ENHANCING HEALTH SERVICES IN REMOTE AND RURAL COMMUNITIES OF BRITISH COLUMBIA

November 1, 1999

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EXECUTIVE SUMMARY

British Columbia has a population of 3.9 million people, with the bulk of the population residing in the three large urban centres. The balance of the population is scattered over a large landmass characterized largely by mountainous and forested terrain. Communities are small and are often separated by long distances. In many areas surface transport is difficult or non-existent. In winter, transportation between communities can be especially hazardous and time-consuming. Transportation can also be particularly difficult for First Nations populations living on reserves.

With the concentration of the population there is an even greater concentration of specialist services. Tertiary services are confined to the urban areas. Secondary services are varyingly available in the medium and smaller communities in the province, but there are many smaller communities without easy access to secondary specialist services. Primary health care services are generally available throughout the province, but in remote and rural communities there are communities too small to support a general practitioner.

The health status of remote and rural populations is inferior to that of urban populations. The aboriginal population, which is concentrated in the more remote areas of the province, has a health status that is inferior to that of the non-aboriginal population resident in the same area.

This plan to enhance health services in remote and rural communities of British Columbia was developed by the Provincial Co-ordinating Committee for Remote and Rural Health Services and with broader input from health authorities, professional associations, tertiary care facilities, and educational institutes.

It details the committee's direction with respect to the provision of health services in remote and rural areas of British Columbia – in particular primary health care services, aboriginal health services, and mental health services; service delivery issues including co-ordination of outreach services and transportation issues. It is important to note that health authorities are responsible for the planning and delivery of health services in British Columbia. A strong and effective regional governance and health services delivery will only be achieved through enhancing the role of health authorities in integrating and coordinating health services.

Lastly, a workplan has been developed to guide the on-going work of the committee.

ENHANCING HEALTH SERVICES IN REMOTE AND RURAL COMMUNITIES OF BRITISH COLUMBIA

INTRODUCTION

Difficulties with the provision of health services are not uncommon in remote and rural communities throughout British Columbia, Canada and, indeed, in the rest of the world. The problems associated with the development and maintenance of health services in such areas has been the subject of much research in the international community, with documentation in the world literature.

In British Columbia, the special problems experienced in remote and rural communities have received attention by a number of groups, and a series of programs have been established -- each designed to meet the health needs of the remote and rural areas of the province. In spite of much work and expenditure of public funds there remains a belief, that the health needs of the population residing in the remote and rural communities are not being met to the same degree as they are met in the southern urban parts of the province. Rural residents in BC generally have poorer health status. Furthermore, they receive a higher proportion of their care in speciality and teaching hospitals, and thus, have to travel more to receive their health services.

This paper will briefly review advice government has received on these issues. A vision for health services in rural areas will be described. The major initiatives that have been established by government to solve problems will be outlined and a co-ordinated approach for achieving the vision described. Each region and community has its own special needs, but the establishment of a co-ordinated system to address those needs that affect most remote and rural communities should serve as a sound basis on which to build solutions to local problems of health delivery.

A VISION FOR THE FUTURE

The goal of this rural action plan is to enhance the provision of appropriate and timely access to all necessary health services to improve the health of rural residents. Health care services should encourage and support individuals, family and communities to be self-reliant in achieving health.

Access to health services for rural/remote residents may be provided locally, on a permanent or itinerant basis, or through regional and tertiary centres. It is important that services are planned with local involvement and are culturally sensitive. Furthermore, the Ministry of Health in funding and monitoring of services should recognize rural uniqueness and special service needs. Lastly, services must be cost effective and sustainable and should not place an undue financial burden on the client.

BACKGROUND

ADVICE TO GOVERNMENT

In 1991, the Royal Commission on Health Care and Costs identified the importance of the development of a strategy to address the needs of populations in rural and northern areas of British Columbia.

In 1994, a Northern and Rural Health Task Force was appointed to determine the health needs of residents of remote and rural communities and to identify creative and feasible ways to address those needs. The recommendations of the Task Force were to guide policy development at the Ministry of Health and to serve as a resource for Health Authorities (Regional Health Boards, Community Health Councils and Community Health Services Societies). The report of the Task Force, with its 129 recommendations, 42 of which were directly related to the provision of medical services, was released in May 1995.

In 1994, a "Review of Health Services to Aboriginal People in the Prince George Area" was commissioned by the Aboriginal Health Policy Branch of the Ministry of Health. The review was to examine service roles, identify areas of overlap or gaps, and to make recommendations to the Ministry for the integration and co-ordination of services to Aboriginal people in the Prince George area.

A Physician Supply Plan was in place from February 1994 to July 1997. During this period, 125 physicians were recruited to communities eligible for the Northern Isolation Allowance. The courts struck down the Physician Supply Measures in 1997.

In June 1997, the Health Employers Association of British Columbia (HEABC) released a document "Putting the Pieces Together: Strategies for Successful Physician Recruitment and Retention in Remote and Rural BC". This document described the basis of the Physician Recruitment Program developed by the HEABC, in response to the Physician Recruitment Program for Remote and Rural Areas of British Columbia in September 1995, and entrusted to the HEABC.

In June 1998, the Dobbin Report made several recommendations with respect to provider support programs for physicians working in remote and rural communities.

These documents have each set out the problems associated with the provision of health services in remote and rural areas in British Columbia and have also offered solutions. Documents from other provinces and from national organizations have addressed similar issues and have been reviewed, including:

"Report of the Advisory Panel on the Provision of Medical Services in Under serviced Regions," Canadian Medical Association, 1992.

"Pockets of Good News: Physician Recruitment in Rural Alberta," Alberta Health, 1994.

"Small/Rural Hospital Emergency Department Physician Service," Ontario Ministry of Health, Ontario Hospital Association and Ontario Medical Association.

"Provincial and Territorial Initiatives for Recruiting and Retaining Physicians in Rural Areas," Health Canada, 1996.

"Access to Quality Health Care in Rural and Northern Ontario, The Rural and Northern Health Care Framework," Ministry of Health of Ontario, 1997.

"Health for all Rural People," The Durban Declaration, 2nd World Rural Health Congress, Durban, South Africa, 1997.

THE CURRENT REALITY

SOME PROBLEMS ASSOCIATED WITH THE PROVISION OF HEALTH SERVICES IN REMOTE AND RURAL BRITISH COLUMBIA

British Columbia has a population of 3.9 million people, with the bulk of the population residing in the urban centres of southern Vancouver Island, Vancouver and the lower Fraser Valley, and the Okanagan Valley in the central south of the province. The balance of the population is scattered over a large land mass characterized largely by mountainous and forested terrain. Communities are small and are often separated by long distances. In many areas surface transport is difficult or non-existent. In winter, transportation between communities can be especially hazardous and time-consuming. Transportation can also be particularly difficult for First Nations populations living on reserves.

With the concentration of the population into the three large urban areas of the province, there is also a corresponding concentration of specialist services. Tertiary services are confined to the urban areas. Secondary services are varyingly available in the medium and smaller communities in the province, but there are many smaller communities without easy access to secondary specialist services. General practitioner services are usually available throughout the province, but in remote and rural communities there are communities too small to support a general practitioner.

The distribution of physicians and their associated services gives rise to claims of inequitable access to services for those living outside urban areas. On the whole, the per capita expenditures on physician services tend to be less in remote and rural communities than in urban communities. On the other hand, the consumption of acute/rehab hospital days is higher in rural communities. Residents of rural communities use more surgical services than do residents of urban communities. Residents often travel long distances to gain access to secondary and tertiary care. Some residents have to travel long distances for primary care.

The health status of remote and rural populations is inferior to that of southern urban populations. The aboriginal population, which is concentrated in the more remote areas of the province, has a health status that is inferior to that of the non-aboriginal population resident in the same area. In British Columbia, the average life expectancy of aboriginal people is 12 years less than the general population.

The reasons for these disparities in health status and resource utilization between rural and urban communities, aboriginal and non-aboriginal people, may be due to resource availability, established practice patterns, transportation problems and/or differences in need. These issues are not unique to BC; however, there is a need for a greater understanding of the true resource needs of remote and rural communities.

Issues with respect to service delivery in rural communities include:

- Communication between physicians and hospital staffs and aboriginal people is often poor due to cultural and language barriers.
- Sophisticated diagnostic equipment may not be available locally.
- Urban hospitals often fail to accommodate the special needs of patients who have travelled from distant rural communities. Establishing connections between specialists in secondary and tertiary hospitals and physicians in remote and rural communities can facilitate patients' access to these services. Small and rural hospitals, as well as urban hospitals, do not meet the needs upon discharge of patients travelling long distances.
- Community support services (e.g. home nursing, home support worker services) in small isolated communities are not easily available to residents and the services are not co-ordinated with physician services.
- The provision of mental health services is often hampered by lack of physicians trained in psychiatry and by poor access to mental health support services.

Many small communities are well served by health care professionals who recognize advantages of rural practice over urban practice such as:

- greater professional opportunities;
- personal safety;
- strong sense of community; and,
- opportunities for community involvement and/or leadership.

Most often these are people who grew up in a rural environment and prefer to work in the same environment.

However, small communities across Canada often have difficulty recruiting and retaining physicians, nurses and other health care providers. Factors particularly affecting recruitment and retention are:

- working hours are often long in rural practice;
- difficulty with an often unrewarding call schedule;

- difficulty obtaining replacements such as locums and as a result, difficulty arranging vacations, weekends away from the practice, attendance at courses and conferences, etc.;
- few employment opportunities for spouses;
- limited educational opportunities for children;
- few opportunities for professional support; fewer sophisticated recreational activities available for the practitioner and his/her family;
- recently trained general practitioners often believe their training has not equipped them adequately for the broader and more intense demands of rural practice;
- advanced nursing education is also required or of great assistance for practice in many remote and rural areas;
- little co-ordination of recruitment attempts;
- communities sometimes fail to support and welcome a new professional even though the professional was actively recruited; and,
- travel requirements in the course of work and for professional education are often onerous and expensive.

PROGRAMS ALREADY IN PLACE

A. Service Delivery Support Programs

1. Northern and Isolation Travel Assistance Program/Physician Outreach Program

This program provides funding to defray direct travel and accommodation costs for specialists who travel to 29 rural and isolated communities to hold special clinics. The Physician Outreach Program, which began in July 1998, provides an honorarium to physicians for their time spent travelling to the sites. Projected NITA/POP expenditures for 1998/99: $800,000.

2. Other Outreach Programs

The UBC has a Psychiatric Outreach Program under which it funds psychiatrists to travel from Vancouver to outlying regions to provide treatment and to train general practitioners. The program provides adult psychiatric services, child and youth psychiatric services, and suicide prevention programs for children and youths. The Outreach Program raises the level of knowledge and skill among local primary caregivers, through workshops and training programs on topics identified by local practitioners, and uses case consultation as a basis for continuing education.

In addition, British Columbia Children's Hospital, the British Columbia Cancer Agency, and the Arthritis Society all have outreach programs designed to serve the more remote areas of the province.

3. Emergency Medical Coverage Program

Since June 1998, payments to health authorities have been made to ensure after-hours emergency medical coverage is available in communities eligible for the Northern Isolation Allowance. These payments vary according to whether a community has a hospital or not, and the number of physicians providing the coverage. This program recognizes the added service provided by rural general practitioners, in providing emergency medical coverage to a community, is beyond that normally provided for their own patients.

4. *Travel Assistance Program (TAP)*

This program was begun in June 1993. It is a corporate partnership administered by the Ministry of Health. TAP, with co-operation from physicians, facilitates travel fare discounts offered by public and private sector transportation partners, for those who must travel to obtain non-emergency medical care not available in their own community.

B. Provider Support/Incentive Programs

1. Northern and Isolation Allowance Program (NIA)

This program provides a fee premium of between 4.0 percent and 30 percent, for approximately 386 physicians (326 general practitioner/family medicine and 60 specialists, including functional specialists) who live, work, and take calls in 103 rural and isolated communities.

The number of communities eligible for a Northern Isolation Allowance has increased from 69 in 1989/90 to 103 in 1999/2000, with the total number of physicians living and practising in these communities and eligible for NIA at 386 for 1999/2000, up from 212 in 1989/90.

The NIA Program, begun in 1978, is administered by the Medical Services Plan (MSP), funded through the Available Amount (the funding for fee-for-service physicians) and overseen by the Northern and Isolation Committee (MSP/BCMA). Projected expenditures for 1998/99 were $9.2 M.

2. The Northern and Rural Locum Program

This program, administered by MSP, was established to assist physicians practising in small communities to secure subsidized vacation relief. Physicians may access up to twenty-eight days annually in 5-day minimum blocks. In 1998/99, 1,670 days of locum coverage were provided in 165 assignments. Long-term locum coverage was provided to communities that were temporarily without resident physicians.

Under this program, locums are guaranteed $600 per day by MSP. They bill fee-for-service, with billings split 60/40 by MSP (60 percent to the locum, 40 percent to the rural physician). Where billings are less than $600 per day, MSP provides a top up to $600. 1998/99 projected expenditures were $700,000.

College of Physicians and Surgeons of British Columbia (CPSBC)
The College keeps a register of physicians who require locums and a register of physicians who are interested in locum appointments. These two lists are circulated to physicians in British Columbia on a regular basis. Arrangements for placements are left to individuals. The CPSBC does not provide a matching service.

C. Other Programs

1. Health Professionals Recruitment Service – Health Match BC

In 1998, an independent central recruitment agency was developed to provide proactive recruitment of all difficult to recruit health professionals. Health Match BC has an Advisory Council of external stakeholders which includes representatives from the Health Authorities, Union of BC Municipalities, BC Chamber of Commerce, BCMA, RNABC, Central Interior Native Health Society, UBC, Ministry of Health, College of Physicians and Surgeons of BC, BC College of Family Physicians, and the Professional Association of Residents of BC. The service is hosted by the Health Employers' Association of BC.

Health Match BC is currently focused on physician recruitment, but will expand in 1999 to cover other health care professionals. A matching service linking physicians interested in providing locum services with those seeking locums is also available.

The agency represents an enhancement on earlier recruitment service operated by HEABC since 1996. The Ministry of Health funded the startup costs of this enhanced service, which operates with an annual grant from the Ministry and through fees for its services.

2. *Physician Training Programs*

Numerous programs exist to enhance the preparedness of physicians for rural practice. These include:

- ***UBC Family Practice Rural and Remote Program*** - All Family Practice residents are required to complete a minimum of one month training in a rural setting. In addition, 12 of the 26 second-year residents spend 9 months training in rural locations. 57.5% of the graduates who participated in this program between 1982 and 1997, currently practice in rural communities.

- ***Special Skills Post M.D. Training Positions at UBC*** - Eight positions allow rural and urban GP/FP to upgrade their skills where there is an identified community need for those skills.
- ***Rural Postgraduate Medical Speciality Training at UBC*** - Mandatory rural rotations are included speciality training for General Surgery; Urology; Obstetrics/Gynaecology; Adult Cardiology; Respiratory Medicine; Rheumatology and Psychiatry.
- ***UBC Undergraduate Rural Practice Program*** - offers medical students summer employment as apprentices to rural family physician preceptors. A rural exposure of between 4 and 8 weeks was provided to 108 (1997/98) students in 59 locations in BC and the Yukon.
- ***Prince George Teaching Unit*** - offers a two-year residency in Family Medicine in a northern setting. The program was implemented in June 1995, and has a total of 12 residency positions, 6 in first year and 6 in the second year.

3. *Health Education Programs*

Training programs exist for other health care professionals to prepare them for rural practice. These include:

- ***UNBC's Nursing Program*** – offers a certificate in Rural and Northern Nursing, provides experienced registered nurses post diploma undergraduate studies to provide students with the knowledge and clinical skills to provide nursing care in rural and northern community hospitals, clinics, and health centres.
- ***University College of the Cariboo*** – offers a Primary Clinical Nursing Program, a 16-week full-time program to prepare registered nurses for work in rural hospitals, emergency settings and nursing stations.

NEED FOR GREATER INTER-AGENCY CO-ORDINATION

There is an opportunity for improving the co-ordination between these multiple organizations and divisions within organizations. The broad representation and interest expressed for a Provincial Co-ordinating Committee on Remote and Rural Health Services, indicates that many organizations are actively involved in addressing the issues facing rural residents of British Columbia. Indeed, a review of the mission statements and goals of these organizations illustrates a high degree of commonality of interest, and reinforces the need for co-ordinated action in this regard.

The funding envelopes for medical services, pharmacare and ambulance services have not been regionalized and continue to be administered centrally from the Ministry of Health. Regionalization, with the consequent devolution of responsibility for the provision of health care services to geographically defined populations, however, should be used to assist in the solution of the problems associated with the provision of these services to remote and rural communities.

Many of the problems associated with the provision of health services are local in nature. Those involved in their solutions need to have extensive local knowledge and influence. This does not trivialize the contribution that is required from national and provincial organizations, but it suggests that the leadership required, and the responsibility for solution of problems, should reside locally with the Health Authorities.

While much of the problem associated with the provision of medical services can be dealt with as a purely medical problem, it is important to address the associated issue of the place of nursing services in remote and rural communities. The provision of nurses working in expanded roles as sources of primary health care as a complement to physicians will have merit in some communities, either as a part of current practice style, or as part of more innovative approaches to the delivery of medical services. Similarly, it is essential to address the issue of recruitment and retention of other care providers, such as physical therapists. Any community which has difficulty recruiting and retaining physicians is very likely to be experiencing similar difficulties in relation to other providers.

Health Authorities already employ home care nurses, social workers, and home support workers. These providers need to be deployed in remote and rural communities in concert with physicians. The advantage of this approach would be to enhance the services to the populations of the smaller communities. Their services could assist patients who have been discharged from sometimes-distant hospitals, working collaboratively with physicians and other professionals in helping patients avoid admission to hospitals and in providing care which is culturally sensitive to the populations served.

Both the Ministry and the Medical Services Commission continue to have a major stake in the delivery of medical services, by virtue of the fact that MSP retains its role as the physician-paying agency. Within the Ministry, there exist stakeholders in medical service delivery beyond MSP. Acute and Continuing Care has a major interest in the integrity of medical services in hospitals and long-term care institutions, Community Health is responsible for mental health services, including psychiatric care, and for overseeing adequate health services for the aboriginal community. The Legislation and Professional Regulation Division is responsible for delineating the regulatory bases of medical practice and for some policy development concerning health services. The issue of remote and rural medical services carries aspects which cross the boundaries between these four departments within the Ministry.

In order for the Ministry to proceed with the implementation of a plan to resolve issues in remote and rural health services, there needs to be a commitment to a plan. The Ministry can take a leadership role by **co-ordinating approaches to improving access to health services in remote and rural areas of the province.** The need to share information and ideas on health care delivery in remote and rural communities resulted in the establishment of a co-ordinating body in the form of a Provincial Co-ordinating Committee on Remote and Rural Health Services (PCCRRHS), in April 1998.

PROVINCIAL COORDINATING COMMITTEE ON REMOTE AND RURAL HEALTH SERVICES

The three main roles of this committee are:

- *Clearing House* – shares information on "best practices" in remote and rural health service delivery;
- *Advisor* – makes recommendations to the Ministry and Health Authorities for specific policies, programs and standards to address issues affecting health services in remote and rural communities; and
- *Rural Commentator* – reviews and comments on the impact of any policy or program that has a differential impact on health service delivery in remote and rural communities.

Committee membership has been drawn from the following major stakeholders:

Ministry of Health
Faculty of Medicine, University of British Columbia (UBC)
Deans & Directors of Health Service Education Programs
Regional Health Board Representatives (currently 2)
Community Health Council Representatives (currently 7)
Health Association of British Columbia (HABC)
Union of BC Municipalities (UBCM)
British Columbia Medical Association (BCMA)
College of Physicians and Surgeons of British Columbia
Professional Association of Residents and Interns of British Columbia
Society of Rural Physicians of Canada
College of Family Physicians of Canada
Health Employers Association of British Columbia (HEABC)
Registered Nurses Association of British Columbia (RNABC)
Central Interior Native Health Society
Aboriginal Health Association

This committee reports to the Deputy Minister of Health. The Chair is Martin Serediak, Assistant Deputy Minister of the Medical Services Plan. To support the work of the committee, the Primary and Rural Health Services was created within the Ministry in June 1998.

PRINCIPLES

The committee at its May 1999 meeting outlined the following principles to guide its work in the development of programs, policies and standards:

- reasonable and timely access to all necessary health care services is available to residents of remote and rural communities;

- a strong and effective regional governance and health services delivery will be achieved through enhancing the role of local health authorities in integrating and coordinating health services appropriate to rural communities;
- services are cost effective and sustainable and do not place an undue financial burden on the client;
- the knowledge, skills and ideas of all stakeholders are acknowledged, shared and utilized in a respectful manner;
- providers are supported in their efforts to provide excellent service;
- the health care system is evidence based, appropriately funded, adaptive and dynamic reflecting the needs of its residents; and,
- continuous improvement and a focus on those least well served will guide the work of the committee.

ROLES

Numerous stakeholders have important roles to play in the achieving the vision:

- ***Ministry of Health***
  The Ministry of Health is accountable for the provision of health services to the residents of British Columbia. The Ministry is ultimately responsible for setting standards for health services.
- ***Health Authorities and their Associations***
  Health Authorities are responsible for planning and delivery of services within a region. They make decisions regarding resources allocated based on assessed needs and continuously improve quality of care.
- ***Health Care Professionals and their Associations***
  Health Care Professionals provide quality services that meet health system goals. They support clients in taking responsibility for their own care in many cases. Together, with their associations, they provide input into the planning of service delivery models and monitor the quality of care.
- ***Municipalities***
  Local governments support health authorities in the provision of health services including attracting and retaining health care professionals and promotion of healthy public policy.
- ***Non-Government Agencies***
  Many other agencies work with health authorities in the provision of health services and in provision of programs that address the determinants of health.
- ***Patients/Clients/Family Caregivers***
  Users of the health system and their families are invaluable sources of information as to their needs and the quality of services provided to them. They take responsibility for their appropriate use of the services.

- ***Health Researchers and Educators***
  Researchers provide information on utilization and effectiveness of health services that can inform public debate. Training professionals to meet the unique needs of rural communities is the role of health educators.

- ***The Public***
  The public is the ultimate funder of the health care system, and thus, a key participant in an informed debate with respect to improvements to the system.

FUTURE DIRECTIONS

The Provincial Co-ordinating Committee for Remote and Rural Health Services has identified a number of specific strategies for achieving its vision for health care in remote and rural communities. It should be noted that the development of a "Rural Action Plan" will ultimately require integration of the various inter-regional initiatives (detailed below), and the regional services plans being developed by health authorities (beginning in 1999 with the health boards and expanding to include CHSSs by 2000).

A. PROVISION OF HEALTH CARE SERVICES

1. PRIMARY HEALTH CARE

The delivery of primary health care in Canada has been under examination by governments and professional organizations for several years. The advantages of a reorganization of primary health care into a care system which integrates primary medical care with such other services as home, community, and primary care nursing, social services, dietary services, mental health services, physical therapy services, etc. have been articulated in a series of documents during the past five years. Strengthening primary health care involves responsibility for the health of a defined population. Shared responsibility through the use of multi-disciplinary teams and alternate funding methods can support enhanced primary health care. For example, in small remote communities, establishing service contracts between providers and governing bodies, and between providers and patients, may support provision of primary care where traditional funding methods are not sufficient.

The establishment of primary health care organizations, which embody the concepts outlined above, may address many of the current barriers to the satisfactory recruitment and retention of physicians and other health care providers. Practice in small and remote communities would be seen as an acceptable career path rather than a second best to urban practice, or worse still, an alternative not to be considered at all. Opportunities would be created to recruit physicians who have a particular interest in the special practice opportunities provided.

Recommendations:

Health Authorities, working with health care providers, establish a primary health care plan for each community that incorporates innovative ways of delivering health services and would address the issue of deployment of health care providers to meet the needs of the community.

The Ministry of Health explore development of systems and funding options that foster the concept of improved primary health care.

2. ABORIGINAL HEALTH SERVICES

The health status of aboriginal people in British Columbia does not match that of the non-aboriginal population sharing the same environment. "Aboriginal peoples in British Columbia, as elsewhere in Canada, experience very significant health status inequalities in comparison to the general population. Although Aboriginal people have made significant gains in recent years, they still have a much shorter life expectancy and a much higher rate of death than the general population."1

"The factors that determine poor health status in Aboriginal communities are the same as those in other populations - poverty, unemployment, lack of education, inadequate housing, family violence, poor diet, smoking, and lack of empowerment."
A Report on the Health of British Columbians. Provincial Health Officer's Annual Report, 1996.

In some respects, the measures of health indicate the existence of a third world situation within the boundaries of the province. The reasons for the disparity in health status between aboriginal and non-aboriginal populations in the province are multiple. The provision of more health services alone will not solve the problem. What will improve the situation as it relates to health services will be to improve access to primary and secondary services by improving physical access to these services, and by improving cultural access to the same services. In addition, preventative services must be enhanced and must be supported by health promotion activities, directed not only to individuals, but also to whole aboriginal communities.

The provision of health services to aboriginal peoples requires meaningful involvement of aboriginal people in the planning, implementation and provision of services. Services directed towards aboriginal people need to be developed in areas of need. Services in all communities must be culturally sensitive.

1

	Status Indians	Total BC Population
Life expectancy at birth, 1993	66.6 years	78.3 years
Infant Mortality Rate/1000 Live Births, 1994	9.9	6.2

In order to achieve these goals, there is a need to:

- develop information on aboriginal health status that recognizes distinctions between aboriginal people living in remote and rural areas and those living in urban settings; and between status and non-status aboriginal people;
- provide education to non-aboriginal health care providers, who provide services to aboriginal people, on aboriginal cultures and on the development of sensitivity to the cultural needs of aboriginal people;
- increase the availability of aboriginal liaison staff in primary health care practices; staff should be readily available to management, staff and aboriginal clients;
- recruit, where possible, aboriginal providers to serve aboriginal clients; where this is not possible, the selection of non-aboriginal providers should be conducted with a recognition of the special cultural needs of the aboriginal community. The aboriginal community should be encouraged to provide aboriginal healing techniques alongside conventional western health care methods in selected primary health care delivery systems;
- provide integrated primary health care organizations in communities with a large aboriginal population to ensure the cultural needs of the clients are met, while placing a greater emphasis on prevention and health promotion; and,
- enhance the involvement of aboriginal people in the planning and provision of health care in aboriginal communities.

Recommendations:

Health Authorities actively encourage the involvement of the aboriginal community in planning and implementing health services.

Health Authorities work with aboriginal groups for improvement of the health of aboriginal people and develop a primary health care plan designed to meet those goals.

Health Authorities increase understanding and sensitivity of health professionals to the unique needs of aboriginal people.

3. MENTAL HEALTH SERVICES

Access to local and regional mental health services, both assessment and treatment of mental illnesses is a problem to many remote and rural communities. The availability of mental health professionals, psychiatrists, psychologists, is a major constraint on access to appropriate services.

Other issues that are frequently raised include difficulties in ensuring privacy of patients; and the provision of supportive housing and other community based mental health services.

The Ministry of Health's Mental Health Plan is focused on addressing the need for improved mental health services, consistent with the recommendations of the national document, *"Best Practices in Mental Health Reform"*.

Recommendation:

Health Authorities develop local mental health plans that build on existing strengths and which implements the best practices in mental health. Existing services and programs, such as Health Match BC and the Psychiatric Outreach Program, to be examined as to how they might best support mental health programs.

B. SERVICE COORDINATION

1. LOCAL ACCESS - GETTING SERVICES TO RESIDENTS

Thought must also be given as to how services are delivered in remote and rural locations in safe, cost effective ways, on a permanent or outreach basis, which improve access and minimize the need for patient travel.

Provision of Itinerant Services

A recent review of the Travel Assistance Program (TAP) revealed that approximately 50 percent of authorized travel were for consultations with specialists only. Although some of these consultations could not have been provided locally and would require highly specialized expertise, the figures do suggest that more consultations could be provided locally by travelling specialists.

The NITA provides grant funding to communities to pay for the travel costs of visiting specialists. Currently, there are 29 communities funded under this program.

Although, it is not clear how many consultations could be provided locally by itinerant specialists, MSP figures suggest a need for more consultations to be provided locally as a means of reducing inconvenience and travel costs for patients. A needs assessment by each community for each specialty would give an indication of unmet needs, which could be filled by an itinerant specialist service.

The NITA is in place and is described above. In addition, the Minister announced in 1996, a Physician Outreach Program (POP) for remote and rural areas with an assigned $1 million annual funding. The POP program is a major supplement to NITA and should enfold the latter with transfer of funds (approximately $400,000) to supplement the $1 million, giving a total of $1.4 million. The POP needs to be well organized and reliable in its service to the appropriate communities. Groups of communities should be served through hospitals and diagnostic and treatment centres,

which should be asked by Health Authorities to provide outpatient clinic space with receptionist support to accommodate visiting specialists. There should also be space available for the conducting of diagnostic and therapeutic procedures such as endoscopy. The Health Authorities would set up schedules for visiting specialists so that, for instance, a general surgical and a general internal medical clinic would be held at a frequency needed by the local referral load. General medical and surgical clinics may be necessary on a weekly basis in some communities. Subspecialty clinics would be available on a less frequent basis, but again the frequency would depend on projected workload. The frequency of clinics would depend also on specialist availability, but planning should be done on the basis of need in the first instance.

In order to ensure regular and frequent specialist availability, a cadre of specialists in regional centres who would be willing to provide services would be identified by advertising. The specialists would be contracted to provide a certain number of clinics within a fixed period of time of six months or a year. A retainer fee would be paid, as would travel and accommodation costs. Both tertiary care centres and the Faculty of Medicine at the University of British Columbia have significant roles to play in both providing itinerant specialist services, and providing continuing medical education as part of this program. Similarly, it may be advantageous to extend the locum program to include the more heavily used secondary care specialists such as general surgeons and general internists, as well as subspecialty services.

The delivery of primary health care services on an outreach basis in very small, remote communities should also be considered.

Recommendations:

Tertiary care centres, major urban hospitals and the UBC Faculty of Medicine work with local authorities to support enhanced speciality outreach services in a co-ordinated manner wherever they are needed in remote and rural areas.

Existing programs be reviewed and co-ordinated to ensure such programs enhance outreach services for both speciality and primary health care services.

Use of Newer Communications Technology

(i) Telehealth/Telemedicine

Telehealth or telemedicine is the name given to a health delivery system that provides health-related activities at a distance between two or more locations using technology-assisted communications. Currently, worldwide initiatives in telehealth encompass videoconferencing consultations, counselling and communication, medical image and data transfers, multi-disciplinary and specialist support for health workers and patients, education and training, and access to databases for health worker and consumer applications. In addition, algorithm driven telephone triage systems are available. These techniques will become valuable to assist providers in remote areas and will improve access to care for some segments of rural populations where medical services are sparse and where patients may have to travel long distances to obtain care.

Telehealth employs a wide range of communications and electronic management support systems infrastructure including radio, telephone lines, narrow-cast television, CD-ROM, Internet, Intranet, coaxial and fibre-optic cables, microwave and satellite systems. Where there are clear advantages in terms of the improvement in service to patients the techniques should be introduced. These technologies are now easily available and are being used with success in other provinces and countries, such as Australia.

There is a need to co-ordinate the introduction of telehealth projects within the province. An organization needs to be charged with the responsibility of taking advantage of the benefits the newer communication technologies can bring to clients in rural areas by bringing expertise to the patients over great distances. In addition, the benefits to rural health care providers afforded by easier access to on-site professional education need to be understood and exploited. The introduction of these new technologies will require vision and commitment in the absence of a convincing conventional cost benefit ratio determination. The benefits will always be difficult to quantify in financial terms.

Technology can also be used to enhance continuing education opportunities of rural health care professionals. Its use is discussed in the section training of rural health professionals that follows.

Recommendation:

Current applications of Telehealth be reviewed and new applications for improving access to health care services be explored. Barriers to use of technology to enhance services in remote and rural areas of the province be identified and removed.

(ii) Telecare/Selfcare

Technology can also be used to provide information and advice to patients. Telephone triage, of which Telecare is an example, can be used in two ways:

(a) To improve access to care from primary health care providers.
Individuals in remote areas would gain some benefit from telecare, in that exposure to the service may save the patient travel to access care if the triage system indicated to the individual that self-care would be appropriate.

(b) To assist self-care.
Telephone triage has been used successfully in the USA and in New Brunswick to reduce patient visits to emergency departments by diverting care to the patient's own home or to a physician's office.

Recommendation:

The Ministry of Health in conjunction with all Health Authorities in the province explore applications for telecare/self-care.

CENTRALIZED SERVICES - GETTING RESIDENTS TO SERVICES

Even if more services can be provided locally, rural residents will still be required to travel more frequently than other BC residents to receive regional or provincial health care services. Transportation is a high priority issue.

Emergency Transportation

Transportation on an emergency basis is provided through the Provincial Ambulance Program. The British Columbia Ambulance Service (BCAS) provides emergency pre-hospital medical care and ambulance transport to residents of remote and rural British Columbia. Ground ambulances are located in the most populated centres. Air ambulance services are provided through a combination of dedicated prop and jet aircraft and helicopters. Local air carriers are also frequently utilized in remote areas. Enhanced training programs for rural ambulance attendants and the dedication of a fixed-wing, air ambulance based in Prince George have helped to improve services for some rural residents. While the ambulance service is heavily subsidized, the costs to users can still be significant. Evaluation of the existing services continues to be a priority.

Transportation to centralized services of a non-emergency nature

The Travel Assistance Program (TAP) assists residents in defraying the cost of travel for medical services not classified as emergency. This program is provided through the co-operation of the transportation companies. Discounts of varying amounts (up to 100% from BC ferries) are provided for travel. Participants include airlines, although not all airlines participate in the program. The Ministry of Health administers the service. No other costs of the program are borne by the Ministry. Of concern to many smaller communities is that many bus companies do not participate in the program and some residents can not afford even the discounted airfares. Reviews of the Program have shown that the main beneficiaries of the program are residents who are served by ferries.

Local Transportation Barriers

In areas without public transportation system, even transportation to local health services can be problematic.

Recommendation:

Options to be developed to address transportation issues, in conjunction with municipal governments and other committees, such as the Trauma Advisory Committee and the Intensive Care Committee, as appropriate.

D. INFORMATION ON RURAL HEALTH

Information is needed to support decision-making processes. At present, much data is collected by a number of agencies, but little is analyzed and shared. Indicators need to be developed so that real progress can be monitored. This will facilitate the work of the PCCRRHS, as well as Health Authorities and health care providers. It will facilitate informed debate on approaches to be undertaken. Benchmark and best practices need to be identified and shared so that all stakeholders may learn from the success of others.

Information required for decision making may include health status; determinants of health; use of health services; wait-times; referral patterns; satisfaction rates (client and providers); and, expenditures. This data needs to be analysed specifically with respect to residents in remote and rural British Columbia and, as identified earlier, also for aboriginal people.

Developing a solid information base will allow for effective evaluation of different approaches to improving access to health services for rural residents.

Challenges to enhancing data-driven approach include the need to develop standards for data quality including commonly accepted definitions, and the infrastructure to support data collection and analysis.

Recommendation:

The development and use of appropriate data sets to address specific issues affecting the delivery of health services to residents of remote and rural communities be encouraged.

An inventory of currently available data be developed and barriers to its use be identified.

E. REPORTING

The committee has a responsibility to provide regular updates to the Deputy Minister of Health on the state of health care services in remote and rural communities in BC; issues affecting access to health care services; and to make recommendations to address these issues. Members of the committee are also committed to sharing information with each other and with the agencies that they represent. To that end, performance indicators need to be developed and communicated.

Recommendation:

An annual report of the committee be provided to the Deputy Minister of Health evaluating access to health care services by residents of remote and rural communities of BC; identifies issues affecting their provision of health care services; makes recommendations for addressing these issues; and monitors the effectiveness of any changes.

NEXT STEPS

This plan outlines the direction of Provincial Coordinating Committee for Remote and Rural Health Services. Specific activities including timelines and responsibilities are detailed in the ***Enhancing Health Services in Remote & Rural Communities of British Columbia Work Plan***.

APPENDIX A

LIST OF RECOMMENDATIONS

Health Authorities, working with health care providers, establish a primary health care plan for each community that incorporates innovative ways of delivering health services and would address the issue of deployment of other health care providers to meet the needs of the community.

The Ministry of Health explore development of systems and funding options that foster the concept of improved primary health care.

Health Authorities actively encourage the involvement of the aboriginal community in planning and implementing health services.

Health Authorities work with aboriginal groups to improve the health of aboriginal people and develop a primary health care plan designed to meet those goals.

Health Authorities increase understanding and sensitivity of health professionals to the unique needs of aboriginal people.

Health Authorities develop local mental health plans that build on existing strengths and which implements best practices in mental health.

Existing services and programs, such as Health Match BC and the Psychiatric Outreach Program, be examined as to how they might best support mental health programs.

Tertiary care centres, major urban hospitals and the UBC Faculty of Medicine work with local authorities to support enhanced speciality outreach services in a co-ordinated manner wherever they are needed in remote and rural areas.

Existing programs be reviewed and co-ordinated to ensure such programs enhance outreach services for both speciality and primary health care services.

Current applications of Telehealth be reviewed; and new applications for the use of technology in improving access to health care services be explored. Barriers to use of technology to enhance services in remote and rural areas of the province be identified and removed.

The Ministry of Health, in conjunction with Health Authorities, explore applications for telephone triage/self care.

Options to address transportation issues be developed in conjunction with municipal governments and other committees, such as the Trauma Advisory Committee and the Intensive Care Committee.

The unique needs of remote and rural communities need to be addressed within a provincial context. Input into provincial initiatives be provided to the appropriate parties involved in human resource planning.

A template for human resource planning in remote and rural communities be developed to support Health Authorities and local providers in the establishment of dynamic regional human resource plans for communities within their boundaries.

Training needs for health care professionals in remote and rural communities be assessed.

Monitor and provide input into current reviews of health care education programs to ensure an increase the supply of health care providers.

Review programs focusing on the maintenance of competence of current providers, and make recommendations to Health Authorities, Education Institutions and to the Ministry accordingly.

A central recruitment agency be developed and enhanced to provide a co-ordinated approach to recruitment and retention of health care professionals in remote and rural communities

Existing provider support programs in BC and other jurisdictions be identified and evaluated with respect to their effectiveness in attracting and retaining health care professions.

The development and use of appropriate data sets to address specific issues affecting the delivery of health services to residents of remote and rural communities be encouraged.

An inventory of currently available data be developed and barriers to its use be identified.

An annual report of the committee be provided to the Deputy Minister of Health evaluating access to health care services by residents of remote and rural communities of BC; identifies issues affecting their provision of health care services; makes recommendations for addressing these issues; and monitors the effectiveness of any changes.

APPENDIX B

GLOSSARY OF TERMS

Term	Definition	Source
Aboriginal people	All indigenous people of Canada, including Indians, (status and non-status), Metis, and Inuit people (as identified in the Constitution Act 1982)	Nisga'a Treaty background information
First Nation	a) an aboriginal governing body, organized and established by an aboriginal community, or b) the aboriginal community itself	Nisga'a Treaty background information
Insured health services	means hospital services, physician services and surgical dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation	Canada Health Act , Section 2.
Isolated	communities of fewer than 10,000 people, greater than 80 km from a regional centre of more than 50,000 people	Ontario Ministry of Health and OMA Agreement
Medical services	medical services performed by a medical practitioner	Master Agreement between BCMA and government
Metro	Population centres greater than 100,000 and tertiary care centres.	
Non-status Indian	A person who claims aboriginal ancestry but does not meet the criteria for registration, or has chosen not to be registered, under the Indian Act.	Nisga'a Treaty background information
Nurse first call	First call is an approach to care which fully utilizes registered nurses' knowledge and skills to provide primary health care services in the emergency unit and in some situations, calls are received at home. Registered nurses assess, formulate a diagnosis, initiate treatment and discharge patients with minor health problems from the emergency unit. The nurses' practice is supported by evidence-based protocols, developed in consultation with medical staff, which delineate the limits of the care nurses may provide and describe approaches to be used to assess and manage specific problems.	RNABC
Physician services	physician services means any medically required services rendered by medical practitioners	Canada Health Act, article 2.
Primary Care	Primary care is considered to be the first point of contact with the health care system. It involves diagnosis, treatment and follow-up of a specific disease or health problem by health practitioners. When primary care is provided by a physician, it is primary care.	Canadian Nurses Association, 1996

Term	Definition	Source
Primary Health Care **Definition 1**	Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of self-reliance and self-determination . . . . It is the first level of contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process.	World Health Organization
Primary Health Care **Definition 2**	Primary Health Care is that level of care "where the health system is entered and basic services received and where all health services are mobilized and coordinated."	*The Dimensions of Primary Care: Blueprints for Change*. A.W. Parker in: Primary Care: Where Medicine Fails, Andepoulos S. ed; Wiley & Sons, 1974
Primary Health Care **Definition 3**	"Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford. It forms an integral part of the country's health care system of which it is the nucleus ... It is the first level of contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process ... Primary Health Care addresses the main health problems in the community, providing promotive, preventative, curative, supportive and rehabilitative services accordingly."	*Primary Health Care*. A joint report by the Director General of the WHO and the Executive Director of the United Nations Children's Fund. Alma Ata: World Health Organisation, 1978.
Primary Medical Care	Primary medical care consists of a first-contact assessment of a patient and the provision of continuing care for a wide range of health concerns. Primary medical care includes the diagnosis, treatment and management of health problems (conditions); prevention and health promotion; and ongoing support, with family and community intervention where needed.	Canadian Medical Association
Remote	A long way from a tertiary care centre (may or may not be rural).	
Rural area	means territory not organized as a municipality.	Interpretation Act RS Chap 238, section 29
Rural **Definition 1**	a non-urban area where most medical care is provided by a small number of GPs/FPs with limited or distant access to specialist services and high technology health care facilities.	Rourke J. In search of a definition of 'rural'. Can J Rural Med. 1997; 2(3): 113-115
Rural **Definition 2**	in, of, suggesting the country as opposed to urban.	Concise Oxford Dictionary

Term	Definition	Source
Rural Definition 3	Communities of up to 10,000	Report of the Advisory panel on the Provision of Medical Services in Underserviced Regions. Ottawa: Canadian Medical Association; 1992
Rural Remote	rural communities about 80-400 km or about one to fours hours transport in good weather from a major regional hospital	Rural Committee of the Canadian Association of Emergency Physicians
Rural Isolated	rural communities greater than about 400 km or about four hours transport in good weather from a major regional hospital	Rural Committee of the Canadian Association of Emergency Physicians
Rurality	Rurality is assessed using six weighted variables: remoteness from a basic referral centre, remoteness from closest advanced referral centre, drawing population, number of general practitioners, number of specialists and presence of an acute care hospital.	Leduc E. Defining Rurality: a General Practice Rurality Index for Canada. Can J Rural Med. 1997; 2(3): 125-131
Status Indian	Person defined as an Indian under the Indian Act.	Nisga'a Treaty background information
Telephone triage (telecare)	Telephone triage that provides consumers with patient information, assessment and referral service as a first level of care.	
Teleradiology	Basic radiology and nuclear medicine with transmission of images from isolated communities to radiologists in larger centres.	
Urban	Within 120km and 1.5 hours travel time of a tertiary care centre	