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THE FEDERAL ROLE IN RURAL HEALTH

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THE FEDERAL ROLE IN RURAL HEALTH

"The health of rural people is inextricably bound up with the health of rural communities."(1)

This paper looks briefly at how Canada defines its rural population and why people in rural communities might experience particular health outcomes. It then examines the current federal government's efforts to address rural health issues and discusses selected variables that influence the extent of future federal involvement and ability to act on rural health concerns.

THE CONTEXT OF RURAL HEALTH

A significant part of Canada is rural. When population density and geographical location are considered, rural Canada comprises approximately 31% of the population and 95% of the territory.(2) This rural population encompasses people with divergent needs related to age, gender, socio-economic status, occupation and ethnicity, while this geographical space embraces diverse terrain and a mixture of economic activities across resource, manufacturing and service industries.

The 1998 *Rural Dialogue Notebook*, prepared by the federal government for public consultation, observed differences in rural Canada regarding the people and where they live. It stated that "rural Canada includes rural and remote communities and small towns outside major urban centres, whether in the far North or close to major metropolitan cities."(3) It pointed out that, in Atlantic Canada, almost half of the population lived in rural areas and this included a

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(1) William Ramp, "Where do we go from here," in William Ramp, Judith Kulig, Ivan Townshend, Virginia McGowan (eds.), *Health in Rural Settings: Contexts for Action*, Lethbridge: University of Lethbridge, 1999, p. 297.

(2) *Ibid*., p. 17.

(3) Canada, Canadian Rural Partnership, *Questions for Rural Canadians: Rural Dialogue Workbook*, Ottawa, 1998. http://www.rural.gc.ca/overvi_e.htm

majority of the region's Acadian and African-Canadian communities. Also, it noted that across Canada, more than half of the Aboriginal peoples (whether on reserves or in Inuit or Métis communities) lived in rural areas. Other sources pointed out that rural populations continue to decline, particularly as young people leave for educational and employment opportunities and seniors leave to seek greater access to long-term care. At the same time, rural populations in closer proximity to cities or in recreational areas are increasing.(4)

Thus, rural Canada is comprised of many different communities, with diverse languages, cultures, environments, landscapes and economies. Each community in turn faces different challenges in meeting the multiple needs of its population. This variety across people and space makes it difficult to take a single national approach to rural health.

Although approaches to health have never been uni-dimensional or static, the more common viewpoint has been through narrower biological or medical interpretations rather than through broader social, economic, cultural or political contexts. However, Canada's federal, provincial and territorial governments, recognizing that health cannot be achieved solely by the provision of medical services, have moved toward broader approaches.(5) They have taken steps to embrace a population health approach emphasizing that any strategy to influence the health status of a population must address a broad range of health determinants. These determinants include: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.(6)

It is not difficult to see where geography and rural location might fit as an issue that cuts across several of these determinants. The *Rural Dialogue Notebook* indicated that "National figures show that rural areas are different than urban areas: for example, rural areas

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(4) Canada, Rural Secretariat, *Working Together in Rural Canada: Annual Report to Parliament*, Agriculture and Agri-Food Canada, May 2000, p. 18. www.rural.gc.ca

(5) Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians,* Health Canada, Ottawa, 1994.

(6) Health Canada, Population Health Approach website. http://www.hc-sc.gc.ca/hppb/phdd/

have generally higher unemployment rates; formal education levels are lower; and, in many communities, more people are leaving than moving in."(7)

More specifically on health, the federal Office of Rural Health noted that:

> Rural realities and health needs differ from those of urban areas. These needs may be particular to the environment (e.g., the need for education on tractor roll-over prevention), changing demographics (e.g., an increase in the seniors' population in some rural areas), a common health need present in a rural environment (e.g., the health status of First Nations' communities), or the need for health concerns to be expressed in a 'rurally sensitive' way (e.g., obstetrical services that do not generate an excessive 'travel burden' on rural women).(8)

The particular health reality of people living in rural areas can differ not only from their urban counterparts but also from other rural situations. For example, it is suggested that "the average rural Canadian lives 10 kilometres from the nearest doctor" but "the further north you are, the further away the closest physician is."(9) On other perspectives such as employment related to seasonal economies, rural people living in the Prairie provinces have a much lower unemployment rate than do people living in the Atlantic provinces.

The report of the October 1999 Rural Health Research Summit in British Columbia, provided a broad perspective, stating that:

> Those who live in rural Canada know instinctively that their health is compromised, life expectancy is shorter, health care is less accessible, and comprehensive and continuing care is not a realistic expectation. Death rates and infant mortality rates are higher, but so are fertility rates, creating a demographic of young children and older adults associated with a loss of young adults to the urban opportunities. Communities too can be fragile while others have acquired a resilience that is hard to ignore.(10)

As this contextual overview suggests, rural Canada comprises a significant proportion of this country's population and territory. The diversity of the people and the

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(7) Canada, Canadian Rural Partnership, *Questions for Rural Canadians* (1998).

(8) Health Canada, *Rural Health*, Ottawa, 2000. http://www.hc-sc.gc.ca/ruralhealth/

(9) Canada, Rural Secretariat, *Working Together in Rural Canada* (2000), p. 19.

(10) M. Watanabe with A. Casebeer, *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, October 1999, p. 4. http://www.unbc.ca/ruralhealth/

geography pose particular challenges for individual provincial and territorial governments responsible for providing regional health services. For the federal government, efforts to facilitate a broader national perspective sensitive to rural health must be made within pre-established jurisdictional boundaries.

CURRENT FEDERAL ATTENTION TO RURAL HEALTH

Although calls for federal attention to the health concerns of rural Canadians are not new, the late 1990s saw renewed commitment.(11) Federal throne speeches, parliamentary reports and budgets indicated political and financial commitment to the broad infrastructures needed to support rural communities. In 1999, the Prime Minister created the Cabinet position of Secretary of State for Rural Development. On rural health specifically, Health Canada's establishment of the Office of Rural Health in 1998 provided an institutional mechanism for applying the rural perspective to departmental and national health efforts. The following sections explore some of the recent federal departmental and parliamentary actions in the area of rural health.

A. Key Federal Departments Organizing for Rural Health

At the departmental level, Health Canada currently takes a national leadership role in efforts to maintain and enhance the health of all Canadians, including those living in rural areas. It is expected to work in partnership with other federal departments and agencies as well as with provincial and territorial governments. This ability to work in a coordinated horizontal fashion to ensure an integrated approach was a key theme of the 1999 federal framework for rural action. Several of the 11 governmental priorities in the framework have relevance to rural health; in addition to access to health care, these include access to financial resources, human resource leadership development, rural telecommunications and partnerships for community development.(12)

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(11) Canada, Rural Secretariat, *Working Together in Rural Canada* (2000), pp. 9-15.

(12) Federal Framework for Action in Rural Canada. http://www.rural.gc.ca/framework_e.html

Health Canada supports rural health initiatives through multiple efforts:[13]

- *rural health needs* (for example, the Innovations in Rural and Community Health Initiative, and the Canada Health Infostructure Partnerships Program);
- *affected groups* (for example, the First Nations and Inuit Home and Community Care Program, and the National First Nations Telehealth Project); and
- *rural health concerns* (for example, the Health Transition Fund, Centres of Excellence for Women's Health, and the Canada Prenatal Nutrition Program).

In addition to Health Canada's direct role, the first annual report on federal departments' and agencies' actions to meet the federal commitment to rural Canadians cited multiple examples of initiatives by other departments either alone or in partnership.[14] These included:

- Environment Canada with Health Canada helping rural communities make informed decisions through the Community Animation Program on Health and Environment;
- Public Works and Government Services Canada working with Environment Canada to clean up contaminated sites in remote areas and working with Indian and Northern Affairs Canada to improve water and sewage facilities on reserves;
- Industry Canada funding projects to improve the access of rural communities to telehealth services;
- Human Resources Development Canada helping rural communities to increase their knowledge of rural child development and care through Child Care Visions and assisting eligible rural students to pursue post-secondary education through the Canada Student Loans Program;
- Agriculture and Agri-Food Canada supporting food safety and quality through its Canadian Adaptation and Rural Development Fund;
- Veterans Affairs Canada partnering with provincial departments and veterans organizations to enhance access to health information and health technology;

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(13) Health Canada, *Taking Action on Rural Health*, Ottawa: Public Works and Government Services Canada, 2000. http://www.hc-sc.gc.ca/ruralhealth/TakingAction.pdf

(14) Canada, Rural Secretariat, *Working Together in Rural Canada* (2000).

- Royal Canadian Mounted Police addressing rural crime, suicide and family violence through community participation.

As the preceding selective list suggests, rural health is currently seen as a horizontal issue cutting across multiple federal institutions. These federal bodies, in turn, interact with provincial and territorial governments as well as a plethora of non-governmental organizations that represent rural Canadians and rural communities or groups that share an interest in some aspect of rural health. These non-governmental organizations or groups, often called stakeholders or partners, are quite varied in composition and mission. The multiple partners that influence federal rural initiatives include:

- aboriginal entrepreneurs such as Peace Hills Trust and the National Aboriginal Capital Corporation Association;
- youth-oriented bodies such as the YMCA and school associations;
- academic-focused associations for universities and colleges; and
- health professional bodies such as the Aboriginal Nurses Association and the Society of Rural Physicians of Canada.(15)

Different federal ministers with initiatives in the rural health area respond to this diversity in their public interactions with the groups. Although Health Canada interacts with the multiple non-governmental organizations that have a stake in specific traditional and other broader health concerns, it also works with diverse groups on broader health determinants affecting particular populations. For example, during an address to the Canadian Federation of Agriculture (a group representing farmers), the Minister of Health announced plans to create a position of Executive Director of Rural Health.(16) From another departmental perspective, the Minister of Industry spoke with the Empire Club and the Prince George Chamber of Commerce about health technology and particularly information technology for rural and remote areas.(17)

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(15) Canada, Rural Secretariat, *Working Together in Rural Canada* (2000).

(16) Speaking Notes for Allan Rock, Minister of Health, The Canadian Federation of Agriculture Annual Meeting, Ottawa, February 1998. http://www.hc-sc.gc.ca/english/archives/speeches/cfafin.htm

B. Parliamentary Initiatives on Rural Health

Direct parliamentary activities related to rural health were not prominent in the late 1990s. For example, unlike the two earlier Parliaments, no House of Commons or Senate Committee undertook a study specifically focused on the health of rural or remote Canadians during the 36th Parliament (1997-2000).(18)

Parliamentarians of both houses, however, raised the issue through direct questions during debate or in committees studying broader health-related issues. For example, during debate, parliamentarians referred to initiatives by federal departments such as Health Canada or by non-governmental organizations such as the Canadian Medical Association. In committees, the House of Commons Finance Committee in its fall 1999 pre-budget consultations heard from the Society of Rural Physicians of Canada about the need for a national rural health strategy that would provide $150 million a year to fund programs to train, recruit and retain health care providers in rural Canada.(19)

The 1999 federal budget, presented to and approved by Parliamentarians, included $50 million over three fiscal years (1999-2000 to 2001-2002) to support the Innovations in Rural and Community Health Initiative. Of this total amount, $18 million has been set aside specifically for rural initiatives: $11 million for grants and contributions, $2 million for national policy projects, and $5 million to support the Office of Rural Health.(20) By June 1999, the National Liberal Rural Caucus had issued a report to the Minister of Health calling for the development of a national rural health strategy.(21) Several recommendations related to the need for Members of Parliament to have effective tools for gathering information from rural constituents about possible components of such a strategy.

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(17) http://www.ic.gc.ca/cmb/welcomeic.nsf/searchEnglish/$searchForm?SearchView&Seq=1

(18) In earlier parliaments, a 1993 Senate Agricultural Committee report focused on farm stress as an occupational hazard and a 1995 House of Commons report focused on mental health among Indian, Inuit and Métis.

(19) House of Commons, Standing Committee on Finance, testimony from the Society of Rural Physicians of Canada, 9 November 1999. http://www.parl.gc.ca/InfoComDoc/36/2/FINA/Meetings/Minutes/finamn10%288928%29-e.htm

(20) Health Canada, News Release, "Minister of Health announces initiatives to benefit rural Canadians," 12 June 2000. http://www.hc-sc.gc.ca/english/archives/releases/2000/2000_61e.htm

(21) National Liberal Rural Caucus, *Toward Development of a National Rural Health Strategy, Phase I,* Ottawa, June 1999.

Parliamentarians have primarily been concerned with questions of what the federal government might do in the area of rural health. Although sensitive to the fact that most health care services were a provincial responsibility, they noted that many innovations could be and have been facilitated by federal and provincial collaboration. They sought greater understanding of how federal action could be initiated and supported in areas of service and program funding, training of health providers, and research.

DOMINANT IDEAS INFLUENCING FEDERAL ACTION IN RURAL HEALTH

Broadly speaking, the federal government can, and does, work to protect rural health, promote rural health, and support the rural health system. However, in the area of rural health as in others, all its actions now and in the future are influenced by certain interconnected factors characteristic of broader health debate; these include constitutional authority, health strategies, funding mechanisms, access to services, and availability of research evidence.

A. Constitutional Authority

With respect to rural health generally, the federal government's constitutional role is not absolutely clear. It could be argued that, constitutionally, the precise division of power on health as distinct from health care is not defined. In 1982, the Supreme Court of Canada stated:

> … 'health' is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question.(22)

Generally, the provincial governments have powers to regulate local health matters, particularly the delivery of health care services, while the federal government relies primarily on

(22) *Schneider* v. *The Queen* [1982] 2 S.C.R. 112 at 142.

constitutional powers, such as those pertaining to criminal law, spending, and peace, order and good government (POGG).(23)

This criminal law power has been used to authorize actions over conduct that is dangerous to health and forms the base for the *Food and Drugs Act* covering the safety of foods produced rurally as well as drugs used for animals and humans. Other legislation based on the same power such as the *Tobacco Act* and the *Pest Products Control Act* could be seen as having a double-edged effect for rural people; while designed to protect their physical health, the controls could produce detrimental effects on crop production, commodity prices and the overall economic health of the rural community.

In relation to the federal spending power, involvement in health care is pursued through the administration of the *Canada Health Act* and the Canada Health and Social Transfer. The *Canada Health Act* sets certain national standards, and the CHST ensures certain financial contributions to support the health-care system.

The federal POGG power may be a supplementary or alternative avenue to provide for federal legislative initiatives in areas of "national concern" including environmental actions. Other areas that are considered to be extra-provincial in nature and with relevance for rural areas could include the prevention of the spread of disease and the facilitation of interprovincial movement of health professionals. In addition, the federal government – through specific authority for groups such as veterans and First Nations people on reserves – provides direct delivery of some health services. The *Canada Labour Code* can also address the occupational health and safety of employees in federally regulated economic sectors. This allows some oversight of rural occupational health in relevant industrial sectors such as interprovincial transportation, uranium and certain other mines, telecommunications and Crown corporations.

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(23) Dale Gibson, "The Canada Health Act and the Constitution," *Health Law Journal* 4, 1996, pp. 1-33; Martha Jackman, "The Constitutional Basis for Federal Regulation of Health," 5(3) *Health Law Journal*, 1996, pp. 3-10.

B. Health Approaches

The application of different health strategies or approaches is of particular interest in discussions of a federal role in rural health. Most governments, provincial as well as federal, agree that "there is more to health than health care."(24) Provincial health system reviews since the late 1980s have agreed that the definition of health must be broadened and the emphasis shifted from curing to promotion and prevention through community-based rather than institution-based care.(25)

Approaches such as population health and health promotion involve all Canadians and, accordingly, may give the federal government some authority through its constitutional powers. Thus, health approaches that focus on socio-economic determinants may be viewed as appropriate for federal action in rural health when distinguished from a traditional health care emphasis on particular diseases and availability of provincial medical services. Furthermore, any health approach that aims at the promotion and preservation of the health of the broad Canadian population could be distinguished from traditional health care services for sick individuals.

Proponents of the "health is broader than health care" approach claim that overall good health in rural areas is more often determined by policies affecting employment, education, housing and the general economy than by access to health care through physicians and hospitals. Critics, on the other hand, argue that this conceptual approach diverts attention away from meaningful change of existing health inequalities among the rural Canadian population and can lead to major cutbacks in health care services without guarantees that resources will be reallocated. All argue that the federal government will have to commit money, time and political will if it is to effectively develop and implement positive rural health outcomes.

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(24) Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians,* Ottawa, September 1994.

(25) Sharmila Mhatre and Raisa Deber, "From Equal Access to Health Care to Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports," *International Journal of Health Services*, 22(4), 1992, pp. 645-668.

C. Funding Distribution

Money provides the solid financial base for ensuring continuity and stability in initiatives relevant to rural health and well-being. The federal spending power continues as the central basis for health involvement, enabling both direct and indirect participation in rural health as in other health areas.

The best-known federal funding for health is the Canada Health and Social Transfer (CHST). This block fund was intended to give the provinces greater ability to reform their systems to meet particular regional needs, by ensuring that the specific social and health concerns of particular municipalities – including those in rural and remote areas – were reflected in each province's approach. This, in turn, was to give various community sectors – including health, social and educational service organizations – more opportunity to consolidate efforts and to establish joint consultative mechanisms.(26)

Because all the discretion in dividing funds among health care, social assistance and post-secondary education rests with the provinces, it is unclear how much funding goes beyond the health services sector. The same inability to track such CHST funds seems to apply to the additional $21 billion over five years agreed to on 11 September 2000 in the First Ministers' Action Plan for Health System Renewal.(27)

Other funding that could be directed to the broad needs of rural health flow through programs such as those for veterans' and First Nations' health as well as others such as the Health Transition Fund and the Health Infostructure Support Program. For example, Health Canada provides Non-Insured Health Benefits including drugs, medical supplies and equipment, dental care, vision care and medical insurance premiums directly to the Status Indian and Inuit populations and to the Innu of Labrador when these supplies and services are not provided by other provincial or territorial agencies or third-party plans.(28) Of the Health Transition Fund's

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(26) For a general overview of the Canada Health and Social Transfer, see Odette Madore, *The Canada Health and Social Transfer: Operation and Possible Repercussions on the Health Care Sector*, 95-2E, Ottawa: Parliamentary Research Branch, February 2000.

(27) First Ministers' Meeting, *Communiqué on Health*, 11 September 2000. http://www.scics.gc.ca/cinfo00/800038004_e.html

(28) Health Canada, Non-Insured Health Benefits. http://www.hc-sc.gc.ca/msb/nihb/index_e.htm

$150 million for 140 projects, $14 million was earmarked for 27 projects with a rural and remote focus.(29) Even when federal money goes to rural health, it is difficult to measure the effect on rural health outcomes in the four priority areas: home care, pharmacare, primary care reform, and integrated service delivery.

Less directly but very significantly for rural health status, the federal government has had an important role in the health of rural communities through economic means such as farm assistance and insurance programs, supply marketing strategies, transportation services, and infrastructure. As federal policy in these and other areas changed (e.g., privatization of CNR and abandonment of rail lines, the closure of rural post offices, changes to employment insurance), it directly affected rural Canada.

D. Access to Professionals and Facilities

The federal role in monitoring and administering the *Canada Health Act* and its five principles (accessibility, portability, comprehensiveness, public administration, and universality) is important in relation to rural needs for hospital and physician services.(30) Of all the *Canada Health Act* principles, accessibility may be the most significant for rural residents. The executive director of the federal Office of Rural Health noted the rural access problem, stating: "If there is two-tiered medicine in Canada, it's not rich and poor, it's urban versus rural."(31) Rural residents are limited to a smaller range of medical professionals when seeking care and may be less able to avoid (or report) extra billing or user fees.(32) For example, it is estimated that the 30% of Canadians living in rural areas receive care from 15% of the country's physicians.(33) If the insured health services are not available locally, rural residents may have to travel long distances and incur additional costs for transportation and other needs such as hotels.

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(29) Health Canada, Rural Health: Information Backgrounder, June 2000. http://www.hc-sc.gc.ca/english/archives/releases/2000/2000_61ebk2.htm

(30) For general discussion of the *Canada Health Act*, see Odette Madore, *Canada Health Act: Overview and Options*, PRB 94-4E, Ottawa: Parliamentary Research Branch, January 2000.

(31) "New Office to Focus on Rural Health Issues," *Farm Family Health*, 7(1) Spring 1999. http://www.hc-sc.gc.ca/hpb/lcdc/publicat/farmfam/vol7-1/index.html

(32) Therese Jennissen, *Health Issues in Rural Canada*, BR-325E, Ottawa: Parliamentary Research Branch, December 1992.

(33) "Strategic investment needed for rural health," *CMA News*, 10(1), 11 January 2000, p. 6.

The question of medically necessary services, currently limited to hospital and physician services defined by provinces, can have implications for rural residents who want early hospital discharges so they can be close to their families. Any initiatives for home care, pharmacare and telehealth must also be assessed in light of both the *Canada Health Act* and particular rural applications. In relation to telehealth for remote communities, Industry Canada's Community Access Program (CAP) is currently working to connect rural and remote communities to the Internet, a particular problem when basic physical access to single phone lines is still a barrier for many rural households and businesses.

Even with advanced telehealth structures, the recruitment and retention of all health professionals (including nurses, technicians, social workers, psychologists and nutritionists) to remote and rural areas will continue to be an issue. The federal/provincial/territorial ministers of health considered strategies for physician resource management in the early 1990s and by the end of the decade were examining options for all health human resource development.(34) For example, the goal of the October 2000 Nursing Strategy for Canada is "to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed…"(35) Although this document emphasizes that "in keeping with the Agreement on Internal Trade, nurses within Canada should not be restricted from practice in any province/territory,"(36) other analysts have called for attention to the role of federal immigration policy in limiting foreign health professionals. Graduates of foreign medical schools currently face multiple challenges from governments and professional associations when they try to obtain a licence to practice.(37)

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(34) *News Release*, "F/P/T Health Ministers take action on key health issues," 16 September 1999; with respect to access, Ministers received two discussion papers addressing physician services for rural communities. http://www.hc-sc.gc.ca/english/archives/releases/1999/99_pice.htm

(35) Federal, Provincial and Territorial Advisory Committee on Health Human Resources, *The Nursing Strategy for Canada*, October 2000, p. 2. http://www.hc-sc.gc.ca/english/nursing/nursing.pdf

(36) *Ibid*., p. 4.

(37) Health Canada, *Medical Licensure in Canada: Information for Graduates of Foreign Medical Schools*, Online Edition, 1997. www.hc-sc.gc.ca (Search for "medical licensure"; it is the first document listed.)

E. Research

Currently, there are increased calls for "evidence-based decision-making," i.e., basing decisions about health actions on reliable evidence that determines whether particular current procedures, practices or programs are effective or efficient. To gain a fuller understanding of this within the rural health context, Health Canada provided $200,000 to the University of Northern British Columbia to host an invitational Rural Health Research Summit in October 1999. The report from this initiative highlighted the "blueprint" for a health research process inclusive of rural citizens and observed that "Just as rural health issues can be unique, the research needs and approaches required to study and understand rural health are equally distinct." (38)

Access to good health data could mean funding rurally-relevant research and evaluation initiatives (within existing bodies such as the Canadian Institutes for Health Research and the Social Sciences and Humanities Research Council) as well as consistent data collection and analysis on rural populations (within departments and agencies such as Statistics Canada and the Canadian Institute for Health Information). In fact, the newly created Canadian Institutes for Health Research indicated that rural issues cut across the work of several of their individual institutes (aboriginal, health services, etc.) while the Canadian Institute for Health Information is organizing billing data – both nationally and by province – for surgical, obstetrical and anaesthetic services provided in rural Canada. Other organizations, such as the Federal / Provincial / Territorial Canadian Co-ordinating Office for Health Technology Assessment, could provide informed evaluations of rural medical practices and technologies in areas such as telemedicine.

As the Rural Health Research Summit report noted:

- few of the existing funding agencies and foundations have made rural research a high priority;
- the establishment of a Rural Health Research Initiative, a Rural Health Research Secretariat and a Rural Health Research Foundation would demonstrate commitment and to provide continuity for research programs and information dissemination;(39) and

(38) M. Watanabe with A. Casebeer, *Rural, Remote and Northern Health Research* (1999), p. 23.

(39) *Ibid*., p. 9.

- its proposed blueprint for rural health research was congruent with sentiments expressed by the federal government in its declarations on collaborative policy-relevant research and evidence-based decision-making.

In the same vein of collecting comparable evidence for decisions, the September 2000 First Ministers' Meeting adopted an Action Plan on Health that called for clear accountability as well as other elements.(40) This included comprehensive and regular public reporting to Canadians with appropriate independent third-party verification and the requirement to measure, track and report on comparable indicators such as health status, health outcomes and quality of services. Accountability through any "report card" on health should contain measures of outcomes that are relevant to rural populations and their particular situations.

CONCLUDING OBSERVATIONS

- A person's geographic location and associated factors such as social support networks, employment and working conditions, and health services availability influence health status. In Canada, where almost one-third of the population lives in rural areas, more detailed analysis of the connections between rural residency and health is essential.

- Continuous and coordinated horizontal efforts – both among federal departments and among federal, provincial and territorial levels of government – can reduce unnecessary duplication and encourage shared learning about rural health. Any actions in this area – including the ongoing negotiations among federal, provincial and territorial officials as well as annual debates among ministers of health and first ministers – need to be more transparent and accessible to affected rural populations including aboriginal peoples, youth, seniors, farmers, etc.

- Given the breadth and ambiguity of its constitutional powers, the federal government can continue to interpret its powers broadly and carry out key rural health-related activities in the

(40) First Ministers' Meeting, *Communiqué on Health*, Ottawa (2000).

area of health policy development, health regulation enforcement, healthy living promotion, disease prevention, and health service provision to particular populations.

- A broader health approach gives more opportunity for federal involvement to address the multiple factors that determine health (not just the risks and clinical factors related to particular diseases) and to refer to the needs of broad populations (not just single individuals who already have or are close to developing health problems).

- The distribution of health funding in ways that ensure equitable treatment of rural health concerns is not an easy task. Collaborative methods for tagging and tracking CHST transfers and other health-related funding, although difficult to achieve, could produce greater equity and efficiency for rural health.

- From a federal perspective, in addition to a leadership and coordination role, the *Canada Health Act* and various policies related to everything from electronic systems to immigration can affect access, not only to medical care by physicians in hospitals, but also to other essential health professionals in other settings.

- Research has already been directed toward rural health, and the results have been used to guide further work. However, there is still a need to assign a higher priority to research establishing baseline data on rural health status, special needs groups, effectiveness of existing services, differing health behaviours, and other issues.

- Rural health partnerships between rural communities and governments must be based on long-term commitments with full recognition both of geographical barriers that make frequent physical connections difficult and of the time and resource constraints that limit participation by rural Canadians. Partnerships must guard against government downloading efforts and must reflect the diversity of rural communities where populations vary by age, ethnicity, occupational and other factors that determine different health needs.