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# Health and Health Care Needs in Rural and Northern Ontario: A Holistic Nursing Perspective

March 17, 2011

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**SUBMISSION**

**ON**

**THE RURAL AND NORTHERN HEALTH CARE PANEL STAGE 1 REPORT**

**HEALTH AND HEALTH CARE NEEDS IN RURAL AND NORTHERN ONTARIO: A  
HOLISTIC NURSING PERSPECTIVE**

March 17, 2011



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## **Summary of ONA Recommendations on the Rural and Northern Health Care Panel Stage 1 Report**

1. Given the historic role of RNs as key providers of health care in rural and Northern Ontario, the expertise of frontline RNs should be made part of the basis for further development of the rural and northern healthcare framework, whether through the Local Health Integration Networks or other bodies.

2. Socio-economic and environmental issues particular to Northern Ontario must be examined – in addition to lifestyle behaviors and genetic predisposition – in order to address the root causes of lower life expectancy, higher relative obesity, and high infant mortality in the rural and urban north. Only through a comprehensive approach addressing socio-economic problems and job creation without further environmental degradation will health and wellness be improved in northern Ontario. This, in turn, will likely decrease demand for health care services to a certain extent. Such a comprehensive approach is appropriate for the province as a whole.

3. ONA calls for investment in the implementation of a public, province-wide, woman and family-centered maternal and newborn care plan. Every woman in Ontario should have access to high quality, woman and family-centered maternity care 30 minutes away from home, including:

- birthing services
- pre-conception counseling
- prenatal care and education
- services for mothers and infants for 6 weeks after birth.

Women, frontline RNs, nurse practitioners, midwives, and other relevant professionals should be incorporated as decision makers in the creation of the plan, with deliberate outreach to include women and health professionals in northern and rural Ontario. Community members, midwives, aboriginal RNs, and non-aboriginal RNs working in aboriginal communities should be mobilized to assess, plan, and provide culturally appropriate maternal and newborn care in aboriginal communities.

4. In addition to the full range of maternal and newborn care, ONA sees other community and hospital-based care as part of a bundle of basic care necessary for all communities, close to home. ONA thus calls for investment in the creation and implementation of a public, province-wide plan for stable, accessible services for seniors – including homecare and long term care – with provincial standards.

5. Completing the bundle of basic care, the following services should be available in every hospital in the province, including in the smallest and amalgamated or allied hospitals: emergency departments and special care units or monitored beds; blood services; laboratory and x-ray; mental health services; diabetes programs; palliative care; rehabilitation; chemotherapy/oncology program in larger small hospitals; dialysis for stable patients in larger small hospitals; remote hospitals, and coordinated between small hospitals in close proximity; minor surgeries, simple geriatrics, and internal medicine coordinated between small hospitals in close proximity.

6. The need for patient transfers in rural and northern Ontario will be reduced significantly with the establishment of the bundle of basic care elaborated in Recommendations 3, 4 and 5. To respond to patient transfer and transportation needs, which will always exist, a plan must be devised and resourced for both non-urgent and urgent patient transfers based on public provision, and adequate staffing levels of RNs to accompany travelling patients. ONA is opposed to transport provision by private and volunteer providers, and accompaniment by volunteers and unregulated health workers, as suggested in Recommendations 10 and 11 of the Rural and Northern Health Care Framework/Plan, Stage 1 Report .

7. Fund the creation and protection of full-time, permanent RN positions, including funding for late-career nurse retention initiatives, through permanent, ongoing, annualized funding. Given the need for RNs to be “expert generalists” in rural and northern regions, experienced RNs are particularly important in rural and northern Ontario for the transfer of knowledge and skills to new graduates. Adequate staffing of full-time hospital RNs is a crucial corollary to this in order to allow late-career nurses the time necessary to properly mentor new RN graduates. In turn, the creation of more full-time equivalent RN positions in all sectors - hospitals, public health, community, and long term care - in rural and northern Ontario is necessary to retain new graduates. According to recent ONA statistics (March 2011), 65 per cent of frontline RN jobs held by ONA members in northern Ontario are part-time positions. This compares with 54 per cent of frontline RN jobs held by ONA members in the rest of the province.

8. Fund RN education programs in rural and northern Ontario universities oriented specifically to the practice on nursing in rural and northern communities. This will likely include a different balance of theoretical and practical training than in southern, urban-oriented RN education programs. Rotations in aboriginal communities should be part of practical training of all RN students in rural and northern Ontario.

9. Given lower income levels in rural and northern Ontario, especially in aboriginal communities, the introduction of the four-year, university RN training program has made RN careers particularly inaccessible to residents of rural and northern Ontario. In order to increase accessibility for these residents – individuals who are more likely to remain in rural and northern Ontario if gainfully employed – study and child care subsidies should be made available for low-income RN students based in rural and northern Ontario. Moral and career support during training and upon employment have proven to be successful for retention of aboriginal health workers and should be included as part of RN education programs targeting aboriginal students.

10. Nurse Practitioners (NPs) are a key part of solving the shortage of primary care providers in rural and northern communities. For frontline RNs based in both hospitals and the community, collaboration with NPs is effective for patient care given the decision making powers included in the NP scope of practice. This is not the case with Physicians Assistants (PAs), from whom RNs are not permitted to take direction due to the unregulated nature of this designation. Provincial government commitment and funds are required to increase the employment of NPs rather than PAs in rural and northern communities.

11. Telemedicine has been very useful in alleviating shortages of specialist physicians in rural and northern Ontario. Due to the scientific knowledge required to carry-out instructions of specialist physicians during long-distance examinations, to probe for

answers to questions of specialist physicians, and to follow the progress of patients after examinations, RN expertise is crucial for the successful use of telemedicine. ONA is opposed to the replacement of RNs with technicians in this area, a trend which seems to be emerging in northern Ontario.

12. Given the need for an especially broad range of skills for nursing practice in rural and northern communities, ONA calls for the funding of continuing education for RNs based in rural and northern communities. This would include more in-depth training programs whereby rural nurses work periodically in urban settings, and financial support for nurses completing specialty nursing recertifications required yearly.

13. More investment in hiring incentives is required to attract health professionals to practice in rural and northern settings. Given the growing shortage of RNs in Ontario, and ongoing emigration of Ontario RNs to other countries, however, signing bonuses are unlikely to draw adequate numbers of RNs to rural and northern Ontario. A program to recruit and support low-income nursing students already based in rural and northern Ontario, as elaborated in Recommendation 9, is the longer term solution to the shortage of RNs in rural and northern Ontario. Along with increasing the number of seats bridging registered practical nurse to RN education programs, this should be a major element of a province-wide RN labour force development strategy. In formulating such a strategy, Ontario could take the lead in orienting a pan-Canadian health labour force development strategy forming part of the 2014 Health Accord.

The Ontario Nurses' Association (ONA) is the union representing 55,000 registered nurses and allied health professionals and more than 12,000 nursing student affiliates providing care in Ontario hospitals, long-term care facilities, public health, the community, industry and clinics.

ONA welcomes the opportunity to contribute to the creation of a rural and northern health care framework. ONA commends the Minister of Health and Long-Term Care (MOHLTC) for focusing on the health care needs of those living in rural and Northern Ontario, communities which have been particularly vulnerable to hospital closures and other forms of health care service reduction in recent years.<sup>1</sup> We welcome the creation of a point of accountability within the MOHLTC focused on rural and northern health.

The Stage 1 Report of the Rural and Northern Health Care Panel (hereafter referred to as the Stage 1 Report) touches on several themes of major concern to ONA, while missing others. This submission is therefore organized by theme, offering a holistic nursing perspective on both health and health care delivery in rural and Northern Ontario. Based on expertise collected through interviews and focus group discussions of ONA nurses working on the front lines in Northern and rural Ontario, information drawn from government and other policy reports and academic studies, the following themes are addressed here:

- A. The Socio-Environmental Context of Health
- B. Infant Mortality and Maternal Care
- C. Transportation, Patient Transfers and Planning Standards
- D. Health Labour Shortages and Labour Force Development
- E. Planning Process of Rural and Northern Health Care Framework

## **Introduction**

Nurses have historically been the mainstay of health care delivery in rural and Northern Ontario, as in other parts of rural and Northern Canada. In 1897, the National Council of Women of Canada created the Victoria Order of Nursing (VON), with the primary aim of reducing high rates of maternal and infant mortality. VON nurses provided pre- and postnatal care in small cottage hospitals throughout Ontario. The VON also established "training homes" in Ottawa, Montreal, Toronto and Halifax, in which nurses learned the public health and visiting nursing key to providing health services in rural and Northern locations. (MacKinnon: 2009, 21)

Following the approach of the National Council of Women of Canada, the Red Cross created outpost nursing stations and hospitals in rural and remote Canada after World War I, including 42 in Ontario. (MacKinnon: 2009, 22) By the year 2000, 399 rural communities in Canada were being served by a registered nurse (RN) operating single-handedly. (Canadian Institutes for Health Information: 2000, 39) Nurses in rural and remote areas have therefore been and continue to be "expert generalists" - providing a breadth of care, from health education, to birthing services, emergency care, and mental health crisis intervention.

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<sup>1</sup> The term "rural and northern Ontario" is used here to refer to all communities in Ontario self-identifying as "rural" and "northern", including remote communities.

### **Recommendation 1.**

Given the historic role of RNs as key providers of health care in rural and Northern Ontario, the expertise of front line RNs should be made part of the basis for further development of the rural and northern healthcare framework, whether through the Local Health Integration Networks or other bodies.

### **A. The Socio-Environmental Context of Health**

Due to the major influence of social and environmental forces on health status, vulnerability to illness, and the need for health care, this section lays out examples of the ways in which social and environmental forces influence health outcomes in northern Ontario.

While highlighting the incidence of lower life expectancy at birth (relative to the Ontario average) in both rural and urban Northern Ontario, the Stage 1 Report does not propose explanations. (see Table 1)

**Table 1. Average Life Expectancy at Birth, Ontario**

<b>Region</b>	<b>Average Life Expectancy at Birth (years)</b>
Rural Northern Ontario	75.5 to 77
Urban Northern Ontario	77.1 to 78.1
Southern Rural Ontario	78.6 to 79.2
Ontario Average	79.7

Source: Statistics Canada, Health Profile (2009) as cited in Rural and Northern Health Care Framework/Plan, Stage 1 Report, p. 30.

Similarly, the Stage 1 Report underlines the relatively higher incidence of “obesity and overweight” in northern Ontario – 57.9 to 68.5 per cent of the Northern population versus the provincial average of 52 per cent of the population – without offering an explanation. In rural southern Ontario the incidence of “obesity and overweight” is also noted to be above the Ontario average, ranging from 59.6 to 63.2 per cent of the population. (MOHLTC, undated: 31)

Elsewhere in the Stage 1 Report, statistics from an article published in the **New England Journal of Medicine** are used to substantiate the claim that “lifestyle behaviors play the most significant role in affecting health status and point to the importance of each individual in taking responsibility for his/her own health and wellness.” (MOHLTC: undated, 21) Using a US American perspective which itself can be debated within US American contexts, lifestyle behaviors are noted to contribute to individual health and longevity by 41 per cent. Social circumstances and environmental exposure are noted to contribute by 13 per cent and five per cent respectively. (Schroeder as cited in MOHLTC: undated, 21)

A brief exploration of food security and environmental degradation in northern Ontario demonstrates that these contributor statistics are inaccurate within the context of Ontario. In turn, from a holistic, Canadian nursing perspective, the link inferred between lesser health outcomes and individual behaviors in the Stage 1 Report is an oversimplification, and the role of individual responsibility is overstated.

### Food Security

The policy concept of “food security” consists of four components – *availability*, *stability*, *accessibility*, and *utilization* – all of which are in question for communities in northern Canada, including northern Ontario. The need to transport food from southern to northern Canada reduces the *availability* of fresh foods and the long distances involved affect quality. The availability of traditional food sources for aboriginal communities is affected by the forced relocation of communities, declining familiarity with traditional foods and the capacity to harvest them, and diminishing supply due to environmental contamination and climate change. (Butler Walker et al.: 2009, 7, 9)

Shortages of food are common in remote, fly-in communities where food is transported infrequently by air, barge, ice road, and other delay-prone means. For aboriginal communities relying on traditional foods, *stability* of food supply is intimately linked to possessing knowledge and tools for food preservation and storage. (Butler Walker et al.: 2009, 7)

Given the tendency of high unemployment rates and low cash income levels in northern communities, the inability to pay affects the *accessibility* of fresh, nutritious food for many in northern Ontario. (Butler Walker et al.: 2009, 7) Alongside the inability to pay is the high price of food due to the limited number of retailers and wholesalers importing food from southern locations, and to a lesser extent, transportation costs. At present it is unclear that the federal government’s new, market-driven program, “Nutrition North Canada” will decrease food prices in northern locations given its focus on subsidizing for-profit retailers and wholesalers already active in this area. (Government of Canada: 2010) Increasing prices of food and fuel on a global scale due to speculation and other forces will also further affect the accessibility of healthy food for communities in northern Ontario.

A further barrier to the accessibility of good food is that as in other parts of Ontario, the working poor in northern Ontario carry two or more jobs and have little time or energy to prepare unprocessed, healthier foods. (ONA Focus Group 3, Toronto, March 2, 2011)

Lastly, *utilization*, or the effective use of traditional and imported foods in northern Ontario, particularly in aboriginal communities, is severely restricted by the absence of clean water, adequate housing, and sanitation facilities. (Butler Walker et al.: 2009, 8; Interview with ONA member, March 9, 2011)

The health-related consequences of food insecurity are chronic problems such as obesity, diabetes, anemia, heart disease – health problems typically attributed to lifestyle choices and individual behaviors. (Butler Walker et al.: 2009, 6) In terms of southern Ontario, though food insecurity is not so relevant, relatively higher obesity can be partially explained by lack of physical exercise due to low income levels, the high price of gym and sports league memberships, and geographic distance playgrounds, ball diamonds and other sports facilities. (ONA Focus Group 2, Toronto, March 2, 2011; Interview with ONA member, March 9, 2011)

### Environmental Degradation

The extent of environmental degradation caused by mining in northern Ontario is well documented. In 2003, for example, the nickel company INCO (now Vale Inco Limited) was named the worst mining polluter in Canada by Pollution Watch, a monitoring service of the Canadian Environmental Law Association and Environmental Defense Canada.

Based on Environment Canada data, INCO was found to have emitted, in 2001, more than double the amount of heavy metal pollutants than the second-highest mining polluter in Canada. More than 85 per cent of INCO's poisonous heavy metals were emitted in Copper Cliff, Ontario, located just outside of Sudbury. (Pollution Watch: 2003) Heavy metals are associated with kidney and blood problems, neurological disorders, cancer, and fetus development problems. Based on this example alone, the figure used in the Stage 1 Report attributing five per cent to environmental exposure as a contributor to health and longevity is extremely low.

Taking a more recently exposed instance, as raised by MPP Gilles Bisson (Timmins-James Bay) in the Ontario legislature in late-February 2011, the chemicals 2,4,5-T and 2,4-D – popularly known as “Agent Orange” – were used to defoliate trees in publically owned forestry operations in Northern Ontario, from the 1950s to the 1970s. According to MPP Bisson, if the toxic herbicide was used by the Ontario Ministry of Natural Resources in Hearst and Kapuskasing, it was likely also used by private forestry companies in northern as well as other parts of Ontario. (**Timmins Daily Press**: 2011) In mid-March, the Ontario Ministry of Natural Resources announced the appointment of University of Guelph toxicology professor, Dr. Leonard Ritter, to lead a panel of experts to study the use and health effects of Agent Orange, which the Ministry admitted was used widely in Ontario to spray agricultural land not used for crops and to control weeds in municipalities. (National Post: 2011)

Agent Orange has been recognized by the United States Department of Veterans Affairs to be associated with several cancers, acute peripheral neuropathy, leukemia, Type II diabetes, Parkinson's disease, non-Hodgkin's lymphoma, and other serious conditions. (Office of Public Health and Environmental Hazards: 2010) It should be underlined that the negative effects of Agent Orange are likely to have impacted the health of not only the predominantly male workers employed in forestry and other industries, but also the female workers having served as chefs and in other services, as well as people living in the vicinity of where the chemicals were used.

## **Recommendation 2**

Socio-economic and environmental issues particular to Northern Ontario must be examined - in addition to lifestyle behaviors and genetic predisposition - in order to address the root causes of lower life expectancy, higher relative obesity, and high infant mortality in the rural and urban north. Only through a comprehensive approach addressing socio-economic problems and job creation without further environmental degradation will health and wellness be improved in northern Ontario. This, in turn, will likely decrease demand for health care services to a certain extent. Such a comprehensive approach is appropriate for the province as a whole.

### **B) Infant Mortality and Maternal Care**

The Stage 1 Report highlights high infant mortality rates in rural and northern Ontario without providing analysis or addressing high infant mortality in its recommendations. The highest infant mortality rate in Ontario is in urban northern Ontario – relative to the Ontario average – with rural northern Ontario and rural southern Ontario following suite. Particularly high rates are found in Sudbury, Northwestern, Grey Bruce and Porcupine. (see Table 2 below)

**Table 2. Infant Mortality Rates per 1000 Live Births, Ontario**

<b>Region/City/County</b>	<b>Infant Mortality per 1000 Live Births</b>
Urban, northern Ontario	5.3 to 8
Rural, northern Ontario	4.2 to 7.5
Rural, southern Ontario	3.4 to 7.1
Sudbury	8
Northwestern	7.5
Grey and Bruce Counties	7.1
Porcupine	7
Ontario Average	5.3

Source: Statistics Canada, Health Profile (2009) as cited in Rural and Northern Health Care Framework/Plan, Stage 1 Report, p. 31.

Alongside the importance of addressing high infant mortality for vulnerable families in northern and rural Ontario, a thorough analysis of high infant mortality is important from a public policy perspective given the low birthrate and an increasingly aging workforce in Ontario. One major element to consider in such an analysis, in addition to environmental pollution as demonstrated above, is the phasing out of maternity services in rural and remote communities, beginning in 2000.

In 2004, the Ontario Women's Health Council appointed the Ontario Maternity Care Expert Panel (OMCEP) to examine and make recommendations around improving the maternity care system. In its 2006 report, "Emerging Crisis, Emerging Solutions," the OMCEP stressed that prenatal care is central to better births and long-term health outcomes. (OMCEP: 2006, 4) Specifically, prenatal care early in the first trimester of pregnancy is critical to optimum health outcomes. (OMCEP: 2006, 23) The OMCEP further noted that at the time of its study, hospitals in small and medium urban settings as well as rural communities were under financial pressure to withdraw from maternity care.

Defining basic maternity care as not only birthing services, but also pre-conception counselling, prenatal care and education, and services for mothers and infants for six weeks after birth, the OMCEP vision was clear: that "Every woman in Ontario has access to high quality, woman and family-centered maternity care as close to home as possible." (OMCEP: 2006, 3) Several years following the release of the OMCEP report, the effects of the withdrawal of maternity care services close to home are apparent and very likely linked to high infant mortality rates in rural and northern Ontario.

For most rural communities in Grey and Bruce counties, for example, merely to access birthing services involves a 45 minute or longer drive to Owen Sound, where the centralized Grey Bruce Health Services is located. If pre- and postnatal care are available an hour or more away, mothers are unlikely to travel to access this care, particularly if problems are not apparent. (ONA Focus Group 1, Toronto, March 1, 2011) This reinforces the OMCEP vision emphasizing that maternity care be located "close to home."

The OMCEP report further highlights that "poor access for women to early/timely prenatal care contributes to financial and human resource pressures for hospitals due to increased incidence of preventable acute care needs." (OMCEP: 2006, 4) Early and timely prenatal care for optimal health outcomes is defined as early in the first trimester. (OMCEP: 2006, 23) In addition to assuring adequate care for all mothers and infants,

then, there is an economic rationale for offering prenatal care to all women in the province. Prenatal care can prevent certain chronic health issues arising later in life, thereby contributing to decreased demand for health care services.

A study recently released as part of the Ontario Women's Health Evidence-Based Report revealed a high rate of births by caesarean section in the North Simcoe Muskoka LHIN: 31 per cent of deliveries, in contrast to the lowest provincial rate of 24 per cent in South West LHIN. (Dunn et al: 2011) Relatively higher rates of caesarean delivery and infant mortality in this region - 5.7 per 1000 births versus the provincial average 5.3 per 1000 births (Health System Intelligence Project: undated) – may also be linked to the lack of access to prenatal care through which complications may be detected and tended to early.

Pre- and postnatal care, and even birthing services are yet more inaccessible in northern Ontario. This is due to the lack of “close-to-home” birthing services in several communities, an inadequate number of airplanes to transport pregnant women, a lack of RNs to accompany women during air travel, and unpredictable, inclement weather. (ONA Focus Group 2, March 2, 2011) Arranging air travel can take up to three or four hours, and this work falls in the hands of RNs working at a 100 per cent standard output level, as opposed to the recommended 85 per cent. (ONA Focus Groups 1 and 2, Toronto, March 1 and 2, 2011)

In some communities, for example in Red Lake, birthing services are not available on weekends. RNs handle the weekend births when air travel is impossible due to the lack of airplanes and staff, or where women do not want to leave the community to give birth. As underlined in the OMCEP report, by front line nurses based in northern Ontario, and by academic researchers, key to all this is the shortage of RNs and family physicians in rural and northern Ontario. (OMCEP: 2006, 3; ONA Focus Groups 1 and 2, Toronto, March 1 and 2, 2011; MacKinnon: 2010, 23)

Finally, for the province as a whole, public health programs related to maternity care have faced funding cuts or consistent underfunding, for example the Healthy Babies, Healthy Children program. As in hospital budgets, mothers and babies are typically regarded as low priority because pregnancy and childbirth are perceived by predominantly male decision makers as “happy stories.” (ONA Focus Groups 1, 2 and 3, Toronto, March 1 and 2, 2011) This may be in part the reason for the OMCEP's emphasis on a “woman and family-centered” approach to maternity care.

### **Recommendation 3**

As recommended in the OMCEP report (2006, 8), “Emerging Crisis, Emerging Solutions”, a report fully funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC), ONA calls for investment in the implementation of a public, province-wide, woman- and family-centered maternal and newborn care plan.

Every woman in Ontario should have access to high quality woman- and family-centered maternity care 30 minutes away from home, including:

- birthing services
- pre-conception counseling
- prenatal care and education
- services for mothers and infants for six weeks after birth.

Women, front line RNs, nurse practitioners, midwives, and other relevant professionals should be incorporated as decision makers in the creation of the plan, with deliberate outreach to include women and health professionals in northern and rural Ontario. Community members, midwives, aboriginal RNs, and non-aboriginal RNs working in aboriginal communities should be mobilized to assess, plan, and provide culturally appropriate maternal and newborn care in aboriginal communities.

#### **Recommendation 4**

In addition to the full range of maternal and newborn care, ONA sees other community- and hospital-based care as part of a bundle of basic care necessary for all communities, close to home. ONA thus calls for investment in the creation and implementation of a public, province-wide plan for stable, accessible services for seniors – including homecare and long term care – with provincial standards.

#### **Recommendation 5**

Completing the bundle of basic care, the following services should be available in every hospital in the province, including in the smallest and amalgamated or allied hospitals:

- emergency departments and special care units or monitored beds
- blood services
- laboratory and x-ray
- mental health services
- diabetes programs
- palliative care
- rehabilitation
- chemotherapy/oncology program in larger small hospitals
- dialysis for stable patients in larger small hospitals, remote hospitals, and coordinated between small hospitals in close proximity, with a focus on accessibility
- minor surgeries, simple geriatrics, and internal medicine coordinated between small hospitals in close proximity, with a focus on accessibility.

### **C. Transportation, Patient Transfers and Planning Standards**

The Stage 1 Report offers four planning standards through which to improve access to health care in rural and northern Ontario. (MOHLTC: undated, 38) In brief, these are as follows, based on road travel under normal road conditions:

- primary care and emergency services (24/7/52) for 90 per cent of residents in a community or local hub within 30 minutes of travel time from places of residence
- basic inpatient hospital services for 90 per cent of residents in a community or local hub within one hour of travel time from places of residence
- specialty inpatient hospital and tertiary diagnostic services for 90 per cent of residents in a community or local hub within four hours of travel time from places of residence.

Using more or less the same set of guidelines, a report commissioned by the MOHLTC, entitled “Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities” (Glazier et al.: 2011, 1) concludes that over 90 per cent of

residents of rural communities (i.e. communities of 30,000 or fewer residents, as defined in the Stage 1 Report) are able to access:

- primary care providers (physicians or nurses in remote nursing stations) within 30 minutes of travel time
- emergency departments within 30 minutes of travel time, including communities of at least 5,000 residents
- obstetrical delivery beds within 60 minutes of travel time

In terms of access to specialty inpatient hospital and tertiary diagnostic services, the report concludes that highly specialized hospitals are accessible to only 72.2 per cent of rural community residents. (Glazier et al.: 2011, 1)

Given these conclusions, it would appear that most of the Stage 1 Report planning guidelines have already been met, with access to specialized hospitals being the only guideline requiring additional attention and resources. As the authors of the MOHLTC-commissioned report point out, however, these conclusions are **limited to geographical access**. More specifically, the availability of road and air transportation, adequacy of staffing levels, on-call arrangements for after-hours care and larger hospital capacity in rural and northern areas are **not** considered. (Glazier et al: 2011, 14; emphasis added)

This brings out the major shortcoming of both the Stage 1 Report planning guidelines and the conclusions of the commissioned report. Only by addressing the shortage of RNs and physicians in rural and northern Ontario, the shortage of air transportation in northern Ontario, as well as hospital capacity in small and large hospitals in northern and rural Ontario – can meaning be brought to the Stage 1 Report planning guidelines. This is particularly with regard to meeting the stated goal of the Stage 1 Report, which is “a health care system that promotes access and achieves equitable outcomes for residents of rural, remote and northern Ontario.” (MOHLTC: undated, 3) The testimony of a frontline RN working in small hospitals in Huron and Perth counties illustrates the inter-relatedness of the issues:

Transferring-out is a regular occurrence in our hospitals because we are so small and limited in capacity. All of the work involved in transferring-out falls on nurses. This is especially challenging at night, when there is only one RN working the emergency room. During the night, there is no intake staff, no registration clerk, and no building maintenance staff. The single RN on duty must manage the facility – monitoring the fire alarm system and boilers to assure the hospital is adequately heated – manage unregulated staff, *and* care for patients. When an emergency patient comes in, the RN must perform the initial testing and other work involved in stabilizing the patient, arrange the transfer which means finding a bed, coordinating the emergency vehicle, and finding an RN to accompany the travelling patient. Calculating the time involved to complete all of this, the four-hour travel time guideline to access specialty inpatient hospital and tertiary diagnostic services is not feasible if there are not enough fully trained RNs working the emergency room. Training is not a simple matter either. Newly graduated nurses are placed in the emergency room through the Nursing Graduate Guarantee (NGG) program, but without any basic nursing experience. It is very difficult for already overworked RNs in the emergency room to train new graduates in basic nursing *and* the particular skills and strengths needed in the understaffed rural emergency room. After finishing the NGG program, new

nurses don't get work anyway because of the lack of full-time job openings. (Interview with ONA nurse, Toronto, March 1, 2011)

### **Recommendation 6**

The need for patient transfers in rural and northern Ontario will be reduced significantly with the establishment of the bundle of basic care elaborated in Recommendations 3, 4 and 5.

To respond to patient transfer and transportation needs, which will always exist, a plan must be devised and resourced for both non-urgent and urgent patient transfers based on public provision, and adequate staffing levels of RNs to accompany travelling patients. ONA is opposed to transport provision by private and volunteer providers, and accompaniment by volunteers and unregulated health workers, as suggested in Recommendations 10 and 11 of the Stage 1 Report. (MOHLTC: undated, 50)

### **D) Health Labour Shortages and Labour Force Development**

In the previous sections, the shortage of RNs and full-time RN positions in rural and northern Ontario arises repeatedly. ONA commends the Stage 1 Report for recognizing health labour shortages in rural and northern Ontario. What follows are ONA's recommendations around solving health labour shortages in rural and northern Ontario. These should be seen as part of a province-wide, RN labour force development strategy. These recommendations build on some of the recommendations of the Stage 1 Report as well as ONA's priority recommendations for the 2011 provincial budget. In order to help fund a provincial RN labour force development strategy, further tax reductions for corporations and wealthy individuals should be cancelled.

### **Recommendation 7**

Fund the creation and protection of full-time, permanent RN positions, including funding for late-career nurse retention initiatives, through permanent, ongoing, annualized funding. Given the need for RNs to be "expert generalists" in rural and northern regions, experienced RNs are particularly important in rural and northern Ontario for the transfer of knowledge and skills to new graduates. Adequate staffing of full-time hospital RNs is a crucial corollary to this in order to allow late-career nurses the time necessary to properly mentor new RN graduates. In turn, the creation of more full-time equivalent RN positions in all sectors – hospitals, public health, community, and long-term care – in rural and northern Ontario is crucial to retain new graduates. According to recent ONA statistics (March 2011), 65 per cent of RN positions held by ONA members in northern Ontario are part-time positions. This compares with 54 per cent of positions held by ONA members in the rest of the province.

### **Recommendation 8**

Fund RN education programs in rural and northern Ontario universities oriented specifically to the practice on nursing in rural and northern communities. This will likely include a different balance of theoretical and practical training than in southern, urban-oriented RN education programs. Rotations in aboriginal communities should be part of practical training of all RN students in rural and northern Ontario.

### **Recommendation 9**

Given lower income levels in rural and northern Ontario, especially in aboriginal communities, the introduction of the four-year, university RN training program has made

RN careers particularly inaccessible to residents of rural and northern Ontario. In order to increase accessibility for these residents – individuals who are more likely to remain in rural and northern Ontario if gainfully employed – study and child care subsidies should be made available for low-income RN students based in rural and northern Ontario. To increase the number of aboriginal RNs – particularly important for the delivery of appropriate care to aboriginal people in rural as well as urban settings – moral and career support during training and upon employment should be included as part of RN education programs targeting aboriginal students. Such support has proven to be successful in training and retaining aboriginal health workers in Saskatchewan. (see Labour Education Centre: 2009, 63-67)

A program aimed at recruiting and supporting rural- and northern-based RN students could be a combined federal and provincial government initiative to parallel the recently announced federal funding for family medicine residents in remote and rural communities. (Health Canada: 2011) The Ontario government will use these federal funds to provide some 60 additional third-year training positions to medicine residents in rural and remote Ontario.

#### **Recommendation 10**

As acknowledged in the Stage 1 Report, Nurse Practitioners (NPs) are a key part of solving the shortage of primary care providers in rural and northern communities. (MOHLTC: undated, 42) For front line RNs based in both hospitals and the community, collaboration with NPs is effective for patient care given the decision-making powers included in the NP scope of practice. This is not the case with Physician Assistants (PAs), from whom RNs are not permitted to take direction due to the unregulated nature of this designation. (ONA Focus Groups 1 and 2, March 1 and 2, 2011) Provincial government commitment and funds are required to increase the employment of NPs rather than PAs in rural and northern communities.

#### **Recommendation 11**

Telemedicine has been very useful in alleviating shortages of specialist physicians in rural and northern Ontario. Due to the scientific knowledge required to carry-out instructions of specialist physicians during long-distance examinations, to probe for answers to questions of specialist physicians, and to follow the progress of patients after examinations, RN expertise is crucial for the successful use of telemedicine. (ONA Focus Group 2, March 2, 2011) ONA is opposed to the replacement of RNs with technicians in this area, a trend which seems to be emerging in northern Ontario.

#### **Recommendation 12**

Given the need for an especially broad range of skills for nursing practice in rural and northern communities, ONA calls for the funding of continuing education for RNs based in rural and northern communities. This would include more in-depth training programs whereby rural nurses work periodically in urban settings, as highlighted in the Stage 1 Report (MOHLTC: undated, 47), but also, more basically, financial support for nurses completing specialty nursing recertifications required yearly. The latter includes ICU, emergency, neonatal, trauma and other specialties.

#### **Recommendation 13**

Finally, as recognized in the Stage 1 Report, more investment in hiring incentives is required to attract health professionals to practice in rural and northern settings. (MOHLTC: undated, 42) In order for incentives to be effective, considerable funds are

needed. In hospitals in Kirkwood and Sioux Lookout, for instance, signing bonuses of 10,000 CAD have been successful in attracting small numbers of out-of-area RNs. (ONA Focus Group 2, March 2, 2011) Given the growing shortage of RNs in Ontario, and ongoing emigration of Ontario RNs to other countries due to superior working conditions and wages – some 3,494 in 2010 (College of Nurses of Ontario: 2011, 12) – signing bonuses are unlikely to draw adequate numbers of RNs to rural and northern Ontario. A program to recruit and support low-income nursing students already based in rural and northern Ontario, as elaborated in Recommendation 9, is the longer-term solution to the shortage of RNs in rural and northern Ontario. Along with increasing the number of seats bridging registered practical nurse to RN education programs, this should be a major element of a province-wide RN labour force development strategy. In formulating such a strategy, Ontario could take the lead in orienting a pan-Canadian health labour force development strategy forming part of the 2014 Health Accord.

### **E. Planning Process of Rural and Northern Health Care Framework**

In closing, ONA is extremely concerned with the process unfolding around the creation of the Rural and Northern Health Framework/Plan. Consultation with the public, Stage 2 of the planning process, as laid out in the Stage 1 Report, is severely limited in various ways. At the February 2011 consultation in Petrolia, for example, members of the public were obliged to answer questions pre-set by the Panel. Very little time was left for open discussion of issues of concern to residents, for example, telemedicine for residents of Walpole Island First Nation, ongoing operation of 24-hour emergency room services in small hospitals and assuring the viability of hospitals in rural southwest Ontario. (**Sarnia This Week**: 2011)

Furthermore, it is unclear how the Stage 2 public consultations will have an impact on the formulation of the framework given that the Stage 1 Report urged the MOHLTC and Local Health Integration Networks to begin creating a process to implement the recommendations of the Stage 1 Report upon release of the Report.

In conclusion, given the Stage 1 Report recommendation that a separate planning process is needed for the formulation of strategies and guidelines for aboriginal and remote communities, ONA fears that health and health care access issues of aboriginal communities will continue to be sidelined and neglected.

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