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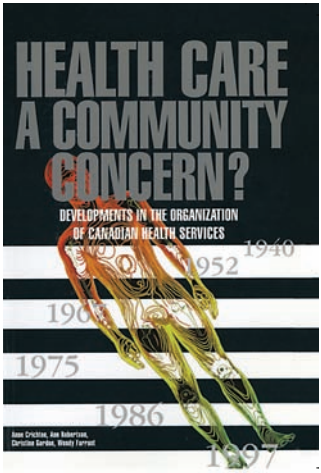

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 14

Rural Health Services

Because of its vast extent, its harsh winter climate and in some provinces, geographical features which make travel very difficult, Canada has major problems in providing universal and equally accessible health care to all citizens.

Although the emphasis in the early days of the shift to collectivist health care organization was put upon universal access to medical and hospital services, this has not been easy to achieve. The provincial inquiries into health service provision conducted in the second half of the 1980s (which will be discussed in Chapter 29) reported that rural dwellers were not satisfied with what was being provided for them. The population is unevenly and widely spread. There are far fewer people living in rural areas than in metropolitan centres and so it is difficult to meet the promise of providing readily available comprehensive care to all Canadian citizens.

As discussed in Chapter 9 the clinical medical care system is organized into regional hierarchies. Tertiary care is given only in metropolitan centres where there are medical schools (or regionally by some arrangement with them), secondary care is available in larger towns and primary care is at the base of the pyramid. But the primary and secondary care physicians are not evenly distributed. There is a clustering of most of them as near to the university teaching centres as they can manage to locate their practices.[1]

There was a growing concern about the distribution of care between metropolitan and rural areas in the late 1980s. Ontario (Rourke 1989), Quebec (Hirsch and Wooton 1990), and the Alberta Medical Association (1989)

1 It is not necessarily the doctors themselves who choose to live in the major cities; often it is their husbands, wives and families who want to be there (British Columbia 1991).

published studies showing how uneven this distribution was. British Columbia's Royal Commission (British Columbia 1991) received many complaints from people living in rural areas. Lee (1988) has reviewed the literature on rural health care. Lepurnam and Trowell (1989) provided information about the satisfactions of family doctors living outside the cities.

Hospitals in Rural Areas

The organization of rural medical care today is closely related to structures set up in the past to try to compensate for this uneven distribution of doctors. When National Health Grants 1948–69 made it easier for rural communities to build hospitals (because they had only to find one quarter of the capital cost) many did so in the hope of attracting doctors to their areas (Taylor 1978).[2]

The offers of grants for hospital construction (i.e., National Health Grants in 1948) were taken up more enthusiastically than the governments had expected, for hospitals, then, were the symbol of collectivist caring. Rational planning of hospitals was conducted by consultants or committees in most provinces (Taylor 1953). (Only Saskatchewan had its own professional planners.) But the plans were often swept aside by back-bench Members of provincial Legislative Assemblies (MLAs) anxious to see these symbols of caring set up in their constituencies. Most provinces found that they were pressured to build many small rural hospitals.

As the roads improved and modern technology was brought into the larger population centres, the smaller hospitals became relatively limited in what they could provide. The governments usually set up secondary referral hospitals in larger rural centres to provide services of specialists who were supported by laboratories and other diagnostic facilities. As well, they encouraged development of travelling clinics staffed by tertiary care specialists who saw patient referrals and provided further training for local doctors to follow up their cases.

Reorganizing the Hospitals

Because travel to the secondary centres is much easier than it used to be, provincial governments have often tried to close rural hospitals, but there has been tremendous resistance (Houston 1990). Hospitals are more than

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2 Some places were too remote for a hospital. There the government might set up a nursing station or the Red Cross provide an outpost. Newfoundland decided on the opposite strategy — to bring people from the outposts nearer into civilization rather than trying to take services to them. That province is well provided with cottage hospitals in larger rural settlements.

treatment centres — they provide local employment and encourage local businesses.

Rural dwellers have argued the necessity for maintaining emergency services and birthing centres closer to home and for many years provincial governments kept the small hospitals open because it was politically suicidal to close them.

In 1993 Saskatchewan finally "bit the bullet." The province was in imminent danger of going bankrupt and it used this as the reason for closing many of its rural hospitals.[3] Although there were strong protests, the New Democratic Party (NDP) government was reelected in 1995 but with a smaller majority, which some have linked to the hospital closures.

Restructuring

If the hospitals could not easily be closed, then perhaps they could be restructured. Alberta and Saskatchewan redesignated some of their small acute care hospitals as extended or personal care homes (Canada 1986b). Texeira (1987) described the way in which Saskatchewan turned some of these small rural hospitals into "community health centres" (CHCs) from 1972 onwards. He said that, if the hospital board could arrange the services of a visiting physician, it could open a centre staffed by a resident nurse on twenty-four-hour call, and recruit part-time staff for laboratory, x-ray and maintenance services. Social services could choose to use the facilities, too, if they so wished. By 1987 there were eleven rural so-called CHCs in the province, three in the pipeline and seven others which, Texeira said, might qualify for financial aid.

Other provinces, such as Nova Scotia (1984), were also interested in turning rural hospitals into outpatient medical clinics. The Valley Health Services Association of Kentville, Nova Scotia, has established a Division of Community Health within the association to provide services to the Fundy region in order to increase the use of outpatient services and reduce hospital inpatient stays. The hospitals have been working together with the public health departments to evaluate the restructured services (Nova Scotia 1990a).

In Manitoba the government has had some success with its CHC policy. The five rural health centres have, by now, been incorporated into a hospital outreach system. The Hamiota District Health Centre provides one example of good horizontal and vertical integration: comprehensive care is

3 In 1971 the Deputy Minister of Health had been anxious to close some of these hospitals.

given through a medical complex attached to an acute care setting. Extended care, elderly housing and continuing care units are also available. All physicians in the area work through the centre and are salaried. A health care team manages individual patient's cases and the continuing care coordinator ensures linkage of services (Beaudin 1989).

Quebec's rational plan for health service development proposed that gaps in service in rural areas would be filled by Centres locaux des services communautaires (CLSCs). Although this took many years to achieve, it was thought that by 1991 there was complete coverage of the province through the provision of 159 CLSCs, many in rural areas.

Some Hospital Outreach Programs for the North

The University of Manitoba has a circumpolar medical centre in Churchill, set up to develop special concern for northern peoples and their particular problems (Medd 1978). Angus and Manga (1990) discussed the development of remote clinics in Ontario, affiliated with city teaching hospitals. These clinics claim to be bringing care to areas which would not otherwise have services. The authors were critical of the development of a hospital rather than a community base for providing such services.

Some Other Hospital Outreach Programs

At a British Columbia Health Association Conference for Rural Hospitals in 1990, five hospitals' outreach programs were described and help was offered to any other hospitals which wished to start up their own programs in outreach for rehabilitation,[4] treatment of chemical dependency, family support services, emergency response to family violence (Coleman 1990) and mental health outreach (Riverview 1990). It may well be asked whether the hospital is the most appropriate place to start these last four programs or whether there are other centres from which community development could be launched. In the British Columbia context these new outreach programs were linked into the experimental Hospital/Community Partnership Program which sought to turn over some of the hospitals' funds to prevention and promotion activities but they were still hospital-based. Now they will be taken over by the regions set up in 1993–94.

Community Home Support Services

If it has been difficult to get doctors to settle in outlying areas, it has often been more difficult to organize community home support services. Thus

4 Outreach rehabilitation services in Northern Ontario were cited as an example (Beggs and Lanthier 1989).

while the cities had the Victorian Order of Nurses (VON) to provide district nursing care, the rural areas were not often served. Consequently patients usually expected to stay longer in hospital. Utilization was likely to be related to availability of resources and there was often an oversupply of hospital beds in rural areas (Northcott and Rall 1983; Pope 1978; Robinson and Evans 1973; Bartel, Waldie and Rix 1970).

However, in the mid 1970s, home care services began to be provided by public health departments, and later, continuing care was organized in some provinces, usually out of health units. And although acute care cases might stay on in general hospitals for a few extra days, these did not always provide outpatient follow-up services for chronically sick or disabled patients who needed intermittent therapy, unless special arrangements were made.

Outreach Rehabilitation Services

Rehabilitation hospitals have argued that it is particularly important that they provide outreach, for many of their patients need extensive social support services to make their readjustments to society, as well as needing continuing medical supervision. Pack (1974) has described the development of rural community support services for arthritis patients in British Columbia, backed up by local hospital services. Attention is also being given to setting up similar programs for children with long-term care problems (Sunnyhill Health Centre 1994a,b).

Rural Mental Health Services

Mental health services in rural areas are usually provided by outpatient clinics of provincial mental health departments because rural hospitals seldom have psychiatric specialists on staff. Efforts are now being made to train family practitioners in psychotherapy (Trent 1990) and some universities have developed travelling clinics. Richman (1989) has discussed the problems of general practitioners in deciding how to cope with psychiatric problems.

Kyle (1985) listed a number of alternative approaches to rural psychiatric care — the psycho-educational approach, lay counselling programs, residential retraining programs in life skills, therapeutic caring for disturbed children, community supported housing for disturbed individuals in a rural centre of treatment. These British Columbia services have been well publicized by the federal government. A report on the conference of mental health workers from the western provinces (Canada 1984) addressed questions of personal, professional and program survival in rural areas.

Development of Greater Concern for Rural Health Care

The provincial health reviews of the 1980s have laid out the problems of providing egalitarian care in rural areas. Now it is an issue which governments cannot ignore.

The problem of rural health care is not only one of medical care distribution. Many rural dwellers are poor. They have gone to find cheap living accommodation out of the cities. The Active Health Survey (Canada 1985c) found that there were many Canadians with low incomes whose lifestyles were not healthy. This suggests that there is a need for other kinds of support services to help such minority populations. Because Quebec's provincial inquiry looked at both medical care and social services, this province has identified a number of social issues which need to be tackled together with providing physicians' services in rural areas if the population is to be kept well (Quebec 1988).

Summary

Canada has found it difficult to provide universal, comprehensive and equitable health care to people living in rural areas, partly because of the way in which the medical profession is organized into regional hierarchies located mainly in the larger cities, and partly because of the more advanced technology which requires complex services to be centralized. But great efforts have been made to establish up-to-date secondary level treatment centres and travelling clinics across the provinces. Public health departments have moved into providing community home support schemes in rural areas.

Hospitals were overbuilt from 1950 to 1969 when it was easy to get hospital construction grants. But it is politically difficult to close any hospital. Many rural hospitals have been restructured into outpatient clinics or extended care homes though some provinces are now committed to closing down unneeded hospitals.

The provincial health reviews, 1984–91, identified many gaps in their systems of rural health care. Some provinces have developed community health centres in rural areas and outreach programs have been established in rehabilitation and mental health sectors. Despite these changes it is known that many rural dwellers are poor and that they need social supports as well as medical care, and there is still much that needs to be done to provide comprehensive care for these people.