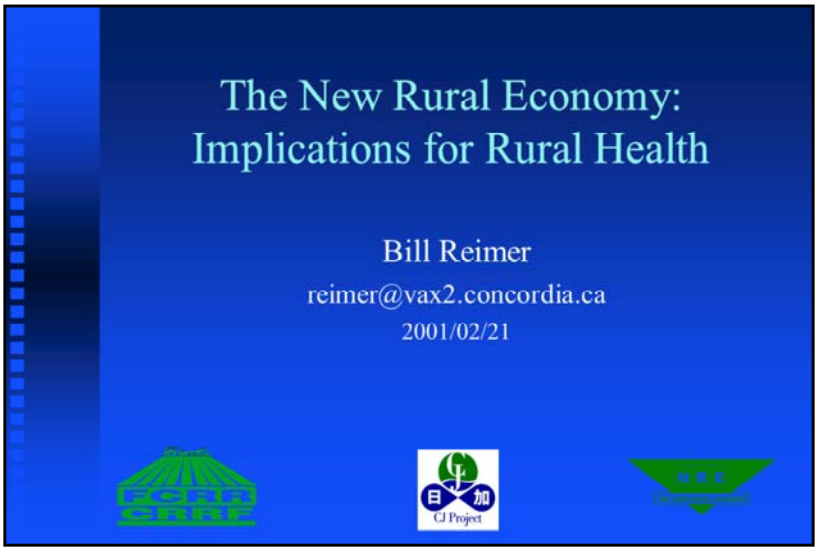


•Acknowledgements:
•The Centre for Rural and Northern Health Research

- Characteristics
  - What are some of the major changes that have occurred in rural Canada over the last 50 or so years?
- Implications for Health
  - First: What health-related characteristics have changed?
  - Second: What health issues do they touch?
- What should we put on our research agendas in the light of the points above?
- How might the NRE Project help that agenda?

What Have We Learned?

- Technology, trade, and policy are devitalizing rural Canada
  - Technology is labour shedding
  - Global commodity trading removes rural assets
  - Sectoral policies reduce rural capacity
- Rural change is too fast for health policy
  - Institutions are relatively slow to respond
  - Institutions resist change
- Building local capacity is key
  - Including the capacity to cope with problems arising as a result of the NRE
  - And capacity to seize opportunities emerging

What is getting in the way of health revitalization?

- Traditional bases of community undermined
- New social forms developing
- Pressures on service delivery
- New forms of exclusion
- Increased importance of environment
- Reduced access to real assets

Traditional bases of community are undermined

- Higher levels of mobility mean people move both in and out of rural areas
  - Mostly OUT of remote areas
  - Mostly IN for those adjacent to metropolitan regions
  - This mobility also has a strong selective aspect:
    - Youth out
    - Elderly left or in some cases move in (prefer small towns from more remote regions)
- Traditional bases for social cohesion have eroded
  - Traditional – based on reciprocal and associative relations.
    - social support from family, friends, religious organizations -- often those people who lived close by
    - Access to those resources determined by shared interests and experiences, history of exchanging and sharing, custom and culture
    - Not always inclusive
  - Now – based on bureaucratic and fiscal criteria, with increasing pressure from market
    - Social support provided through bureaucratic institutions with more restricted knowledge and interest in each person, and through people who don't necessarily live in the same neighbourhood
    - Access determined by rules of inclusion and exclusion applicable to all people
    - Rules of inclusion and exclusion (entitlements) heavily influenced by national, not regional or local considerations:
      - e.g. fiscal demands
      - e.g. come to the medical practitioner, not the other way around (works well where population density is high)
- Results:
  - New stressors – both for those who become ill and those who must care for them
    - e.g. family members who have to fly in should serious illness occur
  - Stress on health institutions
    - Commitment to acute problems and high tech (centralized) solutions are inadequate to cope with the increasing demand arising from the weakening informal support systems (especially chronic care)

Development of New Forms of Community

•Gentrification of urban-adjacent areas

- •Midage and elderly people moving in with different expectations of community and a pleasant environment
- •Often moving because of desire to get away from the city

•Greater importance of amenities

- •Often unreasonable views of rural
- •Creates conflicts with previous residents

•Changing family structure

- •more blended families
- •more single parents

•Part-time, part-year, low pay, insecure jobs increase the stress on people – the Risk Society

•Results:

- •Urban standards of health and health service delivery applied to rural areas
  - •Often by people who know how to make themselves heard
  - •Note: our results – administrators vs. local people and acceptable levels of services
- •Mobility requires national infrastructure to monitor records, etc.
  - •Reinforces bureaucratic bases for relations
- •Chronic and social-psychological problems increase and change form as stress from risk and family fragmentation occur

•Medical technologies have been high tech and expensive

- •The fiscal crisis of the state has favoured centralization – bringing the patients to the machines (and personnel)
- •Technologies accommodating distributed systems are now emerging (telecommunications, biotechnology)

•But - medicine has developed a tradition of professionalization that severely controls the conditions of entry into medicine

- •e.g. Alaska version of local paramedic training (2 people per family)
  - •Rejected by doctors as inappropriate for Canada

•Training in specialization has made doctors unfit for rural practice

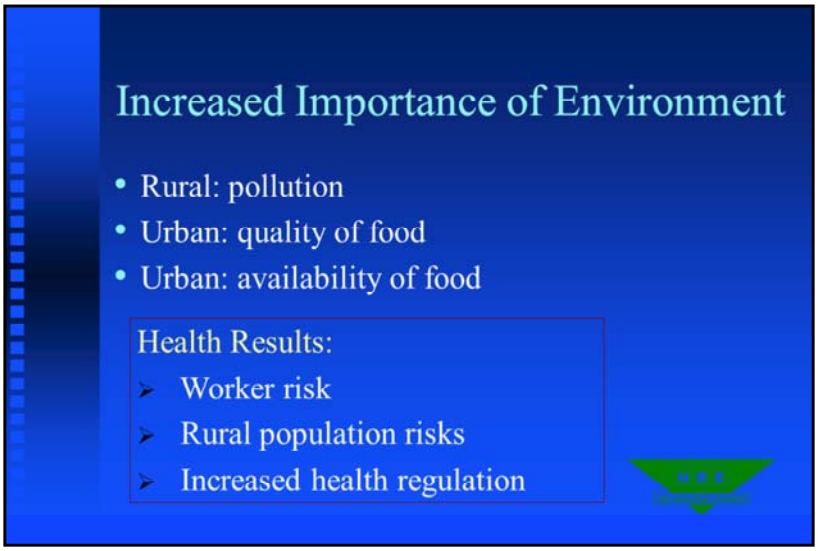
- •Not trained in diverse types of medical problems
- •Face isolation – social and professional

•State inadequacies in chronic care leave more of the burden to volunteers – without sufficient backup

•Result:

- •Crisis in attracting and keeping medical personnel in rural areas
- •Inadequate training in the use of new technologies
- •Greater demands on volunteers
  - •Especially women
  - •Especially conflicts with their greater entry into the labour force (often out of necessity as incomes diminish and families break up)

- The special characteristics of the rural context place particular types of people at risk for health
  - Occupational
    - Rural jobs (e.g forestry, agriculture very dangerous occupations)
    - Rural health problems – driving accidents, isolation-related
  - Social categories
    - Elderly
    - Single parents (especially women) and their children
    - Working poor (family stress: violence, alcoholism, depression)
    - Youth
    - Aboriginal Peoples
- Problems are dispersed and often socially isolated – therefore not recognized until crisis stage
  - e.g. Rural post offices in Scotland – if people don't pick up their mail then someone calls – the importance of routines
- Transportation demands as services centralize place those without a license or car at risk (elderly., youths, single parents, and parents at home without car since spouse at job).
  - Exacerbated without a telephone



Importance of Environment

•Pollution in rural areas from several sources

- •Large industry (mining, forestry)
- •Distributed industries (agriculture) (elevated levels of cancer among farmers)
- •Isolation and distribution of population makes monitoring and managing water supplies difficult (e.g. wells, septic tanks)

•Urban demands for high quality foods increases concern for the conditions under which it is produced and processed (who is responsible: producer, processor, consumer?

•Even its availability is a problem – difficult to get non-GMO, and special diet foods.

- •Note: healthy lifestyles lower in rural areas (obesity high, exercise levels low)

•Results for health:

- •Demands for monitoring risks increase – difficult in rural areas
- •Increased regulations increase pressure for standardization and concentration of production
  - •Therefore increasing risks to disease


Little Access to Real Assets
• Commodity trade removes local control of assets
• Reduces capacity for sustainable action
• Increases dependency
Health Results:
➢ Increased inequality
➢ Cycle of dependency
➢ Individual and social stress

Policy Options (cf. Rob Hood – Dalhousie)

- Collect more appropriate data
  - Sufficiently detailed to reflect local variation
- Make it more accessible
  - To researchers and local populations
  - Must be engaged to develop learning re. how to use it.
- Monitor health care services, but don't get fixated on them.
  - Good health the result of nutrition, environment, lifestyle, socio-economic considerations as well as services
  - Wellness and prevention must be emphasized to a greater extent
- Regionalization of services (resources organized and shared among communities)
- Decentralization (spending decisions made locally rather than centrally)
  - Creates the conditions that facilitate locally appropriate services and programs
  - Note: must be accomplished with health care practitioners to reduce the negative effects of professionalization
- Healthy Communities – a model for optimizing health
  - Health is a matter of environment, social relations, and economy, not just acute care and services
  - e.g. inequality impacts on health
  - Note the importance of sustaining rural communities in this perspective.
- As Hood points out – this goes well beyond rural communities to touch the issue of health and quality of life for all Canadians.

What types of research are suggested by these issues?

•How is social cohesion changing?

•How do the new forms improve or undermine rural health?

•What patterns of migration are found between rural and urban areas and between rural areas?

•What types of people are moving and what are their demands on health systems?

•How are service delivery systems changing?

•Who is more vulnerable as a result of these changes?

•What new forms of service delivery are emerging and how do they improve or undermine rural health?

•To what extent are rural Canadians open to a para-medic approach to rural health?

•Under what circumstances might it be acceptable?

•Which industries and occupations carry the greatest health risks for:

•those working in the industries,

•rural people,

•urban people?

•How safe is our food?

•What parts of the food production chain contain the greatest risk to food quality?

•What are the major health risks faced by the socially excluded?

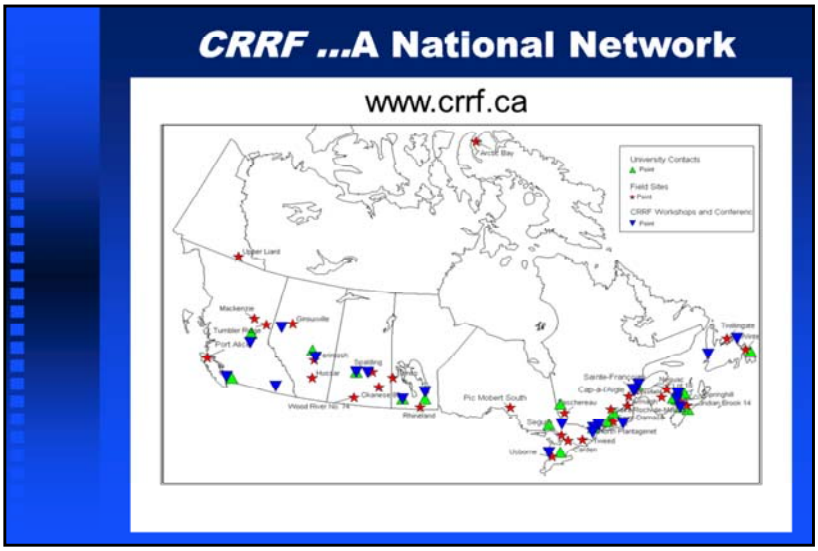
•How might they be better integrated into health delivery systems?

•What are the relationships between community dynamics and health?

•What community characteristics are associated with wellness and health?

•What are the processes that contribute to this relationship?

- The New Rural Economy Project has several resources that can help to answer these research questions.
- Use them to supplement existing work, not duplicate it.
- Data
  - CSD-level census data for 1986, 1991, 1996
  - Special database of CSDs that preserved their boundaries over those 10 years
  - GSS surveys – limitations on rural/urban (special tabulations with postal codes)
  - Detailed information from the field sites (25)
    - Background profiles
    - Access to services (including details re. Medical services)
    - Problems faced by voluntary associations
    - Small and Medium-Sized Enterprises
    - Coops
    - Community Events
    - Community Institutions
    - Community Capacity
    - Field notes and experiential information
- Access to rural people and communities
  - Developed relationships with these people over 2+ years
  - They are part of the research program
- Access to networks
  - To put your questions to
  - To develop answers and new questions
  - International – agreement with Japan, contacts in Europe, USA, Mexico, Australia
- Web site – an important part of our experiment in distributed research network
- Conferences and workshops
  - 1 each per year
  - Always in rural areas



- Universities represented
- 32 field sites chosen (5 dimensions of comparison)
- Workshops and conferences

- Invitation to work with us

How does this framework help us understand the problems associated with exclusion?

- I will explore this question by focusing on the changes occurring in rural context (Canada specifically)
  - In what ways have these changes contributed to new forms of exclusion?
  - What are some of the strategies available for mitigating or overcoming these new forms of exclusion?


Understanding the New Rural Economy: Options and Choices
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