**A Comparison of Rural Health Policy and Politics in British Columbia and Washington State**

Comparing Canada and the United States in health care is productive given that they have similarities in terms of politics, economics, geography, culture, and history, along with sharing over 5,500 miles of border (International Boundary Commission 2015). There are critical differences as well. The United States has around three hundred million more people, the countries have different governing systems (presidential versus parliamentary), and they diverged in health policy paths in the second half of the 20th Century. Since the mid-1960s, Canada has a universal health insurance system, while the United States has retained a mixed private and public health insurance system with no universal guarantee to health insurance.

While there is much to be garnered by national comparison, the sprawling countries have tremendous within-country variation. This diminishes the precision of cross-national comparison. Subnational comparison offers a way to compare across countries while accounting for this within-country variation**.** A further mechanism for addressing within-country variation is to focus on an issue that has similar features across borders. Thus, this paper examines rural health in British Columbia and Washington State (here on referred to as Washington). The specific questions addressed are: 1) What are the similarities and differences in health care inputs and outcomes from a rural lens? 2) What explains the factors driving these similarities and differences? 3) What role does the political environment play in rural health care? 4) What are the practical applications of such a comparison?

First is a description of subnational comparison followed by discussion of a rural lens. Next, is a description of the political environments of Washington and British Columbia, followed by an examination of health outcomes and policy from a rural lens. Finally, the discussion considers how this informs the research questions. Information for addressing the questions comes from government and public sources along with three key informant interviews.

***A Subnational Lens***

Sellers (2019, 85) illustrates how research has increasingly used subnational comparison employing more than one country, an approach he refers to as “transnational comparison.”According to Sellers (2019, 85-86), transnational comparison shows that subnational comparison has utility beyond one country. For quantitative approaches it can improve “analytical scope” and “statistical power.” It includes “the many political, economic, and social phenomenon that do not map onto national borders” and improves the understanding of national politics. For policy and advocacy purposes it can reveal “how policies, governance arrangements, and political strategies work within context.”

A subnational approach is a good fit for comparing Canada and the United States. First, both countries employ federal systems that afford agency to subnational governments in health care. Second there is significant demographic, political, economic, geographic, and cultural subnational variation among subnational units within countries, meanwhile there are often striking similarities between provinces and states. For instance, similarities between North Dakota and Saskatchewan are strong in comparison to the differences between North Dakota and New York, or between Saskatchewan and British Columbia. Third, regions in Canada and the United States have similarities across national borders.

In *Divided States of America,* Donald Kettel (2020, viii) makes the case federalism is “an important driver of differences, both within and between states,” and “the government Americans get depends on where they live.” This describes health care policy in the United States. The United States has a health care system involving a significant role for both public and private actors enmeshed in a federal system that mixes state and national responsibilities.

Likewise, Canada also has a system reliant on both national and provincial action. The federal government created a health insurance system, known as Medicare, and each province creates and administers their health insurance plan based on required basic principles. Thus, there are thirteen different health plans representing the ten provinces and three territories.

Another reason for a subnational approach is that there are similarities that provinces and states share. For instance, the Plains states in the United States have much in common with Plains provinces in Canada. In a comparison of health care in Saskatchewan and Nebraska, Blankenau (2021) points out that despite different health care systems, there are many similar health outcomes, and these outcomes are driven by shared characteristics outside of the health care system, e.g., expansive rural areas, agriculture economies.

British Columbia and Washington have similar economic foundations. They both are historically rooted in in extractive industries logging, mining, and fishing. Both are home to international cities that are on the cutting edge of developments in innovation. The economic drivers of Washington in recent times are computer software development, including Microsoft, online retail, including Amazon, and aircraft construction. Other key industries include lumber/wood production, agriculture, and tourism (KFF 2014). The top industries in British Columbia measured by GDP are real estate, construction, professional/scientific/technical services, and health care/social assistance (Statista 2022).

Cultural differences at the subnational level have long been identified in both countries. Daniel Elazar (1966) describes three political cultures in the United States. Traditional political culture embraces the existing social order where government is “at the top of the social structure” (Elazar 1966, 93). Individualistic political culture stresses a minimal, marketplace role for government. The moralistic culture sees government as providing a common good.

Canadian provinces have also been documented as having considerable variation in political culture.Henderson (2004, 596) notes that through this research there is “a belief that provincial sub-cultures reflect very real variation in political practice.” However, Henderson’s analysis emphasizes regional variation rather than provincial subcultures. A poll by the Angus Reid Institute found that at least 68% of residents in British Columbia, Alberta, Saskatchewan, and Manitoba, believe that ‘“the west”’ is a unique region within Canada (Plana 2019). Polls have shown that people in British Columbia see their values closely aligned with Washington and California (Plana 2019). In fact, there has long been a movement to conceptualize Washington, British Columbia, and Oregon as a region known as Cascadia, as the area is similar in terms of geography (Engelson 2022), political culture, and economics (Todd 2008).

***Comparing From a Rural Lens***

Rural health care is vital to the population health of residents, has unique challenges that are universal, and is connected to rural economic health. Population health is often worse in rural areas (Strasser 2003). In the United States rural patients often have multiple chronic diseases and deal with social determinants of health that worsen their position such as social isolation, poor access to healthy, affordable food, and poverty (Nielson, D’Agostino, and Gregory 2017). A literature review by Weinhold and Gurtner (2014, 208) reveals that of the different factors affecting health care shortages in rural areas “provider shortage remains the most widely recognized problem in the literature.” Many other factors affect access to care. For instance, rural culture, includes “self-reliance,” “independence,” and “stoicism” and a focus on “getting the job done” can lead rural people to deemphasize medical services (Strasser 2003). Factors such as topography and “transport and communication” exacerbate access problems (Strasser 2003). Regardless of these issues, rural health care is foundational to the economic health of rural areas. For instance, rural hospitals are typically one of the largest employers for rural communities (National Rural Health Association 2018).

In terms of political culture, the rural urban divide in the United States is evident as “Republicans tend to live in locales that are less dense and farther away from population centers than their Democratic counterparts (Gimpel et al. 2020, 1344).Polls show that about two-thirds of rural voters view the Democratic Party unfavorably (Yokley 2022).In 2016, Donald Trump bested Hillary Clinton in large part due to rural support. President Trump outperformed his rural support in 2020, however, he lost because of a larger urban turnout for President Biden (Albrecht 2022).

The Covid-19 pandemic illustrates the role of party identification in health care. For instance, Democratic governors were “more likely” and “quicker” in issuing stay at home orders than Republican governors (Hiserodt et al. 2022). Individually, research shows that conservatives were less likely to view Covid-19 as a threat, and liberals were more likely to adhere to Covid-19 recommendations (Hiserodt et al. 2022).Republican counties had more deaths and “a lack of implementation or compliance with policies to prevent COVID-19 transmission played a significant role in explaining the difference in mortality between majority Republican and majority Democratic counties (Sehgal 2022, 859).”

Canada is also experiencing a rural urban political divide, with rural more conservative. Armstrong, Lucas, Taylor (2022) examine Canadian federal election results in Canada from 1896 to the present. There have been periods of rural and urban splits in the past, but currently the rural urban voting divide is the strongest in history and “one of the most important features of the contemporary Canadian political landscape (Armstrong, Lucas, Taylor 2022, 102).” Arguably, the Covid-19 pandemic did not lead to as much polarization in Canada.Merkley et al. (2020) examined the Canadian response from the lens of partisan politics and found that both elites and the public were in consensus on the response to Covid-19. Members of Parliament supported the experts, and they found relationship “between the partisan leanings of municipalities and interest in the coronavirus.”

***Washington Political Environment***

From 1900-1984 Washington supported Republican and Democratic presidential candidates similarly. Since 1988, Washington has supported only Democratic candidates for the presidency (Ballotpedia n.d.*a*). In the state legislature, Democrats have mostly held the majority in the House since 1992, and entirely since 2002. Republicans have had slightly more success in the Senate and controlled the majority from 2013-2017 (Ballotpedia n.d.*b*). The last Republican governor of Washington was John Spellman elected in 1980 lasting one term (Camden 2018).

Pierce, Lovrich, and Elway (2004) note that Washington has a moralistic political culture. Its foundation resides with those who settled the area and was reinforced during later Populist and Progressive movements of the western part of the United States in the early 20th century. The moralist political culture permeates throughout political parties, interest groups, the ubiquitous use of initiatives, and political institutions of state and local government. While Washingtonians have a high expectation for government, they are inclined to view its outcomes as falling short on many issues (Pierce, Lovrich, and Elway 2004, 24)

There is tension between rural and urban areas. A recent poll showed that a large majority of rural Washingtonians see their communities as losing political influence in the state (Elway 2021). In an opinion piece in the *Seattle Times* former Democrat State Representative Brian Blake (2021) called out natural resource policy that has come from urban legislators for hurting rural economies. Longtime Washington political observer Knute Berger noted that “the two parties have gravitated away from policies that benefit areas beyond where their respective support is…. Republicans are largely no-shows these days when it comes to urban development, sustainability, transportation, and equity. And the Democrats, who dominate statewide offices and now control the state Legislature, have often neglected rural areas (Berger 2019).”

***Washington Rural Health***

Washington operates within a national health care system that includes significant roles for federal, state, non-profit, and private actors in the financing and delivery of health care. The federal government finances and manages Medicare, which is universal health care primarily for Americans 65 and older. The federal government also plays a role in providing care for specific populations, such as veterans, low-income Americans including children, and it funds and manages the Indian Health Service (Commonwealth Fund 2020*a*). States manage and partially finances federal programs for low-income children and Medicaid. Medicaid is a program that provides health care for low-income Americans. States have a considerable role in the determination of Medicaid eligibility and benefits. Under the Affordable Care Act (ACA) of 2010, states choose whether to expand Medicaid eligibility (Commonwealth Fund 2020*a*).

Public financing contributes about 45% of all health care spending. About two-thirds of Americans get health insurance through private insurance, with about 55% of that coming through employment. Those not covered by employment plans get insurance access through individual payment, public programs, or are they are uninsured. In 2020, the national uninsurance rate was 8.5% down considerably after the passage of the ACA in 2010, when it stood at 16% (Commonwealth Fund 2020*a*).

Washington does well in health care rankings. The Commonwealth Fund ranks it at 8th nationally. It highest (6th) on “avoidable use and cost,” “healthy lives,” (9th) and “access and affordability(12th).” Washington’s infant mortality rate is second best in the country at 3.9 per 1,000 live births compared to the national average of 5.8 (Commonwealth Fund 2020*b*). Washington has a mixed record on mental health. It has a mental health prevalence (32.6%) close to the national average (32.3%). However, it compares unfavorably in terms of the “percent of need for mental health professional met,” with only 16.2% of needs met compared to the national percentage of 27.7% (KFF 2023*a*). As of February 2021, the uninsurance rate was 6% (Office of the Insurance Commissioner/Washington State 2021, 3)**,** which compares well to the national average. It ranks number one in access and affordability regarding employee insurance cost as a share of median income and performs well in terms of child uninsurance rates (3% versus national average of 5%). It has a comparatively lower percentage of adults under 65 with high out of pocket costs relative to their annual household income (Commonwealth Fund 2020*b*).

When considering rural health in Washington, it is important to start with the people and the land. Washington has a population of roughly 7.5 million people, with about 10% of the population classified as non-metropolitan. Rural Washingtonians have lower socio-economic status. In 2021, the average per capita income was $73,775 for urban residents and $53,597 for rural residents. The poverty rate in 2021 was higher in rural (12.8%) than urban (9.6%). The unemployment rate was 5.8% for rural Washington, with the urban rate at 4.1%. Rural Washingtonians are slightly more likely to lack a high school degree, 10% compared to 7.9% (Rural Health Information Hub n.d.). The geography of Washington is vast covering 240 miles by 360 miles. The topography is varied, containing coastline, harbors, temperate rainforests mountain ranges, semi-arid regions, and agriculture land (Washington State Department of Commerce)

There are differences between rural and urban Washington in health care outcomes. According to the Washington State Office of Health (2017) “Health disparities between communities in rural and urban areas are persistent problems.” Their research shows that rural residents do poorly on many self-reported measures, including: adults with unmet needs due to costs, lower screenings for breast and colorectal cancer, higher smoking rates and obesity rates, and higher self-reported diabetes, heart disease, and cancer (Washington State Office of Health 2017). Rural areas are more affected by accidents and suicides (Freidberg et al. 2016, 67).

People in rural areas in Washington are more likely to be uninsured (Office of the Insurance Commission/Washington State 2021, 28). However, in the first several years after the passage of the ACA, the uninsurance rate has fallen (Protecting Our Health Care 2019). Medicaid is a key source of funding for providers and access for residents. Nationally, Medicaid covers about one-fourth of all people living in rural areas and 45% of children. It also plays a vital role for health funding of rural senior citizens (Rural Forward 2019, 1).

In the last few decades over 160 rural hospitals have closed across the country, with the trend accelerating in the last decade (Ollove 2020). However, research shows that expanding Medicaid under the ACA has helped hospital finances and has decreased hospital closures (Levinson, Goodwin, and Hulver 2023). Hospitals in rural Washington rely much more on Medicare for their funding than urban hospitals, 50.08% versus 37.59% and receive less revenue from private insurance, 27.35% versus 38.57% (Freidberg 2016, 67).

According to Pat Justis Executive Director for Rural Health/Office of Community Health Systems for Washington, the state has very few integrated health systems found in other states (Pat Justis, Executive Director for Rural Health/Office of Community Health Systems for Washington State, Zoom interview with the author(s), July 6, 2023)**.** Thus, hospitals are typically independent and public hospitals bring local ownership of health care decisions.The climate of state government supports a strong rural independence, and decentralization allows for rural citizens to feed their concerns through public health commissioners.

According to Justis, the main issue is maintaining access to health care, which hinges on two key factors, workforce development and fiscal performance. She cites that one-third of critical access hospitals are at risk. The problem is related to remoteness. At the core of the problem is that the necessary volume of patients does not exist, and payment schemes are not adequate in these situations**(**Justis interview, 2023).

Rural Washington faces continued stress due to provider shortages. In fact, according to Elya Prystowsky, Executive Director of the Washington Rural Health Collaborative, the most important issue facing rural Washington is workforce shortages (Elya Prystowsky, Executive Director of the Washington Rural Health Collaborative, Zoom interview with author(s), July 6, 2023).A recent accounting of physicians in rural Washington found that most rural areas had fewer physicians per 100,0000 people, and many rural counties had older physicians (Dahal and Skillman 2022, 1). The Rand Corporation predicts that this this trend will likely worsen (Friedberg et al. 2016, xvi).

Overall, providers in rural area in the U.S. must deal with unique obstacles in running their business operations such as less income from private pay, which is more lucrative than Medicaid reimbursement, delays in Medicaid payment, costly and difficult health information technology, along with limited emergency care services, and access to public transportation. (Frieberg 2016, 9).Prystowsky notes that state government needs to understand the difficulties of operating rural hospitals. State government burdens rural hospitals by having them follow the same regulations as urban hospitals. For instance, state government crackdown on hospital profiteering in urban settings affects rural hospitals as they are held to the same accountability practices, e.g., price transparency, which is difficult for rural hospitals. Overall, rural hospitals have the same administrative burden but a much smaller administrative workforce (Prystowsky interview, 2023).

The problems providers face has real consequences for rural residents. Maternity care is an example. Reporting by the *New York Times* describes the national phenomenon of dwindling maternity care in rural America. Rural hospitals struggle with the financing of running maternity units, as they are costly, and hospitals are reliant on Medicaid that pays about one-third as much as private insurance. Thus, rural hospitals across the United States, including Washington, are shutting down their maternity units. Research shows that women living in ‘maternity-care deserts” face three times the mortality rate during pregnancy and a year after birth (Rabin 2023).

About 37% of the state’s residents live in areas with a shortage of mental health providers, and the problem is pronounced in rural areas. Driving provider shortages is rural hospitals’ reliance on lower paying government health plans. This depresses salaries and is a barrier to recruitment, particularly if a provider is not originally from a rural area (Furfaro 2021).

Another pressing issue is the aging of rural Washington (Justis interview, 2023). Rural Washington will face extraordinary demands to help their citizens age in place, but there is not enough being done to accommodate this aging population. There are workforce problems here as well (Justis interview, 2023)**.**

Washington is active in health policy reform, which affects rural health. State government embraced the ACA and according to Prystowsky, it has been a “very rural friendly” law (Prystowsky interview, 2023.) Washington employed Medicaid expansion under the ACA on January 1, 2014, at its first availability and currently 30% of rural Washingtonians rely on Medicaid. Washington has also participated in the health insurance exchange component of the ACA. Most recently, it become the first state to adopt a public option as part of the health insurance exchange (Washington State Health Care Authority 2022)**.**

The legislature has addressed shortages by creating a new medical school in the eastern part of Washington, which is largely rural. According to Prystowsky, the new medical school is an attempt to address worker shortages and drawing on a workforce that identifies with different groups in rural Washington(Prystowsky interview, 2023**).**

The state has been active in addressing other access problems in rural health care. The Covid pandemic helped make telepsychiatry more acceptable and utilized in rural areas. In 2020, the legislature made health care plans to reimburse telehealth services at the same rate as in person care and further expanded that to include audio-only telehealth services. However, demand still outpaces supply. The University of Washington School of Medicine has developed an innovative collaborative model for rural Washington where on-site primary care providers team up with remote psychiatrists (Furfaro 2021). According to Prystowsky, telehealth would benefit rural health, but the broadband access is insufficient, and the state does not have an adequate process for helping rural (Prystowsky interview, 2023).

While Prystowsky sees state government addressing some rural needs, she notes rural advocates play more defense than offense in policymaking (Prystowsky interview, 2023). Justis posits that governments need to recognize the unique risk of rurality. While there has been an acceptance of other forms of risk e.g., race and income, rurality as a stand-alone risk factor remains elusive (Justis interview, 2023). While Prystowsky sees the state Office of Rural Health as working diligently for rural issues, overall rural concerns are not as strongly considered by government as other groups that traditionally face health risks (Prystowsky interview, 2023). An example of not recognizing the importance of the rural lens is a recent settlement with pharmaceutical companies that delegates resources based on the total number of deaths due to the drug crisis, rather than a per capita approach where rural has a higher proportion of deaths. Further, it costs more to treat people in rural areas for substance abuse treatment risks (Prystowsky interview, 2023).

Why is there an inattention to the rural lens of health on the part of government? According to Justis, one reason is that rural areas have fewer people who can advocate for their needs, and rural citizens often work multiple jobs limiting free time. Legislators are driven to address the needs of their constituents who are primarily in urban areas, and rural concerns are often missed in the time-constricted policymaking environment. Rural legislators are typically fiscally conservative, and while focused on their communities, are wary of expansive budget items that might address health issues more broadly (Justis interview, 2023). While there are advocates for rural health in the legislature, there are not enough (Prystowsky interview, 2023). Further, rural communities have a sense of independence and feel that they should take care of their health care needs. Despite Washington being in a region of the country with a more moralist political culture, rural independence may lead rural people to feel ultimate responsibility for their health.

While there are barriers to rural citizen involvement in health advocacy, according to Prystowsky, rural citizens want local decision-making regarding health care and are concerned about state and federal influence. For instance, she cites Governor Inslee’s Covid polices as upsetting many rural Washingtonians. Further, rural people might complain about their local hospitals, but they want to keep them, and they appreciate care from people who they connect with(Prystowsky interview, 2023)**.**

***British Columbia Political Environment***

British Columbia is a parliamentary system. The premier is typically chosen by the majority party in the unicameral legislature, although there can be minority governments if no party receives a majority. Parliamentary systems typically afford an “executive dominance” in the government (Radin and Boase 2000, 84).

A key to understanding British Columbia politics is the decoupling of provincial and regional parties. Voters typically choose between the Liberals, The Democratic Party (NDP), Conservatives, Bloc Québécois, and the Green Party, but in provincial elections they vote from the BC Liberals (as of April 2023 known as BC United) BC NDP and the BC Greens.According to political scientist Stephen Phillips of Langara College, “In BC, we have two political worlds — provincial and federal — and so you have a number of people, who vote for the Liberals in the federal elections, who vote NDP in provincial elections, as they see the provincial NDP as being a more progressive party than the provincial namesake of the Liberal (Daily Hive 2020).**”**

The narrow ideological spectrum of the three major parties in British Columbia is reflected in their proposals for health care. An assessment of the policies of the three parties on five areas of health care by the College of Family Physicians/BC College of Family Physicians in 2017 provided a nearly identical rating for each of the party (College of Family Physicians/BC College of Family Physicians 2017).Paul Adams, Executive Director of the BC Rural Health Network, also sees little difference between political parties in terms of rural health policy and notes that no major party offers policy that works well for rural British Columbia. According to Adams, politicians focus more on urban areas because the votes are there, they make political calculations regarding policy (Paul Adams, Executive Director BC Rural Health Network, Zoom interview with author(s), June 6, 2023).

***Rural Health in British Columbia***

British Columbia operates its provincial health plan within a decentralized national health insurance system. The federal government has key principles that each health plan must adhere to and provides about 25% of the funding. Provinces/territories are responsible for the development of the specifications of each plan, funding, and implementation. Each plan provides free at the points of service “medically necessary hospital, diagnostic, and physician services” (Commonwealth Fund 2020*c*). Governments contract with physicians for providing care and use health authorities, which vary in their organizational structure across governments, to provide hospital care and other services (e.g., mental, and public health). Public sector funding accounts for about 70% of total funding, leaving 30% of financing to the private sector. The private sector plays a key role in providing services not covered under Medicare, with those services financed by individuals directly or through private insurance typically accessed through employment. About two-thirds of Canadians rely on private insurance for services not a part of Medicare, such as vision, dental, and rehabilitation care, along with outpatient pharmaceuticals (Commonwealth Fund 2020*c*).

As is in the US, the national government facilitates health care for specific populations such as “eligible First Nations and Inuit peoples, members of the Canadian Armed Forces, veterans, resettled refugees and some refugee claimants, and inmates in federal penitentiaries.” It has a regulatory role over medical devices, pharmaceuticals, and natural health products. The federal government funds research and information technology. It also has national public health responsibilities (Commonwealth Fund 2020c).

The Medical Services Plan (MSP) is British Columbia’s provincial health plan and required for all British Columbia residents. MSP covers medically required services provided by physicians, hospitals, surgeries, diagnostic procedures, and other medically necessary services Except for dental care provided in hospitals, the MSP does not cover dental services (Desoutter 2023).As of 2020, there are no longer premiums charged to residents for the MPS (BC Gov News 2019).

British Columbia compares favorably to the rest of the country in health outcomes. The Conference Board of Canada provides a detailed comparison of provincial health including a comparison with fifteen other countries. They use the following measures, “life expectancy, premature mortality, infant mortality, self-reported health status, mortality due to cancer, mortality due to heart disease and stroke, mortality due to respiratory disease, mortality due to diabetes, mortality due to diseases of the nervous system, and suicides.” **British Columbia** was Canada’s top ranked province and was third overall behind Switzerland and Sweden. British Columbia has one of the world’s highest life expectancies (82.2 years) and received top marks for outcomes on premature mortality, mortality due to cancer, and self-reported health status (Conference Board of Canada n.d.). Overall, British Columbia received and an A grade, while overall Canada received a B grade. Four provinces received a D mark, and the territories of Canada were at the bottom of the rankings. The lowest ranked province of Newfoundland and Labrador, score a D- placing below the worst peer country, the United States (Conference Board of Canada n.d).

While overall British Columbia does very well in terms of health care, there is variation of health experiences within the province. People and geography are at the foundation for understanding health care in rural British Columbia. Mostly British Columbia is an urban province with only 14% of its roughly five million residents in rural areas. Its geography is defined by its vastness and diversity, including 27,000km of coastline and daunting mountain ranges that provide many hazards for travel (Johnston et al., 2023).

People tend to live in smaller groups and spread out across the province with less than five people/km (Ministry of Health/British Columbia 2015, 13). Given a reliance on forestry, silviculture, agriculture, and mining, populations in areas can fluctuate. (Ministry of Health/British Columbia 2015, 14). Rural residents tend to have lower social economic status, are trending older in many places, and around 11.3% identify as Aboriginal, compared to 3.7% in urban British Columbia (Ministry of Health/British Columbia 2015, 14).

There are health challenges linked to lower social economic status. The resource-based economy tends to put residents in more dangerous jobs and often away from home for extended periods. Rural residents have lower education, income, and are at risk for unsafe housing and other conditions related to lower socio-economic status. They partake in more risky health behaviors related to inactivity, smoking, and diet. These unhealthy behaviors can lead to higher rates of chronic disease and circulatory disease. Rural residents often have more difficulty in attaining proper maternal care due to travel and other issues and have higher infant mortality in some areas. Injury mortality is higher in more rural areas, along with much higher suicide rates for both boys and girls compared to those in urban areas. Life expectancy is generally five years less in rural areas than someurban areas (Ministry of Health/British Columbia 2015, 16-17).

Demographics and geography affect rural health delivery. The paucity of people in many areas makes it difficult to sustain a broad ranges of health services. Low volume of patients leads to higher per capita costs. Providers have difficulty in meeting their competencies or quality standards. These dynamics are particularly problematic for acute services, e.g., obstetrics, critical care, and emergency care (Ministry of Health/British Columbia, 2015, 20) These forces also affect ancillary services, which can lead to more acute dental issues (Ministry of Health/British Columbia 2015, 20**).** Adams sees rural health challenges as multidimensional, but recruitment and retention of health providers is a core issue. Providers want to practice at their fullest ability and having the appropriate facilities and supporting systems of care (Adams interview, 2023).

Rural residents must often have to travel for care, particularly for higher level care. Travelling costs lead to a “rural tax.” One study found that rural residents pay typically $856 and $674 for transport and accommodation (Kornelsen et al., 2021a).The researchers note that these costs are particularly problematic for those without sufficient financial and social resources. While government programs that assist with the financial burden of travel for qualifying residents, the real key to assuring that residents have the financial means to travel would provide comprehensive assistance up front (Adams interview, 2023).

The health crisis for rural British Columbia has been around for decades, but Covid highlighted the challenges (Adams interview, 2023). Pressures on the primary health system exacerbated by the pandemic sparked a few British Columbia politicians to warn that the “rural primary health-care system is facing erosion, and even collapse, due to pandemic burnout, long-standing staffing shortages at hospitals and the inability to attract or keep family physicians in small communities” (Baker 2022).The myriad of problems facing rural health care in British Columbia prior to, and through Covid, are evident in the closures of emergency rooms throughout rural British Columbia. Canadian Broadcasting Corporation News analyzed data regarding emergency room closure and found that thirteen rural hospitals had closures amounting to four months in 2022 (Kulkarni 2022).

In 2017, the College of Family Physicians of Canada/BC College of Family physicians evaluated the performance of the British Columbia government regarding five areas of health, access to a family doctor, mental health addiction, indigenous health, rural and remote health; and support for a patient’s medical home. They used a stoplight rating system with a green light showing the government with strong leadership in the area, a yellow light showing the government as somewhat involved and a red light showing no involvement. The government received a yellow light in all areas except for a patient’s medical home, which it received a green light. In rural and remote care, the report noted the government supporting recruitment and retention policies, however more effort is needed for areas struggling with recruitment and retention and access to surgery and maternity care (College of Family Physicians/BC College of Family Physicians 2017).

A 2021 study of rural British Columbia residents about their reflections on the problems facing them mirrors the issues described the Ministry of Health and others. Kornelsen et al. (2021b) accumulated citizen-patient voices through survey and interview methods. Respondents were primarily concerned with issues of access across the spectrum of care, but access to primary care was the greatest concern. Concern over access to care creates a sense of vulnerability that the authors note leads to “treatment avoidance” (Kornelsen et al. 2021b, 8), exacerbated by financial problems and low social capital.

In a 2006 British *Columbia Medical Journal* essay, Ralph J. Maddess was clear about the problems of accessing mental health services in rural British Columbia as British Columbia has a “severe shortage of mental health services.” He connected the shortage to “prevailing attitudes.” Rural people decided to live in rural areas and should “accept” that reality and that many people see rural life as less stressful and thus having a diminished need for mental health services (Maddess 2006).Campol (2020) cites subsequent research that describes the continuing struggle of getting mental health care in rural British Columbia.

Another concerning area of shortages is maternal care. The Ministry of Health reported that in the last two decades twenty rural maternity sites have closed. This has forced many parents to relocate prior to birth to have access to services. The Canadian Broadcasting System describes one such situation where a birth cost a family $4,000 dollars due to travel cost. Further, travel often leaves out spouses and other family members because of the cost leading to isolation. There are ways to get assistance through non-profits and the government, but these programs do not cover the full cost of travel (Gomez 2022). The health effects of limited access to maternal care overshadow cost and inconvenience. A study found that when parents had to travel four or more hours for delivery, the infant mortality rate was three times higher and pre-term births and lower birth weights were more prevalent when parents had to drive over two hours (Gomez 2022).

Another challenge centers on trust and communication. According to Adams, the regionalization of health authority in British Columbia has undermined the trust in health decision making. Formerly communities had more direct input into communicating their concerns, and the RHA tend towards uniform decisions that are not necessarily in line with the unique needs of communities (Adams interview, 2023). Mayor Leonard Casley of New Denver echoes these sentiments when addressing the recent problem of emergency rooms closures in his area as he decried the “centralization of health-care” that occurred when the Liberal government in 2001 replaced fifty-two health authorities in the province with just five regional ones. While the mayor surmises that this might work for urban areas, it does not for rural areas as “they do not understand rural B.C. at all.” (Kulkarni 2022). According to Adams, this centralization has led to a distrust that is particularly evident during times of crisis like Covid. This breakdown of connection between health authorities and communities undermines the fabric of rural communities, and there has been more extremism and racial stereotyping (Adams interview, 2023).

Issues of bias are not just a problem within the broader community, according to Adams health providers need to address this as well. Cultural sensitivity is very important in rural area health care in order to address diversity, particularly with Aboriginal populations (Adams interview, 2023). There are around 200,000 indigenous people residing in the province with more than 200 First Nations, more than 30 First Nation languages and nearly 60 dialects (British Columbia). Adams points out that trust for indigenous populations has eroded over the years because of harsh government treatment in the past.

Clearly rural British Columbia has unique challenges that call for policy to address these challenges. However, according to Kornelsen et al. (2021b) there is a “historical lack of attention to rural health care needs.” According to Adams, the British Columbia government is simply not doing enough to address the unique challenges of rural health. Adams notes that in policy there is a tendency to treat rural like small urban, but it does not work well given the diversity of rural British Columbia and the uniqueness of needs. Further, he argues that bureaucracy has a tendency towards the status quo and prefers uniform policies, which is problematic for communities that need dynamic policy changes and who have unique problems (Adams interview, 2023). Low population density and geographic isolation affect the ability of rural citizens to advocate for health concerns (Kornelsen et al. 2021b). The 2023 budget is emblematic of government health care policy without a rural focus. The budget has a strong increase in health care spending however, except for the new parliamentary secretary and travel assistance for oncology care, “there is no mention of any rural-specific investments in rural healthcare systems (Adams 2023).”

While government lacks attention to the unique features of rural health, there is policy directed at addressing rural health needs. In terms of raising awareness and providing a rural focus the government does research and identifies challenges (Ministry of Health 2015). Also, Premier David Eby recently create a new parliamentary secretary for rural health. In his statement announcing the appointment the premier recognized that “Rural, remote and First Nations communities face urgent and unique challenges, particularly when it comes to attracting and retaining health professionals.” (BC Gov New 2023).Adams noted this as a positive development for rural health (Adams interview, 2023).

The government has a myriad of incentive programs to encourage physicians to practice in rural areas. Working with the Medical Services Commission and the Doctors of BC, the government has created The Rural Practice Subsidiary Agreement (RSA). The RSA establishes a Joint Standing Committee on Rural Issues and is comprised of representatives from the Doctors of BC, the Ministry of health and health authorities. This committee advises the government and the Doctors of BC about rural practice and oversees the programs directed at recruitment and retention issues (Joint Standing Committee on Rural Issues/Doctors of BC 2022).

The Joint Committee on Rural Issues financially supports and collaborates with the Rural Coordination Centre of Rural British Columbia (RCC). With a grassroots beginning, it “has grown into a network of hundreds of people—rural doctors and other healthcare providers, healthcare administrators, community members, policymakers, educators, researchers, and non-profit and business leaders.” The RCC works towards health equity and inclusivity through developing relationships, discussion, project coordination, research, education, advocacy, and leadership development (Rural Coordination Centre of British Columbia 2023).

**Discussion**

Table 1 provides a broad summary of factors affecting rural health in British Columbia and Washington for reference in considering the four research questions.

**Table 1**

|  |  |  |
| --- | --- | --- |
| **Factors affecting rural health** | **British Columbia** | **Washington** |
| *Social environment for rural* | Lower SES than urban, aging population | Lower SES than urban, aging population |
| *Rural geography* | Difficult travel conditions, long distances | Difficult travel conditions, long distances |
| *Political environment* | Leans left of center, competitive center right party | Leans left center, one dominant party |
| *State/provincial health policy* | Improving but underdeveloped, but lacks rural consciousness | Attempts to increase access but lack of rural consciousness |
| *Rural economy* | Extractive | Extractive |
| *Overall health of state/province compared to entire country* | Strong | Generally strong |
| *Rural health outcomes compared to urban* | Typically worse | Typically worse |
| *Percent rural covered by insurance* | Guaranteed | Not guaranteed, comparatively higher than other states |
| *Main barrier to care* | Provider shortages | Provider shortages |

The first question is what are the similarities and differences in health care inputs and outcomes from a rural lens? To reiterate both subnational governments have significant authority within their respective health systems. However, a major difference regarding inputs is that in British Columbia Medicare ensures all eligible residents of Canada receive medical/hospital care that is free at the point of service. Washington does not guarantee access to health insurance. However, Washington has seen a significant decline it its uninsurance rate since embracing Medicaid expansion, which they chose to be a part of while many states initially did not. Rural Washington continues to lag urban in terms of insurance coverage, but it has seen improvements in this regard.

There are many similarities among the people and places in rural British Columbia and Washington. They both have rural residents that are generally worse off in terms of socio-economic status and some key lifestyle behaviors. Both places have difficult geography in terms of providing health care with large land bases and rugged terrain. This makes travel for health care difficult, along with providing adequate services. While both have subnational units that fare well compared to other subnational units within their countries, their rural populations fare worse on health measures than their urban populations.

Both rural areas deal with provider shortages. The recruitment and retention of health providers is the fundamental driver of these shortages. Both struggle with keeping health care facilities open and the problem increases by the extent of remoteness. For instance, access to maternity care is a struggle in rural areas in both Washington and British Columbia.

Both perform well in health measures compared to other subnational units within their countries, however their rural populations fare worse on health measures than their urban populations. Despite a key difference health care financing, i.e., guaranteed access to health care in British Columbia, their rural areas have many similar experiences in health outcomes.

So why is there so much similarity in health experiences even though they are separated by national borders and have significantly different health financing systems? Both areas face systemic issues that are familiar to rural health. As Strasser (2003) notes about rural structural factors worldwide, the rural areas of both places deal with issues of distance, topography, and health resource concentration in rural areas. Further, their rural populations have lower social-economic status and rely on extractive industries.

In terms of the third question, the role of politics is intriguing. In British Columbia political parties are similar in their approaches to rural health issues. The extent that politics place a role is more of an urban versus rural dynamic. In Washington, the Democratic majority addresses health care issues more aggressively than other states and rural Washingtonians have benefited in certain ways, e.g., Medicaid expansion. Democrats and Republicans support rural hospitals. Democrats do for issues of equity and Republicans for their rural constituents (Prystowsky interview, 2023). However, there is criticism for both governments in British Columbia and Washington for not addressing health care with a stronger rural consciousness. Rurality is not treated sufficiently as a stand-alone risk factor. The consequence is that policies are not crafted to address the unique issues of rural health.

Another important political dynamic to consider in the study of comparative politics is that national boundaries are not always as compelling as an explanation for differences between countries. As other studies have noted, and found here, there is often variation within countries and shared similarities between subnational units in different countries that makes national comparisons less helpful in understanding differences in policy areas.

Finally, Sellers (2019) argues that practical applications can be found in transnational comparison at the subnational level. In this analysis there are several. First, there while financing structures matter for health care delivery, many other factors are also important opening the door for policy and advocacy to address. For instance, advocacy should continue to push for a rural perspective to addressing health care needs, working towards making rurality as a stand-alone risk factor. Relatedly, it might be more effective to focus on the politics of urban versus rural rather than political party politics. Policy development needs to be holistic in addressing health, e.g., travel barriers elevated to a significant policy issue. Barriers associated SES and reliance on extractive industries also need adequate attention for their unique rural characteristics. Finally, given the similarities of barriers and opportunities across the national barriers noted here, there is fertile opportunity to share ideas and resources between the subnational governments. For instance, British Columbia might want to consider studying how decentralization of health systems works in Washington.

There are many limitations to this study, and here are a few. First, the study is impressionistic and provides only a summary review of the key issues. For instance, it does not delve into how the lack of guaranteed access to health insurance in rural Washington plays out in a broader impact on quality of life, e.g., people staying with jobs just for the health insurance. It needs to broaden the voices of experts interviewed to include different perspectives, e.g., politicians, urban concerns. Further, the paper focuses too much on the similar experiences of the areas, and not enough attention to differences.

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