

## EDITORIAL

# The North American section of Rural and Remote Health: the time has come!

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This editorial marks the inaugural issue of the North American section of *Rural and Remote Health*. It is the result of several years of negotiation and development to what we hope will increasingly become a forum for rural health researchers, clinicians and educators to discuss, present and demonstrate how rural plays out in their research, clinical work and educational settings.

For this Journal section, North America is defined as inclusive of Canada, the United States, Mexico, Greenland, Central America and the Caribbean. The 23 countries included in this vast geographical range are diverse in their governance, level of development, research funding opportunities, health status and health concerns, availability of education and types and numbers of healthcare professionals. This diversity can provide the North American section with a full spectrum of ideas, projects, educational programs and policy issues to be shared through articles,

commentaries and project descriptions and used as lessons learned for others involved in rural health issues.

Regardless of the specific country listed in our North American definition, there are several key issues shared by all:

1. What is rural?
2. What are the key health issues and concerns in rural areas?
3. What are the effective healthcare delivery models?
4. Who are the health care professionals and how are they prepared?
5. Are policies being developed that incorporate the uniqueness of 'rural'?
6. Who are the First Nations groups in rural areas?

Each of these key issues provides avenues for further discussion, as noted below.



The meaning of 'rural' is continually being debated and discussed. In many countries, the definition of rural is considered alongside the definition of remote. Rural tends to be a natural state whereas urban is the result of changes in orientation and organization related to increasing population density. Differentiating these terms helps gain understanding about how individuals see themselves in their world. The resurgence of linking place to peoples' health status begins with how they define themselves. Comparing and contrasting the meaning of rural within North America would be a useful beginning exercise to understanding this large geographic land mass with socioeconomic diversity.

Rural health status is often linked to geographic location because of the nature of employment, recreational activities, economics, and health status related to these areas. Culture, nutrition, vocations, avocations, and tradition shape health care. Generating information about health status and disease patterns among rural individuals and communities throughout North America is linked to the type of healthcare professional required within a specific type of healthcare delivery model demonstrating implementation of particular health policies. Injuries related to working in mines, on farms and within the fishing industry are often more easily understood than the reasons for specific patterns of illness and disease between and among rural women from one area of North America to another. It is time for this lack of understanding to be rectified.

Rural peoples also have a wide variety of relational patterns. These are different from one another, but often similar across the rural dimension. Relationships are often very different compared with urban populations, particularly in the densely populated areas around seats of government where most leaders and health professionals are trained. Attempting to raise awareness regarding important issues such as rural health, rural education, rural child development, and other critical areas is difficult when national leaders are born, raised, educated, and trained in top concentrations, have little contact even with relatively normal people, and have no common ground frame of reference to gain understanding. Healthcare concepts shift

dramatically from concentrations of specialists to a complete dependence upon Indigenous care, nursing, and primary care.

There is extensive discussion about the cost of health services and the need for effective healthcare delivery models. There is very little evidence about which specific models meet these criteria in rural areas. The differing health systems throughout North America with various funding mechanisms makes understanding and comparison of this issue complex and challenging but nonetheless important to comprehend. Many countries within our definition of North America lack basic health services and have developed their own means to address health concerns. These ideas also need to be recorded because of the valuable lessons learned that can be considered by other rural areas which are struggling with delivering effective health care.

Healthcare professionals are a significant and necessary component of the healthcare delivery system. Shortages of registered nurses and physicians have become worldwide. Given the shortages, which are often more acutely felt in rural areas, what are the initiatives to address the shortages? What are the challenges to recruiting and retaining healthcare professionals in rural areas? What, if any, programs and incentives work to address the shortages? Is there a need for 'special' educational preparation for healthcare professionals in rural areas? If so, what does it consist of and how can it be achieved? What types of other health professionals (such as traditional birth attendants or physician assistants) are emerging or are in existence to deal with health issues and challenges? Has their effectiveness been documented? Finally, how have the opinions and perceptions of rural residents been incorporated into such evaluations?

New perspectives are needed. Rural origins are often promoted as rural health solutions because rural-origin children have a higher probability of rural health career location; however, most rural services will be provided by urban-origin professionals. This is because even though urban-origin children are lower probability for rural location,



there are more of them and they are also more likely to gain admission. More studies documenting rural-origin advantages are not likely to help address rural health needs. More studies directed to understanding the types of trainees with urban origins that distribute rural at higher levels are needed. These are more complex studies. Rural origins are easier to track, compared with parent income, personal characteristics of trainees, or more sensitive areas.

Policies are often urbancentric, not taking into consideration the uniqueness of rural settings and their impact on the need for policy and how it can be successfully implemented. Translating research findings and knowledge gained from clinical practice in rural areas into useful information that will be accessed by decision-makers is an acquired skill. Such a skill is becoming increasingly important if rural needs are to be addressed through the development of appropriate policies. Locating key champions for rural issues within government and non-government agencies is a vital part of the policy cycle. Commentaries and letters shared by rural researchers, clinicians and policy makers that explicate these notions would be constructive for the North American section, so that others engaged in the knowledge translation and policy-making process become more informed.

First Nations, Native American, or Aboriginal peoples are greatly impacted on by patterns of urbanization. In addition, combinations of geographic, cultural, language and other differences have an impact on First Nations groups. Often

those most distant have been least impacted, but are also the most misunderstood. Despite the length of time that there have been interactions between healthcare professionals and First Nations groups, there remains a lack of comprehension about their cultural practices and health behaviors. Generally speaking, the health status of First Nations groups remains marginal or much poorer than mainstream populations. Solutions involve integration of existing health practices and practitioners with the more formal and highly regulated urbanized forms. Best practices to achieve improved health status while also enhancing health workforce capacity among these groups need to be developed and discussed in forums such as the North American section.

This editorial illustrates that there is much to be discussed and debated among those involved in rural health research, clinical practice and education within North America. Such discussions will add to the growing understanding and examination of rural health across the globe. There are often more opportunities than time allows, but we hope that our readers, authors and reviewers across North America will contribute to ensure that this new section is successful. We look forward to presenting a comprehensive view of what is happening in our geographic area.

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**Co-North American Regional Editors**  
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