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Evaluation of the Rural and Remote Care Component of the Innovations in Rural and Community Health Initiative

Final Report

Presented to:

Health Canada

Departmental Audit and Evaluation Committee

July 3, 2003

Canada

RURAL AND REMOTE CARE COMPONENT OF THE INNOVATIONS IN RURAL AND COMMUNITY HEALTH INITIATIVE EVALUATION

ACTION PLAN

June 3, 2003

Prepared By:
Office of Rural Health, Healthy Community Division, Human Development Centre

For the Departmental Audit and Evaluation Committee, Health Canada and the Treasury Board Secretariat

Introduction

Background

The Rural and Remote Care Component (RRCC) of the Innovations in Rural and Community Health Initiative (IRCHI), established by the Government of Canada in 1999, was designed to promote and improve the integration and accessibility of health services in rural and remote communities and to address relevant workforce issues in ensuring the effective delivery of health services in these communities. The purpose of the RRCC was to facilitate and support the development of information, resources and models for improving the health of Canadians living in rural and remote communities through the provision of funds for relevant community-based projects via the Rural and Remote Health Innovations Initiative (RRHII).

In 1999, the federal government identified and responded to the need to further support innovative health initiatives through the provision of $50 million in funding over three fiscal years (1999-2000 to 2001-2002). This funding was established under the umbrella of the Innovations in Rural and Community Health Initiative (IRCHI) or the "Innovations Initiative." Of the $50 million in funding for the IRCHI, $16 million was allocated to the RRCC.

The objective and mandate of the Rural and Remote Care Component (RRCC)

The objectives and mandate of the RRCC were fulfilled through two key program activities. The first component of the RRCC focussed on the application and promotion of a rural perspective on health through the activities of the Office of Rural Health (ORH). The ORH, established in 1998, is situated within the Population and Public Health Branch of Health Canada (HC) and acts as the "rural lens" for Health Canada. The overall mandate of the ORH is to work with federal departments and relevant agencies to ensure ongoing awareness of the effects of federal policies, programs and services on rural health in Canada and to factor in these effects in its consideration of future initiatives. In order to fulfill its RRCC mandate, ORH worked closely with other federal government partners and Health Canada's Regional Offices. A significant component of the work of the ORH has involved taking overall responsibility for the management and coordination of the RRCC.

The second component of the RRCC was the implementation of its $11 million Grants and Contributions Program, namely the Rural and Remote Health Innovations Initiative (RRHII). While the RRHII was overseen by the ORH, a National Steering Committee took responsibility for setting the standards for the national evaluation and for ensuring coordination of funding activities across the country. In addition, designated staff members within Health Canada's Regional Offices were responsible for managing

regional aspects of the RRHII within their respective jurisdictions. The Regional Offices took steps (e.g., consultations, participation of provincial/territorial representatives in the project review process) to ensure complementarity between projects funded through the RRHII and provincial/territorial priorities.

Through the RRHII, Health Canada provided project funding to support pilot projects and other activities that may contribute to improved health in rural and remote areas and to increased capacity of rural and remote communities to engage in action on the range of determinants of health experienced in these communities. Funded RRHII endeavours were designed to focus on a number of key activities which were intended to: improve and have an impact on the health of rural and remote communities and the individuals that reside within these communities; design and test models for use in other parts of the country; and support the development of a national rural health strategy for Canadians.

Evaluation Objectives and Issues

The objectives of this evaluation were threefold: (1) to provide a progress update on the overall functioning and success of the RRCC; (2) to identify future directions for ongoing resource requirements; and (3) to support planning for federal action on rural and remote health following the termination of funding for the Innovations in Rural and Community Health Initiative in March of 2002. The evaluation assessed the continuing relevance of an approach such as the RRCC, the extent to which the RRCC has achieved its objectives and intended impacts, the degree to which the Component's overall design and delivery contributed to its success, and the perceived cost-effectiveness of this unique approach to identifying and responding to rural and remote health issues in Canada. The specific evaluation issues and questions are discussed below.

Methodology

The methodology for the RRCC evaluation consisted of the following components and lines of evidence:

- **Review of Literature, Program Documents and F/P/T Policies and Programs:** This component of the evaluation provided three broad streams of evidence relating to key evaluation issues: (1) a small-scale review of the literature on rural/remote health issues and major public health programs to meet these needs in Canada; (2) a review of current, relevant federal/provincial/territorial (F/P/T) rural and remote health policies and programs; and (3) a review of existing program-based documents and data in order to provide the context within which to assess the various aspects of the RRCC.

- **Review of Project Evaluation Reports:** A review of reports for projects funded under the RRHII provided valuable information relevant to a number of evaluation issues, including the relevance of the RRCC, interim project outputs and results, the effectiveness of partnerships, and dissemination or dissemination plans for the results. A total of 24 project evaluations were reviewed, including two national and 22 regional projects.
- **Survey of Funding Recipients:** A telephone survey of 50 recipients of funding through the RRHII was conducted in December 2001 and January 2002. The primary objective of the survey was to collect a standard set of measures relating to the evaluation issues on completed and in-progress projects.
- **Key Informant Interviews:** Telephone interviews were conducted with a total of 53 key informants, including: RRCC program managers and staff (17 interviews), provincial/territorial government officials (17), representatives of research organizations (3) and non-governmental organizations (8), and academics (8).
- **Case Studies and Focus Groups:** Seven case studies of funded RRCC projects were conducted (one national project and six regional projects). For each case study, there was a site visit, a review of project documentation, interviews with two project staff/participants, and a focus group with project stakeholders and/or local health service providers, some of whom had experience with the project.
- **Virtual Expert Panel:** Five experts (i.e., researchers, academics, rural/remote health service providers) were consulted in two rounds of questioning via e-mail. Panellists were provided with a summary of key evaluation findings and asked for their views on the continuing relevance of an initiative such as the RRCC, the most urgent needs/priorities in rural and remote health for the next five years, and related issues. In the second round, panel members were provided with a summary of the first round responses of all members and asked some follow-up questions.

Action Plan of the Rural and Remote Care Component (RRCC) of the Innovations in Rural and Community Health Initiative
June 2003

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
1. Building Blocks: The evaluation findings indicate that the RRCC has made some progress in terms of contributing the "building blocks" of a federal rural health strategy.	In program communications and materials, explain clearly how funded projects are intended to make a contribution to a broader federal initiative as well as benefit rural and remote communities.	The Rural and Remote Care Component (RRCC) was not renewed, consequently no fund for new projects.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations of the evaluation, such as the importance of explaining the context of the program how it relates to broader Initiative.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 951-4600
2. Continuing need for Federal role in rural health: there was a clear message that there is an important need for the RRCC or a similar program if there is to be a federal rural health strategy.	As part of a federal rural health strategy, consider the feasibility of continuing the RRCC or a similar initiative in order to address rural and remote health issues which are numerous, serious and under-funded.	The Rural and Remote Care (RRCC) Component was not renewed, but the Office of Rural Health continues to provide policy direction on issues concerning the health status of people in rural and remote communities. In addition the ORH also supports the Ministerial Advisory Council on Rural Health which submitted his report in November 2002.	ORH has been actively involved and will continue to make connections within the department to influence and apply rural perspective post FMM and the Budget 2003. Some examples include participating in the development of the Health Human Resources Strategy, Primary Health Care Transition Fund to ensure that these Initiatives address the needs of rural and remote population.	Ongoing	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 951-4600

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
3. Partnership: The consensus was that there is a strong continuing need for the federal government to develop and nurture partnerships for purposes of addressing rural and remote health issues. The federal government is uniquely positioned to fill this role, ensuring a national perspective.	Continue the federal government involvement in nurturing partnerships and facilitating information sharing, dissemination and networking with respect to rural and remote health issues.	The Office of Rural Health (ORH) is developing partnership with different divisions in Health Canada and other federal departments to ensure that impact on rural and remote Canadians is being considered while developing new programs, strategies and or policies.	ORH is a member of an Interdepartmental working group (IWG) lead by the Rural Secretariat of Agriculture and Agri-Food Canada. The IWG mandate is to share information and to insure that federal programs, policies and activities provide support to rural communities. ORH will continue to work with the Rural Secretariat on the development of a National Rural Policy Framework focussing on the economic and social development of communities ORH will continue to work with Industry Canada on their pilot program on the application of Broaband in Rural Areas. ORH will review the proposals for this program. ORH will review project proposals from the Primary Health Care Transition Fund to ensure that rural health needs are addressed.	Ongoing December 2004 September 2003	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100 Rukshanda Ahmad and Paule Giguere Policy Analysts Office of Rural Health 957-6484 Paule Giguere Policy Analyst Office of Rural Health

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
			ORH plans to post on HC website a series of documents on Health Information Technology in Rural, Healthy Rural Community and Aboriginal Health.\	April 2004	Paule Giguere Policy Analyst Office of Rural Health 941-7560
4. Community/Citizen involvement; The community/citizens play an important role in identifying, addressing rural health issues, in establishing priorities and in the development of rural health strategies.	Continue to emphasize the active participation of community members in developing project proposals and identifying the most suitable health solutions for their communities, as opposed to imposing strategies developed without community/citizen engagement.	ORH ensures that rural citizen are consulted where appropriate while developing policies or new initiatives. For example, The Council members represented voices from their communities which served in the formulation of the Report's recommendations Presently, The Healthy Living Initiative is in the process of consulting with different NGOs (including rural) on the development of this Initiative.	ORH will continue to influence HC consultations to include rural citizen/NGO etc. especially G&Cs programs to establish requirements of involvement of communities in project proposals.	Ongoing	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
5. Volunteers work: A lot of projects rely on the work of volunteers and it was found that often volunteers are burnout because of high workload.	Formally recognize the work of volunteers in the development and delivery of community health initiatives, the success of which would be impossible without volunteers in the community. Due to the fact that it is becoming increasingly difficult to find and keep volunteers, future initiatives will also need to find ways to reduce the dependence on volunteers (e.g., more stable funding for hiring project staff).		ORH will work with the voluntary division in Health Canada on the possibility of developing formal mechanism to recognize volunteers efforts in projects funded by Health Canada. At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations of the evaluation such as that G&C programs need to allow more funds to hire pay staff.	April 2004 April 2004	Paule Giguere Policy Analyst Office of Rural Health 941-7560 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100
6. Programs communication: the use of internet to promote programs in rural and remote areas is not appropriate because of the low level of internet access and use.	Promote federal programs like the RRCC to communities in a proactive fashion (e.g., in local community newspapers and at local events), rather than relying on measures such as the Health Canada website.	RRCC was not renewed.	At a PPHB G&C programs meeting, ORH will mentioned the importance of using the local newspaper and local events to advertise their programs.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
7. Focus on Rural Health: It was stressed the importance of maintaining a focus on rural health issues in federal policy development and ensuring that these issues are given enough political and social "weight" to warrant continued attention.	Maintain the current focus on rural/remote health issues in federal policies and programs and respond with stronger initiatives and more sustained funding for community-level interventions.	The Office of Rural (ORH) is the focal point in HC regarding the rural health issues. Rural Health is treated as a horizontal issue across the department. ORH role is to sensitized the HC divisions on rural health issues. Each division has the responsibility to insure that rural health issues are integrated in their programs/projects/policies. ORH works in partnership with the Rural Secretariat of Agriculture and Agri-Food Canada on the development of a rural national framework.	At a PPHB G&C programs meeting, ORH will mentioned the need of funding rural community-level interventions.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100
8. Application of rural perspective: There was moderate increase of awareness and capacity to apply a rural perspective to policy and program development within and outside the health sector.	Continue to encourage the application of a rural perspective in the development of health programs and policies, and ensure that rural/remote community members participate in consultations and decision-making regarding these programs and policies.	The role of the ORH is to ensure that health policies/programs /projects have a rural component or address the rural health needs. Presently, The Healthy Living Initiative is in the process of consulting with different NGOs (including rural) on the development of this Initiative. Up to now one roundtable was conducted in the North.	ORH will continue to promote the use of rural lens in HC programs and policies in order to address the rural health needs.	Ongoing	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
9. Integrated approach: there needs to be a more integrated approach with other departments, other jurisdictions, etc. to effectively address direct and indirect rural health issues.	In future initiatives designed to address health problems in rural and remote areas, endeavour to take a more integrated approach that involves other federal departments and other jurisdictions.	Being the member of Inter-departmental Working Group on Rural, the ORH works with other federal departments such as Rural Secretariat of Agriculture and Agri-Food Canada, Co-operative Secretariat, Industry Canada, Environment Canada, INAC etc.	The ORH will continue to work with the Rural Secretariat of Agriculture and Agri-Food Canada on the development of a National Rural Policy Framework focussing on the economic and social development of communities. ORH will continue to work with Industry Canada in reviewing the projects proposals of their Broadband Pilot Program on Broadband for Rural and Northern. The ORH is planning to present the Ministerial Advisory Council on Rural Health report to different P/P/T Advisory Committees (Population Health and Health Security and on Delivery and Human Resources) to address rural health issues.	April 2004 December 2004 April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946-5100
10. Rural Health Research: there should be greater support for research on rural/remote health issues.	If feasible, provide more federal funding and support for research into rural and remote health issues.	ORH is working in collaboration with CIHR, Rural and Northern Health National Research Agency Working Group in providing leadership by identifying opportunities for enhancing the value of existing work, promoting research and capacity building in rural and northern health.	ORH will pursue their work with CIHR through Rural and Northern Health National Research Agency Working Group.	Ongoing	Paule Giguere Policy Analyst Office of Rural Health 941-7560

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11. Formal criteria: An effective proposal solicitation process at the regional level was thought to be the reason for the equitable distribution of the resources under the RRCC. Some respondents argued that there should have been formal criteria for the distribution of funds among regions.	Establish formal criteria (incorporating an appropriate degree of regional flexibility) for how resources should be distributed in future grants and contributions programs like the RRHII.	RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations of the evaluation such as establishing formal criteria.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100
12. Leverage Funding: In many cases RRCC funding served to attract other funding, or that other non-federal partners contributed additional resources, both financial and in-kind. Most project sponsors said that they were able to leverage resources in their respective projects.	As one of the formal criteria for funding under future grants and contributions programs of this nature, specify that funding recipients are required to leverage financial and/or in-kind resources from sources/partners other than the federal government.	RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations of the evaluation such as requiring leverage financial or in kind resources.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100

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13. Projects partnership: Partners and stakeholders from a variety of sectors were involved to a significant extent in many RRHII funded projects. Most of the projects had been implemented or designed in partnership with other individuals or organizations (86 per cent). These projects were most likely to have between three and five project partners (40 per cent) or between six and ten project partners (33 per cent), with an overall average of 6.8 partners The impacts of partnerships were overwhelmingly positive.	Continue to encourage and support project partnerships in future initiatives in rural and remote health.	RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the success of this partnership approach, as well as lessons learned from other not so successful projects i.e CMA-Locum project.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100
14. Complementary of RRCC. The general opinion was that RRCC is a unique program within Health Canada. In fact, many respondents feel that this is the only program that elevates the level of knowledge of specifically rural concerns. It is also the only program that complements some of the provinces' and territories' efforts to improve health status in rural communities by providing funding for specialized short-term projects.	Continue to build some flexibility into similar future programs to enable the provinces and territories to address their own unique needs.	The RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will underline the importance that G&C programs to complement some of the provinces' and territories' efforts to improve health status in rural communities by providing funding for specialized short-term projects.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
15. Data need on rural health: The evaluation identified gaps in the data sources available to effectively monitor and assess the implementation and impact of the RRCC, including: rural health indicators, analysis of rural demographics, quality of life indicators in rural communities etc.	Assess the feasibility of developing the suggested additional data sources to improve the performance monitoring of the RRCC and future rural and remote health initiatives	ORH has attended CCHS meetings to provide an expertise on the needs of information on Rural Health. ORH is a member of Health Canada and Statistics Canada steering committee to influence Statistics Canada to include enough rural citizen in their major surveys in order to do analysis. The Rural Secretariat of Agriculture and Agri-Food Canada, is now taking an holistic approach towards building sustainable communities and is interested in focusing on the social side of this in particular 'Health'. The Rural Secretariat is interested in building a a "Business case for Rural Health". Some ideas included addressing gaps in the availability of data on rural population.	ORH will make presentations to different CIHR Institutes on the Ministerial Advisory Council on Rural Health Report in order to encourage Institutes to do research on Rural Health. ORH will to attend CCHS meeting and HC & Statistics steering committee to ensure data availability at the rural level. ORH will continue to work closely with the Rural Secretarial on their project on the development of a rural data base. ORH will continue to provide advises to the Bureau of Cardio-respiratory diseases and diabetes special populations of the Center of Chronic Disease and Control on their national research program entitled "Canada's Rural Communities: Understanding Rural Health and its Determinants".	December 2003 Ongoing Ongoing Ongoing	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100 Paule Giguere Policy Analyst Office of Rural Health 941-7560 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100 Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100

Evaluation: Conclusions	Evaluation: Recommendations	Program response: Current Status	Program response: Action Required	Due Date for Completion	Contact Person
16. Approval time line: Project sponsors indicated being very satisfied with most aspects of the project application and funding process, with the exception of the timeliness of the approval process.	Explore potential strategies to improve the timeliness of the project approval process.	The RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations of the evaluation such as to improve the timeliness of the project approval process.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100
17. Improvements implementation: Some key suggestions for improvement include ongoing information sharing between projects, improved performance indicators of rural health, requesting letters of interest rather than detailed proposals from applicants due to the limited proposal-writing capacity of community organizations, and standardized record keeping from regional staff and project sponsors.	Consider the feasibility of implementing the suggested improvements in future initiatives aimed at rural and remote health.	The RRCC was not renewed.	At a meeting of PPHB G&C programs (date to be confirmed) ORH will present the results and the recommendations and discuss on how the suggested improvements can be implemented in future initiatives.	April 2004	Jean Pruneau Senior Advisor, Centre of Healthy Human Development 946 -5100

Evaluation of the Rural and Remote Care Component of the Innovations in Rural and Community Health Initiative

Final Report

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EXECUTIVE SUMMARY

Evaluation Objectives and Issues

The Rural and Remote Care Component (RRCC) of the Innovations in Rural and Community Health Initiative (IRCHI), established by the Government of Canada in 1999, was designed to promote and improve the integration and accessibility of health services in rural and remote communities and to address relevant workforce issues in ensuring the effective delivery of health services in these communities. The purpose of the RRCC was to facilitate and support the development of information, resources and models for improving the health of Canadians living in rural and remote communities through the provision of funds for relevant community-based projects via the Rural and Remote Health Innovations Initiative (RRHII). The IRCHI received a total of $50 million in funding over three fiscal years (1999-2000 to 2002-2002). Of this total, $16 million was allocated to the RRCC.

The objectives of the RRCC evaluation were: (1) to provide a progress update on the overall functioning and success of the RRCC; (2) to identify future directions for ongoing resource requirements; and (3) to support planning for federal action on rural and remote health following the termination of funding for the Innovations in Rural and Community Health Initiative in March of 2002. The evaluation assessed the continuing relevance of an approach such as the RRCC, the extent to which the RRCC has achieved its objectives and intended impacts, the degree to which the Component's overall design and delivery contributed to its success, and the perceived cost-effectiveness of this unique approach to identifying and responding to rural and remote health issues in Canada.

Methodology

The methodology for the RRCC evaluation consisted of the following components and lines of evidence:

- **Review of Literature, Program Documents and F/P/T Policies and Programs:** This component of the evaluation provided three broad streams of evidence relating to key evaluation issues: (1) a small-scale review of the literature on rural/remote health issues and major public health programs to meet these needs in Canada; (2) a review of current, relevant federal/provincial/territorial (F/P/T) rural and remote health policies and programs; and (3) a review of existing program-based documents and data in order to provide the context within which to assess the various aspects of the RRCC.
- **Review of Project Evaluation Reports:** A review of reports for projects funded under the RRHII provided valuable information relevant to a number of

evaluation issues, including the relevance of the RRCC, interim project outputs and results, the effectiveness of partnerships, and dissemination or dissemination plans for the results. A total of 24 project evaluations were reviewed, including two national and 22 regional projects.

- **Survey of Funding Recipients:** A telephone survey of 50 recipients of funding through the RRHII was conducted in December 2001 and January 2002. The primary objective of the survey was to collect a standard set of measures relating to the evaluation issues on completed and in-progress projects.
- **Key Informant Interviews:** Telephone interviews were conducted with a total of 53 key informants, including: RRCC program managers and staff (17 interviews), provincial/territorial government officials (17), representatives of research organizations (3) and non-governmental organizations (8), and academics (8).
- **Case Studies and Focus Groups:** Seven case studies of funded RRCC projects were conducted (one national project and six regional projects). For each case study, there was a site visit, a review of project documentation, interviews with two project staff/participants, and a focus group with project stakeholders and/or local health service providers, some of whom had experience with the project.
- **Virtual Expert Panel:** Five experts (i.e., researchers, academics, rural/remote health service providers) were consulted in two rounds of questioning via e-mail. Panellists were provided with a summary of key evaluation findings and asked for their views on the continuing relevance of an initiative such as the RRCC, the most urgent needs/priorities in rural and remote health for the next five years, and related issues. In the second round, panel members were provided with a summary of the first round responses of all members and asked some follow-up questions.

Relevance

The evaluation findings indicate that the RRCC has made some progress in terms of contributing the "building blocks" of a federal rural health strategy. Although respondents in three case studies could only comment on project impacts at their own community level due to a lack of understanding of how their project fits into the broader federal strategy, those in the other four case studies felt strongly that their project outcomes and outputs should be considered "building blocks". They regarded the tools and service models they were developing as well as the networking they had done as valuable contributions that could inspire, guide, and be replicated (at least partially) in other communities. As such, these contributions could be viewed as developmental elements of a broader federal rural health strategy. While most expert panellists could not comment or felt it is premature to assess this impact, some were hopeful that the RRCC has made some contribution of "building blocks".

There was, on the part of all respondents from all lines of evidence, a clear message that there is an important need for the RRCC or a similar program if there is to be a federal rural health strategy. Rural and remote health issues have in the past mostly "fallen through the cracks" and the RRCC is essential for maintaining a focus on these issues for future enhancement of the rural and remote health situation. Expert panellists observed that the RRCC is the only available initiative for the development of a rural health strategy.

The consensus was that there is a strong continuing need for the federal government to develop and nurture partnerships for purposes of addressing rural and remote health issues. The federal government is uniquely positioned to fill this role, ensuring a national perspective. In addition, respondents in the evaluation stress that the federal government should encourage provincial/territorial involvement in addressing health issues in rural and remote communities. Similarly, the evaluation findings indicate that there is a strong need for the federal government to support communities and engage citizens in the development and implementation of rural health strategies.

Most respondents in the evaluation could not identify specific changes to the rural health policy environment, but stressed the importance of maintaining a focus on rural health issues in federal policy development and ensuring that these issues are given enough political and social "weight" to warrant continued attention. Expert panellists feared that rural health issues may be just a passing "fad" and that, without ongoing efforts to focus attention on these issues, they may receive increasingly less emphasis in federal policies. Although current consultations on health care such as the Romanow Commission are incorporating rural/remote health care needs, the trend toward more centralization of health services as well as the demographic trend for more Canadians to live in urban centers present challenges for a continuing emphasis on rural health.

Progress and Success

The evaluation findings indicate that awareness and capacity have increased to apply a rural perspective to policy and program development within and outside the health sector. However, most respondents feel that it has increased only to a moderate extent since more work is still needed in both policy and program development. There was uncertainty as to whether it was the RRCC that influenced this increase or if it was part of or a result of an overall political push for an increased rural and remote focus. In any case, the RRCC was seen as pivotal in increasing discussion and awareness of rural health issues within the governments and in providing direction for research and development concerning these issues.

Examples of improved capacity in spheres related to the determinants of health include: an increased number of rural related programs and policies within Health Canada; an increased number of working groups; the establishment of the Ministerial Advisory Council on Rural Health; and the appointment of the Special Advisor to the President of the Canadian Institutes of Health Research (CIHR). Other examples are Telehealth, health information technology for rural/remote areas and primary care reform efforts.

All lines of evidence indicate that RRCC priorities are congruent with provincial/territorial priorities and community needs. In the view of some respondents, however,

the RRCC priorities encompass too wide a range of issues and should be better focused. Findings from the project case studies indicate that transportation and access to health care services are the most urgent priority areas. Many of these issues are not exclusively a health concern as they involve other aspects of life. For instance, poor road conditions affect fresh food delivery, which in turn has an adverse impact on the diet of rural/remote community members and can contribute to a high incidence of diabetes.

In the view of some respondents, there needs to be a more integrated approach with other departments, other jurisdictions, etc. to effectively address direct and indirect rural health problems. In addition, some respondents and expert panellists feel that there should be greater support for research on rural/remote health issues.

The evaluation findings suggest that the primary impacts of the RRCC related to research and research networks have been in increasing community involvement in academic networks and in increasing contact between communities, provinces and other jurisdictions. The strength of the RRCC has been in encouraging community level participation in rural health concerns and in finding solutions. Although the evaluation evidence suggests that there is the potential for knowledge development on rural health issues, it is premature to draw definitive conclusions regarding these impacts of the RRCC.

Findings from the survey of project sponsors/funding recipients indicate that RRCC knowledge has been (or is planned to be) disseminated. The project sponsors tend to share project information mostly with those in close proximity to them (e.g., health service providers in their own community and region/province), and this is most commonly done by word of mouth, media coverage, project reports/products and conferences. In the view of some interview respondents, however, it is too early in the life of many funded projects to observe results, there has been insufficient ongoing dissemination of available results, and coverage of the RRCC on the Health Canada website has been inadequate. Expert panellists also feel that there is a need to improve the dissemination of knowledge on rural and remote health (e.g., by providing a virtual clearinghouse of information on rural/remote health research and projects).

Most respondents feel that rural community capacity to address local health issues has increased at least to some extent. The degree to which RRCC funding played a role in this respect could not be determined definitively, particularly as it was seen as still too early to do so. However, the opinion expressed by some respondents is that the funding has contributed somewhat in terms of developing awareness, tools, reports, directories, and partnerships that would be expected to help participating rural communities address their health needs. This capacity building would also apply to other communities able to adopt these models and adapt them to their own needs.

Most respondents feel that in general terms and in recent years the federal government's capacity to address rural health issues has increased, at least to some extent. The RRCC has played a role in this increased capacity, along with the Office of Rural Health and Rural Teams more broadly. In addition, most respondents consulted for the evaluation are of the opinion that RRCC funding has contributed at least somewhat to an improved relationship between federal and provincial/territorial government staff with regard to rural health issues.

Few respondents could comment on the degree to which the RRCC has helped rural/remote health issues to be considered in the development and application of health systems information technology. Among those who could, the role of the RRCC in this respect was seen as modest.

Cost-Effectiveness

In the view of most respondent in the evaluation, RRCC funds were equitably distributed according to need for and cost of health services in communities. An effective proposal solicitation process at the regional level was thought to be the reason for the equitable distribution of the resources under the RRCC. Some respondents argued that there should have been formal criteria for the distribution of funds among regions, however.

The consensus among respondents consulted in the evaluation was that in many cases RRCC funding served to attract other funding, or that other non-federal partners contributed additional resources, both financial and in-kind. In-kind resources included free travel, accommodation, advertising, or technical expertise. Most project sponsors said that they were able to leverage resources in their respective projects. It was pointed out by key informants, however, that leveraging was not a formal criterion for funding under the program but perhaps it should be.

It is difficult to draw firm conclusions about the sustainability of results produced by RRCC projects because, in the view of many respondents, it is too early to observe this. Among those who responded to this issue, views varied widely about the actual or potential sustainability of projects beyond the funding period. A suggested drawback to sustainability is the dependence on federal funding – it would be and has been difficult to attract additional funding to keep a project going. Two in three funding recipients indicated in the survey that their project results would continue to be relevant, however, after the project ended.

Implementation

The evaluation results indicate that partners and stakeholders from a variety of sectors were involved to a significant extent in many RRCC funded projects, and all projects appeared to have more than one partner. Partner and stakeholder involvement was seen as appropriate. Moreover, the impacts of partnerships were overwhelmingly positive. Partnerships usually resulted in financial or in-kind contributions, and their impacts varied from allowing the project to proceed in the first place, to increasing community buy-in and networking.

While some duplication between the RRCC and other programs was reported, the consensus is that the RRCC is a unique program and any existing overlap is complementary and in some cases even an asset to the Component. For example, the Canada Health Infostructure Partnership Program (CHIPP) provides funding for projects aimed at improving access to medical care in rural and remote areas (e.g., video-conferencing telehealth facilities in rural/remote communities). Respondents observed that there is some variation in how the RRCC is implemented from region to region, however this is not considered to be a negative thing and the RRCC was in fact praised for its flexibility towards different provincial and territorial priorities and needs.

A number of gaps were noted in the currently available sources of data to assess the RRCC's implementation and impacts. Respondents made a number of suggestions for additional data sources to address the cited gaps, most notably for more detailed project-specific information

and more data and indicators on the rural health needs and health status of individual communities.

In the survey, project sponsors indicated being very satisfied with most aspects of the project application and funding process, with the exception of the timeliness of the approval process – fewer than half were satisfied and fully one-third of respondents were dissatisfied with this aspect.

Although key informants and case study respondents had a great deal of praise for the RRCC, they also had some complaints. Particular perceived strengths include the high degree of collaboration in the development and implementation of the RRCC, the priorities, scope and flexibility of the program, and the beneficial project impacts such as heightened awareness of rural health issues. On the other hand, the major limitations pertain to inadequate program communications, aspects of the proposal solicitation and application process, and the short time frame of project funding in light of ambitious program objectives. Some key suggestions for improvement include ongoing information sharing between projects, improved performance indicators of rural health, requesting letters of interest rather than detailed proposals from applicants due to the limited proposal-writing capacity of community organizations, and standardized record keeping from regional staff and project sponsors.

1. INTRODUCTION

1.1 Background

The Rural and Remote Care Component (RRCC) of the Innovations in Rural and Community Health Initiative (IRCHI), established by the Government of Canada in 1999, was designed to promote and improve the integration and accessibility of health services in rural and remote communities and to address relevant workforce issues in ensuring the effective delivery of health services in these communities. The purpose of the RRCC was to facilitate and support the development of information, resources and models for improving the health of Canadians living in rural and remote communities through the provision of funds for relevant community-based projects via the Rural and Remote Health Innovations Initiative (RRHII). More details on the IRCHI and RRCC are provided in the remainder of this section.

(a) The Innovations in Rural and Community Health Initiative

In 1999, the federal government identified and responded to the need to further support innovative health initiatives through the provision of $50 million in funding over three fiscal years (1999-2000 to 2001-2002). This funding was established under the umbrella of the Innovations in Rural and Community Health Initiative (IRCHI) or the “Innovations Initiative.” The Initiative was designed to address the complexity surrounding the range of factors or determinants that affect the health of Canadians through a number of key objectives including:

- better meeting the health needs of Canadians living in rural and remote communities;
- improving the quality and accessibility of home and community care as an integral component of an integrated health system;
- improving Canadians’ access to drugs and the affordability and sustainability of drug plans; and

- improving the integration and quality of health services across the entire health system.[1]

The IRCHI emerged in response to a number of growing concerns related to changes being witnessed within the health care system in Canada, and also within the general Canadian population, that were likely to have an impact on the Canadian health care system. Among the changes identified as needing to be addressed by the IRCHI were: the fact that more Canadians are receiving care from a greater and much broader range of health care providers in a variety of locations; increasing pressure on Canadian families and their communities to care for those who are ill or disabled outside of the hospital environment; a continually aging population; and the ongoing changes in the nature and use of technology within the Canadian health care system.[2]

The Innovations Initiative was charged with addressing the challenges presented by these changes. The key priorities established by the Initiative included focussing on innovative approaches to home and community care as well as access to quality health services, particularly in rural and remote communities. These priority areas were subsequently developed into four Initiative components:

- rural and remote care;
- home and community care;
- access to and affordability of drugs; and
- quality and access.

The Rural and Remote Care Component (RRCC) of the Initiative was the focus of this evaluation study.

1. *Evaluation Framework for the Rural and Remote Component of Innovations in Rural and Community Health Initiative of Health Canada.* February 2001.

2. *Innovations in Rural and Community Health (Fact Sheet)*. Produced by Health Canada and made available on the Department's website, 1999.

(b) The Rural and Remote Care Component (RRCC) of the Innovations Initiative

Nearly one-third of all Canadians reside in rural and remote communities (i.e., communities of less than 10,000 population and removed from many urban services and resources) across the country. Given this reality and the constantly changing nature of the demands for rural health services, the RRCC was established to focus on identifying and addressing issues that affect health in rural Canada. Of the $50 million in funding for the IRCHI, $16 million was allocated to the RRCC.

Rural Health Issues

Research has clearly shown that residents of rural and remote communities face a distinct disadvantage with respect to health. The rural health disadvantage is discussed below from two perspectives: access and outcomes.

With respect to differential *access* in rural areas, it is clear that rural residents are less able to access health care than their urban counterparts. This is due in part to the rationalization of health care in recent years and the difficulties in attracting practitioners to rural areas as well as the low density population in remote areas. Research has shown that, in rural and remote communities, there is less than one family doctor for every 1,000 rural residents, compared to two or more in larger, urban areas. Moreover, the average rural resident must travel about 10 kilometres to a physician and over 40 per cent are located five or more kilometres from a doctor, compared to two kilometres and 10 per cent, respectively, for urban residents. These transportation difficulties are particularly onerous for older rural residents, as well as those with disabilities or low incomes.[3] These deficits are exacerbated by the fact that access to home care, which can help alleviate the burden imposed by declines in health care delivery, are greatly

3. Jean Lederer and Moffatt Clarke, *Rural Communities, Rural Users: Summary of Association from Health Canada in Rural Health and Primary Care Workshops*, Silver Star Mountain, April 27-28, 2001.

reduced or absent in rural areas[4]. Moreover, as rural Canadians are less likely to be connected to the Internet, they are less able to access new technology-based health information delivery mechanisms such as Telehealth, which hold the promise of benefiting particularly rural areas.[5]

A number of examples of the gap in rural health care access may be observed in particular regions.[6] First, over one-half of Atlantic rural communities suffered from a loss of doctors leaving for opportunities elsewhere. Recruitment, retention and adequate supply of health care professionals are noted as particular challenges for Nova Scotia and New Brunswick, though this is likely true of all Atlantic provinces. Second, a recent study based on a survey of rural Alberta residents found respondents were most likely to identify accessible quality health care as the top priority among a list of priorities[7]. Third, a recent study of rural health in Quebec found that almost one in four municipalities reported health care gaps or anticipated gaps in the near future, with access problems being particularly acute in smaller (rural) communities[8].

The aforementioned health practitioner staffing difficulties in rural areas can be attributed to at least three factors. First, health care providers are often not prepared for the intimacy and high volume of working in rural communities. This often leads to burnout and departure of health personnel. Second, doctors are reluctant to work in remote areas because, under certain provincial remuneration arrangements, doctors' potential earning ability is limited because of typically lower

4. Marika Morris, Jane Robinson, and Janet Simpson, *The Changing Nature of Home Care and its Impact on Women's Vulnerability to Poverty*, Status of Women Canada Policy Research Paper, 2000.

5. *Rural Canada in the Knowledge-Based Economy*, deck, Rural Secretariat, Health Canada, p. M-12, undated.

6. These examples are based on sources obtained from Health Canada: Carl Robbins, *Rural Health Research in Canada: A Time for Action*, Strategic Alliance for Rural, Remote and Northern Health Research; Cooperation de travail Interface, *Access to healthcare in rural and semi-rural areas of Quebec* for Health Canada, 1999; and David Bruce and Gwen Lister, *Rural and Remote Health Initiatives in Atlantic Canada: Environmental Scan of Activities*, Rural and Small Town Programme, Mount Allison University, October, 2001.

7. Marianne Sorensen, *Rural Priorities: Results from a Survey of Rural Albertans*, prepared for the Alberta Rural Team, August 2001.

8. Cooperation de travail Interface, *Access to healthcare in rural and semi-rural areas of Quebec*, for Health Canada, 1999.

incomes in remote areas. Third, access to medical training and equipment — which are integral to health practitioners' career aspirations and how well the job is done — is often lower in rural areas.[9] These factors have contributed, to some extent, to the difficulty in recruiting health care workers for these communities and retaining them in their jobs.

Bruce and Lister[10] point also to government/institutional and community capacity issues affecting how health care is delivered in rural areas. First, the fact that health care in rural areas will have to be increasingly based on non-physician health practitioners necessitates changes to the Canada Health Act which focuses on health care delivered by doctors and hospitals. Second is the fact that health care policy at the provincial level is in a constant state of flux, citing the example of Nova Scotia which introduced regional/community health boards in the 1990s, only to dismiss and reduce spending on the boards more recently. Third is the notion of community capacity in rural areas — the extent to which rural areas are able to identify issues, take actions and achieve objectives. Capacity can also be seen as the ability of rural communities to deliver high quality health care and prevention programs, which is severely limited by the diminished economic base in such communities, owing to the declining importance of resource-based industries on which rural communities depend, and to the out-migration of well-off seniors and job-seeking youth.

The other perspective on the rural health disadvantage may be seen in a number of indicators of health *outcomes*[11]. The data indicate that life expectancy is lower and infant mortality rates higher in rural than urban communities. Despite this, there are greater proportions of the rural population who are children and seniors, owing to the higher birth rate in rural communities and the fact that prime-age rural residents are more likely to be drawn away by urban job opportunities, as noted above. Moreover, it is the more affluent seniors who are more likely to abandon rural communities in order to live in areas with greater access to amenities such as health

9. Bruce and Lister, 2001.

10. David Bruce and Gwen Lister, *Rural and Remote Health Initiatives in Atlantic Canada: Environmental Scan of Activities*, Rural and Small Town Programme, Mount Allison University, October, 2001.

11. Much of this evidence is drawn from the Census of Canada, which, though from 1996 and earlier, is likely representative of current conditions in these communities.

care, leaving behind a more vulnerable group of seniors[12]. These patterns mean not only greater proportionate demands for health care in rural areas, but also a lower tax base to support health care facilities that is exacerbated by shifts in the economic base away from natural resources (which are predominantly in rural areas). Furthermore, in rural regions there is a higher incidence of injuries owing to larger proportionate numbers of persons in occupations (such as farming) with higher injury rates, leading in turn to a greater incidence of health problems and higher rates of long-term disability and illness.[13]

RRCC Objectives, Activities and Priorities

The objectives and mandate of the RRCC were fulfilled through two key program activities. The first component of the RRCC focussed on the application and promotion of a rural perspective on health through the activities of the Office of Rural Health (ORH). The ORH, established in 1998, is situated within the Population and Public Health Branch of Health Canada (HC) and acts as the "rural lens" for Health Canada. The overall mandate of the ORH is to work with federal departments and relevant agencies to ensure ongoing awareness of the effects of federal policies, programs and services on rural health in Canada and to factor in these effects in its consideration of future initiatives. In order to fulfill its RRCC mandate, ORH worked closely with other federal government partners and Health Canada's Regional Offices. A significant component of the work of the ORH has involved taking overall responsibility for the management and coordination of the RRCC.

The second component of the RRCC was the implementation of its $11 million Grants and Contributions Program, namely the Rural and Remote Health Innovations Initiative (RRHII). While the RRHII was overseen by the ORH, a National Steering Committee took responsibility for setting the standards for the national evaluation and for ensuring coordination of funding activities across the country. In addition, designated staff members within Health Canada's

12. Bruce and Lister, 2001.

13. Carl Robbins, *Rural Health Research in Canada. A Time for Action*, Memorial University and the Strategic Alliance for Rural, Remote and Northern Health Research, circa 2000, http://www.nalberta.ca/~ccinst/RNR-Alliance/Preamble.html.

Regional Offices were responsible for managing regional aspects of the RRHII within their respective jurisdictions. The Regional Offices took steps (e.g., consultations, participation of provincial/territorial representatives in the project review process) to ensure complementarity between projects funded through the RRHII and provincial/territorial priorities.

Through the RRHII, Health Canada provided project funding to support pilot projects and other activities that may contribute to improved health in rural and remote areas and to increased capacity of rural and remote communities to engage in action on the range of determinants of health experienced in these communities. Funded RRHII endeavours were designed to focus on a number of key activities which were intended to: improve and have an impact on the health of rural and remote communities and the individuals that reside within these communities; design and test models for use in other parts of the country; and support the development of a national rural health strategy for Canadians.

Projects funded under the RRHII were required to meet at least one of the following program objectives:

- promote the integration and accessibility of a full range of health services in rural and remote areas, including primary and specialty care;
- explore ways to address workforce issues, including but not limited to gaps in the supply of health professionals; and
- explore system reforms to improve the delivery of health services in rural and remote areas.

In addition, to qualify for funding, projects were required to meet the RRHII's national and/or provincial and territorial priorities and to demonstrate how the project would serve the population within its community. Although each province and territory had its own priorities for RRHII funded projects, these often included some of the nine national priorities:

- developing and piloting solutions to rural health issues and problems related to access to health services;
- addressing issues of distance to health services in rural and remote areas;
- addressing issues of recruitment and retention of rural health providers;
- developing networks in rural and remote areas to reduce health problems and provide options;
- developing models of integrated, multi-disciplinary teams to support rural health needs;
- examining the physical environments (natural and human made) in rural and remote communities which contribute to accidents or disease;
- fostering intersectoral collaboration on rural health issues;
- developing innovative models which address the determinants of health as experienced by Canadians living in rural and remote areas; and
- transportation.

Calls for proposals were issued by RRHII encouraging interested parties to undertake projects in these priority areas. Projects proposed were required to include collaborative and strategic partnerships in the development of the proposal and in implementation of the funded project. Applicants were asked to submit proposals in compliance with application guidelines developed and provided by RRHII. Proposals were assessed by a review committee, typically composed of federal, provincial/territorial and community representatives. Applicants were subsequently informed in writing about the status and success of their application. The entire review process took anywhere from three to six months from submission of the proposal to notification that a decision had been made.

RRCC Stakeholders and Target Groups

Through its two key activities, the RRCC was designed to address the needs and interests of a range of clients, stakeholders and target populations. The clientele and stakeholders targeted by the RRCC included those most likely to be affected by and/or to benefit from the Component's activities and outputs. The direct stakeholders/clients were Canadians living in rural and remote communities. Other groups and individuals could also benefit from their involvement in the Component and/or from access to the results of the RRCC. These other stakeholders included: policy and program staff of Health Canada and other federal government departments who were kept apprised of rural health issues and concerns to guide the development of ongoing and future initiatives; provincial/territorial government staff; research organizations; rural and remote health care providers; and other non-government organizations (NGOs) with an interest in the health of Canadians. This latter group of stakeholders was provided with the opportunity to have their rural/remote issues and concerns identified, discussed and even addressed through both the general operations of the ORH and the implementation of funded RRHII projects.

1.2 Evaluation Objectives and Issues

The objectives of this evaluation were threefold: (1) to provide a progress update on the overall functioning and success of the RRCC; (2) to identify future directions for ongoing resource requirements; and (3) to support planning for federal action on rural and remote health following the termination of funding for the Innovations in Rural and Community Health Initiative in March of 2002. The evaluation assessed the continuing relevance of an approach such as the RRCC, the extent to which the RRCC has achieved its objectives and intended impacts, the degree to which the Component's overall design and delivery contributed to its success, and the perceived cost-effectiveness of this unique approach to identifying and responding to rural and remote health issues in Canada. The specific evaluation issues and questions are discussed below.

(a) Relevance

Determination of the continuing relevance of this component of the Innovations Initiative is integral to future decisions pertaining to the value of such a program in terms of its mandate, focus and overall operations. Findings from most lines of evidence in the evaluation provided useful information on relevance issues.

The specific issues and questions examined in the evaluation were as follows:

- To what extent has the RRCC contributed "building blocks" to the development of a rural health strategy?
- Is there a continuing need for the federal government to develop/nurture partnerships to address rural and remote health issues?
- Is there a continuing need to support communities and engage citizens in efforts to develop and implement effective rural health strategies?
- Has the broader policy environment concerning rural health issues changed?
- Is there a continuing need for the RRCC as part of a federal rural health strategy?

(b) Progress and Success

A number of questions relating to the progress and degree of success of the RRCC were examined. These issues included the intended impacts and effects for which the RRCC is held accountable. Data from several lines of evidence were examined to help determine the extent to which the RRCC's overall mandate and objectives have been met and the impacts of its efforts.

The key questions in this category were:

- Are awareness of, and capacity to apply, a rural perspective to policy and program development increasing, in spheres that relate to the determinants of health?
- Are RRCC priorities focussed on, and reflective of, provincial/territorial priorities and rural and remote community needs?
- Is research on issues of concern to Canadians living in rural and remote areas advancing? If so, what role has the RRCC played in the advancement witnessed?
- Has a research network been created? If not, why not?
- Is knowledge on rural health issues being created? How has or can this knowledge be used by federal and provincial/territorial governments in their efforts to support and address the health needs of Canadians living in rural and remote communities?
- To what extent has RRCC knowledge been disseminated or plans for dissemination been developed? In what ways and to whom has this knowledge been disseminated?
- Is capacity in rural and remote areas to address local health issues of concern increasing? If so, to what extent can these increases be attributed

to the impact of the RRCC?

- Is the capacity within the federal government to address rural health issues increasing? If so, to what extent can these increases be attributed to the impact of the RRCC?
- Has the RRCC enhanced the working relationship between federal and provincial/ territorial staff at the working level? If so, in what ways?
- Are rural and remote health issues being considered in the development and application of health systems information technology? If not, why not? If so, what are the linkages between these considerations and the role and impact of the RRCC?

(c) Cost-Effectiveness

The third category under investigation for this evaluation was the perceived cost-effectiveness of the Component. The concept of cost-effectiveness largely pertains to the extent to which the RRCC made effective and efficient utilization of available funds. Information from the review of documentation and project evaluation reports, key informant interviews and project case studies were examined to assess cost-effectiveness and related issues.

The following cost-effectiveness issues were examined:

- Were resources distributed in a balanced and equitable manner?
- To what extent has the RRCC leveraged its resources to meet RRCC priorities?
- To what extent will the results of the RRCC be sustainable beyond the life of the IRCHI?

(d) Process and Implementation

The final category of evaluation issues related to the design, delivery and implementation of the RRCC and funded projects. Responses to these evaluation questions facilitated an assessment of the extent to which the Component's progress and success can be linked to the overall process involved in the implementation of the RRCC. Information to address these issues was gathered mainly through key informant interviews, a survey of funding recipients/project sponsors, project case studies and the document review.

The issues/questions related to RRCC process and implementation were as follows:

- To what extent have partners and stakeholders been appropriately involved in the design and implementation of the activities of the RRCC?
- What have been the benefits and impacts of partnerships on the RRCC?
- To what extent does the RRCC complement, duplicate or overlap with other Health Canada (HC) programs? Other provincial/territorial government programs?
- What is the variation in implementation of the RRCC across HC regions? What impact, if any, have these variations had on the overall progress and success of the RRCC?
- How much collaboration is there across the RRCC and between the RRCC and other parts of HC?
- Is comprehensive, representative, generalizable, valid, reliable, timely and accessible data being collected? What are the costs involved and how is the data being used?
- What are the gaps in data sources? How can these be addressed?

1.3 Purpose and Organization of the Report

The purpose of this document is to report on the methodology, integrated findings and conclusions of the evaluation of the RRCC. In Chapter Two the methodological approaches utilized for the evaluation are described, including: a review of literature, policies and programs; a review of RRCC documents and data; a review of project evaluation reports; a survey of 50 project sponsors/funding recipients; 53 key informant interviews; seven (7) project case studies and focus groups; and a "virtual" expert panel conducted by e-mail. The integrated evaluation findings are then presented in Chapters Three through Chapter Six, organized by the major evaluation issues. Finally, the evaluation conclusions and recommendations are presented in Chapter Seven.

2. METHODOLOGY

2.1 Review of Literature

This first component of the evaluation involved a small-scale review and analysis of literature on health issues unique to rural and remote communities as well as major public health programming currently available to meet these needs in Canada and the United States. The literature review was useful for identifying key issues, trends, promising practices and gaps in programming and for providing political, sociodemographic and technological context for the RRCC evaluation. This component was integral to developing an understanding of the RRCC's relevance. Specifically, this component of the research helped to answer key evaluation questions concerning: the relevance and continuing need for the RRCC as part of the federal rural health strategy and to build capacity for the development of this strategy; the continuing need for the federal government to develop and support partnerships to address rural and remote health issues; and changes in the policy environment concerning rural health issues. The results of the literature review are presented in detail in a separate Interim Report.

2.2 Review of F/P/T Policies and Programs

This component of the evaluation provided a description of current federal/provincial/territorial (F/P/T) programs and policies on rural and remote health issues in Canada, broken down by province/territory and by federal department. In an effort to ensure that the most relevant policies and programs were included in the review process, interviews were conducted with key contacts identified by HC Regional Offices and the Office of Rural Health. In these interviews, the contacts were asked to identify and, if possible, provide copies of provincial/territorial policies and programs to be included in the review. This review of existing policies and programs helped to answer key evaluation questions relating to the relevance and continuing need for a federal role in rural and remote health as well as changes in the policy environment. The results of the policy/program review are presented in detail in a separate report.

2.3 Document and Database Review

The purpose of this component of the evaluation was to review existing program-based sources of evidence in order to provide further context within which to assess the various aspects of the RRCC. In particular, the objectives of this review were to provide insights into the development and delivery history of the RRCC, to verify information gathered through other evaluation methodologies, and to provide evidence on several of the evaluation issues (e.g., the development of partnerships and the proportion of acceptable proposals funded through the RRCC). In addition, annual and other progress reports supplied some information against performance measures, thus reducing the need to collect performance measurement data during the evaluation.

The following types of program information were reviewed:

- Treasury Board submissions;
- financial records;
- progress reports;
- annual reports;
- project files;
- minutes of F/P/T and other meetings; and
- departmental databases.

A guide was developed to facilitate the review of documentation and data. This guide was utilized to help identify: which specific documents/databases address each evaluation issue; what information each source provides to help address the evaluation issues; the extent to which the available documents/databases provide credible evidence to comprehensively address the evaluation issues; and issues/questions that are not readily addressed by the available documentation/databases.

2.4 Review of Project Evaluation Reports

A total of 24 project evaluation reports were reviewed, consisting of reports on two (2) national and 22 regional projects. These project evaluations were selected from among 47 available interim evaluation reports; reports with very little useful information were excluded from the review. Although the availability and quality of information in the project evaluation reports varied, the review provided some evidence to help address a range of evaluation issues, including: the relevance of the RRCC; community/citizen engagement; interim project outputs, process information and results; dissemination or dissemination plans for the results; and the effectiveness of partnerships.

A data collection template was used to facilitate the gathering and analysis of information from project evaluation reports. Using this template, we endeavoured to identify the specific information available in the reports to address the evaluation issues, the degree to which this information is sufficient to address the issues, and gaps in the available information for purposes of project performance monitoring and evaluation. In addition, the review was helpful for identifying issues/information gaps to be explored in the survey of funding recipients (described in the next section) as well as the range of potential responses for some survey questions.

2.5 Survey of Funding Recipients

A telephone survey of 50 recipients of funding through the RRHII was conducted in December 2001 and January 2002. The primary objective of the survey was to collect standard data on a set of measures on completed and in-progress projects, with a particular focus on filling information gaps identified through the review of project evaluation reports. The survey questionnaire was composed primarily of closed-ended questions on RRCC relevance (e.g., the need for a federal government role in rural and remote health issues), process/implementation (e.g., satisfaction with the application and funding process), progress/success (e.g., the extent to which the funded project met its intended objectives and other progress made to date), and cost-effectiveness (e.g., the potential for the project to be sustainable). Interviews were an average of

20 minutes in duration, and all funding recipients were interviewed in their preferred official language.

The sampling frame for the survey (i.e., the listing of all project funding recipients) was provided by the Office of Rural Health. This listing consisted of eight sponsors of national projects and 68 sponsors of regional projects, for a total of 76 funding recipients. Potential respondents were called a maximum of once per day and calls were made no later than 5:00 p.m. (the respondent's local time), unless otherwise requested. All telephone numbers were given a rest of one day before subsequent contacts were attempted, and appointments were made at the convenience of the respondent. By the end of the data collection, interviews were completed with five sponsors of national projects and 45 sponsors of regional projects for a total of 50 respondents. The response rate for the survey was very high (78.1 per cent), with only a 3.1 per cent refusal rate. The detailed survey findings are presented in a separate Interim Report.

2.6 Key Informant Interviews

A total of 53 interviews were conducted with project officials and knowledgeable stakeholders in order to solicit their opinions and observations on the evaluation issues. The focus of these interviews was also on gathering suggestions for improvements for future initiatives. In these interviews, all of the key RRCC stakeholder groups were consulted, including:

- ❑ RRCC program managers and staff (17 interviews);
- ❑ provincial/territorial government officials (17);
- ❑ representatives of research organizations (3);
- ❑ academics (8); and
- ❑ representatives of non-governmental organizations (8).

Three interview guides were designed and utilized to address all of the pertinent issues and questions. These guides were tailored for three respondents groups –- one guide for federal and provincial/territorial government staff, one for research organizations and academics, and one

for non-governmental organizations (NGOs). The interview candidates were sent (by e-mail or fax) a letter of introduction and a copy of the interview guide in advance of their appointment. The letter of introduction provided the key informants with information on the purpose of the evaluation and what was being requested of them in the interview. The advance copy of the interview guide provided the respondents with an opportunity to review the interview questions and think about their answers. Each respondent was interviewed by telephone in his/her preferred official language. The interview findings are presented in detail in a separate Interim Report.

2.7 Case Studies and Focus Groups

We conducted seven case studies of funded RRCC projects. For each case study, there was a site visit during which we reviewed project documentation (e.g., proposal, project evaluation report, communications with Health Canada), interviewed two project staff/participants, and conducted a focus group with project stakeholders and/or local health service providers, some of whom had experience with the project. The purpose of this methodological component was to obtain the participants' opinions and observations on the relevance, progress and success of the RRCC with a specific focus on their project. In the interviews, the respondent's position determined the specific questions asked. For example, senior project administrators were asked about the broader context within which the project and the RRCC operate, while health service providers and participants with hands-on experience were asked about their satisfaction with and impacts of the project. This qualitative evidence supplemented and assisted with the interpretation of other lines of evidence, in particular, the review of project evaluation reports and the telephone survey of project sponsors.

Some of the specific issues addressed in the case studies included: the relevance and continuing need for the RRCC to build capacity for the development of the federal rural health strategy; the degree to which RRCC priorities are focussed on and reflective of provincial/territorial priorities and rural and remote community needs; and impacts on the capacity of rural and remote communities to address local health issues of concern.

(a) Selection of Projects

The first step in the project selection process involved stratifying the list of 50 RRCC projects that were surveyed according to four key criteria: (1) the six Health Canada regions, with national projects categorized as a seventh region; (2) project completion status (i.e., projects completed, soon to be completed in 2002, or to be completed in 2003); (3) the nine national priority areas (e.g., transportation issues, recruitment and retention of rural health providers, inter-sectoral collaboration on rural health issues); and (4) the language in which the project was delivered. In order to assist in the stratification process, a content analysis of the projects was conducted as part of the document and database review. This stratification was then used to select seven projects for the case studies as well as 12 back-up projects. The final selection of the seven projects for case studies was based on the agreement of the selected project sponsors and the approval of the Working Group for the evaluation and the HC Regional Offices.

The selected projects included one project per region: Atlantic, Ontario/Nunavut, Quebec, Manitoba/Saskatchewan, Alberta/Northwest Territories, British Columbia/Yukon and a national project. These projects were focussed on a range of priority areas. There were two French projects (one in Quebec and one in Alberta), one bilingual project and four English projects. One of the projects was completed last year (2001), four were completed by the end of March 2002, and one will be completed next year (2003).

(b) Case Study Interviews

Once the seven sites were selected, the sponsors of the projects were contacted to assist in the identification of one senior and one junior staff person with direct involvement in the project. An interview guide was developed and utilized for the two case study interviews at each site. Each interview was an average of 60 minutes in duration. The findings from these interviews were summarized, by evaluation issue, as part of the case study analysis.

(c) Focus Group Discussions

We conducted one focus group with project stakeholders and/or health service providers at each of the seven sites selected for the case studies. In order to recruit participants for each focus group, interviewers contacted health service providers at work by telephone, using lists of potential participants provided by Health Canada and/or available in the project files. In these telephone contacts, the interviewers described the study sponsor, purpose and details of the group discussion (e.g., time, place and duration of discussion); stressed that participation was entirely voluntary, and refusal to participate would in no way affect entitlement to services; and noted that the discussion would be tape recorded for purposes of analysis but that all information provided in the focus group would be kept strictly confidential.

In order to ensure the participation of six to eight participants, we attempted to recruit ten confirmed participants for each focus group. The specific types of participants to be included in the focus group, as well as the implications of their participation, were discussed with a Health Canada representative from each of the participating regions prior to approaching individual focus group candidates. All participants were sent an information letter in advance of their focus group providing a brief description of the purpose and issues to be discussed. In addition, all participants were given a reminder call a day or two before their scheduled group discussion.

All focus groups were held during the evening in hotel meeting rooms. Each discussion was two hours in duration and all participants received an incentive of $50 for participating. This $50 served both as an honorarium for participants and as reimbursement for their travel expenses.

Following a pre-designed discussion guide, the focus group moderator asked the group questions in a non-directive way, probing for clarification and more detail when necessary, and intervening as appropriate to involve all participants and keep the discussion on topic. All focus group sessions were audio tape-recorded so that accurate summary notes could be prepared. Along with the interview findings, the focus group findings for each case study were summarized for each major evaluation issue and these internal notes were used for purposes of analysis.

2.8 Virtual Expert Panel

We convened a panel of experts to review the major evaluation findings and respond to some questions in order to provide more depth to the conclusions and recommendations drawn from other lines of evidence. The expert panel was composed of five experts in the area of health services in rural and remote communities. These persons included researchers, academics, members of the Canadian Rural Partnership, health service providers working in rural and remote areas, and local citizens active in the area of health services.

We initially selected approximately 20 experts from among candidates suggested by the Working Group, representatives from regional offices, and from respondents in the key informant interviews. From this list of candidates, which was approved by the Working Group, we endeavoured to secure the participation of eight experts representing a range of geographical and subject area interests. These candidates were contacted and invited to participate in the exercise. In the invitation to prospective panellists, we briefly summarized the RRCC and the objectives of the evaluation study, described that we were asking them to respond to some questions in two rounds of consultations, emphasized the importance of their participation for the evaluation, and offered them an $800 honorarium.

Eight experts who agreed to participate and were sent by e-mail: (1) an introductory letter; (2) an overview of the evaluation methodologies; (3) a summary of the major evaluation findings from the key informant interviews and survey of funding recipients; and (4) a questionnaire focussed on issues related to the continuing relevance of an initiative such as the RRCC, outstanding needs that will need to be addressed over the next five years, and possible directions for future federal initiatives related to rural and remote health. In formulating their responses, panellists were asked to review the background information and to draw on their own experience and knowledge. Unfortunately, three candidates did not follow through and respond and other back-ups were unavailable, so the final number of panellists was five.

Given the high cost of assembling a group of experts for an in-person meeting, this expert panel was conducted via e-mail. For this “virtual expert panel”, the panellists were asked to

provide their responses to two rounds of questioning by e-mail. The responses from the first round were synthesized and sent to the panellists along with a set of follow-up questions for the second round of consultations. The questions in the second round asked for clarification and expansion of some issues and offered panellists an opportunity to reconsider their initial views (in light of the responses from the entire panel) and to provide further reactions and/or rebuttal of key points. In addition, panellists were asked for their views on the priorities for a federal rural health strategy over the next five years. Given the iterative nature of these consultations, this approach was essentially a "Delphi panel" conducted by e-mail.

2.9 Integrated Analysis

Following the collection and analysis of data from all individual lines of evidence, the evaluation findings were summarized and synthesized to arrive at the integrated findings for each evaluation issue. The results of the different lines of evidence were triangulated with the findings stemming from other lines of evidence to corroborate notable findings or reconcile differences. The integrated evaluation findings are presented, by issue, in Chapters Three to Six of this report.

3. RELEVANCE

3.1 RRCC Contribution of "Building Blocks" of a Rural Health Strategy

The degree to which the RRCC has contributed "building blocks" of a rural health strategy was addressed solely through the case studies, as key informants and survey respondents were unable to respond in an informed fashion to this issue, and the expert panel members felt that it is too early to assess this type of contribution. In the case studies, there were two divergent perceptions of this issue. For three case studies, interviewees felt that their project has definitely generated outputs that benefited their respective community. They could not say, however, whether or not the outputs could contribute to a rural health strategy. They regarded this question as an intellectual, administrative or governmental exercise, well beyond their interest and responsibility.

On the other hand, representatives from the other four case study sites saw their respective project's outputs and outcomes as contributing "building blocks". These outcomes included organizational or service models of rural health care such as: an integrated, multi-disciplinary rural health support network; an injury prevention model; delivery of French language health and social services in a minority setting; and a model to enhance women's health services in a rural environment. The extent to which their projects were actually contributing to a rural health strategy was difficult to determine, as this would require extensive information gathering and comparisons with other initiatives. Nevertheless, respondents from these sites strongly believed that their initiatives would be completely or partially replicable in other sites across the country and, as such, constituted "building blocks" of a rural health strategy.

3.2 Continuing Need for RRCC as Part of a Rural Health Strategy

Evidence gathered in open-ended questions in the survey of funding recipients, key informant interviews and the case studies indicates that the RRCC (or another such initiative) is strongly felt to be an essential element in the development of a rural health strategy. Without such funding and direction, it was felt that some health related needs would "fall through the cracks" of provincial/territorial health services and that future development of rural health services would be in peril. Indeed, health related issues are seen to be so serious and numerous in rural and remote areas that respondents were surprised that the need for the RRCC, or an RRCC-type federal initiative, could even be questioned.

Expert panel members who could comment on this issue agreed that RRCC, or a similar initiative, is a necessity in a rural health strategy. According to panel members, RRCC has facilitated the development of "real" grass roots community based initiatives that are fundamental for such a strategy. Also, panellists cannot see any other replacement programs. Their fear is that, with the termination of federal funding, all the good work that has been done under the RRCC will be for naught, and RRCC projects and their outcomes will not be sustainable or spawn new rural and remote health endeavours.

3.3 Continuing Need for Federal Role in Partnership Development

Evidence was gathered on two different issues with respect to partnerships: (1) reasons for a continuing federal role in partnership development, and (2) partnerships that were formed under the RRCC. Each issue is discussed in turn.

(a) Reasons for and Benefits of Continuing Federal Involvement

All lines of evidence for this evaluation pointed toward the continuing need for the federal government to develop partnerships to address rural health issues. The federal government was judged by federal government representatives as the most suitable candidate for encouraging partnerships for the following reasons:

- addressing health and wellness in rural communities requires multiple approaches/partners and the federal government is best positioned to exploit synergies across provincial boundaries;
- the federal government has a *national* mandate for health care and ensuring some level of support for this; and
- it has a broad-based understanding of what various organizations are doing in the area.

Provincial/territorial respondents offered the following reasons for federal involvement in partnership building:

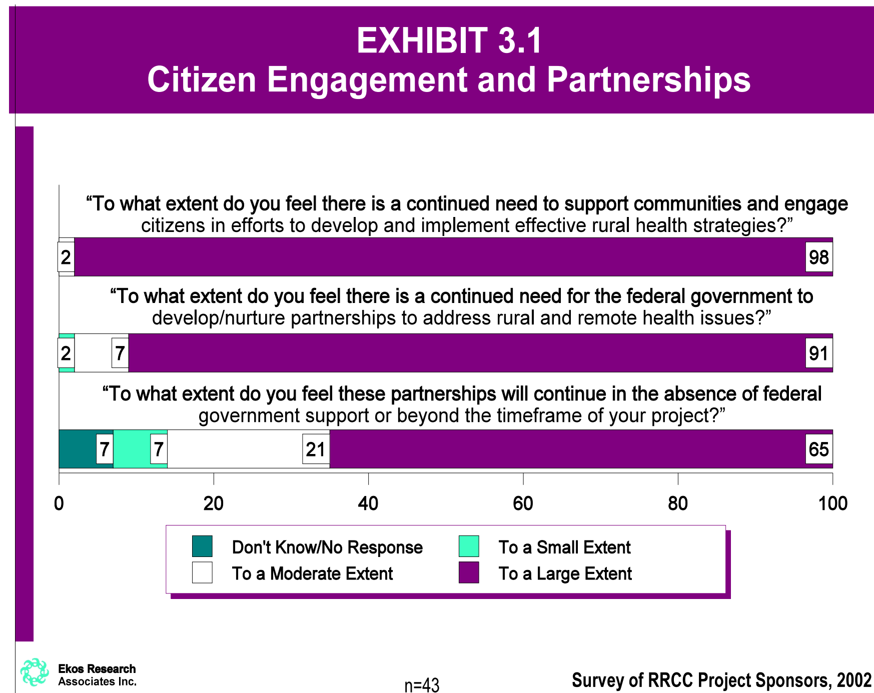
- the federal government plays an essential leadership role in providing funding since most rural and remote communities are bearing an increasing share of health care costs but do not have any other source of funding;
- increased federal involvement in health issues forces provincial/territorial governments to maintain rural health as an important part of their policy package (e.g., the Primary Care renewal funding);
- the federal government is well positioned to provide large one-time contributions to capital requirements/transition costs often required in health care projects;

- increased partnership between the federal and provincial/territorial governments encourages the dissemination and sharing of information; and
- federal-provincial/territorial partnerships strengthen the focus on common opportunities and lead to the development of common goals and national strategies that all provinces and territories can collaborate on.

Academics and representatives of research organizations also indicated that there is a strong continuing need for the federal government to develop and nurture partnerships to address rural and remote health issues, for the following reasons:

- the federal government has been more effective than the provinces/territories in considering the rural perspective, as the latter have often had too narrow a perspective on health issues;
- it has done a good job of developing collaborations and partnerships in the past;
- the federal government can facilitate the pooling of funding and resources across jurisdictions; and
- it is in a better financial position than the provinces and territories to ensure positive outcomes through partnerships.

In the survey of project sponsors/funding recipients, the vast majority of respondents who reported a partnership (91 per cent) felt there is a great need for the federal government to develop/nurture partnerships to address rural and remote health issues (see Exhibit 3.1). Moreover, two-thirds (65 per cent) of sponsors felt to a large extent that the partnerships would continue in the absence of federal government support or beyond the timeframe of their project.



The expert panellists who responded to this question all believe that the federal government must continue to play a role in supporting and developing partnerships that contribute to the enhancement of rural and remote health services. It is believed that, without federal leadership and funding, most initiatives would not have proceeded, there would be fewer intersectoral partnerships, and the emphasis placed on rural health would be inconsistent across the country. Rural and remote health projects and the partnerships that are involved are regarded as fragile relationships, relying on very "soft money" and yearly program allocations, new policies and priorities, changing personnel and volunteers, which only the federal government is believed to be able to support.

Panellists offered other reasons for continuing federal involvement. They said that provincial and territorial governments are stretched to the limit regarding their health care dollars and because they are so busy "fighting fires", rural and remote health care is not a priority for them. Some panellists also feel that rural and remote health care is, in many situations even within

provinces, considered to be a federal responsibility or at least something that should involve the federal government. It was also suggested that the federal government should play a lead role across the country and across provincial and territorial borders in areas such as telehealth, information gathering and sharing, innovative rural health research and pilot/demonstration projects — areas that provincial/territorial governments are not well positioned to address.

One provincial/territorial respondent noted that an extensive partnership with others is not always beneficial, however. While some RRCC projects in the respondent's jurisdiction have developed strong partnerships that help ensure the sustainability of the project beyond its funding, the involvement of partners in other RRCC proposals has complicated the project to some degree, in terms of communications and, when academics are involved, putting project results beyond the reach of grass roots participants.

(b) Partnerships Formed

Federal government respondents were asked to describe what partnerships have been established as a result of the RRCC, which may be seen as one outcome of the RRCC. A number of partnerships with provincial/territorial government organizations and with non-provincial/territorial organizations were identified by federal government key informants. The latter include partnerships with research institutes, federal departments, universities, community groups, rural secretariats, professional associations, and NGOs.

Examples of provincial and territorial partnerships include the following:

- federal/provincial/territorial advisory committees (e.g., advisory committee on health human resources);
- provincial/territorial representatives sitting on some Health Canada projects;
- provision of Northwest Territories government staff to collaborate in delivering RRCC in the territory;

- a partnership with the Ontario government to establish a northern medical school;
- the Wellness Group, which included provincial ministries of health, the environment, and children and family services, as well as federal organizations such as Health Canada, Status of Women Canada, and Environment Canada (to develop ideas for RRCC projects);
- bilateral meetings between Health Canada and provincial and territorial governments regarding funding criteria, project approval, and updates; and
- working with provinces/regional health authorities to ensure the role of the federal government is complementary.

Provincial/territorial government key informants indicated having been involved as partners in the RRCC typically in two ways: (1) initial discussion/consultation regarding the administration of the RRHII and definition of provincial/territorial priorities, and (2) reviewing proposals received under the RRHII program. These key informants also provided examples of several partners involved in RRHII projects, including the following: NGOs (e.g., Red Cross), health service provider organizations (e.g., Rural Health Nurses, Society of Rural Physicians of Canada), academics/colleges and universities, regional health districts, and Métis/First Nations organizations. Also, there were partnerships and exchanges of information out of the Rural Health Research Consortium and partnerships with the Office of Health and Information Highway on Telehealth. While most respondents felt it was too early to comment on the sustainability or success of the partnerships, there were examples of partnerships that have already proven fruitful such as that with the Canada Health Infostructure Partnership Program (CHIPP).

Provincial/territorial representatives from the Atlantic region mentioned projects involving a large variety of partners. One of their RRCC projects is based on a partnership among community-based organizations, a provincial department of health, an early childhood learning association and a literacy association. All partners in this project participated in the design, the

establishment of the goals and objectives, and delivery and implementation. In another Atlantic project, the four Atlantic provinces were partners along with academics and community-based organizations. Here the provinces were involved in implementation and evaluation of the project as well as the overall direction at the steering committee level.

One provincial/territorial respondent suggested the need for an additional or alternative partnerships between the patient research centres of the local health board, and the provincial ministry of health and Health Canada. With this partnership, the patient research centre would do the health research, while the province would formulate the policy and Health Canada would pay for the research.

None of the academics or representatives of research organizations interviewed could clearly identify partnerships related to RRCC or the impact of partnerships on the RRCC. The issue of partnerships developed was not raised with non-government organizations or in the case studies.

3.4 Continuing Need to Support Communities and Engage Citizens

The opinion of most groups consulted for this evaluation, including federal and provincial/territorial representatives, non-government organizations, and case study participants, is that there is a continuing need for the involvement of communities in the development of rural health strategies. This issue was not raised with academics and representatives of research organizations, nor with expert panel members. In this section, evidence on this issue is presented in three parts: first, the suggested reasons for the continuing need for community involvement; second, examples of how communities have been involved in rural health projects; and third, suggestions on how community/citizen engagement can be enhanced.

(a) Continuing Need for Community and Citizen Involvement

All federal government respondents consulted in the key informant interviews believe there is a continued need to support communities and engage citizens in efforts to develop and implement effective rural health strategies. A number of reasons were forwarded to defend these views, with respondents pointing out that community and citizen engagement contributes to:

- *Relevance of solutions:* ensures that we are developing solutions that are relevant for these communities;
- *Buy-in:* enduring solutions are only achieved through ensuring communities are permitted a means to contribute to development of solutions to their health problems;
- *Accountability:* community groups want more accountability from provincial/territorial and federal governments; and
- *Responsiveness:* communities are, by definition, closer to the issues and are more responsive to them.

Federal respondents also suggested that the continuing need for community involvement is indicated by the contributions that have been (or can be) made by community members and citizens. Examples of these contributions are:

- *Providing information about local needs:* Community members bring different experiences and backgrounds to the table and most are very familiar with rural issues at the working level, thus ensuring that RFPs are properly focussed and that what is developed is relevant and can address gaps.
- *Developing ways to address needs:* The fact that community members sit

on project advisory committees as well as actually conduct the research ensures that the research really caters to the needs of the rural area, and that the results are communicated.

- *Disseminating project results:* Project results are effectively disseminated because of informal networks among participating community members.
- *Advocating for rural health issues:* Community members are effective in ensuring that rural concerns are at the top of the politicians' minds.

Virtually all provincial/territorial respondents noted the importance of involving communities and citizens in addressing rural health issues, for a number of reasons. The first is community involvement ensures *effective identification of issues*, in that health care providers and beneficiaries, as representatives of the community, have an important stake in identifying issues and finding solutions. Physicians and community groups can identify problem areas to study and sometimes design measures to alleviate these problems. Moreover, identification of needs by the community leads to greater commitment in implementing solutions, greater influence on policy, and improved equity and efficiency in the health system.

One respondent warned, however, that putting the responsibility on communities to initiate projects could lead to too broad a range of project types to address the differing issues. It was suggested that there be greater emphasis on establishing a provincial/regional focus before taking this to the community level. However, most respondents stressed the importance of community input for establishing such regional and provincial priorities.

Second, some provincial/territorial respondents believed there is a continued need to enhance community involvement because of *changes occurring at the provincial political level*. Changes in government in many provinces have led to a decrease in provincial support of rural issues and health issues at the community level and, often, a more centralized philosophy for delivery of medical services. One respondent believes that, without federal support, provincial changes will lead to decreased access to medical services for rural and remote residents and that

communities will have less input into their own affairs than they had before.

Third, provincial/territorial key informants felt that community/citizen involvement is very important because it develops a *sense of ownership or "buy-in"*. This in turn ensures sustainability of the initiative beyond the project funding phase and helps in the development of further projects that address community needs, though this may be limited by the small number of volunteers in a community, which in turn could lead to volunteer "burnout".

As well, provincial/territorial respondents offered several other reasons for or benefits of involving communities in rural health issues. These include: greater understanding of local resources/services and health needs; provision of the Aboriginal perspective; the crafting of strategies that will be effective on a local level; enabling the identification of contacts such as potential partners; and ensuring successful recruitment and retention of medical personnel by identifying the desired skills, mobilizing resources and integrating professionals into their communities.

As for non-government organizations, the four key informants who could comment on this issue suggested that community leaders and rural community residents were the best persons for identifying needs in their settings. Citizens in their own "milieu" are well positioned to identify the best strategies or best practices and, by involving them, local capacity for developing improved health initiatives and services is enhanced.

In the survey of project sponsors, virtually all respondents (98 per cent) agreed that there is a great need to continue supporting communities and engaging citizens in efforts to develop and implement effective rural health strategies (see Exhibit 3.1 in Section 3.3). On the other hand, only about two-thirds (64 per cent) of sponsors indicated that the community and its citizens were involved in the development and implementation of their project to a large extent. Two-thirds of project sponsors felt that these contributions were of great value (66 per cent), while approximately one-quarter felt that they were of moderate value (26 per cent).

Finally, evidence gathered in the project case studies also clearly points to the perceived

need for continued support of communities and the engagement of citizens. All the case study respondents saw community and citizen engagement as integral to the project's success. One reason for this is the community networking that exists in rural settings which health care initiatives can tap into and which results in cost savings and project efficiency. Many case study respondents also spoke of the need for continued support and guidance in raising awareness among rural residents of the importance of living healthy lives (instead of solely emphasizing the treatment of "disease"), and in linking economic development to the establishment of rural health strategies attracting doctors and helping with funding. In all case studies, the need for support of community and citizen engagement in rural health issues was seen as beyond question.

(b) How Communities Have Been Involved in Rural Health Issues

Federal respondents pointed to a number of ways in which communities and citizens have been involved in the development and implementation of rural health strategies, including the following:

- *Setting funding guidelines:* Funding guidelines for each proposal require that the proponents visibly demonstrate how communities and citizens were involved in the design and implementation of the project. Every project approved is required to demonstrate that there was some community involvement in project planning and implementation.
- *Canadian Rural Partnership (CRP) dialogues:* Health Canada partners with Agriculture and Agri-Food Canada in dialogues with communities. CRP Rural Teams are a mechanism to obtain ongoing feedback from communities and offer other departments the opportunity to get information to suit their needs.
- *Community initiatives:* Projects are submitted by communities and local partnerships.
- *Health Canada consultations:* There are many examples of community engagement by Health Canada, including: invitations to the ORH to participate in rural health round tables at the request of rural communities or others (e.g., federal MPs of rural ridings); RRCC working in regional offices which automatically affords local residents in rural areas more access; rural citizens sitting on advisory committees for RRCC in some regions to make sure the issues reflect their concerns; and the inclusion of rural and remote citizens on the Ministerial Advisory Council on Rural Health.

Provincial/territorial government respondents noted that communities were involved in the project development stage for many RRCC projects. This involvement included developing the proposal, finding funding partners, and implementing the project. Many communities initiated their own project after having gone through the process of identifying their community's health needs. Citizens also helped disseminate information on the projects and helped recruit participants and volunteers. Beyond this, however, the majority of provincial/territorial key informants did not have detailed knowledge of how communities or citizens were involved in the RRCC per se (though community-based organizations often have citizens represented on their boards). They were generally aware that citizens are often involved in the area of rural health on local advisory groups regarding emergency services and on local health boards, and that volunteers often drive local projects addressing issues such as safety.

(c) Suggestions for Enhancing Community/Citizen Engagement

To enhance community and citizen involvement in the ongoing development and implementation of rural health strategies, most federal respondents suggested continuing current engagement activities or following through on plans that have already been devised. Among these suggestions, respondents recommend continuing:

- *Feedback:* maintain the relationship with the Canadian Rural Partnership, Rural Teams and any other citizen engagement activities to continue getting feedback to the Department;
- *Citizen engagement:* engage citizens through the Ministerial Advisory Council on Rural Health, which is a way of honing input at a fairly high level (although provincial/ territorial governments may not want the federal government consulting citizens and many issues raised would likely involve areas within provincial/territorial jurisdiction);

- *Dissemination and communications:* post information on the Internet for rural communities and publish a newsletter through the Rural Secretariat to inform citizens of developments; and
- *Solicitation of proposals:* solicit and implement proposals from communities thereby enabling communities and citizens to be actively engaged in approaches to address local health concerns.

Provincial/territorial respondents also offered several suggestions on how community and citizen involvement could be further enhanced in the ongoing development and implementation of rural health strategies. One way is to establish requirements for involvement of communities in proposals and to provide support for communities/citizens to enable community members to develop proposals to engage in their own research projects. A second way is to address volunteer "burnout" issues because the success of rural health projects depends greatly on volunteers. Recognizing volunteer/citizen contribution (such as at a luncheon) is essential to sustain morale and encourage them in their efforts. Third, respondents suggested that the RRCC needed to be better advertised to reach more communities and that the information on the Health Canada website was scant and must be improved. Many communities and citizens, however, cannot access the Internet and should receive information on the program by other means.

3.5 Changes to Rural Health Policy Environment

In interviews, representatives of federal and provincial/territorial governments and non-government organizations identified a number of changes in the broader policy environment that could affect federal involvement in rural and remote health issues. Academics and representatives of research organizations, survey respondents, and case study participants were not asked about this issue.

Among the factors that would *hinder* the federal government's ability to become involved in rural health issues, federal government respondents identified the lack of a coordinated

approach across the jurisdictions, reduced funding for health, debate about public *versus* private health care provision, and the sunsetting of the RRHII funding program.

On the other hand, federal officials identified a number of factors that could *facilitate* the federal government's ability to become involved in rural and remote health issues, including:

- provincial/territorial governments' increasing openness to change;
- new technology-assisted methods of communication;
- establishment of Nunavut, which will focus more attention on the residents of that territory;
- the trend toward greater collaboration; and
- greater apparent awareness of rural issues generally.

Few provincial/territorial respondents were able to identify specific policies in the broad policy environment that would pertain particularly to federal involvement. Some noted that rural health and rural issues in general are being "talked about" more. There is currently a sense of momentum around the issue and a recognition that "rural" is different from "urban" and the conditions in rural and remote areas are worsening, especially with respect to health care issues.

There were a few other factors affecting rural health identified by provincial/territorial respondents. About one-half mentioned the problem of people crossing provincial borders to seek medical attention, particularly at the Ontario-Quebec and Alberta-Saskatchewan borders, which respondents feel the federal government should take greater initiative in resolving. Second, several respondents mentioned how policies concerning rural issues are going to be affected by the Romanow Commission, as rural interests are being heard and recognized through this consultation process. Third, respondents mentioned the apparent shifting of focus away from rural issues in some provinces.

Half of the NGO respondents could not comment on the broader policy environment concerning health issues because they lacked the proper information. The other key informants indicated that there was now more political emphasis on rural and remote health initiatives and issues. They also suggested that the time to act is now, in that the rural and remote setting is changing rapidly.

Finally, among expert panellists, a concern is that political interest in rural and remote health issues may be a passing "fad" and that other priorities associated with new funding may soon be brought to the fore to replace rural issues. Some panellists said that rural health issues, no matter how serious, have tended to be addressed politically in a piecemeal manner and that policy changes must be made in a concerted fashion, in collaboration with the provinces/ territories and other key stakeholders, to deal effectively with the fundamental rural health problems. It was suggested that a review of key policy documents be regularly conducted to see whether or not rural issues and concerns are being included in health policies across the country. Such a review should include the context within which documents are prepared, for instance, the increased emphasis on security immediately following the events of September 11, 2001.

3.6 Priorities for the Future

Expert panellists were asked to specify the top seven priorities for a federal rural health strategy over the next five years. They selected their priorities from among the current nine RRCC national priority areas as well as additional priorities they had identified in the first round of the panel.

The top seven priority areas, each identified by at least two or three of the panel members, are as follows:

1. building the capacity of rural health researchers, for instance, by funding training/mentoring programs in which senior researchers work with junior researchers and by funding rural health research programs;
2. addressing issues of recruitment and retention of rural health providers;

3. developing innovative models which address the determinants of health as experienced by Canadians living in rural and remote areas – because determinants of rural/remote health have not received enough attention and this type of approach can examine a wide range of health issues in a holistic fashion and can allow comparisons among different communities;

4. developing and piloting solutions to rural health issues and problems related to access to health services;

5. developing community-based research infrastructure that will enable communities and researchers to enter into enduring partnerships for research projects that can produce knowledge directly linked to the lives of community members as well as contribute more broadly to knowledge in the rural health field;

6. developing a coherent framework for understanding rural health and guiding serious, sustained rural health research – not just piecemeal, "fire-fighting" types of studies; and

7. developing leadership in rural communities (e.g., by conducting leadership workshops for local residents) to develop the capacity to take on rural health projects.

Additional priorities for the future, each identified by only one panel member, are:

- ❑ developing models of integrated, multi-disciplinary teams to support rural health needs;
- ❑ fostering intersectoral collaboration on rural health issues;
- ❑ addressing issues of distance to health services in rural and remote areas;
- ❑ examining physical environments (natural and man made) in rural and remote communities which contribute to accidents or disease – though it was suggested that "injuries" is a more appropriate term than "accidents" because most injuries are preventable and that this priority should be expanded to include an examination of the contribution of all aspects of the environment (physical, social, cultural, economic, etc.) to both healthy and unhealthy rural/remote communities;

- developing networks in rural and remote areas to reduce health problems and provide options;
- transportation;
- generating, maintaining and disseminating information, knowledge and research on rural health issues;
- addressing federal/provincial/territorial jurisdictional issues in order to better meet the health needs of First Nations people; and
- developing information and community-level interventions aimed at improving prenatal and early childhood nutrition and nurturing.

Panellists were also asked if it would be better in the long run to continue with a broad list of priority areas that could encompass the widest possible range of projects or to adopt a narrower list of priorities that would support fewer types of projects but in greater numbers. Mixed views were expressed on this matter. Panellists who supported the former strategy argued that a broad list of priorities is necessary because of the diversity of needs and regions in this country. Such a broad list allows projects to be tailored to the unique needs in a given community. Moreover, even with a broad list, projects will share some common elements that can be compared and generalized. On the other hand, panel members who supported the latter approach noted that it would be more effective to fund more projects targeted at a narrower range of priorities – as long as the priorities selected are the "right" ones.

4. PROCESS AND SUCCESS

4.1 Awareness and Capacity for a Rural Perspective in Policy and Program Development

Key informants were asked to comment on the degree to which each of a number of outcomes has been witnessed recently in spheres related to the determinants of health. These outcomes concern the general level of awareness and capacity to apply a rural perspective in policy and program development.

Regarding an improved consideration of the rural perspective in policy analysis and development within the health sector, most federal and provincial/territorial officials, representatives of research organizations and academics reported that they have witnessed this outcome to a moderate extent. Respondents representing non-government organizations could not comment on this point, however.

Key informants mentioned the following examples as indicators of an improved consideration of the rural perspective in policy analysis and development within the health sector:

- a willingness within Health Canada to work with the Office of Rural Health (e.g., inviting staff to meetings and to review documents);
- the Rural Secretariat in Ontario working with the rural health council and the University of Western Ontario to influence policy thinking;
- the inclusion of provincial/territorial health representatives on regional Rural Teams, administered by the Agriculture and Agri-food Canada Rural Secretariat, in the discussion on differentiating between rural and urban health care delivery;

- an increased use of dialogue events (e.g. surveys, meetings, conferences) and news media reports of provinces and territories to address rural issues;
- the creation of the Canadian Rural Partnership by the federal government in 1998 (resulting from the Rural Dialogue and National Rural Workshop) as a coordinated, flexible policy framework supporting federal policy efforts in rural and remote communities;
- the Health Rally held in Prince George in June 2000 (involving over 7,000 citizens to bring attention to health/health services problems in northern British Columbia), which led to (1) the National Rural Health Summit in October 1999 which resulted in the creation of the Canadian Rural and Remote Health Association as a voice for people living outside urban and suburban areas and (2) the provincial government's establishment of the Northern Medical Program — involving UBC, UNBC and UVic — to help increase the supply of doctors in northern and rural areas of British Columbia;
- the budding rural research institutes; and
- the inclusion of the rural health issue in political platforms.

Respondents also observed an improved consideration of the rural perspective in policy analysis and development outside of the health sector (e.g., the work of the Canadian Rural Partnership on community economic development and education). They attributed this improvement to the formal mechanisms addressing rural issues within interdepartmental working groups on rural issues, and to political pressure from the Canadian Alliance.

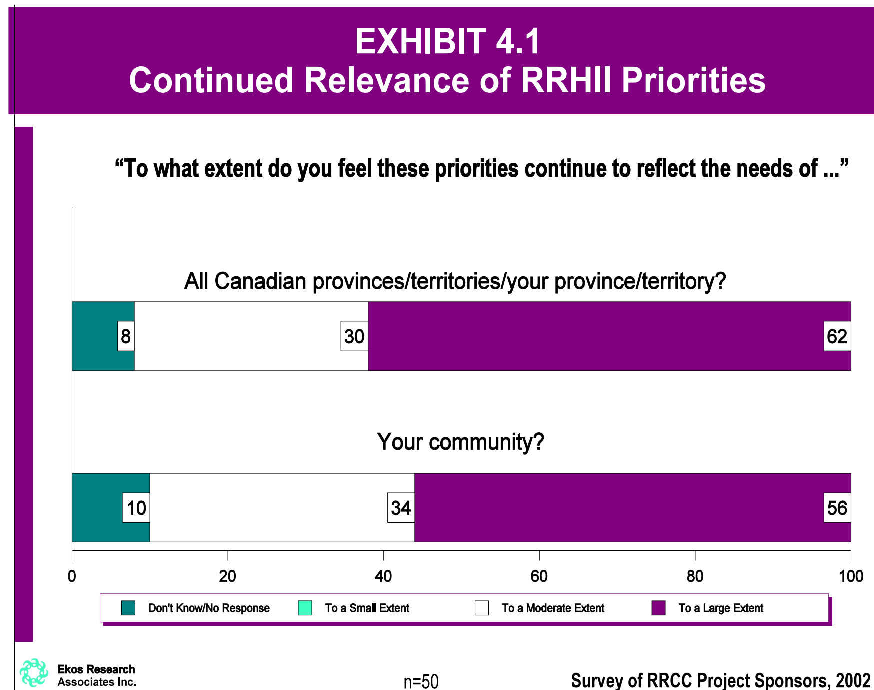
Key informants were asked to what extent they had observed an increase in the number and range of health programs that reflect rural issues, concerns, and perspectives within the health sector. While most respondents feel there is much more work to do in this regard, they nonetheless

provided examples of some positive steps that have been taken to date. First, respondents noted an increase in the number of rural related programs and policies within Health Canada, an increase of working groups, the establishment of the Ministerial Advisory Council on Rural Health, and the appointment of the Special Advisor to the President of the Canadian Institutes of Health Research — Rural Health and Rehabilitation Research. Second, there has been an increase in the establishment of programs that respond to rural health issues such as health information technology in rural/remote areas, Telehealth, and primary care reform efforts. All provinces, even those setting up their own offices of rural health activities, have not yet addressed some issues, such as recruitment. Ongoing rural discussions have had an impact on decision-making but it remains to be seen whether this will result in a noticeable increase in recruitment.

When asked to describe the ways in which witnessed improvements could be attributed to RRCC, a number of respondents said they were not in a position to draw this causal link. Respondents generally feel that the RRCC has been responsible for increasing the discussion and raising awareness of rural health issues within the governments, and for providing direction for research and development concerning these issues.

4.2 Congruence of RRCC with Provincial/Territorial Priorities and Community Needs

All lines of evidence indicate that RRCC priorities are in congruence with provincial/territorial priorities and community needs. Almost two-thirds (62 per cent) of surveyed project sponsors stated that the RRHII's priorities continue to reflect the needs of either all Canadian provinces and territories or their province or territory to a large extent (see Exhibit 4.1). In addition, more than half (56 per cent) of the project sponsors indicated that these priorities largely reflect the needs of their community.



Focus groups with rural and remote community members revealed that certain priority areas were consistent for all regions. By far the most mentioned issues by focus group participants in the case studies were those involving transportation and access to health care services. In the view of these respondents, the issue of transportation is not limited to the problems associated with having to travel great distances for health procedures such as surgery, radiation and so on (e.g., some respondents reported up to an eight hour drive). The problem is compounded for day procedures because the patient needs to travel back home the same distance on the same day, and often in great discomfort. Transportation problems also affect the aging population and food delivery to northern communities during winters. Food delivery is a problem for northern areas in particular since their high diabetes rate is associated with poor nutrition. These communities also report a higher incidence of amputation of limbs from diabetes because of the lack of access to health care and fewer preventative measures than are available in urban areas. Focus group respondents reported that there is a higher rate of procedures such as mastectomies because most

people cannot afford to travel the distances for the daily radiation treatment. These are only a few of the examples that were noted in the project case studies.

Interview and case study findings indicate that the main issues of health for rural and remote communities are consistent across the country. Respondents explained that consistency with provincial/territorial objectives was reached through consultation with the provinces and territories when determining the broad objectives of the program. Community needs were considered in the development of some provincial priorities (i.e., in Manitoba and Saskatchewan) through an examination of provincial documents produced as a result of community assessments.

Very few respondents identified gaps in the priorities. Some suggestions included greater emphasis on research. Federal respondents mentioned the need to develop performance indicators of rural health to facilitate comparisons of health issues between urban and rural populations that could influence programming options and/or communication strategies. Interview and focus group respondents in the case studies noted the need to change policy to simplify procedures to allow foreign medical doctors to practice in rural and remote areas. Case study respondents also recommended encouraging the provinces/territories to utilize the services of nurse practitioners, particularly for rural and remote communities.

Additional issues and needs that are not addressed in the priorities include:

- the needs of an aging population and poverty in rural and remote areas;
- mental health in rural and remote communities;
- the need for integrating First Nations with non-First Nations communities as well as a need for more coordination and communication between the federal and provincial/territorial governments regarding jurisdiction over Aboriginal health care;
- technological hook-up for the Internet;
- access to tools developed by other provinces/territories or other projects, in particular those dealing with mental health and preventative medicine;
- social measures (e.g., capacity building) to help communities develop these interventions for mental health and preventative medicine; and
- the need to address environmental and industry-specific factors, such as unique health risks related to farm equipment and products as well as health-related problems related to mining.

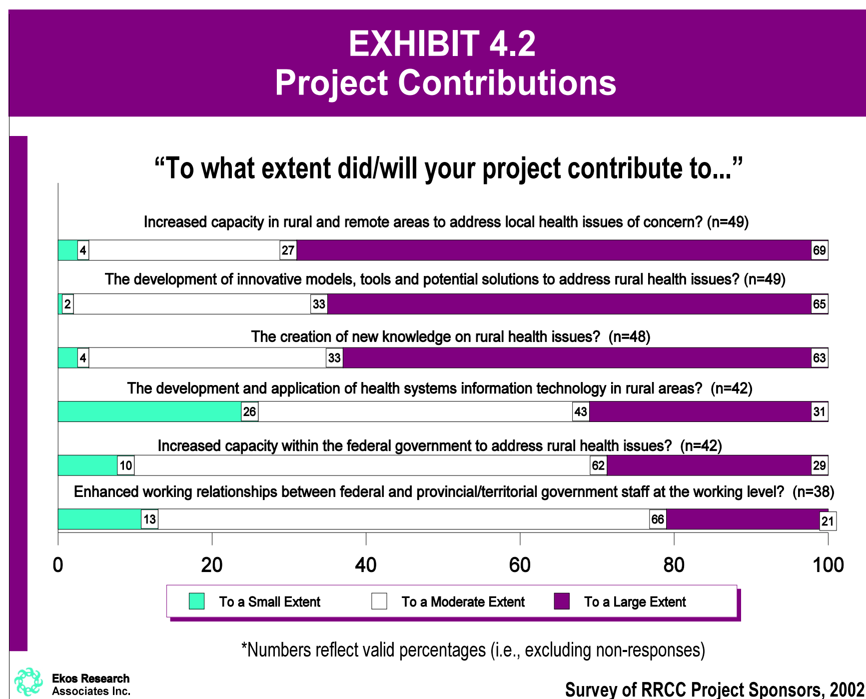
In the opinion of many respondents, the problem is not in the priority areas per se, but rather the lack of capacity on the part of RRCC and its partners to address these priority issues. Respondents feel that two or three years per project is insufficient to address all priority areas and most provincial/territorial governments lack the resources and energy to collaborate outside or within their borders. Provincial/territorial respondents, however, appreciated the fact that they could select the priorities that best reflect their needs. Some of the provincial/territorial respondents also expressed disappointment that few proposals covered these issues. They attributed this to a lack of time/resources for community groups to develop proposals to respond

adequately to priorities and to structural barriers that prevented government health service providers from accessing funds.

4.3 Impacts on Rural Health Research and Research Networks

Responses varied on the issue relating to the impacts of the RRCC on research and research networks focussed on rural/remote health issues. Some interview respondents who feel that RRCC has had a significant impact on research and research networks noted that the interest is mostly in academia as indicated, for example, by the Rural Health Research Summit sponsored by ORH. The ORH and Canadian Institutes of Health Research (CIHR) have been key in identifying rural health as an issue. There is also the appointment of the Special Advisor to the President of the CIHR on rural health issues. Other respondents believe that RRCC has generally contributed to creating and expanding the research network on rural/remote health issues beyond academia and into communities (e.g., project coordinators have become interested in the research). Representatives of research organizations/academia and non-government organizations did not feel that they had enough knowledge to comment on this issue.

In case studies, the perception of the respondents representing the projects themselves was that research networks have been expanded to the project/community level since funded community projects have actively been seeking out research tools, methods and results that could be applied to their own projects. In addition, a majority of project sponsors in the survey (65 per cent) indicated that their project has or will contribute greatly to the development of innovative models, tools and potential solutions to address rural health issues (see Exhibit 4.2). Only 29 per cent of the project evaluation reports that were reviewed mentioned how their project was expected to contribute to an understanding of health issues in rural and remote communities. Of these, all reports suggested that their projects could create knowledge or raise awareness. Some evaluation reports also mentioned emerging research networks resulting from their projects that included academics and governments.



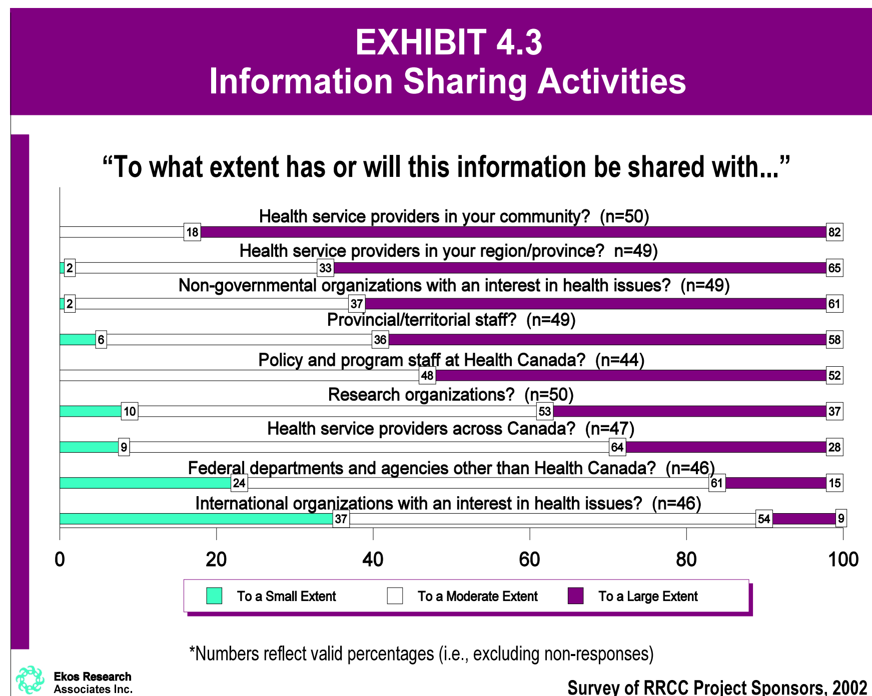
4.4 Impacts on Knowledge of Rural Health Issues

A majority of project sponsors in the survey (63 per cent) indicated that their project has or will contribute to a large extent to the creation of new knowledge on rural health issues (see Exhibit 4.2 in the previous section). Although interview respondents also feel that there is potential for new knowledge to be produced as a result of RRCC projects, they note that it is too early to measure this outcome. In the view of some of the federal government respondents, however, RRCC has not created new knowledge because the issue of rural and remote health existed prior to the program. Instead, they suggest that the creation of RRCC is a result of increased federal interest in rural and remote health, noting that it was created at the same time as the Canadian Institutes of Health Research. Some of the provincial respondents also support the notion that RRCC is a result of an overall increased interest in rural health issues rather than the instigator of it. They noted that universities have a larger role in creating new knowledge on rural health issues with an increased focus on such issues as teen pregnancy and diabetes among

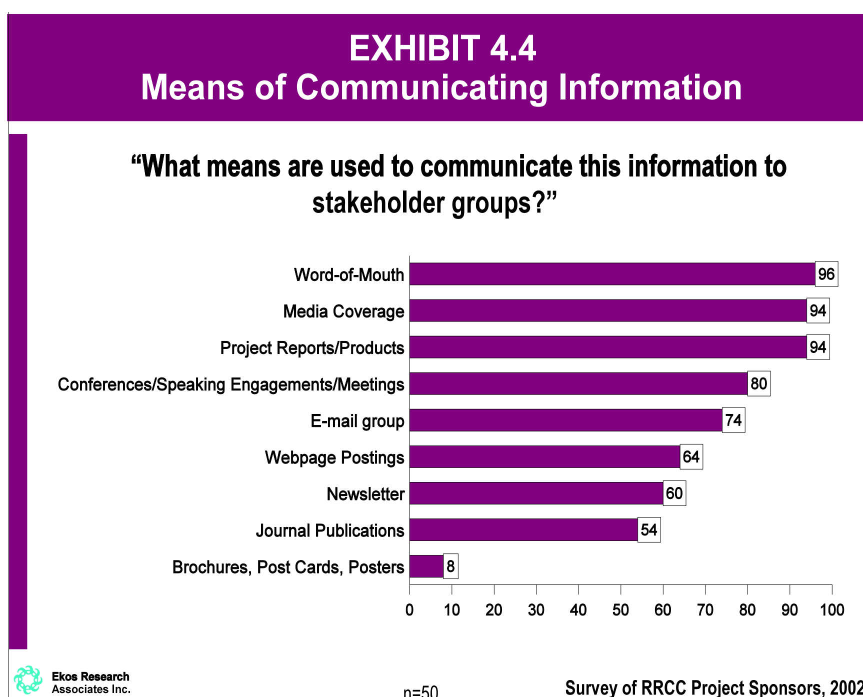
First Nations peoples. Representatives of research organizations/academia and non-government organizations could not comment on this issue due to their lack of knowledge of RRCC results.

4.5 Dissemination of RRCC Knowledge

The survey results indicate that RRCC knowledge has been (or is planned to be) disseminated. The responses of project sponsors suggest that the likelihood of project information being shared varies according to the stakeholders' geographic proximity to the project sponsor. As indicated in Exhibit 4.3, project sponsors are most likely to share project information with health service providers in their own community (82 per cent) and in their region/province (65 per cent) but least likely to do so with health service providers across Canada (28 per cent), federal departments/agencies other than Health Canada (15 per cent) and international organizations (nine per cent).



In the survey, project sponsors also indicated the means of communicating project information (see Exhibit 4.4). The most common methods are word of mouth (96 per cent), media coverage (94 per cent), project reports/products (94 per cent) and conferences, etc. (80 per cent). Similarly, the review of program evaluation reports revealed that project information is most commonly disseminated by television, radio, newspapers, newsletters, the Internet, conferences and word of mouth.



Expert panellists commented on the current status of dissemination of information on rural and remote health issues. Although rural health information/knowledge is disseminated to some degree, panellists generally agreed that there is much room for improvement. At the level of researchers, planners and decision-makers, the sharing of information and knowledge is currently done by word of mouth, at academic/research conferences, at conferences of the Canadian Society of Rural and Remote Health, and by the Office of Rural Health. Due to a lack of dedicated funding and infrastructure support in the past, however, there are insufficient linkages among researchers, health care planners, etc. As a result, the impact of rural health research has been reduced and diffused, there has been duplication of effort and there are gaps in knowledge not being identified.

At the level of rural community members, information dissemination is a challenge due to the small, widely dispersed population and to lower literacy levels than in urban populations. Although new information technology should help to improve access to information/knowledge in rural and remote areas, currently there is very limited access to the Internet in many remote communities so much work remains to be done.

Panellists offered the following suggestions for improving dissemination:

- Focus on translating knowledge appropriately for use by rural/remote community members and by the community of academic researchers, health care planners, etc.
- Provide information on the Internet.
- Attract some media attention to rural health issues and to alternative solutions to address these issues.
- Support a national peer-reviewed journal and national and regional conferences on rural health research/issues.
- Coordinate information dissemination among funding agencies (e.g., the Canadian Institutes of Health Research, the Canadian Health Services Research Foundation) and provide a centralized virtual clearinghouse to improve the accessibility of information on rural/remote research and projects.
- Improve the website for the Office of Rural Health (e.g., update the information more often, provide more general information about rural health).

4.6 Impacts on Rural and Remote Community Capacity to Address Local Health Issues

Mixed views were offered by key informants on the perceived impacts of RRCC funding on community capacity to address local health issues. The two-thirds of federal government staff who could comment on this question reported that the RRCC has made moderate to great progress in this area. One respondent feels, however, that limited funding will prevent this program from fully attaining this outcome. As for provincial/territorial staff, most feel it is premature to assess rural and remote area capacity impacts, though one said that one project did enhance capacity, which led to a better understanding of rural women's health needs and the community's ability to meet them. The two representatives of NGOs who could comment on this issue indicated that the RRCC has contributed to some extent to reaching this outcome. Representatives of research organizations and academics were not asked in the key informant interviews to comment on this issue.

At the project level, Exhibit 4.2 (in Section 4.3) indicates that community capacity building was most frequently mentioned as being attained through funded projects among listed outcomes, with almost seven in ten sponsors (69 per cent) reporting that this outcome has been attained to a great extent. The review of project evaluations indicated that just two projects of those with reports to review appeared to have contributed to increasing community capacity to address local health issues.

Similarly, there was some evidence drawn from the case studies indicating that community capacity has been to some extent enhanced through project funding. For some projects, it was felt to be still too early to detect capacity building impacts, while for others it was not within the immediate, feasible scope of the project to have increased capacity: the objective of such projects was merely to identify needs or collect data, which only *in the long term* could possibly enhance capacity to address local health issues.

Other case studies conducted were of projects of a more advanced nature. One such project led to the development of a number of products expected to be sustained beyond the life

of the project, including: an advisory/working group, an action plan, a collection of relevant reports, a directory of health services, a working guide for informing other similar projects, and partnerships. These products can be expected to enhance the capacity of the community in question to address local health issues, and they might also inform other similar communities to do so.

Similarly, in another case study, it was found that the project has: increased understanding and awareness of community health needs and the availability of and need for services to address them; developed a forum for problem-solving through community advisory committees; and developed a dissemination plan and a health model/template and lessons learned. Again, such activities are expected to remain in place beyond the life of RRCC funding and in the longer run to contribute to increased capacity not only in the affected community but also in other rural communities that might adopt this particular community’ s model.

4.7 Impacts on Federal Capacity to Address Rural Health Issues

Opinion is mixed on the question of federal government capacity being enhanced. Federal government respondents varied widely in their views on the degree to which the RRCC has made progress toward this goal. The ways in which federal capacity has been strengthened cannot all be attributed to RRCC funding, but include the following: participation on Rural Teams; the ability of the Office for Rural Health (ORH) to generate information that has increased understanding of rural issues among sectors of the federal government; intensive workshops/seminars revolving around health issues, delivered by the Summer Health Institute (a partnership between Health Canada and Brandon University), that raise the profile of health issues and identify potential ways of dealing with them; and partnerships and linkages with other federal departments. The few provincial/territorial staff who could comment on this issue suggested that federal capacity has been enhanced through increased awareness. Academics and representatives of research organizations and non-government organizations were not asked to comment on this issue.

At the project level, survey results indicate that increased capacity in the federal government was, according to project sponsors, among the least likely of outcomes to have been attained. Fewer than three in ten survey respondents (29 per cent) said that this outcome was attained to a great extent (see Exhibit 4.2 in Section 4.3). There were suggestions in the progress reports for two projects that federal capacity has been enhanced somewhat by the particular projects. This question was not asked in the case studies.

4.8 Impacts on Working Relationship Between Federal and Provincial/Territorial Staff

There were mixed opinions on this issue in the key informant interviews. Federal government representatives tended to suggest that the RRCC has made progress toward this outcome to a moderate or great extent. Again, examples of the enhanced relationship between the federal and provincial/territorial governments include those that are not necessarily attributable to program funding: regional staff establishing new relationships with different provincial ministries and working closely with the provinces; RRHII program managers developing positive working relationships with provincial/territorial staff; Rural Teams and regional consultations; and provincial staff sitting on advisory committees. The few provincial/territorial representatives who commented on this issue said the relationship between federal and provincial/territorial staff was positive, but they did not say if this was due to RRCC funding. Representatives of research organizations and non-government organizations and academics were not asked to comment on this issue.

In the view of project sponsors in the survey, this outcome was the least likely to have been achieved, with only one-fifth of sponsors indicating that this outcome has been attained to a great extent (Exhibit 4.2). The project evaluations review failed to turn up any evidence on this question, while case studies did not address this issue at all.

4.9 Consideration of Rural and Remote Health Issues in Health Information Technology

Few key informants could comment on this issue and among those who did the response was generally that RRCC funding has led, to some extent, to enhanced health system information technology (IT). Among the half of the federal government representatives who could comment on this issue, the majority said the RRCC' s contribution was modest in this regard. One reason offered for this was that the existence of the Canada Health Infostructure Partnership Program (CHIPP) has meant that relatively few of the 70 RRCC funded projects looked at IT. A substantial proportion (44 per cent) of the projects funded by the CHIPP is in fact related to rural health.

Similarly, the representatives of the two non-government organizations who addressed this issue said RRCC funding contributed to this outcome to only some extent. No provincial/territorial representatives could comment on this, while representatives of research organizations and academics were not asked to address this issue. Finally, less than one-third of project sponsors (31 per cent) in the survey felt that RRCC funding has greatly contributed to the development and application of rural health systems information technology (Exhibit 4.2). It should be noted, however, that the RRHII was always intended to complement the CHIPP, rather than replace it for purposes of rural health IT, because it was recognized at the outset that the level of funding available through the RRHII (i.e., $11 million over two years) was insufficient to support large-scale rural health IT projects.

5. COST-EFFECTIVENESS

5.1 Equitable Distribution of RRCC Resources

Opinion was varied on the question of how equitably RRCC resources were distributed. Of the two-thirds of the federal government representatives who could respond to this question, most said that RRCC resources were distributed in a very balanced and equitable manner. This was ensured by: distributing funds on a traditional per capita basis and according to need for and capacity to spend the money; providing the regions with sufficient operations and management budgets; and involving the regions in the funding decisions. Still, federal officials identified some weaknesses in how funds were distributed, including the fact that per capita funding may not be suitable for rural areas where the population is sparse, in some regions only one project was funded which does not do much for the entire region, and there were no criteria for the equitable distribution of funds.

Provincial government officials interpreted this issue in two different ways. Most said that the distribution of funds from the region to the projects was equitable, whereas a minority indicated that there was equitable distribution from Health Canada to the regions. In either case, however, a majority of the respondents who took one perspective or the other felt the funds were equitably distributed. Some respondents concurred with federal officials that there should be

formal criteria for the distribution of funds, for example, according to need for or the cost of health services in communities. Equitable distribution from the regions to projects was facilitated by the fact that most regions undertook a targeted or broad-based proposal solicitation process, with the review of proposals being conducted by panel members with different perspectives. Balance and equity were sometimes compromised, however, by an occasionally flawed proposal solicitation process owing to insufficient time, resources and capacity as well as poor understanding of the population health concept.

Consistent with the key informant interview findings, the majority of project funding recipients in the survey (91 per cent) were satisfied with the rationale used to make decisions about the allocation of resources to fund their project. In addition, the review of project evaluations revealed that there were two progress reports indicating equitable distribution of funds. As for the case studies, one respondent suggested that too much was spent on administration and bureaucracy, leaving insufficient funds for the actual work of the project.

5.2 Leveraging of Resources

This issue refers to the ability of RRCC funding to attract further funding from partners or other sources for the project. Among the two-thirds of federal government respondents able to comment on the issue, views ranged from a moderate to large impact in this regard. In support of their views, federal key informants cited the following organizations that contributed additional funding or in-kind resources to an RRHII project: the Department of Canadian Heritage (language being a health access issue); other Health Canada divisions (e.g., the mortality atlas incorporating a rural perspective); a health association in BC; health service providers (in-kind services such as covering travel costs, advertising, free space); a college (a foundation grant); and a city and a city hospital (keeping a project product on the website). One federal government respondent pointed out that it has been difficult for rural communities to leverage resources, and, at any rate, leveraging was not a requirement of the program.

Similarly, not all provincial/territorial representatives could comment on this issue and,

among those who could, responses were wide-ranging. Where leveraging was said to have occurred, it involved funds from the regional health district, the province/territory, volunteers, and other federal departments. This issue was not addressed with representatives of research organizations and academics, or with representatives of non-government organizations.

When asked in the survey what other kinds of support or assistance their organization has received through the RRHII to assist them in conducting the project, more than half of the project sponsors reported that they were provided with technical expertise (54 per cent), followed by in-kind supports such as office space and equipment (14 per cent). More than one-third (34 per cent) stated that they have not received any other kinds of support. Also, in another question on the benefits of partnerships, four in five sponsors stated that they have obtained technical expertise (81 per cent) or in-kind supports (81 per cent) from their project partners, while one-half (49 per cent) reported that they have received funding.

5.3 Sustainability of RRCC Results

Sustainability of project results refers to outcomes continuing beyond the life of the project, i.e., after funding has ended. Only one half of the federal government representatives interviewed were able to address this issue, with some indicating that it was simply too early to tell if projects, let alone the results of projects, had been sustained. Among those who responded, views varied widely, from very little to a great deal of progress having been made in this regard. Examples of sustained activities include: a program attracting youth to health professions; a city travel guide; and a website that was developed in a project that is now being kept up-to-date. Provincial/territorial key informants, however, were fairly pessimistic about the sustainability of funded projects because of the dependence on federal funding through leveraging. That is, once federal funds dried up, funding to keep the project going was difficult to secure. Long-term reliance on volunteers was also seen as unrealistic. Academics and representatives of research organizations and non-government organizations were unable to comment on this issue.

Almost two-thirds of project sponsors in the survey (64 per cent) said that their project's results would continue to be relevant to a large extent. As well, about one half (46 per cent) indicated that their project did or will contribute to a large extent to sustainable activities beyond the funding period. No case study evidence could be brought to bear on this issue.

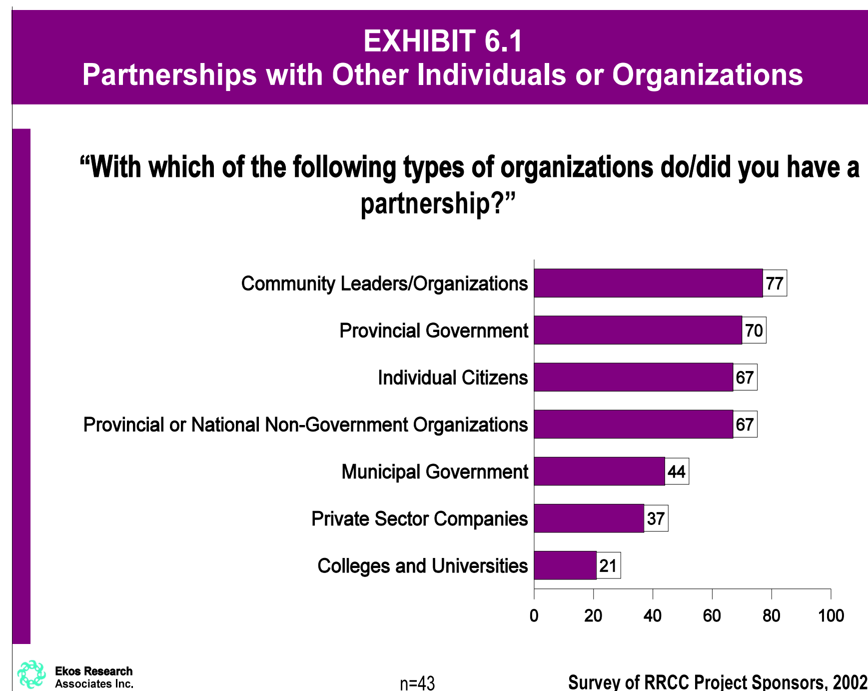
6. PROCESS AND IMPLEMENTATION

6.1 Involvement of Partners and Stakeholders

Overall, federal and provincial/territorial staff consulted in key informant interviews had mostly positive things to say about the involvement of partners and stakeholders. For example, federal respondents tend to feel that partners and stakeholders have been appropriately involved in the design and implementation of the activities of the RRCC, with most rating this involvement as moderately to very appropriate. In the case of provincial and territorial respondents, this question prompted two types of responses depending on the type of key informant and their knowledge of the program. The first response addressed the involvement of partners and stakeholders at the level of design of the RRCC and at the level of individual projects. Responses were generally positive in both respects. With respect to involvement in the design and implementation of the RRCC, individuals from the provinces/territories noted that partners and stakeholders had involvement in the definition of provincial and territorial priorities and in the review of proposals submitted under the RRHII. There were some complaints about lack of responsiveness to provincial/territorial concerns, specifically the eligibility criteria and about not remaining informed as the RRCC unfolded. At the level of projects, project members were required to include partners within the proposal.

Interviews with academics and representatives of non-government organizations, however, yielded more varied results. Most academic key informants and half of the NGO key informants did not know if partners or stakeholders had been involved in the design or implementation of the RRCC. Two respondents had the impression that many partners had been involved in the design and implementation of the project, but could not substantiate their beliefs. One respondent had reviewed projects and had encountered considerable variation in both degree and effectiveness of partner involvement. The remaining NGOs said the partners had been involved either to some or to a great extent.

In the survey of project sponsors, most of the respondents stated that their project had been implemented or designed in partnership with other individuals or organizations (86 per cent). These projects were most likely to have between three and five project partners (40 per cent) or between six and ten project partners (33 per cent), with an overall average of 6.8 partners. A review of available project files revealed comparable results. Just over half of the project reports provided a figure for the number of partnerships created for or during the project, and these figures ranged from three to 15 partners, with the most commonly cited number of partnerships being seven (for about one-quarter of these projects), and the average number of partnerships at nine.



When the sponsors surveyed were asked to identify the types of organizations with which they have or had a partnership, more than three-quarters (77 per cent) stated that they had a partnership with community leaders or organizations (see Exhibit 6.1). Other commonly identified partners include provincial governments (70 per cent), individual citizens and provincial or national non-government organizations (both at 67 per cent). The case studies revealed a variety

of additional project partners such as local schools, local media and hospitals. Furthermore, case study participants suggested the potential for partnerships with police and other communities. Examples of partnerships were also found in the document review. According to one progress report, examples of collaborations between the RRCC and other Health Canada branches/divisions include Regional Offices, the Northern Secretariat, First Nations and Inuit Health, the Health Research Secretariat and the Information, Analysis and Connectivity Branch.

Information on the nature of the partnerships was also provided in just over half of the evaluation reports. Partnerships, according to these 13 reports, were most likely to take the form of steering or advisory committees.

6.2 Benefits and Impacts of Partnerships

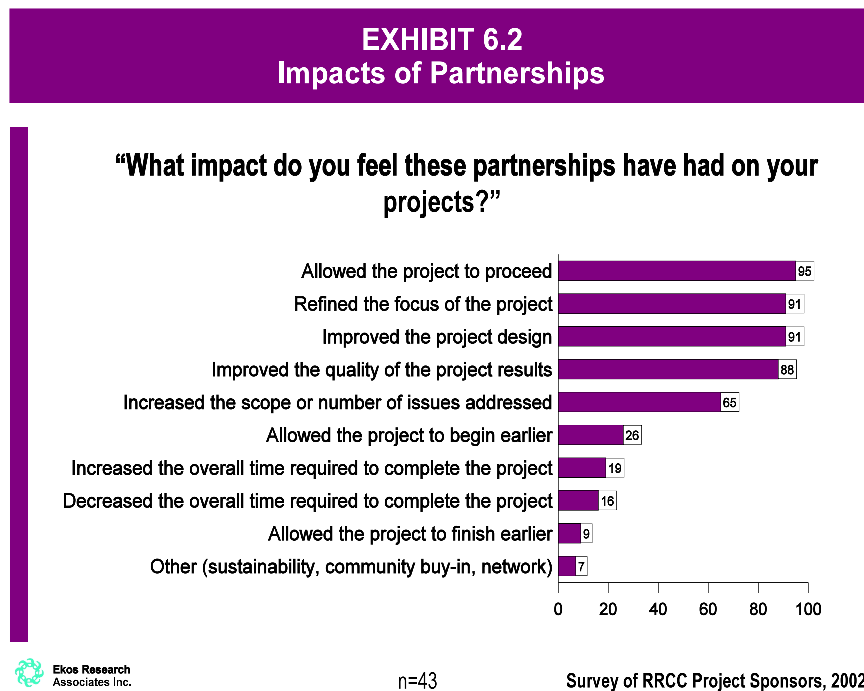
Although a number of respondents in the evaluation were unable to identify the specific impacts of partnerships, others described overwhelmingly positive impacts often even suggesting that the projects would not have gone forward without the partnerships. Findings from both key informant interviews and case studies revealed positive impacts including: ensured sustainability of the initiative beyond its funding; enhanced relationships with Health Canada and other federal departments; increased perceived relevance of project to the community; provision of necessary information; greater awareness of available community services; a renewed sense of cooperation within and between communities; improved relations with the provinces/territories; and more effective projects.

One interviewee did suggest, however, that multi-jurisdictional involvement complicated projects at a communications level, and academic partnerships steered the project focus away from a grass roots perspective.

Project sponsors were asked in the survey about the benefits of the partnership on their project. Most project sponsors stated that they had obtained technical expertise (81 per cent) or in-kind supports (81 per cent) from their project partners, though funding (49 per cent) and "other" contributions (two per cent) were also cited.

When asked to rate the relative percentage contribution (both financial and in-kind) of RRHII and project partners in supporting their project, project sponsors were most likely to report that the RRHII contributed between 76 and 100 per cent of the overall support for their project (40 per cent), followed by between 51 and 75 per cent of project support (28 per cent). RRHII support accounted for 50 per cent or less of the overall support received for the project in just over one-quarter of cases (28 per cent).

When asked what impact these partnerships have had on their project, nearly all of the sponsors with partners indicated that the partnerships allowed the project to proceed (95 per cent), that they refined the focus of the project and improved the project design (91 per cent), and that they improved the quality of the project results (88 per cent) (see Exhibit 6.2).



6.3 Complementarity or Duplication with Other HC Programs

The review of literature, policy and programs uncovered the other programs and projects supported by Health Canada that focus on rural health issues. There have been a number of efforts besides the RRCC of the ICRHI that were designed to correct the imbalance in health care access and outcomes. At the federal government level, there is the Office of Rural Health (ORH), which oversees the RRCC, as well as the wider government rural initiative and the Canadian Rural Partnership, which aims to increase consideration of rural issues in the design and delivery of federal policies and programs, including those of a health care nature. There is also the Health Transition Fund which has provided funding for 27 rural health projects (out of a total of 141 funded projects). In addition, there was the Rural Health Research Summit, held in Prince George in October 1999 and sponsored by Health Canada, which helped to establish the first national network of rural health researchers in Canada and resulted in a framework to guide research. Also, there was the establishment of the Ministerial Advisory Council on Rural Health.

There has also been much program activity at the provincial/territorial, municipal and university levels, much of which is co-funded by the federal government. These programs include approaches that focus on staffing issues (e.g., retention and recruitment of health workers) and Telehealth, which links rural doctors, through teleconferencing, to urban specialists as a way of expanding health care in rural communities. Findings from the literature, policy and program review provided an indication that there is some potential duplication and overlap, however this issue was addressed more directly in the interviews and survey.

Among both federal and provincial/territorial government respondents, the general opinion was that RRCC is a unique program within Health Canada. In fact, many respondents feel that this is the only program that elevates the level of knowledge of specifically rural concerns. It is also the only program that complements some of the provinces' and territories' efforts to improve health status in rural communities by providing funding for specialized short-term projects. The project sponsors surveyed expressed similar sentiments about the RRCC, as more than three-quarters (76 per cent) reported that they were not aware of any other Health Canada programs that provide services and supports that are similar to or complement those received through the RRHII. While only one NGO key informant said that there was no duplication, seven

of the eight NGO key informants did not know if the RRCC duplicated or overlapped with other Health Canada programs.

In providing specific reasons for their view that no overlap exists, the key informants noted the following features of the RRCC:

- it is a corporate program that represents interests of all policy and program areas in the Department;
- it looks at issues in other branches as well and works with them on these issues;
- Health Canada is the only department other than Agriculture and Argri-food Canada that has identified and devoted separate funds/resources to support a commitment to rural development issues within their mandate;
- it targets rural issues and works informally with other programs and policy areas within the Department (e.g., builds effective working relationships) to help encourage a rural component; and
- it is the first time applied rural health issues have been treated as separate issues and have taken geography into consideration.

Rather than duplicating or overlapping with other Health Canada or provincial/territorial programs, most respondents feel the RRCC is complementary to other initiatives in the area of rural health because:

- some provinces/territories have an office of rural health (that deals with broader issues, such as payment of rural physicians, establishment of a northern school) and the RRCC provides some modest value-added to the provincial/territorial responsibilities;

- the RRCC is delivered in close consultation with provincial/territorial colleagues;
- the CHIPP (Canada Health Infostructure Partnership Program) funding allows the development of data systems that can be used to track, monitor and evaluate projects, though these systems still are in the developmental stage;
- other departments and jurisdictions have begun thinking with a rural lens, which has led to more complementary policies and programs and many projects that "married" well (e.g., Agriculture and Agri-food Canada and Health Canada jointly preparing documentation for Cabinet);
- the RRCC complements a number of Population and Public Health Branch (PPHB) programs, adding perspectives and resources;
- provinces/territories are provided with more front-end capacity (e.g., for mental health promotion, health care system delivery); and
- there is information sharing among stakeholder groups.

Nonetheless, some evidence for duplication was found. For instance, one respondent mentioned duplication of RRCC with other programs (e.g., Health Transition Fund), which can have a rural focus. Another respondent pointed out that small similarities exist between the RRHII and other initiatives (e.g., Population Health Fund).

It is worth noting that some respondents feel that duplication is not always a bad thing when priorities (but not activities) overlap, but there is a need for concerted efforts to ensure complementarity and synchronicity because:

- health care is not easily compartmentalized and there needs to be coordination and communication at the federal level across programs (e.g.,

through the use of departmental committees so that programs can coordinate with one another at the individual project level); and

- like a number of Health Canada programs, the RRCC is delivered regionally while other HC programs (e.g., CHIPP, Health Transition Fund) are delivered nationally, and some respondents perceive that Health Canada sometimes funds regional initiatives with RRCC community partners without the ORH knowing of this.

Finally, one key informant feels that there should have been more overlap with the CHIPP in terms of information technology to rural communities since the CHIPP did not focus as much on rural communities as it might have. Note, however, that fully 44 per cent of projects funded by the CHIPP were related to rural health. The survey of project sponsors also uncovered some evidence of duplication. Roughly one-quarter (24 per cent) of project sponsors reported that they were aware of other programs similar to the RRCC. Sponsors who reported being aware of these programs were most likely to mention programs administered by Health Canada's various branches (67 per cent) or other programs such as community projects or research funding agencies (50 per cent). A minority (17 per cent) also mentioned programs or projects funded by the RRHII.

6.4 Regional Variation in RRCC Implementation

When asked if the implementation of RRCC has been uniform across Health Canada regions, many key informants were unable to answer, particularly provincial and territorial staff (as they could not comment on RRCC implementation in HC regions other than their own). Some respondents, however, indicated that implementation has been uniform because: staff with the ORH kept regions informed and in touch with one another, and have invited regions to participate in all aspects of the implementation; monthly conference calls were held between the ORH and regions to keep track of the RRHII; and a meeting of regional managers in November 2001 suggested a high degree of consistency in that all regions were funding similar types of innovative initiatives. These respondents feel that this consistency facilitates the delivery and evaluation of the RRCC and enables a comparison of projects (i.e., projects that deal with similar issues can touch base and inform similar projects in other regions).

Most interview respondents who were able to comment on this issue, however, indicated that RRCC implementation across regions has not been entirely uniform, but argued that this is neither surprising nor necessarily negative for the following reasons:

- ❑ differences between provincial/territorial priorities mean there would be variations in the types of projects under way to ensure they complement provincial/territorial efforts, and furthermore the processes of consultation and implementation are different in each region;
- ❑ each region has differences in rural and remote population composition and in the proportion of non-rural to rural areas;
- ❑ managers in different regions have different (but no less effective) styles;
- ❑ regions having some autonomy in how the RRCC is implemented, which is appropriate because the regions are different;
- ❑ some jurisdictions chose to do a larger number of smaller projects while

others chose to use funds for more consolidated, limited projects;

- the timing and emphasis on priorities may not always be uniform across regions; and

- provincial/territorial governments have participated to different degrees (e.g., because rural office capacity varies by region, urban issues dominate in some regions, and Quebec has only recently participated because of close collaboration with the provincial government).

Regarding the impacts of regional variation on the progress and success of the RRCC, all federal respondents indicated that this has had no adverse effect and could often be seen as having a positive effect, because the RRCC is flexible enough to allow complementary establishment of priorities between provincial/territorial and federal governments, and RRCC projects are more likely to suit regional and provincial/territorial needs. Provincial/territorial respondents also stressed the importance of allowing each province and territory sufficient flexibility to address its own needs.

6.5 Collaboration in RRCC and with Other HC Programs

Although very little direct evidence was collected in the evaluation to assess the degree of collaboration within the RRCC and between the RRCC and other HC programs, there are some indications of such collaboration. For instance, within the RRCC, interview findings suggest some degree of collaboration/communication between regions as facilitated by the ORH, and in the conference calls among regional staff. In addition, as noted earlier, key informants observed that the RRCC has offered a complementary perspective or resources to other PPHB programs and that it has worked informally (e.g., by building working relationships) with other Health Canada programs and policy areas to encourage a rural perspective.

6.6 Data Availability and Gaps for Performance Monitoring

Several key informant interview respondents identified gaps in the data sources available to effectively monitor and assess the implementation and impact of the RRCC, including:

- broad health indicators from a rural/urban perspective (although the development and collection of some useful data is coming from the provinces/territories, Canadian Institute for Health Information (CIHI) and Canadian Institutes of Health Research (CIHR), and ORH is working with these organizations to make progress);
- analysis of rural demographics and data conducted by "Ottawa" (presumably the ORH or another appropriate division at the national office of Health Canada);
- quality of life indicators in rural communities from a holistic perspective, including health not just economic well-being;
- accurate information on rural communities, because many rural residents have to go to urban centres for health care — thus there are no tools for finding out aspects of the problem (though Newfoundland Statistics has a data bank on all communities in this province);
- the national databases have small sample sizes that do not allow sub-provincial or community comparisons;
- a lack of community-level indicators (e.g., indicators of community cohesiveness) that can illustrate and help explain regional variation in health outcomes; and
- a lack of evaluations at the regional and provincial levels.

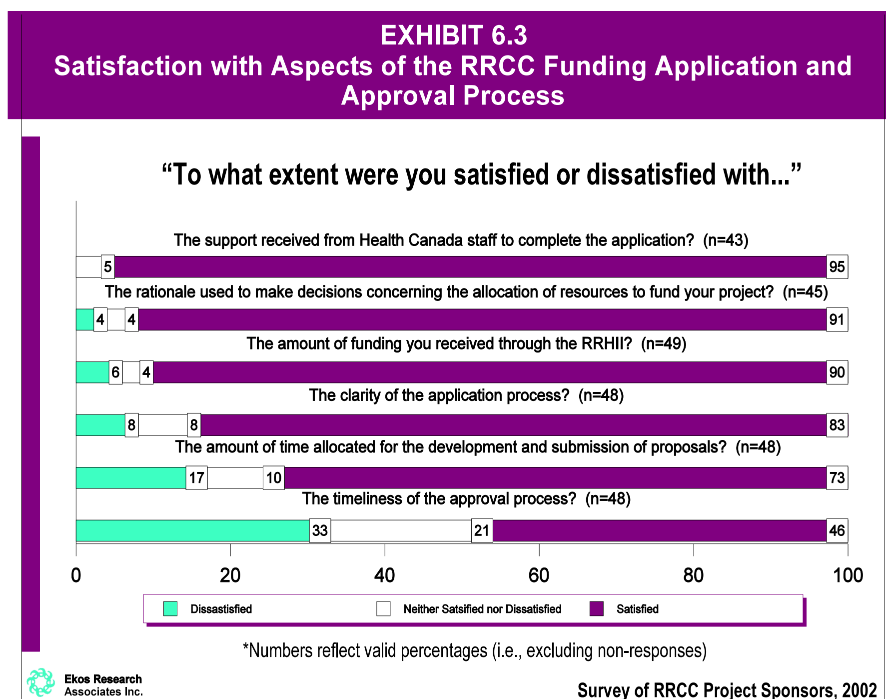
When asked to comment on what alternative or additional data needs to be gathered and how this data can be used to enhance the monitoring of RRCC implementation, process and impact, key informants made the following suggestions:

- better distribution of information (e.g., use of websites, e-mail, conferences, public media, local newspapers);
- more data specifically from rural areas (e.g., input from citizens, research on rural health issues, needs assessments);
- information on which projects are being sustained after program funding ends;
- development of an Industry Canada initiative to increase the bandwidth for remote, northern communities so that they have high speed access to the Internet;
- more detailed information on each specific project; and
- a longer timeframe for projects in order to obtain better information on outcomes.

6.7 Project Application and Approval Process

In the survey, project sponsors were asked about their satisfaction with various aspects of the application and approval process. For most aspects of the process, the majority of respondents indicated that they were satisfied (Exhibit 6.3). Sponsors were most likely to report being satisfied with the support received from Health Canada staff to complete the application (95 per cent), the rationale used to make decisions concerning the allocation of resources to fund their project (91 per cent), and the amount of funding they received through the RRHII (90 per

cent). The lowest rate of satisfaction was observed with respect to the timeliness of the approval process (46 per cent).



6.8 Strengths of RRCC

Interview respondents cited a variety of strengths of the RRCC that can be organized under the following broader categories:

❑ *Collaboration:* Several interviewees reported that a key strength of the RRCC was the kind of collaboration involved in its implementation, such as: partnering with other funding agencies so the community could top up funding from other agencies to achieve a level required for their project; Rural Teams, whereby the Rural Secretariat encouraged collaboration

among departments to determine rural issues broadly and facilitated partnerships around common issues; collaborative work across regions and in Ottawa; consultations with the provincial/territorial governments; creating a network of expertise to go to concerning rural health issues; collaboration with other local and regional partners; the relationship with CRP and the Rural Secretariat; the involvement of rural citizens in determining the RRCC's direction; good cooperation from NGO sectors; and good communication among various partners.

- *Priorities, scope and flexibility of the program:* A number of strengths cited in the key informant interviews related to the program's priorities and focus, for example: the program's breadth and flexibility; the consistency of RRCC priorities nationally and regionally with those of the provinces and territories; strong priority setting; flexibility to allow the various population groups to use the RRCC to address their specific issue or challenge; flexibility in terms of regional implementation to better address provincial/territorial priorities; providing value-added to rural initiatives that are the primary mandate of the provincial/territorial ministries of health; and the focus on innovative approaches.

- *Administrative aspects:* Some respondents had positive comments about various administrative and organizational elements of the program, such as: the disbursement of funds once the decision was made about funding projects; the selection committee which was thorough and well coordinated; the efficiency of project organizations; feedback from Health Canada; and the fact that projects function at the local level.

- *Project impacts:* Finally, the actual project outcomes were praised in a number of key informant interviews. For instance, pilot projects were described as "innovative"; awareness among the public and politicians

about rural issues was heightened; awareness of the unique needs of rural and remote citizens from the perspective of health care was raised (e.g., feedback from citizens on health care was obtained through rural dialogue activities, and this information was shared with Health Canada); and the RRCC raised the profile of rural issues and enhanced partnerships as a result of dedicating funds and developing planning guidelines for rural health (e.g., these measures worked as a catalyst to get people thinking of rural issues).

6.9 Weaknesses of RRCC

Respondents also identified aspects of the RRCC that they felt were not working well:

- *Communications:* Many respondents had concerns about communications in the RRCC. For instance, there was no framework for a rural health strategy, and without this projects must operate in a vacuum. Insufficient exchange of information and available statistics between RRCC and the First Nations and Inuit Health Branch was an issue, since the latter represents a significant part of the population living in rural and remote areas. Better exchange could have been mutually beneficial to learn about rural health concerns, avoid duplication of efforts, etc. Some respondents who participated in proposal evaluation committees received no follow-up communication regarding how their recommendations were used, and what projects had been funded. Respondents would also liked to have seen greater sharing of results between projects by having RRCC encourage links between compatible projects. The availability of grants and contributions was not well advertised, so it is unclear whether the best proposals were received

nationally. There was an absence of F/P/T consultation and involvement in the solicitation of proposals. Furthermore, the Component was not sufficiently marketed — little information was available. Finally, there was a perceived need to get more information on project or program results on a continuing basis.

- *Program scope:* Although some respondents felt very positively about the scope and priorities of the program (as noted above), others took issue with various aspects of the RRCC's scope. It was argued that program priorities could have been more clearly stated in simpler language; some saw Health Canada as encroaching on the jurisdiction of provinces and territories; prevention and promotion were not sufficiently stressed; and there was a lack of cohesion and focus because the program was trying to be all things to all people.

- *Project application/funding process and timeframe:* Despite some positive survey results (see Exhibit 6.3), the largest volume of complaints in interviews concerned the project funding process. The project timelines were seen as problematic because two years is a short time and the objectives of the Initiative are very ambitious – it is very difficult to effect major change in this short period. There was a limited amount of money, which may have discouraged some groups from applying – they may have felt their chances were slim or that their projects were too big for a small pool of money. The deadline for proposals was seen as unrealistic because summer is a difficult time to do proposal development, or there simply was not enough time. There was a lack of foresight on the part of the RRCC to have funding re-profiled (i.e., 15 months is not enough time to finish the project and while it is hoped that the evaluation will lead to evidence to continue the program, this is not likely to happen for 2002 and 2003, therefore many

projects will be left in limbo). The quality of proposals varied considerably – some proposals were prepared professionally so that small community groups could not compete. Competition for the funds was so pronounced in some communities that it either prevented some stakeholders from becoming involved, or caused several weaker proposals to be produced from a single community instead of one solid one. Eligibility criteria were not compatible with the reality of service delivery in remote areas, particularly in Northern regions (i.e., government is responsible for service delivery, yet is barred from accessing funds). Restrictive guidelines prevented some RRCC-funded projects from meshing well with provincial/territorial priorities. Sustainability of initiatives was seen as questionable, as short-term money for short-term initiatives is not effective. Also, many projects were too dependent on volunteers. Finally, it was suggested that the process could have been more streamlined if there was potential for collaboration among federal grants and contributions programs (i.e., one application form, one accounting form) so community organizations would not need to keep separate records for each funding department.

6.10 Suggested Improvements to RRCC

Respondents in the evaluation made the following major suggestions for improving the RRCC:

- Sharing should not take place only at the end of the program – there should be on-line information on projects, what has been produced, contact names to allow sharing between jurisdictions, and contacts made. The federal government could promote an active electronic exchange between researchers.
- Performance indicators are needed to provide a more detailed picture of rural health in order to facilitate comparisons of health issues between urban and rural populations and to inform decision-making regarding health programming and communication strategies. The RRHII does not support research and this is an area that could be enhanced to provide valuable information.
- The RRCC should expand its scope to address other health care issues such as mental health and complementary treatments.
- The manner in which the RRCC is implemented across the regions could be improved in a number of ways, including: streamlining the approval process; having stronger program representation in the north; improving how the program is designed to partner with other federal departments or provincial/territorial groups; giving more capacity to the regions to respond and disseminate project evaluation results; national consultation with NGOs and a national F/P/T group; increasing the number of national projects to enhance F/P/T collaboration in future; national surveillance of the regions; and improving relations with the provincial/territorial governments.
- Use RFPs to solicit letters of interest instead of full proposals because many community organizations do not have the capacity to write detailed proposals.
- Look strategically at the concept of healthy communities in a broader way, rather than focussing only on service delivery.
- Standardize record keeping and inform regional staff/project sponsors of what they need to document to have an audit trail, and encourage them to maintain conversation records to document verbal exchanges.
- Create a database to develop tools (e.g., standardized project evaluation questionnaires, forms and check lists).

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Relevance

The evaluation findings indicate that the RRCC has made some progress in terms of contributing the "building blocks" of a federal rural health strategy. Although respondents in three case studies could only comment on project impacts at their own community level due to a lack of understanding of how their project fits into the broader federal strategy, those in the other four case studies felt strongly that their project outcomes and outputs should be considered "building blocks". They regarded the tools and service models they were developing as well as the networking they had done as valuable contributions that could inspire, guide, and be replicated (at least partially) in other communities. As such, these contributions could be viewed as developmental elements of a broader federal rural health strategy. While most expert panellists could not comment or felt it is premature to assess this impact, some were hopeful that the RRCC has made some contribution of "building blocks". Key informants were not asked about this issue.

- ❑ ***Recommendation 1:*** In program communications and materials, explain clearly how funded projects are intended to make a contribution to a broader federal initiative as well as benefit rural and remote communities.

There was, on the part of all respondents from all lines of evidence, a clear message that there is an important need for the RRCC or a similar program if there is to be a federal rural health strategy. Rural and remote health issues have in the past mostly "fallen through the cracks" and the RRCC is essential for maintaining a focus on these issues for future enhancement of the rural and remote health situation. Expert panellists observed that the RRCC is the only available initiative for the development of a rural health strategy.

- ❑ ***Recommendation 2:*** As part of a federal rural health strategy, consider the feasibility of continuing the RRCC or a similar initiative in order to address rural and remote health issues which are numerous, serious and under-funded.

The consensus was that there is a strong continuing need for the federal government to

develop and nurture partnerships for purposes of addressing rural and remote health issues. The federal government is uniquely positioned to fill this role, ensuring a national perspective. In addition, respondents in the evaluation stress that the federal government should encourage provincial/territorial involvement in addressing health issues in rural and remote communities. Similarly, the evaluation findings indicate that there is a strong need for the federal government to support communities and engage citizens in the development and implementation of rural health strategies.

- ***Recommendation 3:*** Continue the federal government involvement in nurturing partnerships and facilitating information sharing, dissemination and networking with respect to rural and remote health issues.
- ***Recommendation 4:*** Continue to emphasize the active participation of community members in developing project proposals and identifying the most suitable health solutions for their communities, as opposed to imposing strategies developed without community/citizen engagement.
- ***Recommendation 5:*** Formally recognize the work of volunteers in the development and delivery of community health initiatives, the success of which would be impossible without volunteers in the community. Due to the fact that it is becoming increasingly difficult to find and keep volunteers, future initiatives will also need to find ways to reduce the dependence on volunteers (e.g., more stable funding for hiring project staff).
- ***Recommendation 6:*** Promote federal programs like the RRCC to communities in a proactive fashion (e.g., in local community newspapers and at local events), rather than relying on measures such as the Health Canada website.

Most respondents in the evaluation could not identify specific changes to the rural health policy environment, but stressed the importance of maintaining a focus on rural health issues in federal policy development and ensuring that these issues are given enough political and social "weight" to warrant continued attention. Expert panellists feared that rural health issues may be just a passing "fad" and that, without ongoing efforts to focus attention on these issues, they may receive increasingly less emphasis in federal policies. Although current consultations on health care such as the Romanow Commission are incorporating rural/remote health care needs, the trend

toward more centralization of health services as well as the demographic trend for more Canadians to live in urban centers present challenges for a continuing emphasis on rural health.

- ❑ ***Recommendation 7:*** Maintain the current focus on rural/remote health issues in federal policies and programs and respond with stronger initiatives and more sustained funding for community-level interventions.

7.2 Progress and Success

The evaluation findings indicate that awareness and capacity have increased to apply a rural perspective to policy and program development within and outside the health sector. However, most respondents feel that it has increased only to a moderate extent since more work is still needed in both policy and program development. There was uncertainty as to whether it was the RRCC that influenced this increase or if it was part of or a result of an overall political push for an increased rural and remote focus. In any case, the RRCC was seen as pivotal in increasing discussion and awareness of rural health issues within the governments and in providing direction for research and development concerning these issues.

Examples of improved capacity in spheres related to the determinants of health include: an increased number of rural related programs and policies within Health Canada; an increased number of working groups; the establishment of the Ministerial Advisory Council on Rural Health; and the appointment of the Special Advisor to the President of the CIHR. Other examples are Telehealth, health information technology for rural/remote areas and primary care reform efforts.

- ❑ ***Recommendation 8:*** Continue to encourage the application of a rural perspective in the development of health programs and policies, and ensure that rural/remote community members participate in consultations and decision-making regarding these programs and policies.

All lines of evidence indicate that RRCC priorities are congruent with provincial/territorial priorities and community needs. In the view of some respondents, however, the RRCC priorities encompass too wide a range of issues and should be better focussed. Findings from the

project case studies indicate that transportation and access to health care services are the most urgent priority areas. Many of these issues are not exclusively a health concern as they involve other aspects of life. For instance, poor road conditions affect fresh food delivery, which in turn has an adverse impact on the diet of rural/remote community members and can contribute to a high incidence of diabetes.

In the view of some respondents, there needs to be a more integrated approach with other departments, other jurisdictions, etc. to effectively address direct and indirect rural health problems. In addition, some respondents and expert panellists feel that there should be greater support for research on rural/remote health issues.

- ❑ ***Recommendation 9:*** In future initiatives designed to address health problems in rural and remote areas, endeavour to take a more integrated approach that involves other federal departments and other jurisdictions.
- ❑ ***Recommendation 10:*** If feasible, provide more federal funding and support for research into rural and remote health issues.

The evaluation findings suggest that the primary impacts of the RRCC related to research and research networks have been in increasing community involvement in academic networks and in increasing contact between communities, provinces and other jurisdictions. The strength of the RRCC has been in encouraging community level participation in rural health concerns and in finding solutions. Although the evaluation evidence suggests that there is the potential for knowledge development on rural health issues, it is premature to draw definitive conclusions regarding these impacts of the RRCC.

Findings from the survey of project sponsors/funding recipients indicate that RRCC knowledge has been (or is planned to be) disseminated. The project sponsors tend to share project information mostly with those in close proximity to them (e.g., health service providers in their own community and region/province), and this is most commonly done by word of mouth, media coverage, project reports/products and conferences. In the view of some interview respondents, however, it is too early in the life of many funded projects to observe results, there has been insufficient ongoing dissemination of available results, and coverage of the RRCC on the Health Canada website has been inadequate. Expert panellists also feel that there is a need to improve the

dissemination of knowledge on rural and remote health (e.g., by providing a virtual clearinghouse of information on rural/remote research and projects).

Most respondents feel that rural community capacity to address local health issues has increased at least to some extent. The degree to which RRCC funding played a role in this respect could not be determined definitively, particularly as it was seen as still too early to do so. However, the opinion expressed by some respondents is that the funding has contributed somewhat in terms of developing awareness, tools, reports, directories, and partnerships that would be expected to help participating rural communities address their health needs. This capacity building would also apply to other communities able to adopt these models and adapt them to their own needs.

Most respondents feel that in general terms and in recent years the federal government's capacity to address rural health issues has increased, at least to some extent. The RRCC has played a role in this increased capacity, along with the Office of Rural Health and Rural Teams more broadly. In addition, most respondents consulted for the evaluation are of the opinion that RRCC funding has contributed at least somewhat to an improved relationship between federal and provincial/territorial government staff with regard to rural health issues.

Few respondents could comment on the degree to which the RRCC has helped rural/remote health issues to be considered in the development and application of health systems information technology. Among those who could, the role of the RRCC in this respect was seen as modest.

7.3 Cost-Effectiveness

In the view of most respondent in the evaluation, RRCC funds were equitably distributed according to need for and cost of health services in communities. An effective proposal solicitation process at the regional level was thought to be the reason for the equitable distribution of the resources under the RRCC. Some respondents argued that there should have been formal criteria for the distribution of funds among regions, however.

❑ ***Recommendation 11:*** Establish formal criteria (incorporating an appropriate degree of regional flexibility) for how resources should be distributed in future grants and contributions programs like the RRHII.

The consensus among respondents consulted in the evaluation was that in many cases RRCC funding served to attract other funding, or that other non-federal partners contributed additional resources, both financial and in-kind. In-kind resources included free travel, accommodation, advertising, or technical expertise. Most project sponsors said that they were able to leverage resources in their respective projects. It was pointed out by key informants, however, that leveraging was not a formal criterion for funding under the program but perhaps it should be.

❑ ***Recommendation 12:*** As one of the formal criteria for funding under future grants and contributions programs of this nature, specify that funding recipients are required to leverage financial and/or in-kind resources from sources/partners other than the federal government.

It is difficult to draw firm conclusions about the sustainability of results produced by RRCC projects because, in the view of many respondents, it is too early to observe this. Among those who responded to this issue, views varied widely about the actual or potential sustainability of projects beyond the funding period. A suggested drawback to sustainability is the dependence on federal funding — it would be and has been difficult to attract additional funding to keep a project going. Two in three funding recipients indicated in the survey that their project results would continue to be relevant, however, after the project ended.

7.4 Implementation

The evaluation results indicate that partners and stakeholders from a variety of sectors were involved to a significant extent in many RRCC funded projects, and all projects appeared to have more than one partner. Partner and stakeholder involvement was seen as appropriate. Moreover, the impacts of partnerships were overwhelmingly positive. Partnerships usually resulted in financial or in-kind contributions, and their impacts varied from allowing the project to proceed in the first place, to increasing community buy-in and networking.

- ***Recommendation 13:*** Continue to encourage and support project partnerships in future initiatives in rural and remote health.

While some duplication between the RRCC and other programs (e.g., CHIPP) was reported, the consensus is that the RRCC is a unique program and any existing overlap is complementary and in some cases even an asset to the Component. Respondents observed that there is some variation in how the RRCC is implemented from region to region, however this is not considered to be a negative thing and the RRCC was in fact praised for its flexibility towards different provincial and territorial priorities and needs.

- ***Recommendation 14:*** Continue to build some flexibility into similar future programs to enable the provinces and territories to address their own unique needs.

A number of gaps were noted in the currently available sources of data to assess the RRCC's implementation and impacts. Respondents made a number of suggestions for additional data sources to address the cited gaps, most notably for more detailed project-specific information and more data and indicators on the rural health needs and health status of individual communities.

❑ ***Recommendation 15:*** Assess the feasibility of developing the suggested additional data sources to improve the performance monitoring of the RRCC and future rural and remote health initiatives.

In the survey, project sponsors indicated being very satisfied with most aspects of the project application and funding process, with the exception of the timeliness of the approval process – fewer than half were satisfied and fully one-third of respondents were dissatisfied with this aspect.

❑ ***Recommendation 16:*** Explore potential strategies to improve the timeliness of the project approval process.

Although key informants and case study respondents had a great deal of praise for the RRCC, they also had some complaints. Particular perceived strengths include the high degree of collaboration in the development and implementation of the RRCC, the priorities, scope and flexibility of the program, and the beneficial project impacts such as heightened awareness of rural health issues. On the other hand, the major limitations pertain to inadequate program communications, aspects of the proposal solicitation and application process, and the short time frame of project funding in light of ambitious program objectives. Some key suggestions for improvement include ongoing information sharing between projects, improved performance indicators of rural health, requesting letters of interest rather than detailed proposals from applicants due to the limited proposal-writing capacity of community organizations, and standardized record keeping from regional staff and project sponsors.

❑ ***Recommendation 17:*** Consider the feasibility of implementing the suggested improvements in future initiatives aimed at rural and remote health.