

Frontline Health Care in Canada: Innovations in Delivering Services to Vulnerable Populations

**David Hay
Judi Varga-Toth
Emily Hines**

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By

**David Hay
Judi Varga-Toth
Emily Hines**

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Contents

Executive Summary	iii
1. Introduction and Overview	1
2. Research Questions and Methods	3
3. Profiling the People on the Frontlines	4
3.1 Rural Populations in Canada	4
3.1.1 <i>What Is Defined as Rural, Remote, Northern?</i>	4
3.1.2 <i>Health Status of Rural, Remote and Northern Canadians</i>	5
3.1.3 <i>Access to Health Care in Rural Canada</i>	6
3.2 Inner City and Marginalized Populations in Canada	10
3.2.1 <i>What Is Defined as Inner City?</i>	10
3.2.2 <i>Health Status of Inner City and Marginalized Canadians</i>	11
3.2.3 <i>Access to Health Care in the Inner City</i>	13
3.3 Determinants of Health in Inner City and Rural Canada	14
4. Frontline Health Services in Canada	16
4.1 Rural, Remote, Northern and Aboriginal Communities	16
4.1.1 <i>Access Points</i>	16
4.1.2 <i>Gaps in Access to Primary Health Care Services in Rural Canada</i>	25
4.2 Inner City and Marginalized Communities	27
4.2.1 <i>Access Points</i>	27
4.2.2 <i>Gaps in Access to Primary Health Care Services in the Inner City</i>	33
5. Policy Perspectives for Frontline Health	35
5.1 Why Are Some People Healthy and Others Are Not?	35
5.2 Who Is Responsible for Community Health and Well-Being?	36
5.3 Supporting Community Innovation	37
5.4 Health Services, Access and “Waiting Times”	38
6. Conclusion	40
Our Support	95

Appendices

Appendix 1.	Project Team Profile	43
Appendix 2.	CPRN Profile	47
Appendix 3.	List of Documents Reviewed	50
Appendix 4.	List of Web Sites Accessed	65
Appendix 5.	Data Gathering Framework/Approach	73
Appendix 6.	Key Informants	76
Appendix 7.	Key Informant Interview Guide – General	86
Appendix 8.	Key Informant Interview Guide – Researchers and Academics	91

Boxes, Figures and Tables

Box 1.	A Snapshot of the Rural Population in Canada	5
Box 2.	Health of Aboriginal Peoples	6
Box 3.	A Snapshot of the Inner City Population in Canada	10
Box 4.	Health Status of Off-Reserve Aboriginal Populations	12
Box 5.	Comparison of Similarities and Differences of Determinants of Health in Inner City and Rural Areas	14
Box 6.	Community Wellness Initiative, Arviat, Nunavut	17
Box 7.	United Church Health Services, Hazelton, British Columbia	17
Box 8.	All Nations' Healing Hospital, Fort Qu'Appelle, Saskatchewan	18
Box 9.	Telehealth	18
Box 10.	Islands' Health Centre, Freeport, Nova Scotia	24
Box 11.	NorFam Medical Training in Goose Bay, Newfoundland and Labrador	27
Box 12.	Women's Health in Women's Hands	28
Box 13.	Aboriginal Health and Wellness Centre, Winnipeg, Manitoba	29
Box 14.	An Innovative Initiative: Ottawa Inner City Health (OICH)	32
Figure 1.	The Determinants of Health	35
Figure 2.	The Well-Being Diamond	37
Table 1.	The Research Framework	3

Executive Summary

AstraZeneca Canada commissioned Canadian Policy Research Networks to conduct research and prepare a report on “frontline health” in Canada. The purpose of the report was 1) to better understand the nature of populations in Canada who are unserved or underserved by the mainstream health care system, in particular people in rural and remote communities, people living in the inner city, and people living in conditions of poverty and low income; 2) to explore and describe the nature of frontline health services; and 3) to describe the public policy environment in which patients and providers on the margins have been operating. The research was carried out using qualitative research methodologies including environmental scans, literature reviews, key informant interviews and site visits.

Profiling the People on the Frontlines

The diversity of urban populations and significant gaps in research, data collection and comparative analysis of sub-populations makes it difficult to comprehensively describe the overall health status of urban marginalized groups. It is clear, however, that some sub-populations living in urban areas are facing challenging economic, social and environmental conditions with one result being poor health. Conditions that determine health such as education, employment, housing, and food are less than adequate for some Canadians living in urban areas. Health care can help, but vulnerable urban populations often face difficulty in accessing mainstream health care services.

The health status of the population living in Canada’s diverse and distinct non-urban regions, including rural, remote and northern regions, is lower than that of their urban counterparts. Aboriginal peoples (First Nations, Metis and Inuit), in particular, tend to have the poorest overall health status in Canada. Rural, remote and northern populations exhibit a set of health needs influenced by aging, depopulation, poverty and occupational hazards. Health needs for rural, remote and northern populations may be particular to the environment, geography, changing demographics, a common health need present in a rural environment, or the need for health concerns to be expressed in a “rurally sensitive” way.

Critically important to the health of vulnerable Canadians living in both urban and rural areas are issues related to social causes of ill health. The problem is not, or certainly not only, lack of health care provision, inappropriate health care delivery systems, and barriers to accessing care. While access to health care is one “determinant” of health, it is only one of a long list of factors that research has clearly demonstrated significantly affects the health of populations. Furthermore, while there are similarities in determinants of health in urban and rural areas in Canada, there are also significant differences. This fact argues well for the appropriateness of community-based frontline health responses to health care needs – because they have the ability to respond to local determinants of health.

Frontline Health Services in Canada

The frontlines of health care provision exist wherever there are people unserved or underserved by mainstream health care in both urban and rural areas. Frontline service providers offer health care to geographically, socially, economically and culturally marginalized populations in inner city and rural Canada. Frontline providers are people, programs and organizations that deliver health care to these people and populations facing barriers to accessing health care.

This research report highlights a number of innovative, creative and effective health care models that are struggling to deliver frontline care and services to marginalized populations, in spite of extremely challenging conditions and demands.

Comprehensive data on access to frontline health care services in urban areas is limited. While this is a challenge that should be addressed, we do know that there are several points at which marginalized populations in urban areas typically access health care services, including: community health centres, specialized health initiatives, and hospital emergency departments.

There are many health care services that are not being provided adequately or appropriately to marginalized populations resident in inner city areas. These gaps in health care provision tend to vary by population and community. Some gaps in service are unsurprising and speak to chronically underserved health needs; others are emerging as areas of increasing need spurred by economic, political, social and cultural changes in society.

Canadians living in rural, remote and northern regions of the country experience more health care challenges compared to those living in Canada's cities and towns. Access to health care services in rural Canada is more restricted than in urban areas. This is often due to distances, and the struggle to attract and retain nurses, doctors and other health care providers.

The most common health service access points for rural residents are family physicians, small rural hospitals, community health centres or clinics, nursing stations and mobile health units. There is often a great deal of overlap between these access points, as, for example, most rural hospitals are staffed by local family physicians. Generally speaking, the further away a rural community is from an urban centre the fewer the options for health care services and the less specialized the service providers are.

Gaps in access to health care services in rural Canada are many. Similar to inner city gaps, some gaps can be categorized as chronic as they have existed for a significant period of time or since a particular health challenge has existed. Others can be defined as emerging gaps, as the gap in access is due to recent phenomenon and current trends. And yet others are gaps or challenges at the system-wide level.

Issues and Challenges for Frontline Health Care

- *Inadequate Training:* Health care professionals are not always adequately trained in the health care issues specific to inner city or rural populations.
- *Overall Shortage of Health Care Professionals:* There is a recognized shortage of health care professionals and providers right across Canada and in rural, inner city and isolated areas, the understaffing of emergency medical services is particularly acute. There is also a critical shortage of nurses especially in the north and far northern communities.
- *Conflicting Funding Models:* Community Health Centres operate as non-profit organizations with the majority of funding coming from government or health authorities, with some funding from private foundations and donors. Funding comes attached to specific reporting and evaluation criteria that are not standardized. Global funding would allow for more efficient and effective management.
- *Lack of Community Health Centres (CHCs):* The number of rural CHCs is small but the potential to offer more comprehensive health services to rural residents is high.
- *Inadequate Services in the Suburbs:* More health care services are needed, particularly for marginalized populations in the urban periphery and not just in the downtown core.
- *Lack of Integrated Care:* It is recognized that integrated care is more successful in improving the health status of marginalized populations. This is especially important for vulnerable clients who may see several different health care providers to address their health care needs.

Policy Perspectives for Frontline Health

The “determinants of health” are the factors that interact to affect personal health and well-being. Generally, there are three kinds of factors:

- *Personal Attributes and Acquired Behaviours* – biology and genetic endowment, healthy child and youth development, and personal health practices and coping skills
- *Physical Environments*
- *Social and Cultural Resources and Environments* – income and social status, education, social support networks, employment and working conditions, social environments, health services, gender and culture/ethnicity

Research has shown that social issues appear to explain more about variations in health and well-being than do any combination of individual factors. A focus on social issues also reinforces that individual and physical environment factors have social aspects (e.g. obesity is dependent on the quantity and quality of food available, and the available opportunities for physical activity).

Still prevalent in Canada is the thinking that to address the health needs of Canadians we need more of the same: e.g. doctors, nurses, hospitals; or, delivering the same thing in a different way: e.g. redesign of services, community-based care. But health services are only one of many

determinants of health. It is important to understand the interdependence of the determinants and their ability to influence health. No one determinant on its own can guarantee good health for the population. Health services are certainly essential, but a number of other things are also essential – work, environmental conditions, income, genetics, social networks, gender, culture, and so on.

It is at the community level, of course, where the connections between health and its influences are clear. And, it is at the community level where individuals and organizations take action through community innovation. Innovation is about finding creative and concrete ways to deal with social and economic problems so as to make a real difference in the lives of people in the community.

Innovation sits deep within the community sector. With its in-depth knowledge of the community, capacity to mobilize volunteer and professional resources, creativity and entrepreneurial skills, and the ability to take a holistic approach to social and economic challenges, communities can find solutions to community challenges that cut across sectoral and jurisdictional boundaries and limitations. They find local community responses to local community problems.

There are major challenges facing the community sector in Canada, however. Financial sustainability is of primary concern, with a large part of the community sector dependent on governments for large parts of their annual budgets. Over the last 25 years, governments have been cutting back on their funding for community organizations. Human resource challenges are also significant – with lower compensation levels than the private sector it can be difficult for community organizations to attract and retain skilled and competent staff, and this is particularly true at the management level. Community organizations also depend on volunteer resources – as staff to deliver programs and services, and as board members to govern and direct the organization's activities – and the number of Canadians who actively volunteer is declining.

Frontline health services can generally be characterized as primary care services, although some of the services provided have a specialized focus (e.g. substance abuse, sexually transmitted disease). The current debate and dialogue in Canada on access to health care is essentially restricted to consideration of waiting times for access to certain primary care diagnostic tests and treatments (e.g. joint replacements, cancer treatments).

A truly accessible health care system demands discussion about access to a range of services and service providers that are currently not part of the debate about wait times. There is consensus that an accessible health system provides the right service at the right time in the right context. Frontline health services can be conceived as a response to that goal.

Conclusion

The Frontline Health Report clearly addresses the question, “What can be done to ensure support for frontline health services in Canada?” Support begins with recognition, and while there are no simple answers, the report provides a broader understanding of frontline health in Canada.

Our research has shown that while the needs and issues of frontline populations are diverse, they commonly face restricted access to health care due to geographic, social or physical barriers.

Similarly, frontline health providers must also deal with common barriers such as geographic and social isolation, insufficient training and services, inadequate networks and support, and inappropriate funding models.

Frontline health service professionals strive to find a way to meet the needs of their respective communities. Innovation is always evident in the daily activity of providers. Across Canada, community health centres, community organizations, innovative initiatives, hospitals and mobile services are attempting to creatively address the health needs of marginalized and rural and remote populations.

There are a number of innovations in how frontline health care is being delivered:

- Building partnerships among frontline health providers, public agencies, faith-based and other community organizations, and other allied health professionals;
- Developing new education, training and support models that help to attract, prepare and retain frontline medical professionals;
- Specific models of care for particular populations, e.g. women, ethnocultural groups;
- Taking care and services out to the community, e.g. community health centres, street-based outreach programs and mobile services;
- Using technology such as virtual communities and telehealth (psychiatry, home care, psychology, diagnostic services, etc.);
- Utilizing interdisciplinary teams and integrated service models that combine health services with other social services, i.e. “one-stop shops”;
- Undertaking community economic development initiatives that provide services, skill development and income for individuals and agencies; and
- Adopting new funding models, e.g. moving from fee-for-service arrangements to salary; putting organizations on global budgets.

In talking with the people living and working on the frontlines, our research has found that frontline health services need more than recognition. They also need adequate staffing, financial resources, management, infrastructure, networks, partnerships and technology to sustain them.

There also needs to be a broader acknowledgement that frontline health services will be needed more and more if action is not taken to address the underlying social causes of many of the health problems faced by the people living on Canada’s frontlines. The more attention given to these health issues and determinants and the more we draw upon those successful and innovative models for delivering health care services to marginalized populations, the less pressure there will be on these health care services.

Please Note:

For a more detailed summary of this report, see the *Research Highlights of Frontline Health Care in Canada: Innovations in Delivering Services to Vulnerable Populations*.

Frontline Health Care in Canada: Innovations in Delivering Services to Vulnerable Populations

1. Introduction and Overview

The purpose of this report is to tell the story of frontline health in Canada. In simplest terms, there are two sides to the frontline health story – the people and the providers.

There are many people and communities in Canada that are vulnerable and at risk, i.e. they exist on the margins (geographic and social) of mainstream society. These populations in Canada are very disparate – from people living in rural and remote parts of Canada to street youth to isolated seniors – and include low-income individuals and families, people without shelter, recent immigrants and refugees, Aboriginal peoples, and so on. While we have a broad sense of who these people are, we need to know more about these groups in Canadian society and how they are served by Canada's health care system. The focus of this research is populations who have difficulty accessing or don't have access to mainstream health care services in both urban and rural areas.

Research demonstrates that there are a number of factors that determine health beyond availability of and access to health care. These factors, or determinants of health, often occur well before a person becomes ill or seeks out health care. The range of factors includes food, housing, poverty, education, child development, gender, genetics, work conditions, physical and social environment, health practices, social networks, and culture. These factors are critically important in shaping the overall health of a population. Differences in people's access to these factors can create differences in people's health. Understanding the interdependence of these health determinants is critical; promoting good health for any given population must not only take health care services into account, but also other determinants of health.

Frontline health services are as wide-ranging as the populations they serve. For the most part, the services and service providers are isolated from one another. Who are the providers that are helping and serving people in both urban areas and rural and remote communities across Canada? What do we know about what they do and how they do it? What kinds of services do they deliver? What innovations do they create to address the challenges facing these populations in their communities? Who supports frontline health care providers in their work?

Primarily, current public policy debates about health care in Canada have not engaged in discussions about frontline health. What is the public policy environment in which patients and providers on the margins have been operating? What is the current level of support from various levels of government to broaden access to health services for underserved populations? What has been the trend with respect to such support? What assumptions underpin public policy initiatives in this critical area? By better understanding the playing field as it exists, we can identify some gaps and possibly some opportunities.

The purposes of the study are three-fold: to better understand the nature of populations in Canada who are unserved or underserved by the mainstream health care system; to explore the nature of frontline health services; and to describe the public policy environment in which patients and providers on the margins have been operating.

This project attempts to answer these three main questions to tell the frontline health story – an important and neglected aspect of Canada’s health care story that needs illuminating. From what we know, people who are marginalized, vulnerable and at risk have needs that can, and do, go unmet. Frontline health care providers attempt to meet those needs and fill the gaps. This research report contributes to our understanding of the needs of these populations, and those on the frontline who work to provide them with health care services. The report also highlights findings that have implications for public policies that can further develop, support and sustain these initiatives.

There are four main sections that follow. Section 2 outlines the research questions and data gathering framework. Section 3 describes populations with barriers to accessing the mainstream health care system in rural, remote, northern and urban areas in Canada. Section 4 describes frontline health providers in Canada by answering the question, “who is doing what to serve whom?” Section 5 provides an overview of the policy context in Canada for understanding frontline health. Section 5 closes with a synthesis of the preceding sections to provide a summary of the issues including successes, challenges and policy implications.

2. Research Questions and Methods

Qualitative research methodologies were used for the project. These included environmental scans, literature reviews, Key Informant (KI) interviews (by telephone and in-person) and site visits.

The research framework is outlined in Table 1. The three study objectives, associated research questions and the data collection methods are listed. Appendices 3 and 4 list the documents reviewed and Web sites accessed and scanned. Appendix 5 includes the research protocol for the Key Informant interviews and site visits. The Key Informants interviewed are listed in Appendix 6. Appendices 7 and 8 contain the Key Informant Interview Guides.

Table 1. The Research Framework		
Research Objectives	The Key Questions	How the Data Was Collected
1. To better understand the nature of populations in Canada who are unserved or underserved by the mainstream health care system. The focus will be: people in rural and remote communities; people living in the inner city; and people living in conditions of poverty and low income.	<ul style="list-style-type: none"> • What are the characteristics of the populations in question? • How many are there? Is this number growing or shrinking? Why? • What are their needs as they relate to health, broadly understood? • How and where do they access health services? • Which needs are currently unmet? • Can priority areas of concern be identified? 	<ul style="list-style-type: none"> • Primary method: environmental scan and literature review • Secondary method: KI interviews and site visits
2. To explore the nature of frontline health services.	<ul style="list-style-type: none"> • Who are the providers that are serving people in rural and remote communities, in the inner city, and people living in poverty? • What do we know, about what they do and how they do it? • What kinds of services do they deliver? • What innovations do they create to address the challenges facing these populations in their communities? • Who supports frontline health care providers in their work? 	<ul style="list-style-type: none"> • Primary method: environmental scan • Secondary method: KI interviews and site visits
3. To describe the public policy environment in which patients and providers on the margins have been operating.	<ul style="list-style-type: none"> • What is the current level of support from various levels of government to broaden access to health services for underserved populations? • What has been the trend with respect to such support? • What assumptions underpin public policy initiatives in this critical area? • What are the gaps? The opportunities? 	<ul style="list-style-type: none"> • Primary method: literature review • Secondary method: expert advisors comments

3. Profiling the People on the Frontlines

3.1 Rural Populations in Canada

3.1.1 What Is Defined as Rural, Remote, Northern?

Within Canada there are many diverse non-urban regions including rural regions, remote regions and northern regions – and each is distinct.

Rural areas are defined as communities with a population of fewer than 10,000 people. This is the definition used by Statistics Canada and called Rural and Small Town Canada. Rural areas can be further classified by how far they are from a major urban centre. Using Statistics Canada's definition, Canada's rural and small town population now represents 22 percent of Canada's population (Statistics Canada, 1998).

Some other government departments and national bodies (e.g. Health Canada, the Society of Rural Physicians) use other definitions of rural. The Organisation of Economic Co-operation and Development (OECD) defines a community as being "rural" if its population density is less than 150 people per square kilometre. Using this definition, the federal Rural Secretariat indicated that in 2001 over 30 percent of Canadians – nearly nine million people – lived in predominantly rural regions.¹

Remote communities are sometimes regarded as a subset of rural communities; however, not all remote communities are also rural – some are simply remote. In order to make a distinction between rural, remote and northern, it is helpful to look both at population density and also the socio-economic basis of a community. A community made up of small agricultural producers intimately tied to the broader economy is different from a similarly sized community rooted in subsistence hunting and trapping with limited economic ties to the broader economy. For example, Bethune, Saskatchewan is rural but not remote because it is 40 minutes from Regina. Holman, Northwest Territories, on the south shore of Victoria Island and accessible only by air and ship, is remote but not rural – it's northern. The social and economic bases of these communities change the ways that the broad set of factors affecting health play themselves out and make remote communities qualitatively different from rural communities.

Census data reveal that an aging population, declining birth rates, and out-migration are resulting in the depopulation of Canada's rural areas, municipalities and smaller cities.² While some rural areas are experiencing population growth either due to higher birth rates, such as Nunavut, or due to in-migration from other parts of Canada, such as rural Alberta oil patch communities, the overall trend towards rural depopulation is accurate for most provinces. The most affected provinces are the Atlantic and Prairie provinces and the most affected rural areas are the more remote ones in any province. In fact some rural areas in close proximity to larger urban centres are growing due to urbanites' desire for a "country life" near to amenities they value.

¹ See www.rural.gc.ca/research/note/note1_e.phtml.

² See http://canada.metropolis.net/events/conversation/conversation_summary_9.pdf.

Generally, rural Canadian's exhibit a set of health needs influenced by aging, depopulation, poverty and occupational hazards.

Box 1. A Snapshot of the Rural Population in Canada

- Rural Canada's population tends to be older than the urban population.
- On average, Canadians in rural areas are less educated than those in metro areas (Micro-Economic Monitor, 2001).
- Within each province, the income in rural regions is lower than the income in urban regions.
- Average income in rural regions was \$19,491 in 2000 compared to in urban regions, which was \$24,248.
- "In 2000, 14% of Canada's rural population as a whole had average incomes below Statistics Canada's low-income cut-off. This was in contrast to urban regions of Canada, where the share of people with low incomes was 18%" (Statistics Canada RSTC Bulletin, Vol. 5, No. 7, 2004).
- "Predominantly rural regions have a higher concentration of unskilled occupations, within most industries, compared to predominantly urban regions and, during the 1990s, predominantly rural regions tended to become more intensive in unskilled occupations, within most industries" (Statistics Canada RSTC Bulletin, Vol. 5, No. 6, 2004).
- The retail and wholesale trade sector is the biggest sector of employment in rural Canada with manufacturing another top sector, particularly in Nova Scotia, New Brunswick, Quebec, Ontario and the primary sector in the Prairies and Prince Edward Island (Statistics Canada RSTC Bulletin, Vol. 2, No. 6, 2001).

3.1.2 Health Status of Rural, Remote and Northern Canadians

According to research experts, rural Canadians have a much lower health status relative to other Canadians. This means an increased need amongst rural Canadians for the whole range of health services while at the same time having the lowest or most limited access to the health services they need. The health status of rural residents is inferior to urban Canadians on almost all indicators, including lifestyle related illnesses, injuries, cardiovascular diseases, poisoning, infant mortality, and life expectancy.³ Farming has been called by one researcher "one of the most dangerous occupations in Canada" and statistics show that mining is *the* most dangerous, thus putting rural workers at a much higher risk.

Generally, the health status of rural, remote and northern residents is lower than that of their urban counterparts, decreasing as one moves from areas bordering urban centres into extreme remote regions. The Romanow Report spoke of the "inverse care law" phenomenon in Canada whereby "[p]eople in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres" (Commission on the Future of Health Care in Canada, 2002: 162).

³ See www.phac-aspc.gc.ca/rh-sr/rural_hands-mains_rurales_e.html#2.

A recent report from Statistics Canada paints a disturbing and challenging picture about the health of rural citizens in this country. Generally speaking, more rural citizens are overweight, smokers, and less likely to be physically active than their more urban counterparts. Rural citizens are less likely to self-report that they are in excellent health, and less likely to take action to improve their health situation.⁴ Other evidence suggests that rural populations may have specific health vulnerabilities, poorer health status, lower life expectancy, higher accident and injury rates, and higher levels of disability.⁵

Aboriginal peoples tend to have the poorest overall health status in Canada. The gap in life expectancy between Aboriginal peoples and the general Canadian population varies from six to 14 years (Canadian Population Health Initiative, 2004). Moreover, the infant mortality rate for Aboriginal peoples is double that of the Canadian population overall. Aboriginal communities have a high prevalence of all major chronic diseases and high rates of suicide, fatal injuries, smoking and alcohol consumption (Hanvey, 2005). In addition, serious and untreated mental health conditions often lead to catastrophic levels of child abuse and maltreatment, which cause or exacerbate physical health problems for the next generation.

Box 2. Health of Aboriginal Peoples

- The health of First Nations, Inuit, and Metis is worse than for the non-Aboriginal population on virtually every indicator
- First Nations and Inuit have a shorter lifespan, higher infant mortality rates, higher number of suicides, and higher Potential Years of Life Lost compared to the non-Aboriginal population
- Aboriginal People have higher rates of obesity, diabetes, arthritis and rheumatism, heart problems, high blood pressure, tuberculosis, and smoking than the non-Aboriginal population in Canada

Source: Canadian Population Health Initiative, "Improving the Health of Canadians," Chapter 4 – Aboriginal Peoples' Health, 2004.

3.1.3 Access to Health Care in Rural Canada

Given the higher health safety risk of occupations prevalent in rural Canada, the impact of environmental contamination and the overall poorer health status of rural Canadians, it is clear that the health needs of rural Canadians are different from those of urban Canadians. Northern and isolated communities face additional and unique health needs posed by geography and long distances. These needs may be particular to the environment (e.g. the need for education on tractor rollover prevention), changing demographics (e.g. an increase in the population of seniors in some rural areas), a common health need present in a rural environment (e.g. diabetes prevention and treatment for First Nations living on-reserve), 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).⁶

Specific barriers to accessing health care services in rural Canada vary by region and population and include varying combinations of the following: the shortage of physicians and nurses; the severely limited availability of many specialist providers; the growing shortage of rural hospitals

⁴ See www.mta.ca/rstp/pdf/novcommentary.pdf.

⁵ See http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_communities_mdesmeules_e.

⁶ See www.phac-aspc.gc.ca/rh-sr/faq_e.html.

and closure of rural emergency departments; issues of distance, weather and cost as it relates to transportation; the stigma associated with seeking care; and the lack of culturally or linguistically appropriate services.

Furthermore, services and approaches created for urban populations often are not appropriate for remote or northern populations. According to Josée Gauthier, a coordinator of remote services for northern Quebec, policy-makers must be conscious that there are particular models that must be applied in remote regions. You cannot apply the same model as in the city.

Shortage of Physicians and Nurses and Other Health Care Providers

Some of the challenges associated with accessing health care in rural Canada are a result of an unequal distribution of physicians and nurses, as well as all other health care professionals, across the country. While 31 percent of Canadians live in rural areas, only about 17 percent of family physicians and about four percent of specialists practice there. Approximately 18 percent of the 232,412 registered nurses employed in nursing in Canada in the year 2000 were located in rural areas.⁷ James Rourke, Assistant Dean for rural and regional medicine at the University of Western Ontario estimates that Canada is lacking about 1,500 rural doctors.

We are short about 1500 rural family doctors [in Canada]. That's a huge number to fill and it's pretty well spread from coast to coast. Every province has got rural communities that simply can't get enough family doctors to practice in those communities and provide the care that those families need.⁸

The shortage of nurses is most prevalent in northern and far northern communities. According to one researcher Dr. Judith Kulig, Health Canada's First Nations and Inuit Health Branch, for example, is chronically short of nursing staff for remote nursing stations and outposts. In addition, many nurses will work in remote communities for only very short periods of time, occasionally as little as six weeks at a time, in some cases leading to instability and inappropriate health service delivery.

Research findings and extensive interviews have highlighted the serious and chronic lack of a range of health care providers in rural Canada. The specific gaps vary from region to region and some innovative initiatives have been able to overcome some of these gaps, however, generally speaking rural Canadians lack access to dentists, psychiatrists and other medical specialists as well as other health service providers commonly available and taken for granted in urban Canada. (See Section 4.2.1 for a more detailed discussion.)

The Saskatchewan Commission on Directions in Health Care, for example, found that there is a serious shortage of psychiatric nurses, physical and occupational therapists, and speech and language pathologists in rural areas of that province.⁹

⁷ See <http://ruralnursing.unbc.ca/RNDB002.php>.

⁸ See <http://agvisiontv.farms.com/story.cfm?segment=150>.

⁹ See <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp325-e.htm>.

Hospitals and Emergency Care

A disproportionate number of traumatic deaths occur in rural environments; 70 percent of traumatic deaths in Canada occur in rural areas though only 30 percent of Canadians live there. Studies have shown that the mortality rate of a given traumatic injury in rural Canada is twice that of a similar injury in urban Canada. Significant injuries are encountered in rural Canada and the rural emergency department must be prepared. There are unique patterns of injury encountered in the rural workplace be it the farm, the forest, the mine or in fishing outposts. In road accidents, bad weather, poor roads, lack of vehicle maintenance and inadequate use of restraint systems all contribute to the increased mortality rates. Compounding this situation is the lack of adequately trained health care providers in rural areas. Rural ambulance attendants may be poorly trained and inadequately equipped. The rural emergency department may have insufficient human and technological resources to manage acute medical illness and trauma. The departments may suffer from lack of standardization of equipment and the diagnostic resources may be minimal. Furthermore, there is a marked reduction in the number of family physicians even willing to consider working in the rural emergency departments. Nationwide, many rural hospitals have had to either close or reduce hours of service in the emergency department because of a lack of physicians.¹⁰

Transportation Issues Related to Geographic Distance, Weather and Cost

Most rural health researchers agree that the distance to health care providers and facilities is increasing for rural residents as physicians and hospitals become more concentrated in urban and urban fringe areas. According to a recent study, more than two-thirds of residents of remote northern communities live more than 100 kilometres from the nearest physician.¹¹

The need to travel imposes an increased financial burden in the form of transportation costs and hotels; it also means people are separated from their families and community supports. Travelling long distances for health services may also adversely affect health outcomes because of delays due to the hazards of transport or inclement weather. This is the case for pregnant women. Studies have shown that in communities lacking maternity services there is an increased incidence of perinatal deaths and premature births.¹² The health of rural seniors is also linked to the availability of transportation to the local doctor's office or travel to major centres for specialized health services.¹³

In some remote communities, the weather plays a critical role in determining access when transportation is involved. In northern communities, roads may be accessible only during the summer or winter months. In island communities, ferries are affected by storms and other weather conditions.

¹⁰ See www.caep.ca/page.asp?id=7BD52CAFD85E4EE1A964838EBA055571.

¹¹ See <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/prb0245-e.htm#Health>.

¹² See www.phac-aspc.gc.ca/rh-sr/rural_hands-mains_rurales_e.html#endnotes#endnotes.

¹³ See www.phac-aspc.gc.ca/rh-sr/rural_hands-mains_rurales_e.html#2.

Stigma and Privacy Issues

Given the small, even tiny, size of some rural communities, unique barriers to access come in the form of stigma associated with seeking certain types of health care services. In a community with only one addiction counsellor or HIV clinic and a small population, the very act of being seen walking into their offices or parking in front of their building may discourage residents from seeking care for fear of being stigmatized in the community. As well, in the smallest communities, very common in the territories, the service providers are likely to be related, closely or distantly to the patient seeking care or otherwise connected to them. This poses some challenges around privacy and confidentiality. If, for example, a young woman wishes to obtain information on sexually transmitted diseases or have a pregnancy confirmed and the only health care provider in the community is her aunt or her mother's close friend, this can be a significant barrier to accessing health care.

Summary

Clearly the health care needs of residents of rural and northern Canada are difficult to meet. The evidence points to a higher level of need and to a significant and growing number of barriers to accessing appropriate and necessary health care services.

Despite the fact that the *Canada Health Act* includes a guarantee of reasonable access to health care services for all Canadians, rural residents have access to a much narrower range of services than their urban counterparts.

They have to travel long distances (weather permitting) to attend to any serious illness, with their expenses only partially covered. In some cases, facilities are sub-standard. The problems are further compounded by the closure of rural hospitals in many parts of the country. Another serious problem is the shortage of health personnel, especially physicians. Waiting times mean little when there is nothing to wait for (Nagarajan, 2004).

Barriers to accessing mainstream health care are high in rural areas. However, more importantly the simple lack of existing care in many rural and remote areas due to the decreasing presence of health care providers and facilities is alarming. Clearly, rural, remote, northern and Aboriginal populations are in need of an increased level of health care in their communities and regions. And it is important to highlight that it isn't just about shortages but about looking at different models for delivery and accepting that these other health care delivery models need to be incorporated.

3.2 Inner City and Marginalized Populations in Canada

3.2.1 What is Defined as Inner City?

“Inner city” has generally been used to describe a geographical area of the core of an urban area. Specifically, the inner city referred to spatial features such as poor physical and economic development, crime and few neighbourhood amenities. Increasingly, the term inner city has come to be understood as referring to a vulnerable population with an increasingly a-spatial distribution. For example, the Inner City Health Research Unit at St. Michael’s Hospital in Toronto, Ontario describes the inner city population more conceptually as “those individuals who tend to be on the losing end of inequality issues.”

This study has contextualized the inner city population in geographical terms but hasn’t characterized the population as living in the geographical urban core. One of the principal characteristics of “inner city populations” is living in low income. Urban vulnerable or “inner city” populations reside, for the most part, in Canada’s low-income neighbourhoods. In fact, between 1980 and 2000 the concentration of low-income persons in low-income neighbourhoods increased (Statistics Canada, 2004b).

Populations who experience difficulty in accessing mainstream health care often face many challenges, including employment, education, housing, chronic and infectious diseases, language and cultural barriers, transportation barriers, and addiction (see Box 3).

Box 3. A Snapshot of the Inner City Population in Canada

- Vulnerable populations generally face one or more of the following: low employment or unemployment, lower level of education, older age, social dysfunction, homelessness or inadequate, overcrowded housing, mental health issues, long-term diseases, language and cultural barriers, transportation barriers, no health card, and/or substance abuse.
- Over the last 20 years, some Census Metropolitan Areas in Canada have exhibited a pattern of a single cluster of low-income neighbourhoods while others have exhibited patterns of multiple clusters of low-income neighbourhoods.
- The percentage of poor visible minority and immigrant families has increased in Canada’s poorer urban neighbourhoods over the past 20 years.
- The percentage of Aboriginal people living in low-income neighbourhoods of urban areas with large Aboriginal populations has also increased over the past 20 years.
- In 2000, nearly 20% of residents in low-income neighbourhoods were recent immigrants and 4% were Aboriginal persons; more than double the rates in the general urban populations (9% and 1.6%, respectively) (Statistics Canada, 2004b).
- People in lone-parent families and unattached adults were more likely to live in low-income neighbourhoods in 2000.
- In 2000, three groups had higher low-income rates relative to the population of a given urban area (“Ten Things to Know About Canadian Metropolitan Areas,” Statistics Canada, 2005).
 - Recent immigrants (those who arrived within the decade preceding the census) 35%
 - Aboriginal peoples 41.6%
 - Lone-parent families 46.6%

Although direct correlations between the low-income neighbourhood populations of Canada's 10 largest cities and other cities cannot be drawn, there are similarities. Overall, every urban area in Canada has diverse populations with diverse health care needs – vulnerable subgroups whose health needs are not met by the mainstream health care system.

3.2.2 Health Status of Inner City and Marginalized Canadians

Generally this section outlines the health status of sub-populations living in low-income areas in Canada's major cities. Compiling an overview of the health status of urban Canadians living on the margins is challenging due to the diversity of this group. Furthermore, they have varied and complex health issues. Some data on the health status of specific sub-populations is available, but there are gaps – for example, experts working with vulnerable populations point out the absence of health data analyzed by ethnicity and racial visibility.

Diverse sub-populations include the homeless and underhoused, recent immigrants and refugees, Aboriginal peoples, street youth, psychiatric ward patients, incarcerated individuals and others. The health status of these groups is compromised as a result of homelessness, unemployment and precarious employment, violence, poverty, and so on. Marginalized inner city populations often have severe and complex health issues; however, the following characteristics are generally common – lack of proper nutrition, poor oral and dental health, high rates of chronic long-term disease, mental illness, and infection. For example, one expert consulted highlighted dental care as a “massive issue for people that are marginalized.”

It is beyond obvious to say that the homeless population in particular is in a state of precarious health. As one expert working in the field noted, “the homeless experience absolute health deterioration in every realm.” It has been estimated that well over 100,000 Canadians are living in absolute homelessness, in overcrowded or unsuitable accommodations (Hay, 2005; Pye, n.d.). Within the homeless population, mental health issues are often of the greatest concern. This population requires not only adequate services for prevention and care of mental health issues but also parallel services such as shelter, health care follow up, and post-hospital services.¹⁴

Experts working in the field in Toronto emphasized that stereotypes about the homeless population are turned upside down. “The largest group of homeless are families and they are not mentally ill or abusing substances.” In fact, in Toronto there is an increasing refugee and immigrant homeless population, and the average age of the homeless is 30 years. As one health care provider highlighted, “there is nothing in common about the homeless population; the only thing common is that they have all been de-housed.” Addressing the larger factors that determine health therefore must necessarily be part of addressing specific health issues.

Prevalent medical issues of the homeless population include seizures, chronic obstructive pulmonary disease, arthritis/rheumatism, other musculoskeletal disorders, diabetes, hypertension, anemia, respiratory tract infections, heart attack, epilepsy, frequent skin and foot problems, increased risk of contacting tuberculosis, high risk of HIV and Hepatitis C infection, sexual and reproductive health issues, unintentional injuries and violence (Ambrosio *et al.*, 1992: 25-34).

¹⁴ See National Homelessness Initiative, “Summary of Conclusions of Consultations on National Research Program (2003-2006) on Homelessness” at www.homelessness.gc.ca/research/consultations2003/index_e.asp.

Homeless women experience high rates of physical and sexual assault and rape. Street youth in particular face mental health issues, social issues, drug and alcohol abuse, and sexual and reproductive health issues. According to experts in the field, new and emerging infectious and communicable diseases have been observed in the street population and amongst the poor.

The health status of immigrants is slightly different. Generally, female immigrants and refugees have higher rates of hypertension, HIV/AIDS, diabetes, sickle cell anemia, and lupus than the general population. Experts working with immigrant and refugee women note that poverty, violence, inadequate housing and gender biases all contribute to poor health of newcomer women. South Asian immigrant men and women have higher rates of diabetes than native-born Canadians (Beiser, 2005: S34). Long-term immigrants who have been in Canada for longer than 30 years are at high risk for mental disorder (Beiser, 2005: S35). Interestingly, the health status of immigrants and native-born Canadians converges after about 10 years; therefore, health issues for long-term immigrants and native-born Canadians are similar.

Statistics Canada reports that Aboriginal off-reserve populations living in cities and towns are in poorer health than the non-Aboriginal population (Statistics Canada, 2002a) – see Box 4. Dr. John O’Neil, Director of the Centre for Aboriginal Health Research in Winnipeg, noted that this population is often ignored due in part to the difficulty in identifying Aboriginal people living in urban areas. Furthermore, Dr. O’Neil emphasized that the health care needs of urban Aboriginal peoples should have been addressed more than 20 years ago; however, Aboriginal people still face health care challenges.

Researchers of Aboriginal peoples’ health note that, in general, mental health issues almost always come to the forefront in talking with Aboriginal communities. According to Malcolm King, Chair of the Institute Advisory Board of the CIHR Institute of Aboriginal Peoples Health, the impact of these issues is particularly great when they lead to outcome behaviours such as addiction, suicide and violence. Dr. Judith Bartlett, a Winnipeg physician and former board member of Aboriginal Health and Wellness Centre, notes that there has been little research in Canada specifically regarding Metis health status, due largely to issues of identification; although some data is available from the Aboriginal Peoples Survey based on the 2001 Census. Generally, this data shows that there is no statistical difference between the health status of First Nations and Metis except on tuberculosis and diabetes. Arthritis has the highest incidence of any disease in the First Nations and Metis populations. Fifty-two percent of Metis women over 65 years of age have hypertension, similar to First Nations women. According to Dr. Bartlett, overall the most prevalent chronic diseases in the Metis population are (in order):

Box 4. Health Status of Off-Reserve Aboriginal Populations

- 2000-01 – 20% of the off-reserve Aboriginal population reported an unmet health care need; 13% of the non-Aboriginal population reported an unmet health care need.
- “... when a broad range of socio-economic factors such as education, work status and household income were taken into account, the off-reserve Aboriginal population was still 1.5 times more likely than the non-Aboriginal population to report fair or poor health.”
- adjusting for age, 23% of Aboriginal people off-reserve rated their health as fair or poor compared to 12% of the non-Aboriginal population.
- the gap between reported health for Aboriginal and non-Aboriginal people persisted at all income levels.

Source: Statistics Canada, 2002a.

arthritis/rheumatism, high blood pressure, asthma, stomach problems and ulcers, heart problems and diabetes.

Malcolm King noted that because Metis are not the recipients of targeted funding like First Nations and Inuit, there is little health data collected. Although the health data that is available indicates that there are health care needs in the Metis population, there is absolutely no information on health service utilization rates because it is difficult for researchers to identify Metis health care use.

The health status of street youth is generally lower than other youth. Mortality rates among street youth are about 40 times that of other youths of the same age (Roy *et al.*, 1998). Sexual and reproductive health is a large issue for street youth and sexually transmitted diseases are widespread among street youth (Hwang, 2001). The Public Health Agency of Canada reports that the rate of chlamydia and gonorrhoea amongst street youth is more than 10 times the rate in the general youth population (Public Health Agency of Canada, 2006).

3.2.3 Access to Health Care in the Inner City

The health status of specific sub-populations in urban areas is poor due to social and environmental factors as mentioned above and also due to barriers to accessing mainstream health care. These barriers are as diverse as the sub-populations themselves. They include: transportation barriers, cultural and linguistic barriers, lack of a health card, lack of additional health benefits, and discrimination and stigmatization. Barriers also include lack of specific health services such as: those targeted at street youth, palliative care for homeless, services for mental illness and substance abuse, and more.

For immigrants, access to mainstream health care is a particular problem in British Columbia and Ontario. These provinces do not provide medical services to immigrants until three months after arrival. Therefore there is a huge need in these provinces for health care services that do not require a provincial health card. According to key informants, the alternatives for immigrants in this situation are to see a private physician, use the emergency room of the local hospital, go to a drop-in clinic that doesn't require a health card, or simply not seek health care. To underline the issue, Stephen Hwang of St. Michaels' Inner City Health Research Unit noted that generally health care gaps are greater for immigrants than for homeless people.

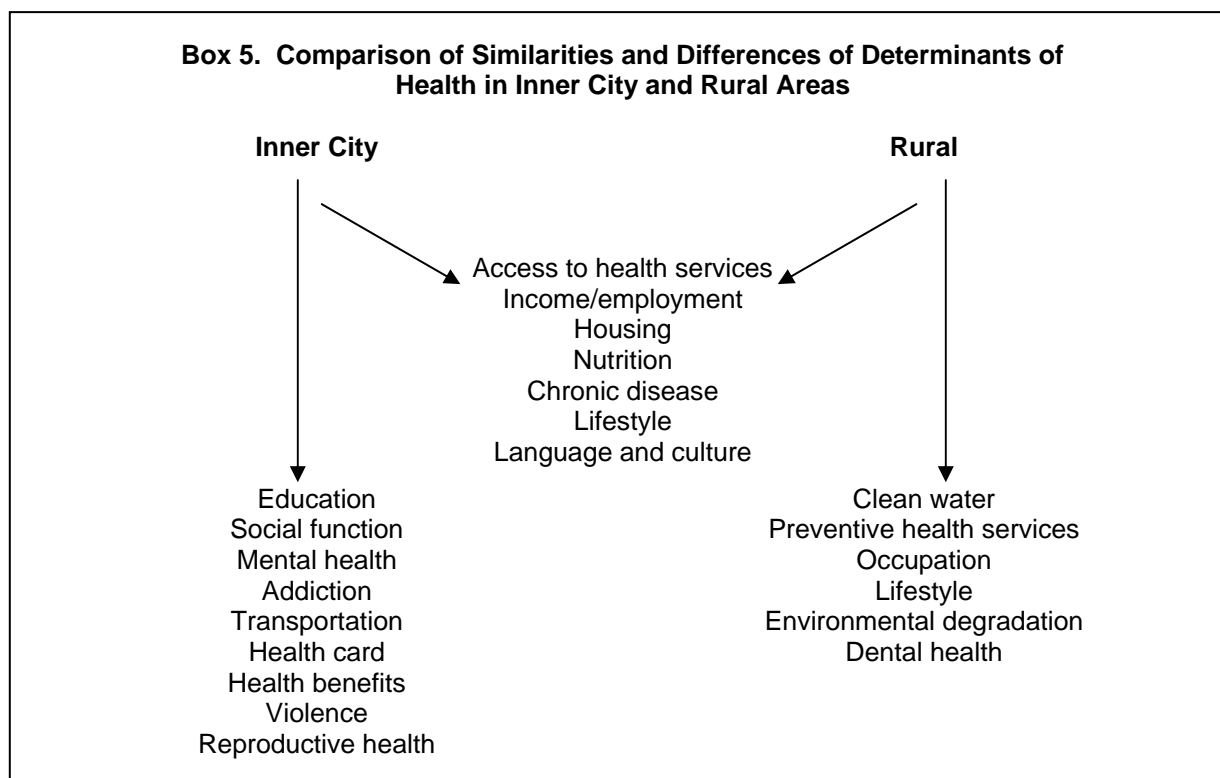
It is difficult to determine the barriers experienced by Aboriginal peoples to accessing health care in urban areas. This is due to issues of identification and analysis based on statistics collected for First Nations living on-reserve and First Nations living off-reserve. Imperfect as the data may be, overall 40.8 percent of First Nations adults reported feeling that they had the same access to health care as other Canadians, 23.6 percent reported their access as better, and 35.6 percent reported feeling that their access to health care was less than for other Canadians (National Aboriginal Health Organization, 2005a). Experts working in the area of Aboriginal health research highlight the following barriers to accessing health care: financial barriers, social, cultural and language barriers, transportation barriers and barriers in the education of health care professionals. For example, Malcolm King highlighted the need for education or re-education of health care professionals working with and providing care to Aboriginal people.

3.3 Determinants of Health in Inner City and Rural Canada

Critically important to the health of vulnerable Canadians living in both urban and rural areas are issues related to upstream causes of ill health. Many experts consulted agreed that the problem is not, or certainly not only, lack of health care provision, inappropriate health care delivery systems, and barriers to accessing care. It is also a lack of nutritious, affordable food, clean water, air and soil, adequate housing, sufficient income, education, and other factors that determine an individual's health. While access to health care is one factor, or "determinant," of health it is only one of a long list of factors that research has clearly demonstrated significantly affects the health of a population.

Earning a sufficient income in inner city areas can be challenging. For example, in Winnipeg, 76.6 percent of the general population gets its income from earnings and 76.3 percent of the Aboriginal population gets its income from earnings. But the income gap is such that Aboriginal individuals in Winnipeg are struggling to make ends meet (United Way of Winnipeg, 2004). One consequence is their lowered health status.

The lack of sufficient affordable housing in urban areas is a large and widespread problem across Canada. For example, many experts in large cities noted the lack of supervised housing for street youth and drug users with chronic illness such as HIV/AIDS. As one expert said, there can be "no good health care without adequate housing." Similarly, the health needs of those living in rooming houses are largely or wholly unmet because they are "not visible." Health care providers working in Canada's major cities highlighted this as a problem across Canada.



Rural communities struggle with finding personnel to go beyond acute care to deliver preventive health services. Much of the scarce medical resources need to be spent on dealing with the high morbidity found in rural areas (e.g. high rates of diabetes, trauma and heart disease). When most of the time is spent treating acute problems, there is a significant lack of capacity to deal with “upstream” causes such as adolescent obesity, farm safety and smoking.¹⁵

Occupational and lifestyle related factors contribute to the poor health status of many rural residents in Canada. Many of the rural occupations such as farming, mining, logging or fishing are dangerous occupations often leading to serious injuries. In addition, smoking rates are higher in rural Canada as are the rates of obesity and addictions. There is a clear need for more health promotion and prevention work in rural Canada however the very limited resources tend to be centered on treatment of chronic diseases and dealing with injuries.

Environmental degradation is another serious and growing problem in rural Canada. The impact of many natural resource-based activities, such as mining, oil drilling or farming, on the environment has been significant in many rural and northern regions of Canada. The impact has been the contamination of soil, air and water, which has serious consequences for the health of residents. A clear example is the high rate of infant respiratory illness in many northern communities due to poor air quality both indoors, in overcrowded housing, and outdoors. In addition, the environmental changes, such as climate change, are radically altering the availability and pattern of migration of animals and fish that many residents still count on to supplement their diets. There has been a large increase in the number of hunting and fishing accidents, because of unanticipated changes in migratory patterns and timing, with attendant higher mortality due to distance from emergency treatment facilities. Local residents are no longer able to predict where, when and how traditional species can be hunted or fished successfully.

In rural Canada, large numbers of First Nations live, our tractors overturn, mineshafts collapse, fishers get swept to sea, smoking rates are higher, poverty is more common and the litany goes on with mortality rates higher for most causes of death. In the end our most isolated rural Canadians live three years shorter lives than our urban counterparts. This difference is the same as what would happen if we had a cure for cancers but you could only get it if you lived in the cities (Hutten-Czapski, 2002).

The evidence clearly shows that there are significant challenges with respect to the determinants of health in rural Canada and that these challenges are growing.

While there are similarities in determinants of health in urban and rural areas in Canada, there are also significant differences. This fact argues well for the appropriateness of community-based frontline health responses to health care needs – because they have the ability to respond to local determinants of health.

¹⁵ See www.srpc.ca/librarydocs/PCRpolicy.html.

4. Frontline Health Services in Canada

The frontlines of health care provision exist wherever there are people unserved or underserved by mainstream health care in both urban and rural areas. Frontline service providers offer health care to geographically, socially, economically and culturally marginalized populations in inner city and rural Canada. Frontline providers are people, programs and organizations that provide health care to these people and populations facing barriers to accessing health care.

This research report highlights a number of innovative, creative and effective health care models that are struggling to deliver frontline care and services to marginalized populations, in spite of extremely challenging conditions and demands.

The frontlines of Canada's health care system are present everywhere, not just in remote or isolated communities. Frontline health care services attempt to meet community needs and fill service gaps. Frontline services are effective and responsive and often incorporate health delivery systems different from mainstream health care systems such as hospitals and doctor's offices. In some cases they join existing programs (like community health centres). But often they have to invent their own.

Frontline health care providers have chosen to respond to the needs of the underserved as best they can: doctors, nurses, social and health care professionals who serve on the margins in street clinics, inner city emergency departments, mobile outreach units, solo rural practices and remote outposts. From what we have learned in our cross-country research, some of these health care professionals are specialized in their area and/or in the population they serve (such as those working with street youth with HIV).

There are several points at which marginalized populations in urban areas typically access health care services. These include: hospital emergency departments, community health centres and innovative health initiatives. The most common access points for rural residents are family physicians, small rural hospitals, community health centres or clinics, nursing stations and mobile health units.

4.1 Rural, Remote, Northern and Aboriginal Communities

4.1.1 Access Points

Canadians living in rural, remote and northern regions of the country experience poorer health and more health care challenges compared to those living in Canada's cities and towns. According to the Romanow Report, "People in rural and remote communities have poorer health status than Canadians who live in larger centres. Access to health care is also a problem, not only because of distances, but because these communities struggle to attract and keep nurses, doctors and other health care providers" (Commission on the Future of Health Care in Canada, 2002: 159).

Access to health care services in rural Canada is more restricted than in urban areas. The most common access points for rural residents are family physicians, small rural hospitals, community health centres or clinics, nursing stations and mobile health units. There is often a great deal of overlap between these access points, as, for example, most rural hospitals are staffed by local family physicians. Generally speaking, the further away a rural community is from an urban centre the fewer the options for health care services and the less specialized the service providers are.

Box 6. Community Wellness Initiative, Arviat, Nunavut

The community of Arviat, with a population of 2,600, is considered a best practice in community-based health initiatives in Nunavut. In 2003, community members gathered to discuss the crisis in their community and how they might respond. The Arviat Health Committee consulted extensively with community members to draw up a plan and agree upon the most urgent priorities. A whole series of research and intervention activities have been initiated and are ongoing in the community, meeting with great success. The community currently has six nurses, of whom five have been long-term residents.

Small Rural Hospitals

Rural hospitals provide significant services to populations spread over fairly large territories. Rural hospitals are not simply a “smaller version” of big city hospitals. City hospitals are often large, monolithic and intimidating institutions. Small rural hospitals are often a “home away from home” for rural people who often know staff members as family or friends. They are a key link in the health care chain, not only for rural residents needing access to primary or specialized care but also for rural health care providers who rely on them for many services and supports. In addition, they are often the main or only major employer in small communities (e.g. Bella Coola, British Columbia). In recent years, the number of small rural hospitals has declined in all provinces and territories, and the range of services being offered by the hospitals has also been reduced.

Box 7. United Church Health Services, Hazelton, British Columbia

For over 100 years, United Church Health Services (UCHS) has been offering health care to remote and isolated residents at the request of rural communities across Canada. UCHS was involved in the establishment of 35 rural hospitals from coast-to-coast and currently still operate four hospitals. In northern British Columbia, they operate three small rural hospitals in isolated communities. They pioneered many approaches to rural health care including placing physicians on salary and working in multidisciplinary teams. They continue to offer a broad range of very high quality care to the residents of their communities in contrast to many other similar communities that have seen their hospitals closed or reduced to small health clinics.

A rural hospital is defined as one where most or all specialist services provided locally are carried out by non-specialist medical staff and other health care providers. In fact, rural practitioners in all health professions provide a wider range of services and carry a higher level of clinical responsibility in relative professional isolation when compared to their metropolitan counterparts. Typically, the definition of a rural hospital is a functional one with a wide range of services provided by a small number of rural practitioners.

Rural hospitals provide services tailored to the needs of the community. This often includes emergency care, maternity care and in-patient treatment of common medical problems (Mann, 2000).

**Box 8. All Nations' Healing Hospital,
Fort Qu'Appelle, Saskatchewan**

The All-Nations' Healing Hospital is one of the first hospitals in Canada to be owned and operated by First Nations. The hospital delivers both acute care services and community health services out of the same facility. The hospital uses a holistic, integrated approach to their health care delivery. They offer a cultural healing program, the "All Nations Healing Centre," which provides access to traditional ceremonies, elders and helpers. The elder makes rounds at the hospital. Staff at the centre include mental health therapists, addictions workers, psychologists, and residential school support workers.

Many small rural hospitals have an emergency department, staffed by local family physicians, some with additional specialized training in emergency care, surgery or anaesthesia. Some of these emergency departments are being closed down or are offering restricted hours due to shortages of physicians or nurses. Some hospital emergency departments are "one retirement away from closure." A study undertaken over a decade ago in Ontario on rural health care concluded that "Hospital based services for this at risk population, such as in-patient care and obstetrics, are

being threatened both by a lower number of physicians and by an attrition of services" (Hutten-Czapski, Peter, *et al.*, 1999). According to the study, a large number of small rural hospitals are no longer capable of offering either obstetrical or anaesthesia services. As a result, in Ontario, almost half of these hospitals are unable to maintain an operating room.

Small rural hospitals are staffed primarily by family physicians, some of whom have additional qualifications, and by nurses with a variety of professional certifications ranging from registered nurses to licensed practical nurses. Some of the rural physicians have specific advanced competencies in procedures such as endoscopy, orthopedics, cardiac stress testing and critical care. Some rural hospitals have intensive care beds that are managed by rural family physicians. The Society of Rural Physicians of Canada offers the Rural Critical Care Course for rural doctors who require these skill sets for their communities. In addition, there are generally emergency medical technicians and patient care aides on staff, as well as general staff to provide administrative, food and housekeeping services.

Telehealth has been promoted as an important part of improving access to appropriate and timely health services in rural areas. The majority of small rural hospitals have now been equipped with technology to allow at least some level of telehealth provision. Telehealth is often used to allow specialists to consult with local health care providers but it is also useful for training purposes. However, as the Society of Rural

Box 9. Telehealth

Dr. Patrick McGrath, Professor of Psychology and Psychiatry at Dalhousie University, and colleagues have been involved in a unique and highly innovative initiative to provide accessible and cost-effective mental health service to rural residents. The model relies on the simple technology of the telephone, accompanied by written manuals and either a video or Web-based program. The approach involves providing recipients with a series of 12-14 telephone sessions with trained non-professionals, accompanied by supporting materials as outlined above. The intervention has been tested and evaluated for rural women with postpartum depression as well as for parents of children with serious behavioural challenges and has been shown to be effective.

Physicians points out, “The most common problem with telehealth, however, is that fascination with the technology becomes the focus and the process is made irrelevant. How much TeleVideo conference equipment sits unused in rural hospital offices?”¹⁶

Small rural hospitals offer a wide and varying range of health services to residents living up to 80 kilometres from the hospital and in rural isolated areas patients may be as far as 400 kilometres away. These hospitals, unlike their small urban counterparts, provide primary care in addition to a continuum of other services depending on many factors. The types of services offered by small rural hospitals, in addition to primary care, include services such as chemotherapy, obstetrics, minor surgery and access to a limited range of other local health care providers (e.g. pharmacists, occupational therapists, speech therapists and nutritionists). Many of these small rural hospitals are struggling with severe shortages not only of doctors but also of other health care providers.

In all cases, small rural hospitals also serve as access points for travelling specialists. These specialist physicians travel to remote communities regularly to treat patients referred by local general practitioners, nurse practitioners or other health care providers. Typically, travelling physicians offer the following specialties – orthopaedics, pediatrics, general surgery, cardiology, psychiatry, obstetrics/gynecology, geriatrics, rheumatology, nephrology, ophthalmology, rehabilitation, neurology and internal medicine. In addition, there are travelling dentists for some communities, such as First Nations’ reserves. The frequency of visits varies greatly according to local and government contracts and can vary from once a month to six times per year. In some cases, there is limited continuity of care as a different specialist may make the visit each time.

Rural Community Health Centres (CHCs)

Community health centres are non-profit organizations that offer a range of coordinated primary care and related services with an emphasis on one or more priority group(s). Services are provided in an interdisciplinary manner and are specifically designed to meet the health needs of the priority group(s). CHCs are sponsored and managed by incorporated non-profit community boards made up of members of the community and others who provide health and social services. Today, there are over 300 CHCs across Canada.¹⁷ However they serve only a small fraction of the population and mostly in urban areas.

Rural community health centres operate similarly to their urban counterparts. They tend to involve an interdisciplinary team of health care providers offering a range of health promotion, prevention and primary care services to rural residents. According to the Canadian Alliance of Community Health Centre Associations, in rural areas a CHC serves a community or cluster of communities with a population ideally below 25,000.¹⁸ Another important distinguishing point of CHCs is that the physicians are on a salary rather than working on a fee-for-service basis.

In some provinces, the closure of small rural hospitals precipitated the need for alternative forms of health care provision such as rural CHCs. Some provincial governments formally undertook to

¹⁶ See www.srpc.ca.

¹⁷ See www.aohc.org.

¹⁸ See www.cachca.ca.

establish these rural CHCs, as was the case in British Columbia (e.g. Enderby). In other regions and communities, local citizens recognized the need to take action and joined together to establish community-owned CHCs, such as in Manitoba (e.g. Winkler).

Much like small rural hospitals, rural CHCs are staffed by family physicians and nurses, as well as other health care providers. Unlike their hospital counterparts, they do not have an emergency department or other typical hospital services. In some instances rural CHCs were set up explicitly to reduce reliance on the emergency departments of rural hospitals, which are often overcrowded and understaffed (e.g. Kelowna, British Columbia).

Rural CHCs have the potential to offer more comprehensive health services to rural residents. Provinces such as Ontario and British Columbia have been investing heavily in the CHC model, including expansion of rural networks. In Quebec, the Centre local de services communautaires (CLSC) model has been serving the health needs of rural residents for many years; however the future is uncertain because of recent plans to amalgamate services.

Nursing Stations/Medical Clinics

The more remote and isolated rural communities, in particular those in the north and far north, are generally served by nursing stations or small medical clinics. A nursing station is understood to be a field unit located in an isolated community where there is no road access to other health care facilities. They house field unit staff of two or more community health nurses or nurse practitioners and other support and primary health care staff organized to carry out primary health care services including urgent care, short-term in-patient care and public/community health. Access for urgent health needs is available on a 24-hour basis. Normally these communities receive regular physician visits as well as travelling specialists. Local agencies (i.e. hospitals, public health units, etc.) usually administer the nursing stations or medical clinics.¹⁹

Nursing staff working at these remote or outpost facilities, much like their rural physician counterparts, require extensive skills as the scope of practice is much larger than in urban settings. Staff work in isolation, often with very limited opportunities to share or discuss the workload with colleagues, and in communities that are usually very small and culturally distinct. The work and workload in nursing stations can be difficult and often leads to high turnover. Many nurses work only for short periods, sometimes as short as six weeks, thereby leading to a lack of continuity of care for these communities.

In the smallest and most isolated communities, or where there is difficulty in recruiting and retaining nurses, often in the far North, community health representatives (CHRs) and lay dispensers provide some access to basic health services. CHRs live and work in First Nations communities throughout Canada, and in Metis communities in a few provinces, and make a contribution toward improving the health of Canadians as they play a key role in health promotion, protection, and injury prevention.²⁰ CHRs generally have several months to one year of training. In isolated communities, CHRs provide temporary emergency care; consult with

¹⁹ See www.health.gov.on.ca/english/providers/program/uap/about/access.html.

²⁰ See www.hc-sc.gc.ca/hcs-sss/pubs/hisp-phis/community-health-representatives/index_e.html.

health care professionals regarding emergency situations or escort patients to the appropriate health care facilities.

Northern aboriginal communities have their own mental health counsellors trained through workshops as well as using traditional knowledge and sometimes with personal experience of having recovered from illness. Counsellors provide valuable support to their community members.

Lay dispensers work in communities where no doctor or nurse is available. They prepare reports on the condition of patients and arrange evacuations when required. The job requires little or no previous education, and on-the-job training may be available in some communities.²¹

Nursing stations and other outpost facilities are generally funded by provincial governments except in the case of services on First Nations reserves, where the federal government, through the First Nations and Inuit Health Branch of Health Canada, provides funding and management.

Family Physicians

Family physicians in rural Canada typically operate in a traditional way, with one or two doctors sharing a practice and an office in the community. The responsibilities of a family physician in rural areas tend to be much broader than those of urban physicians. Their responsibilities involve office practice, house calls, nursing home coverage, hospital visits and emergency coverage. This scope of work can be both satisfying and overwhelming as the number of hours of work is significantly above a regular 40-hour work week.

Given the broad scope of rural practice, the keys to ensuring adequate health care provision and providing job satisfaction are improved medical training and continuing and regular professional development once in the field. The Northern Family Medicine Education Program (NorFam) in Goose Bay, Labrador is an excellent example of how these factors affect outcomes. NorFam's training program confronts students in all the complex challenges and opportunities found in a remote practice, instilling the confidence necessary to succeed. It provides extensive opportunities to engage with the community issues and rural lifestyle. And both staff and students are constantly challenged to keep abreast of new developments in health care delivery. The proof of the program's effectiveness shows in their best practices compliance statistics, which are consistently at and above the national average, and their staffing statistics. They are fully staffed for doctors, most of whom have trained with NorFam.

The number of family physicians in rural areas is declining for many reasons. On average, rural family physicians are older and when they retire there are often no younger physicians to replace them. For many reasons, some rural family physicians choose to relocate to larger urban areas. Reasons include heavy workload, academic appointments, decreasing supports as rural hospitals close and a desire to pursue other opportunities, professionally or personally.

²¹ See www.ece.gov.nt.ca/Divisions/CollegeCareerDevelopment/Career%20PDF/JOBS%20IN%20HEALTH%20SERVICES.pdf.

Most rural family physicians are men; fewer than 30 percent are women, in part because of the heavy workload and incompatibility with family responsibilities. This gender divide is of concern since an increasing number of new medical school graduates are women. If women do not see rural practice as appealing, the shortage of rural physicians could increase. Many provinces have compensated for the shortage of physicians in rural areas by successfully recruiting foreign-trained physicians. Currently over one-quarter of the rural physician work force is foreign-trained. One of the problems associated with this trend is that many of these doctors only stay for short periods of time before moving to larger cities. In addition, the sources of foreign-trained physicians are not inexhaustible and some provinces, such as Manitoba, have stopped recruiting them for ethical reasons.

The work of rural family physicians is varied and challenging. As put by one rural doctor:

Rural practice is a really exciting kind of practice. The reason is because it's not just office practice. Most of us in rural practice have a broad array of skills. We work in our offices; we make house calls; we may see the nursing home and we also do a lot of hospital work. Things like work in the emergency department, doing shifts there dealing with everything from the minor patient that needs sutures or a fishhook removed to major trauma or heart attacks. Things that in the cities are done by emergency physicians rather than family doctors. Many of us also deliver babies which again is a very richly rewarding part of practice.²²

Most rural family physicians have active admitting privileges to their community hospital and are responsible for the care of their patients while in hospital. They tend to be generalists, and provide care for a variety of health needs during the patient's lifetime. Many do obstetric deliveries, anaesthesia, assist in surgery and work shifts in the emergency department. They provide not only primary care, but selected secondary and tertiary care. Studies have found that over 60 percent of them offer Aboriginal health care and another 18 percent have practices where Aboriginal patients comprise more than 10 percent of their patient load.

The challenges of working in a rural practice are also significant. In addition to heavy workloads and isolation (both geographic and professional), rural family physicians face great difficulty in finding a replacement doctor (a "locum"). It can also be difficult for the spouses of rural physicians, particularly employment and social networks.

Rural Mobile Health Units

Across Canada, rural communities have benefited from various mobile health care initiatives over the years. All mobile health units share a common purpose: deliver education and health care to "hard to reach" clients due to geographic isolation or lack of financial resources.²³

Generally the principle of mobile health care is to take the health service to the individual seeking or needing access rather than bring that individual to the health care facility, whether at their own cost or at the cost of the health care system. For rural Canada, this approach can be

²² See <http://agvisiontv.farms.com/story.cfm?segment=150>.

²³ See www.thealex.ca/publications/community_health_bus_summary.pdf.

very helpful as it reduces the need for travel by residents, as well as the associated financial burden for the resident or the government, in the cases where residents are eligible for such reimbursement. It also reduces the need to take time off work or to be away from family members.

There have been many studies conducted on the effectiveness of mobile primary care strategies that have concluded that problems associated with providing health services to a dispersed population can be overcome through such approaches (Mable and Marriott, 2002). In one instance, a mobile service in Saskatchewan successfully reduced occupational injury and disease in a high-risk farming community. In another case, in Alberta, a mobile multidisciplinary team of health professionals was able to enhance access to services in small rural communities:

The team included a physician, a nurse, pharmacists, a laboratory technician, a respiratory therapist, and a speech language pathologist, supported by a second ad hoc team providing other services in breast health, nutrition, diabetic education, and other areas. The population reported a high degree of satisfaction with their services and demonstrated more compliance with prescribed diets, drugs, and flu shots than did a control community. As a result, fewer residents left to use health services elsewhere (Mable and Marriott, 2002: 21).

In Ontario, the Canadian National Institute for the Blind (CNIB) Eye Van is another unique and highly successful example of enhanced access due to mobile services. The CNIB Eye Van is a state-of-the-art eye clinic designed to fit in a 48-foot long trailer. Each year, since its inaugural journey in 1972, the Eye Van has delivered vision care to more than 30 small towns and communities across northern Ontario.

Another type of mobile health care delivery, quite different from the above, is provided by provincial emergency services in the form of ambulance services staffed by paramedics. Although not typically considered a mobile health care initiative, paramedics do offer emergency health care services to rural residents and in some innovative cases (e.g. Long Island, Nova Scotia and Toronto, Ontario) offer additional primary care to “hard-to-reach” clients. In the emerging field of Community Paramedicine, paramedics are provided with additional training and responsibility to provide health services in addition to the standard first response for emergency calls. The scope of practice for community paramedics includes IV antibiotic administration, wound care, phlebotomy, glucose checks, prescription compliance, fall assessments, congestive heart failure (CHF) follow ups, flu vaccinations, B12 injections and tetanus immunizations. Paramedics in Nova Scotia also do first responder training for the three island fire and first responder departments and work closely with the local coast guard. In Toronto, paramedics have been offering enhanced services to the downtown homeless population.

Paramedics in both standard and enhanced roles offer critically important health care services to rural residents and work in close collaboration with small rural hospitals in ensuring access to health care. The shortage of health care professionals extends to paramedics as well. In both rural and urban areas there is dramatic understaffing for emergency medical services (EMS). According to a recent report by Ontario health care workers, there are significant and often life-threatening shortages of paramedic staff. In one northern area, the EMS centre is only staffed for

eight hours during the day and the remainder of time paramedics are on-call, however distances are very large and paramedics have to drive great distances to respond to a call, often along dangerous roads.

There is a big distance between stations in rural areas and sometimes only one ambulance for coverage. So if things get busy, other ambulances have to come from 45 minutes away, or even longer. When I have to do that, it means someone else has to leave their area to cover me and on and on. It's a domino effect. It is one thing for dispatch to say that an ambulance is en route, but if the ambulance is coming from way out of the area, it's not going to do much good, is it? We need a lot more staffed units. Patients in these situations deserve the best care but we can't give it to them right now (Ontario Federation of Labour, 2005).

Box 10. Islands' Health Centre, Freeport, Nova Scotia

The Islands' Health Centre is located in Freeport on Long Island, and serves the two very remote islands off Digby Neck in Nova Scotia. Long and Brier Islands collectively have a population of about 1,200 and they are considered to be the most remote and isolated parts of the province. It is a unique service in rural Canada bringing together three elements: paramedics with an enhanced scope of practice, a nurse practitioner and an off-island consulting physician. Since 2003, the health centre has been offering enhanced access to a range of health services and the level of satisfaction of the community is high. This unusual and successful approach to collaboration has received interest from across the province and country as well as places as far away as Australia, Russia and Japan.

What they do: deliver primary health care and 24-hour emergency services through a partnership between a nurse practitioner and community paramedics working in expanded roles

Who they serve: the residents of Long and Brier islands – two very isolated islands in Nova Scotia; about 60% of the population are over 65 years old

How many clients they serve: 1,200 residents

What type and how many health care professionals they employ: nurse practitioner and paramedics working in expanded roles with physician phone support

When they started: in 2001, the paramedics began serving the community in their expanded role; in 2003, the services of a nurse practitioner were added to the centre

How they are funded: by the provincial government and the regional health authority

Why their services are needed: there is no physician on either of the two islands and residents needed to use one or two ferries to reach the mainland to access even the most basic care

Why they are unique: the only health centre of its kind in Canada, possibly North America

Innovation: partnership of nurse practitioner and community paramedics working in expanded roles and without physician back-up in the community

The work of rural paramedics tends to be very different from those working in urban settings. Rural paramedics handle significantly fewer calls however they have to travel much greater distances and often deal with more serious conditions. This poses a unique challenge for rural paramedicine. Paramedics working rurally will have less frequent exposure to emergency cases, which may mean their skills are not as highly tuned, yet they often face much more serious conditions which require a higher level of skill and experience. Thus older, more mature and experienced paramedics are in high demand in rural areas. Yet, given the very high stress of rural

paramedics, the research suggests that older professionals may find the work unappealing and salaries may not be high enough to compensate for the stress and workload.

4.1.2 Gaps in Access to Primary Health Care Services in Rural Canada

There are many gaps in access to health care services in rural Canada. Some gaps can be categorized as chronic as they have existed for a significant period of time or since a particular health challenge has existed. Others can be defined as emerging gaps, as the gap in access is due to recent phenomenon and current trends. And yet others are gaps or challenges at the system-wide level. Given the interconnectedness of health issues and the differences amongst regions, many of the gaps can belong to more than one category. For discussion purposes, however, these categories are used to outline gaps in access in rural Canada.

Chronic

Chronic gaps in access to services for rural Canadians include mental health services, aged care, palliative care, major surgery, cancer care beyond chemotherapy, major trauma, dialysis, dental health services, nutrition and addictions services and services for children with special needs. In most instances, these services are either not available, not culturally or linguistically appropriate or only available sporadically through visiting specialist programs or when a vacancy is successfully filled, even for a short-term. In other words, in many cases residents needing these particular services will either go without, thereby exacerbating other existing conditions, or have to travel great distances, often at their own cost, to access care.

Emerging

Given the many changes that have occurred in the prevalence of certain diseases and conditions across Canada and the transformations in rural Canada in recent years, a number of new and emerging gaps in health needs are becoming apparent.

A serious and growing gap in health care in rural areas concerns women's health. As described earlier, many rural family physicians are also trained in obstetrics and have been involved in providing pre and postnatal care to women as well as doing deliveries. However, as the absolute number of rural family physicians declines, so does the number that provide obstetrical services. Furthermore, many rural family physicians rely on other family physicians trained in anaesthesiology and caesarean sections for more complicated deliveries and the number of these physicians is also declining. Compounding the problem is the fact that some rural physicians are reducing the scope of their practice to manage workloads and are no longer offering maternity care. The closure of small rural hospitals has also affected the ability and willingness of rural family physicians to deliver babies. The resulting picture is one where a large number of rural women have to travel significant distances, away from family and other children, to give birth in regional hospitals, far from their support networks. A recent study in Bella Coola demonstrated that requiring women to travel to urban centres about one month prior to their date of delivery results in an increased level of stress for the women and their families as well as a decrease in breast-feeding rates (presented at Society of Obstetricians and Gynaecologists of Canada, July 2006, Stefan Grybowski).

There is an emerging gap in access to minor surgical procedures. In the past, rural family physicians have conducted minor surgical procedures either in their offices or in small rural hospitals. For much the same reasons as above, the availability of these procedures in rural areas has declined and appears to be on a continuing downward trend.

As small rural hospitals are closed or reduce their services, often pharmacists associated with these centres also leave the community, contributing to a gap in access to their services.

Some gaps are related to the aging of the rural population. This aging increases the need for services to seniors. In particular, the increase in cases of dementia and Alzheimer's disease pose a serious problem in rural Canada as there is a lack of facilities and providers that specialize in the housing or treatment of such patients. Often small rural nursing or retirement homes are forced to accept patients with Alzheimer's who are young but in need of 24-hour care and supervision. The impact on the healthier but older patients is negative as is the impact on staff that are neither trained nor prepared for such issues.

Other types of health services, now commonly available in larger towns and major urban centres, are rare or completely lacking in rural Canada. These services include occupational therapists, speech language therapists and physiotherapists. These services are understood to be helpful and often necessary to remedy problems or hasten recovery and yet they are often not available to rural residents, particularly in more remote and northern communities.

Finally, Fetal Alcohol Spectrum Disorder (FASD) and HIV/AIDS are two relatively recent health issues that are underserved in rural areas. Those with HIV/AIDS in rural areas lack services and face discrimination. There are, for example, no HIV specific hospices or palliative care centres in rural areas in Canada. There is also a lack of educational resources and prevention initiatives such as needle exchange sites in rural communities, thus exacerbating the spread of the disease.

FASD is a growing concern amongst the rural population, in particular for Aboriginal peoples. The prevalence of FASD is not known, however researchers and frontline health care providers indicate that it is a large concern and is often going unrecognized and untreated. To address this problem, some family physicians in Labrador have specialized training to diagnose FASD.

System-Level Challenges in the Rural Health Care System

On a broad and systemic level, it is clear that there are numerous challenges facing the rural health care system. Many of these were identified in both the Kirby Report (2002) and the Romanow Report (2002). Generally speaking, there are significant problems in the following areas: recognizing the critical importance of and addressing the determinants of health; recruitment and retention of the whole range of health care professionals; culturally and linguistically appropriate services; availability and scope of telehealth initiatives; lack of a coherent national approach to addressing rural issues; training and ongoing professional development of health care professionals working in rural areas; and absence of adequate research and data on health care provision in rural Canada on a national scale, in particular outside the realm of physicians and nurses.

**Box 11. NorFam Medical Training in Goose Bay,
Newfoundland and Labrador**

Since 1992, the Northern Family Medicine Education Program (NorFam) of Memorial University of Newfoundland has been training physicians in Goose Bay, Labrador. This highly successful initiative has trained rural doctors who have mostly stayed to work in the region. In addition, the presence of this teaching unit in Goose Bay has contributed to retaining many physicians in the community because of professional opportunities and availability of colleagues and ongoing training and support. Infant mortality rates declined from 16 per 1,000 live births in 1996 to 3.6 per 1,000 live births by 2001. The Canadian infant mortality rate in 2001 was 5 per 1,000 live births. An audit of best practice drug treatment for coronary heart disease, stroke and diabetes mellitus resulted in a 90% or more compliance rate with recommended treatment – better than some of the centers involved in drug trials. Telehealth is used in management of chronic and acute diseases leading to successful resuscitation in remote nursing stations.

4.2 Inner City and Marginalized Communities

4.2.1 Access Points

Given the limited available data regarding the number and types of access points engaged in frontline health care provision, there is a significant challenge to developing a comprehensive profile of the providers of frontline health services to the inner city population. However, there are several points at which marginalized populations in urban areas typically access health care services including: community health centres, specialized health initiatives, and hospital emergency departments.

Provision of health services to low-income Canadians living in inner city areas in many cases overlaps with the services rendered to other vulnerable groups of the population, for example, isolated seniors, immigrants and refugees, the homeless and underhoused, and Aboriginal people. Generally, most members of disadvantaged inner city populations receive some sort of service regarding health care; however, gaps exist.

Urban Community Health Centres (CHCs)

It is very difficult to quantify the health care provision of community health centres nationally, due to the fact that provincial administrative data is not rolled up into a single national profile. The Canadian Alliance of Community Health Centre Associations supports community health centres and represents them at the national level.²⁴ The Association of Ontario Health Centres estimates that there are over 300 community health centres across Canada.²⁵ Despite the difficulty in quantifying them, it is clear that community health centres play a key role in delivering health services in urban areas. As one expert noted, the majority of health services are provided by medium-sized community health organizations who are almost 100 percent provincially funded with some extra fundraising for things that the provinces don't cover.

²⁴ See www.cachca.ca/english/home/default.asp?s=1.

²⁵ See www.aohc.org.

Community health centres typically provide services to a specific geographical catchment area. However, some CHC's have determined the need to serve specific populations of clients and therefore offer services to street youth, immigrant and refugee women, gay, lesbian, bisexual, transgendered people, and the homeless, despite the location of their residence. For example, the Sherbourne Health Centre provides primary care to diverse communities in southeast Toronto but specifically targets services at the homeless, newcomers and people who are lesbian, gay, bisexual, transsexual, and transgendered.

Women's Health in Women's Hands, a CHC in Toronto, provides health services specifically to black women and women of colour. Experts consulted noted that the centre began with the express purpose of providing care to immigrant and refugee women of colour because they were experiencing difficulty in accessing care. The Immigrant Women's Health Centre in Toronto specifically provides reproductive and sexual health care to immigrant and refugee women in a female environment. Culturally-sensitive services delivered in different languages are necessary in Toronto to ensure that newcomer women get health care they need. In Montreal, a clinic targeting street youth is necessary because street youth are uncared for by the regular system, one expert noted. Many of these centres provide care to individuals even if they don't have a health card, as discussed in the previous section.

Box 12. Women's Health in Women's Hands

Women's Health in Women's Hands is a Community Health Centre in Toronto that provides primary health care to immigrant and refugee black women and women of colour who are South Asian, Latin American, Caribbean or African. They employ a unique model of care that places the health care needs of women in their own hands. The model is one of empowerment and choice that encourages women to take responsibility for their own health care. The centre is a place where women are encouraged to put their own health needs first before their partner's and children's needs. They focus on the intersectionality of race, class, gender, disability, etc., in addressing the realities of their clients' experiences and health needs. They have also done innovative work in the areas of female genital mutilation and HIV/AIDS.

These providers understand and attempt to address the health care issues of the populations; however they can't do it alone. They recognize the need to work together in partnership where possible. They innovate by being available to their clients in different places and at different times. They provide diverse and integrated care managed by one agency or several agencies in partnership. They attempt to address the determinants of health alongside their delivery of primary care. They expand the roles of health care providers so they are utilized to their highest capacity.

Some provinces, such as Ontario and Manitoba, have community health centres specifically for First Nations, Inuit and Metis communities. These are located both on- and off-reserve, including in urban areas.²⁶ These centres provide a similar range of services as community health centres, however, these services are provided in a culturally appropriate way and traditional healing approaches are substituted for or combined with clinical Western medical approaches. See Box 13 for an example.

²⁶ In Ontario, see the CHCs for Aboriginal Peoples in Toronto and Timmins; in Manitoba, see the Aboriginal Health and Wellness Centre.

Research indicates that community health centres in every province and territory provide a similar range of services including primary health care and social services. Primary health care means applicable, simple and appropriate care, delivered at a grass roots level and overseen by community-based advisory boards. Ideally the definition also includes the social determinants of health and creative uses of health care. Community health centres provide primary health care, health promotion and community development services to low-income and marginalized populations. Beyond the physician and nurse services of primary health care delivery, health programs are designed to promote good health, prevent disease and attend to mental health issues. Examples of the types of programs provided include pre and postnatal care, HIV/AIDS, diabetes, well women, well baby, immunization, sexual and reproductive health, and basic laboratory and pharmacy services.

Social programs and services address the social determinants of health of the community including: employment, education, environment, isolation, social exclusion, income, social support, violence, housing and poverty. These services are crucial in alleviating future health care needs. The Alex Community Health Centre in Calgary, Alberta offers fresh food programs, a good food box, food bank, laundromat, social club, book club and more. Some CHCs offer home support and home management services, mostly for seniors. Many CHCs began with community support services and expanded to health services.

CHCs often serve a pivotal role in referring clients to other services in the community. Expert advisors consulted noted that there is a great need for case management services that connect people to services in their community. Furthermore, those consulted highlighted the fact that the complexity of the health care system is often difficult to navigate, making referral services critical for target groups. The barriers to accessing care are such that most community health organizations will not turn anyone away who arrives at their door; most have an unwritten policy to see anyone who comes to them.

Mobile services are another means to meet the needs of hard to reach populations, including those with transportation barriers and those facing discrimination. These providers bring health care services directly to the population on foot or by bus. “All mobile health units share a

Box 13. Aboriginal Health and Wellness Centre, Winnipeg, Manitoba

The Aboriginal Health and Wellness Centre (AHWC) in Winnipeg is a community-driven centre; the local community was consulted and requested a holistic family medical facility. The Aboriginal Health and Wellness Centre is a wellness centre that does clinical work and is founded on Aboriginal philosophy and life course philosophy. The centre is “one of the better primary health care models” because it “actually delivers on a holistic approach/model” to health care (Dr. Judith Bartlett, physician and previous board member). After establishing itself the AHWC became a full-fledged community health centre. The centre currently has the capacity to serve only 700 clients because of the dire shortage of physicians. Even with a full complement of physicians, the AHWC is only able to serve approximately 2,000 individuals; therefore, in a community of 60-70,000 Aboriginal people, health care needs are still going unmet. Expert advisors consulted advocate the creation of more Aboriginal specific clinics, targeted at First Nations, Metis and Inuit across Canada. One of its unique programs is a mobile PAP unit. The centre is not always accessible to women so they use a mobile bed to deliver health care to their patients in the community.

common purpose: deliver education and health care to “hard to reach” clients due to geographic isolation, or lack of financial resources.”²⁷

CHCs are often a part of a network of community groups providing health and social services to clients. Networking and collaboration enables a holistic approach to addressing the health and social issues of clients; for example, mental health issues, addiction and housing can all be focused on simultaneously. Through the integration of services provided by CHCs and other community agencies, and the number of quality health care professionals working with them, health care services to marginalized groups in the inner city areas are becoming “normalized.”

In most cases, community health centres employ multidisciplinary health care teams of physicians, nurses, nurse practitioners, dietitians/nutritionists, health promoters, psychologists, psychiatrists, social workers, counsellors, researchers and sometimes traditional healers. These professionals coordinate services, and target populations who experience difficulty accessing the system as well as individuals with complicated health issues.²⁸ Health care providers are usually paid by salary, a distinguishing feature from other models of health provision. This allows health professionals to focus on providing care to the patient, which enables the broader context of the health issue to be discovered, and enables links to be made across disciplines and through networks. Many experts emphasized that having doctors on salary, and working with an interdisciplinary model of care were great strengths in the work that they do. As well, nurses working at community health centres sometimes work in expanded roles; some community health centres believe nurses are underutilized and are actively looking at ways to expand the role of nurses.

Community health centres are community-governed organizations often run by a Board of Directors consisting of members of the community and health and social service providers. They are non-profit and the majority of their funding comes from the provincial government or municipal/regional health authorities with some specific program funding and research funding from private foundations and donors, or other government departments. Dr. Judith Bartlett, physician and former board member of the Aboriginal Health and Wellness Centre in Winnipeg, highlighted that while the mix of funding for community health centres is working, there is a big problem with the methodology. Funding comes attached to specific reporting and evaluation criteria that is not standardized across funding sources. For example, federal and provincial funding comes with different reporting frameworks. Therefore critical staff time is spent complying with funding requirements. Global funding would allow for more efficient and effective management.

Funding security is one of the benefits of community health centres funded largely or wholly by government. In the development of health services, Dr. Judith Bartlett notes that often “those that have get more.” In other words, once a small base of funding is accessed through development such as a community health centre, further program and capacity development is possible. With regards to First Nations health care provision, the federal government plays a critical role in funding. As well, this brings the services provided by CHCs into the mainstream health care system, even if the population served is not the mainstream. This means a certain level of quality

²⁷ See The Alex Web site at www.thealex.ca/index.php.

²⁸ See www.aohc.org/ and <http://cupe.ca/chc/chcfactsheet>.

care is available for marginalized populations. Although, interaction with the mainstream health care system is not yet routine, some community health organizations have developed a certain rapport with some health institutions.

Innovative Health Initiatives

In every urban area in Canada there are innovative health initiatives, which have grown out of recognition that specific groups in the community have health needs that are unmet by the mainstream health care system. These initiatives provide health care services to populations facing barriers to accessing care – in addition to services provided by local community health centres and hospitals. They are typically grassroots, community organizations but can also be corporations, such as Ottawa Inner City Health, or initiatives of other centres or institutions.

It is not known how many urban health initiatives there are across Canada and there is no organizing body to administer them; however, it is estimated that three percent of all small- and medium-sized organizations in Canada work in the health sector, not including hospitals. There is some data available by target group or service offered. For example, over 850 shelters are known to provide accommodations and support services to the Canadian homeless population (Pye, n.d.).

Services provided by innovative health initiatives are usually targeted at a specific population such as street youth, people with HIV/AIDS, immigrants and refugees, women, the homeless and underhoused, or substance users. They provide a broad range of services that include a combination of the following: primary health care, palliative care, chronic care, foot care, HIV/AIDS care, substance use counselling and management, sexual and reproductive health care, health education, simple pharmacy services, prevention and promotion, mental health care and referrals service to other health providers.

In many cases, mainstream health care services are not suitable for individuals in these target groups. Sometimes clients of innovative health initiatives have been banned from accessing mainstream services due to behaviour or abuse of services. These health initiatives therefore have developed different delivery practices and provide different delivery systems to target populations. For example, services are often available in the evening/at night or even 24-hours a day in order to accommodate the needs of the population. Likewise, mobile health units have been created to reach clients. In this case, health care professionals, most often nurses, travel on foot or by bus to deliver care. The Immigrant Women's Health Centre in Toronto uses a bus to deliver care to working immigrant women who are otherwise unable to access services.

Innovative initiatives, similar to community health centres, play a significant role in referring clients to other health and social services they are in need of. These initiatives also serve important roles as a community or family home, encouraging clients to rest, hang out, clean up and eat nutritious food. The objectives of these initiatives are often diverse including providing and managing health care, employing harm reduction strategies to deal with addictions, preventing the inappropriate use of mainstream health care resources, and ultimately restoring clients to mainstream society to be able to use resources appropriately and be contributing citizens (e.g. Victoria Youth Centre).

Box 14. An Innovative Initiative: Ottawa Inner City Health (OICH)

Ottawa Inner City Health is a non-profit corporation in Ottawa that delivers primary health care, chronic and convalescent care, palliative care and addictions management to the chronically homeless. It is highly unique in its ability to bring together numerous partners with different areas of expertise to deliver several valuable services from the same organization. Partners contribute expertise, human resources, funding and support. Ottawa Inner City Health offers integrated and managed care to a transient population with complex health needs including mental health issues, addictions and chronic/long-term disease. Their services successfully meet the needs of a population with multiple health needs and prevent the inappropriate use of mainstream health resources. OICH was also designed with direct input from clients. The organization takes a harm reduction approach to all health care provided. They provide dignity and culturally appropriate care to their clients and work to restore clients to mainstream society. They are the first organization of its kind in Canada and a model for others.

What they do: provide primary health care, palliative care, convalescent care, long-term care and a managed alcohol program to the chronically homeless.

Who they serve: chronically homeless shelter users with complex health needs.

The most common client is male, 45-50 years of age, with severe mental disorders, a long-term disease such as HIV or Hepatitis, an addiction, and other complicating health issues such as diabetes or pulmonary disorders.

How many clients they serve: at any given point, there are about 85 in the program; there are 175 in the program over the course of a year plus an additional 200 who are treated through the program but not admitted.

What type and how many health care professionals they employ: OICH employs physicians, nurse practitioners, nurses, and personal support workers; there are 45 staff paid by OICH plus another 10 who work for OICH but are paid by its partners.

When they started: 2001

How they are funded: they receive substantial funding from the Ontario Ministry of Health; the partner agencies also contribute directly to the project.

How they are governed: they are set up as a corporation; there are a number of partner agencies involved including the Shepherds of Good Hope, The Mission, the Salvation Army and the University of Ottawa.

Why their services are needed: there is a lack of health care services for the homeless, particularly those with complex needs.

Innovation: partnership between many agencies, set up as a non-profit corporation, provide seamless, integrated health care.

These initiatives are typically non-profit and receive the bulk of their funding as project funding from the government; however, they often struggle to maintain secure funding and get beyond the project stage. In a real sense, these services are “marginalized” like the people they serve. Other project funding comes from foundations, the private sector, and the community agencies themselves. In some instances, specialized health initiatives are provided as part of a larger effort to provide the basics of life to a vulnerable population. For example, shelter-based care for the homeless population can benefit from Ministry of Health alternate funding models that allow a global budget for primary care services delivered through a family health team.

Health care providers typically employed by the innovative health initiatives include physicians, nurses, nurse practitioners, personal support workers, mental health specialists, and other social service support workers. It is not uncommon for these health care professionals to be specialized in their area and/or in the population they serve, i.e. street youth with HIV. Often the health care providers need unique training, skills and/or experience to work with target populations who face barriers in accessing mainstream care.

Hospital Emergency Departments

The emergency departments in urban hospitals are a health care access point for people who experience challenges in accessing health care providers in other settings. Generally, access challenges include unavailability of other health care providers, lack of health insurance, lack of knowledge of the health care system, discrimination, and lack of available appropriate care targeted to their needs, etc. Urban hospitals also provide outreach programs and clinics for vulnerable populations. These are still rare but are becoming more common (e.g. Scarborough Hospital, Ottawa Hospital). Some hospitals provide mobile services to bring health care services directly to the population. Hospitals typically employ nurses and social service support workers for mobile clinics.

4.2.2 Gaps in Access to Primary Health Care Services in the Inner City

There are many health care services that are not being provided adequately or appropriately to marginalized populations resident in inner city areas. These gaps in health care provision tend to vary by population and community. Some gaps in service are unsurprising and speak to chronically underserved health needs; others are emerging as areas of increasing need spurred on by economic, political, social and cultural changes in society.

Chronic

Generally, chronic gaps in health care are experienced most acutely by particular populations who have specific and/or complex health care needs that are not fulfilled by mainstream health care provision. Experts consulted for this project noted that the following are chronically underprovided: dental care, psychiatric and mental health services, street outreach programs for women, First Nations maternal and child health services, clean drug resources especially in prisons, and long-term care facilities for the homeless and underhoused who have HIV/AIDS. Additionally, numerous social issues need addressing for many populations; this is having a significant impact on health. Specifically, key informants interviewed emphasized that there is a lack of supervised and adequate housing for many, including street youth, HIV/AIDS patients, Aboriginal people, and transgendered people. As one researcher states, there can't be "good health care without adequate housing." For many populations the problem is poverty and according to some experts interviewed, despite the increasingly elaborate system of health care provided to marginalized populations in the inner city, these services can't help to solve the upstream problem – poverty.

Emerging

Emerging health care requirements include the need for culturally appropriate models of care – particularly important for immigrants, refugees and Aboriginal peoples. Also, there is a need for palliative care facilities, in particular, for the homeless and street population. This is a new and emerging crisis that didn't exist to the same extent 10-15 years ago. The majority of provinces do not have residential hospices. There is only 25 percent palliative care coverage across Canada and those with a disability, Aboriginal peoples and in general those living on the margins don't have access to palliative care. Additionally, inner city health providers note that "hunger is a new trend." They are seeing an increasing lack of nutrition in the populations they serve; poverty is affecting the nutritional levels of marginalized populations. Those interviewed also highlighted new and emerging infectious and communicable diseases in the homeless population. According to health care providers in Montreal, an emerging trend is the increasing number of youth on the street and the increasingly younger age of youth on the street – in particular boys involved in prostitution.

System-Level Challenges in the Urban Health Care System

First, health care professionals are sometimes not well prepared for the health care issues specific to inner city populations. The context of the homeless population, substance users, recent immigrants and refugees or Aboriginal peoples may be unknown to health care professionals, in particular recent graduates. Young physicians may not understand population health, community development, and the cross-cultural issues of the inner city population. For example, medical education generally doesn't prepare doctors to deal with addiction, disease, infection, and mental illness all in the same client.

There is also a need for more multi-use rooms in existing facilities that can be used to address health and social care needs in different ways at different times. This has been proposed as potentially a better way to provide health care to marginalized populations rather than using mobile services. Multi-purpose rooms may "normalize" health care provision to marginalized populations in a sustainable way.

It was also suggested that more health care services, particularly for marginalized populations, in the urban periphery and not just in the downtown core would be beneficial. This is especially crucial as the suburban areas of Canada's cities continue to grow. Suburban areas are not only attracting the middle and upper class but also lower income families and individuals.

Research and clinical practice indicate that integrated care is more successful in improving the health status of populations; this is especially important for vulnerable populations who may see several different health care providers to address their health care needs. Linked with integrated care is the need for adequate systems in the community for follow up. As marginalized populations are being discharged from hospitals earlier and earlier due to stress on the mainstream health system, the need for follow up and integrated care becomes even more crucial. Treatment regimes and services are often organized for people with homes and family supports.

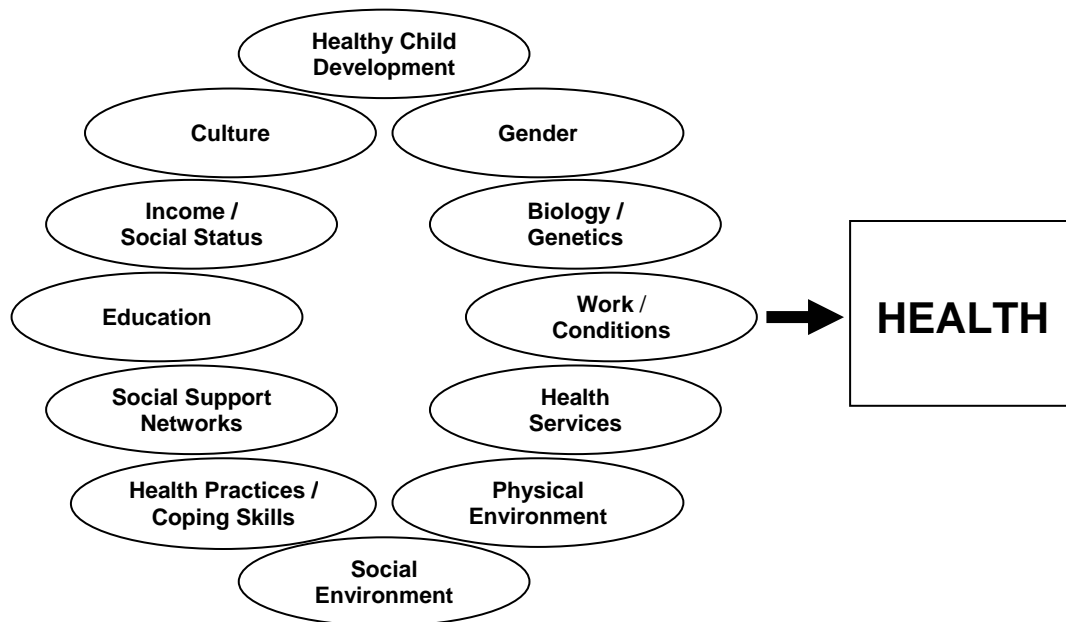
5. Policy Perspectives for Frontline Health

5.1 Why Are Some People Healthy and Others Are Not?

A person's health is the result of many things, referred to as the “determinants of health.” These are the factors that interact to affect personal health and well-being. Generally, there are three kinds of factors (see Figure 1):

- *Personal attributes and acquired behaviours* – biology and genetic endowment, healthy child and youth development, and personal health practices and coping skills
- *Physical environments*
- *Social and cultural resources and environments* – income and social status, education, social support networks, employment and working conditions, social environments, health services, gender and culture/ethnicity

Figure 1. The Determinants of Health



Each of the determinants can be examined for how it influences health outcomes at the individual, family, institutional, community and societal levels. To fully understand and act in support of the health of the entire population, action has to be taken at all of these levels.

Canadian researchers were some of the original contributors to this perspective of multiple influences on health (Hay and Wachtel, 1998). It is an area of investigation that has benefited from decades of work and is now well-researched and documented, in Canada and internationally. Research has shown that social issues appear to explain more about variations in health and well-being than does any combination of individual factors. A focus on social issues also reinforces that the individual and physical environment factors have social aspects (e.g. obesity is dependent on the quantity and quality of food available, and the available opportunities for physical activity).

Still prevalent in Canada is the thinking that to address the health needs of Canadians we need more of the same: e.g. doctors, nurses, hospitals; or, delivering the same thing in a different way: e.g. redesign of services, community-based care. Figure 1 makes clear that health services are but one of many determinants of health. It is important to understand the interdependence of the determinants and their ability to influence health. No one determinant on its own can guarantee good health for the population. Health services are certainly essential, but a number of other things are also essential – work, environmental conditions, income, genetics, social networks, gender, culture, and so on.

It is at the community level, of course, where the connections between health and its influences is clear. For example, the link between the lack of adequate housing (or homelessness) and health conditions caused or aggravated by environmental exposure. Health services can address symptoms presented, but cannot address the underlying conditions that produced the symptoms in the first place.

The evidence for the determinants of health perspective is very persuasive, sufficiently so that many governments and policy-makers have adopted the framework of the determinants of population health as a guide to policy-making in the health field (Canadian Population Health Initiative, 2004). The World Health Organization is concerned that governments are not actually doing enough to act on the social determinants of health, however, and has formed an international commission to draw the attention of governments and civil society to pragmatic ways of creating better social conditions for health (WHO Commission, 2006).

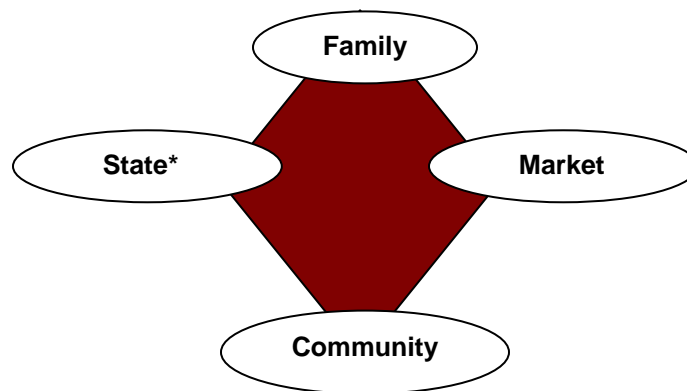
5.2 Who Is Responsible for Community Health and Well-Being?

What combination of family responsibility, private provision, community supports and public policy will ensure that Canadians achieve health and well-being? There is, of course, no definitive answer. Ongoing debate and dialogue amongst the four sectors is required to find the right balance of roles and responsibilities for the health and well-being challenges that Canadians are facing at any point in time.

This means that appropriate governance arrangements are crucial, and that a shared understanding of the challenges facing each sector is equally important. The good news is that communication achieved through open and accessible governance supports both goals.

Over the last few decades in Canada, the nature of the fundamental challenges facing Canadians has changed. For example, the family is more stretched than ever to support itself and care for its members. Businesses faces ever more competition from a larger and larger marketplace. The very sustainability of some communities and their organizations are threatened. And governments, where Canadians have traditionally looked for leadership and support, are more and more turning the responsibility for achieving health and well-being back to the family, business and community (Hay, 2005a).

Figure 2. The Well-Being Diamond



* State includes governments (federal, provincial, territorial and municipal) and core public services such as education and health care

Figure 2 represents these four key groups that contribute to community health and social well-being – the family, community, market (i.e. business) and state. The well-being diamond is simply a tool that helps to focus our thoughts and attentions on the “best mix” of policies, programs and responsibilities in support of the health and well-being of Canadians.

The well-being diamond helps us to highlight three themes about the way forward to achieving health and well-being for Canadians – addressing the unmet needs that have arisen due to new social challenges; addressing the underdeveloped capacity in each of the sectors to respond to these challenges; and, dealing with the ineffectiveness of current governance arrangements so as to provide the opportunities for dialogue and debate to address the challenges.

5.3 Supporting Community Innovation

Innovation is the creative process of applying knowledge and the outcome of that process. At the community level, innovation is about finding creative and concrete ways to deal with social and economic problems so as to make a real difference in the lives of people in the community.

Innovation sits deep within the community sector. A report from Canadian Policy Research Networks on *The Future of Social Innovation in Canada* stated that the non-profit, charitable and voluntary sector “is uniquely qualified to foster innovation at the community level, thanks to its in-depth knowledge of the community, capacity to mobilize volunteer and professional resources, creativity and entrepreneurial skills, and the ability to take a holistic approach to social and economic challenges, finding solutions that cut across sectoral and jurisdictional boundaries and limitations” (Goldenberg, 2004: 1).

Notwithstanding the many challenges facing Canadian communities, social innovation is active today in the social economy, the cooperative movement, the voluntary sector, and the community economic development movement. These sectors overlap, but each is a distinct piece of the

community social sector – some are charities and some are not. All of them have the unique asset of deep roots in their communities. They find local community responses to local community problems.

The community sector is a laboratory for community innovation. Organizations come into being to respond to new or unmet needs, or to take a new approach to their work. New groupings are created, and partnerships form across organizations to innovate with collaborative approaches to meeting those community needs.

There are major challenges facing the community sector in Canada, however. Financial sustainability is of primary concern, with a large part of the community sector dependent on governments for large parts of their annual budgets. Over the last 25 years, governments have been cutting back on their funding for community organizations. Human resource challenges are also significant – with lower compensation levels than the private sector, it can be difficult for community organizations to attract and retain skilled and competent staff, and this is particularly true at the management level. Community organizations also depend on volunteer resources – as staff to deliver programs and services, and as board members to govern and direct the organization's activities. However, the number of Canadians who actively volunteer has been declining (National Survey of Giving, Volunteering and Participating, 2006).

To get broader value and benefit from community innovation, enhanced and sustained resources are needed to permit the development, implementation, and sustainability of community organizations. Critical to innovation in the community sector are supports for those things that have been clearly identified in the research literature as success factors – management skills; entrepreneurial spirit; and connections to local networks of human resources, collaborative opportunities and partnerships (Goldenberg *et al.*, 2006). Further, capacity and resources for the sector are required if successful innovations are to be demonstrated and shared with others for their “best practices” value. This can create the potential for integration into the mainstream of the community sector, and potentially for the public and private sectors as well.

5.4 Health Services, Access and “Waiting Times”

Frontline health services can generally be characterized as primary care services, although some of the services provided have a specialized focus (e.g. substance abuse, sexually transmitted disease). It is important to distinguish between primary care and primary health care.

Primary health care was defined by the World Health Organization in the late 1970s to identify a system and philosophy of health promotion, prevention and care that incorporates an understanding of the social determinants of health. Important characteristics of primary health care are that it is the first level of contact with the health care system; brings health care as close as possible to where people are; encourages self-care and empowerment of community members; promotes community participation in decisions about health services; is evidence-based and uses appropriate technology; and is provided at a cost the community can afford.

Primary care refers to the first contact people have with the health care system to seek out primary care services for the diagnosis, treatment, and follow up for a specific health problem. Primary care is provided by family physicians, home care and public health nurses, pharmacists,

physiotherapists, dentists, and so on. Primary care is a core component of primary health care, although it is more narrowly focused on illness treatment and rehabilitation (Alberta Association of Registered Nurses, 2003).

The current debate and dialogue in Canada on access to health care is essentially restricted to consideration of waiting times for access to certain primary care diagnostic tests and treatments (e.g. joint replacements, cancer treatments) (Commission on the Future of Health Care in Canada, 2002; Statistics Canada, 2006).

The Canadian Nurses Association and Canadian Policy Research Networks recently released a report that attempts to broaden this health care accessibility “framework” (McIntosh, Torgerson, and Wortsman, 2006). For example, health care system indicators of accessibility often focus on benchmarks for hospital and physician-based services. These measures are useful and important, but they are insufficient to gauge accessibility of the overall health system. The researchers argue that a truly accessible health system demands discussion about access to a range of services and service providers that currently are not part of the debate about wait times.

Torgerson *et al.* provide a preliminary framework for understanding the host of factors that affect Canadians’ ability to obtain a complete range of essential health services. The factors include patient needs, available resources, available services, health system factors, and so on, situated within the social and political context of the determinants of population health. It is a complicated framework and requires consideration and debate – by the full range of health system stakeholders, including patients. It is an important framework, however, and serves as a crucial foundation upon which to build a broader framework for access to primary health care in Canada. And Torgerson *et al.* nicely define the accessibility goal by stating that “there is strong consensus that the hallmark of an accessible health system is one that can provide the right service at the right time in the right context.” (Torgerson *et al.*, 2006: 1). Frontline health services can be conceived as a response to that goal.

6. Conclusion

The Frontline Health Report clearly addresses the question, “What can be done to ensure support for frontline health services in Canada?” Support begins with recognition, and while there are no simple answers, the report provides a broader understanding of frontline health in Canada.

Our research has shown that while the needs and issues of frontline populations are diverse, they commonly face restricted access to health care due to geographic, social or physical barriers. Similarly, frontline health providers must also deal with common barriers such as geographic and social isolation, outdated delivery models, insufficient training and services, inadequate networks and support, and inappropriate funding models.

And yet, these dedicated and resourceful professionals strive to find a way to meet the needs of their respective communities. Innovation is always evident in the daily activity of frontline health providers. Across Canada, community health centres, community organizations, innovative initiatives, hospitals and mobile services are attempting to creatively address the health needs of marginalized and rural, remote and northern populations.

There are a number of innovations in how frontline health care is being delivered:

- Building partnerships among frontline health providers, public agencies, faith-based and other community organizations, and other allied health professionals;
- Developing new education, training and support models that help to attract, prepare and retain frontline medical professionals;
- Specific models of care for particular populations, e.g. women, ethnocultural groups;
- Taking care and services out to the community – e.g. community health centres, street-based outreach programs and mobile services;
- Using technology such as virtual communities and telehealth (psychiatry, home care, psychology, diagnostic services, etc.);
- Utilizing interdisciplinary teams and integrated service models that combine health services with other social services, i.e. “one-stop shops”;
- Undertaking community economic development initiatives that provide services, skill development and income for individuals and agencies; and
- Adopting new funding models, e.g. moving from fee-for-service arrangements to salary; putting organizations on global budgets.

This overview of frontline health shows that good communication, mutual trust and collaborative decision-making – within organizations and between partners and sectors – contributes to success. Roles and responsibilities are understood and, if they are not, or if they need to change, governance arrangements support information flows that ensure shared understandings and effective decision-making.

In talking with the people living and working on the frontlines, our research has found that frontline health services need more than recognition. They also need adequate staffing, financial resources, management, infrastructure, networks, partnerships and technology to sustain them.

There also needs to be a broader acknowledgement that frontline health services will be needed more and more, if action is not taken to address the underlying social causes of many of the health problems faced by the people living on Canada's frontlines. The more attention given to these social determinants of health and the more we can draw upon successful, innovative models for delivering health care services to marginalized populations, the less pressure there will be on these health care services in the future.

Appendix 1. Project Team Profile

Project Team

David Hay will be the project director and lead researcher, in collaboration with Judi Varga-Toth (content) and Lynda Becker (project management). Tom McIntosh and Cynthia Williams will be expert advisors. Emily Hines will provide research support. Trish Adams will provide administrative support. Brief bio-sketches of all team members follow.

David Hay – Director, Family Network: David I. Hay, PhD, joined Canadian Policy Research Networks as the Director of the Family Network in July 2004. Previously he was Manager of Reports and Analysis for the Canadian Population Health Initiative at the Canadian Institute for Health Information, where he was responsible for coordinating knowledge exchange and public engagement strategies for CPHI. David led the research, writing and production of CPHI's national population health report, *Improving the Health of Canadians 2004*. David has many years of experience researching and writing in the areas of population health, well-being, and social development in the private, public and non-profit sectors. Particular areas of expertise include child and family policy, poverty and inequality, and measurement and evaluation. Since joining CPRN, David has produced a number of papers and presentations, including, *Housing, Horizontality and Social Policy* (January 2005); *A New Social Architecture for Canada's 21st Century* (February 2005); *The Social and Non-Profit Agenda* (July 2005); and, *Building a Creative Community* (August 2005).

Judi Varga-Toth – Assistant Director, Family Network: Judi Varga-Toth, MA, joined CPRN in February 2005 to work with the Director to develop the Family Network's research programs and projects and its outreach activities. Previously, Judi was the National Programs Manager for Family Service Canada. Judi has many years of experience managing projects related to family well-being in Canada as well as researching and writing in the area of children's issues. Her particular areas of interest and expertise include social capital and family well-being, social policy affecting the most vulnerable segments of the Canadian population, the impact of violence on children and the interface between families and municipalities. Judi holds an MA in European Studies from the Institut des hautes études européennes, Université Robert Schuman, Strasbourg, France, focusing on the social, political and legal impacts of the European Union, and a BA in Political Studies from Queen's University, Kingston, Ontario.

Emily Hines – Researcher, Family Network: Emily Hines, MA, has been with CPRN since April 2004. She completed her MA in Public History at Carleton University in 2005. Her research focused on cultural policy and Aboriginal communities. Emily has experience researching and writing, and managing research and public education projects. Previously, Emily worked as Assistant Regional Coordinator for Médecins Sans Frontières/Doctors Without Borders in Vancouver. She also holds a BA from the University of British Columbia in International Relations.

Tatyana Teplova – Research Assistant: Tatyana Teplova, MA, started working with CPRN in January 2005. Previously, she was with the Centre for Voluntary Sector Research and Development, a joint unit between Carleton University and the University of Ottawa. Her areas of interest and expertise include social and child care policies, evaluation, work-life balance and welfare state sustainability. Tatyana is working on her doctoral dissertation in public policy at the School of Public Policy and Administration, Carleton University with a focus on social and family policies.

Lynda Becker – Family Network Project Manager: Lynda Becker joined CPRN in December 2001 to manage the Network's research projects and core budget. Prior to this, Lynda spent eight years as the office manager for Big Sisters of Ottawa-Carleton. Her 20 plus years of business experience, much of which has been with non-profit enterprises, has provided her with significant financial and administrative management skills, as well as considerable experience with editing and document production.

Trish Adams – Administrative Assistant, Work and Family Networks: Trish Adams came to Canada in 1990 from England, where she held a number of senior administrative positions. She worked as Administrative Assistant to the Deputy Chairman of the Economic Council of Canada until its closure in 1992, and then moved with Judith Maxwell and a small staff to help build CPRN. She now provides administrative support to both the Family and Work Networks.

Project Advisors

Tom McIntosh – Director, Health Network: In September 2004, Tom McIntosh was appointed as the new Director of the Health Network. He is also Associate Professor, Department of Political Science, University of Regina, and Research Faculty at the Saskatchewan Population Health and Evaluation Research Unit, at the university. He rejoined the university after working as Research Coordinator for the Romanow Commission. Prior to that, Tom McIntosh was a Research Fellow and Senior Policy Analyst at the Saskatchewan Institute of Public Policy, a Senior Policy Consultant for the Saskatchewan Department of Health and a Senior Research Associate at the Institute of Intergovernmental Relations at Queen's University. He has a PhD in Political Studies from Queen's.

Cynthia Whitaker – Senior Research Fellow, Family Network: In September 2004, Cynthia Whitaker began a two-year interchange assignment from the Government of Canada with Canadian Policy Research Networks as Senior Research Fellow in the Family Network. She is also a Fellow in the Public Policy Program at Simon Fraser University. Prior to this assignment, Cynthia was Assistant Deputy Minister of Strategic Policy in Social Development Canada. She has also had ADM assignments in Human Resources Development Canada, the Atlantic Canada Opportunities Agency, the Public Service Commission of Canada, and Indian and Northern Affairs Canada. She holds an MA in Political Studies from Queen's University and a BA from the University of Victoria and has taught at several Canadian universities. She is also co-editor and author of several publications on Canadian social policy and governance. In her volunteer life, Cynthia has been President of the Canadian Institute of Public Administration and Chairman of the Forum for Young Canadians.

Roger Strasser – Dean, Faculty of Medicine, Northern Medical School: Dr. Strasser is the Dean of the Northern Ontario School of Medicine, a joint initiative of Lakehead University in Thunder Bay, and Laurentian University in Sudbury. One of the world's foremost experts in the field of rural and remote medical education, he was chosen as Founding Dean of Canada's newest medical school following a global search in the spring of 2002. A graduate of Monash University in Melbourne, Australia, Dr. Strasser was Head of the Monash University School of Rural Health, which he helped to found, at the time of his selection to lead the creation of Canada's first new medical school in more than 30 years. From 1992 to 2004 Dr. Strasser was Chair of the Working Party on Rural Practice of Wonca, the World Organization of Family Doctors. Dr. Strasser has received numerous awards and citations for his efforts in putting rural medicine on the global medical map, including an Honorary Fellowship from Great Britain's Royal College of General Practitioners, and Australia's Louis Ariotti Award for Excellence and Innovation in Rural and Remote Health.

Stephen Hwang – Research Scientist, Centre for Research on Inner City Health, St. Michael's Hospital: Dr. Hwang's research focuses on homelessness and health, examining issues such as death rates among homeless people in Canada and the US, barriers to access to health care among the homeless, and chronic disease management in the homeless. Dr. Hwang completed his undergraduate training at Harvard University, his medical degree at the Johns Hopkins School of Medicine, and his Masters of Public Health Degree at Harvard University. Prior to joining the faculty of the University of Toronto in 1996, Dr. Hwang worked with the Boston Health Care for the Homeless Program. Dr. Hwang practices general internal medicine at St. Michael's Hospital in Toronto, and he is a staff physician at Seaton House, the largest homeless shelter in Canada.

Agnieszka (Iggy) Kosny – Institute for Work and Health: Iggy Kosny is a doctoral candidate in Public Health Sciences at the University of Toronto. She is a qualitative researcher with research interests in the areas of "marginalized" and non-profit workplaces; gender, work and health; and women's health. Her dissertation research examined working conditions and worker perceptions of risk and safety in non-profit social service organizations. In the course of her doctoral studies she has also worked as a research associate at the Institute for Work and Health and has been involved in a series of research projects which, broadly speaking, have examined how workers navigate return to work, the health care and compensation systems post injury.

Michael Jong – President, Society of Rural Physicians of Canada: Dr. Michael Jong, a full-time faculty member in the Discipline of Family Medicine based at the Labrador Health Centre in Goose Bay, was elected president-elect of the Society of Rural Physicians of Canada (SRPC) in the fall of 2005. He was also honoured by the College of Family Physicians of Canada (CFPC) as Newfoundland and Labrador Family Physician of the Year. The 10 provincial awards were presented during Family Doctor Week in Canada held in early December at the CFPC's annual meeting in Vancouver, BC. Happy Valley-Goose Bay has been home to Dr. Jong since September 1982, with a two-year break from 1989-91 to complete a Family Medicine residency at Memorial. Originally from Malaysia, Dr. Jong graduated from the University of Malaya in 1975 and then trained in internal medicine in England. A sense of adventure brought him to St. Anthony for a year and then to Goose Bay. During his family medicine residency at Memorial University of Newfoundland (MUN), Dr. Jong worked with Dr. Carl Robbins and other faculty members at MUN to start the Northern Family Medicine Education Program (NorFam), which offers residents a seven-month rural practice rotation in Goose Bay as part of their two-year program.

Communications Personnel

Jennifer Fry – Director of Public Affairs, CPRN: Jennifer Fry is a journalist of 30 years experience, best known for her documentary work with CBC Radio's flagship program on national politics, *The House*. She has worn many hats during her journalistic career – as a reporter, documentary maker, announcer, program host, producer, instructor and trainer. She has worked in a variety of locations including Québec City, Fredericton and Ottawa and abroad, in West Germany and the United Kingdom.

Gisèle Lacelle – Publications Coordinator: Gisèle Lacelle has been organizing research events for CPRN since its inception in 1995. As the coordinator for Publications, she also brings extensive experience in the production and publishing of CPRN's research reports, newsletter and the Annual Report. She is also responsible for posting all documents to the CPRN's Web site. Prior to joining CPRN, she held the position of Administrative Assistant to the Deputy Chairman, Economic Council of Canada.

Appendix 2. CPRN Profile

Who We Are

Canadian Policy Research Networks (CPRN) is one of Canada's leading creators of high quality and relevant social policy research. It is a non-profit charitable organization based in Ottawa with a staff of 30 and a voluntary Board of Directors. Its research products are available free at www.cprn.org.

CPRN's neutral space, coupled with evidence-based research, sets it apart from other policy research think-tanks. CPRN's mission is

to create knowledge and lead public dialogue and debate on social and economic issues important to Canadians. Our goal is to help make Canada a more just, prosperous and caring society for all Canadians.

The values inherent in this statement resonate with Canadians and guide our research programs and projects. These values also draw remarkably talented people to work at CPRN, where they serve as a magnet to attract audiences, and create rich networks of working relationships.

CPRN was founded by Judith Maxwell in 1994 and is now led by Sharon Manson Singer. The Board of Directors, chaired by Arthur Kroeger, includes distinguished Canadians from across Canada in the private, non-profit and public sectors.

To sustain its operations and ensure its independence, CPRN relies on diverse funding sources. Revenues include a combination of research contracts and donations, supported by a federal grant. The contracts come primarily from the public sector – federal, provincial and municipal governments. Donations from foundations, corporations and individuals support innovation and specific projects of mutual interest. All funders are encouraged to participate in the research process, working with the team and other participants to clarify the issues and extract meaning from the results. Cost-effective operations ensure every dollar is used to good effect.

What We Do That's Different

CPRN is distinguished by its unique approach to research:

- **Independent and neutral**, allowing perspectives to be shared
- **Evidence-based**, not designed to score ideological points, or to place blame for past faults
- **Founded on public values** as articulated by representative groups of citizens
- **Developed through engagement** with decision-makers, stakeholders and the public
- **Responsive** to the needs of decision-makers and stakeholders
- **Cost-effective** compared to our think-tank peers and to government policy shops
- **Widely disseminated and promoted** in the interest of fostering debate

Research and outreach elements are interwoven from the earliest days of a project or program. The CPRN research process is open and interactive and involves users from start to finish. Project and program activities are conceived in consultation with partners and stakeholders. We ask users to describe what they need to know, review research designs, and participate in roundtables to critique and interpret work in progress. Users contribute insights to enrich the research. In return, the research results and their policy implications become embedded in their own thinking.

Among those users of research are “frontline workers,” people who are rooted in the community and devote their lives to community-building and public service. This is a clientele without the resources to pay for advice and research. Given CPRN’s ability to facilitate public participation, and our “place-based” focus, our research is particularly relevant to community-building efforts.

These attributes – CPRN’s values base, the openness of its research processes, and its connection to the frontlines – have helped create rich networks that generate ideas for new research programs and projects. This, in turn, keeps CPRN “one step ahead” of the emerging public policy agenda and provides an evidence base when it is needed.

CPRN’s ideas have an impact on decision-making in provincial and federal governments and in communities across Canada. CPRN is seen as creative, responsive and non-partisan. It is respected for the quality and practicality of its ideas.

- *Quality* is assured by an open and interactive research process that involves diverse users from start to finish **providing community leaders with the opportunity to work with senior policy advisors and academics on national issues.**
- *Priorities and values* are established through dialogue with unaffiliated citizens.
- *Accessibility* is assured through a lively website; attracting 1.3 million downloads a year, plus a commitment to outreach.
- *Democracy* is enriched by giving representative groups of citizens a voice in public policy discussion.

How We Do It: Research and Dissemination

CPRN’s Research teams are organized into Networks – Health, Work, Family and Public Involvement – all backed up by highly trained research support staff. Network Directors are responsible for conceptual design, financing, quality control, and policy synthesis. The small staff teams in each network are supplemented by networks of external contributors as our research programs tap into the expertise of academic and consulting associates from across Canada, making CPRN an organization with a truly national perspective.

Public Affairs and IT teams provide support to disseminate the results and sustain the outreach activities of the Network teams with hard-copy and web-based information vehicles. CPRN’s large and popular bilingual web site registers more than a million visitors and over 1.3 million downloads a year of CPRN’s free research publications.

To carry its findings forward, CPRN's President, Directors and senior research staff participate in a wide range of outreach activities in principal centres across the country and, increasingly, internationally.

Why It's Important

Canada needs a creative, responsive, non-partisan and reliable source of relevant policy research and analysis.

- CPRN meets that need, and a recent independent evaluation assessed CPRN's research to be of high quality, unique, and relevant to users.
- In a governmental environment focused on short-term fixes, CPRN thinks long term. We see the trends developing, and anticipate the needs so that policy options are available when governments are ready deal with the issue.
- CPRN's inclusive process brings the players together as policy responses to issues are being formulated. This collaborative approach "road tests" the concepts with the policy-makers and the end users, avoiding problems created by a "top down" approach to policy implementation.
- With the free access to its research work via the web, CPRN provides useful tools and resources for front line workers in the community.
- The extensive dissemination of CPRN's work via the website puts CPRN on the cutting edge of knowledge transfer, a key element of the information society
- With websites sites such as www.jobquality.ca, CPRN provides both employers and employees with "news they can use" in terms of workplace issues, including job satisfaction and worker retention.

Our unique Canadian model taps into the minds and hearts of Canadians who want to build a better country. Together, we are generating *Fresh Ideas for Canada's Future*.

CPRN offers you the opportunity to invest in these Fresh Ideas. We welcome your active participation in the wide-ranging research programs being undertaken by our Work, Family, Health and Public Involvement Networks. We will be pleased to provide details on how you can contribute to a research program that matches your interests, or to provide sponsorship support for our web-based initiatives and youth internship program.

*For more information on the Canadian Policy Research Networks programs and how you can become involved, please contact the President, **Sharon Manson Singer** at (613) 567-7500, x2001, or by email at SMansonSinger@CPRN.org*

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Appendix 4. List of Web Sites Accessed

Action for Neighbourhood Change

www.anccommunity.ca/index_english.html

Active Living Coalition for Older Adults

www.alcoa.ca

AGVISION Inc.

<http://agvisiontv.farms.com/story.cfm?segment=150>

Assembly of First Nations

www.afn.ca

Association of Ontario Health Centres

www.aohc.org/

BC Network of Community Health Centres

www.chcnet.bc.ca/chcsinbc.htm

British Columbia Ministry of Health

www.hlth.gov.bc.ca/cpa/publications/index.html

Calgary Health Region

www.crha-health.ab.ca/yourhealth/index.html

Dental and Oral Health

www.calgaryhealthregion.ca/hecomm/oral/reducedfeedental.htm

Canada Health Portal – Clinics and Services

http://chp-pcs.gc.ca/CHP/index_e.jsp/pageid/4005/odp/Top/Health/Clinics_and_Services

Canadian Aboriginal AIDS Network

www.caan.ca

Canadian Academy of Physician Assistants

www.caopa.net

Canadian AIDS Society

www.cdnids.ca

Canadian Association for Rural and Remote Nursing

www.carrn.com

Canadian Association of Emergency Physicians – Rural Emergency Care

www.caep.ca/page.asp?id=7BD52CAFD85E4EE1A964838EBA055571

Canadian Council on Social Development – Presentation Notes
Aboriginal Children in Poverty in Urban Communities: Social Exclusion and the Growing Racialization of Poverty in Canada
www.ccsd.ca/pr/2003/aboriginal.htm

Canadian HIV/AIDS Information Centre
www.aidssida.cpha.ca/

Canadian Institute for Health Information
www.cihi.ca

Canadian Population Health Initiative
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_aboutcphi_e

Canada's Rural Communities: Understanding Rural Health and Its Determinants (2005)
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_communities_mdesmeules_e

Data Users' Conference 2006 – Quality Health Data for Effective Decision-Making
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=home_e

Rural Family Doctors Offer Wider Range of Services to Meet Their Patients' Needs (2006)
www.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_11jan2006_e

Canadian Institutes of Health Research
www.cihr-irsc.gc.ca/

Institute of Health Services and Policy Research (IHSPR) – Spotlight: Health Human Resources
www.cihr-irsc.gc.ca/e/28365.html#Strengthening%20the%20Medical%20Workforce%20in%20Rural%20Canada:%20The%20Role%20of%20Rural/Northern%20Medical%20Education

Institute of Aboriginal Peoples' Health
www.cihr-irsc.gc.ca/e/8668.html

Canadian Mental Health Association
www.cmha.ca

Canadian Public Health Association
www.cpha.ca

Canadian Society of Telehealth
www.cst-sct.org

Canadian Union of Public Employees (CUPE) – Community Health Centres (Fact Sheet)
<http://cupe.ca/chc/chcfactsheet>

Centre for Addiction and Mental Health

www.camh.net

Program Descriptions

[www.camh.net/Care Treatment/Program Descriptions/index.html](http://www.camh.net/Care_Treatment/Program_Descriptions/index.html)

Centre for Research on Inner City Health, St. Michael's Hospital

www.crich.ca/

Centre for Rural and Northern Health Research, Laurentian University

<http://cranhr.laurentian.ca/>

Rural Health Indicators, Chapter 5, Summary and Conclusions.

www.cranhr.ca/pdf/indcat/CHPTR5.pdf

Rural Health in the Interim Report of the Standing Senate Committee on Social Affairs,
Science and Technology

www.cranhr.ca/kirby.html

Centres of Excellence for Women's Health

www.cewh-cesf.ca/search/en/Results.htm?BasicSearch=rural&select=All&OwningOrg=All&submit=Search&batch_start=50&batch_count=10

College of Family Physicians of Canada

www.cfpc.ca

Appendix #1 – The College of Family Physicians of Canada JANUS Project (2004)

www.cfpc.ca/English/cfpc/education/rural/Apendix1/default.asp?s=1

Joint Position Paper on Rural Maternity Care (1997)

www.cfpc.ca/English/cfpc/programs/patient%20care/maternity/rural%20maternity/default.asp?s=1

Community Foundations of Canada

www.cfc-fcc.ca

What's New

www.cfc-fcc.ca/whats_new_view.cfm?id=800

Who We Are

www.cfc-fcc.ca/who_we_are/finder.cfm

Community Health Nurses Association of Canada

www.chnac.ca

Congress of Aboriginal Peoples

www.abo-peoples.org

First Nations Regional Longitudinal Health Survey (RHS)

www.naho.ca/firstnations/english/first_nation_regional.php

First Nations University of Canada – FN Nursing Program
www.firstnationsuniversity.ca

Four Neighbourhoods Community Health Centre
www3.pei.sympatico.ca/fnchc/public_html/

Government of Canada, Canadian Rural Partnership – Rural Research Note (2002)
www.rural.gc.ca/research/note/note1_e.phtml

Government of New Brunswick, Department of Health, Services for the Elderly
www.gnb.ca/0055/elderly-e.asp

Government of Newfoundland and Labrador
Guide to Health and Community Services
www.health.gov.nl.ca/health/guide/hcse.html

Health and Community Services
www.commhealth.nf.ca/

Health and Community Services – St. John's Region
www.health.gov.nl.ca/health/guide/hcssj.html

Health Canada
www.hc-sc.gc.ca/

eHealth
www.hc-sc.gc.ca/hcs-sss/ehealth-esante/index_e.html

First Nations and Inuit Health Branch
www.hc-sc.gc.ca/fnih-spni/index_e.html

National Native Alcohol and Drug Abuse Program
www.hc-sc.gc.ca/fnih-spni/substan/ads/nnadap-pnlaada_e.html

Rural Health
www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_06bk2_e.html

News Release – Rural Health (2001)
www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2001/2001_46bk1_e.html

News Release – Centre of Excellence for Children and Adolescents with Special Needs (2000)
www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2000/2000_97bk6_e.html

News Release – Centre of Excellence for Child and Youth-Centred Communities (2000)
www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2000/2000_97bk2_e.html

HIV and Poverty in Canada
www.hivandpoverty.ca

Information Centre on Aboriginal Health

www.ica.h.ca/content/en/

Institute for Aboriginal Health, University of British Columbia

www.health-sciences.ubc.ca/iah/index.php

Inuit Tapiriit Kanatami

www.itk.ca

Health Department

www.itk.ca/health/index.php

Manitoba's Office of Rural and Northern Health

www.ornh.mb.ca/index.html

Maytree Foundation

www.maytree.com

McGill University Libraries – Report: Income Trends in Canada, 1980-2000

www.library.mcgill.ca/edrs/data/dli/statcan/incometrends00/income_trends00.html

Metis National Council

www.metisnation.ca

Mount Carmel Clinic

www.mountcarmel.ca/

National Aboriginal Health Organization

www.naho.ca

Ajunnginiq (Inuit) Centre

www.naho.ca/inuit/english/our_centre.php

Regional Health Survey Homepage

www.naho.ca/firstnations/english/regional_health.php

Health Issues Information Sheets

www.naho.ca/firstnations/english/health_information_sheets.php

National Advisory Council on Aging

www.naca-ccnta.ca

National Homelessness Initiative, Government of Canada

www.homelessness.gc.ca

Case Studies

www.homelessness.gc.ca/projects/casestudies/index_e.asp

NSH Research Agenda

www.homelessness.gc.ca/research/index_e.asp

National Indian and Inuit Community Health Representatives Organization
www.niichro.com

National Organization of Immigrant and Visible Minority Women of Canada
www.noivmwc.org

National Union of Public and General Employees – Saskatchewan Decides to Keep Rural Hospitals Open
www.nupge.ca/news_2001/news_de01/n07de01a.htm

National Youth in Care Network
www.youthincare.ca

Nechi Training, Research and Health Promotions Institute
www.nechi.com

Northern Ontario School of Medicine
www.normed.ca

Nursing Practice in Rural and Remote Canada
<http://ruralnursing.unbc.ca/>

How Many Nurses (RNs) Are There in Rural Canada?
www.ruralnursing.unbc.ca/RNDB002.php

Ontario Ministry of Health and Long-Term Care
www.health.gov.on.ca/
www.health.gov.on.ca/english/public/contact/chc/chcloc_dt.html
www.health.gov.on.ca/english/hlinks/substance.html

Poundmaker's Lodge Treatment Centres
www.poundmaker.org

Public Health Agency of Canada
www.phac-aspc.gc.ca/

Aging and Seniors
www.phac-aspc.gc.ca/seniors-aines/index_pages/whatsnew_e.htm

Canadian Health Network
www.canadian-health-network.ca

Definitions of "Rural" Summary (2002)
www.phac-aspc.gc.ca/rh-sr/paper_e.html

Diabetes in Canada: Diabetes and Aboriginal People (1998)
www.phac-aspc.gc.ca/publicat/dic-dac99/d12_e.html

Division of Aging and Seniors
www.hc-sc.gc.ca/seniors-aines/

Frequently Asked Questions

www.phac-aspc.gc.ca/rh-sr/faq_e.html

Housing as a Determinant of Health (2002)

www.phac-aspc.gc.ca/ph-sp/phdd/overview_implications/09_housing.html

Improving the Health of Canada's Aboriginal People (2002)

www.phac-aspc.gc.ca/ph-sp/phdd/report/toward/back/impro.html

Population Health Approach

www.phac-aspc.gc.ca/ph-sp/phdd/index.html

Rural Health

www.phac-aspc.gc.ca/rh-sr/index.html

Social Inclusion as a Determinant of Health (2002)

www.phac-aspc.gc.ca/ph-sp/phdd/overview_implications/03_inclusion.html

Quality of Life Challenge

www.qolchallenge.ca

Rural Health Online

www.ruralhealth.ca

Community Success Stories: Recruitment and Retention of Health Care Professionals

www.ruralhealth.ca/success_stories.htm

Society of Rural Physicians of Canada

www.srpc.ca

Primary Care Renewal Policy (2003)

www.srpc.ca/librarydocs/PCRpolicy.html

Statistics Canada

Census Geography – Profiling our Large Metropolitan Areas

http://geodepot.statcan.ca/Diss/Highlights/Page8/Page8_e.cfm

News Release – Aboriginal Peoples Survey: Well-Being of the Non-Reserve Aboriginal Population (2003)

www.statcan.ca/Daily/English/030924/d030924b.htm

Rural and Small Town Canada Analysis Bulletin

www.statcan.ca/bsolc/english/bsolc?catno=21-006-X&CHROPG=1

News Release – Health Reports: Seniors' Health Care Use (2006)

www.statcan.ca/Daily/English/060207/d060207a.htm

Toronto Community Care Access Centre

www.torontoccac.com/

Toronto Disaster Relief Committee

www.tdrc.net

Toronto *Globe and Mail* – Behind Closed Doors: The Struggle Over Homecare (1999)
www.andrepicard.com/behind.html

Treasury Board of Canada Secretariat – Nursing Station
www.tbs-sct.gc.ca/rpm-gbi/lexicon-lexique/term-terme.asp?Language=EN&id=476

Unicef – News Release: Innocenti Report Card (2001)
www.unicef.org/newsline/01pr10.htm

United Way of Canada
www.unitedway.ca

University of Manitoba – Report Summary: Assessing the Performance of Rural And Northern Hospitals (2000)
www.umanitoba.ca/centres/mchp/reports/reports_97-00/rurhosp.htm

University of Northern British Columbia – British Columbia Rural and Remote Health Research Institute
www.unbc.ca/ruralhealth

University of Ottawa - Faculty of Medicine – How to Set Up a Family Medicine Elective
www.medicine.uottawa.ca/electives/eng/family_med.html

Vancouver Coastal Health
www.nscg.ca/services/seniors_info_northshore.cfm

Vancouver Community Health – Three Bridges Community Health Centre
www.vch.ca/community/Docs/Community_Health_Three_Bridges_Brochure.pdf

Victoria Cool Aid Society
www.coolaid.org/

Victorian Order of Nurses
www.von.ca

Youth Services Bureau of Ottawa
www.ysb.on.ca

Appendix 5. Data Gathering Framework/Approach

1. The Framework

Research Objectives	The Key Questions	How the Data Is to be Collected
1. To better understand the nature of populations in Canada who are unserved or underserved by the mainstream health care system. The focus will be: people in rural and remote communities; people living in the inner city; and people living in conditions of poverty and low income.	<ul style="list-style-type: none"> • What are the characteristics of the populations in question? • How many are there? Is this number growing or shrinking? Why? • What are their needs as they relate to health, broadly understood? • How and where do they access health services? • Which needs are currently unmet? • Can priority areas of concern be identified? 	<ul style="list-style-type: none"> • Primary method: environmental scan and literature review • Secondary method: KI interviews and site visits
2. To explore the nature of Frontline health services.	<ul style="list-style-type: none"> • Who are the providers that are serving people in rural and remote communities, in the inner city, and people living in poverty? • What do we know, about what they do and how they do it? • What kinds of services do they deliver? • What innovations do they create to address the challenges facing these populations in their communities? • Who supports frontline health care providers in their work? 	<ul style="list-style-type: none"> • Primary method: environmental scan • Secondary method: KI interviews and site visits
3. To describe the public policy environment in which patients and providers on the margins have been operating.	<ul style="list-style-type: none"> • What is the current level of support from various levels of government to broaden access to health services for underserved populations? • What has been the trend with respect to such support? • What assumptions underpin public policy initiatives in this critical area? • What are the gaps? The opportunities? 	<ul style="list-style-type: none"> • Primary method: literature review • Secondary method: expert consultation (i.e. Tom & Cynthia)

2. Research Protocol for Key Informant Interviews and Site Visits

2.1 Selection of the Key Informants

Initial round of interviews

An initial sample of up to 5 key informants was selected, with regional representation. These key informants are key staff_within identified health service organizations that have excellent knowledge of the health care needs and services in their area or they are researchers with expertise in the areas of health identified for this project.

The purpose of the interview was to fill in the gaps in the environmental scan and literature review. As well, these individuals were asked to nominate other potential informants who could identify further sources of information or case studies of interest.

Second round of interviews

A second round of interviews was conducted with approximately 50 people nominated either directly through the initial interview process (above) or through the materials provided by AstraZeneca. These people are representative of both the target populations being investigated (i.e. inner city, rural and remote) and the types of innovative service provision. Regional balance was considered in determining the final list of key informants.

Site Visits

Where possible key informant interviews were combined with site visits. These site visits allowed for a deeper understanding of the realities faced by frontline health service providers and supplemented the research with real life stories and examples.

2.2 Interview Procedures

A semi-structured interview guide was developed on the basis of the key questions identified above.

Initial interviews were conducted over the phone. All informants were contacted by members of the CPRN team in advance to seek their agreement to participate and to schedule a time for the interview. These interviews took place in May 2006.

Second round interviews took place either face-to-face (on both an individual and a group basis) and/or by telephone, depending on the opportunities and circumstances. When the interview took place by phone, all informants were contacted by members of the CPRN project team in advance to seek their agreement to participate and to schedule a time for the interview. The interviews were conducted from May through July 2006.

The interview guide containing the key questions was sent to all informants prior to the interview (in either English or French as most appropriate). The guide included a preamble that identified the interview objectives and addressed issues of anonymity, confidentiality, and so on.

2.3 Site Visit Procedures

Once a list of case studies has been confirmed, contact will be made by a member of the CPRN team to ascertain their willingness to be a case study for the purposes of this project. It is anticipated that this person will be one of the key informants contacted in the second round of interviews. Once their agreement has been obtained, travel plans will be made. The site visits will take place after all Key Informant interviews are complete.

A case study protocol will be developed which will ensure consistency across all the site visits.

3. Initial Proposed List of Key Informants and Case Studies

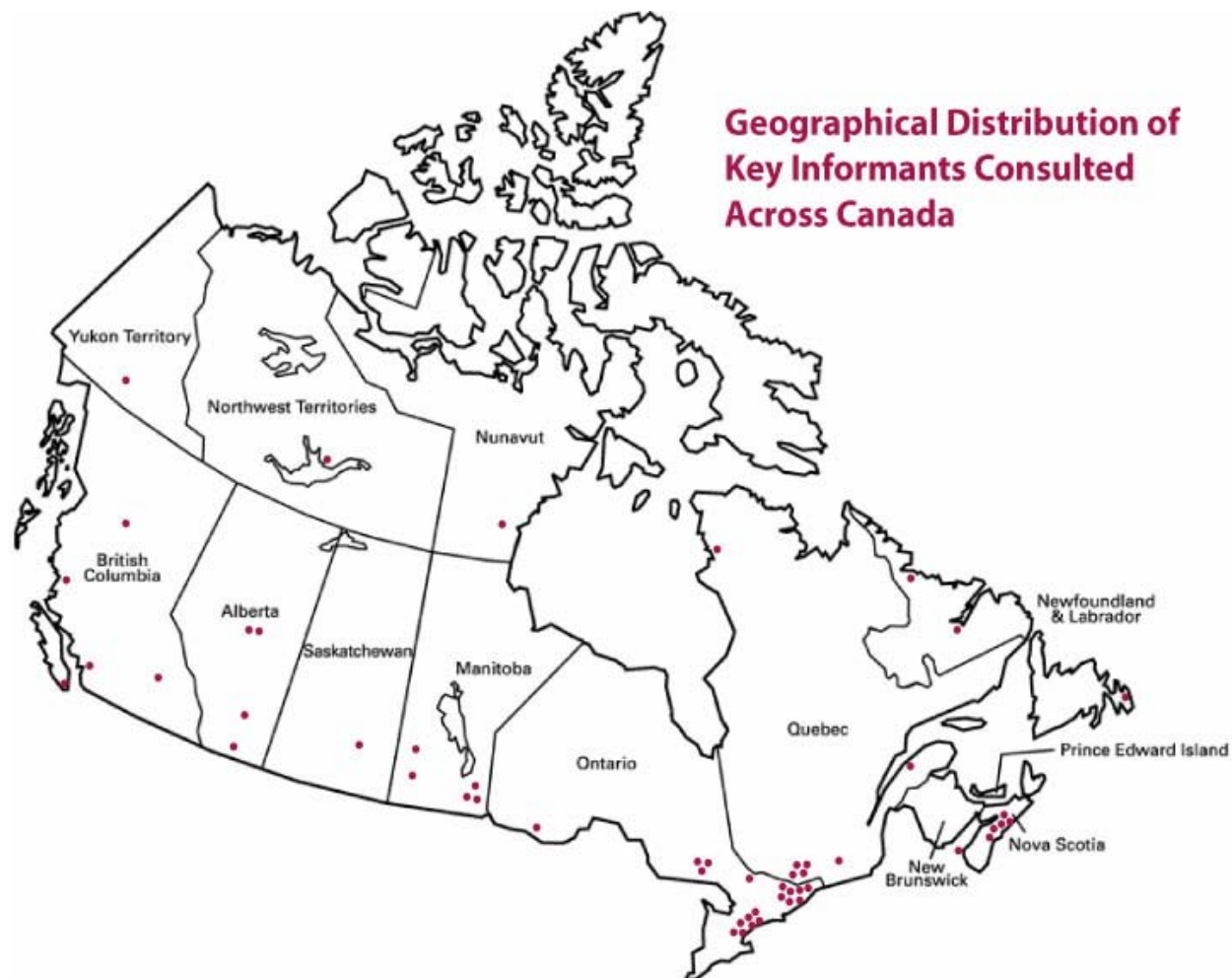
3.1 Initial round of key informants

- Stephen Hwang, Centre for Research on Inner City Health, Toronto
- Professor Raymond Pong, Laurentian University
- Tom McIntosh, Health Network Director, CPRN
- Cathy Crowe, Street Nurse, Toronto
- Judith Kulig, Professor of Nursing, University of Lethbridge

3.2 List of potential case studies

- Ottawa Inner City Health, Ottawa, Ontario
- Islands' Health Centre, Long & Brier Islands, Nova Scotia
- All Nations' Healing Hospital, Fort Qu'Appelle, Saskatchewan
- Health Contact Centre, Downtown Eastside, Vancouver, BC
- Victoria Youth Outreach, Victoria, BC
- United Church Health Services, Hazelton or Bella Coola, BC
- Integrated mental health, Dr. Manon Charbonneau, Sept îles, Quebec or La Popote Roulante, Montreal, Quebec, or Chez Stella, Montreal, Quebec
- The Immigrant Health Network, Ottawa, Ontario or Women's Health in Women's Hands, Toronto, Ontario
- Aboriginal Health and Wellness Centre of Winnipeg, Manitoba
- Community of Arviat Wellness Initiative, Nunavut
- Northern Family Medicine Education Program (NorFam), Happy Valley/Goose Bay
- Outreach Bus, Whitehorse, Yukon

Appendix 6. Key Informants



Urban

1. **Ayesha Adhami**, Administrative Coordinator, Immigrant Women's Health Centre, Toronto. Ayesha Adhami is a social justice activist and a member of Project Threadbare, a group organizing around the detentions of Pakistani men in Toronto.
2. **Evelyn Allen**, Director of Wellness, Aboriginal Health and Wellness Centre of Winnipeg. Evelyn Allen is the Clinical Director of the Aboriginal Health and Wellness Centre. She is a member of the Metis Nation and grew up in a small community in Northern Manitoba called Sheridan. Evelyn is an experienced Registered Nurse who received further training at Red River Community College in Thompson, Manitoba. Her clinical experience centres around the expanded nursing roles in isolated First Nation communities. She was instrumental in developing the delegated program involving cervical screening for Aboriginal women.

3. **Sharon Baxter**, Executive Director, Canadian Hospice Palliative Care Association, Ottawa, ON.
4. **Alice Broughton**, Program Manager, Sherbourne Health Centre, Toronto, ON.
5. **Peter Cooney**, Chief Dental Officer of Canada, Health Canada.
Dr. Peter Cooney completed his Specialty, Masters and Fellowship in Community Dentistry. He joined Health Canada in 1991 and worked with the First Nations and Inuit Health Branch (FNIHB) in Manitoba Region. In 1997, he became the National Dental Officer of the Medical Services Branch (now the First Nations and Inuit Health Branch). From 1999 to 2003, he was the Director General of the Non-Insured Health Benefits Division of FNIHB. Dr. Cooney is a former President of the Canadian Association of Public Health Dentistry and is currently the Chief Examiner for the specialty of Dental Public Health with the Royal College of Dentists of Canada.
6. **Linda Cornwell**, Community Health Promoter, Women's Health in Women's Hands, Toronto, ON.
7. **Louise Crane**, Aboriginal Health Facilitator, Alex Community Health Centre, Calgary, AB.
8. **Cathy Crowe**, RN, Toronto Disaster Relief Committee / Street Nurse and Atkinson Justice Fellow, Sherbourne Health Centre, Toronto, ON.
Cathy Crowe obtained her diploma in nursing from Toronto General Hospital in 1972, her Bachelor of Applied Arts in Nursing from Ryerson in 1985, and her Masters of Education (Sociology) from the Ontario Institute for Studies in Education in 1992. In June 2001, she received an Honorary Doctor of Science in Nursing from the University of Victoria in British Columbia. Cathy has been a Street Nurse in downtown Toronto and worked in the area of homelessness for over 15 years. She prefers to be called a Street Nurse – a term coined about 15 years ago by a homeless man at the corner of Sherbourne and Dundas in downtown Toronto. In October 2003, Cathy received an International Nursing Ethics Award in Amsterdam. In January 2004, she was awarded the Atkinson Charitable Foundation's Economic Justice Award and is now based at the Sherbourne Health Centre. In 1998, Cathy co-founded the Toronto Disaster Relief Committee (TDRC) which declared homelessness a National Disaster. The disaster campaign is a three level campaign targeting federal, provincial and municipal solutions to the homeless disaster and housing crisis. Its signature 1% slogan refers to the demand that all levels of government commit an additional 1% of their budgets to an affordable, social housing program.
9. **Kim Daly**, RN, Nurse Manager, Counselor, Victoria Youth Clinic, Victoria, BC.
10. **Claudette Gatien**, Directrice des services communautaires de Gatineau, CSSS de Gatineau, Gatineau, QC.
Claudette Gatien is presently Director General of CLSC et CHSLD de Gatineau. Prior to that she was Program Director at Régie régionale de la santé des services sociaux de l'Outaouais.

- 11. Nancy Haley**, Full Clinical Professor, Department of Pediatrics, Université de Montréal, QC; Pediatrician, Hôpital Sainte-Justine, Université de Montréal; and Consulting Physician, Montréal-Centre Public Health Directorate.
For seven years, Dr. Haley, together with Dr. Élise Roy of McGill University, has been conducting research on a cohort of 1,040 young street people aged 14 to 25 years in Montreal.
- 12. Stephen Hwang**, Research Scientist, Centre for Research on Inner City Health, St. Michael's Hospital, Toronto.
Dr. Hwang's research focuses on homelessness and health, examining issues such as death rates among homeless people in Canada and the United States, barriers to access to health care among the homeless, and chronic disease management in the homeless. Dr. Hwang completed his undergraduate training at Harvard University, his medical degree at the Johns Hopkins School of Medicine, and his Masters of Public Health Degree at Harvard University. Prior to joining the faculty of the University of Toronto in 1996, Dr. Hwang worked with the Boston Health Care for the Homeless Program. Dr. Hwang practices general internal medicine at St. Michael's Hospital in Toronto, and he is a staff physician at Seaton House, the largest homeless shelter in Canada.
- 13. Linda Lane**, Manager of Addiction Services, Health Contact Centre, Downtown Eastside, Vancouver, BC.
- 14. Dennis Long**, Executive Director, Breakaway Youth Services, Toronto, ON.
- 15. Andrew Morgan**, Community Health Initiative by University Students, Downtown Eastside, Vancouver, BC.
- 16. Wendy Muckle**, RN, BSCN, MHA, Executive Director, Ottawa Inner City Health, Ottawa, ON.
Wendy Muckle is the Executive Director of the Ottawa Inner City Health Project and has been active in the area of homelessness for 17 years.
- 17. Shelley Phipps**, Maxwell Chair in Economics, Department of Economics, Dalhousie University, Halifax, NS.
Dr. Phipps has a BA (Hons.) from the University of Victoria (1981); an MA from the University of British Columbia (1982); and a PhD from the University of British Columbia (1987). Her current research interests include: cross-national comparisons of social and economic policy and the well-being of children; the socio-economic determinants of child health status; decision-making within the family; and women's paid and unpaid work experiences and women's health.
- 18. Geneviève Ruel**, Psychologist, Centre de santé et services sociaux de Gatineau (CLSC de Hull), QC.
- 19. Miriam Stewart**, Social Support Research Program, University of Alberta, Edmonton, and CIHR Institute of Gender and Health, Edmonton, AB.
Dr. Miriam Stewart is Professor in the Faculty of Nursing and in Public Health Sciences, Faculty of Medicine (University of Alberta). She is a Health Senior Scholar, Alberta

Heritage Foundation for Medical Research and a former Medical Research Council of Canada and National Health Research Development Program (MRC/NHRDP) Scholar. Dr. Stewart was Director and Chair of the Centre for Health Promotion Studies University of Alberta (1997- April 2001), Director of the Atlantic Health Promotion Research Centre (1992-1997), and co-principal investigator and co-creator of the Maritime Centre of Excellence on Women's Health (1996-2000). Following an international review, Dr. Stewart was appointed as the first Scientific Director of the Canadian Institutes of Health Research, Institute of Gender and Health. In this capacity, she launched numerous strategic research initiatives, built research capacity, fostered innovative knowledge translation strategies, and attracted over 10 million dollars in national and international partnerships.

Rural

1. **Lorinda Andersen**, RN, Director of Patient Care, Bella Coola Hospital, United Church Health Services, Bella Coola, BC.

Lorinda Andersen is Director of Patient Care at Bella Coola General Hospital, an isolated, remote facility under British Columbia's Central Coastal Health Services. Lorinda has worked in a variety of areas in the past 18 years, including OR, general staff nurse, pharmacy and management. Lorinda is a champion of the IRPbc program, a unique and effective means of addressing recruitment and retention of health professionals.

2. **Judith G. Bartlett**, MD, MSc., CCFP, FCFP, Director, Health and Wellness Department of the Manitoba Metis Federation, and Associate Professor, Department of Community Health Science, University of Manitoba, Winnipeg, MB.

Judith G. Bartlett is a Metis family physician and researcher with many years experience in Aboriginal health. She carries a diverse portfolio relative to professional and business endeavours. She serves in the position of Director of the Health and Wellness Department of the Manitoba Metis Federation, is an Associate Professor in the Department of Community Health Science, University of Manitoba, and continues her clinical work at the Aboriginal Health and Wellness Centre. Additionally, Dr. Bartlett is active in private consulting in developing holistic approaches to health and wellness services, and is co-owner and CEO of JADE Enterprises Inc., an aerospace manufacturing company. She is very active in local, regional and national boards and committees, the majority of which are directly related to the health and well-being of Aboriginal peoples. This work has provided opportunities for networking and building relationships in the development of local, regional, national and international partnerships. Dr. Bartlett has been active in community organizations and initiatives for 24 years.

3. **Doug Blackie**, Manager, Enderby Community Health Centre, Enderby, BC.
4. **Nathalie Bourgeois**, Social Worker, Puvirnituk Youth Protection Centre, Puvirnituk, QC.
5. **Ed Brown**, CEO, Ontario Telehealth Network, (NORTH Network).
Dr. Brown is an emergency physician and the founder and Executive Director of the NORTH Network Telemedicine Program, which he has been developing since 1993. NORTH Network is one of the largest and most active telemedicine networks in North

America. Most recently, NORTH Network received the Government of Ontario's Diamond Award of Excellence in the category of "Serving Ontario's Citizens Better." Dr. Brown currently sits as a board member of the Canadian Society of Telehealth and is Chair of the Nominating Committee. He is a member of the Operational Space Medicine Advisory Panel of the Canadian Space Agency, Astronaut Office and sits as a member of the Toronto District Health Council Systems and IT Task Force. Dr. Brown was the recipient of the 2003 CANARIE I-WAY award for national leadership in the development of Canada's information highway, "Application of Technology" category. He was also the 2003 winner of *Canadian Healthcare Manager* magazine's Who's Who in Healthcare Award in the Technology category. Prior to founding NORTH Network, Dr. Brown worked as a consultant for the Ontario Government's Smart Systems for Health initiative and was Associate Faculty at the Institute for Clinical Evaluative Sciences in Ontario (ICES). Before embarking on his medical career, Dr. Brown studied mathematics and engineering at the University of Waterloo.

6. **Mark Buell**, Policy Analyst, NAHO, Inuit Health and Well Being.
Mr. Buell has worked as a Policy Analyst at the Ajunnginiq (Inuit) Centre at the National Aboriginal Health Organization (NAHO) for the past three years. The focus of his work has been in the areas of environmental health policy and knowledge translation in an Inuit-specific context. Prior to joining NAHO, Mr. Buell worked in community development and health promotions at the Inuvialuit Regional Corporation in the Northwest Territories. Mr. Buell has a Bachelor of Arts from Athabasca University, a Diploma in Public Relations from the Nova Scotia Community College and is presently pursuing his Masters of Arts. He is also an elected member of the Executive Committee for the Canadian Society for Circumpolar Health, and is actively involved with a number of volunteer organizations in Ottawa where he lives with his wife and two children.
7. **Elsie Deroose**, Team leader, Health Promotion, Department of Health and Social Services, Government of the Northwest Territories.
8. **Josée Gauthier**, Coordinatrice de l'organisation des services en régions éloignées, Institut National de Santé Publique, Direction des systèmes de soins et services, Rimouski, QC.
9. **Wayne Heide**, Administrative Director, Office of Rural and Northern Health, Manitoba.
Wayne has over a decade of experience in the area of community development, project development and administration. Transplanted to rural Manitoba from Winnipeg in 1992, he has a first-hand understanding of the value and appeal of rural life.
10. **Jan Horton**, Primary Health Care Transition Fund, Deputy Minister's Office, Health and Social Services, Government of Yukon, Whitehorse.
11. **Michael Jong**, President, Society of Rural Physicians of Canada.
Dr. Michael Jong, a full-time faculty member in the Discipline of Family Medicine based at the Labrador Health Centre in Goose Bay, was elected president-elect of the Society of Rural Physicians of Canada (SRPC) in the fall of 2005. He was also honoured by the College of Family Physicians of Canada (CFPC) as Newfoundland and Labrador Family Physician of the Year. The 10 provincial awards were presented during Family Doctor

Week in Canada held in early December at the CFPC's annual meeting in Vancouver, BC. Happy Valley-Goose Bay has been home to Dr. Jong since September 1982, with a two-year break from 1989-91 to complete a Family Medicine residency at Memorial. Originally from Malaysia, Dr. Jong graduated from the University of Malaya in 1975 and then trained in internal medicine in England. A sense of adventure brought him to St. Anthony for a year and then to Goose Bay. During his family medicine residency at Memorial University of Newfoundland (MUN), Dr. Jong worked with Dr. Carl Robbins and other faculty members at MUN to start the Northern Family Medicine Education Program (NorFam), which offers residents a seven-month rural practice rotation in Goose Bay as part of their two-year program.

12. Michelle Kinney, Deputy Minister, Government of Nunatsiavut, Nain, NL.

13. Rosella Kinoshameg, Home and Community Care Coordinator and Case Manager, Nippissing First Nation, Lawrence Commanda Health Centre, Garden Village.

Rosella Kinoshameg, previously the Nurse-In-Charge at the Native Health Unit on Manitoulin Island in Ontario, has developed a series of teaching models using Anishnabe teachings. In keeping with traditional teachings, Rosella has defined health as: "The power and energy to exist in balance of the body, mind and spirit and to function in harmony with the environment and the people." Rosella teaches that each individual is born with sacred gifts of the creator and these are known as the seven sacred gifts. These gifts are: respect, humility, compassion, honesty, truth, wisdom and love. As well, the creator has given us the circle and medicine wheel so that we can view life in a holistic manner. The circle symbolizes completeness and interdependency that gives unity and strength. The medicine wheel divides the circle into four directions. The framework allows for prenatal teaching using traditional symbols and teachings.

14. Judith Kulig, Faculty of Nursing, School of Health Sciences, University of Lethbridge, AB. Dr. Kulig is a researcher and professor in the School of Health Sciences at the University of Lethbridge, and is the co-leader of a national three-year study of nursing in rural and remote areas that will give communities information to help attract and retain nurses. From the time she arrived in Lethbridge in 1992, Dr. Kulig worked tirelessly to establish a research program relevant to health care in Southern Alberta. Her commitment to the rural communities she serves cannot be understated. One notable aspect of her research is the way in which Dr. Kulig has gained access to various cultural communities including the Hutterite, Kanadier Mennonite and Aboriginal communities. Her work has led to better understanding and care for the health needs of those who otherwise are overlooked and underserved. Dr. Kulig's contributions to intercultural nursing have long been recognized in Canadian nursing circles and her rural health research has gained her international renown. Dr. Kulig is a recipient of the Award for Excellence in Nursing Research.

15. Helen MacRae, Nurse Practitioner, Islands Health Centre, Nova Scotia.

- 16. Ruth Martin Misener**, Primary Health Care Nurse Practitioner, Assistant Professor of Nursing, Dalhousie University, and Coordinator, Nurse Practitioner Program, Dalhousie University, Halifax, NS.
Ruth Martin Misener's research foci include the implementation and evaluation of nurse practitioner roles, and the related areas of primary health care and rural health.
- 17. Patrick McGrath**, Killam Professor of Psychology, and Professor of Psychiatry and Pediatrics, Dalhousie University, Halifax, NS; Canada Research Chair; CIHR Distinguished Scientist.
Dr. McGrath's areas of interest are: Pediatric pain; distance treatment of mental health problems; chronic illness; and Managing our Moods (MOM) and Family Help: Primary Care Mental Health Care for Children.
- 18. Peter J. Newbery**, United Church Health Services, Wrinch Memorial Hospital, Hazelton, BC.
Dr. Newbery is a family physician, a clinical professor of medicine at UBC, a United Church minister, and holds a commercial pilot's licence and, until 2001, was the Director of the United Church Health Services, which operates five hospitals, eight medical clinics, and employs hundreds of health care workers. Dr. Newbery has taught medical students and family physicians, been a board member and president of provincial, national medical associations, and a member of provincial and national task forces on rural health. He belongs to an international group of rural doctors developing training in rural family medicine worldwide.
- 19. Barbara Oke**, Executive Director, Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada, Ottawa, ON.
- 20. Conleth O'Maonaigh**, Professor, Memorial University, St. John's, NF, and rural physician.
Dr. Conleth O'Maonaigh first visited Fogo Island in 1981 when he accepted a six-week locum. Trained at University College Dublin, he had a yen to travel and didn't anticipate settling down in Newfoundland. But he found he enjoyed the experience on Fogo, and in 1982 returned with the intention of staying only six months. He remained for 19 years.
- 21. Monique Pilkington**, Manager, Ontario Mobile Medical Eye Care Unit, CNIB, Sudbury, ON.
- 22. Raymond Pong**, Research Director, Centre for Rural and Northern Health Research, Laurentian University, Sudbury.
Dr. Pong is the Research Director of the Centre for Rural and Northern Research at Laurentian University in Sudbury, Ontario. A sociologist by training, he has many years experience of public service and academic experience in health services research, planning and policy. His areas of research interest include the health workforce, rural health, health care delivery, health policy and medical sociology. Ray is a principal investigator of many major studies including an examination of community-based health care in Canada, the 1997 and 2001 National Family Physicians Surveys, policy issues on telehealth, geographic distribution of physicians, and rural population health. He sits on many committees and boards, including being a member of the editorial board of the Canadian Journal of Program Evaluation, a Council member of FICOSSER and a member of the Scientific Advisory Committee on Rural and Northern Health Research of CIHR.

- 23. Shirley Watson Poole**, Director of Patient Care, Yarmouth Regional Hospital, Nova Scotia.
- 24. Fran Racher**, PhD, School of Health Studies, Brandon University, Manitoba.
Dr. Racher is actively engaged in research and teaching related to the health of rural and northern populations and communities. Her interests include: population health promotion, community development, access to health services, rural gerontology, and nursing leadership. She is a co-investigator on the three-year research project *Determinants of Health of Rural Populations and Communities* funded by the Social Science and Humanities Research Council and implemented through the Rural Development Institute (RDI). Dr. Racher recently completed the study *Accessing Health Services: The Experiences of Elderly Rural Couples* and is undertaking a study *Consumer Participation in Mental Health Program and Service Evaluation and Development* in partnership with the Assiniboine Regional Health Authority and the mental health consumer self-help organizations in the area. She earned a BScN and BA (Psych) from Brandon University; a MSc from the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba; and PhD from the Faculty of Nursing, University of Calgary.
- 25. Sheila Rose**, Yukon, used to be with the Government of Yukon but now with Canadian Breakfast for Living.
- 26. Roger Strasser**, Dean, Northern Ontario School of Medicine, Lakehead University, Thunder Bay/Laurentian University, Sudbury, ON.
Dr. Strasser is the Dean of the Northern Ontario School of Medicine, a joint initiative of Lakehead University in Thunder Bay, and Laurentian University in Sudbury. One of the world's foremost experts in the field of rural and remote medical education, he was chosen as Founding Dean of Canada's newest medical school following a global search in the spring of 2002. A graduate of Monash University in Melbourne, Australia, Dr. Strasser was Head of the Monash University School of Rural Health, which he helped to found, at the time of his selection to lead the creation of Canada's first new medical school in more than 30 years. From 1992 to 2004, Dr. Strasser was Chair of the Working Party on Rural Practice of Wonca, the World Organization of Family Doctors. Dr. Strasser has received numerous awards and citations for his efforts in putting rural medicine on the global medical map, including an Honorary Fellowship from Great Britain's Royal College of General Practitioners, and Australia's Louis Ariotti Award for Excellence and Innovation in Rural and Remote Health.
- 27. Shirley Tagalik**, Co-Director, CECASN.
Shirley Tagalik is a co-Director of the Mental Health Task Force for the Centre of Excellence for Children and Adolescents with Special Needs (CECASN). She is a long-time educator who has worked at all grade levels and as an administrator in schools of Nunavut. Presently, Shirley works for the Department of Education, Government of Nunavut. She is the manager of the Curriculum and School Services Division.

28. Marian Zerr, All Nations' Healing Hospital, Fort Qu'Appelle, SK.

Marian was the previous Executive Director of the Saskatchewan Federal Council and strongly supported the establishment and growth of the Managers' Community in the province. Marian has provided advice, guidance, active support in a number of ways, and most effectively as a voice for managers at the Federal Council table. She was instrumental in the formation of a managers' committee and has been the champion for the Managers' Council from its origin. Marian promoted networking for managers within the province as well as connecting managers to learning events sponsored by APEX and IPAC. Marian has also been instrumental in promoting the creation of a Youth Network in Saskatchewan, ensuring that there were connections between the Managers Council and the Youth Network.

Other

1. Michel Brazeau, MD, FRCPC, Services professionnels et affaires médicales pour le Centre de santé et services sociaux (CSSS) de Gatineau, Gatineau, QC.

Dr. Brazeau was the former Chief Executive Officer of The Royal College of Physicians and Surgeons of Canada. He is also Chair of the Steering Committee of Task Force Two: A Human Resource Strategy for Physicians in Canada. Prior to accepting his current position in 1998, Dr. Brazeau was Director for Health Policy, and Director of the Office for Continuing Medical Education, of the Federation of Medical Specialists of Quebec. From 1982 to 1993, Dr. Brazeau was Director of the Quebec Public Health Laboratory, an arms-length operation of the Ministry of Health responsible for quality management in laboratory medicine and public health. Dr. Brazeau is a medical microbiologist and infectious disease physician, having studied in these fields at the Université de Montréal, Institut Pasteur de Paris and teaching hospitals associated with these institutions. Strategy development and implementation are currently his major fields of interest.

2. Ed Cain, Provincial Medical Director, Emergency Health Services, Department of Health, Government of Nova Scotia.

3. Ainsley Chapman, Programs Consultant, Canadian Aids Society, Ottawa, ON. www.cdn aids.ca/ Responsible for project addressing HIV income and benefits information and files on income security and active living.

4. Alexandre Dumas, PhD, Professor, University of Ottawa, Ottawa, ON.

Alex Dumas received his PhD in Kinesiology (sociology) from the University of Montreal and completed post-doctoral research in the Faculty of Social and Political Sciences, University of Cambridge. He has taught undergraduate courses in the sociology of sport, history of sport, sociology of health, gerontology and qualitative research methods. His research interests focus primarily on social groups' relation to the body, specifically building on Pierre Bourdieu's socio-cultural theory of practice. Using qualitative research methods, his publications articulate "social class" and "age" to understand body dispositions towards health, physical activity and bodily appearance practices of different age groups. His current research deals with older women's practical knowledge and their embodiment of social and biological conditions of existence, and social logics of teenagers attending skate parks in Montreal.

5. **Bryan Hendry**, Communications Officer, Health and Social Secretariat, Assembly of First Nations, Ottawa, ON.
6. **David Holmes**, Professor and Nurse, School of Nursing, University of Ottawa, Ottawa, ON. David Holmes is currently Associate Professor at the University of Ottawa's School of Nursing and Nurse-Researcher at both the University of Ottawa, Institute of Mental Health Research (Forensic Psychiatry Program) and the Douglas Hospital Research Centre in Montreal (Psychosocial Division). For several years, he has been a clinical nurse in forensic psychiatry (both in hospitals and in the community) as well as in public health. His research interests focus primarily on the issue of the power relationship between nurses and vulnerable clients. He is also interested in the control mechanisms deployed by nurses. Most of his work, including research, essays, analyses and comments are based on the theoretical work of Michel Foucault.
7. **Malcolm King**, PhD, Institute of Aboriginal People's Health, Canadian Institute for Health Research, Alberta.
Malcolm King is a health researcher at the University of Alberta and Principal Investigator of the Alberta ACADRE Network, a training program for Aboriginal health research funded by the CIHR Institute of Aboriginal Peoples' Health. A member of the Mississaugas of the New Credit First Nation (Ontario), Dr. King obtained his doctorate in polymer chemistry from McGill University in 1973. He moved to the University of Alberta in 1985, and was promoted to Professor in the Department of Medicine in 1990. In his career in pulmonary research, he has developed new approaches to treat mucus clearance dysfunction in cystic fibrosis and chronic obstructive lung disease. He has served as Chair of the Faculty of Medicine and Dentistry Aboriginal Health Care Careers Committee since 1993. He served as President of the Canadian Thoracic Society in 1999-2000, and from 2000-2004 was a member of the Governing Council of the Canadian Institutes of Health Research. He is currently Chair of the CIHR Institute of Aboriginal Peoples' Health Advisory Board.
8. **John D. O'Neil**, PhD Faculty of Medicine, Community Health Sciences, University of Manitoba; Director of the Centre for Aboriginal Health Research, University of Manitoba, Winnipeg; and Senior Investigator, Canadian Institute for Health Research, Ottawa.
John O'Neil received his PhD in 1983 from the University of California (San Francisco-Berkeley) in medical anthropology and is currently a Professor and Director of the Centre for Aboriginal Health Research and Head of the Department of Community Health Sciences in the Faculty of Medicine at the University of Manitoba. He also chairs the Advisory Board of the Institute for Aboriginal People's Health at the Canadian Institutes for Health Research and is a CIHR Senior Investigator. From 1993-1996, he was the Research Advisor to the Health and Social Policy Team for the Royal Commission on Aboriginal Peoples. He has published over 75 papers and several monographs on a variety of Aboriginal health issues including self-government and health services, perceptions of environmental health risks, birthing options in remote communities, and health communication.

Appendix 7. Key Informant Interview Guide – General



Frontline Health: Innovation in Health Care Delivery

Project Overview and Key Informant Interview Guide

Frontline Health: Innovation in Health Care Delivery

“The Frontlines of Canada’s healthcare system are present virtually everywhere, not just in remote or isolated communities. The Frontlines exist wherever there are people unserved (or underserved) by mainstream healthcare. The Frontlines also include the health professionals who serve these patients and populations.”

Organizations and Partners

Canadian Policy Research Networks (CPRN), a not-for-profit, policy research organization, has been engaged by AstraZeneca Canada to conduct this project. David Hay, Director of CPRN’s Family Network, and Judi Varga-Toth, Assistant Director of the Family Network, are the project’s senior researchers, assisted by Emily Hines, Family Network Researcher and other CPRN research, project management and communication staff.

AstraZeneca Canada is one of the world’s leading pharmaceutical companies. Their business is focused on providing innovative, effective medicines that make a real difference in important areas of health care. AstraZeneca also supports communities as part of their commitment to improving the health and quality of life of Canadians. Part of the company’s philosophy is a dedication to giving back to local communities and supporting charitable and educational initiatives across the country.

Goals and Objectives

CPRN is undertaking research to provide a report that reveals the two sides of the Frontline Health story – the people and the providers. There are many people and communities in Canada that are vulnerable and at risk. These underserved populations in Canada are very disparate – from people living in rural and remote parts of Canada to street youth to isolated seniors – and include low-income individuals and families, people without shelter, recent immigrants and refugees, and Aboriginal peoples.

Frontline health services are also disparate and, for the most part, isolated from one another. Who are the providers that are helping and serving people in rural and remote communities, in the inner city, and those people living in poverty? What do we know, about what they do and how they do it? What kinds of services do they deliver? What innovations do they create to address the challenges facing these populations in their communities? Who supports frontline health care providers in their work?

The broad aims of this study are three-fold: first, to understand and profile the people living on the margins and lacking access to sufficient health care services; second, to identify and describe the frontline health providers working in communities across Canada, often unrecognized and unsupported by our mainstream health care system; and third, to contextualize these findings within the broader policy context in Canada today.

Activities

The project will use qualitative research methods to collect the needed information. These will include an environmental scan, a literature review, key informant interviews and site visits. The final report will be used by AstraZeneca to develop and support its community investment signature program, to be publicly released in the fall of 2006. The research report will also be disseminated by CPRN through its established communication mechanisms.

Intended Outcomes

The goal is to produce an agenda-setting report for the Frontline Health program at AstraZeneca Canada.

Key Informant Interview Guide

Thank you for agreeing to be a key informant for this project. Your insights are extremely valuable to us and are essential in meeting project objectives. The objectives of the interview are:

- Helping us better understand the population you serve
- Obtaining information on your service, the innovations you have undertaken and the outlook for the future
- Identifying the strengths (innovations/successes), weaknesses (challenges/gaps), opportunities and threats of your service and the environment you function in
- Identifying other key informants

For any particular question, please free to indicate that you don't know or have no opinion; you can decline to answer any question or withdraw from the interview completely at any time. The interview data will not be shared with anyone outside of the Research Team. Your name, position and the information you provide us may be used in the final report unless you indicate that this is not desirable, in which case all information will be kept strictly confidential. You may be quoted or paraphrased, however the report will not identify you by name or position, unless you have indicated agreement.

1. Discuss Identification of Key Informant in Report

2. Population Served

- 2.1 Who do you serve? Is it population specific or area specific or both/neither?
- 2.2 How do you let potential users know about your service?
- 2.3 How many people do you serve per month/year? Is there a backlog/waiting list?
- 2.4 Are there still unserved people in your target clientele? How many? If not sure, please give an approximation.
- 2.5 What other health services do your clients typically access? Do they have other unmet needs besides what you provide and what other services they access? If so, what are these needs?

- 2.6 Why is your service needed? Do you think your clients are best served by you/your service or would another service/method be better?
- 2.7 Are you aware of any specific research and/or data on the population you serve?

3. Service Offered

Historical

- 3.1 How did your service get started and what need were you trying to fill?
- 3.2 Who was part of the establishment of your service?
- 3.3 How was it funded?
- 3.4 Who were your partners and collaborators when you began?

Current

- 3.5 What is your service? Please describe the work that you do.
- 3.6 How long have you been offering the service?
- 3.7 Is the service unique? How do you know?
- 3.8 How is the service financially supported and operated? Do you feel this is the right mix of funding sources? Why or why not?
- 3.9 Do you have paid staff? If so, how many? If not, how do you staff the service? Do you have any difficulty with staff retention? Burn-out? Other problems? What might help to alleviate these problems?
- 3.10 Do you use volunteers? If so, how do you recruit them, train them, retain them?
- 3.11 Have your initial partnerships expanded? Who are your best partners? Who has not lived up to your expectations?
- 3.12 Did your health/medical training/education/experience prepare you for this work/position?

4. Strengths Weaknesses Opportunities and Threats

- 4.1 Would you consider your service to be part of the mainstream health care system? Why or why not?
- 4.2 What are the strengths of your approach? Do you feel you are successful in meeting the identified needs? How do you define success? What have been your major successes?
- 4.3 What are the weaknesses of your approach? Have you had any major disappointments?
- 4.4 Has the need for your service grown since you began? How do you know?
- 4.5 What threats do you perceive with respect to your service? To the population you serve more broadly? What actions do you plan to take to mitigate these threats, if at all?
- 4.6 What changes has your service undergone since start-up? Have these been improvements or reductions in service? Why have they taken place?

- 4.7 What innovations are you particularly proud of?
- 4.8 What opportunities do you see on the horizon? What plans do you have to take advantage of these?

5. Broader Context

- 5.1 Are you aware of similar services in other communities across Canada?
- 5.2 Are you aware of other service providers working under similar conditions and constraints?
- 5.3 Do you have a network of such providers that you can turn to for ideas and support? If so, is this a formal or informal arrangement? If not, would this be useful to you? If yes, why, if not why not?
- 5.4 How do you interact with the mainstream health system, i.e. doctors, hospitals...?
- 5.5 How important are health care services in general, and your service in particular, to achieving health and well-being for the population you serve? Are there other elements that policy-makers should be considering when looking at the overall health and well-being of this population?
- 5.6 Do you have any additional comments about the broader policy environment, municipal, regional, provincial or federal?

6. Other Key Informants

- 6.1 Can you name other people we should contact with regards to your service or who may have critical additional information?
- 6.2 Are you aware of other innovative services across the country that would merit mention in this report?
- 6.3 Is there anything else you would like to comment on?

If you have any questions or comments, or for more information on the project, please contact David Hay, Judi Varga-Toth, Emily Hines or Tatyana Teplova.

David Hay
613-567-7500 x2007
dhay@cprn.org

Judi Varga-Toth
613-567-7500 x2018
jvargatoth@cprn.org

Emily Hines
613-567-7500 x2033
ehines@cprn.org

Tatyana Teplova
819-772-0098
t_teplova@yahoo.com

Appendix 8. Key Informant Interview Guide – Researchers and Academics



Frontline Health: Innovation in Health Care Delivery

Project Overview and Key Informant Interview Guide

Frontline Health: Innovation in Health Care Delivery

“The Frontlines of Canada’s healthcare system are present virtually everywhere, not just in remote or isolated communities. The Frontlines exist wherever there are people unserved (or underserved) by mainstream healthcare. The Frontlines also include the health professionals who serve these patients and populations”

Organizations and Partners

Canadian Policy Research Networks (CPRN), a not-for-profit, policy research organization, has been engaged by AstraZeneca Canada to conduct this project. David Hay, Director of CPRN’s Family Network, and Judi Varga-Toth, Assistant Director of the Family Network, are the project’s senior researchers, assisted by Emily Hines, Family Network Researcher and other CPRN research, project management and communication staff.

AstraZeneca Canada is one of the world’s leading pharmaceutical companies. Their business is focused on providing innovative, effective medicines that make a real difference in important areas of health care. AstraZeneca also supports communities as part of their commitment to improving the health and quality of life of Canadians. Part of the company’s philosophy is a dedication to giving back to local communities and supporting charitable and educational initiatives across the country.

Goals and Objectives

CPRN is undertaking research to provide a report that reveals the two sides of the Frontline Health story – the people and the providers. There are many people and communities in Canada that are vulnerable and at risk. These underserved populations in Canada are very disparate – from people living in rural and remote parts of Canada to street youth to isolated seniors – and include low-income individuals and families, people without shelter, recent immigrants and refugees, and Aboriginal peoples.

Frontline health services are also disparate and, for the most part, isolated from one another. Who are the providers that are helping and serving people in rural and remote communities, in the inner city, and those people living in poverty? What do we know, about what they do and how they do it? What kinds of services do they deliver? What innovations do they create to address the challenges facing these populations in their communities? Who supports frontline health care providers in their work?

The broad aims of this study are three-fold: first, to understand and profile the people living on the margins and lacking access to sufficient health care services; second, to identify and describe the frontline health providers working in communities across Canada, often unrecognized and unsupported by our mainstream health care system; and third, to contextualize these findings within the broader policy context in Canada today.

Activities

The project will use qualitative research methods to collect the needed information. These will include an environmental scan, a literature review, key informant interviews and site visits. The final report will be used by AstraZeneca to develop and support its community investment signature program, to be publicly released in the fall of 2006. The research report will also be disseminated by CPRN through its established communication mechanisms.

Intended Outcomes

The goal is to produce an agenda-setting report for the Frontline Health program at AstraZeneca Canada.

Key Informant Interview Guide

Thank you for agreeing to be a key informant for this project. Your insights are extremely valuable to us and are essential in meeting project objectives. The objectives of the interview are:

- Helping us better understand the population you study
- Obtaining information on the current situation facing Canadians in your area of expertise, in particular the health care provision innovations you are aware of in Canada or elsewhere and the outlook for the future
- Identifying the major gaps in service delivery and research, and any specific recommendations you are aware of for improving the health research, policy or practice environment to benefit the target population
- Identifying other key informants

For any particular question, please free to indicate that you don't know or have no opinion; you can decline to answer any question or withdraw from the interview completely at any time. The interview data will not be shared with anyone outside of the Research Team. Your name, position and the information you provide us may be used in the final report unless you indicate that this is not desirable, in which case all information will be kept strictly confidential. You may be quoted or paraphrased, however the report will not identify you by name or position, unless you have indicated agreement.

1. Discuss Identification of Key Informant in Report

2. Population

- 2.1 What population do you study? How do you define this population?
- 2.2 How many people make up this population? What portion of the population you serve live in poverty?
- 2.3 Who are the unserved or underserved people in your population? How many? If not sure, please give an approximation.
- 2.4 How many health care providers serve this population?
- 2.5 Are you aware of any specific research and/or data on the population you study?

3. Health Care and Health Status

- 3.1 What, generally, are the health care needs of the population you study?
- 3.2 Can you differentiate between mainstream health care and the so-called “frontlines” for your population? Why or why not?
- 3.3 Who are the primary providers of health care for your population? Are they sufficient to meet current needs? If not, what is needed to address this situation? Are you aware of any specific research and/or data on the health care providers who serve your population?
- 3.4 What are the main health challenges that are being unmet or underserved in your population? Why?
- 3.5 Are the problems growing, diminishing or continuing?
- 3.6 What are the most innovative approaches to meeting the health care needs of this population?

4. Broader Context

- 4.1 Are you aware of similar challenges in other provinces or countries? Can you explain?
- 4.2 Are you aware of “frontline” service providers working with your population?
- 4.3 Is there a network of such providers? Is there research being conducted on “frontline” health providers to your population?
- 4.4 How important are health care services in general, whether mainstream or frontline, to achieving health and well-being for the population you study? Are there other elements that policy-makers should be considering when looking at the overall health and well-being of this population?
- 4.5 Do you have any additional comments about the broader policy environment, municipal, regional, provincial or federal?

5. Other Key Informants

- 5.1 Can you name other people we should contact with regards to this population or who may have critical additional information?
- 5.2 Are you aware of other innovative services across the country that would merit mention in this report?
- 5.3 Can you recommend other sources of information, such as reports or publications?
- 5.4 Is there anything else you would like to comment on?

If you have any questions or comments, or for more information on the project, please contact David Hay, Judi Varga-Toth, Emily Hines or Tatyana Teplova.

David Hay
613-567-7500 x2007
dhay@cprn.org

Judi Varga-Toth
613-567-7500 x2018
jvargatoth@cprn.org

Emily Hines
613-567-7500 x2033
ehines@cprn.org

Tatyana Teplova
819-772-0098
t_teplova@yahoo.com

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British Columbia

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- Department of Training and Employment Development

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- Department of Education

- Department of Environment and Labour

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- Strategic Planning and Elementary/Secondary Programs

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600 - 250 Albert, Ottawa, ON K1P 6M1

☎ 613-567-7500 – 📠 613-567-7640 – 🌐 www.cprn.org