“IT’S THE ONLY DRAWBACK TO LIVING HERE”

Citizens’ Perceptions of Health Care Services in The Digby Area

A Community-Sponsored Action Report
Supported by the Citizens of the Digby Area,
The Digby Area Health Coalition &
The Municipality of Digby

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DIGBY AREA HEALTH COALITION

Municipality OF Digby

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Introduction from The Digby Area Health Coalition

This Report of the Digby Area Health Coalition (DAHC) was commissioned as part of the DAHC's mandate to shed light on what is happening to health services in the Digby Area. Specifically, we are interested in how citizens cope with the system and how they access care. Our goal is to work towards transparency and change. At this juncture our method is based on what social scientists and anthropologists call testimonials and witnessing, hearing and seeing what residents have lived through here, in this place.

Most of us in Digby County have lived through the experience of reduced services. We have watched family members suffer the consequences. Not only have we watched this process, a process that our neighbours claim borders on institutional and political neglect, but many have had to move, donate to others, or spend out of pocket for what is supposed to be an accessible public health care system.

The DAHC is grateful for this brilliant and moving window on our world. It is difficult and challenging work to be invited into the lives, living rooms, and the various town hall meetings knowing that many in attendance will have heartfelt tales of discontinuity of care to express. Indeed, it is the nightmare of neoliberal governments that ordinary people wake up to the social fact that not all technocratic, so called rational, progress is able to deliver the goods, or serve the people. The time for change is at hand. The DAHC is grateful for the financial support of Digby area citizens, as well as the Municipality of Digby. This project truly was a community effort.

- *Tony N. Kelly Ph.D., Little River NS*
  Coordinator of the Digby Area Health Coalition

Executive Summary

Introduction

In the spring of 2016 a group of citizens in the Digby area held a series of town hall meetings to discuss frustrations with the quality and availability of health care services in their community. After the meetings a group of motivated citizens formed The Digby Area Health Coalition, in order to take action against health inequities in their community. The Coalition's first project was to conduct a research study exploring the community's experiences with health care services in the area.

Methods

The coalition hired two social-sciences researchers from outside the community to conduct the research. Taking a cue from the work already done by the community, researchers used a Community Based Participatory Research (CBPR) approach to the project. Data, in the form of personal stories, were collected between September 2016 and February 2017, over which time 48 citizens from 20 different communities in the Digby area participated in either an individual interview or focus group. After conducting a thematic analysis on the data collected, researchers identified five main themes and two sub-themes which connected the experiences of the 48 participants.

Themes

The five main themes found across the data were: *family doctors, travel, quality of care, lack of communication,* and *effects.* The two sub themes were: *community health* and *Nova Scotia's rural/urban divide*.

Family Doctors: The topic of family doctors came up in every one of the interviews and at every focus group. Very few participants had a family doctor. Those who did often traveled significant distances to visit doctors in communities across the province. Participants spoke highly of the Nurse Practitioners working in their community, but expressed concern that Nurse Practitioners are not an adequate replacement for family doctors, as the do not have the same privileges or training. Due in part to the doctor shortage, participants experienced very little continuity in their medical care; often seeing multiple doctors for the same medical issue at drop in clinics or hospital emergency rooms. Inconsistent care complicated health care access for many participants, making it difficult to access basic medical testing, a high number of unmonitored chronic medical conditions, missed diagnoses, misdiagnosis, and healthcare avoidance. Participants who did not have access to a family doctor or nurse practitioner visited the Digby Hospital Emergency Department for primary medical care, putting further strain on emergency services.

Travel: Travel is a part of accessing health care services in Digby area, both outside of and within the Digby area. Many participants spent many hours traveling the 101 highway between Digby area and medical services in Kentville or Halifax, putting thousands of kilometres on their vehicles, and spending a similar amount of money on gas. For some participants the cost of vehicle maintenance and the price of gas were a significant source of stress, while others simply did not have access to a reliable vehicle of their own and were

forced to beg favours from friends and family when their medical needs required them to travel.

Quality of Care: Participants described inconsistent experiences with health care services in the Digby area, depending on which staff members were working in the emergency room, or which doctor was on call. Some experiences were positive, wherein the patient was treated with respect, and had their needs adequately assessed and addressed. Other experiences were quite negative, even disrespectful. Participants described being shamed and lectured by physicians, or having their concerns dismissed.

Lack of Communication: Participants provided numerous examples of situations when there was a communication breakdown either between health care professionals (ex. referrals not sent), between health care professionals and patients (ex. patient chastised for emergency room visit for routine treatment), and between the province and citizens (ex. citizens in Digby area feel left in the dark regarding government decisions that affect their community).

Effects: The inaccessibility of health services in the Digby area can be isolating. Family caregivers may be isolated in their homes without support, while others may feel isolated from the health care system itself, which is all but absent in some communities. The lack of available health services deters new people from moving to the community, and forces existing residents to leave. The financial strain of travel further exacerbates the stress experienced by residents living in poverty, and the potential of a medical emergency hangs over the heads of others. Participants made it clear that the effects of an ineffective health care system are extensive.

Community Health: Many participants expressed deep concern that the lack of health care services available in the Digby area is threatening the prosperity of the community.

*Rural/Urban Divide***:** Several participants felt that health care services in Nova Scotia are too heavily focused in urban areas, especially the city of Halifax. They reported feeling that their health is being jeopardized based solely on the fact that they live in rural Nova Scotia.

Discussion

Most of the themes identified in the data either directly or implicitly examine the social determinants of health, which include income and social status, education, working conditions, social environments, social support networks, gender, race, social exclusion, personal health practices, among others. The Social determinants of health are the primary factors that shape the health of Canadians, ahead of medical treatments or lifestyle choices. The lack of health care services in the Digby area jeopardizes not only the physical health of Digby area citizens, but their economic, social and mental health as well.

Conclusion

The data reveal five consistently reoccurring themes, which describe the struggles participants face while trying to access adequate healthcare services. The current state of the healthcare system in Digby Area does not allow for residents to have reliable access to family doctors, to have access to quality healthcare services within a reasonable distance of their communities, or to be treated fairly by the healthcare system. These inequities cannot justly be ignored, as such, the final section of this report outlines several recommendations that we believe may benefit community members, healthcare providers, and improve access to the healthcare system in the Digby area.

Demographic Overview

Over the course of the research process forty-eight people participated in the project, sharing their stories and experiences with researchers in individual interviews and during focus groups. In order to better understand the information collected from participants it is important that we know who these participants were. This section describes who we talked to, based on information provided by participants[1].

Over the course of the research period we spoke to ***48*** people from ***20 different communities*** in the Digby Area, including communities on ***Digby Neck, Long Island, Brier Island, in the Town of Digby*** as well as around the ***Weymouth*** area. We spoke to ***24 female identified*** people and ***24 male identified*** people between the ages of ***29 and 79***. The average age of the people we spoke to was ***60 years***, and nearly ***40%*** of participants were ***retired***. Those who were still working had a ***wide variety of careers***. We spoke with ***fishers, farmers and business owners*** as well as several ***professionals***, and multiple people working in the field of ***education.***

Participants represented a ***wide range of racial and cultural*** identities and backgrounds. Slightly more than ***30%*** of participants identified as ***black, African Nova Scotian, African Canadian or of African Ancestry***[2]. Nearly ***30%*** of participants identified as ***white or Caucasian***, while slightly over ***15%*** identified as ***Canadian*** and a further ***25%*** identified as a person of ***European Ancestry***. Other identities listed included: ***Nova Scotian, Aboriginal, Metis and Acadian***.

Participants had varied educational backgrounds. Each participant was asked *to report* ***the highest level of education*** they had completed. Nearly ***20%*** of participants had ***not completed high school***, while just about ***21%*** had a Grade 12 education. About ***12%*** had completed ***some post secondary*** education, while almost ***30%*** had a ***college diploma*** and about ***15%*** had completed a ***university degree***.

The above information provides us with a general understanding of ***who we talked to***, however, it is important to remember that this information is tidy, organized and presented in a

[1] Please see Appendix A for a complete presentation of the demographic data.

[2] We would like to note that while citizens of African descent make up 30% of our study's participants, this proportion is higher than the proportion of African Nova Scotians living in the Digby Area (exact statistics on the population of African descended community members will be released in the 2016 Census information later this year). However, the experiences of African Nova Scotians are underrepresented in the academic literature (Etowa, Wiens, Bernard & Clow, 2007). Thus, we have included the data from all of the African Nova Scotian participants in order to elevate the voices of marginalized Nova Scotians, so that they may be more meaningfully engaged in policies and decision making that directly affects their health and well being.

way that does not necessarily reflect the ***complex and intersectional***[3] realities that complicate people's lives and abilities to ***access health care services***. In the "Themes" section of this report we will describe the ***intersecting barriers*** to health care access experienced by participants.

Methods

This section provides an overview of the research methods and approach used to conduct the research completed for this project.

Community Based Participatory Research

This project was conducted using a Community Based Participant Research (CBPR) approach, which is increasingly used in health-based research[4]. CBPR's approach to public health research is based on researcher and participant reflection, data collection, and the creation of an action plan that involves the community and aims to improve health and reduce health-based inequities (Baum, MacDougall, & Smith, 2006). We felt this approach was best suited to this research project, as CBPR is a collaborative process between researchers and participants where both parties benefit, as it provides "researchers with insight into participants' needs, values and customs; it also improves community capacity, creates critical understanding of self-consciousness and increases community-based participation and social action outcomes" (Datta et al., 2015, 582). The use of a CBPR approach allowed for the communities in the Digby Area to play a significant role in the research, and to have significant input into the process of data collection and research outcomes.

Data collection was completed through two complementary methods: focus groups[5] and individual interviews conducted between September 2016 and February 2017. Over several months we facilitated several 'kitchen talks', a colloquial term we used for focus groups. Our focus groups involved two facilitators and ranged in size between five and nine participants. We facilitated the conversation through the use of 3 guiding questions, but did not intrude or insert ourselves into the discussion. Written consent was obtained from each focus group and interview participants. Each discussion was audio recorded, and notes were taken by each of the two facilitators. Focus groups differ from singular interviews as they allow participants to speak and interact with each other. These interactions were either complementary or argumentative, luckily very few interactions within our focus groups were argumentative. These complementary interactions allowed for each participant to build on the preceding remark (Bryman, Bell, & Teevan, 2012) and improved the flow of conversation. Focus groups "allow participants to probe one another's reasons [in response to interviewer's questions]" (Bryman

[3] Intersectionality is a concept defined by Kimberlé Crenshaw in 1989. Intersectionality describes how the many parts of a person's identity (race, gender, ability, education, economic and social class etc.) intersect to create multiple burdens, and intensify experiences of marginalization.

[4] For further information, see: Minkler, M. (2005), Minkler, M. (2004), and Wallerstein, N. & Duran, B. (2006)

[5] A focus group is defined as a planned discussion that aims to obtain perceptions about a defined area of research interest (Krueger & Casey, 2009).

et al., 2012, 174) and this can be more informative and revealing than question followed by answers in basic interviews.

Individual interviews were conducted with individuals and within communities in the Digby Area that we considered to be vulnerable, including racialized communities, communities of a very small size, those living on limited incomes, or those who had concerns about sharing their medical information in a group setting. Interviews took place in participants' homes, or at community halls and recreation spaces. Depending upon the preference of the participants, interviews were conducted with either one or both researchers present.

While we were hired by the Digby Area Health Coalition, it is important to note that we are researchers from outside the Digby Area. We as the researchers play a direct and intimate role in data collection and analysis, and it is important to acknowledge our position as outsiders. This was a positive as it meant that we had no explicit biases about the community coming into this research. The negative side of being outsiders is that some participants were more hesitant to speak with us, as we were not trusted members of the community. In some interactions with community members we were insiders, meaning we shared a common experience, role, or characteristic with participants (Dwyer & Buckle, 2009). Specifically, our experiences with the healthcare system in our own region. We used our own personal experiences accessing health care services to build trust and facilitate communication with participants, in a way that did not influence participant responses. Despite our outsider status, we believe that we have a wide range of responses and comments from participants that encapsulate the Digby Area's perceptions of health care services and challenges to access.

Our focus groups and interviews were semi-structured, meaning that we had three main questions that we asked, and from there allowed the conversation and additional questions to flow from participants' responses. Our three standard questions were as follows:

1. Please tell us about a time when you faced (or witnessed) barriers or challenges to accessing the health care services in the Digby Area.
2. What are three words you would use to describe your experience?
3. How could your experience have happened differently? What could have been changed to make it a better experience? Do you have any specific suggestions for change?

After each interview, researchers reviewed the interview audio, and conducted a thematic analysis using the six-phase method outlined by Braun and Clarke. The six-phases of analysis conducted were: familiarization with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes and writing the report (Braun & Clarke, 2006, p. 16-23). Based on this analysis of the interview data we were able to identify several themes that we found throughout our research. These themes are described in the next section of this report.

Confirmation Circles

The Community Based Participant Research, as used for this project, included three phases: the initial identification of community priorities, research and a third phase where researchers go back to the community and present their initial findings, to ensure that researchers are accurately representing the community's point of view (Minkler, 2004). After the focus group and interview process we returned to the Digby Area to conduct 4 "confirmation circles" in Freeport, Sandy Cove, Digby and Weymouth. These meetings were all open to the public, were generally well attended and included many people who had not participated in the research process. At each meeting we presented an overview of the interim report we created, outlining the key themes identified in the data we collected. The audience was asked for feedback on each theme. At each of the 4 meetings the audience reported to us that the data presented accurately represented their personal experiences with health care, and the community's experience more generally.

Notes were taken by one of the researchers, or a member of the Digby Area Health Coalition at each confirmation circle. These notes were compared to the data collected through focus groups and interviews, in order to confirm its accuracy before the final report was written.

At each of the 4 confirmation circles we heard a whole new slew of stories from audience members, which further confirmed the relevancy of the stories we had collected during the interview and focus group process. These stories, although valuable to the research process, are not directly reflected in the following report, as the goal of the confirmation circles was to ensure that the existing data was representative of the community's experience.

The next section of this report provides an overview of the themes identified in the initial round of interviews and focus groups, and confirmed at the 4 confirmation circle community meetings.

Themes

In this section, we outline the 5 dominant themes which were present throughout the stories of the 48 participants who contributed to this project. The 5 themes are: *family doctors, travel, quality of care, lack of communication,* and *effects.*

In addition to the five key themes listed above, we identified two other significant themes which did not occur as frequently in the data, but which warrant contemplation. These are: *community health* and *Nova Scotia's rural/urban divide*.

Family Doctors

The topic of family doctors came up in every one of our interviews, often in different ways, expressed in the following five themes:

- Nurse Practitioners
- Lack of continuity and trust
- Work and patient loads for new doctors
- Resulting misuse of emergency rooms

After the first few interviews, we began to ask participants if they had a family doctor, as it seemed to be the norm not to have access to a family doctor or a regular healthcare provider (for example, a nurse practitioner). As participants described:

> "It's been seven or eight years since I had a family doctor."
>
> "I have three children who don't have a doctor, I have five grandchildren who have no doctor."
>
> "[I've had] four doctors in six years."
>
> "My [older child] and I drive to Middleton [to see the child's doctor], my [younger child] is [has a doctor in] Digby and my husband has no doctor right now."

The majority of participants did not have a family doctor in the Digby Area. Many had to travel out of the area to visit their family doctor. Many participants had had numerous doctors in a short period of time due to rapid physician turn over in the area, or could not find a family doctor in their area or anywhere within a reasonable travel distance. Unable to find a family doctor, many participants had become patients of a nurse practitioner.

Participants spoke highly of the Nurse Practitioners who work in the community, however, several participants told us that they had been hesitant to become a patient of a nurse practitioner because once they had done so, they were no longer eligible to be on the waiting list to get a family doctor. Several participants also expressed frustrations at the limitations put on Nurse Practitioners' ability to provide comprehensive treatment, like a family doctor is able to. As a few participants explained:

> "The Nurse Practitioner lives right here, but you can't go to the Nurse Practitioner if you have an emergency… You have to rush to Digby and hopefully the emergency is open."
>
> "There's only so much that she [the nurse practitioner] can do for me."

Several participants stated that it is unrealistic to expect Nurse Practitioners to replace family doctors, when they do not have the same level of training or medical privileges. Other concerns included long wait times to get onto a Nurse Practitioner's patient list, and a high turnover rate in Nurse Practitioners practicing in their communities, and thus little continuity in their medical care.

Based on the data collected, it became apparent that even when residents had access to a doctor or other health care provider, residents of the Digby Area often have very little continuity in their medical care. One participant who did not have a family doctor described multiple visits to the walk-in clinic over several days:

> "If you go back [to the walk-in clinic], and you get another doctor on call you have to repeat the same [medical history] over again. And you never get to have a relationship like you did with your family doctor. Someone who knows your history."

Participants described similar experiences when visiting the emergency room at Digby Regional hospital, where many doctorless patients are forced to go in order to access primary healthcare services.

The lack of continuity in health care provision can be connected to many of the hurdles participants faced to obtaining adequate care, including the inability to access basic medical testing, the proliferation of unmonitored chronic medical conditions, missed diagnoses, misdiagnosis, and healthcare avoidance. As this participant explained:

> "Sometimes when we have no doctor at arm's reach, you sometimes ignore things, like you put it [health issues] on the back bench."

Participants also expressed frustration with seeing physicians who do not know their medical history, and with whom they had no personal relationship. As this participant described:

> "I went to the doctor on call and it was a hassle to get my prescription filled because it's a heavy narcotic. And he [said] 'I want to know why you're on this'… to go to him and to have to go through all my history of everything… I need a doctor. It's frustrating, especially when we are used to having a doctor right here in [Digby Area community], that you *know*, that knows you [so you don't need to describe your medical history]. Nobody's keeping track."

Several participants described the process of trying to find a new family doctor in the Digby Area through the "doctor lottery". The lottery requires potential patients to call a phone number over and over, with the hope of getting through and being assigned to an available doctor. Participants described this process as very frustrating; spending many hours redialing the phone, without success. One participant described it as "barbaric", explaining:

> "[my friend] sat on the phone trying to get the two of us in [the doctor lottery]. And no way, there was no way… I thought that was the craziest thing I had ever heard of."

The doctor lottery provides no guarantees, as it functions on a first come first serve basis, requiring patients to compete with one another to access basic medical services.

While residents spoke of how this lack of continuity affected them as patients, they also spoke to how this affected doctors. In recent years there have been several doctors who have come to the Digby Area, but very few of them have stayed on permanently. Participants explained that the doctors that do stay in the Digby Area are overworked and have massive patient lists. Participants felt that new doctors who come to the community do not stay because of the workload, and unrealistic expectations. For instance, one participant reported:

> "[The doctor who left recently] said 'I have no life'… the expectations that they put on these new doctors that come here, they expect them to take on a workload that would really be for four or five doctors."

Participants were not only able to describe how the lack of family doctors affected their care, but also how family doctors that are in the area are affected by the shortage. For the most part participants did not hold any singular doctor, administrator, or bureaucrat responsible for the inadequacies of the healthcare system. Rather, they saw the problem as a systemic one, where "confusing and illogical" policy and financial decisions affect patients and doctors alike.

Because of the doctor shortage, participants were forced to access health care services wherever they could find them. Many participants described going to the emergency room to access primary care services[6], as they had no family doctor, or their doctor was located far away. One participant described one such visit:

> "I thought I had a bladder infection… so I went to the emergency center after calling 811, and when I got there the attending doctor, who I think was out of the city and wasn't really familiar with the Digby healthcare problem. He said to me 'what are you doing here?... this is something a [family] doctor should do. You're wasting my time.' We don't have a doctor; we don't have a choice."

Use of emergency rooms for primary health care provision puts an undue amount of strain on the emergency health care services, and may increase wait times. Participants expressed frustration that they were forced to use the emergency room in this way, but saw no other option.

[6] Participants visited emergency room doctors in order to get prescriptions refilled, for blood work or routine medical exams, among other reasons.

Travel

Travel and access to healthcare went hand in hand for every participant. During the course of the research process, participants described five specific frustrations they experienced in relation to travelling to and from medical appointments and other healthcare services:

- Leaving Digby area to access health care services
- Travel time and distance to access care within the Digby Area
- Physical difficulties with travel
- Economic difficulties with travel

Participants spoke of leaving the Digby Area to access healthcare services; for regular doctor appointments, for specialists, or for surgery. Examples included:

> "We'd be gone six or eight hours, driving up [to Kentville for a specialist appointment] and driving back… in the wintertime, that's challenging."
>
> "It's unreasonable [to drive six hours for a doctor's appointment], but she [the doctor] knows me, she has my chart."

Along with the need to travel out of the Digby Area to access healthcare, come physical and economic challenges. Examples of physical challenges include elderly residents in rural areas who have difficulty making long trips due to the physical strain it puts on their bodies. One participant told us about their partner falling into a ditch during a roadside bathroom break on a long drive. Additional examples included the following stories:

> "My husband was in excruciating pain… I bundled him up… we got up to the ferry… the captain wasn't in the wheelhouse... we couldn't get their attention… we had to sit there half an hour to get on the ferry to get across."
>
> "We took five hours to get to the appointment [in Halifax], I could barely walk into the hospital [this participant had back/leg issues] … it was almost nine hours there and back… I have been worse off since then."

Participants described regularly traveling the 101 highway for multiple hours, and medical trips which sometimes required an overnight stay in preparation for an early morning appointment. Aside from the physical strain caused by long trips, excessive travel as well as the associated expenses (gas, hotel bills, cost of food etc.) caused economic stress to participants. Several people reported that they had to take time off work to attend distant medical appointments, or to drive a friend or family member who did not have access to reliable transportation of their own. Participants explained:

> "When a hospital closes [in one area] there should be some concern about transportation… how would people get home? It's a significant distance [to Yarmouth]. There's a lot of people who don't have the money, they couldn't afford to get a taxi. There's no public transportation that goes all the way from Digby to Yarmouth."
>
> "When I think about people who are working at McDonald's, whose wages are significantly less and they have to take time off [to travel to access healthcare] and they're not getting paid for it."

Participants explained that the lack of adequate healthcare in the Digby Area means that the ability to travel is necessary to access healthcare. However, travelling comes with its own challenges and barriers to access (i.e. owning a car, affording gas etc.), which further complicate Digby Area residents' ability to access necessary healthcare services.

Quality of Care

The "quality of care" theme refers to numerous aspects of the healthcare system in the Digby Area which participants felt created barriers to access, including:

- Inconsistency in patients' experiences
- Disrespect experienced by patients
- The lack of local surgical options and access to medical specialists
- Illogical administrative policies and procedures
- Long wait times
- The lack of culturally appropriate care

Participants reported feeling so frustrated with the inadequate quality of care provided, that they avoided accessing the healthcare system whenever possible. As one person said "The quality of care is so inconsistent. It all depends on who you get". Participants described vastly different experiences, all based on which doctor was on-call in the emergency room, or which nurse was working.

In some cases, the treatment given during one visit was drastically different than the treatment given for the same condition when a different doctor was on-call. In some cases, these inconsistencies were especially noteworthy because they put the wellbeing of the patient at risk. One participant described taking their child to the emergency room, where the child was treated for a severe medical condition (after a dangerously long wait time). During a subsequent visit to the same emergency room (for the same condition) a different doctor told the parents that the treatment their child had been given previously "hasn't been what's traditionally done with children having [medical emergency] for decades".

Another participant described being treated disrespectfully while seeking care for an upset stomach at the Digby ER, and then being sent home without any follow up:

> "[Explaining a trip to the emergency room in the middle of the night] The nurses told me 'The doctor is here but he's asleep and he told us not to wake him up, he told us to get you to drink this stuff.'"

A few days later, after constant pain, the participant went to Yarmouth where they were treated for a gallbladder infection/rupture. This participant compared their experience at the Digby hospital to a "third world country", i.e. a country where there are not enough resources to provide adequate health services to citizens.

Participants also described the challenges associated with first obtaining a referral (difficult without a family doctor), and then being able to attend specialist medical appointments, which are not available in the area:

> "[As for] specialty appointments… we can rarely get things done in Digby… it's always at least a two and half hour journey [one way] to go see specialists."

Seeing a specialist can be especially difficult in the winter. Participants reported waiting months for an appointment, only to be unable to attend due to a snowstorm or other winter weather event. For example, one participant had a dislocated shoulder for over a year (at time of interview) and was still unable to get an appointment with an orthopedic surgeon after the doctor they had been seeing previously, moved away. The process can also seem illogical and mismanaged. For example, many Digby Area residents told us they were expected to be present at early morning appointments in Halifax or Kentville, when it is possible to schedule them later in the day to accommodate travel time and unpredictable weather. Participants expressed frustration with this practice, and asked: if medical services have to be concentrated in urban areas, should there not be consideration for those required to travel to access them?

According to participants, the quality of care available to the African Nova Scotian population in the Digby Area is further complicated and affected by the existence of racism and discrimination in the community. As one participant explained:

> "Race is an issue here. Racism is a big-time problem… I'd love to have a person of colour here as a doctor… I don't know what their experience would be like… how do you make somebody feel welcome? This is a white town."

Participants also expressed concern that the healthcare professionals they do have access to are not knowledgeable about the unique medical needs of the African Nova Scotian community:

> "Culturally, Dr._____ had it together. Different things that Black people get that white people don't, Dr._____ would be checking into that. That makes a big difference."

Many participants, from all communities, said that they are willing to travel and jump through hoops to access medical care if that is what is required of them. However, they were deeply frustrated and disheartened by the poor quality of medical care they received, and the seeming lack of compassion expressed by some of the medical professionals attending to the needs of the community. This sentiment was expressed strongly by one participant who said a lot of people's frustration with the system could be reduced if the province would "hire somebody that gives a s***" and made patients feel cared for and about.

Lack of Communication

During the course of the study it became apparent that participants were frustrated by three specific forms of miscommunication:

- Between healthcare providers (i.e. between doctors, nurses, etc. regarding patient care)
- Between healthcare professionals and their patients
- Between the province of Nova Scotia and the public

Stories of miscommunication or lack of communication were frequent. As one participant said "We should get news, whether it's good or bad… we need complete circulation of information". In many cases participants were not informed of test results, or medical decisions that directly affected their health. Miscommunication between those within the healthcare system also affected patients, as one participant described:

> "I had to have a hip replacement, and I went to my nurse practitioner… she had to put a referral into Kentville, and I had [a] wait time of two years, and a year went by and I'm in pain for this whole year, so I called Kentville and they lost my referral- they never got it! So I had waited almost three years for a hip replacement [and wasn't even on the list]."

Participants were frustrated that they are often left out of the communication loop. Several people spoke about being upset at not being informed by their doctor about when there was something happening with their health, or a decision being made without their input. Others expressed frustration that the public is not consulted about what is happening on a larger scale within the healthcare system. As a participant from Weymouth succinctly said, "Perception is reality, we are uninformed, and so that becomes reality to us, because we don't have the story".

Effects

In every interview and focus group, throughout the research process, participants described how their lives were negatively affected by inadequate and inaccessible healthcare services in the Digby Area. While the stories we heard were each unique to the experiences of

the storyteller, five underlying themes emerged:

- Isolation
- Stress
- Financial strain
- Out migration and attraction of people to live in the Digby Area

Participants discussed isolation in two distinct ways. First, many participants reported feeling isolated from the healthcare system. Many people lived in communities which used to have a doctor that lived there, but now must travel a minimum of an hour each direction to go to the emergency department for basic healthcare needs. Having to travel so far to access the healthcare system proved difficult for those in rural areas, especially seniors and those living on the islands and Digby Neck. As these participants described:

> "When you get older, and you live on an island, it is very intimidating sometimes to know that you do not have proper medical care."
>
> "My husband and I thought about moving, because we're so far from reliable health care."

Some participants also reported experiencing social isolation. Some participants were primary caregivers for family members with severe medical needs, a responsibility which required that they never leave that family member alone in the house. As this participant said:

> "Some of the consequences [of being a primary caregiver]: I don't go out… when they have these suppers at the hall… 12 years [of taking care of my family member] I can't get out to anything like that."

Physical disabilities isolate people as well. We spoke with participants who found it very difficult to leave the house, and were dependent on their neighbours and family members to visit them when they were able. These participants relied on the kindness of friends and family to do day-to-day tasks like grocery shop and clean their houses. Social isolation can affect a person's mental health and general well-being, and as this participant said, mental health and well-being are not always considered in the treatment of a physical ailment:

> "And you know what, you are the first person to ever ask about my mental health… nobody, not one person, and to me that's the biggest thing."

As we have discussed in previous themes, there is a monetary cost to having poor access to healthcare. Examples participants provided include the following;

> "[Discussion of a relative who is on social assistance and has high blood pressure] Not that she can always afford to get [her medication], but even when she can

she doesn't have a care [to pick it up]. And she doesn't have a phone so she can't call and say can you go get my stuff, it had to be that I stopped by."

"For a checkup in Halifax at the QE2, I had to go get a hotel room and stay the night, pay for that gas, and loss of work… I got a room and stayed all night, I went and waited at the hospital, and they called me in and said 'I'm sorry he can't see you today, he's out at another appointment' I had to come home, and rebook again, and I did that a couple of times."

To access the healthcare system, participants are spending excessive amounts of money that those in urban or other rural areas of the province where more services are available, do not have to pay. In addition to the financial cost, the lack of healthcare services and adequate care in the Digby Area causes residents a great deal of stress and concern, which often leads to out migration, and a decreased attraction for people to live in the Digby Area. As these participants said:

"I've talked to a lot of people and they've said they don't feel comfortable staying. They don't feel comfortable having a family here because what if something happens? What if there's a medical emergency?"

"If I hadn't have grown up here [in Digby] I don't think I would have stayed."

Participants indicated that the lack of adequate and accessible healthcare services in the Digby Area creates further financial, physical and mental strain on Digby Area residents, as well as jeopardizing the economic and social prosperity of the community.

Community Health

The 'community health' sub-theme describes how the lack of adequate and accessible healthcare services in the Digby Area affects residents' quality of life, and the economic and social prosperity of the community. Examples included family members who wanted to move back home to Digby, but would not because they knew their medical needs would not be met, as well as people who were leaving, or had left, the Digby Area because they could not afford to travel to and from medical appointments across the province. As participants explained:

[About the healthcare system] "It's the only drawback to living here."

"I've talked to a lot of people and they've said that they don't feel comfortable staying. They don't feel comfortable having a family here because what if something happens? What if there's a medical emergency?"

During interviews and focus groups research participants expressed deep concern not only for their own health and the health of their families, but also for the health of the community itself. Many participants felt that the lack of adequate health services, and challenges to accessing health services in the area contributes to out migration from the area, and deters any new

people from moving to the community[7].

Rural/Urban Divide

During the analysis of the interview data we noticed that several participants expressed an underlying concern about the rural/urban divide within the province of Nova Scotia. Participants felt that the healthcare system in Nova Scotia is very urban focused[8]. Participants expressed frustration with the allocation of government funding, and the location and availability of medical specialists and access to surgeons. For example:

> "It's [upsetting] how metro-centric our healthcare has become, I understand going to the VG [the main hospital in Halifax] for surgery absolutely... they said the day before your surgery we'll call you and we'll tell you when your surgery's going to be, which is standard. She had to be at the VG for 6:30 in the morning… my husband took the day off work to drive her up. He had to get up and leave at quarter to four in the morning… Why couldn't they at least take into consideration, patients are driving a distance maybe we should schedule their surgeries later in the day… there's a lack of consideration of rural Nova Scotia."

Participants reported feeling that their health is being jeopardized based solely on the fact that they live in rural Nova Scotia. The rurality of the Digby Area was a recurring topic throughout our research, and based on the experiences of the research participants, rurality does appear to have an effect on accessibility, availability and quality of healthcare services.

Discussion

While it is important for us to identify themes in the data collected, it is also vital to compare what we have found to existing research. This section reviews the themes found throughout this study in relation to one another, and compares these themes to current health research literature.

Social Determinants of Health

Most of the themes identified in the data either directly or implicitly examine the social determinants of health[9]. The social determinants of health can include income and social status, education, working conditions, social environments, social support networks, gender,

[7] The population of the town of Digby dropped 4.3% between 2011 and 2016, and the population of the Municipality of Digby dropped 4.8% in the same time period (Statistics Canada, 2016).

[8] Specifically focused in the Halifax Regional Municipality.

[9] The World Health Organization defines the social determinants of health as, "the conditions in which people are born, grow, live, work and age, including the health system", and notes that these determinants "are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries" (WHO, 2017).

race, social exclusion, personal health practices, and more (Government of Canada, 2016; Mikkonen & Raphael, 2010). Social determinants of health are the primary factors that shape the health of Canadians, ahead of medical treatments or lifestyle choices (Mikkonen & Raphael, 2010). For the purposes of report length, we chose to only focus on a few of the social determinants of health, however, multiple determinants often intersect with one another, and cannot realistically be considered in isolation.

Income

A person's income shapes their overall living conditions, and according to Mikkonen and Raphael, those living in poverty are especially affected by health inequalities (2010). Health and income relate in that a person's individual or family income affects the healthcare they receive and where they live affects how income is distributed across a population (Government of Canada, 2016; Mikkonen & Raphael, 2010). In relation to income, job security also plays a role in a person's health. Across Canada, job security has been increasing over the past few decades (Mikkonen & Raphael, 2010), however, in Digby Area, much of the available work is precarious in nature. Precarious work includes working part-time, being self-employed, and having temporary or seasonal work. Many participants in this research reported working in fishing or farming, were self-employed, or had only part-time work (excluding those who are retired, unemployed, or on disability). Often precarious work does not offer the option of health insurance, thus the cost of prescriptions and some medical procedures must come out of pocket. Precarious work is also inconsistent, meaning that precariously employed people often have a lower income (Mikkonen & Raphael, 2010). The inconsistent nature of precarious work also affects *when* a person is able access health care. People who work in the fishing and farming industries, or those who are self-employed, work endlessly for months at a time. Thus, the demands of work restrict when they can access healthcare, unless they are willing to lose work hours. Precarious work can also be dangerous, increasing the risk of injury, for which precarious workers may not have the time or expendable income to seek treatment (Mikkonen & Raphael, 2010).

Education

A person's level of education also plays a role in their health status. Those with higher education tend to be healthier than those with lower educational attainment. This association holds true for other social determinants of health, including: income, job security, and working conditions (Government of Canada, 2016; Mikkonen & Raphael, 2010). This simply means that those with higher education generally have better-paying jobs, secure jobs, and healthy working conditions. Just over half of our participants had completed a post-secondary degree or partially completed a degree, and the other half had attained a grade 12 education, or less.

Social Exclusion

Social exclusion refers to specific groups being denied certain opportunities to participate in Canadian life, including healthcare, both in access to services and the creation of policy (Mikkonen & Raphael, 2010). It is important to note that Aboriginals, Canadians of colour, recent immigrants, women, and those with disabilities are most likely to be socially excluded (Mikkonen & Raphael, 2010). Here we see race, gender, and ability at play as social determinants of health. Exclusion can fall into several categories; denial of participation in civil affairs, such as the formation of laws; economic exclusion, when individuals cannot access economic resources such as steady paid work; and, denial of social goods, such as healthcare, education, housing, and income security (Mikkonen & Raphael, 2010). All of these forms of exclusion were present in the data collected for this study.

Health inequalities affect all Canadians, but especially those experiencing challenging social and material living conditions. These conditions can cause instances of physiological and psychological stress arising from "coping with conditions of low income, poor quality housing, food insecurity, inadequate working conditions, insecure employment, and various forms of discrimination based on aboriginal status, disability, gender, or race." (Mikkonen & Raphael, 2010, 10). These stressful living conditions have had an effect on many participants we spoke to, and affect the quality of their lives.

Rurality

Participants in our study as well as participants in the confirmation circles spoke of the divide between rural and urban parts of Nova Scotia, especially in relation to healthcare funding and resource allocation. Current research reflects this view, i.e. *place is important*. Where an individual lives affects community context, which includes their physical environment, social and demographic forces, economy, culture, and healthcare system (Canadian Population Health Initiative, 2006). In rural Digby and the surrounding areas, there is a strong sense of community, but the community faces issues that their urban counterparts do not. Those in rural areas are more likely to have a lower socioeconomic status, lower education levels, and are more often precariously employed (Canadian Population Health Initiative, 2006). In the context of this research, rurality is a significant determinant of health. In comparison to their urban counterparts, "People living in rural communities generally need to travel longer distances, and often on more dangerous roads, for work, shopping and other reasons. Not surprisingly, injuries and death due to traffic accidents are much more common in rural areas." (Canadian Population Health Initiative, 2006, VI). The isolation of rural communities causes those to live there to have to travel to see specialists and sometimes a doctor, which in Nova Scotian weather can be dangerous and costly.

Isolation is a subtheme of several of the main themes outlined in the previous section. Participants felt isolated from health professionals, as there are so few doctors in the Digby Area. Participants felt isolated from surgical services, as there are so few surgery and specialist options in the Digby Area. Participants were physically isolated from health care services, as they had to travel out of the Digby Area to access a wide variety of healthcare services. The effect of the physical isolation participants experienced was an associated psychological isolation, which may have been associated with participants' general feeling that they are not being cared for or about by either their government or some healthcare professionals.

The rurality of the Digby Area also affects the few doctors who are there. Many rural family doctors are heavily involved in hospital work such as emergency medicine and general care of inpatients, and have less time for their office work in comparison to urban family doctors (Rourke, 1993). The increased workload for rural doctors outlined in the literature was reflected by study participants, a theme which we will unpack further in the following section.

Family Doctors

In a national study, it was found that 65% of Nova Scotians felt that their doctor spent enough time with them during visits. This statistic was higher than any other province or territory in the country (Health Council of Canada, 2014). It is not our intention to argue that family doctors in the Digby Area dedicate enough time to their patients. Rather, we are making the point that **most people do not have a family doctor**. Having a regular doctor is not the only measure of access to healthcare, but it is a large part of what accessible healthcare looks like. Those without a regular source of care, like a doctor, tend to have no health insurance (an indicator of unemployment or precarious work), are racialized, and have a lower income than average (Lambrew, DeFriese, Carey, Ricketts, & Biddle, 1996).

A person's status in the social determinants of health is directly linked with their ability to access to regular care. It has also been shown that those with a family doctor have better access to healthcare than those with another health care provider, such as a nurse practitioner (Lindström et al., 2006). Nurse practitioners play an important role for many community members in the Digby Area, but they cannot replace the role and benefits of having a family doctor. Those with a family doctor are more likely to have visits that are preventative, not treatment based (Ettner, 1999). The primary care offered by a doctor means that people can access regular checkups rather than trying to access healthcare when they know they are already sick. This also means that there is less need for hospital based care for those who have a family doctor (Fung, Wong, Fong, Lee, & Lam, 2015). People in the Digby Area have limited access to family doctors, and as a result use hospital emergency rooms for primary care purposes.

Nearly half of Canadians said they had used an emergency room (ER) for a problem a regular doctor could have treated (Health Council of Canada, 2014), arguably, primary care (family doctors) should be able to gate-keep for hospital health services (Fung et al., 2015;

Hunt, Weber, Showstack, Colby, & Callaham, 2006). In the Digby Area, there are not enough doctors to service the community, therefore people use ER's as family doctors. It has been found that patient-centered care, which is a key element of family medicine, is directly related to a significantly decreased annual number of visits for specialty care and less visits to the hospital (Fung et al., 2015). Having a family doctor is not only the first step in accessing the healthcare system, but also improves overall health status. Those without a doctor access healthcare through an already overloaded hospital system, for basics like prescriptions, or seek help once they know they already have a health issue.

The simplest way to address the doctor shortage is an influx of doctors. However, there are issues with retaining and getting doctors to stay, as pointed out by many community members. We explored what factors may influence a doctor's decision to move to a rural area. These included: a strong desire for a rural practice; does their spouse want to live in a rural area; considerations for children (schools, afterschool programs and activities); recreational opportunities; experience in training, community size; and financial incentives (Rourke, 1993). Based on this list, it makes sense that the Digby Area has issues retaining doctors. Digby Area is an isolated rural area with a strong sense of community, but it has small schools, few recreational activities, or employment opportunities for spouses, and overall lower socioeconomic status than urban areas of the province. Professional considerations listed by doctors included reasonable work hours, professional backup, speciality services locally, hospital services, and earning potential (Rourke, 1993). As discussed throughout this report, the healthcare services in the Digby Area are very limited and the few current doctors have huge workloads, this not only negatively affects community members' access to healthcare, but also prevents potential healthcare professionals from relocating to the Digby Area, and staying.

Travel

Much of the Travel theme can be connected to Rurality, as the main reason people in the Digby Area need to travel so far is because of the rurality of the Digby Area. People need to travel to health care services, because there are so few services available in the Digby Area. The Digby hospital offers very limited services, and therefore people must travel to Yarmouth, Kentville, or Halifax regularly for hospital visits. Others within the community chose to travel long distances to visit their family doctors, as they could not access a doctor locally. Even to access healthcare within the Digby Area, people must travel. Those who live on the Islands or Digby Neck have to travel at least an hour round-trip to get to Digby Hospital for emergency care. Participants with chronic health challenges reported that long periods of sitting during travel worsened their condition. As a 2015 report from the Health Council of Canada summarizes; "Imagine arriving at an appointment with a specialist after waiting more than a month to see her, as 60% of Canadians do, to find that your lab results have not been sent over by your family doctor. This kind of frustration wastes everyone's time, delays care, and erodes confidence in our health care system" (Health Council of Canada, 2014, 5). This experience was echoed among many of participants within the study.

Quality of Care

Participants experienced an inconsistent quality of care, primarily at the Digby Hospital ER. Also, the quality of care received varied depending on which healthcare professionals were working on a given day. One consistent experience reported by participants was long wait times. Participants said that they almost always had hours of waiting should they go to the ER. Participants also felt disrespected at times when visiting the ER. We believe this to be because of patient frustration with the healthcare system, as well as healthcare professionals who are overworked and also frustrated with the healthcare system. Participants also pointed to a lack of culturally appropriate care, and felt that some doctors and the Nova Scotia Health Authority are not taking into account the different ways people are marginalized, by race, culture, or gender. The illogical policies and procedures reflect not having a universal system from one hospital to another or one doctor to another. This will be further explored in the theme of Lack of Communication.

Lack of Communication

Communication breakdown is apparent in three main ways in the Digby Area healthcare system: between healthcare providers, between healthcare providers and patients, and between the Province of Nova Scotia and the public. Improved communication between healthcare providers can reduce the potential for errors that affect patients (Roughead, Kalisch, Ramsay, Ryan, & Gilbert, 2011). Only 28% of Nova Scotians felt that doctors or staff where they normally get medical care seemed informed and up-to-date about the care they had received in the hospital ER (Health Council of Canada, 2014). Health providers "need to communicate efficiently and effectively – with one another and with patients—to ensure that care is timely, sage, appropriate, and patient-centered" (Health Council of Canada, 2014, 30). Better communication between healthcare providers and patients would mean a decrease in patient frustration towards the healthcare system, as pointed out by participants. Participants also expressed frustration towards the government as they can acknowledge that the healthcare system issues are systemic and a provincial problem.

Effects

All the themes we have discussed are an effect of poor access to healthcare, but we felt it important for it to be its own theme, in order to highlight how participants'' lives are being affected. Geographically isolated communities such as those within the Digby Area are places where services are widely dispersed and access to services is poor. People living in isolated communities often have delayed treatments or incomplete surgical options, low levels of screening, and delayed diagnoses (Smith, Humphreys, & Wilson, 2008). The stress of worrying about your health, your family's health, the cost of accessing health, not having a doctor, not knowing if your local ER will be open when you need it, and a variety of issues with accessing health care, cause physiological and psychological issues. For example, between 8% and 15% of Canadians (percentage varied provincially) have not filled a prescription or skipped a dose

because they cannot afford the cost of medication (Health Council of Canada, 2014). This cost-saving approach was taken by several participants, while other participants reported avoiding other forms of treatment, because they could not afford it.

Conclusion

Fewer than half of Canadians feel that our healthcare system is working well, with the lowest percentages in the Maritime Provinces. Only 39% of Nova Scotians felt that the provincial healthcare system works well. The importance of this research is reflected in the importance of community experiences with the healthcare system. Patients' views and experiences are "an important source of information about the quality of health care, one that a wide range of organizations – from clinics and hospitals to whole systems – are increasingly using to monitor and improve their performance" (Health Council of Canada, 2014, 49). This research project has aimed to reveal how residents of the Digby Area perceive the availability and quality of the healthcare system. The data reveal five consistently reoccurring themes, which describe the struggles participants face while trying to access adequate healthcare services. The current state of the healthcare system in Digby Area does not allow for residents to have reliable access to family doctors, to have access to quality healthcare services within a reasonable distance of their communities, or to be treated fairly by the healthcare system.

Throughout the interview and focus group process it became evident that, due to the poor quality of care, residents in the Digby Area are required to advocate for themselves. Several participates spoke of their strong self-advocacy, without which they would not have received the care they need. In addition, participants spoke about community members advocating for each other and for family members. While residents should not have to rely on advocacy to ensure access to health care services, it was a part of the story we thought important to acknowledge. Although participants face overwhelming and frustrating barriers to health care access, they continue to support one another and fight for the prosperity of their community.

The health disparities experienced by participants in this study cannot be ignored. As a report from the Pan-Canadian Public Health Network stated, "health disparities are inconsistent with Canadian values, threaten the cohesiveness of the community and society, challenge the sustainability of the health system, and have an impact on the economy" (Population Health Promotion Expert Group & Healthy Living Issue Group, 2009, 1). As such, we have made several recommendations that we believe may benefit community members, healthcare providers, and improve overall access to the healthcare system in the Digby area.

Recommendations

The following recommendations have been made by independent researchers, knowledgeable in what has been reported to us by community members. The following recommendations are based on the experiences of research participants. Therefore,

recommendations which are already reflected (wholly or in part) in existing Nova Scotia Health Authority health policy, may need to be revisited, as they are not currently addressing the needs of citizens in the Digby Area.

General Recommendation

1. *Prioritize The Social Determinants of Health:*
   Health policy decisions which prioritize improving citizens' access to the social determinants of health will help to address the systemic causes of health inequities. In the Digby Area, focus should be on increasing access to the tangible social determinants of health (including: income and education, working conditions, social environments, social support networks and transportation), with consideration for the ways in which policies may interact with or affect the less tangible social determinants of health (including: social status, gender, race, and social inclusion). The social determinants of health play a direct role in the health of all Nova Scotians, however, the social, cultural and economic realities unique to the Digby Area (and other rural areas) must be understood, and directly addressed in health policy decisions.

Rurality

1. *Engage Rural Communities*
   In order for the Digby Area community members and healthcare providers to feel as though they are more involved in the urban-focused healthcare system, we recommend the Nova Scotia Health Authority should have rotating meetings across Nova Scotia, including meetings in rural areas such as Digby and surrounding areas.

2. *Increase Support for Members of Rural Industry*
   We recommend increased support for those who are self-employed, and those working within the fishing, farming and tourism industries. These are Digby Area community members who have the added pressure of choosing between their livelihoods and attempting to access healthcare.

Family Doctors

1. *Increase Support for Doctors*
   Doctors in the Digby Area need more supports from the Nova Scotia Health Authority, as well as the provincial government. Supports may take the form of increased administrative support, and/or decreased rent for the family practice offices.

2. *More Doctors*
   More doctors per capita. Increasing the number of doctors in Digby alone would be beneficial, however, the Islands, Digby Neck, and the Weymouth area should be taken into consideration. An increase of doctors would hopefully decrease the workload on

doctors currently in Digby as well.

3. *Reopen The Weymouth Clinic*
   Weymouth acts as the center for several adjacent communities, and the village has a long history of delivering effective care. The local clinic there should be returned to a full functioning state.

4. *Change the Doctor Lottery*
   We suggest an alternative to the 'doctor lottery'. We suggest a triage system, which allocates doctors to patients based on need.

Travel

1. *Consideration of Distance Travelled*
   Healthcare providers should take the location of the patient into consideration. For example, booking appointments later in the day for those travelling a long distance. This would remove the necessity of overnight accommodations for early morning appointments, and reduce the likelihood of patients being on the road already if an early morning appointment is cancelled.

2. *Visiting Specialists*
   Bring specialists from areas like Halifax, Kentville, and Yarmouth to spend a day in the Digby Hospital, in order to reduce travel times and costs.

3. *Bring Back the Medi-Bus*
   The traveling medical service reduced travel times and costs for people living in very rural areas, and increased availability of services for those who have difficulties traveling.

4. *Increase Use of Technology*
   Teleconferencing, where appropriate, should be made an option for patients required to travel great distances.

Quality of Care

1. *Standard Procedures for Consistent Treatment Experiences*
   Though we are unsure of current procedures at the Digby Hospital and ER, based on participants' experiences, we suggest the implementation of standardized procedures for incoming patients, as well as an evaluation of the application of existing procedures.

2. *Wait Times*
   An exploration into long wait times in the Digby Hospital ER.

3. *Cultural Competency Training*
   Professional development sessions for doctors, nurses, and other healthcare professionals focused on the treatment of those in poverty, people of colour, and gender non-conforming people.

4. *Increase Service Availability at Digby Regional Hospital*
   We strongly suggest increased services at the Digby Hospital, this would decrease the need for people to travel so far, and would allow people to access healthcare more easily.

Lack of Communication

1. *Communication Policy*
   We suggest the creation of several communication strategies: between health care professionals, between the province and citizens and between health care professionals and patients.
   a. Communication between health care professionals and their patients, and between professionals can be worked out through professional associations.
   b. Improved communication between the province and citizens is a high priority. Although communication policies already exist, an element addressing the government's accountability to the public needs to be added.

   Some Suggestions for Increased Accountability:
   - Regular meetings between the Digby Area community and the Nova Scotia Health Authority, to ensure there is an open line of communication between the government and the public, with a focus on building trust.
   - Evaluation of existing procedures and policies, in order to assess their effectiveness and the level to which they are being consistently applied.

2. *Universally Accessible Digital Patient Records*
   Health care providers should have access to a patient's medical records no matter where the patient goes to access care, be it a walk in clinic, or emergency room. A digital system which shares patient records across the province may reduce the likelihood of misdiagnosis, and would eliminate the requirement for patients to recount their medical history each time they see a different medical professional.

References

Baum, F., MacDougall, C., & Smith, D. (2006). GLOSSARY: Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854–857.

Bryman, A., Bell, E., & Teevan, J. J. (2012). *Social Research Methods: Third Canadian Edition*. Don Mills, Ontario: Oxford University Press.

Canadian Population Health Initiative. (2006). *How Healthy are Rural Canadians? An Assessment of their Health Status and Health Determinants*. Ottawa, Ontario: Canadian Institute for Health Information.

Datta, R., Khyang, N. U., Khyang, H. K. P., Kheyang, H. A. P., Khyang, M. C., & Chapola, J. (2015). Participatory Action Research and Researcher's Responsibilities: An Experience with an Indigenous Community. *International Journal of Social Research Methodology*, *18*(6), 581–599.

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1).

Etowa, J., Wiens, J., Bernard, W., & Clow, B. (2007). Determinants of Black Women's Health in Rural and remote Communities. *CJNR 39*(3).

Ettner, S. L. (1999). The Relationship between Continuity of Care and the Health Behaviors of Patients: Does Having a Usual Physician Make a Difference? *Medical Care*, *37*(6), 547–555.

Fung, C. S., Wong, C. K., Fong, D. Y., Lee, A., & Lam, C. L. (2015). Having a family doctor was associated with lower utilization of hospital-based health services. *BMC Health Services Research*, *15*. https://doi.org/10.1186/s12913-015-0705-7

Government of Canada. (2016, June 27). Social Determinants of Health. Retrieved April 19, 2017, from http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/

Health Council of Canada. (2014). *Where You Live Matters: Canadian Views on Health Care Quality*. Toronto, Ontario: Health Council of Canada. Retrieved from http://publications.gc.ca/collections/collection_2014/ccs-hcc/H173-1-8-2014-eng.pdf

Hunt, K. A., Weber, E. J., Showstack, J. A., Colby, D. C., & Callaham, M. L. (2006). Characteristics of Frequent Users of Emergency Departments. *Annals of Emergency Medicine*, *48*(1), 1–8. https://doi.org/10.1016/j.annemergmed.2005.12.030

Lambrew, J. M., DeFriese, G. H., Carey, T. S., Ricketts, T. C., & Biddle, A. K. (1996). The Effects of Having a Regular Doctor on Access to Primary Care. *Medical Care*, *34*(2), 138–151.

Lindström, M., Axén, E., Lindström, C., Beckman, A., Moghaddassi, M., & Merlo, J. (2006). Social capital and administrative contextual determinants of lack of access to a regular doctor: A multilevel analysis in southern Sweden. *Health Policy*, *79*(2–3), 153–164. https://doi.org/10.1016/j.healthpol.2005.12.001

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. Toronto, Ontario: York University School of Health Policy and Management. Retrieved from http://www.thecanadianfacts.org/the_canadian_facts.pdf

Population Health Promotion Expert Group, & Healthy Living Issue Group. (2009). *Indicators of Health Inequalities*. Canada: Pan-Canadian Public Health Network.

Roughead, E. E., Kalisch, L. M., Ramsay, E. N., Ryan, P., & Gilbert, A. L. (2011). Continuity of care: when do patients visit community healthcare providers after leaving hospital? *Internal Medicine Journal*, *41*(9), 662–667. https://doi.org/10.1111/j.1445-5994.2009.02105.x

Rourke, J. T. (1993). Politics of rural health care: recruitment and retention of physicians. *CMAJ: Canadian Medical Association Journal*, *148*(8), 1281–1284.

Smith, K. B., Humphreys, J. S., & Wilson, M. G. A. (2008). Addressing the health disadvantage of rural populations: How does epidemiological evidence inform rural health policies and research? *Australian Journal of Rural Health*, *16*(2), 56–66. https://doi.org/10.1111/j.1440-1584.2008.00953.x

Wallerstein, N. & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*(3), 312-323.

World Health Organization. (2017). Social Determinants of Health. Retrieved from WHO website http://www.who.int/topics/social_determinants/en/

APPENDIX A

Demographic Data Tables

Age (n 48)
Mean 59.9
Mode 65
Range 29-79

Identity (n 45)	**n**
Black/African NS/African Canadian/African Ancestry	15
White/Caucasian	13
Canadian	8
English/European Ancestry	12
Nova Scotian	2
Mixed Race	1
Jewish	1
Aboriginal/Native	1
Metis	1
Acadian	1
New England Planter	2
French	2

Education Level (n 48)	**n**	**%**
Did not complete High School	9	18.75%
Did not complete High School/attended trade school	2	4.16%

Completed Grade 12	10	20.83%
Completed College	14	29.16%
Completed an Undergraduate Degree	6	12.50%
Completed a Graduate Degree	1	2.10%
Completed "some" of a post secondary education	6	12.50%
	n 48	100.00%

Home Community	n
Barton	1
Central Grove	2
Clare	1
Cornwallis	1
Danvers	3
Digby	7
East Ferry	1
Freeport	1
Gilberts Cove	1
Gullivers Cove	1
Ross Creek	1
Sandy Cove	1
Smiths Cove	1
Southville	5
Tiddville	1
Tiverton	1
Westport	7
Weymouth	7
Weymouth Falls	3
Weymouth North	2

n 48

Occupation	n	% of total
Retired	19	39.58%
Self Employed	5	10.42%
Disabled/Unemployed	3	6.25%
Professionals	3	6.25%
Farming and fishing	5	10.42%
Education	3	6.25%
Trades	3	6.25%
Administration Assistant or Receptionist	2	4.17%
Homemaker	1	2.08%
Postal Worker	1	2.08%
Cleaner	1	2.08%
Retail	1	2.08%
Residential Care	1	2.08%
	n 48	100%