Breaking the Cycle of Neglect: Strengthening Healthcare Access for Rural Communities in Alberta

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Neglect is an apt description of the attention and compassion given to rural communities across Alberta. In rural communities, cases of drug poisonings, mental health crises, suicide, HPV transmission, and chronic health conditions are all on the rise (Reilly, 2021). The lack of attention paid to rural healthcare has escalated from a problem to a crisis, resulting in a breakdown in the province's health care delivery system. The crisis strains Alberta's healthcare system, while rural communities report lower life expectancies compared to urban areas (Yangzom et al., 2023). The current healthcare delivery system is insufficient to meet the needs of rural communities. The paper provides individual accounts of how living in a rural community impacts one's health and wellbeing. In addition, the paper includes the thoughts of a rural Registered Nurse and their revelation of what reality can be in rural emergency centres. Healthcare is a human right regardless of the place you live. Alberta is a province that often boasts about its economic might and budget surpluses but rarely uses the resources to affirm the

right to healthcare in rural communities across Alberta. This paper provides a case study analysis and individual concerns, of how the situation developed over decades, what the current state of healthcare is in Alberta, and what we can do to move forward.

History of Rural Healthcare in Alberta

The Origins of Rural Healthcare Challenges in Alberta

Since its establishment in 1905, Alberta has been a province where residents relied on one another for survival. Early European settlers often turned to the knowledge of their elders, particularly mothers and grandmothers, for health treatments. At that time, Alberta's understanding of healthcare was described as being at an elementary school level (Alberta Bureau of Public Health, 1925). Due to the remoteness of many communities and a shortage of medical professionals, healthcare services and infrastructure were limited, and rural areas were often overlooked. This neglect laid the foundation for long-standing disparities in rural healthcare. As a result, early Albertans had to depend on home remedies such as berries and roots to treat various ailments. The knowledge passed down through generations enabled settlers to treat minor wounds by making their own salves—topical ointments made from beeswax and herbs for skin conditions (National Museum of

American History, n.d.). They also learned to set broken bones to promote healing (Alberta Bureau of Public Health, 1925).

The leading causes of death among Albertans during the early days of Alberta was Influenza, Pneumonia, and violent means (McLaren et al., 2024). This data was collected by the Department of Agriculture, as this was the department tasked with collecting vitals statistics. During the period of 1910-1930, communicable diseases posed a great threat to Albertans' health. Communicable diseases were decimating communities, and with the onset of the 1918/1919 Influenza pandemic it resulted in the deaths of over 4300 Albertans (McLaren et al., 2024). It was after the Influenza pandemic that the Alberta Government established the Department of Health. A change occurred after 1919, as communities provided waterworks, sewage and immunization services to the population, the leading causes of death among Alberta's switched from communicable diseases to a less transmissible form of death. In the 1930's, diseases of the heart and cancer surpassed communicable disease as the leading cause of death among Albertans, and have remained the dominant causes of death to the present day (McLaren et al., 2024).

In the early 1920s, Alberta faced a persistent shortage of physicians. The shortage was caused by the high demand needed during WWI to aid in the war effort in Europe and to care for

Alberta's rapidly growing population. This gap in medical care allowed for an emerging healthcare profession—Nursing—to take on a crucial role in providing healthcare to those living in rural and remote areas. Established in 1919, the District Nursing Service was a group of nurses who provided both nursing and limited medical care to residents living more than 60 miles from the nearest railway station (Franchuk, 2020). The district nurses of the time worked under a much larger scope of practice compared to the nurses of modern day. The nurses were authorized by the Public Health Nurses Act of 1919 to provide services including midwifery, dispense medications, and make diagnoses, while working under a physician (Franchuk, 2020). These nurses were instrumental in bringing healthcare to isolated communities and were often the only healthcare providers for miles. Despite their importance this essential service was inexplicably discontinued with the implementation of Medicare in the 1970s (Alberta Department of Health, n.d.).

1990's Budget Cuts

The 1990s were a transformative period for Alberta's healthcare system, driven by an economic downturn. After a considerable increase in the price of crude oil per barrel, climbing from around $30 per barrel in 1973 to over $150 in 1980 (Macrotrends, n.d). This surge in oil prices resulted in

economic prosperity for Alberta, however fortunes changed by the mid 1980's. From May 1980 to May 1986 the price per barrel of oil dropped by $112.79 (Macrotrends, n.d). This massive decline in oil prices resulted in economic hardships in Alberta, similar to other areas of Canada (Canadian Broadcasting Corporation, 2001). In response to the fiscal crisis, the Alberta government, under Premier Ralph Klein, introduced sweeping budget cuts as part of a broader effort to balance the provincial budget. One of the most affected sectors was healthcare, with funding for public health services slashed by a staggering 16% (Thomson, 2019). These cuts had wide-reaching and lasting consequences, particularly for rural communities that were already grappling with inadequate healthcare services.

While the province's urban centres had well-established healthcare infrastructure and resources, rural communities faced long-standing challenges in access to care. The budget cuts exacerbated these challenges. Small towns, which depended on local hospitals for essential medical services, saw a wave of closures and reductions in the scope of healthcare available. Rural hospitals, already understaffed due to the difficulty of attracting healthcare workers to remote areas, experienced even further reductions in personnel. As a result, many healthcare professionals—doctors, nurses, and other support staff—relocated to urban centres in search of more stable and higher-

paying opportunities. This migration created a deepening divide between urban and rural healthcare access, a gap that continues to be felt today.

In particular, the shortage of healthcare workers in rural areas meant that residents faced increasing difficulties in accessing even basic services such as primary care, emergency services, and specialist consultations. The closure of rural healthcare facilities compounded the isolation of these communities, making it harder for residents to access timely and effective care.

Current Day

In 2025, Alberta's healthcare system is in crisis. Rural areas in particular are facing significant challenges as the number of healthcare professionals available to serve these communities continue to dwindle. As the population ages, the demand for healthcare services has increased, and the lack of local care providers has only worsened the situation. Rural healthcare professionals are retiring at higher rates, and the inability to attract new talent has left a gaping hole in healthcare delivery. The lack of health services disproportionately impacts those over the age of 65. Statistic Canada (2023) reports 8.4% of Canadians over the age of 65 used home care services, and those 65 and older reported the highest rate of unmet home care

needs. It is expected that without immediate intervention, Alberta will soon lack the capacity to care for its senior population in the very communities they have lived in for decades (MNP LLP, 2021).

The situation is further compounded by the opioid epidemic, which has disproportionately affected rural communities. According to Pijl et al. (2022), the opioid crisis has been exacerbated in rural Alberta due to limited access to addiction treatment and mental health services. With fewer healthcare facilities offering specialized services, rural residents struggling with addiction often find themselves without necessary support systems. This lack of reputable and evidence-based treatment options has led to higher rates of overdose and addiction-related deaths in rural areas, making the opioid epidemic another pressing issue that rural healthcare systems are ill-equipped to address.

A Nurse's Perspective

As a third-year BScN student, I would like to dedicate a portion of this paper to the perspective of a Registered Nurse who has spent the majority of her career in rural healthcare. The following reflections are shared by Jean Smith, an RN and Nursing Instructor at Red Deer Polytechnic. Jean has a wealth of knowledge and experience in rural Alberta, having worked for

nearly four decades in various acute care roles in remote and small-town health centres. I had the privilege of learning from Jean during my six-week rural health clinical rotation at the Rocky Mountain House Health Centre, where her mentorship and insight deeply influenced my understanding of rural nursing practice. I am sincerely grateful to her for sharing her story and contributing her perspective to this topic.

As an RN who has worked in the rural acute care environment in a variety of capacities for nearly 40 years, I have experienced what it means when "I'm It" (Smith & Vandall-Walker, 2017, para. 31) due to lack of access to resources, but also how the rural team works together like family to provide patients the best care possible. For instance, when working one day in the emergency department (ED) during an extremely busy shift, the team was providing care for multiple high acuity patients requiring transport to a higher level of care by either ground ambulance or the Shock Trauma Air Rescue Service (STARS). We called for extra help from the registered nurses (RNs) on the acute care ward and of course they came to our rescue. Our ED team only consisted of two RNs, a Unit Clerk, and one physician. Given that we had no respiratory therapist, I was "It" providing airway support for a patient, while the other RNs worked with the physician providing the necessary treatments to stabilize the other patients. A second physician was

called and had arrived to assist the team. Even then, we required extra hands for safe patient care, so I willingly stayed beyond my shift to help. However, I also needed to pick up my children from school. Like family, one member of the Environmental Services team offered to retrieve my children from school and a physician who was not involved in the ED activities offered to look after them in the physicians' lounge (approximately two hours). The Environmental Services member also stopped by Tim Hortons bringing beverages for the entire ED team. We stabilized the patients as best we could and debriefed afterwards with nourishment provided by our friend. The patients were safely cared for and transported out. It was a good day! (Smith & Vandall-Walker, 2017)

Jean's account offers a vivid picture of the adaptability, dedication, and community spirit required in rural nursing. Jean sacrificing her personal time to go above and beyond her responsibilities as a RN, showcases the true dedication and commitment healthcare workers have for the communities they serve. Jean's example also underscores a broader issue: the increasing frequency with which RNs are required to take on responsibilities that extend beyond their traditional scope of practice due to staffing shortages and limited access to specialized services. While nurses are often trained in advanced skills such as airway management, these tasks are ideally

handled by professionals like respiratory therapists who specialize in that domain. The problem arises when such professionals are simply unavailable—leaving nurses to fill those gaps, often without additional compensation, time, or institutional support.

This growing expectation places significant stress on rural nurses and can contribute to burnout, moral distress, and workforce attrition. As the healthcare system continues to grapple with resource limitations, it is crucial to recognize the essential, multifaceted role that RNs play in rural settings. Furthermore we need to ensure RNs are adequately supported, trained, and staffed to meet these demands safely, so they can serve Rural and Remote communities to the best of their abilities.

A Rural Community Resident Perspective

While compiling this paper I wanted to include the thoughts and opinions of those who live in rural communities. For residents of rural communities, having a hospital nearby provides a vital sense of security. It reassures individuals that if the unthinkable happens—whether it be a sudden illness, injury, or medical emergency—help is not far away. Individuals across Alberta often feel a sense of comfort and ease when their community has a healthcare centre.

However, in many rural and remote areas, including Swan Hills, Alberta, this sense of security is rapidly eroding. The Swan Hills Healthcare Centre has been forced on more than once occasion to change its operating hours due to lack of physician services. Furthermore, many of the services the healthcare centre previously provided are not in use now as there are no qualified technicians to operate this equipment such as the X-ray machine.

To better illustrate the personal experiences of those living in rural communities, I posed two qualitative questions to residents of Swan Hills. Members of the community graciously answered my questions; their responses reflect sentiments echoed by many in similar rural communities.

Question 1: What has having a hospital in Swan Hills meant to you?

"Having a hospital in a small town like Swan Hills is everything. Being in a remote community, having a hospital where you can go to get medical attention is both practical and emotional. For many, it offers a sense of security and peace of mind, knowing that if something unexpected happens—whether it is an injury, illness, or emergency—a hospital is nearby to get immediate care. It is also an important economic anchor, providing jobs and services for the local population." — *Resident of Swan Hills*

Question 2: How do healthcare disruptions impact your life?

"Healthcare disruptions have a significant impact on life, especially when they create uncertainty or affect access to necessary care. It affects residents' emotional well-being, leading to stress, anxiety, and even fear about not getting the care needed in a timely manner. Healthcare disruptions mean traveling out of town for treatment or prescription refills. Travel expenses are another factor in healthcare disruptions." — *Resident of Swan Hills*

Another resident emphasized the stress of delayed emergency care, stating:

"It is very stressful, as when emergencies happen, help is over an hour away."

These responses clearly demonstrate the critical importance of local healthcare services in rural and remote communities—not only for physical well-being but for emotional and psychological health as well.

Hospitals also play a key economic role in rural communities by providing high paying and respectable jobs to the residents. Hospitals employ a wide range of professions, including physicians, nurses, lab technicians, and janitorial staff. When a hospital closes or operates below capacity, these professionals are often forced to seek employment elsewhere—

typically in more urban areas. As healthcare professionals and their families leave, this outmigration contributes to further population decline in rural areas. With shrinking populations, health facilities struggle to recruit and retain staff, creating a cycle of under-resourced care. One resident noted:

"Our hospital does not serve us and does not contain the necessary services that are tailored to the community of Swan Hills. The hospital has a birthing suite, but no babies have been born here in years."

The lack of accessible healthcare also places a burden on working residents. One individual shared:

"Having to take the whole day off work is a huge inconvenience for me. I have to take off an entire day just to access basic healthcare."

In summary, the absence or reduction of healthcare services in rural communities like Swan Hills impacts far more than just health outcomes—it touches every aspect of daily life, from employment and population stability to emotional well-being and economic productivity.

Indigenous Communities

Those living in Indigenous communities are particularly hard hit by the crisis unfolding in rural healthcare. The crisis grows more complex when we review the state of rural

Indigenous communities in Alberta. Beyond geographical location, Indigenous communities face additional barriers rooted in a long history of systemic racism and colonization. These are not abstract concepts, but real and ongoing forces that shape the lived experiences of Indigenous peoples. The result of systemic racism and colonization has fractured the fragile relationship that exists between Indigenous peoples and the healthcare system in Alberta and across Canada (Canadian Medical Association, n.d.). This historical trauma, compounded by present-day inequities, has fostered deep mistrust in a system that has often failed to recognize or respect Indigenous ways of knowing, being, and healing.

Access to care remains one of the most pressing issues. As many as 50% of First Nations, Métis, and Inuit individuals report not having access to a regular healthcare provider (Yangzom et al., 2023). Not having a primary provider means limited opportunities for early intervention, continuity of care, or preventative health services—gaps that can have devastating consequences. This is yet another disparity that exists for those of Indigenous heritage compared to non-Indigenous peoples. The consequences of this unequal access are reflected in health outcomes: Indigenous peoples experience significantly higher rates of chronic health conditions such as diabetes, heart disease, and respiratory illness, as well as disproportionately poorer

mental health statuses (Yangzom et al., 2023). These health inequities are not just medical concerns—they are indicators of social injustice.

Addressing the healthcare crisis in Indigenous rural communities requires more than just infrastructure and funding. It demands a culturally safe, trauma-informed approach that centres reconciliation, respect, and partnership with Indigenous communities. Solutions must be Indigenous-led and reflect the voices, needs, and knowledge systems of the people they intend to serve. Rebuilding trust and restoring equity will take time, but it begins with recognizing the historical harms and acting with accountability and humility.

Primary Care Networks: A Strategy to Address the Issue

One solution to address this crisis is the expansion of Primary Care Networks (PCNs) across Alberta, specifically in Indigenous and rural communities. PCNs operate using a collaborative care model that includes family doctors, nurses, pharmacists, and social workers. This team-based approach ensures patients receive timely, community-based care, reducing the risk of expensive complications or hospitalizations (Health Canada, 2024). PCNs care models include routine checks, early screening, and chronic disease management. Expanding PCNs would provide access to preventive and primary care for over

800,000 Albertans (Canadian Rural Revitalization Foundation, 2024). The Canadian Institute for Health Information (n.d.) found in 2023-2024 over 17% of cases that presented to the emergency room could have been treated with Primary Care services. The expansion of PCNs into rural and Indigenous communities will improve healthcare accessibility, addressing issues such as rural isolation, limited facilities, and poverty. This strategy requires a comprehensive, publicly funded plan. Public funding ensures equitable access to healthcare services, ensuring no one is denied care based on their socioeconomic status or geographic location (Canadian Medical Association [CMA], 2024). In addition, the public funding model ensures that the care services that Albertans require or want are made readily available to them. Private models often favour cheaper services and will often avoid costly services in order to protect profit margins. As stated before in this essay, Healthcare is a right, and it should always be placed above profits.

Why Address the Issue?

There are a number of reasons why we should be providing high-quality healthcare to those living in rural and remote communities. This paper addresses two reasons, which the author believes are both practical and reasonable. The first reason being that, as citizens of Alberta—like those who lived

here before us—we have a responsibility to help one another when they are in need. The second reason being that providing high-quality and efficient healthcare to rural and remote communities can actually be a cost-saving measure for the province and individuals' own funds.

A Moral Responsibility

Access to quality and affordable healthcare is a fundamental right in Canada, enshrined in both national values and public policy, regardless of a person's geographical location. Yet, as this paper has demonstrated, individuals living who reside in Albertan rural and remote communities are not being equitably served by the current healthcare delivery systems. Despite consistent recognition of healthcare as a public good, these communities continue to face systemic neglect. This is particularly troubling when viewed in the context of Alberta's economic prosperity. The province of Alberta frequently reports one of the highest gross domestic products (GDP) in the country. In 2023, Alberta's GDP reached 336.3 billion dollars—an increase of 4.8 billion, or 1.5%, from the previous year (Statista, 2024; Statistics Canada, 2024). This economic strength underscores a stark contradiction: the province has the financial capacity to support robust healthcare infrastructure, yet rural healthcare continues to deteriorate.

This is not simply a policy failure—it is a moral failure. The disparity cannot be justified by population size or geography alone. People in rural and remote areas do not have fewer healthcare needs. In fact, due to geographic isolation, higher rates of chronic disease, mental health challenges, and limited access to preventative care, their needs are often more complex (Laurent, 2002). So why do they have less access to care? This disconnect raises ethical questions about equity, justice, and our collective priorities as a society. It suggests that the barriers are not purely logistical or financial, but rooted in long-standing systemic inequities and a lack of political will. Addressing this is not just a matter of improving service delivery—it is a matter of doing what is right.

Cost Savings

Primary Care Networks (PCNs) can address minor health ailments before they escalate into chronic conditions (Alberta Primary Care Network, 2024). This proactive care model can drastically reduce healthcare costs in rural and Indigenous communities. Treating severe illnesses such as diabetes or heart disease in inpatient settings is significantly more expensive than preventive care (Alberta Primary Care Network, 2024). Additionally, individuals in Indigenous and rural communities who lack access to primary or preventive care

often present at emergency rooms, further increasing healthcare expenses and depleting system resources (Basu & Phillips, 2016). Rural and Indigenous populations also face barriers such as limited local healthcare facilities and the need to travel long distances for care. Expanding PCNs reduces the need for costly transportation and accommodation, which are often necessary to access urban healthcare services. While PCNs often exist in some form in large urban centres such as Red Deer, PCNs are not present in rural and remote communities, where they are desperately needed. Furthermore, consistent preventive care within PCNs can reduce hospital readmission rates by managing chronic conditions more effectively (Centers for Disease Control and Prevention [CDC], 2021). These measures not only improve health equity but also ensure more efficient resource utilization, creating long-term savings for Alberta's healthcare system while enhancing the quality of life for rural and Indigenous populations.

Conclusion

Improving healthcare access in rural, remote and Indigenous communities is not merely a policy challenge—it is a moral imperative grounded in the values of equity, reconciliation, and human dignity. The voices of rural nurses and community members underscore the urgency of addressing long

standing barriers to care, and the expansion of Primary Care Networks offers a practical, community-centred solution. By investing in culturally safe, locally driven models of care and ensuring that healthcare professionals are supported and retained in underserved areas, Alberta has an opportunity to lead the way in creating a more just and responsive healthcare system. This paper and the ideas presented within it are not the only path forward in addressing the crisis in rural healthcare and Alberta's healthcare system as a whole. However, it offers a starting point for how we can begin the journey toward improving healthcare access and services for those living in rural and remote communities. The path forward must be shaped by collaboration, evidence-based treatment, respect for Indigenous sovereignty, and a commitment to health as a human right. Now is the time for action—because where someone lives should never determine if they live.

References

Alberta Bureau of Public Health. (1925). *Annual report of the Department of Public Health of the Province of Alberta for the year 1925*. Government of Alberta. http://peel.library.ualberta.ca/bibliography/9021.49.1/18.html

Alberta Department of Health. (n.d.). *District Nursing Service funds*. Alberta On Record. https://edit.albertaonrecord.ca/alberta-department-of-health-district-nursing-service

Alberta Primary Care Network. (2024). *Alberta find a doctor*. Alberta PCNs. https://albertafindadoctor.ca/pc

Basu, S., & Phillips, R. S. (2016). Reduced emergency department utilization after increased access to primary care. *PLOS Medicine, 13*(9), e1002114. https://doi.org/10.1371/journal.pmed.1002114

Canadian Institute for Health Information. (n.d.). *Your Health System: In Depth — Indicator 100/2/C20018*. Retrieved May 17, 2025, from https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/100/2/C20018/

Canadian Medical Association. (n.d.). *Indigenous health*. https://www.cma.ca/our-focus/indigenous-health

Canadian Medical Association. (2024). Public and private

health care in Canada: What does the evidence say? The Association. https://digitallibrary.cma.ca/link/digitallibrary125

Canadian Broadcasting Corporation. (2001). *In an uncertain world*. CBC. Retrieved May 16, 2025, from https://www.cbc.ca/history/EPISCONTENTSE1EP17CH3PA1LE.html

Centers for Disease Control and Prevention. (2021). Outpatient follow-up visits to reduce 30-day all-cause readmissions for heart failure, COPD, myocardial infarction, and stroke: A systematic review and meta-analysis. Retrieved from https://www.cdc.gov

Health Canada. (2024). Canada's Health Care System. Government of Canada. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/helth-care-system/canada.html#a9

Laurent, S. (2002). *Rural Canada: Access to health care* (PRB 02- 45E). Library of Parliament. https://publications.gc.ca/Collection-R/LoPBdP/BP/prb0245-e.htm

Macrotrends. (n.d.). *Crude oil prices - 70 year historical chart*. https://www.macrotrends.net/1369/crude-oil-price-history-chart

McLaren, L., Juzwishin, D., & Velez Mendoza, R. (Eds.). (2024). *A history of public health in Alberta, 1919-2019*. University of Calgary Press.

MNP LLP. (2021). *Improving quality of life for residents in facility-based continuing care: Alberta facility-based continuing care review recommendations: Final report*. Alberta Health. https://open.alberta.ca/publications/improving-quality-life-residents-facility-based-continuing-care-review-recommendations

National Museum of American History. (n.d.). *Cure-alls and salves*. Smithsonian Institution. https://americanhistory.si.edu/collections/object-groups/health-hygiene-and-beauty/cure-alls-and-salves

Reilly, M. (2021). Health Disparities and Access to Healthcare in Rural vs. Urban Areas. Theory in Action, 14(2), 6–27. https://doi-org.rdpolytech.idm.oclc.org/10.3798/tia.1937-0237.2109

Smith, J. C., & Vandall-Walker, V. (2017). A double whammy! New baccalaureate nurses' transitions into rural acute care. Rural and Remote Health, 17(4), 1-14. https://doi.org/10.22605/RRH4256

Statista. (2024). *Gross domestic product of Alberta, Canada*

from 2000 to 2023. https://www.statista.com/statistics/577560/gdp-of-alberta-canada/Statista

Statistics Canada. (2023). *Section 3: Access to health care services*. In *Access to health care services in Canada, 2023* (Catalogue No. 82-570-X). https://www150.statcan.gc.ca/n1/pub/82-570-x/2023001/section3-eng.htm

Statistics Canada. (2024). *Real gross domestic product growth, Canada, provinces and territories, 2023*. The Daily. https://www150.statcan.gc.ca/n1/daily-quotidien/240501/g-a001-eng.htm

Swanepoel, L.-M., Heck, C., Hallstrom, L. K., & Yarmey, N. (2024, November 5). *Alberta: Change and inertia during volatile times - state of rural Canada 2024*. State of Rural Canada. https://sorc.crrf.ca/alberta-2024/

Thomson, S. (2019, September 23). *How Alberta's health spending has changed over the past 50 years*. CBC News. https://www.cbc.ca/news/canada/calgary/alberta-health-spending-history-1.5289747

Pijl, E. M., Alraja, A., Duff, E., Cooke, C., Dash, S., Nayak, N., Lamoureux, J., Poulin, G., Knight, E., & Fry, B. (2022). Barriers and facilitators to opioid agonist therapy in rural and remote communities in Canada: An

integrative review. *Substance Abuse Treatment, Prevention, and Policy, 17*, Article 62. https://doi.org/10.1186/s13011-022-00463-5

Yangzom, K., Masoud, H., & Hahmann, T. (2023). *Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020* (41-20-0002). Centre for Indigenous Statistics and Partnerships. https://www150.statcan.gc.ca/n1/pub/41-20-0002/412000022023005-eng.htm