector to create adequate funding sources for model implementation of nationwide telehealth initiative to address rural health needs.

5.3 That Health Canada work in partnership with such organizations as the Federation of Canadian Municipalities to assess and build community readiness and mobilize action to develop appropriate infrastructure to support information and communications technology applications and services.

5.4 That Health Canada invest in a rural telehealth bridging fund to protect the investments already made in telehealth through programs such as Health Infostructure Support Program (HISP), Canada Health Infostructure Partnership Program (CHIPP), and CANARIE Inc., until a sustainable strategy for a nationwide rural telehealth initiative is identified.

5.5 That Health Canada, in collaboration with other federal departments, create dedicated funding opportunities for competitive rural health research projects to develop a rigorous evaluation of telehealth projects, to guide future development and investment and to support rural health trainees, researchers and institutions devoted to rural telehealth.

## 6 HEALTH HUMAN RESOURCES

### ***Strategic Direction: Supporting the training, recruitment and retention of health human resources***

- 6.1 That the Minister of Health work with provincial and territorial colleagues to develop a nationwide health human resources strategy, with particular emphasis on recruitment and retention issues for rural, remote, northern and Aboriginal communities.
- 6.2 That Health Canada support a survey of post-secondary educational institutions to identify academic and field-training opportunities and barriers for rural health and Aboriginal health training to establish a benchmark and guide new strategies to address issues related to training rural health care providers.
- 6.3 That Health Canada work with provincial and territorial partners to develop a coordinated action plan to promote health careers to primary and secondary school students in rural, remote, northern and Aboriginal communities.
- 6.4 That Health Canada, together with other federal departments, work with provincial and territorial governments to improve post-secondary health education opportunities for rural students, by exploring strategies such as strengthening existing subsidy programs and promoting investment programs to encourage more rural students to train as health care providers.
- 6.5 That Health Canada work with partners to increase the number of Aboriginal students in post-secondary health programs by augmenting the bursary envelope of the Health Canada Indian and Inuit Health Careers Program, maximizing the use of existing Aboriginal entry programs and spaces reserved for Aboriginal students across the country, and increasing opportunities if needed.
- 6.6 That Health Canada encourage provincial and territorial governments to build on existing curricula and develop new initiatives as needed so that curricula on rural health and Aboriginal health are available in colleges, universities and training centres across the country.
- 6.7 That Health Canada work with provincial and territorial governments and national professional organizations to encourage the creation of opportunities for rural community-based learning for students in the health professions.

- 6.8 That Health Canada, in partnership with other federal departments and the provinces and territories, address the urgency of the health human resources shortage in rural, remote, northern and Aboriginal communities by providing appropriate incentives, facilities and supports for rural health care providers.
- 6.9 That Health Canada, in concert with federal departments and provincial and territorial partners, develop strategies to maximize distance education and continuing professional development opportunities for health care providers in rural, remote and northern communities.
- 6.10 That Health Canada recognize the significant contribution that local health care providers and local citizens make to the health of their communities and work with provincial and territorial partners to provide opportunities for skills development.

## 7 ABORIGINAL HEALTH

### ***Strategic Direction: Promoting Aboriginal-specific healthy community models, national policies and programs that embrace the distinctiveness of Aboriginal cultures***

- 7.1 That Health Canada work with First Nations and Inuit partners as part of the First Nations and Inuit Health System Renewal process, to fully integrate traditional medicine into the current health system for First Nations and Inuit people and ensure new services embrace traditional and western medicine.
  - 7.2 That the Minister of Health work with provincial and territorial colleagues and Aboriginal partners to establish Aboriginal health and wellness centres in their respective health care systems so that all Aboriginal people including Métis and non-status Indians can obtain access to traditional medicine.
  - 7.3 That Health Canada recognize the immediacy of the need to preserve traditional medicine, and ensure that efforts currently being undertaken by national Aboriginal organizations and research institutes are adequately funded.
-

- 
- 7.4 That Health Canada strengthen its community-based health promotion and disease prevention programs by ensuring that specific initiatives are developed and delivered by Aboriginal people for Aboriginal people.
  - 7.5 That Health Canada provide sufficient funding for First Nations and Inuit health services, including non-insured benefits, taking into account the needs of the populations and projected population increases.
  - 7.6 That Health Canada continue to work in partnership with Indian and Northern Affairs Canada, the Aboriginal Healing Foundation, religious institutions and Aboriginal communities to develop a comprehensive action plan with ongoing funding for programs that address the impact of residential schools on the health status of Aboriginal people.
  - 7.7 That Health Canada ensure parenting and family supports are available to all Aboriginal communities in rural, remote and northern areas.

# APPENDIX B

## *List of Members of the Ministerial Advisory Council on Rural Health*

**Dr. Carl Robbins, St. John's, Newfoundland** – A professor of family medicine at the Faculty of Medicine at Memorial University of Newfoundland, practicing physician and formerly health care practitioner in rural communities such as Grand Bank and Labrador City.

**Dr. Bernard Holland, Montague, Prince Edward Island** – A rural family physician from the town of Montague, Prince Edward Island. Also, the Medical Director for the Kings Health Region, and a past Board Member for the Medical Society of Prince Edward Island.

**Ms. Brenda Montgomery, Clementsport, Nova Scotia** – Nurse, educator and recently retired administrator responsible for leading a large rural health board in western Nova Scotia. She is a surveyor with the Canadian Council on Health Services Accreditation and an Honorary Professor at Dalhousie University (Schools of Nursing and Health Administration).

**Mr. Jacques Léger, Caraquet, New Brunswick** – A psychologist and current Director General of the Collectivité Ingénieuse de la Péninsule Acadienne Inc., a demonstration project in the field of information technology also dedicated to sustainable rural development.

**Dr. Réal Lacombe, Rouyn Noranda, Québec** – A family physician who advised the Quebec Ministry of Health and Social Services with its revision of the Public Health Act and on the development of a Provincial Public Health Program.

**Dr. Keith MacLellan, Shawville, Quebec** – A rural physician in practice in Quebec and Newfoundland since 1978. Currently Assistant Professor in the Department of Family Medicine at McGill University.

**Dr. Stanley Vollant, Baie-Comeau, Québec** – Chirurgien général au Centre hospitalier régional Baie-Comeau. Président de l'association médicale du Québec. Il a été désigné Personnalité autochtone modèle par le Gouverneur général du Canada en février 1996.

**Ms. Mary Lou Kelley, Thunder Bay, Ontario** – Professor in the Department of Social Work at Lakehead University and founding Director of the Northern Education Centre for Aging and Health.

**Dr. James Rourke, Goderich, Ontario** – Professor in the Department of Family Medicine and Assistant Dean for Rural and Regional Medicine at The University of Western Ontario; Director of the Southwestern Ontario Rural Medicine Education, Research and Development Network. A rural family physician since 1978.

**Mr. Alexander (Alex) M. Armstrong, Gravenhurst, Ontario** – Retired teacher of 34 years, mostly in rural areas. Board trustee of the South Muskoka Memorial Hospital for the past six years and the Chair for the past year.

**Ms. Avis Gray, Winnipeg, Manitoba** – Public sector health care manager for 25 years, including having served as Provincial director of Primary Health and Regional Director for Continuing Care (Home Care) program.

**Dr. James Dosman, Saskatoon, Saskatchewan** – Director of the Centre for Agricultural Medicine at the University of Saskatchewan and founder of the Rural Health Research Consortium.

**Mr. Bernie Collins, Estevan, Saskatchewan** – Former Member of Parliament, past Mayor of Estevan, and former Saskatchewan Teacher's Federation Councilor.

**Dr. Mamoru (Mo) Watanabe, Calgary, Alberta** – Former Dean of Medicine and recently retired Emeritus Professor of Medicine at the University of Calgary. Member of the National Forum on Health and the Advisory Council on Health Infostructure.

**Ms. Shirley Thomas, Red Deer, Alberta** – Retired Registered Nurse. She has considerable experience in rural nursing and is a former Director of Nursing of a small rural hospital. Former Regional Director (Alberta) Canadian Federation of University Women.

**Dr. Peter Newbery, Hazelton, British Columbia** – A rural family physician and Director of the United Church Health Services with responsibility for its medical work in four hospitals and seven clinics in rural communities in British Columbia and Alberta. Presently Clinical Professor, and Postgraduate Programs Director, University of British Columbia Department of Family Practice.

**Ms. Arlene Thorpe, Dawson Creek, British Columbia** – Community Support Worker at Dawson Creek Society for Community Living and Treasurer of the Dawson Creek and District Hospital Foundation.

**Mr. Colin Kinsley, Prince George, British Columbia** – Current Mayor of Prince George and Vice-President (North America) for the International Association of Mayors of Northern Cities.

**Ms. Alice Isnor, Cambridge Bay, Nunavut** – Former Executive Regional Director (Kitikmeot Region) for Nunavut Department of Health and Social Services.



**Ms. Jeannie Marie-Jewell, Fort Smith, Northwest Territories** – Former Minister of Social Services, instrumental in expanding the Alcohol and Drug Programs in the Northwest Territories, thus eliminating the need to send Northerners south for treatment.

**Mr. Robert Couchman, Whitehorse, Yukon** – Recently retired Executive Director of Yukon Family Services Association and current member of the Legal and Regulatory Table of Revenue Canada’s Voluntary Sector Initiative.

*Ex-officio Member*

**Renée Lyons, Dalhousie, Nova Scotia** – Currently a Professor and Director of the Atlantic Health Promotion Research Centre, Dalhousie University with appointments in the School of Health and Human Performance and the Department of Psychology. She is also Special Advisor to the President of the Canadian Institutes of Health Research on rural and northern research.



*Strategic*