



RURAL HEALTH WORKS:
***Strengthening Rural Health Services through Local Economic
Development Strategies***

The Ontario Rural Council – Public Issue Forum

Tuesday, February 9, 2006

Conference Centre, One Stone Road West, Guelph, Ontario

This forum was presented in partnership with the Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA) and The Ontario Co-operative Development Initiative Collaboration (Conseil de la Cooperation de l'Ontario, Ontario Co-operative Association, Canadian Worker Co-op Federation) with the support of the national CDI Partnership.

The Ontario Rural Council respectfully acknowledges the support of its presenting partners.

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I. Welcome and Opening Remarks

Jim Whaley, Chair, TORC Rural Health Working Group

The future of health care delivery in rural Ontario was the topic of discussion for this one day event, bringing together rural representatives from a variety of sectors. The purpose of the day was threefold: to begin to identify challenges to the access of health care in rural communities; to provide opportunities to learn how other rural communities are meeting these service delivery challenges; and finally, to determine how individuals and communities might work together, develop partnerships, and address the many health care delivery issues identified in this process.

As chair of the TORC Rural Health Working Group, **Jim Whaley** greeted participants, speakers, panel members. He invited comments from **Maria Van Bommel**, (*then*) Parliamentary Assistant – Rural Affairs, Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA). With greetings from Queen’s Park, Ms Van Bommel stressed the need for well informed grassroots contacts as partners in the evolving network of health care.

Speaking from the vantage point of more than 20 years’ experience in the Ontario health care industry, Mr. Whaley went on to highlight the need for collaboration and partnership development among rural health care providers and the wider community. It is becoming apparent that this holistic approach must include collaboration with community economic developers in efforts to meet the goal of creating and sustaining healthy rural communities.

Of particular interest to health care providers in Ontario is the provincial Rural Economic Development (RED) Program. The first presenter provided an overview of the RED Program. This was followed by presentations from two local area success stories:

II. Access to Rural Health Care: Community Driven Approaches

Karen Chan, Rural Investments Branch, OMAFRA

Linda VanLondersele, Delhi Community Health Centre

Laura Overholt/Jessica Burgess/Gwen Devereaux, HealthKick-Huron Project

i) Rural Economic Development (RED) Program

Karen Chan (*Director, Rural Investments Branch, OMAFRA*) provided a full description of the RED Program, identifying the following three priorities:

- Improved access to health care
- Revitalized communities
- Improved access to skills development and enhancement of opportunities

Supporting *Ontario's Rural Plan* (www.omafra.gov.on.ca), the RED Program is designed to assist partnerships and rural stakeholders in addressing economic growth. Approved projects may be eligible for up to 50% in shared costs. The RED Program expects to attract proposals from communities and organizations¹ whose priorities are consistent with government's key priorities of:

- Strong People, Strong Economies
- Better Health
- Success for Students

Ms. Chan noted that communities that work together are the healthiest. They are able to keep young people in the community, businesses are successful, partnerships and alliances are strong. Successful projects are made possible through skills development, internships, training, innovation, shared risk and planning.

ii) The Delhi Community Health Centre

Linda VanLondersele (*DCHC Project Coordinator*) spoke passionately about the Delhi Community Health Centre located in "tobacco country" of southern Ontario. The Centre serves approximately 4,000 local residents and an additional 10,000 people regionally. Having accessed RED funding in 2004, the town of Delhi was able to develop a turnkey operation that younger physicians were seeking.

Located in the centre of town, the health centre offers services for seniors, walk in and flu clinics, and an OHIP satellite office. A Family Health Team consisting of physicians, nurses, a social worker and dietitian with the support of a pharmacist is available. A fully interactive web site provides information about the health centre, opportunities for physicians, business development, community activities and lifestyle, educational opportunities and links to sites of interest to rural health providers.

iii) HealthKick Huron (SHARP Project)

Laura Overholt, Jessica Burgess and Gwen Devereaux spoke on behalf of the successful *HealthKick Huron*, a SHARP -Skills for Healthcare Attraction & Retention Pilot - Project. *HealthKick Huron* was developed with the awareness that healthcare is fundamental to economic development and community growth. This exciting approach to health care planning and provision supports local capacity building, availability of learning opportunities and youth engagement. Programs such as *Med-Quest Camp, Nurse Training* and *Rural Healthcare Career Exploration* are just a few of the successful strategies developed to promote health care careers and attract *International Medical Graduates* and others to make Huron County their home.

¹*Individuals and lone organizations are not eligible to apply for RED funding as independent applicants.*

The *Community Ambassador Program* is aimed at engaging the entire community in the process of health care recruitment and retention. Cross-sectoral “ambassadorship” extends beyond traditional health care links into the realm of housing, business, education and spousal employment, asking all to act as hosts and showcase the best of their community for potential recruits and their families.

Q & A’s - Session “II”

A brief question and answer session took place following these initial presentations. The following is a summary of the *lessons learned* from these successful experiences:

- ✓ *Continual recruitment of physicians is required in order to maintain adequate health care coverage. New doctors tend to see fewer patients per day; it generally requires two new physicians to see as many patients as a more established doctor would see.*
- ✓ *New physicians practice medicine differently than established doctors. They are not willing to put in long hours, may want a part time practice, and prefer to work in a group clinic-type setting rather than operating a private office.*
- ✓ *RED funding for health care centres is generally “seed money” only and is not available for ongoing operating expenses. Communities, however, can also apply to the Ministry of Health’s Community Health Centre (CHC) program.*
- ✓ *Medical centres struggle with the question of partnerships and loyalties. Does a pharmacy have a place in a health centre? Does it undermine the success of other competitors in the larger community?*
- ✓ *New Family Health Team models must be grounded in the reality of each rural community. The makeup of family health teams will be unique to each town, region, and area of the province.*
- ✓ *Where does public health fit into the community health care system? It is essential that public health representatives sit at the community table. Traditionally, public health nurses have provided care for seniors and the disabled, with expertise in nutrition, diabetes and coronary heart disease.*

Information Sources:

- **RED Program** (<http://www.omafra.gov.on.ca/english/rural/index.html>)
- **Delhi Community Health Centre** (www.dchc.ca)
- **HealthKick Huron** (www.healthkickhuron.ca)
- **Community Health Centre (CHC) Program**
(www.health.gov.on.ca/english/public/contact/chc/chc_mn.html)

III. Health Care Co-operatives

Jean Pierre Girard, Université du Québec à Montréal; LPS Productions

Jean Pierre Girard (*Research Coordinator at the Université du Québec à Montréal; Senior Associate, LPS Productions*) provided an overview of the health co-operative model based on his national and international experience. He highlighted the success of a variety of health co-ops, including the Aylmer Co-operative Health Centre.

Health co-operatives have proven to be effective solutions to many health care delivery problems, particularly in rural areas. M. Girard contends that *vision, innovation, and imagination* are essential attributes for working in both health care and cooperative worlds. Shaping the *vision* usually falls to local citizens and, in many instances, an individual or group prepared to ‘champion’ the cause. In any town or region there are many stakeholders who wish to influence local health care, not the least of which is the private sector, potentially including large commercial groups. It is important to understand the surrounding economic climate in order to determine the scope of systems and funding approaches that might be available to the developing health co-operative. *Innovative* funding and financial strategies make each health centre unique.

M. Girard cites the Aylmer Co-operative Health Centre as an excellent example of what can be accomplished. Residents of the community become members of the cooperative for an initial cost of \$50.00 as a one time membership fee. As co-operatives grow they may ask their members to contribute to the expansion, but members are under no obligation to contribute more than the initial membership fee. Residents in the town who choose not to support the co-operative financially are still able to use the health care services provided. However, non-members are not able to vote at annual meetings and are not able to hold a place on the Board of Directors. Multi-stakeholder cooperatives such as the Alymer Co-operative Health Care Centre may work with a variety of members including members/patients, doctors, laboratories, various health specialists and other community partners, to name a few.

Session “III” - Q & A’s:

✓ *What evidence is there of improved health outcomes when a health care co-operative is involved?*

M. Girard spoke of studies in Japan where health care co-operatives have been functioning for some time. The health care co-op has shown to have a positive impact on all members over the long term. These cooperatives have programs dedicated to a wide variety of members from children to seniors, covering many specialties.

✓ *What is the cost per patient for care?*

Patients buy a one time “social share” at a cost of \$50.00. Health care is covered

by the provincial health insurance plan. Citing information from other co-operatives, M. Girard informed participants that the co-operative model has lower per capita costs for provision of health care and can serve many diverse populations. Comparing co-operatives to “for profit clinics”, co-operatives have lower performance costs and lower consumption of drugs.

- ✓ *How does the traditional medical model compare with the co-operative model?*
Traditionally, the medical model has had many doctors and fewer nurses. Adherence to this traditional model will depend on the members of the co-operative. Many co-ops are initiating the use of nurse practitioners with a focus on preventative care. The kind of services and how they are delivered are decided by the members of the co-operative.
- ✓ *What is the impact of the co-operative health care model on social cohesion or exclusion?*
There is very little scientific research on this question.
- ✓ *How are physicians paid?*
There are two models: In the first, the doctor rents space from the co-operative and is paid directly through the provincial health care system for services provided. In the second model, the doctor works for the co-operative. The co-operative receives a subsidy from the government and then pays the doctor.
- ✓ *Health promotion and the health care co-operative?*
Each co-operative will determine the health care model they are to adopt. For example, health co-operatives in Saskatchewan receive a provincial subsidy on a per capita basis. In turn, they provide services to various under-served populations such as aboriginal communities. Although only approximately 20% of patients are members of the co-op, prevention programs and ongoing health care offered through the co-op may be the only health care services available.
- ✓ *What is the difference between non-profit and the co-op model?*
Choosing to focus on the attributes of the co-op model, M. Girard described some of the more notable features:
 - Clear membership rights by law
 - Cost of membership is the value of one share
 - Members can use the services of the co-op
 - Co-ops are generally willing to negotiate new services
 - Co-ops generally support entrepreneurship
- ✓ *How does a health care co-op attract doctors?*
 - Co-op must have a clear philosophical view
 - Members share knowledge and power

- Training programs available for doctors and nurses
- Professionals must be personally interested in the health care model developed by the co-op

Information Sources: www.ontario.coop
www.bcca.coop/programs/healthresources.htm
www.agr.gc.ca/rcs-src/coop/index_e.php?sl=guides&page=intro

IV. Panel Response to Morning Presentations

Patty Stokes, ROSE Program / Federated Women's Institutes of Ontario (FWIO)
 Ross Kirkconnell, Wellington-Dufferin Community Care Access Centre (CCAC)
 Sandra Hanmer, Waterloo-Wellington Local Health Integration Network (LHIN)

Patty Stokes (*Manager, Rural Ontario Sharing Education –ROSE - Program, Federated Women's Institutes of Ontario -FWIO*) presented to participants a voice for rural women and communities. The FWIO began with the explicit purpose of sharing knowledge and support relating to household sciences, sanitation and raising children. The organization has evolved over the past one hundred years and while it supports local meetings and fundraising, the *ROSE* Program is integral to community development and health. *ROSE* currently collaborates with fifteen health and social service partners, with workshops held throughout the province. In the last six years, some 550 *ROSE* workshops have enriched the lives of 30,000 Ontario residents. The FWIO membership is a collection of women who meet regularly throughout the year. They provide support, identify needs and take action where necessary.

In doing their work, FWIO members overcome many challenges. Because the distribution of resources in rural areas is unequal, members must be creative in order to provide networks of support and services throughout the province. As family dynamics change so does membership and support needs. Technology can potentially offer improved communication and information sharing in many ways, however many rural phone lines still cannot accommodate up-to-date services. Preventive health care measures are a top priority for today's members as they spread the word of holistic health awareness across the province.

Ross Kirkconnell (*Executive Director, Wellington-Dufferin Community Care Access Centre - CCAC*) addressed the issue of home delivery of health care for forum participants. The Wellington-Dufferin CCAC has a largely rural catchment area that meets the needs of rural citizens as they wish them to be met. Local resources play a big part in service delivery. Local citizens, partnerships and systems responsive to local needs are critical.

The availability of local retraining for nurses, job shadowing in local hospitals, and community ambassadors play a significant role in the collaborative delivery of health care. These types of

programs involve community members as part of the system, “connecting them to the needs of other members”.

Mr. Kirkconnell supports the belief that people want to work and live in the same community. An enhanced social prosperity will not only provide opportunities but will keep people working close to where they live. Rural residents don’t wish to imitate their urban counterparts, but they do want access to the same state-of-the-art health care services when needed. One of the challenges of the rural health care system is to be able to provide access to those services.

Sandra Hanmer (*CEO, Waterloo Wellington Local Health Integration Network*) provided forum participants with a general overview about the new Local Health Integration Networks (LHINs) and her related experiences to date. As part of the transformation of health care in Ontario, LHINs are a local coordinating body based on community engagement and cooperation.

Ms. Hanmer described the LHIN as “an engagement strategy developed using great ideas”. Built upon a foundation that identifies service strengths and gaps, solutions are created and integrated into the local health service plan. Identification of service strengths and gaps used in development of LHINs must be evidence-based. Each LHIN representing a geographic area will determine local health care needs. Collaboration with other developing LHINs, identification of success stories, and the use of a mentoring model will support the creation of other health care networks.

Ms. Hanmer described the attributes of LHINs as focusing on health and wellness using determinants of health for planning purposes. A variety of models may be utilized depending on the wants and needs of local people working together. Training of local people in the community is part of the community activation plan. Local champions, innovation, collaboration, and shared visions and values are fundamental to the LHIN process.

“Silo” type funding is no longer adequate to meet the needs of rural communities. A holistic approach is essential, incorporating community voices and values as highlighted through health care service provision, community development, economic development, and environmental sustainability.

Information Sources:

- **Local Health Integration Networks**
(http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html)
- **ROSE Program, Federated Women’s Institutes of Ontario**
(www.fwio.ca)
- **Community Care Access Centres** - (www.oaccac.on.ca)
- **CCAC of Wellington-Dufferin** - (www.wd.ccac-ont.ca)

V. Round Table Discussions and Reporting the Results

Jim Whaley, TORC Rural Health Working Group

Participants at each table were prearranged to include representatives from a variety of sectors including, but not limited to: rural residents, health care providers and consumers, economic developers, political representatives, members of rural non-governmental organizations and civil servants. Table discussions thus included the voices of many representatives allowing for a holistic approach to problem solving.

Participants at each table were asked to discuss the following three questions:

1. *What are the major challenges your community faces in terms of access to health services?*
2. *Of the ideas or strategies discussed here today, identify which one(s) you will take back to your community.*
3. *How can we work collaboratively in moving forward on some of the strategies identified here today?*

Following the 45 minutes allotted for round table discussion, each group was asked to report to the whole. Ideas and issues presented have been sorted thematically by question:

MAJOR CHALLENGES FACING ACCESS TO/DELIVERY OF HEALTH SERVICES IN RURAL COMMUNITIES:

i) Physical Challenges

Distance is a fixed feature and weather is unpredictable - these are two challenges facing all rural communities. Therefore, it is essential that physical context be considered a constraint in health care delivery in rural areas. Distance and weather do not discriminate between patient and service provider; they are equal opportunity stressors.

Transportation of rural patients to health care providers - or health care providers to patient - requires significant planning. Volunteers, who traditionally have taken the responsibility for patient transportation, are aging and/or burnt out. Subsidizing patient transportation is expensive and often beyond the ability of either patient or service provider. Public transportation is usually non-existent. Specialists are too far away from the rural centres and the residents who live in outlying areas.

Ambulances dispatched from larger centers pose long waits for rural patients. Drivers who may be unsure of the rural areas they are serving, face unfamiliar terrain and potentially dangerous weather and road conditions.

ii) Systemic Challenges

In an age of unprecedented physician shortages, the number of “orphan patients” continues to plague an already over-worked health care system. Orphan patients - those who for whatever reason do not have a family doctor - must access health care through emergency services or health care clinics, if available. This type of service poses concerns for confidentiality and continuity of care and is particularly stressful for parents of young children, those with chronic illness, and the aged. It is also a strain on an already overworked ER system, which is usually ill equipped to deal with non-emergency medicine. Massive growth in communities unable to attract new physicians will only exacerbate this situation in the future.

A common complaint has been that decision makers do not live in the rural communities they serve. This brings into question their understanding of the needs of the rural communities. Confounded by the traditional manner of funding, the coordination and provision of health care is further complicated by the “silo” approach to funding which refers to the discrete funding and coordination of public services to the detriment of and/or without regard for others. For example, health care, economic development, education, environment, and transportation concerns in one area may all be funded separately with no acknowledgment of duplication/or coordination of services. According to one group, lack of funding is the root cause of challenges facing the health care system. Lack of physicians and difficulty recruiting new doctors and other health care professionals requires an organized approach. Support networks for professionals, lifestyle, spousal and family needs (i.e. access to work and schools) are necessary considerations. Pay equity within the health care industry and within rural communities is essential.

iii) Communication

Smaller rural communities may well lack a local newspaper, radio and/or television station. Without a source of communication accessible by all, issues of change, education, coordination, or health emergency are almost impossible to communicate. As in the past, rural networks such as the Federated Women’s Institute of Ontario, farming cooperatives, churches and local and regional networks, may be used to gather and disseminate information.

iv) Political/Funding

Amalgamation has taken the seat of rural health care decision makers from smaller rural towns to larger urban centres. In so doing, smaller centres have lost their voice on health care boards and decision-making bodies. Infrastructure costs, employment issues as well as capital improvements to aging hospitals, are all community concerns. Upgrading of needed equipment is also often ignored. As financial and planning responsibilities are juggled between provincial and federal governments, current hospitals/health services may be at risk to a change of government policy as financial support may be swayed to other priorities.

Government funding must be balanced regionally and must be evidence-based. However, current lack of data and benchmarks to support service needs provides an “out” for government

accountability and provision of service.

v) Service Delivery Barriers

A lack of doctors and specialists, confounded by a lack of knowledge and strategies for recruiting new physicians, result in long wait times and/or orphan patients. Recruitment of new doctors is difficult, competitive and expensive. The current cohort of doctors is aging and nearing retirement.

Provision of service to new Canadians and immigrants where language and cultural issues are relevant, may pose challenges.

Poor health care delivery may impact on the availability of early diagnosis in rural areas.

vi) Philosophy

The medical model of health continues to be the prevailing philosophy in today's system. It generally defines recovery in negative terms, working to "eliminate" symptoms and complaints, and "curing" illnesses in a bid to return to a "normal" state of health. The medical model supports the expert/patient dichotomy of the past where medical professionals wield much power and are unwilling to share control and decision making with other service providers and patients. The medical model must change to one of *prevention* and *health promotion*.

With current pressures on the health care system, the health prevention model, education and responsibility for one's own health become critical. A health care model for the 21st century must include not only health care professionals but also early childhood educators, mental health professionals, geriatrics etc. to deal with all aspects of physical, mental and spiritual well being.

IDEAS TO TAKE BACK TO YOUR COMMUNITY:

In this section, participants offered opinions as to what possible strategies they might take back to their home community for consideration.

As noted by one participant, in the past, rural communities have been successful due to *sharing*, *volunteering* and *cooperating*. Although the language may be somewhat updated, these rural values continue to dominate.

Potential Follow-up Activities

- Share expertise that is available by seeking out success stories
- Share best practices; collaborate with your LHIN; develop rural skills through innovation

- Actively participate in/form a health board; have your voice heard!
- Use Federated Women's Institute of Ontario (FWIO) and similar existing networks to spread and gather information
- Investigate programs such as *HealthKick Huron's* Med Quest and Nurse Training programs, the RED program, engaging youth in health care, and distance learning as a vehicle for rural students
- Utilize health care brokers to provide services to new Canadians and immigrants
- Strengthen rural partnerships in health care delivery through networking and education
- Use technology to support single access to service, i.e. one-stop shopping
- Integrate transportation with health care system
- Educate consumers as to appropriate use of health care services
- Encourage rural groups to provide input to developing LHINs

STRATEGIES FOR COLLABORATIVELY MOVING FORWARD:

With the challenges identified and the possibilities for action taken back to home communities and organizations, the final question asks *how* can these plans be implemented? This section first looks at research needs that may provide underlying information critical to decision making and planning:

i) Research Needs

There is much information to be gathered to support decision making in the development of local Health Centres and for health care delivery in rural areas. Research is a vehicle for gathering the required information and for determining potential outcomes. Questions and answers relating to each community will no doubt be different, but the process remains critical.

- *What is the relationship between rural living, early diagnosis, and health outcome?*
- *Knowledge about the relationship between rural living and early diagnosis of disease is required especially in the areas of breast health and other types of cancer.*

- *What constitutes a “wanted lifestyle”? It was suggested that health care co-operatives should provide a “wanted” lifestyle for doctors working in rural communities.*
- *Needs assessments by family health teams are required to determine local and regional priorities.*
- *Define “rural health care”. What do we mean when we say it? What makes it effective? How do we measure efficiency and effectiveness?*
- *Are “communities” that work together considered to be the healthiest? What definitions of community and “health” are used? What are the attributes of healthy communities? How are they achieved and maintained?*
- *Farm co-operatives are common in rural Ontario. What can be learned from their experiences that might enlighten the development of health care co-operatives?*
- *It has been suggested that people want to work where they live. What evidence is there to support this? What is the relationship between place of residence, place of work and the provision of health care?*
- *Mental health issues are as important as physical health. Information and pilot studies relating to mental health issues, farming communities and poverty is essential to provide awareness and education. What is the relationship between rural living, health outcomes, and poverty? What is the place of health/mental health services in these outcomes?*
- *How might health care co-ops partner with other rural services to provide support for women living with abuse?*

ii) Communication and Capacity Building

- *Quarterly meetings of the TORC community will help to keep up the momentum, share information and promote discussion. Future meetings should include information and speakers from across Canada and internationally, where possible.*
- *Increased visibility for TORC, its mandate and members will encourage and assist in the process of capacity building. An anticipated increase in membership will help to support the growing rural community.*

- *Professional development seminars including opportunities to learn and utilize capacity building skills and theories would aid in community development and partnering.*
- *“Health teams” should participate in the development of business plans and learn capacity building skills to aid in partnership development.*
- *Seeking out and providing mentoring opportunities to other rural communities would help share skills, knowledge and expertise.*
- *Barrier Busters: Support of locally- grown produce, locally-produced materials and training of local individuals, especially youth, would nurture the local economy.*
- *Actively build partnerships rather than just ‘talking’.*
- *Utilize “team approach” to include nurse practitioners and young physicians who receive training in rural communities. Reduce power dynamics and work toward prevention rather than crisis intervention. Use family health teams with centralized care to provide “one stop shopping”.*
- *Seek out and utilize knowledge-drive, best-practice strategies.*

VI. Forum Wrap Up

Al Lauzon, TORC Chair

“Communities must reach out to each other in an effort to work together rather than compete for limited resources.”

In making his closing remarks, TORC Chair **Al Lauzon** provided context for the day’s forum topic by suggesting the fundamental reason to invest in such discussion was to help all of us create a healthy environment in which we may live, work and play. The status quo is no longer adequate; our health care system is in crisis. Philosophically, the concept of “crisis” presents us with both challenge and opportunity: challenge to identify our health care needs and partners, and opportunity to be both creative and innovative to meet and surpass the challenges we have identified in this forum. He sees collaboration, partnerships, and capacity building as vehicles for the development of a rural health care system second to none.

The development of a new rural health care action plan is a complex issue. It must consider and coordinate care for the whole person, physically, emotionally and spiritually. And, it must include all aspects of the health care system, patients, service providers, support staff, policy

makers, and community members. Similarly, the healthcare system cannot be separated from its surrounding physical environment, economic development and social systems. Negotiating these many and intricate relationships will require planning, patience and care.

In identifying innovative approaches for action, Dr. Lauzon prioritized the need to invest in the development of social relationships, partnerships and community building. Communities must reach out to each other in an effort to work together rather than compete for limited resources. Providing evidence based support for activities that have not been done before will be extremely challenging. For this reason, developers must reach out to and include long standing rural networks such as the Federated Women's Institute of Ontario, the Ontario Federation of Agriculture, as well as existing co-operatives. These and other organizations and networks can inform and assist in the development of action plans. Rural Ontario needs not only our "voice" to be heard at the table, it needs "influence", to demonstrate to the larger audience that rural is a significant player, capable of taking the lead in positively transforming the health care system in Ontario.

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