Resource Municipalities Coalition

Health Care Advocacy

January 2022

Resource Municipalities
COALITION

10631 100th Street
Fort St John, BC V1J 3Z5
RMCoalition.com

Contents

RMC and Health Care Advocacy – How Did We Get Here?

The RMC engaged in a robust Strategic Plan for 2021 - 2023 that includes addressing concerns that are common to its members and rural and remote communities in Northern British Columbia.

During the development of its 2021 – 2023 Strategic Plan, members identified that the provision of health care services delivered in geographically remote and rural communities was a key concern.

Throughout these discussion with member councils during the development of the 2021 - 2023 Strategic Plan, some key gaps and anomalies were identified:

1) The level of service provided to rural and remote communities is not comparable with larger urban centers.
2) The level of service provision by Northern Health differs significantly from community to community.
3) The administrative structure of service delivery differs significantly from community to community.
4) Access to increased levels of service through prioritization of health issues or referral is inconsistent from community to community and overall is considered to take too long (excessive wait times) or to be insufficient. (Specialists, testing, diagnostics)
5) The recruitment of medical professionals is inconsistent regionally and results in unreliable distribution of General Practitioners, Surgeons, Nurses, and other professionals across the region.
6) Recruitment practices include requests for provision of support by local government without transparency in process, use of funds, and return on investment.
7) The compensation structure for doctors (specifically) is inconsistent, exacerbates recruitment challenges, and creates a culture of “desirable and undesirable” community postings.

In follow-up to this initial discussion, the RMC requested that its member councils provide and identify what they individually and collectively felt were the top concerns associated to health care service within their respective jurisdictions.

These concerns were then summarized into three categories to provide the framework for advocacy by the RMC and within each category, there are many single issues that require a more tailored and aggressive approach and while the review and recommendations may not be an exhaustive list of shared concerns, they represent the top concerns raised. It is worth noting that there are significant overlaps of these categories as they have significant influence on one another in various ways and have been prioritized based on feedback from responding councils.

The categories identified for advocacy are as follow:

- Accessibility to Effective Health Care

  Health care and access to basic health care should be recognized as a human right.

- Recruitment and Retention of Health Professionals

  Professional development and support mechanisms possess a greater incentive over monetary gains.

- Mental Health/Addictions

  Mental health is a state of well-being, and we all have it. Mental health is not the absence of mental illness and living with mental illness does not mean you cannot have good mental health.

The interconnectivity of these concerns can easily blur the underlying issue, however, in reviewing documents and studies led or commissioned by governments, academia, and industry for the last 15 years – recruitment and retention is a common element of all recommendations.

Identified challenges, presented by municipal councils, highlights their individual understanding of the complexity to these concerns. While advocacy is a big part of the work that the Resource Municipalities Coalition is taking on in this area, the RMC recognizes that discussion must also offer solutions.

Therefore, the RMC is working to provide informed discussion regarding the concerns raised by councils and provide alternatives that they feel work to a resolution of the issues.

Health Care – The Need for Change

Health care within most industrialized countries have achieved universal and equitable access to primary health care. While the approach and structure of this important service may vary, primary health care service is the point of first contact with health services and facilitates the entry to the rest of the health care system.

The shared concerns amongst industrialized countries reside with maintaining access, quality, and prevention, as they manage the supply of an adequate level of health care workers. This challenge is amplified by the change in demographics of young professionals as well as the challenges of geographic locations of services.

While civilization may be perceived as being advanced from a technological perspective, many challenges exist in rural or geographically remote communities because of government supports to connect or stabilize the fundamentals of 20th century life in these areas. These areas have little return on investment for competitive business and therefore, advancement in these regions is solely dependent on governments support and initiative. This is then further complicate by vote weighting and influence, in many populations.

Advancement of fundamental health services has become an expectation of industrialized countries and its access is a public mandate of their respective governments – *a basic human right*. So, why, after many studies and commitments by governments, does the issue of equitable access to primary health care still exist?

During discussions with Resource Municipalities Coalition (RMC) member councils in the summer of 2020, the following concerns with health care services arose, access to health care, recruitment and retention, and mental health. These concerns are strong enough to support stand-alone advocacy, however, the interconnectivity of these concerns indicate that by finding an effective solution to one, will have beneficial impacts to the others. This was supported through a review of multiple works that span over a period of the last 15 years, in which, a common theme began to emerge and was further qualified through discussions with health care professionals and health care associations.

An overview of the Canada Health Act identifies responsibilities within the Canadian Health Care System, however, the short Act leaves opportunity for conflict between the various levels of government and their responsibilities in delivering effective health care within the provincial or territorial jurisdictions. This disconnect is supported by a recent article by the National Post[14] on October 20, 2021, *"Canada doesn't know how bad its doctor shortage is, let alone how to fix it"*. Dr. David Peachey of Health Intelligence Inc. and Dr. Katherine Smart of the Canadian Medical Associations (CMA) both provide comments of the challenges and suggest that the system itself may in fact be at the root of solving the challenges

Within British Columbia, the foundation of health care stems from the "Primary Health Care Charter" that was established in 2007 and then followed in 2015 by the "Primary and Community Care in BC: A Strategic Policy Framework" policy paper that was established to focus and reenergize the commitments of 2007 "Charter". While the policy paper re-identified the requirements of a strong, effective, accessible, and sustainable health care system, and with supporting action items being taken to review various elements of the system - it failed to affect effective change particularly within rural and remote communities.

The shared concerns of delivering and maintaining equitable access to primary health care is dependent on the ability to manage an adequate supply of health care professionals. Within Canada and in sync with remarks from Dr. Katherine Smart of the CMA, the system prevents a qualitative answer to what that supply looks like, and the needs required to mitigate the impacts.

An analysis of the Canadian medical system is required to determine gaps and provide mitigation efforts, to ensure that Canadians can have patient focused access to effective health care. However, for the purposes of this paper, the focus of recommendations will be on that of the Northern Health region.

Resource Municipalities Coalition Focus

The focus of the RMC's work is to provide information and data where possible, to encourage and support Northern Health in the provision of health care as a strong, sustainable, accessible, and effective primary health care system based on the concerns raised by the member councils and to focus solely on those matters at this time.

It is important to note that while certain concerns have been raised in the development of what challenges communities face in relation to health care. Not all, are within the scope of our individual health care regions throughout the province and would require a separate review to develop strategies and advocacy opportunities. One such concern of importance to communities is that of ambulatory services provided and the impacts to community services.

The overlap and influence of the seven priorities on each other, further complicates the process of providing a strong, sustainable, accessible, and effective primary health care system, specifically in rural and geographically remote communities. An additional influence that must be factored in the discussion and recommendations is that within the Northern Health region, there is only 6.7% of the province's population covering 70% of the land area. This statistic does not reflect the influence of fly-in/fly-out workforces housed in camps outside municipal boundaries but impact the health care system.

After several months of consultation with member municipal councils and in reviewing various reports, studies, and documents on health care developed by provincial, federal governments and from the profession of physicians, the Resource Municipalities Coalition felt the top three areas of concern are as follows:

1) Accessibility to Effective Health Care
2) Recruitment and Retention
3) Mental Health and Addictions

As with the seven priorities identified with the Charter, the overlaps of influence between these three areas of concern are significant, further complicating the determination of effective solutions.

Primary Health Care

Before looking at the top three areas of concern, it is relative to provide some understanding of services provided through primary health care and how primary health care relates to health care as a system.

Primary health care services are significant and quite often misrepresented in the discussion or not recognized as contributors to the development of plans by those not familiar with the system. Primary health care services vary; however, not an exhaustive list, the following provides some overview to the diversity of services that may fall under primary health care:

Minor emergency care

- Broken bones
- Burns
- Illness
- Lacerations, etc.

Follow-up primary care

- Splint or cast removal
- Removal of stitches
- Testing, etc.

Individual and family engagement

- Suicide
- Family trauma

Chronic disease prevention and management

- Heart disease
- Cancer
- Respiratory
- Alzheimer's
- Diabetes
- Mood disorders
- Kidney disease
- Strokes
- ALS
- COPD
- Cystic fibrosis
- High blood pressure
- Asthma
- Arthritis
- Hepatitis

Addiction and mental health treatment and services

- Tobacco
- Alcohol
- Narcotics

Care of patience with complex needs

- Fibromyalgia
- Myalgia Encephalomyelitis (ME)
- Lyme disease

Rehabilitative care services

Family planning and pregnancy counseling services

Maternal and child health services

Palliative and end of life care

Geriatric care

Health promotion and disease and injury prevention services

Population health improvement

- Immunizations
- Health education
- Disease prevention
- Water and air quality
- Population health surveillance
- Diet and nutrition services

Pharmacy

Laboratory and diagnostic services

- Blood work
- Xray
- CT scan
- MRI

Outpatient care services

- Physiotherapy
- Counselling

Primary health care is the center of the province's health care system; it feeds:

Secondary Health Care:

Secondary health care generally is more specialized and may be further from primary health care facilities in geographically remote communities.

- In-patient services
- Emergency care services
- Medical or surgical treatment services
- Diagnostic laboratory and medical imagining services
- Acute mental and physical health assessment

Specialized Health Care:

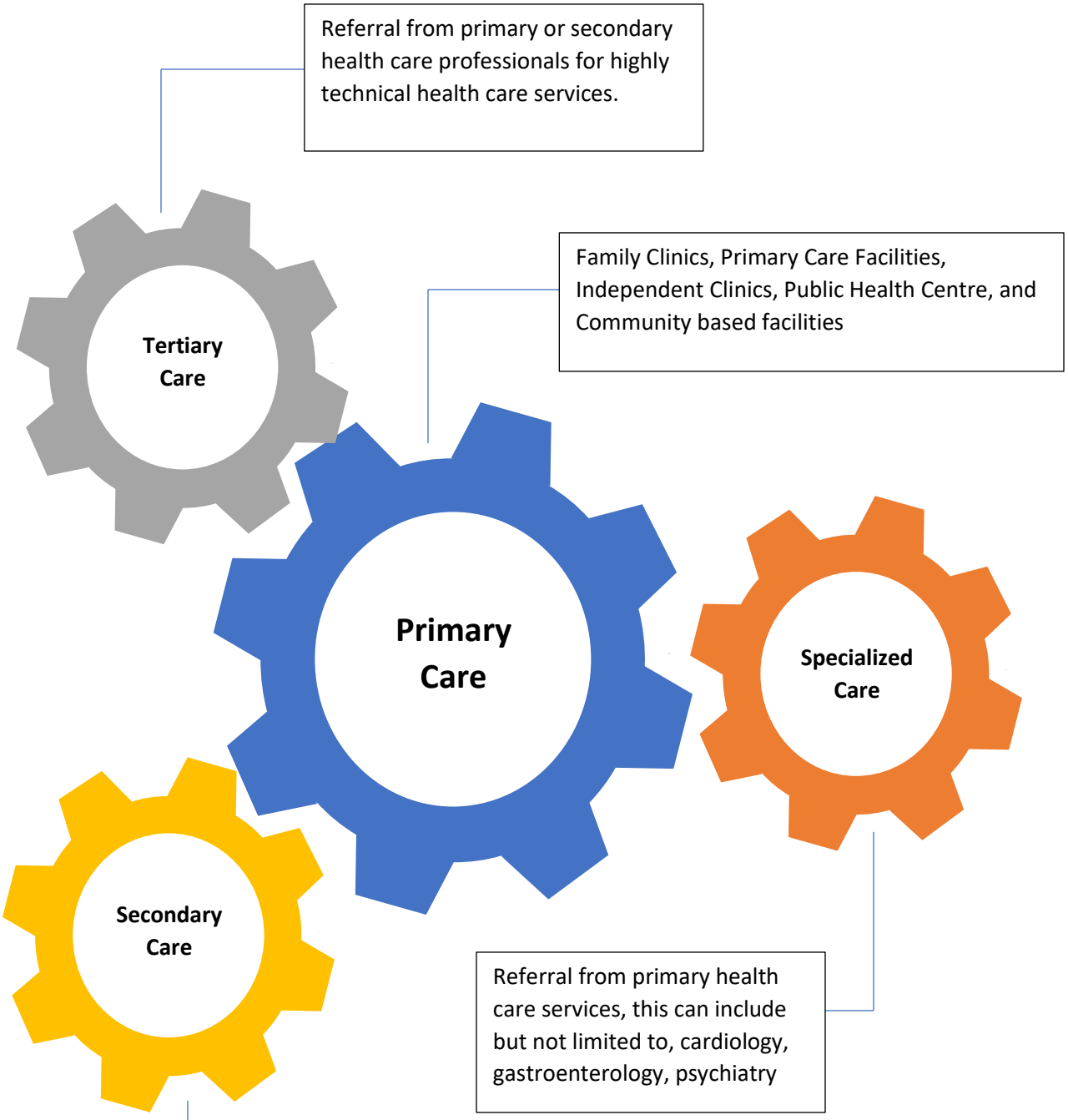
Specialized health care is often centered within major urban centers and require larger distances of travel for geographically remote patients.

- Referral from primary or secondary health care services, this can include but is not limited to, cardiology, gastroenterology, psychiatry…

Tertiary Health Care:

Tertiary health care will typically be located within medical schools or teaching hospitals where specialists reside for the treatment of rare conditions.

- Referral from primary or secondary health care professionals for highly technical health care services like advanced diagnostics.


Referral from primary or secondary health care professionals for highly technical health care services.
Tertiary Care
Family Clinics, Primary Care Facilities, Independent Clinics, Public Health Centre, and Community based facilities
Primary Care
Specialized Care
Secondary Care
Referral from primary health care services, this can include but not limited to, cardiology, gastroenterology, psychiatry
In-patient services
Emergency care services
Medical or surgical treatment services
Diagnostic laboratory and medical imaging services
Acute mental and physical health assessment

Advocacy Categories

The challenges of our local health authority in some ways are systemic, and yet individual in other ways. To further understand the complexity of the issues, one does not have to look much further than the Canada Health Act and the responsibilities of all levels of government as described within the Act.

The Canada Health Act's primary objective, as identified under section 3, is "to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The purpose of the Act is to provide the criteria and conditions required within health care services, as described earlier in this document, provided under provincial law, so that the provinces may receive the Canada Health Transfer.

Fundamentally, if the province meets the (5) elements of criteria (as identified on page 29 of this document), they will receive full transfer of funds from the Canada Health Transfer process. This means that each provinces health care system is independent of each other with the only common ground being that they have all met the (5) elements of criteria.

This disconnect clearly identifies why research and studies conducted of the Canadian health care system rarely gain traction unless they are federally done and have the consensus of all the provinces and territories.

Despite a flawed system, consideration must be given to the impacts that this has on regional health authorities and the quality-of-life benefits this has on British Columbians. As identified within council workshops in 2020, the leading challenges can be addressed at the provincial level and therefore, the following discussion and recommendations are brought forward as advocacy work that the RMC can bring forward to government.

Recruitment and Retention

The Charter[1] in 2007 recognized that the family physician is the cornerstone of primary health care, as they are a part of a broader community network and professional team who provide health care services to the community. Likewise, the Nurse and Nurse Practitioners of British Columbia released a report in 2018, "Enhancing Rural and Remote Nursing Practices for a Healthier BC", that emphasizes the equally important role that nurses provide to primary health care - often the only available health care provider.

The College of Family Physicians of Canada in their 2004 study looked at the scope of family practices in rural and urban settings. Physicians face significant challenges in rural or more

dramatically, geographically remote communities compared to their urban counterparts and may be a piece of the challenges to attract physicians to rural settings - geography may be a deterrent.

A report published by the House of Commons on Labour and Skills Shortages in Canada: "Addressing Current and Future Challenges"[9] in 2012, recognizes the impact on the health care sector due to an aging population. This aging population is also noted within the British Columbia statistics as recently as 2018, in which the aging population was forecasted to represent approximately 25 percent of BC's population by 2031.

Emphasis on incentivizing family physicians to tele-conference with patients living in a facility or in the community with family, as part of the recommendations to improve care for frail elderly becomes a short-term solution to a labour shortage and still omits developing actionable plans that will encourage health professionals to look to rural communities as a place to establish a sustainable practice.

An aging population is a significant challenge and increases the demand for all forms of health care workers, with geographically remote communities further amplify this challenge. The inability to attract physician, nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists, and many other health professionals and non-government organizations who work as a team with patients and their extended families, reduces the quality of life and further impacts labour shortages felt in other sectors throughout the province.

While an aging population creates more challenges to a stretched health care system, it, is not the driver of recruitment and retention. As noted earlier in this review, many geographically remote communities are resource communities that drive the provincial economy and while we may work as a Province to become a carbon-neutral economy, these communities and the need for health care will remain equally as high in this transition. This then means, solutions should be sustainable and relevant to individual locations.

The Canadian Alliance for Sustainable Health Care (CASHC) released a report in November 2018, "Principles of Sustainable Health Care"[10] that states, "influences to health care sustainability is related to human resources, inequalities, safety, citizen's trust and confidence, productivity, and societal expectation."

The province, in many of their reports, note that there is great potential in primary health care to improve the health of the population, supporting statements like CASHCs, however, it only references that the solution is to work together. Working together is articulated by the point that they note needing to co-develop strategic direction based on capturing the activity, experimentation, and successes of past years, however, results of this collaborative approach are

not being widely recognized as attracting and therefore, retention remains a significant issue that impacts access.

Supporting the retention concerns of physicians in geographically remote or rural communities is that of nurses. In a report: "Nursing Practice in Rural and Remote Canada", found in the CIHI's Nursing Database, June 19, 2004[11] and supported by recent work completed by the University of Northern British Columbia: "The Importance of Organizational Commitment in Rural Nurses Intent to Leave", January 24, 2020.[12] Rural nurses represent 6.7% of the provincial workforce and service 12.4% of the provincial population while urban nurses represent 93.3% of the workforce and service 87.6% of the provincial population. Compounding this disproportion and complicating retention concerns is the higher percentage of nurses occupying casual positions compared to their urban counterparts.

It is important to recognize that while this may fluctuate based on health authorities hiring practices, nurses face uncertainty of full-time employment in rural communities while physicians are faced with an excessive workload in rural communities, both equal deterrents to working in geographically remote or rural communities.

There is a direct correlation between quality of life and labour force retention in all sectors and as health care is a fundamental social service that British Columbians rely on, this challenge becomes more critical and unique, and further compounds labour force retention in other sectors. This further demonstrates the interconnectivity within the system and its relationship and influences with other sectors and supports a recent article by the National Post on October 20, 2021, *"Canada doesn't know how bad its doctor shortage is, let alone how to fix it"*. Dr. David Peachey of Health Intelligence Inc. and Dr. Katherine Smart of the Canadian Medical Associations both provide comments of the challenges and suggest that the system itself may in fact be at the root of solving the challenges.

Recommendations

The following recommendations while not exhaustive of each specific issue that may be found through a community-to-community review, are a first step at improving recruitment and retention concerns in primary health care. In addition, these recommendations would improve most access to health care concerns, by providing adequate levels of staffing throughout the region.

1) **Incentivizing Health Care Professionals:** Policy change that encourages physicians and nurses to take on practices within under-served areas and regions would improve access and reduce major cause of death, disorders, and disparities in health care across major population subgroups. This argument is supported by work done by Barbara Starfield[5]. Incentivizing the opportunity is as relevant within the healthcare sector as it is with any

professional services required in the under-served regions and therefore, consideration must be given to a concern of work-life balance and access to amenities rather than increased monetary incentives.

Work-life balance is about creating and maintaining supportive and healthy work environments, which will enable health care professionals to have a balance between work and personal responsibilities to their family and community and this strengthens their loyalty and productivity.

Insufficient staffing levels create challenges to work-life balance due to the need for current staff to work longer hours, impacting the work-to-family balance. Health care is not alone, industry struggles with this as well and some have found solutions that may be applicable to making rural health care retention a little more attractive. Whether this is as simple as the provision of childcare services, or as complex as improving staffing levels to prevent staffing shortages, options must be considered and implemented to preserve the work-life balance.

Amenities not only provide incentive to healthcare professionals and their families, they provide economic opportunities for community growth and development. This enrichment of a community further strengthens the work-life balance for multiple sectors while improving investment and access to health care. By closing the gap between perceived career opportunities for urban verses rural physicians and nurses, it helps to support an attractive opportunity for career development.

As part of achieving a positive work-life balance and access to amenities, education challenges need addressing through better supports systems like connectivity, facilities, and community centric work cultures. Policy change to aggressively advance these supports is required by government in partnership with communities and therefore, supports the need for community-based health care as part of the current system.

2) **Workplace Culture:** Work culture has an impact on attracting and retaining staff regardless of the workplace. This culture will also determine the ability of the workplace to improve engagement and satisfaction amongst its staff, which in-turn improves performance. This is led by a strong and effective leadership team that communicates and interacts with their team effectively by focusing on vision, celebrating, and recognizing accomplishments, strategic and effective decision-making, and earning trust and the beliefs and perceptions they reinforce.

Going beyond the leadership team, the management structure, workplace practices, policies, the people, the mission, vision and values of the organization, work environment, and communications are all equally important to a positive work culture.

3) **Educational Supports:** Establishing opportunities for continuous educational supports and advancements that allow for health care professionals to advance their careers, either through onsite learning or sabbaticals with support mechanisms that prevent loss of services to the community and retain the physicians or nurse's seniority.

   The facilitation of this opportunity requires a need to maximize staffing levels to support healthcare professionals looking to advance or further develop their skill sets, allowing participation without a sense of letting done their co-workers due to their absence.

4) **Career Advancement Opportunities:** Providing a career opportunity through improvements to the educational structure that would encourage and support access to primary health care through the development of career opportunities, rather than providing only an education. In partnership with municipalities and Indigenous communities, a career opportunity can improve access and retention issues within geographically remote communities and promote a sense of ownership.

   Supporting this through province wide connectivity provides access to these programs while also improving local economic opportunities. The development of a province wide program that is comparable to that of a major urban center will also work to narrow the gap between urban and rural settings.

Accessibility to Effective Health Care

Timely access to health care or, '*Patients should receive accessible, appropriate, efficient, effective, safe, and quality care at the right time in the right setting by the right provider'* is a significant concern that affects many areas of the health system, including primary health care. There have been studies completed by the College of Family Physicians of Canada (CFPC)[4] that suggests that when people cannot find a family physician, they become more vulnerable and less satisfied with the system. This study has also identified that the under-served populations have disproportionate difficulties in access, this includes those living within rural and geographically remote regions.

"Timely access" to health care is often perceived differently depending on the geographical location of a community. Therefore, establishing the "timely access" must be driven by community and not by region. This creates its own set of challenges and supports the re-introduction of community-based healthcare throughout the province.

Geographically remote or rural communities throughout British Columbia, and more specifically within the Northern Health jurisdiction, are generally resource-based communities that provide economic stability for the province. The economic spinoff of resource communities within northern BC are upwards of 840 jobs provincially per 100 jobs in the resource sector. This input into the provincial economy is disproportionate to any other economic drivers within the province, however, does not influence the Northern Health care system in a positive way, nor does the impact of a forecasted 1.3% population growth within the northeast corner of the province.

Despite resource communities positive influence on the provincial economy, these communities also have significant challenges to other segments of the social service structure. Access or perceived lack thereof, to health care influences other health care needs like mental illness, maternity care, chronic disease prevention, care for the elderly, and end-of-life care.

With 60% of the population residing within the lower mainland, it often creates challenges to amplify the needs of the northern region as it represents 70% of the land base but, the least density of population at 6.7%. This disproportion significantly influences the urban/rural divide that then challenges perceived levels of service or in this case "timely access".

While we are not suggesting that policy has been developed based solely on a density framework, it most certainly has influence. The recognition of geographical challenges was commented on within the Maternity Care Enhancement Project of 2004, in which it stated,

"*BC has a population of 4,196,383 million people; however, the population is unevenly distributed as the majority of people reside in the southwestern portion of the province, mainly clustered around the Lower Mainland, the Okanagan and the southern tip of Vancouver Island. The rest of*

the province has a low population density with a widespread scattering of small and remote communities, including extremely small Aboriginal communities, throughout the eastern and northern regions where due to the terrain, severe weather conditions can impede on transportation and limit access to health services. The delivery of maternity care services in BC must be examined against this diverse, geographical setting. Given the geographic challenges, it is difficult to ensure equity of access to acute maternity care services in rural and remote areas. Stakeholders participating in this process were forthright in suggesting that a realistic approach must be taken to provide women and their families with a women centered service while in light of women's preferences, safety, the availability of providers and the availability of transportation for both routine and emergency situations in these diverse geographical conditions."

Enhancing or improving the "timely access" to health care must recognize the influence of recruitment and retention of a health care workforce. Noted within a CFPC report, "Scope of family practice in rural and urban settings" completed in 2004, that rural doctors tend to provide a significantly increased variety of services compared to their urban counterparts, often with less support systems, and while we consider the influencers of attracting physicians to geographically remote communities, geography may in fact be the significant deterrent, not money. This deterrent further amplifies the ability to provide "timely access" to health care. These noted remarks are also supported by work completed by the Nurse and Nurse Practitioners of BC in 2018, "Enhancing Rural and Remote Nursing Practices for a Healthier BC" in which they note that nurses are often the only health care provider and do not have the same access to support as their urban counterparts.

The requirement to provide a significantly increased variety of services in rural communities has significant impacts to mental health concerns for health care workers and their families and therefore, requires a social service framework that can provide the supports required to maintain a healthy health care worker community.

This difficulty of access becomes more prominent with people living with mental illness and/or addictions as the primary health care community is over-burdened with relatively non-urgent symptoms in emergency rooms across British Columbia. Access becomes impacted due to availability of physicians, nurses, and associated support health staff to manage this scenario. As noted with a Commonwealth Fund survey[6], "health care systems which are unable to provide same day access to physicians would experience higher non-emergency, emergency room access." Without a breakdown of specific provinces, Canada was seen as having the lowest rate of same day access of all countries surveyed. This survey is supported with data provided by a National Physicians Survey[7] on mental health care, that noted that 66% of family practitioners rated accessibility as fair or poor.

These concerns of access are further amplified within a report completed in 2004 through the Maternity Care Enhancement Project[8] which identified concerns raised by stakeholders, of which

recognizing that maternity services must be appropriately flexible to meet the needs of people and geography of British Columbia, whether those services are situated in Fort Nelson, Kamloops, or Vancouver. The project further identified that stakeholders felt a one-size fits all practice model would not work for all communities. Maternity care models need to offer flexibility to create local solutions while respecting local capacity and resources.

Further concern on access is supported through the BC Chamber of Commerce policy paper on equitable Medivac services for all British Columbians, in which they cite, access to health services and/or Medivac services help attract and retain businesses and industry – a vital part of economic development. The policy also references a lack of follow through in the provision of health care services for residents once access has been achieved. Specifically noting issues where patients are release with insufficient means to return home to their community.

While the RMC respects that the geographical challenges are significant and are unique to each individual community, we believe that access to appropriate health care is critical to the quality of life for all British Columbians, and that, timely access is impeded by multiple factors that cumulatively hinder the implementation of the number one priority of the 2007's Primary Health Care Charter[1]. Thus, in harmony with previous recommendations brought before the Province in 2015 by the Provincial Health Care Strategy "Primary and Community Care in BC: A Strategic Policy Framework"[2], the RMC puts forward the following recommendations:

Recommendations

The following recommendations while not exhaustive of each specific issue that may be found through a community-to-community review, are a first step at improving access to primary health care. In addition, these recommendations would improve access to more local maternity care, access to specialists, sustainable delivery of mental health and addiction services, and improve support care for elderly outside the hospital environment.

5) **Mapping Data to Identify Inequalities and Gaps:** Maintain current and relevant mapping data that identifies inequalities and gaps related to access to primary health care based on geography and primary economic drivers, while maintaining current and relevant policy to support improved access to health care. The policies implemented should be flexible and create local solutions while respecting local capacity and resources by working with communities directly.

   The mapping data should identify existing gaps as it relates to services provided on a community-to-community structure that acts as a benchmark for future development and improvement. To support this, a minimum standards criterion must be established based on a per capita approach, identifying and actioning strategies needed to raise each community to the base level.

Policy and process development that reflects local solutions, local capacity, and local objectives as they relate to distances of access for primary health care, secondary health care and specialized health care. Policy and process should reflect patient needs beyond the confines of a medical facility and its locale.

6) **Recruitment to Rural and Remote Communities:** Encourage physicians and nurses to take on opportunities within under-served communities and regions by providing specific rural supports to balance inequalities found between urban and rural settings.

   Policy change developed to encourage physicians and nurses to take on opportunities within under-served areas and regions would improve access and reduce major cause of death, disorders, and disparities in health care across major population subgroups. This argument is supported by work done by Barbara Starfield[5]. Incentivizing the opportunity is as relevant within the healthcare sector as it is with any professional services required in the under-served regions and therefore, consideration must be given to a concern of work-life balance and access to amenities rather than increased monetary incentives.

   Utilizing the mapping data that identifies service gaps, physician and nursing capacity will also be identified. The identified capacity must factor in allowances for career development by physicians and nurses, providing opportunities to access development opportunities will further diminish the urban/rural access to services or opportunities concerns. This function requires an insertion of government as many rural or geographically remote communities fail to provide basic services to accommodate access to services for physicians and nurses.

   Workplace culture must be identified as a priority to improve retention of physicians and nurses within under-served communities and regions. A positive culture improves the opportunity to provide basic levels of services as prescribed within the community base level of service requirement and has a positive influence on mental health challenges within the sector and improves work-life balance.

7) **Provincial Support System for Health Care Workers:** Access to health care creates challenges and mental health issues associated to the sector must be addressed by developing a province wide support system for physicians, nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists, and many other health professionals and non-government organizations who work as a team with patients and their extended families. This program must address and provide mitigating opportunities equally throughout.

As current global challenges have amplified, many health care professionals have seen excessive stress levels, further amplifying the deficiencies within the sector. Communities have raised awareness and worked to support their local health care providers; however, this must be supported by workplace culture and government involvement.

8) **Collaborative Community-Based Approach:** Policy changes that recognize diversity and make community a part of the health care service delivery by providing transparent discussion and inclusion of decision processes while demonstrating the social service benefits of these partnerships.

   This policy must contain flexibility to implement effective and relevant impact to individual communities and strongly recommended to not follow a “one-size fits all approach”.

   Community based approach further supports the ability to develop effective community base levels of health care services and supports to the health care system and local community.

Mental Health and Addictions

In 2004, 18% of family practitioners surveyed in a National Physician Survey reported that at least 10% of their patient population was composed of patients with chronic mental illness. Additionally, 52% of family practitioners noted that accessibility to support services were fair to poor and 34% of specialists confirmed that statement.

While this review is not meant to delve into the specifics of mental illness, it is important to recognize examples of mental illness as they are compounded by existing concerns within our current medical system. As noted earlier, those suffering from mental illness are more prone to increased effects due to the stress of access to primary health care.

Mental illnesses are characterized by alterations in thinking, mood and behavior associated with significant distress and impairing functioning. Examples of specific mental illness include:

- Mood disorder: major depression and bipolar disorder,
- Schizophrenia,
- Anxiety disorders,
- Personality disorders,
- Eating disorders,
- Problem gambling, and
- Substance dependency.

Mental illness arises from a complex interaction of genetic, biological, personality and environmental factors, and does not discriminate, it affects people of all ages, education levels, income levels, and cultures.

Mental illness currently remains as the most widely under-reported impact to our health care system as reported by Saloni Dattani, Hannah Ritchie and Max Roser in a paper released in April 2018 and then updated in August 2021 by the University of Oxford[13] called "*Mental Health*".

The determining factors of onset and severity of mental health are complex, and they rarely can be contributed to a single factor. Identifying potential risk factors can help to prevent mental health issues in some cases – social supports, meaningful employment, adequate income, physical activity, and an internal locus of control.

As individuals move through what is often referred to as "life-course", risk factors and influencers on mental health vary significantly. A forecast of 25% growth in BC's aging population will increase demands on mental health care, as an aging population is a notably higher risk of poorer mental health and increased decline in physical health. As noted, access becomes more prominent with people living with mental illness and/or addictions as the primary health care community is overburdened with relatively non-urgent symptoms in emergency rooms across

British Columbia. Access becomes impacted due to availability of physicians, nurses, and associated support health staff to manage this scenario at a clinic level.

When looking at the impact of mental health on health care professionals, we must recognize multiple influences like the stress of work culture, work-life balance, physical demands, and often under recognized influencers like, education level, employment status and life satisfaction. These influences can easily be seen in other sectors across the province, however, if the system that supports the well-being of British Columbians is not well, then all other sectors are impacted.

Recommendations

The following recommendations are reflective of earlier comments and emphasize the connectivity between mental health and the ability to provide effective health care services. These recommendations are a first step at improving mental health concerns noted within this review.

9) **Recruitment and Retention to Under-Served Communities:** Policy change that encourages physicians and nurses to take on practices within under-served areas and regions would improve support systems and early diagnosis of mental health concerns.

   Through policy, government can create and maintain supportive and healthy work environments within the health care sector and community, which will enable health care professionals to have a balance between work and personal responsibilities to their family and community while strengthening their loyalty and productivity, which improves their mental health and increases access to primary health care related to mental health issues for the community.

10) **Provincial Mental Health Support System for Health Care Workers:** Improve access to health care through sustainable recruitment and retention programs that positively influence access for community on a community-by-community basis, and by developing a province wide mental health support system for physicians, nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists, and many other health professionals and non-government organizations who work as a team with patients and their extended families. This program must address and provide mitigating opportunities equally throughout.

11) **Mental Health Support Access Post-Pandemic**: Provide access, virtual or in-person, at existing or greater levels than those provided in response to the province's management of the COVID-19 pandemic, recognizing that the impacts of the global pandemic will influence the mental health of British Columbian for many years to comes following the de-registering of the pandemic.

In addition to the psycho-social stressors of not having access to social supports, and the long-standing influences of a pandemic, those seeking access to services are further impacted should those services require time away from home.

Conclusion

Health care in British Columbia currently reflects the disconnect within the Canadian Health Care System and does require a deep evaluation of its ability to deliver the services it is committed to currently. This monumental challenge will inevitably pit province against province and provinces against the federal government, however, if we are to see "our" right to equitable access delivered in the context of the Canada Health Act, this needs to occur.

Without making to lofty of a goal, as a province, we can work to restore an equitable health care system by addressing the concerns raised by many communities throughout the province, and as in this review, lets focus on Northern Health.

As noted earlier in this review we asked - why does the issue of equitable access to primary health care still exist after 15 some years of both government and private sector research and reviews? While the question is simple enough to understand, the solution is of significance, as this issue of access is directly connected to a challenge faced in every sector of the province – recruitment and retention of a skilled workforce.

The current pandemic has amplified a growing concern that our skilled workforce is no longer coming from within and is heavily augmented by immigration. Simply put, British Columbians are not procreating near enough to support the growth and demands of our province.

When considering the shift of that population from rural regions to urban centers because of a demand for services that once were offered within the rural setting - like industry, health care's ability to recruit and retain professionals revolves around a fragile work-life balance. Remembering that individual perception of work-life balance is not viewed in the same light by each individual applicant for positions in rural communities.

Monetary incentives are encouraging to some, while not to others. Being able to take a five-minute drive to your favorite fishing hole is enticing to some, it's inconsequential to others. There are those that look for the quiet and laid-back lifestyle while other want it but, only if they have access to the amenities of a larger urban center.

These issues impede industry's and health care's ability to recruit skilled professionals and while we note that "if our youth are trained locally, they tend to stay locally", this raises concern that if we're challenged to recruit skilled professionals to the sectors, then how do we attract the skilled academics to train our locals?

Recruitment and retention is seen as an individual organizations issue, and often is attributed to low wages and remoteness of the work within rural and remote communities, however, regarding health care as a basic human right, it becomes a political challenge. Within the last decade, the province has retracted community-based health care frameworks to a regional

framework and while the region is to consider the community concerns and challenges, perception is that the community is not being listened to.

Rural and remote communities are the economic backbone of any provincial economy, as they often are resource centric and provide the energy, food security, and materials needed to sustain consumer demand within the economy. These communities understand the challenges associated with recruiting skilled labor to their regions and recognize that often their success is based on focused recruitment campaigns and existing work cultures.

The recommendations given with this review are not solutions to the underlying cause of our concerns within Northern Health, however, they do provide a basis from which we would be better equipped to identify issues proactively and better support the existing skilled professionals and better position the region again as a place to develop your career.

Background: Overview of Canada's Health Care System

Evolution of Our Health Care System

In general, Canada's Constitution sets out the powers of the federal and the provincial and territorial governments. Under the *Constitution Act*, 1867, the provinces were responsible for establishing, maintaining, and managing hospitals, asylums, charities and charitable institutions, and the federal government was given jurisdiction over marine hospitals and quarantine. The federal government was also given powers to tax and borrow, and to spend such money if this did not infringe on provincial powers. The federal Department of Agriculture covered federal health responsibilities from 1867 until 1919, when the Department of Health was created. Over the years the responsibilities of both levels of government have changed.

Before World War II, health care in Canada was, for the most part, privately delivered and funded. In 1947, the government of Saskatchewan introduced a province-wide, universal hospital care plan. By 1950, both British Columbia and Alberta had similar plans. The federal government passed the *Hospital Insurance and Diagnostic Services Act* in 1957, which offered to reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services. This Act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions. Four years later, all the provinces and territories had agreed to provide publicly funded inpatient hospital and diagnostic services.

Saskatchewan introduced a universal, provincial medical insurance plan to provide doctors' services to all its residents in 1962. The federal government passed the *Medical Care Act* in 1966, which offered to reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals. Within six years, all the provinces and territories had universal physician services insurance plans.

From 1957 to 1977, the federal government's financial contribution in support of health care was determined as a percentage (one-half) of provincial and territorial expenditure on insured hospital and physician services. In 1977, under the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, cost sharing was replaced with a block fund, in this case, a combination of cash payments and tax points. A block fund is a sum of money provided from one level of government to another for a specific purpose. With a transfer of tax points, the federal government reduces its tax rates and provincial and territorial governments simultaneously raise their tax rates by an equivalent amount. This new funding arrangement meant that the provincial and territorial governments had the flexibility to invest health care funding according to their needs and priorities. Federal transfers for post-secondary education were also added to the health transfer.

In 1984, federal legislation, the *Canada Health Act*, was passed. This legislation replaced the federal hospital and medical insurance acts, and consolidated their principles by establishing criteria on portability, accessibility, universality, comprehensiveness, and public administration.

The Act also added provisions that prohibited extra billing and user fees for insured services (see this brochure's section on the federal government for further details).

Federal legislation passed in 1995 consolidated federal cash and tax transfers in support of health care and post-secondary education with federal transfers in support of social services and social assistance into a single block funding mechanism, the Canada Health and Social Transfer (CHST), beginning in fiscal year 1996-1997.

An agreement on health reached in 2000 by the federal, provincial, and territorial government leaders (or first ministers) set out key reforms in primary health care, pharmaceuticals management, health information and communications technology, and health equipment and infrastructure. At the same time, the federal government increased cash transfers in support of health.

In 2003, the First Ministers agreed on the *Accord on Health Care Renewal*, which provided for structural change to the health care system to support access, quality, and long-term sustainability. The *Accord* committed governments to work toward targeted reforms in areas such as accelerated primary health care renewal; supporting information technology (e.g., electronic health records, telehealth); coverage for certain home care services and drugs; enhanced access to diagnostic and medical equipment; and better accountability from governments.

Under the Accord, federal government cash transfers in support of health care were increased, and the CHST was split into the Canada Health Transfer for health and the Canada Social Transfer for post-secondary education, social services and social assistance, effective April 2004.

Further reforms were announced by the First Ministers in *A 10-Year Plan to Strengthen Health Care* in 2004. The federal, provincial, and territorial governments committed to a health care renewal plan that included work toward reforms in key areas such as: wait times management; health human resources; Aboriginal health; home care; primary health care; a national pharmaceutical strategy; health care services in the North; medical equipment; prevention, promotion, and public health; and enhanced reporting on progress made on these reforms. To support the Plan, the federal government increased health care cash transfers including annual increases to the Canada Health Transfer from 2006-07 until 2013-14 to provide predictable growth in federal funding.

In spring 2007, all provinces and territories publicly committed to establishing a Patient Wait Times Guarantee in one priority clinical area by 2010 and to undertaking pilot projects to test guarantees and inform their implementation. A Patient Wait Times Guarantee is the offer of alternative care options (e.g., referral to another physician or health care facility) to patients whose wait times exceed a defined timeframe when medically necessary health services should be provided.

The Role of Government

The organization of Canada's health care system is largely determined by the Canadian Constitution, in which roles and responsibilities are divided between the federal, and provincial and territorial governments. The provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is also responsible for some delivery of services for certain groups of people.

Publicly funded health care is financed with general revenue raised through federal, provincial and territorial taxation, such as personal and corporate taxes, sales taxes, payroll levies and other revenue. Provinces may also charge a health premium on their residents to help pay for publicly funded health care services, but non-payment of a premium must not limit access to medically necessary health services.

There is more to health than the health care system. The responsibility for public health, which includes sanitation, infectious diseases, and related education, is shared between the three orders of government: federal, provincial/territorial, and local or municipal. However, these services are generally delivered at the provincial/territorial and local levels.

The Federal Government

The federal government's roles in health care include setting and administering national principles for the system under the *Canada Health Act*; financial support to the provinces and territories; and several other functions, including funding and/or delivery of primary and supplementary services to certain groups of people. These groups include: First Nations people living on reserves; Inuit; serving members of the Canadian Armed Forces; eligible veterans; inmates in federal penitentiaries; and some groups of refugee claimants.

The *Canada Health Act* establishes criteria and conditions for health insurance plans that must be met by provinces and territories for them to receive full federal cash transfers in support of health. Provinces and territories are required to provide reasonable access to medically necessary hospital and doctors' services. The Act also discourages extra-billing and user fees. Extra-billing is the billing of an insured health service by a medical practitioner in an amount greater than the amount paid or to be paid for that service by the provincial or territorial health insurance plan. A user charge is any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health insurance plan and is not payable by the plan.

The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer. To support the costs of publicly funded services, including health care, the federal government also provides equalization payments to less prosperous provinces and territorial financing to the territories.

Direct federal delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services

are readily available; community-based health programs both on reserves and in Inuit communities; and a non-insured health benefits program (drug, dental and ancillary health services) for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided at nursing stations, health centers, in-patient treatment centers, and through community health promotion programs. Increasingly, both orders of government and Aboriginal organizations are working together to integrate the delivery of these services with the provincial and territorial systems.

The federal government is also responsible for health protection and regulation (e.g., regulation of pharmaceuticals, food, and medical devices), consumer safety, and disease surveillance and prevention. It also provides support for health promotion and health research. In addition, the federal government has instituted health-related tax measures, including tax credits for medical expenses, disability, caregivers, and infirm dependents; tax rebates to public institutions for health services; and deductions for private health insurance premiums for the self-employed.

The five *Canada Health Act* principles provide for:

Public Administration: The provincial and territorial plans must be administered and operated on a nonprofit basis by a public authority accountable to the provincial or territorial government.

Comprehensiveness: The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting.

Universality: The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.

Accessibility**:** The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.

Portability: The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency services delivered outside their jurisdiction

The Provincial and Territorial Governments

The provinces and territories administer and deliver most of Canada's health care services, with all provincial and territorial health insurance plans expected to meet national principles set out under the *Canada Health Act*. Each provincial and territorial health insurance plan covers medically necessary hospital and doctors' services that are provided on a pre-paid basis, without direct charges at the point of service. The provincial and territorial governments fund these services with assistance from federal cash and tax transfers.

Medically necessary services are not defined in the *Canada Health Act*. It is up to the provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, to determine which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by the public health insurance plan to follow the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.

The roles of the provincial and territorial governments in health care include:

- administration of their health insurance plans;
- planning and funding of care in hospitals and other health facilities;
- services provided by doctors and other health professionals;
- planning and implementation of health promotion and public health initiatives; and
- negotiation of fee schedules with health professionals.

Most provincial and territorial governments offer and fund supplementary benefits for certain groups (e.g., low-income residents and seniors), such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision, and dental care, that are not covered under the *Canada Health Act*.

Although the provinces and territories provide these additional benefits for certain groups of people, supplementary health services are largely financed privately. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly (out-of-pocket), be covered under an employment-based group insurance plan or buy private insurance. Under most provincial and territorial laws, private insurers are restricted from offering coverage that duplicates that of the publicly funded plans, but they can compete in the supplementary coverage market.

As well, each province and territory have an independent workers compensation agency, funded by employers, which funds services for workers who are injured on the job.

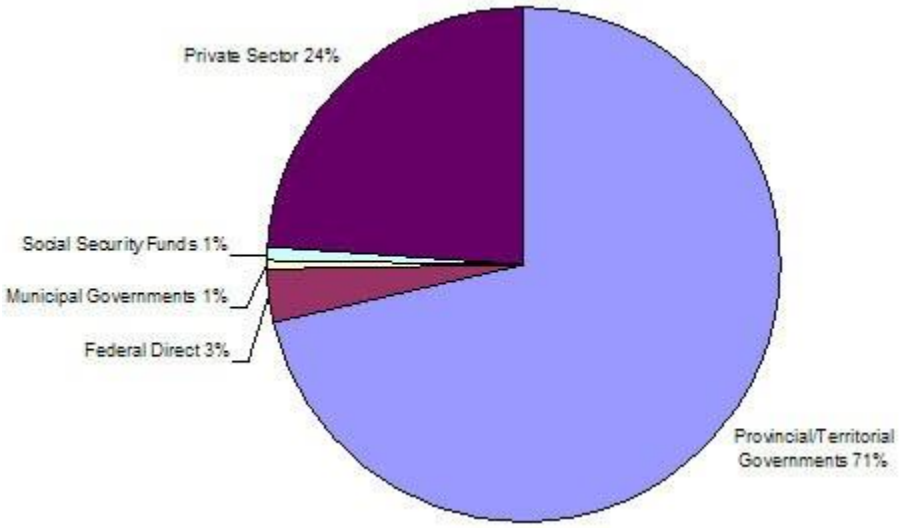
Health Care Expenditures

Within the publicly funded health care system, health expenditures vary across the provinces and territories. This is, in part, due to differences in the services that each province and territory covers and on demographic factors, such as a population's age. Other factors, such as areas where there are small and/or dispersed populations, may also have an impact on health care costs.

According to the Canadian Institute for Health Information (CIHI), in 1975, total Canadian health care costs consumed 7% of the Gross Domestic Product (GDP). Canada's total health care expenditures as a percentage of GDP grew to an estimated 11.7% in 2010 (or $5,614 CDN per person). In 2010, publicly funded health expenditures accounted for seven out of every 10 dollars

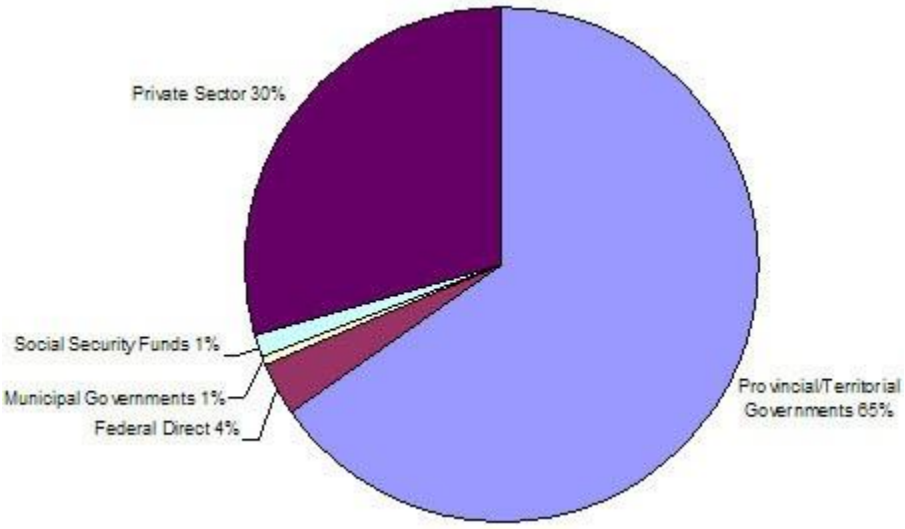
spent on health care. The remaining three out of every 10 dollars came from private sources and covered the costs of supplementary services such as drugs, dental care, and vision care.

Total Health Expenditures by Source of Finance, 1975



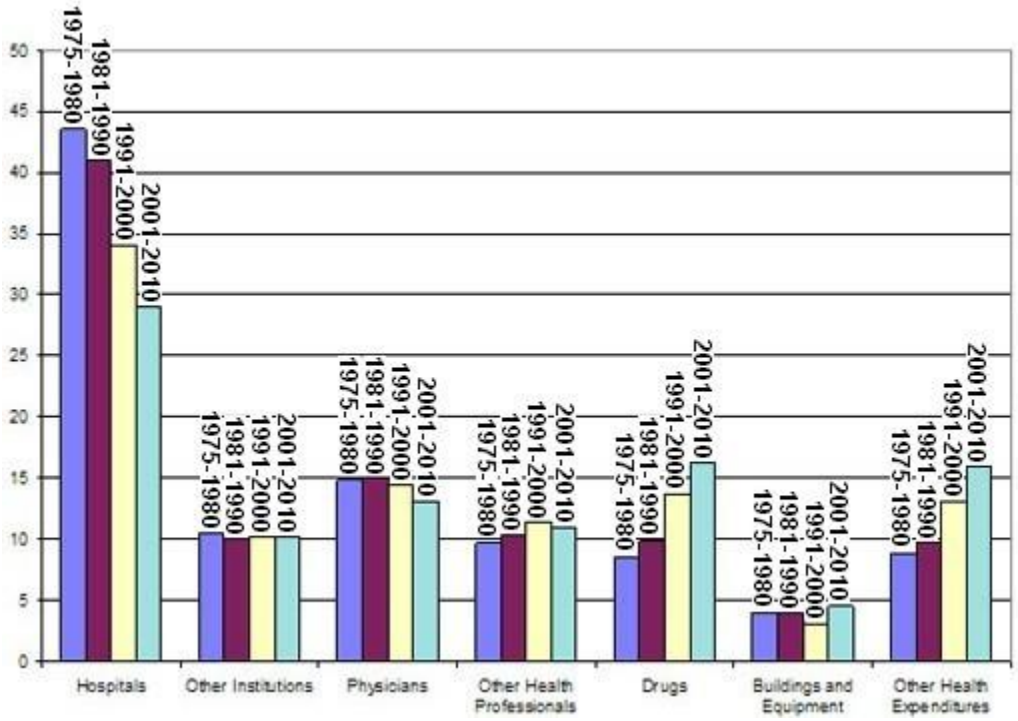
Note: Although the graph notes that provincial/territorial governments pay for 71% of health expenditures in Canada, the federal government supports provincial/territorial expenditures through fiscal transfers.
Source: Canadian Institute for Health Information. *National Health Expenditure Trends*, 1975 - 2010.

Total Health Expenditures by Source of Finance, 2010 Forecast



Note: Although the graph notes that provincial/territorial governments pay for 65% of health expenditures in Canada, the federal government supports provincial/territorial expenditures through fiscal transfers.
Source: Canadian Institute for Health Information. *National Health Expenditure Trends*, 1975 - 2010.

Total Health Expenditures by Use of Funds, Annual Average, 1975-2010



Source: Canadian Institute for Health Information. *National Health Expenditure Trends, 1975 - 2010.*

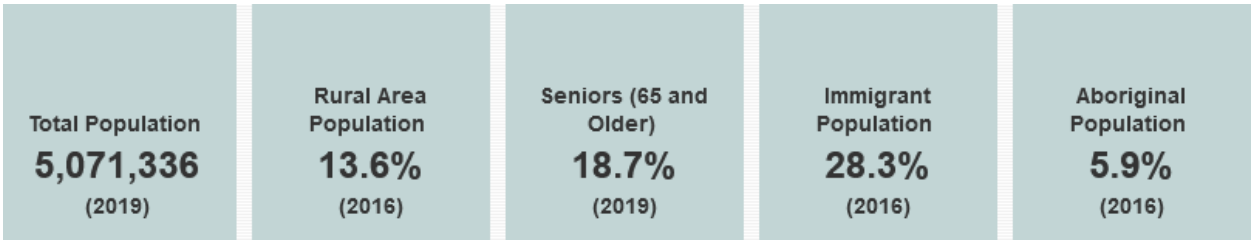
How health care dollars are spent has changed significantly over the last three decades. On average, the share of total health expenditures paid to hospitals and physicians has declined, while spending on drugs has greatly increased.

Though the share of health care expenditures accounted for by hospitals declined to 29% in 2010 from approximately 45% in the mid-1970s, hospitals continue to account for the largest share of health care spending. Spending on drugs has accounted for the second-largest share since 1997, making up 16% of spending in 2010. The third-largest share of health care expenditures is accounted for by spending on physicians, which made up 14% of spending in 2010.

Health Care Standards within British Columbia

A look at the health care system in British Columbia, through the reviewing of research work completed by government and private sectors, that influence today's state of health care services, forms the basis of understanding the complexity of our health care system in BC.

To shape the landscape in British Columbia, consideration must be given to the most recent data used to evaluate and forecast health care needs and trends.



This information is provided by the Canadian Institute for Health Information, www.cihi.ca.

The Primary Health Care Charter

In 2007, the Province of British Columbia developed the Primary Health Care Charter[1] (the Charter) that set out direction, targets, and outcomes to support the creation of a strong, sustainable, accessible, and effective primary health care system for British Columbia.

The completion of the Charter resulted in seven priorities being established:

1) Improve access to primary health care.
2) Increased access to primary maternity care
3) Increased chronic disease prevention.
4) Enhanced management of chronic diseases
5) Improved coordination and management of co-morbidities
6) Improved care for the frail elderly
7) Enhance end-of-life care.

These priorities are supported by the following principles and methods that define and reflect the work in and for British Columbia:

- Improving patient health outcomes will drive what we do.
- Patients and families assume the role of partners in their care.
- A population-based approach will ensure inequalities and needs are identified and addressed.
- We will re-orient health services to align with the patient's journey through patient-centered integrated health system.

- Family physicians are the cornerstone of primary health care. They are a part of a broader community network and professional team that includes nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists, and many other health professionals and non-government organizations who work as a team with patients and their extended families.
- Patients should receive accessible, appropriate, efficient, effective, safe quality care at the right time in the right setting by the right provider.
- Patients and their clinicians must receive key information to make informed decisions at the point of care, and decisions support also must be available for managing patient populations.
- We will implement the Expanded Chronic Care Model through structured collaborative approaches because this model has derived the best results in clinical improvement and system change in BC.

The Charter through the establishment of the seven priorities provided insight and recommendations that would support the advancement or improvement of these priorities, however, the advancement of the Charter faltered and the development of the 2015 Provincial Health Care Strategy "Primary and Community Care in BC: A Strategic Policy Framework"[2] policy paper, was completed to reenergize the commitment to achieve the vision of the 2007 Charter.

With the advancement and efforts to improve the health care system within British Columbia, several more reports were completed, since the development of the Charter, that included a policy paper in 2004, *"Supporting Local Collaborative Models for Sustainable Maternity Care in British Columbia"*, Maternity Enhancement Project, "*BC Health System Strategy Implementation: A Collaborative and Focused Approach*" in 2014, and University of Northern British Columbia: "*The Importance of Organizational Commitment in Rural Nurses Intent to Leave*", January 24, 2020.

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