University of Alberta

Impact and Implications of Health Reform/Renewal Policy for Rural Women in Saskatchewan and Manitoba: A Case Study Approach

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of *Doctor of Philosophy*

Faculty of Nursing

Edmonton, Alberta
Fall 2005

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Abstract

Rural women in Saskatchewan and Manitoba face many challenges to achievement of personal and community health. A major challenge, in recent times, has been the health reform/renewal policy agenda. The two provinces have articulated and implemented this policy in different ways, which may differentially impact rural women. Hence, the purpose of this study was to determine if and how health reform/renewal policy impacted on individual and communities of women in select rural communities in Saskatchewan and Manitoba.

The study's design was a collective case study approach in which three communities (one in Manitoba; two in Saskatchewan) were considered using document reviews, environmental scans, and focus groups/interviews. Within case and cross case analysis were performed to highlight similarities and differences on a provincial and community level.

Four thematic dyads were revealed through the study. The first dyad 'disconnect to connect' considered the explicit objectives of the health renewal/reform agenda in each province and whether these were achieved or not achieved. Secondly, the 'irrational to rational' theme refers to the health renewal/form agenda directed at reducing costs and altering health service utilization patterns. The 'DYS-integration to reintegration' dyad addresses the objective of health reform/renewal policy to enhance coordination and integration of health care services. The final dyad, 'silence to voiced', considered the health reform/renewal policy objective to increase citizen participation in the reconfigured health system.

An Integrated Community Policy Uptake Model was developed proposing four predictable stages – ‘taking in’, ‘taking on’, ‘taking over’, and ‘taking beyond’. This model potentially contributes to identifying opportunities to increase citizen participation in future health policy making and planning.

The study has significant potential to inform health policy makers and policy implementers of the perceptions, needs, and solutions offered by the community of rural women.

Acknowledgements

I wish to acknowledge many of the people who supported, contributed, and assisted me in the completion of this dissertation. First, Dr. Marnie Wood, Professor Emeritus, whose respectful and scholarly approach to my efforts was invaluable. Her direction and thought provoking challenges throughout the process contributed to my learning and development, for this I will be eternally indebted. A sincere thank you must be extended to the other members of my committee, Dr. John Church and Professor Donna Smith who saw me through the challenges of graduate work and guided me to a final product which may contribute to the scholarly literature on this topic. In addition, I extend my appreciation to Dr. Marion Allen and Dr. Margaret Haughey, who willingly contributed their expertise and insights to inform this dissertation. Finally, I was honoured to have Dr. Murray Knuttila, a rural scholar, from the University of Regina serve as the external examiner.

To the women of the Saskatchewan and Manitoba Women's Institutes, there are no words which can adequately express my gratitude. I hope that the words contained within this dissertation have reflected your sincerity, commitment, and diversity.

To the women who participated in the communities I was privileged to meet and dialogue with each of you. I hope that you find **your** words and **your** meaning within this dissertation – only then have I met my commitment to you.

Finally, my efforts were supported through the National Health Research Development Program (later the Canadian Institutes of Health Research), the University of Alberta – Walter Johns Scholarship, and the Saskatchewan Nurses Foundation. These awards allowed me to devote my time and efforts to the rural communities and reflect on the meaning of their contributions.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER I
INTRODUCTION

Health policy is often developed, implemented, and evaluated with minimal consideration of the impact (real or perceived) and implications for individuals, groups, and communities involved. In recent years, health reform or health renewal has become an increasingly debated and scrutinized health policy agenda. Much of the ensuing health policy research focuses on economic, fiscal, and political motivations and consequences of this policy direction. In light of the rapid progression of health reform/renewal initiatives nationally and internationally, there is an increased need to consider the meaning and implications of such health policy decisions to various sectors of the population beyond these traditional indicators. One sector which is frequently minimized or overlooked in health policy research is rural communities, in general, and rural women, specifically. This gap provides an impetus for research which considers the impacts and implications of health policy decisions for rural women. Therefore, this study examines the impacts of health reform/renewal policy as perceived by women in three rural communities in the provinces of Manitoba and Saskatchewan, Canada.

Significance of the Study

According to Corban, D'Arcy, Torrance, and New (1987), "the impact of general social policy and social organizational arrangements on health and well-being is just beginning to be realized and documented" (p. 652). Baumgart and Larsen (1992) state the time is imminent for registered nurses to play a more central role in shaping public policy.

In this study, the issue of the impact and implications of health reform/renewal were examined from the perspective of those experiencing the operationalization of the policy. The perceptions of individual and communities of rural women regarding health reform/renewal policy were studied in an effort to provide a unique perspective on the impacts and implications of health reform policies. Further, this study brings the rural context to the forefront of health policy deliberation recognizing that, although 90% of Canada is geographically rural and only 20% of our population live in rural areas, there is a scant research literature on health, health care, and health policy in rural settings.

According to the Canadian College of Health Service Executives [CCHSE] (1999), "the greatest challenge is providing rural areas with services comparable in quality to those of urban areas" (p. 3). Of even greater concern is the lack of a consideration of the issues and needs of rural women beyond traditional biomedical health care. In fact, women's experiences with health restructuring have been largely overlooked, ignored, or subsumed (Armstrong & Armstrong, 1999; Bernier & Dallaire, 1999; Fuller, 1999; Gurevich, 1999; Howard & Willson, 1999; Rosser, 1994). Through this research, the implications and impacts of health policy on women's health, in general, and rural women's health, specifically, were explored. The World Health Organization [WHO] policy of 'Health for All in the 21st Century' cites the need for incorporation of a gender perspective into all health policies and strategies (Hayes, 1999; WHO, 1978). Grant (2000) states that there is a lack of understanding about the differences between women and men in terms of the effects of health care system restructuring on the quality and nature of the care individuals receive.

By soliciting the perceptions and opinions of rural women, this research potentially contributes to their understanding of health policy and may encourage them to become more directly engaged in future health policy making and planning. There is also significant potential for this research to inform decision makers of the perceptions, needs, and solutions offered by the community of rural women.

Background to the Study

In this research, a wide range of variables, relationships, and contexts related to health reform/renewal and rural women were considered. Although existing literature considers many of these elements individually (i.e., central place theory, rural theory, community development theory, policy analysis), there is no extant literature or theoretical set which connects or explains the relationships amongst them. As the health policy environment is diffuse and complex, it is necessary to be eclectic in the approach used to study it.

Political scientists considering public policy issues, since the early 1970s, use a fairly common heuristic framework to describe public policy analysis. This framework consists of discrete phases or stages associated with the policy process (Anderson, Brady, Bullock, & Stewart, 1978). Some such models have described as many as seven stages in the policy process, but most conventional models cite four stages – agenda setting, policy formulation, policy implementation, and policy evaluation (Barkenbus, 1998). Similarly, Pal (2001) offers a series of steps including problem definition, policy instruments and design, policy implementation, and evaluation.

As a cycle, the process from the initial identification of a policy need through the definition, adoption, implementation, and evaluation of a policy involves many actors ranging from bureaucrats, and politicians to organizations and members of the general public. Although in democratic theory, policy decisions should reflect a compromise between competing values and interests in a society, the current environment to affect change in the policy process would suggest varying degrees of influences are accorded to each of the groups involved.

This study will examine the impact of health policy directives and, more generally, the consequences of health reform/renewal from the perspective of individual women in rural communities with regard to the use of services, service delivery, and participation in decision making regarding the directions for the health care system. According to Torrance (1987), changes in the health system tend to mirror changes in Canadian society (i.e., a shift to urban, decentralization, and individualization). Baumgart and Larsen (1992) add to the list of challenges to the health system with issues of emergent diseases, increasing morbidity rates, cultural diversity, and household composition (i.e., single person households, one parent families). Collier (1993) states that "rural areas and people are still subject to decisions made far away in the economic and political centres. Rural people are still separated from these centres by important differences in ways of living, being, seeing, and thinking." (p. xvii) Hence, a critical consideration is the context within which rural residents interface with health reform/renewal policy.

National trends and nuances in health reform/renewal form the context of the study. According to Crichton, Robertson, Gordon, and Farrant (1997), the four pressures forcing provinces to renegotiate and reorganize health care systems include:

1. Ongoing reduction in federal-provincial transfer payments;
2. Increasing demands for efficiency and effectiveness of health services;
3. Shifting emphasis to improving health status outcomes; and
4. Increasing emphasis on health rather than disease.

These authors noted that each province has varied in addressing these pressures, resulting in a wide range of health care delivery models in the reformed health care environment (Crichton, et al.).

Research Assumptions

This research involves rural communities, specifically rural women, and their experience of health reform/renewal policy. There is an increasing interest in geography and gender in many aspects of health and health care (Health Canada, 2002b; Horne, Donner, & Thurston, 1999; National Forum on Health (NFH), 1997). Therefore, in this research, rural women are assumed to be a significant cohort of interest for Canadian health policy makers and implementers. Based on this assumption, there is a belief that such stakeholders are seeking to incorporate the unique, yet diverse, perspectives and values of rural people, generally, and rural women, specifically, in terms of their health and health care needs in the policy process.

Policies are multi-faceted and multi-sectoral devices. This complexity is recognized in this research and the impacts of health reform/renewal policy are assumed to reach beyond traditional health care services to include economic, social, cultural, and political impacts. The assumption that rural women have been significantly affected by the health reform/renewal policy from a multitude of perspectives is reflected in this research. Rural women have experienced the impact of health reform/renewal policy as an expansive and rapid change in their various roles as women, mothers, informal caregivers, clients, and community agents.

Ethical Framework

The ethical framework adopted for this study was from Flinders' (1992) ontology of ethics as depicted in the following framework table (see Table 1). This research embraced all four ethical approaches. The utilitarian ethical principle is rooted in the goal of achieving the best consequences possible. In this study, confidentiality of the participants was paramount that reported data were unrecognizable or not linkable to the source. Through a rigorous data management, reporting, and dissemination strategy, I was able to establish a trust-based relationship with the communities and informants which potentially maximizes the quality of both sharing and reporting.

Table 1

Ethical Framework

Approach	**Utilitarian**	**Deontological**	**Ecological**	**Relational**
Recruitment	Informed consent	Reciprocity	Cultural sensitivity	Equal Status; collaboration
Fieldwork	Avoid harm; risk/benefit	Avoid wrong	Avoid detachment	Avoid imposition
Reporting	Confidentiality	Fairness	Responsive Communication	Confirmation; support

Adopted from Flinders (1992).

Deontological ethics were seen in this study in the adherence to reciprocity and fairness in selection of participants and reporting. Reciprocity was achieved through the participation of the stakeholders at various stages of the research design including sampling, instrument development, and member checking. With respect to the fairness in selection, this research was rooted in the assumption that women in all rural communities in Saskatchewan and Manitoba constituted potential communities of interest. As indicated by Axelrod (2003), the local context of the study and professional codes dictate aspects of the practitioner's deontological ethics. Fairness was also achieved through the reporting of disparate or opposing perspectives from the various sources through the case studies.

The ecological ethics are embraced through strategies such as the interview site being set by the interviewee, and the ongoing 'dialogue' both written (i.e., transcript copies) and verbal (i.e., post interviews). Further, the sampling strategy recognizes the unique cultural aspects of the rural environment in the recruitment and accessing of participants.

Finally, the relational ethics standards of confirmation and supportiveness were shown through rigorous strategies of member checking. Relational ethics are rooted in treating our subjects as if we have special relationship with them (Dooley, 1990; Galison, 1999). This relationship was realized, in part, through the ongoing involvement with the Women's Institutes. According to Bergum (1998), relational ethics have four central concepts:

- "how" we treat each other while clinical concerns attend to the "why" of a particular treatment;
- ethical action is reciprocal (i.e., providers and recipients both give and both receive);
- personhood (autonomy) is developed and expressed through connections between people rather than through individual rights; and
- ethics is the question "what should I do now?" rather than the statement "this is what you should do now." We are participants by being with rather than merely spectators who only observe, advise, or treat. (p. 1)

Research Questions

The broad question addressed in this research is if and how health reform/renewal policy impacts on individual and communities of women in select rural communities in Saskatchewan and Manitoba. There is an underlying assumption that divergence between policy intent and policy action impacts on the health status (actual and perceived) of target populations. Hence, this research identified, described, compared, and contrasted specific aspects of health reform/renewal initiatives as adopted and implemented by these two provinces.

More specifically, the following research questions were addressed:

- What were the intended (articulated) impacts of the policy changes proposed under the health reform/renewal agenda?
- What have been the short-term impacts of health reform/renewal on rural women in Saskatchewan and Manitoba?
- What are the perceptions of rural women regarding the impact(s) of health reform/renewal policy initiatives in Saskatchewan and Manitoba?
- What are the key learnings from this experience? How do the key learnings inform future public policy decisions/directions?

Summary

This study is a consideration of the relationship of "people to policy change relationship" from the perspective of those most directly affected by the change.

Through a non-traditional consideration of women's health (which will be explored in Chapter II) informed by various theoretical and conceptual frameworks, it considers the meaning and implications of a specific health policy to women beyond the traditional economic, fiscal, and political agendas. It considers the consequences these reforms have on women's health, recognizing the differing roles that women and men play in our society. It considers rural women, an often under-recognized and under-voiced sector of the population. By exploring the specific health policy of health reform/ renewal, this study will yield a better understanding of how rural women view a specific health policy which, in turn, may inform policy makers, politicians, and others in positions of power on strategies to improve the policy process. Essentially, the study challenges the traditional policy processes to include non-traditional policy informants throughout the policy cycle in an effort to enhance and inform the process.

In general, health and health care are topics on which most people hold an opinion. Health reform initiatives are occurring nationally and internationally. There is potential for a new wave of health reform in certain jurisdictions. This study is timely and has the potential to inform the next wave of policy development in health care.

CHAPTER II

LITERATURE REVIEW

A wide array of terms and concepts are fundamental to this topic. Ongoing literature sources were acquired throughout the research process to inform the discussion, analysis, and findings. Sources were derived from primarily English, North American literature using OVID, MedLine, and CINAHL, internet searches through Google and Yahoo, and government libraries. In addition, information created by the three participating health districts/regions was also accessed as appropriate.

The literature review in this study seeks to integrate extant information from the field of study. The review provides the readers with an assessment of the field of study and identifies seminal works on the various aspects of the research (i.e., rural, women's health, public policy). Further, the literature review identifies potential gaps in the existing research which may be addressed by the current research project or considered for future research projects.

Rural

According to Weishert, Falcone, and Wells (1988), the term rural is like concepts such as truth, beauty, and justice, in that everyone knows the term rural, but no one can define it precisely. Bosak and Perlman's (1982) review of 178 rural health and sociology articles revealed that over 40% lacked a formal definition of 'rural'. This finding was mirrored in the present literature review, which failed to provide concept clarification of the term rural or has inconsistently defined the term. However, the conceptualization of rural and its measurement has become increasingly important to decisions concerning health and social policy (Hewitt, 1989; Stabler, Olfert, & Fulton, 1992).

It is critical to address the context in which health services are offered, as well as received, demanded, or accessed. Hewitt (1989) reveals that despite a consistent theme of concern regarding a health care crisis in rural areas, there is a lack of agreement as to what rural areas are. Coward, Bull, Kukulka, and Galliher (1994) suggest that the lack of a consistent definition of rural inhibits the ability to forge cohesive political coalitions, impedes a description of the distinctive health care needs of rural populations, and obstructs the search for solutions to the problems of rural dwellers. Troughton (1998) posits this linguistic difficulty as a consequence of real changes in rural life (i.e., fragmentation of rural society resulting from centralization and urbanization, which has muted the rural voice).

In the past, the rural 'idyll' conjured a composite image of traditional values, pastoral environs, and peaceful retreat. However, increasingly, the term rural has become a negative concept replete with associations of false nostalgia, isolation, marginality, and helplessness (Ramp, 1999). Changes in the perspectives and functions of rural societies have led to quality of life and health concerns in rural areas. Analysis of the literature revealed a multiplicity of corollary terms for rural such as nonmetropolitan, frontier, and rural-farm (Hersh & Van Hook, 1989). The apparent difficulty in defining rural, according to Troughton (1998), is rooted in a highly urban-centric social, economic, and political system. Hence, clarification of the concept of rurality and its measurement are increasingly important to decisions concerning health policy (Hewitt, 1989).

Some sociologists (Hogarth, 1990; Lee & Newby, 1983; Pahl, 1968) have even challenged the legitimacy of the concept rural. Economists and geographers tend to variously reframe rural in terms of environment (i.e., place), social capital, and resource/economic base (Halfacree, 1993; Stabler, Olfert, & Fulton, 1992). Numerous nurse researchers (Hinshaw, Atwood, Gerber, & Erikson, 1986; Weinert & Bunnan, 1994; Weinert & Long, 1991) continue to consider the meaning of rural and rurality. Despite this ongoing work, there continues to be a lack of consensus amongst nurse researchers on key elements of the meaning of rural. However, most nurse researchers continue to explore rural as a critical component of client/community environment, culture, self-definition, and values (Hinshaw, et al.; Weinert & Long).

Health outcome statistics averaged across all communities (rural and urban) will often mask important health disparities experienced by certain population groups. "Rural is not just a geographical area or administrative demarcation, but is a living fabric of history, culture, social relations, economics, and politics in which people strive to build and preserve communities, civic responsibilities, and family well-being" (Ramp, 1999, p. 1). According to Luloff (1990), rural communities are unique in their combination of structural characteristics such as economic resources, employment patterns, demographic composition, and cultural norms. Policies based on these aggregate indicators must be considered suspect as they may, in fact, overlook the needs of the most disadvantaged. The rural context is therefore recognized as unique and cannot simply be reframed as urban with the addition of a geographical component.

For the purpose of this research, the term “rural” as an independent construct will be made operational by delineating the location of participants in health regions/districts which have populations of less than 50,000 people, a population density of less than 6 persons per square kilometer, and a distance from a major centre (i.e., secondary service site or higher) greater than 30 minutes. This definition is derived from the Montana State University (MSU) Rurality Index as developed by Weinert and Boik (1995) and Weinert and Long (1991). By adopting this criterion, this research is more contextualized and comparable with other research efforts on rural health. Further, it recognizes that rural is seen as a context for action, not merely a geographically delineated environment.

Rural Health

According to Thurston, Blundell-Gosselin, and Vollman (2003), Canadian policymakers recognize the imperative for a better understanding of rural health needs and Humphreys (1998) contends that, in order to address and resolve health problems in rural areas, the distinction between rural and urban must be understood. The Office of Rural Health was established by Health Canada in September 1998 with the mandate to apply a "rural lens" to federal health policies, programs and services (Health Canada, 2003c).

One of the largest challenges is the lack of data on health needs of rural residents (Watanabe & Casebeer, 2002; Health Canada, 2002b). Racher (2001) reports that access to health care services is a priority for the residents of rural communities: with rural residents experiencing decreased availability of health professionals (Horner, Ambrogne, Coleman, Hanson, Hodnicki, Lopez, & Talmade, 1994; Joseph & Phillips, 1984); limited proximity to hospitals and emergency services (Lavallee & Crupi, 1992; Merwin, Goldsmith, & Manderscheid, 1996; Nemet & Bailey, 2000); difficulty in acquiring home care and long term care (Bavington, 1994; Coburn & Bolda, 2001;

Kenney, 1993; Neese, Abraham, & Buckwalter, 1999) and problems in ensuring that rural services provide quality care (Magilvy, Congdon, & Martinez, 1994; Moscovice & Rosenblatt, 2000).

Recent studies have indicated that the health status of Canadians living in the most rural and remote parts of Canada is lagging behind that of urban residents (Pitblado, Pong, Irvine, Nagarajan, Sahai, Zelmer, Dunikowski, & Pearson, 1999; Shields & Tremblay, 2002). Almost 29 % of big-city suburbanites and about 27 % of inner-city residents rated their health as excellent, compared with only 20.2 % of rural people, according to a Statistics Canada study in late 2003 (London Free Press, 2003). Approximately seven percent of Canadians in rural settings and small towns live more than 25 km from a physician (Ng, Wilkins, Pole, & Adams, 1999). Canadians living in rural and remote areas of Canada experience unique challenges in maintaining their health and obtaining health care. In addition to the physical geographic location of rural people in Canada, there are social, cultural and environmental differences within the population which may lead to differences in risk factors and, hence, differences in health outcomes.

Rural health is not just about the provision of health care services to people who happen to live in administratively designated rural areas. It is a concept that encompasses both individual health and the health of communities as defined by those individuals and communities (Ramp, 1999). According to Troughton (1998), the challenge is to find the method(s) to identify how health issues are experienced and constructed differently in rural environments. Long (1998) points out that there is no singular concept of rural health just as there is no distinct concept of urban health. She further states that there are general views about health, which are highly valued by rural populations such as self-reliance and role performance (i.e., ability to work) (Long, 1998).

Rural people typically define health in broad terms. Some examples of rural perspectives on health reflected in the literature include:

- ability to work (Bushy, 1994; Long, 1993; Ross, 1982; Weinert & Long, 1987);
- self-reliance (Bushy, 1994; Long, 1993; Stout, 1999; Thorson & Powell, 1992; Weinert & Long, 1987);

- preference to interact with informal social support systems (Bushy, 1994; Magilvy, Congdon & Martinez, 1994; Stein, 1987; Weinert & Long, 1987); and
- favoring informal negotiated solutions for health care concerns (Long & Weinert, 1989).

These unique conceptualizations of health and means of seeking health in the rural environment present issues and challenges for those charged with addressing the health care needs of rural residents. "An understanding of the rural client's concept of health is necessary to conduct relevant and effective health assessment, planning, intervention, and evaluation." (Long, 1993, p. 129) These issues and challenges of the rural health context are succinctly outlined in the following six points presented by Ramp (1999):

> - essential to the design and delivery of effective health programs for rural areas;
> - unique and cannot simply be thought of in terms of urban concepts and priorities, with the addition of geographical extension as a distinguishing criterion;
> - diverse such that local and regional differences must be taken into account;
> - changing rapidly in the face of changes in national and global economies and political priorities;
> - dynamic such that rural people seek and will respond to opportunities to organize their own voices; to articulate and help meet their own needs; and
> - contextualized within the unique development of democratic forms of political expression and action in rural areas, coupled to mutual-aid strategies and a sense of mutual responsibility, which has implications not only for the health of rural communities, but for the democratic shaping of health care nationally and throughout the world. (p. 17)

No discussion of rural health would be complete without a reflection on rural hospitals and their unique role within the rural community. Rural hospitals differ from their urban counterparts in a number of important ways. Health care considerations aside, rural hospitals are often major employers and provide a number of economic spin offs to the towns in which they are located (Doeksen, Loewen, & Strawn, 1990; Muus, Ludtke, & Gibbens, 1995). As well, the role of rural hospitals in the provision of health care differs considerably from urban hospitals. For instance, rural hospitals have a much lower service volume and do not enjoy the same economies of scale as larger urban hospitals (Bindman, Keane, & Lurie, 1990; Samuels, Cunningham, & Choi, 1992). Nor do rural hospitals have access to equipment that is as technologically advanced as the equipment in urban hospitals. Thus, the case mix at these hospitals will inevitably be less intense than the case mix at urban hospitals, and these levels vary considerably in their scale of operations by community (Alexander, D'Aunno, & Succi, 1996).

Based on the above discussion, consideration of rural health must include an understanding of the nuances and attributes of health in the rural context, including an appreciation of the uniquely rural definitions of health and a willingness to look broadly at the issues or challenges of rural health (Pitblado, et al., 1999). As shown in this review of selected literature, rural health is a unique construct which must be recognized and addressed in the policy development, implementation, and evaluation processes. This challenges policy and allied professionals to consider issues such as utility of aggregated urban-rural statistics, diversity of rural contexts, and rural 'health' values and meanings. Once this level of understanding is achieved can one move on to look at rural health from the perspective of select groups, such as rural women.

Rural Women

An awareness of the differences in how health and health care are viewed by rural people does not preclude the need for comprehensive assessment of individuals, target groups, and communities. However, knowledge of the differences provides a useful frame of reference for health care planning that can maximize the delivery of existing health care resources to rural residents. Remarkably, "little of the extant research (on health reform) focuses on women who are, in the majority of cases, the frontline workers, and who are using (or wanting to use) various health services" (Grant, 2000, p. 1).

Rural women constitute a unique segment of the population affected by change in health care services available in their local communities. The impact of change may be reflected in the role of substitute care provider, job loss (due to nursing jobs and health care support jobs being primarily female occupied), and increased fear for safety and health status of family and community. Walters (1987) states that "if (health) policy is to reflect women's priorities, it is critical that women collectively assert their concerns and establish structures for their discovery and articulation" (p. 322). According to the Women's Health Clinic of Manitoba (1998), "it is imperative for women to have a voice in the (health sector) change and any subsequent decision-making structure(s) which would evolve from the reform process" (p. 17).

Rural women can be considered a community, which, according to Christenson and Robertson (1980), includes a consideration of people, geographical area, social interactiveness, and psychological ties with each other and the place they live. Hancock, Labonte, and Edward (1999) suggest that community will exist when a group of people, whether defined by geography or affinity, exhibit some awareness of their identity as a group, and where the group is of a size and nature that direct access to decision making is possible.

This research will emphasize how rural women's priorities and perspectives must be considered as their unique needs and challenges highlight the deficits in existing policy to address and include them.

Women's Health: General and Rural

Women have a huge stake in health, as patients, providers, caregivers, and decision-makers. To capture the range of women's involvement in health care, Graham (1983) challenges researchers to consider women's roles as providers, negotiators, and mediators with respect to their personal, family, and community health status. Although the phrase "women's health" is now widely used, it remains ill defined and subject to debate (Chesney & Ozer, 1995). The impetus is to move beyond the traditional biomedical conceptualizations of health and consider the social forces and community contexts that shape women's health and lives (Ruzek, Clarke, & Olesen, 1997b, p. 12).

Gender structures opportunities in life and influences access to political and economic resources (Kaufert, 1996). Approaching health from a gender perspective recognizes that, beyond the biological differences between the sexes, lie socially constructed differences between men and women that define risks, access to resources, decision-making power, and health needs. These gender differences – together with class and ethnic differences – are key determinants of the inequality of opportunities for access to, and power over the resources and services that facilitate good health. Hence, it is not adequate to focus the discussion of the determinants of health on comparing women and men. Rather, one must examine how determinants such as degree of social support, culture, and geographic location are experienced differently among women.

Canadians are among the healthiest people in the world and the life expectancy of Canadian women is one of the highest. Despite this status, the health system has not always understood the factors that influence the health status of women nor has it addressed women's issues concerning research, education, leadership, and health interventions. Females are more likely to be living on low incomes, to be employed in low paying, less stable jobs, and to be encouraged by societal gender expectations to be the primary givers of support to others - even if this is detrimental to their own needs and health (Graham, 1998; Janzen, 1998; Kaufert, 1996; Townson, 1999). Overall, women utilize health services more extensively than men because of their greater likelihood to engage in preventive health maintenance, and because of the nature of the conditions affecting women and those for whom they provide care (Kandrack, Grant, & Segall, 1991; Macintyre, Hunt, & Sweeting, 1996; Pollard and Hyatt 1999). Much of this differential results from reproductive roles, but females are not always offered the same range of diagnosis and treatment options for some conditions, such as heart disease (Lorber, 1997). American studies show women are less likely to receive high-tech services, and tend to receive less aggressive care for conditions such as heart disease and cancer (Clancy, 2000). Women are much more likely to engage in health protective behaviours, including accessing health screening (e.g., breast self-examination, pap smear screening, regular check-ups) (Miles, 1991). Of note, Mustard, Kaufert, Kozyrskyj, and Mayer (1998) demonstrated that "after removing the costs of sex-specific conditions (including, for women, normal and abnormal reproduction, and for women and men, diseases of the genitourinary system and of the breast) and considering costs for both physicians' services and acute hospital care, that the costs of insured health care services for women were about the same as for men" (p. 1679).

Traditionally, biomedical and epidemiological schools of thought have dominated the scientific view of the relationship between gender and health. According to Health

Canada (1999), the health system continues to typecast women and men based on longstanding traditional roles and attitudes. Hence, there remains a tendency to seek out and link biologically ascribed conditions, illnesses, and roles irrespective of gender. This tendency potentiates continued under-representation or exclusion of women in research, due to assumptions that women can be treated the same way as men. In fact, only because of legislation in the United States (but not in Canada) are women now routinely included in clinical studies (Stewart, Cheung, Layne, & Evis, 2000; United States General Accounting Office, 2000). This context highlights the demand for capacity building and future research efforts to incorporate sex and gender analysis.

In matters of health, it matters whether you are a woman or a man. The realities of men's and women's lives are frequently different (Manitoba Women's Directorate, 2001). Donner, Busch, and Fontaine (2000) women's health concerns extend over the life cycle and are not limited to reproductive problems. Women's health problems include, but are not limited to, conditions, diseases or disorders which are specific to women, occur more commonly in women, or have differing risk factors or course in women than in men. According to Health Canada (1999), there are significant differences in the health of males and females with respect to:

- Patterns of illness, disease, and mortality
    - Women outlive men;
    - Women continue to die from largely preventable conditions (i.e., cervical cancer); and
    - Despite women's life expectancy, their later life is often characterized by isolation, disability, poverty, and health problems;

- Genderized 'experience' of illness
    - In most age groups, women suffer more than men from chronic conditions (i.e., migraines, allergies, and rheumatism);
    - One of the areas of greatest differences between women and men is their respective profiles of mental health disorders; and
    - Interactions with the health system;

- Effects of risk factors on well-being;
    - Women are generally regarded as responsible for contraception
    - Risks due to factors tied to their biological and social characteristics (i.e., osteoporosis)
    - Gender-based violence; and

- Social, cultural, economic, and personal determinants of health.

Recent changes in health services have reinforced traditional women's roles in the family and community as unpaid healthcare providers and support workers. Certain health policy formulations that appear to be neutral with respect to gender frequently conceal significant gender biases (Bernier, Vissandjée, & Dallaire, 2003). A number of studies, both in Canada and abroad, have shown that failure to acknowledge gender differences has negatively affected the circumstances of many women who use and provide care in the public system, in private services, in the community, or in the family (Bernier & Dallaire, 2000). The foundation of such biases is the undervaluation of the work performed by women and the failure to recognize the economic contribution made by their unpaid work in the home. According to McKeever (1997), women currently are bearing a disproportionate share of the costs associated with chronic illness and disability" (p. 15). Therefore, while the economy is defined mainly in terms of market goods and services, the essential activities that women perform – such as raising children, preparing food, running the home, and caring for elderly, sick, and disabled family members – are not remunerated and, consequently, do not figure in national accounts. According to the NFH (1997), these costs must be included in the measuring of impacts of health reform.

The NFH (1997) stressed that special populations exist within women's health with rural women meeting the criterion for minority women, which include:

- isolation from mainstream society created by differing cultural (i.e., rural culture) values (i.e., strong people orientation, traditional and conservative values, suspicion of outsiders, connection to the land);

- lack of access to culturally sensitive (i.e., rural culture) health care services; and

- compromised mental health due to the stigmatization of their socioeconomic status…and marginalization.

Further, the gender experience must not be assumed to be homogeneous, thereby disregarding the wide range of variations it may encompass. Recognition of heterogeneity within gender – determined by factors such as social class, ethnicity, and educational level – highlights the need to incorporate a perspective of diversity within the gender approach. Indeed, the United Nations (1995) "Beijing Platform for Action" stated that, for women, the major barrier for women to the achievement of the highest attainable standard of health is inequality, both between women and men and among women. Women are in a disadvantaged position in the health system, since they are among the lowest wage earners and have the least power in the formal health sector. They perform the informal work of promoting and providing health care in the family and community without remuneration and continue to be under-represented in the community power structures that set priorities and allocate resources for the development of health. Since women are the principal care providers in the family, they bear the greatest burden in this respect and are consequently the most affected by any increase or reduction in public services. Transferring responsibilities to the home setting, which is the outcome of the changes in service organization, considerably alters relations between the government, the public system, community services, private service providers and informal caregivers (primarily female family members) (Broom, 1999; Standing, 1999). Given the gender-based division of social roles, women provide most of the care for persons who are sick or have disabilities.

Donner, Busch, and Fontaine (2000) stated that "many women avoid the health care system because of past encounters where they have experienced discrimination, or felt unsafe or unwelcome" (p. 60). Many women feel their voices are not heard within the health care system. Others find their concerns or contributions are not treated with respect or that the system's response further compounds their problems". Stigma is clearly alive and well in rural communities, not only preventing women from seeking help for their problems but preventing other women from offering support or sharing their personal experiences (Roberts & Falk, 2001, p. 41). According to Phillips (1995), "women's health involves women's emotional, social, cultural, spiritual, and physical well-being . . . determined by the social, political, and economic context of women's lives as well as by biology" (p. 508). This broad position is in keeping with a population health approach that sees women as individuals and as a social group whose health is critically and intimately related to the conditions under which they function.

As current literature on women's health illustrates, inequalities need to be understood as extending beyond gender to include those based on class, race, ethnicity, religion, sexuality, disability, age, and place of residence (Ruzek, Clarke, & Olesen, 1997b). To fully understand women's health is to recognize that policies and programs in health and other sectors must address the economic, social, and political realities of women's lives (Phillips).

In much of the medical and health services literature, women's health is defined in terms of the reproductive system or diseases that are either specific to or most common in women (i.e., osteoporosis). Doyal (1995) suggests that rather than a traditional epidemiological focus on diseases and their causes, there is a need to identify major activities of women's lives and examine how these activities affect women's health and well-being consistent with a health determinants approach. Similarly, Kaufert (1996) calls for a feminist epidemiology that is informed by the lived experiences of women that includes women's voices in the research process.

Social, cultural, and political meanings are inevitably implicated in how health is conceptualized. It also depends on the shared assumptions in any given society about what constitutes health, how health can be preserved or restored, and who is allocated responsibility for its fostering and preservation. Tesh (1988) insists that a health policy that primarily expects individuals to change their behavior is not only myopic but, more ominously, protects those institutions that threaten individual health through discrimination, exploitation, or iatrogenesis. According to Lock (1988), in North America, the privatization of public services and decreased government spending for social welfare give credence to Tesh's argument.

Feminist critiques of a range of biomedical practices have been indispensable in promoting the rights and interests of women with respect to health care. One result of this movement has been the development of community-based action and self-help groups. According to Tesh (1988) "if advocates of personal prevention hope for really effective disease prevention, they do have a responsibility to prescribe social prevention as pre-eminent and to put individual action in a context that indicates its surrogate role" (p. 82).

A number of authors (Armstrong & Armstrong, 1999; Bernier & Dallaire, 1999; Botting, Neis, Kealey, & Solberg, 2000; Fuller 1999; Gurevich,1999; Howard & Willson, 1999; Rosser, 1994) suggest that women have been "overlooked, ignored or subsumed" in studies into the provision of health services and the effects of health care reform on providers and recipients of care. "Consequently, it is difficult to ascertain exactly what consequences (for women) flow from the changes in how health care is organized and delivered in various jurisdictions around this country" (Grant, 2000, p. 2). "As the health system gains a better understanding of the social dynamics of health and health care, there is greater recognition that health planning has much to gain from seeking input from women" (Roberts & Falk, 2001, p. 2). According to Willson and Howard (2000), women, as citizens, as care providers, and as consumers of health services, are seeking ways to make the health system more responsive to their needs and concerns. Health policies must be analyzed for differential impact among women, and between women and men.

The NFH (1997) questions whether health determinants affect male and females in the same way and presents examples of female's experiences that may have negative effects on their health (i.e., violence, sexual harassment). Some researchers (Cohen & Sinding, 1996; Doyal, 1995) present examples of how the social context of female's lives (i.e., violence, power differentials) influence health behaviors (i.e., care seeking). They suggest that women are often coerced, restricted, or pressured with respect to their opportunities and freedoms in accessing, disclosing, and utilizing some health services as a result of these social factors.

In comparing rural and urban areas on several dimensions of gender, one might consider the effects of traditional norms (Fischer, 1978; Tickamyer & Bokemeier, 1993), personal networks (Doeringer, 1984), less inequality within disadvantaged groups (Almquist, 1986), and more limited employment opportunities in rural areas (Tickamyer & Latimer, 1993). The literature suggests that gender norms may be more traditional in rural areas (Bernston, 1993; Health Canada, 1996; Wakewich, 2000), again, highlighting the part of the distinctiveness of rural culture.

According to the National Institutes of Health [NIH] (1991), women and men differ significantly, not only in terms of particular needs and risks, but also with regard to access to critical resources for protecting their health. The goal is to strive for the elimination of unnecessary, unjust, and avoidable differences between men and women in their potential for enjoying good health and in their likelihood of becoming ill, disabled, or dying from preventable causes. Of great importance is the degree of participation in the development of health, such that health care activities, whether remunerated or free, be recognized, facilitated, and appropriately valued, that women and men share in decision-making.

From the narrowly defined concern with reproductive/biomedical health and the impact of gender stereotyping on the experience of health care (O'Rourke, 1984) to its more current understanding as a multidimensional and multidisciplinary area of study (Chesney & Ozer, 1995), women's health has been re-conceptualized not only with a mind to what women "want" and "need" but also with regard to its understanding of the social and biomedical forces that shape the experience of health and illness for numerous and quite different women (Ruzek, Clarke, and Olesen, 1997a; 1997b). As a dynamic and evolving field, women's health research is now more than a set of content areas.

Also important is the task of determining the diverse methods that have been brought to women's health research, and the conceptual models that have framed the ways that researchers from different disciplinary backgrounds view the field. Such research is intended to be emancipatory, to enable women and others to be active agents in their own right. There is an acknowledgment that research is *for* (rather than *on*) women (Ironstone-Catterall, McDonough, Robertson, Payne, Rahder, Shaver, & Wakewich, 2002). Women's Health Clinic (1998) found women from equity communities (i.e., rural, prostitutes, homeless) are often marginalized in the planning of health service delivery. According to Donner, Busch, and Fontaine (2000) and Roberts and Falk (2001), women from such target communities should be involved in the planning, implementation, and evaluation or projects involving their health. As Eichler has pointed out, "gender-based analysis of health research, policies, and programs will help to ensure that health practices (and policies) are not gender-biased" (Eichler, n.d.). Knowledge arising from projects must be accessible to all women but particularly to women in the target community.

While aware that "no single model or paradigm would be sufficient" to encompass the competing approaches to the field of women's health, Chesney and Ozer (1995) stress the need for a research framework which is inclusive and provides a "guide to organize and integrate competing approaches" (p. 5). Such a collaborative model must be based in a broader social model of women's health (Ruzek, Clarket, & Olesen, 1997a; 1997b), and consider the "underlying social dynamics of what actually *produces* health for different groups of women" (Chesney & Ozer, p. 13).

Public Policy

Public policy is the course of action or inaction chosen by public authorities to address a given public problem or an interrelated set of problems (Pal, 1997). This definition is further reflected in the definition of policy as actions, plans, or statements by decision makers that indicate priorities and that are presumed to be based on a consideration of potential risks and benefits advocated by Oliver (1991) and Rothman and Poole (1985). Also critical, according to Pal, public policy is a guide or blueprint to action and is not the action itself. Hence, policies are guides to the course of action. Pestieau (2003) stated that policy making is an art rather than a science as "policy decisions are not purely rational and the paths followed to develop public policies are unpredictable" (p. 1).

The public policy under consideration within this research is health reform/renewal policy. According to Pestieau (2003), the key aspect of policy is 'problem definition' which is rooted in "a strong socio-psychological dimension" (p. 2). The action in this policy is the articulation and implementation of health service strategies (i.e., shifting resources, decentralization, and core services) by the respective provincial governments.

Clarke (2003) describes health policy as one aspect of public policy which establishes direction and goals for promoting the health of the public. She further describes policy as:

- dealing with shoulds and oughts;
- based on values, goals, and principles;
- stages of development from formation of the problem, through adoption of the policy, implementation, and evaluation;

- objective is to be evidence based (e.g., using research, epidemiology, databases in health information, surveys); and
- the chosen theoretical perspective with its values and principles determines details of the policy process. (p. 63)

Policy Making

Policy making is "the process by which governments translate their political vision into programmes and actions to deliver 'outcomes' – desired changes in the real world" (United Kingdom Research Directorate, 1999, p. 1). Pal (2001) states that policymaking is "about trying to solve problems" (p. 93), with Wharf and MacKenzie (1998) describing it as "wrestling with and deciding among various difficult choices" (p. 10).

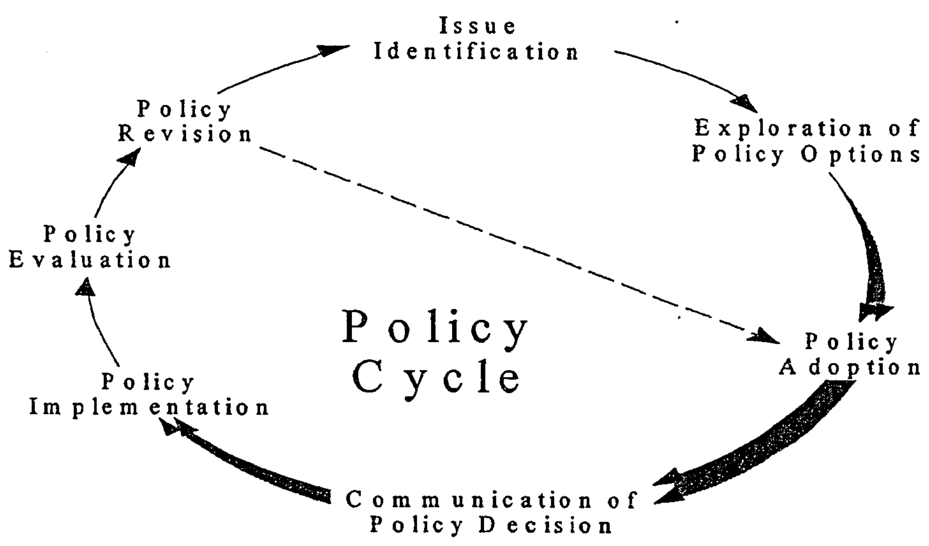
There are a number of models of the policy making process including a systems model described by Weller (1980). Titmus (1974) suggests that policy making occurs at different levels including government, community, and individual, further suggesting that action or non-action in each level influences directions that are ultimately chosen.

Those who have "traditionally had the most power within the policy making process resemble the familiar cast of most power elites in Canada - predominantly white, middle-class males from professional or business backgrounds" (Wharf & MacKenzie, 1998, p. 19). In contrast, they note:

> Relatively few women, poor people, and members of ethnic minorities took part in the decisions that affected them. Although the membership of women has increased, significant participation by other groups is absent from local governing structures. (Wharf & MacKenzie, p. 19)

A commonly used policy model – the policy cycle - is presented in Figure 1 (Gurd, 2004). At the issue identification and exploration of policy options phases, the policy makers are attempting to delimit or define the policy. These stages can elevate an issue or a problem to the level of requiring a policy response within the complex matrix and

Figure 1. Policy cycle.



Adapted from Gurd (2004).

multiple alternatives for the policy articulation. Ultimately these are assumed to yield a well reasoned recommendation for the policy approach to address the issue or problem. Policy adoption is the choice of the specific policy decision which is derived from weighing the alternatives. Once a policy direction has been selected, communication of the policy decision to the policy implementers and select stakeholders occurs. Policy implementation is an extremely important stage of the policy cycle, the magnitude of the process and its integral role in the successful achievement of desired policy outcomes depend upon successful implementation. It is important at all stages of the policy development cycle to consider practical, achievable implementation strategies. In the policy evaluation stage, assessment occurs of what is working and what is not in the implemented policy, relating and assessing connections between actual policies and changes in the areas they are intended to influence. Through this process, policy makers and implementers evaluate the effectiveness of programs by measuring outcomes against performance indicators. The outcomes of the policy evaluation may generate reframing or improvements to the policy.

Bullock, Mountford, and Stanley (2001) describe 9 features of modern policy making (see Table 2) which has the potential to improve public confidence through a more consistent and transparent process.

Table 2

Nine Features of Modern Policy-making

Feature	**Definition**	**Outcomes**
Forward Looking	The policy-making process defines outcomes that the policy is designed to achieve and, where appropriate, takes a long-term view based on statistical trends and informed predictions of social, political, economic and cultural trends, into the future of the likely effect and impact of the policy	• A statement of intended outcomes is prepared at an early stage • Contingency or scenario planning • Taking into account the government's long term strategy
Outward Looking	The policy-making process takes account of influencing factors in national and international situations;. draws on experience in other countries; considers how policy will be communicated with the public.	• Looks at how other countries or jurisdictions dealt with the issue • Communications/presentation strategy prepared and implemented
Innovative, Flexible and Creative	The policy-making process is flexible and innovative, questioning established ways of dealing with things, encouraging new and creative ideas; and where appropriate, making established ways work better. Wherever possible, the process is open to comments and suggestions of others. Risks are identified and actively managed.	• Uses alternatives to the usual ways of working (brainstorming sessions etc) • Defines success in terms of outcomes already identified • Consciously assesses and manages risk • Creates management structures which promote new ideas and effective team working • Brings in people from outside into policy team
Evidence Based	The advice and decisions of policy makers are based upon the best available evidence from a wide range of sources; all key stakeholders are involved at an early stage and throughout the policy's development.	• Reviews existing research • Commissions new research • Consults relevant experts and/or internal and external consultants • Considers a range of properly costed and appraised options
Inclusive	The policy-making process takes account of the impact on and/or meets the needs of all people directly	• Consults those responsible for service delivery/implementation • Consults those at the receiving

	or indirectly affected by the policy; and involves key stakeholders directly.	end or affected by the policy • Carries out an impact assessment • Seeks feedback on policy from recipients and front line deliverers
Joined Up	The process takes a holistic view; looking beyond institutional boundaries to the government's strategic objectives and seeks to establish the ethical, moral and legal base for policy. There is consideration of the appropriate management and organizational structures needed to deliver cross-cutting objectives.	• Cross cutting objectives clearly defined at the outset • Joint working arrangements with other sectors clearly defined and well understood • Barriers to effective joined up clearly identified with a strategy to overcome them • Implementation considered part of the policy making process
Review	Existing/established policy is constantly reviewed to ensure it is really dealing with problems it was designed to solve, taking account of associated effects elsewhere.	• Ongoing review program with a range of meaningful performance measures • Mechanisms to allow service deliverers/customers to provide feedback direct to policy makers • Redundant or failing policies scrapped
Evaluation	Systematic evaluation of the effectiveness of policy is built into the policy making process.	• Clearly defined purpose for the evaluation set at outset • Success criteria defined • Means of evaluation built into the policy making process at outset • Use of pilots to influence final outcomes
Learns Lessons	Learns from experience of what works and what does not.	• Information on lessons learned and good practice disseminated • Accountability by policy-makers as a result of lessons learned • Clear distinction drawn between failure of the policy to impact on the problem it was intended to resolve and managerial/operational failures of implementation.

Adapted from Bullock, Mountford, & Stanley (2001).

Policy-makers are facing contexts and issues which are becoming increasingly complex, uncertain, and unpredictable. The public is better informed, has rising expectations, and is making increasing demands for services to meet their individual needs. Issues switch quickly from the domestic to the international arena and an increasingly wide diversity of interests needs to be co-ordinated and harnessed.

Health Reform/Renewal Policy: An Overview

According to Siler-Wells (1987), health system reform/renewal involves broad-based change in the behaviors of consumers, providers, and government. The momentum of health reform, both nationally and internationally, suggests an intimate tie to social reform and health insurance initiatives (Schwartz, 1977). Glouberman and Mintzberg (2001) state that

> No country appears to be satisfied with the current state of its system; almost everywhere reforms are being contemplated, organized, or implemented. Each is claimed to make the system more responsive to user needs, yet most are designed to bring its component parts under control. (p. 1)

Analysis of the literature reveals an inconsistency in the meaning and interpretation of the term “health reform”. Health reform is frequently equated with terms such as service reorganization/integration (Corban, et al, 1987; Ontario Hospital Association, 2002); resource re-allocation (Naylor, 1993); regionalization (Sutherland & Fulton, 1998); and health service rationalization (Saltman & von Otter, 1995). Frenk and Gonzalez-Block (1992) define health system reform as “changes produced out of explicit intention on the part of government or political groups to transform, for the better, the health sector” (p. 37). This perspective is reiterated by Berman (1993) who states that the essence of health reform is “sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector” (p. 2). Bushy (1995) encapsulated the foci for health reform as being “universal access to care, cost containment, financing of the system, consumer choice, and organizational restructuring” (p. 11), but she further noted that the particular aspects of these foci for rural peoples are often overlooked.

“The objectives of reform invariably begin with the micro-economic concerns of obtaining greater efficiency and productivity from health providers, and maintaining as much equity as possible in the distribution of health care services” (Saltman & von Otter, 1995, p. 1). According to Church and Noseworthy (1998) health care reform occurs within the context of government-wide reform themes of deficit/debt reduction; downsizing; restructuring; deregulation; privatization; and redistribution of planning and power. Baumgart and Larsen (1992) similarly describe the dominant paradigms for public policy development in Canada as being concern for efficiency; individual freedom; equity in service provision; stability; redistribution and equality; regional sensitivity; and national identity and unity. The Ontario Hospital Association (2002) indicated the stated goals of health reform to include cost containment; enhanced public participation in decision-making; improved health system planning; shifted emphasis to population health and wellness; and greater accountability.

Health reform/renewal is occurring within an evolving context shaped by macro social trends in Canada. Casebeer and Hannah (1998) state that "provincial governments across Canada in search of appropriate and affordable care have introduced some significant alterations in their health care systems" (p. 21). Of significance, according to Frankish, Green, Ratner, Chomik, and Larsen (1996), is that these trends include greater demand for community involvement (local autonomy; stronger democratic process), diminishing resources, an aging population, integration, and recognition that health care delivery is one component of health. Other advantages to health reform/renewal include an increased sense of consumer influence, and smaller bureaucracy. For its supporters, health reform/renewal also holds the promises of citizen participation or democratization in decision making (Church & Barker, 1998).

However, Porter O'Grady (1995) warns that "within the current health care system and because of the struggles to reconfigure it financially and structurally there is a danger of miring in the process and missing the point of it all: renewal" (p. xv). The caution is that health reform devoid of a "healing consciousness (results in) health, community, care, presence, and person getting buried in the language and the structure" (Porter O'Grady, p. xv). Other often cited potential disadvantages to health reform/renewal are loss of economies of scale, duplication between districts/regions, loss of standardization, and increased regional disparities. Health reform/renewal policy is not always welcome, nor is it always passively received. There are many cases of lack of cooperation, legal actions, and community end runs to show displeasure in many jurisdictions facing health reform/renewal.

According to Leatt and Nickoloff (2001),

> little has been done in most jurisdictions to evaluate the success of regionalization. There is little empirical measurement or evaluation of whether the expected outcomes of devolution/regionalization, as identified in stated rationales, were achieved. Also lacking is similar information about the implementation process itself – the success of various governance and accountability structures, funding mechanisms, management and delivery systems units of devolution, and planning activities. Most provinces are learning as they go. (p. 41)

According to Finch (1986), the kind of research which has been both stimulated by and conducted with respect to public policy has been positivist, quantitative, and population based. Hence, there is a need for research that looks not so much for causes but for meanings of social events and processes (Finch, p. 1).

Health Reform/Renewal Policy: A Rural Concern

Although there are numerous common themes (i.e., universality, cost containment, financing, consolidation) involved in the debate on health reform/renewal, it is imperative to note that there are specific concerns which are relevant to rural people. According to Bushy (1995), "rural concerns center on lack of available, appropriate, and accessible healthcare providers and facilities and the need for coordination and integration of services to provide a continuum of care in sparsely populated geographical areas with limited resources" (p. 11).

Potential loss of access to basic health care by large segments of rural Canada because of health reform/renewal has prompted a huge public outcry (Christianson & Colleen, 1990; Davis, Zeddies, Zimmerman, & McLean, 1990; Patton & Pushkin, 1989). While some argue that restructuring of health care services can eliminate excess capacity in rural areas (Christianson & Finch, 1981); others consider such actions as threats to geographic and economic access to health services in rural areas (Berry & Seavey, 1994; Mick & Murlock, 1990). For example, rural hospital closures can create barriers to health services for large portions of the population and eliminate sources of employment and income in rural communities (McDermott, Cornea, & Parsons, 1991; Mullner, Rydman, & Whiteis, 1990). In addition, rural residents indicate that health reform/renewal lead to an exodus of health care professionals (Mick & Murlock); a perception of loss of community control related to regional (rather than local) boards (Casebeer & Hannah, 1998); and an imposition of community based (in lieu of previously facility based) programs (Casebeer & Hannah). Additionally, there is a likelihood of secondary erosion of the scope of local services (i.e., education, retailers) with the consolidation into a regional delivery format (National Rural Health Association, 1998). The magnitude of the changes facing most communities can be stressful for providers, individuals, and communities as they are attempting to establish new and complex networks of intra- and inter-community organizations.

Citizen participation

"As citizens, consumers, patients, and volunteers, we are both demanding and being exhorted to become more involved in healthcare decision making and service delivery (Pivik, 2002, p. 1). According to the Pollara survey (2000b), Canadians are seeking a stronger voice for the public in decisions about the future of health care. Nearly 60% feel they should be able to participate all the time. An EKOS-Frosst poll (2002) found that 78% of respondents felt that citizen participation in major health care system decisions was very important. These findings lie in contrast to the historical trend in which consumers had minimal voice and remained on the periphery of decision making allowing physicians and administrative officials to decide the operationalization of the health care system.

According to Horne, Donner, and Thurston (1999), health care reform, with its emphasis on community empowerment and consumer participation, will potentially alter the historical paradigm significantly. Citizen participation (CP) in health planning, according to Lilley (1993), refers to involvement in the identification, development and evaluation of services, programs, policies and laws aimed at keeping citizens healthy. The concept of CP in the health policy process has been articulated by international interests (Consumer's Health Forum of Australia, 1996; Pivik, 2002), federal government (Epp, 1986), provincial governments (Premier's Commission on Future Health Care for Albertans, 1989; Saskatchewan Commission on Directions in Health Care, 1990; Manitoba Health, 1996), health organizations (HSURC, 2000; RHAM, 2000; WHO, 1978), and health researchers (Kouri, Dutchak & Lewis, 1997; Scott, Horne, & Thurston, 2000). According to Mhatre and Derber (1992) increased CP is an important principle for improved health care. Pivik states that

> creation of informed public opinion and its conversion into actionable political will are the means by which the public, acting as citizens, can be most meaningfully involved in developing and maintaining overall vision for the health system consistent with its values and principles. (p. 92)

Church (2001) stated that although the health reform movement in Canada is premised on the assumptions that "citizens want to participate and that citizen participation leads to better decision making . . . (there is no clear) evidence to support these assumptions" (p. 1). Further, he suggested that efforts to involve citizens in decision making perpetuate imbalance in power as well as other difficulties. Abelson (2003) describes citizens as reluctant to take responsibility for difficult decisions and as reluctant rationers.

For much of the last 30 years, CP has remained distinct from political participation. In recent years, there has been a convergence of concern with citizen engagement in policy formation and implementation and with good governance broadening political participation to include a search for new, more direct ways through which citizens may influence governments (or governing bodies), and hold them accountable (Feldberg, 2001; Gaventa & Valderrama, 1999). Historically, according to Richardson (1983), CP envisioned consumers as not only having little interest in policy deliberations but also little capacity for contributing effectively to the process. During this period, the experts – the professionals, politicians, and managers – were entrusted to ensure that consumers' needs were well served. With growing frustration over the limitations of 'user involvement', practitioners began to distinguish between viewing users as consumers shifting the focus to empowerment as the redistribution of power (Croft & Beresford, 1996). Increasingly the concept of CP began to move from one of users and choosers of services provided by others to one in which people became actors and agents in broader processes of governance (Gaventa & Cornwall, 2001). Notionally these varying roles of citizens in the CP are described by Abelson (2003) as governors (direct participants), consultants (solicited contributors), and organized interests (unsolicited contributors).

Policy making depends upon public engagement to ensure governance by the people. Traditionally, however, citizen consultation has been burdensome, even risky, for the official (Abelson, 2003) and unsatisfactory for the citizen. Citizen participation has suffered from problems of under-inclusion, misinformation, parochialism, interest group influence, partisanship, inefficiency and regulatory capture" (Funken, Groebel, Novecdk, & Samanti, 2003, p. 7). The list of potential difficulties with CP is extended to include tokenism, difficulty reaching marginalized populations, and lack of resources (Lilley, 1993; Lord, 1989; Valentine & Cappoini, 1989; Weaver & Pivik, 1997).

The OECD (2001) specifies three strategies for increasing public involvement: informing, consulting, and actively engaging the public in proposing policy options and participating in policy dialogue. Informing includes both production and dissemination of information by the governing bodies to the public, in forms such as annual reports, new releases, and public meetings. These informing strategies of CP tend to be minimally interactive and often generate cynicism about full disclosure. Consulting in CP addresses the issue of interactiveness by enhancing the exchange of information through either deliberative (i.e., focus groups, interview) or non-deliberative methods (i.e., polls, invited public presentations) (Abelson, Forest, Eyles, Smith, Martin, & Gauvin, 2001). Finally, in terms of active public participation in CP, the OECD (2001) sees this as true partnership between government and citizens enabling meaningful public involvement and informed decision making. Meleis (1992) stated active public participation enables community member involvement in the development, implementation, and evaluation of health planning. This level of participation is exhibited in citizen roles on regional health boards, advisory committees, and provincial health councils (Lilley, 1993). According to the Canadian Centre for Analysis of Regionalization and Health [CCARH] (2002), 70 to 80% of RHAs involve the public in setting goals and priorities; 25% involve the public in resource allocation decisions. As stated by Church (2001), citizens are integral to the decision-making mechanism for the health system, but their involvement is critically rooted in transparency and due process.

Lessons Learned: Literature Review

A number of interrelated terms of importance were highlighted in the literature review including rural, rural health, rural women, women's health (general and rural), public policy (health reform/renewal and women and health policy), and citizen participation. The conceptual framework and this research study were informed by the literature findings from three key perspectives – rural context, policy context, and participant context. The participant context is reflected in both the rural and policy context literature discussion herein.

In terms of the rural context, the emphasis on rural as a unique context for action is paramount in the articulation, implementation, and impacts of health reform/renewal policy. The literature sources highlight the necessity of a policy process which recognizes how health is constructed variably in rural communities and special sub-populations within the rural context. Rural women, as a unique sub-population, are conceptualized in the literature as under-represented and significantly impacted from a personal, familial and community perspective by changes in health policy. Gaps in this literature set lie primarily in definitional and conceptual clarification which necessitated a clear articulation of the inclusion criteria for rural community within this study. Further, there remains a call for ongoing research about rural women and their health which is broad enough to address the issue of "what actually produces health for different groups of women" (Chesney & Ozer, 1995, p. 13). The present research considers the perspectives of the participants on those aspects of health reform/renewal policy which have impacted their health status and that of their communities.

In terms of the literature set on the policy context, the clarification of the policy process and the respective roles of policy actors (i.e., government, bureaucrats, interest groups, community, and individuals) was a critical element in informing the conceptual framework for this study. The recognition of policy making as an imperfect, unpredictable, and contextual process is clearly articulated within the extant literature.

Despite its high level of currency and volumes, the health reform/renewal literature, like the rural literature, showed an inability to reach a consensus on the meaning and scope of the term. There exists a fairly extensive literature respecting the potential policy impacts experienced as a result of rural health reform/renewal policy uptake. These impacts ranged from primary access issues to secondary erosion of economic and political status; and from loss of professionals, population, and services to imposition of alternative services or service mixes. Another consideration is that, although health reform/renewal is described as a multi-faceted, multi-dimensional policy initiative, the literature related to this policy in rural areas and respecting rural women is limited and tends to focus on health care service delivery rather than policy impacts and barriers to full participation in the policy process. This synthesis informs the emphasis within the conceptual framework and study about the real and perceived impacts of health reform/renewal in Saskatchewan and Manitoba by rural women.

CHAPTER III

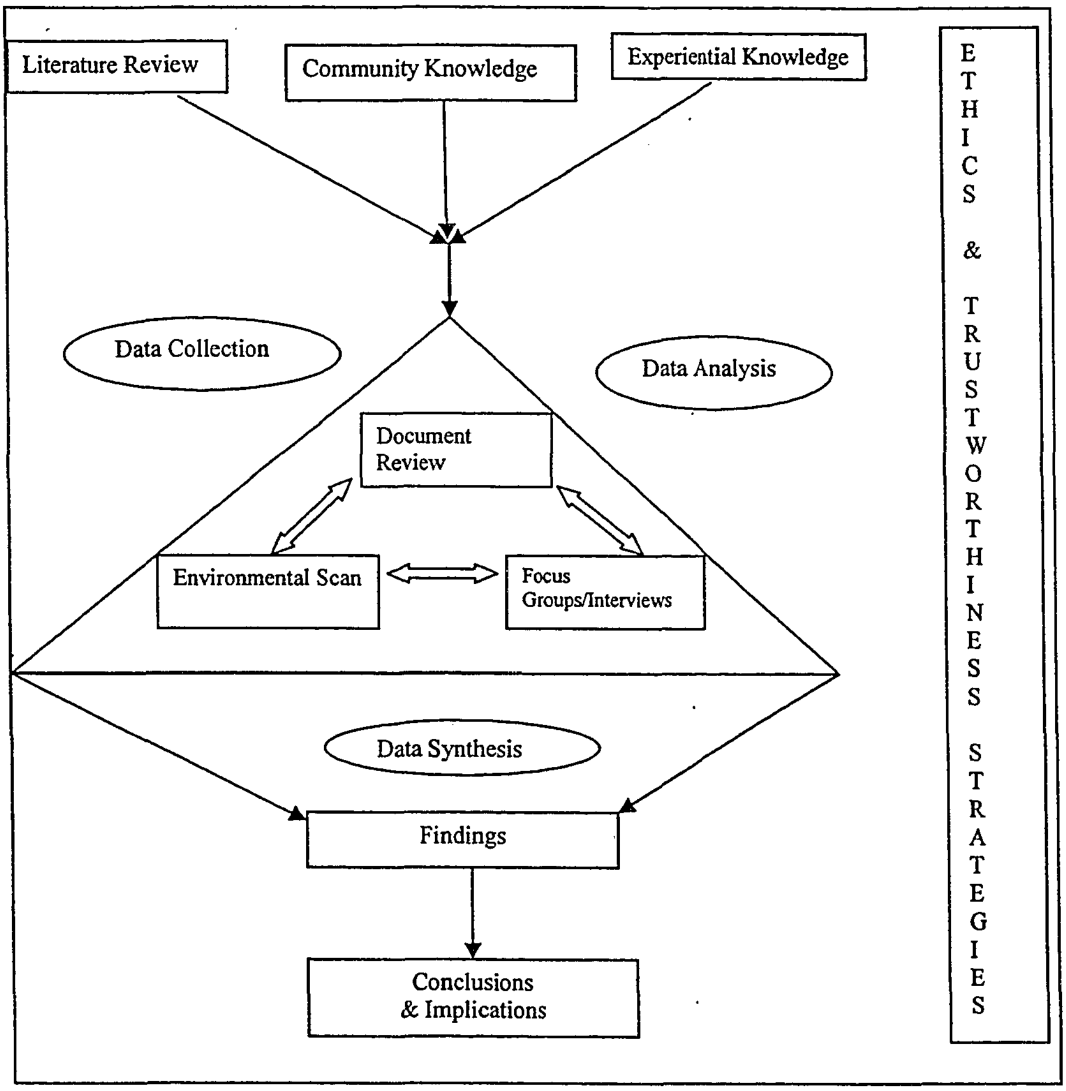
METHOD OF INQUIRY

An exploratory/descriptive case study design was used in this study, which allowed for an in-depth exploration of samples of rural women in Saskatchewan and Manitoba. The selection of a research design included consideration of strategies to identify how health issues are experienced and constructed differently in rural environments as recommended by Ramp (1999). In discussions of women's health research, there tends to be a school of thought in which both quantitative and qualitative methods are advocated in order to address the complexities of women's health on a number of levels (Chesney & Ozer, 1995; Griffin & Phoenix, 1994; Hall & Stevens, 1991; Messing, 1995; Neysmith, 1995; Oakley, 1993a; 1993b; Ruzek & Hill, 1986; Ruzek, Clarke, & Olesen, 1997b). Central to the methodology of this study is the belief, as stated by Ironstone, et al. (2002), that the essential meanings of women's lives can be grasped only by listening to the women themselves.

Such a design embraces methodological diversity as an imperative in addressing the increasingly complex health care system and women's health. Most researchers acknowledge that the complexity of the health care system and the questions that emanate from it cannot be answered through a single approach (Grant, Adelson, Armstrong, Biggs, De Grosbois, De Koenik, Downe, Eakin, Lippman, Messing, Payne, & Wakewich, 1999). The preponderance of evidence, upon which health practice and health policy is based, still uses and privileges a narrow range of methods, and relies disproportionately on a numeric data, which is collected using methods within the positivist/quantitative tradition. This research study reaches beyond such a weighted unilateral approach and embraces both qualitative and quantitative techniques.

Figure 2 depicts the design of the study – a logical flow from preliminary activities through data collection, analysis, and synthesis to findings and conclusions and predicated on a commitment to ethics and trustworthiness in the relationship and research. The preliminary activities of this study included efforts to justify and delineate the study. These activities included an extensive literature review on extant writing on critical concepts and theoretical components of the topic based on literature findings,

Figure 2. Study design flow diagram.



Adapted from Moen (1998).

experiential knowledge, and preliminary input of the community of interest. These sources plus the actively sought data collection sources of the document reviews, environmental scans, and focus group/interviews were considered in accordance with case study methodology. Data collection, analysis, and synthesis activities were rooted in the researcher's efforts to respond to the four research questions through multiple sources of evidence. Collection, analysis, and synthesis were iterative processes which included strategies such as data coding. The findings for this study are presented in the form of 3 case studies. Conclusions and implications are based on the summarizing of results and interpretations into lessons learned and contributions to the knowledge.

Although this section focuses on the collection of data, the inter-relationship with analysis and synthesis has resulted in overview discussions of each of these phases in this chapter.

Preliminary Steps

The three components contributing to the preliminary steps of this research are literature review (which has been previously described), as well as community and experiential knowledge. The latter two components will be discussed in terms of their contribution to the conceptual framework and research strategy utilized in this study.

Community and Experiential Knowledge

The Women's Institutes are rural-based, volunteer women's organizations that stimulate leadership growth in women. Both provincial groups promote the improvement of agricultural and rural communities, through networking and linking provincially, nationally, and globally.

I have a long standing relationship with the Saskatchewan Women's Institutes including a variety of presentations and involvements in the group's activities. In considering the unique role of this group and its intimate knowledge of the rural context, I decided to approach the Women's Institutes about facilitating and participating in the research. I saw their involvement as a means of capacity building in research process and knowledge utilization for the group. This approach also recognized and valued the unique relationship which the organization has within the rural communities in both provinces.

As part of designing the study, initially, the researcher worked closely with the Saskatchewan Women's Institutes provincial office and provincial board to achieve the following:

- to gain preliminary background on the general issues and concerns experienced by this unique community in terms of the health reform/renewal policy;
- to investigate whether the research topic and questions were meritous from the perspective of this informant group;
- to provide a basis for developing the scope and orientation of the research process;

- to assist with the development of the research instrument and sampling plan;
- to assist the researcher in establishing a contact and linkage with the Manitoba Women's Institutes to assist with the case and sample selection strategies in their jurisdiction; and
- to gain entry into the communities of interest in a respectful and culturally acceptable manner.

Appendix A contains select samples of the researcher field notes respecting this data source.

As a key outcome of this preliminary workshop, the clarification of the selection criteria for the communities and the participants was achieved. These criteria were initially derived from the literature review and refined through discussions with the Women's Institute's provincial boards. The final criteria were as follows:

- community rurality – i.e., communities where focus group occurred were at least 30 minutes from a secondary or higher level of service centre; and
- population base – i.e., each district/region did not exceed 50,000 people.

Following this initial involvement with the Saskatchewan Women's Institutes, the Saskatchewan and Manitoba Women's Institutes provincial offices were invited to be involved in the selection of the communities. Through their chapters, each provincial group was asked to recommend health districts/regions and communities for study which met the inclusion criteria of community rurality and population base described earlier. Each provincial group was provided with a list of the health districts/regions which met the second criterion. Because of their intimate knowledge of the communities, their ability to address the first criterion was seen as possible from within their pre-existing knowledge set.

For the purposes of this research, the regions selected were conceptualized as the analysis units (i.e., context and environment in which communities were situated); the focus group participants as the sub-units analyzed to identify the impacts of health reform/renewal policy. For the two Saskatchewan cases, the additional criterion was for one community to experience a conversion of the hospital (i.e., significant change in facility based services) and the other to retain health centre status with a change in service offerings (i.e., moderate change in facility based services). In the case of the

Manitoba community, there was no change in facility based services across the province.

Having accepted the Women's Institute Board recommendation of the communities, a formal request was sent to the two provincial Women's Institute offices to contact the appropriate person(s) in the respective chapter to contact the researcher regarding participation in the research project (see Appendix D). Once the contacts were established, the researcher and chapter representatives were able to establish the focus group strategy and research organization as described herein.

This procedure resulted in the selection of three rural field settings in three health districts/regions – two in Saskatchewan and one in Manitoba. The communities of interest were 35, 37, and 40 minutes away from a secondary service centre. The two health districts in Saskatchewan had populations of 24,500 and 31,000 people; the Manitoba Health Authority 44,000 people. Extensive descriptions of the communities and the districts/regions are included within the individual case studies presented in Chapters VI and VII.

As this study was in progress, Statistics Canada (2002) convened a Health Region Peer Working Group (HRPWG) to develop a taxonomy of comparative health region groupings based on social and economic variables. The key concepts explored by the HRPWG included basic demographics (i.e., population profile), living conditions (i.e., income inequities), and employment conditions. Ten resulting peer groups were derived, and of note the three health regions/districts under consideration in this study all fell into the same peer group. This peer group, which is primarily rural regions in the central prairies, represents 1.7% of the Canadian population. Demographically the group has almost equal numbers of females and males, moderate numbers of Aboriginal peoples, and experiences negative population growth (Statistics Canada, 2002). This finding was significant in that it validated the approach taken in this research and the advice provided by the Women's Institutes.

Data Collection

By the nature of this research design and policy evaluation research, a number of data sources were necessary. This multiplicity of data sources was congruent with the research method of case study and ensures a more holistic consideration of the topic (see Figure 2), enabling fair dealing with a wide range of different perspectives as described by Barbour (2001). According to Reinharz (1992), the research methods in case studies necessarily span the spectrum of literature analysis, surveys, archival research, interviewing, and various other strategies. Both primary and secondary data sources were considered within this research. Thus, as a research method, the case study approach selected for this study appears ideal since it seems to address the "eclectic" nature of the subject matter of this research.

Primary Sources

Primary data sources included transcripts of focus groups and interviews (Babbie, 1992), as well as researcher journal and audit trail notes. In this study, the focus of the primary sources was on obtaining the community sector perspective, specifically that of rural women. In accordance with Yin (1989), interviews and direct observation are sources of primary evidence.

Focus Groups/Interviews

The use of both focus group and individual interviews in this study was instrumental in acquiring insights and corroboratory evidence. By using multiple data sources, the potential for over-reliance on focus group and interview informants was minimized as cautioned against by Yin (1989). For this study, these approaches served several of the purposes listed by Lincoln and Guba (1985):

- Obtaining here and now constructions of a phenomenon;
- Reconstruction of previous events;
- Projections of the future; and
- Verification and corroboration of data from other sources.

Three focus groups (i.e., one for each region), four interviews and one telephone contact were held in late 2001. These strategies were conducted by the researcher following a semi-structured question guide (see Appendix B). The research used non-probability sampling for the focus group, which may or may not accurately represent the population. This sampling method was convenient, economical, and appropriate for exploratory/descriptive studies, as there was an insufficient amount of information about the problem and population to allow for a probability sample. It is rarely possible in case studies to generalize beyond the immediate case; hence, non-probability sampling was congruent with this research method.

In order to gain access to the sample informants, the Manitoba and Saskatchewan Women's Institutes provided assistance as described previously. The Women's Institutes chapters, in the selected districts/regions, aided in determining a mechanism to access individual participants for focus group sessions. This involvement included organizational aspects of the focus groups such as recruitment, sites, and refreshments.

All twenty-four focus group participants were rural women. No health care employees, past or present, were included, as it was felt that this group has a unique relationship with the health care environment which is beyond the scope of this study. Table 3 reflects the age breakdown of the focus group participants.

Table 3

Participant Representation by Age Group

Age Group	**Number of Participants**
25-34	3
35-44	4
45-54	4
55-64	5
65+	4
Unreported	4

Each session began with a brief overview of the project followed by a request for signing of an informed consent. All participants were made aware that the session would be tape recorded for transcription purposes. In addition, a non-participant recorder was included at each session to assist with data capture and observation of participants during the focus group process. A flip chart was utilized to guide the discussion with the guiding questions on individual pages.

The follow-up interviews were conducted at individually arranged locations as requested by the participants. According to Reinharz (1992), interviewing provides access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher. The participants were reminded that the consent they had provided at the focus group session remained in place and that they continued to have the option to withdraw at any time. The semi-structured guide utilized for the focus groups was used to direct the interview process and tape recordings of the interviews were obtained.

The focus group/interview guide was developed using the Institute of Cultural Affairs ORID (objective, reflective, interpretive, and decisional) framework for focus groups (Spencer, 1989). In this framework, questions are set at varying levels to provide a holistic and in-depth exploration of the participant's understanding of the issue. This method has been successfully applied in situations such as handling and settling conflicts, reflecting or reviewing reports, program evaluation, policy assessment, and motivating communities. The questions are set out in the four levels:

1. Objective Level – which aims to establish the facts and data; these questions appeal to the senses – what was seen, and heard.

2. Reflective Level – which explores initial reactions to the facts and data generated in the previous level; these questions appeal to the emotions, memories and associations.

3. Interpretative Level – which requires critical thinking on the experience/issue; these questions appeal to the mind, meaning, value, and significance.

4. Decisional Level – which appeals to future resolves, collective opinion, proposed next steps. Appendix B contains a copy of the focus group and interview guide.

Direct Observation

Direct observation in this study was achieved primarily through environmental scans, which are also known as windshield surveys or community assets analyses. Environmental scans are ideal tools for this type of research as they permit the researcher to make pertinent observations about communities and are used extensively by nurses and policy analysts involved in community development initiatives. The format adopted by this research was derived from the work of Anderson and McFarlane (1996) which identified three overarching elements – community core, subsystems, perceptions – as the framework for a community environmental scan. Table 4 summarizes the key components of the environmental scan.

These surveys reflected environmental scans of the communities and agency walking tours conducted at the time of the focus group sessions. These observations were recorded in the researcher field notes and are represented by the excerpt in Appendix C.

Secondary Sources

Secondary data sources included program/service utilization data (i.e., health district service use statistics; Statistics Canada reports); provincial and health district relevant documents (i.e., reporting documents; needs assessments); and stakeholder relevant reports (i.e., Health Services Utilization Review Commission(HSURC); Prairie Women's Centres for Health Excellence; Manitoba Centre for Health Policy [MCPH]). Key criteria for the selection of these data sources were the authority and relevance of the resource. As appropriate in an exploratory study such as this one, the researcher's criterion of relevance expanded as understanding evolved. Hence, some documents became more relevant on the basis of knowledge gained from the study's other data collection activities (i.e., focus groups) or simply because the researcher was able to synthesize information from those documents in the context of other documents. In accordance with Feagin, Orum, and Sjoberg (1996) and Yin (1989), these sources are categorized as documentation, archival records, and physical artifacts.

Documentation

Yin (1994) states that documentary information "is likely to be relevant to every case study topic" (p. 81). Merriam (1998) claimed that "documents of all types can help the researcher uncover meaning, develop understanding, and discover insights relevant to the research problem" (p. 118). In this study, documentation included needs assessments, annual reports, web sites, and news clippings. These data were critical in answering the first research question and informing the research conceptual model respecting the key elements of policy articulation and policy implementation.

The initial document capture was focused on the consideration of existing national, provincial and regional documents related to health reform/renewal. Documents were obtained from government and regional offices in their original form. Each document was reviewed and summarized for future reference using the reference capture tool (see Appendix H). In addition, reference lists from each document were reviewed as appropriate to gain a listing of supporting documents to be reviewed. These were managed in the same manner. A total of 43 documents were reviewed.

Table 4

Environmental Scan Framework

Element	**Components**
Community Core	a. Boundaries, e.g. natural bodies of water, railroads; economic divisions, e.g. industrial/residential areas b. History: old/established areas; old/new buildings; graves c. Demographics: people seen (age; homeless; solo/families); races noted d. Ethnicity: restaurants; churches; school names; cultural artifacts (i.e., posters, banners, murals) e. Values and Beliefs: Churches, temples, mosques; community newspaper; environmental status (litter free; yard manicuring); signs of art or cultural artifacts
Subsystems	a. Physical Environment: appearance of the community; flora; housing (age, architecture, condition); space (single family; public/private); green areas b. Health and Social Services: clinics/hospitals; health professional services; nursing homes; shelters; ambulances c. Economy: evidence of 'thriving; abandoned businesses/ buildings; industrial/commercial areas; shopping patterns d. Transportation and Safety: private/public transportation; highways; waterways; protective services e. Politics & Government: political posters/messaging; government offices; post-office f. Communication: gathering places (i.e., coffee shop; community centre); message centres g. Education: schools (levels); libraries; colleges h. Recreation: facilities; parks; evidence of participation
Perceptions	General summary statements about the community's health, strengths, potential weaknesses

Twenty-seven additional documents were accessed that emanated from stakeholder and recognized agencies such as HSURC and MCPH. The documents accessed in this document capture phase were referenced in either the initial document capture discussed previously or from the CCARH website.

Internet searches for additional documents produced within the time period of the health reform/renewal policy implementation were also performed using the key words of health reform, health renewal, Saskatchewan, and Manitoba. The documents produced from this search were considered for their relevance and authority for inclusion in the document consideration. Over 90 such sites were considered with 11 new documents extracted for consideration in this study.

Finally, newspaper searches were conducted for all three regions and the selected communities. These searches were conducted by requests to the respective community newspapers and through district/regional offices (i.e., archived documents). Of the 24 articles retrieved, 6 were considered relevant and with authority for referencing purposes.

These sources provided highly credible data related to the articulation and implementation of the health reform/renewal agenda in the two provinces. The reliance on primary sources added to the quality of the data sources used in this research.

Physical Artifacts

According to Hodder (2000), what people say is often different from what people do, so it is important to look at the material traces of behaviors. "The study of material culture is …important for researchers who wish to explore multiple and conflicting voices, differing and interacting interpretations" (p. 705).

Consideration of buildings, community environment, and commemorative mementos were part of this study. These elements contribute to gaining the overall perspective of the presence and presentation of health care in the communities. This information was collected for each community through the environmental scan and through the walking tours of many of the agencies in each community.

Archival Records

For the purpose of this study, consideration of maps, utilization data, organizational records, and available survey data (i.e., community needs assessments) applicable to this topic were accessed. In addition, minutes of the formation meetings for the two Saskatchewan health districts and the minutes of the board for the first year were reviewed. These documents were found to be very generic and of minimal assistance in informing the research. Again, these records were key in clarifying various aspects of the policy articulation and policy implementation aspects of health reform/renewal policy.

Summary of Data Collection Activities

The study's data collection technique offered complementary perspectives on the health reform/renewal policy process in Saskatchewan and Manitoba. A primary concern was to develop a knowledge set to enable me to answer the study's research questions. Table 5 summarizes the various data sources and the utility of each type of data in relation to the conceptual model for the study.

Table 5

Data Collection Summation

Classification	**Sources**	**Contribution**
Primary sources	Text data: • transcripts (interview & focus group) • environmental scans • researcher field notes Taped data: • Transcripts (interview & focus group)	Provided participants perspectives, interpretations, and understandings of the health reform/renewal policy change Corroborated data gathered from other sources Provided insights into the context of the people and activities involved
Secondary sources	Text data: • government documents • historical & chronological documents • websites • news clippings • regional documents Pictorial data: • Maps	Provided official accounts of the health reform/renewal policy process Corroborated data gathered from other sources

Data Analysis and Synthesis

The case study approach calls for a unique combination of multiple methods, empirical strands, and perspectives in a single study as a strategy that adds rigor, breadth, and depth to the investigation. These methods are summarized in Table 6.

Categorizing and Coding

Analytic procedures fall into five modes: "organizing the data; generating categories, themes, and patterns; testing the emergent hypotheses against the data; searching for alternative explanations of the data; and writing the report" (Marshall & Rossman, 1995, p. 113). Each phase of the process requires reduction of the massive amounts of data for the purpose of interpreting or assigning meaning to the words and actions of the members of the community or site being studied.

Miles and Huberman (1994) have described 13 strategies for generating meaning from qualitative data. Such strategies range from descriptive to explanatory and from concrete to abstract (see Table 6). According to Miles and Huberman, five broad categories encapsulate the 13 tactics. The first three tactics tell us "what goes with what"; the next two "what's there"; the next two "sharpen our understanding"; the next four "see things and their relationships more abstractly"; and, the last two "assemble a coherent understanding of the data" (pp. 245-246). It is not necessary to use all of these tactics in any one case study, according to Miles and Huberman. The asterisks indicate those strategies utilized in this study.

Case Study Approach

According to Feagin, Orum, and Sjoberg (1996), a case study permits researchers to discover complex sets of decisions and to recount the effects of the decision over time. In brief, this study's design used a case study approach in which three communities (one in Manitoba; two in Saskatchewan) were considered using document reviews, environmental scans, and focus groups/interviews. Following the focus groups, one telephone follow-up and four individual, key informant interviews of participants self-selected from focus group participants occurred. These contacts provided an opportunity for in-depth explorations and clarification of the findings from the focus groups.

The research employed a multiple case study approach appropriately "investigating a contemporary phenomenon within its real-life context especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 1989, p. 13). Merriam (1998) emphasizes the holistic aspects of case studies in the statement:

> A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved. The interest is in process rather than outcomes, on context rather than a specific variable, in discovery rather than confirmation. (p. 19)

According to Zucker (2001), the case study method can be a "creative alternative to traditional approaches . . . emphasizing the (client's) perspective as central to the process" (p. 1). Knowledge gleaned from case study research differs from other research knowledge in four fundamental ways:

Table 6

Strategies for Generating Meaning from Qualitative Data

Overarching Aspects	**Tactics**
What goes with what	Noting patterns/Look for repetition* Clustering* Seeing plausibility*
What's there	Making metaphors/analogies* Counting
Sharpen our understanding	Making comparisons* Partitioning variables
See things and their relationships more abstractly	Subsuming particulars into general* Factoring Noting relations between variables (similarities and differences)* Finding intervening variables
Assemble a coherent understanding of the data	Building a logical chain of evidence* Making conceptual/theoretical coherence*

Adapted from Miles and Huberman (1994).

- grounded in real-life experience, it is concrete and sensory;
- highly contextual;
- dependent on reader interpretation for its development; and
- the reader, rather than the research determines the extent of generalization (Stake, 1981).

This approach was consistent with the non-interventionist nature of this study. Further, this design is consistent with the study in that consideration is being given to a bounded (i.e., separated out in time, place, or physical boundaries) system, experiencing a process (Stake, 2000a). The findings yielded three case studies recognizing the uniqueness of the communities and provinces in their health reform/renewal policy initiatives.

Multiple (Collective) Case Study Approach

According to Yin (1989), multiple case study design is used when independent innovations occur at different sites, thereby allowing each site to be the subject of an individual case within the study. Stake (1995) suggests that we may be more interested in a phenomenon or a population of cases than in the individual case. This interest leads to the study of a number of cases jointly in order to inquire into the phenomenon, population, or general condition. Multiple (collective) case design involves identification and analysis of individual case studies to produce more compelling evidence regarding the relationship between the variables of interest. By definition, the case study is an in-depth, multi-faceted investigation using several data sources (Feagin, Orum & Sjoberg, 1996). This approach is preferable for this study, as it is a non-interventive, empathetic consideration of a high profile issue – health care reform/renewal.

The collective case study is a grouping of instrumental case studies which are selected because it is believed that "understanding them will lead to better understanding, perhaps better theorizing, about a still larger collection of cases" (Stake, 1995, p. 437). It is imperative to recognize the instrumental rather than intrinsic aspects of this approach. In the intrinsic case approach, the researcher is interested in a particular case with no intention of theory building. Conversely, the instrumental case seeks to look at the case in depth, scrutinize the contexts, and pursue external interests. Essentially, the instrumental case "serves to help us understand phenomena or relationships within it (i.e., the case)." (Stake, p. 77)

Advantages of case study approach

The advantages of case study research according to Feagin, Orum, and Sjoberg (1996) are:

- permits the grounding of observations and concepts about social action and social structures in natural settings studied at close hand;
- provides information from a number of sources and over a period of time, thus permitting a holistic study of complex social networks and of complexes of social action and social meanings;
- furnishes dimensions of time and history to the study of social life, thereby enabling the investigator to examine continuity and change in life world patterns; and
- encourages and facilitates, in practice, theoretical innovation and generalization.

Disadvantages of case study approach

According to Yin (1989), the disadvantages of the case study approach are:

- concern over lack of rigor;

- lacks basis for scientific generalizations as:
  - case study does not represent a 'sample';
  - goal to expand and generalize theories (analytic generalizations) and not to enumerate frequencies (statistical generalizations); and
- results potentially in massive, unreadable documents.

In order to address these disadvantages, the research must be conducted in an accountable and consistent manner as evidenced by the criteria of adequacy and appropriateness of data, audit trail, and member checking. Theoretical rigor is addressed through appropriate choice of methods; methodological rigor via documentation and audit trail; interpretive rigor through quotes and anecdotes; and evaluative rigor through ethical considerations. The goal is to seek the meaning of the policy change experience to participants rather than generalizing results to other groups of people.

Guidelines for field-observation case study

According to Stake (1995), the following set of phases guides planning, conducting, and delivering the case study (see Table 7).

The *anticipation* phase of this study primarily involved the Saskatchewan and Manitoba Women's Institutes and the doctoral committee. Through these groups and individuals, the expectations and conceptualizations relevant to the study were explored and clarified. Further, the development of research questions, scope of the study, and potential audiences for the report was achieved within this context. Clearly, this study has both academic and non-academic target audience components.

During the anticipation phase the Saskatchewan Women's Institute board held a workshop to provide the researcher with guidance and insights into the research methods and sampling. The researcher provided an overview of the project. This session was foundational in formalizing the focus group/interview guide and case selection. Together the board members and the researcher determined the initial order and wording of the questions. A proposed strategy for community selection and recruitment of the participants was jointly developed.

Table 7

Case Study Phases

PHASE	DESCRIPTION
Anticipation	Review expectation at the onset Consider questions/hypothesis/issues Literature review Define the boundaries of the case Consider potential audiences for preliminary and final reporting
First Encounter	Arrange access, negotiate plan of action Discuss arrangements for maintaining confidentiality Discuss member checking
Further Preparation for Observation	Make preliminary observations Literature review Identify informants & sources of data Establish data management system
Further Development of Conceptualization	Consider issues to guide data collection Literature Review Sketch plan for final report & dissemination of findings Identify possible 'multiple realities'
Gather Data, Validate Data	Make observations, interview, debrief, logs Select vignettes Literature review Begin interpretations Redefine issues Gather additional data, replicating or triangulating to validate key observations
Analysis of Data	Review data Search for patterns and linkages Draw tentative conclusions Seek disconfirmation of findings
Providing Audience Opportunity for Understanding	Describe setting extensively Try reports out on representative audience Revise and disseminate

Adapted from Stake (1995).

The initial access *(first encounter)* and action planning were conducted approximately 3 months prior to the focus groups. Each of the provincial Women's Institutes was contacted regarding a willingness and ability to participate within the given timeframe and study expectations. Roles of researcher, community (local) coordinator, and participants were delineated and agreed upon.

The issue of confidentiality was broached in the letters to all participants and re-examined during the focus group and interview sessions. All participants were assured that their contributions were to be treated in confidence and would be presented in a manner that did not directly link the contributor to the information. The strategy to ensure confidentiality included a number of steps including: non-disclosure of the community in which the research occurred; non-identification of participants through avoidance of names or initials (i.e., using pseudonyms if necessary); and a group discussion at each focus group session about the expectation to maintain the information shared in confidence.

Member checking was described in the letters to participants and discussed at the conclusion of each focus group and interview. All participants were sent copies of the transcripts of their respective focus group and, if applicable, interview for their input, corrections, or clarification. Feedback was received from 5 participants and was incorporated as appropriate. Of note, this feedback was primarily stylistic, typographical, and grammatical changes with no significant content changes received. This result was supported by Stake (1995) in that participants should be asked to review the material for accuracy and palatability, despite the fact that few are likely to provide feedback.

Five individuals received a tentative presentation of the themes which were derived from the research. These individuals had indicated a desire to receive the final document, so it was felt that they were motivated beyond the focus group participatory phase of the study.

During the *preparation for observation* phase, a number of the resources, literature sources, and preliminary statistical data were considered. The Women's Institutes were provided with preliminary correspondence to circulate to potential participants. A strategy was established for data management including a reference capture tool, an audit trail mechanism, and a data security plan.

The clarification of key concepts was fundamental to the overall *further conceptualization* of the study. By focusing on these terms, the parameters of the study were clarified. Data collection respecting documents and archival records was limited by date to correspond with the period of time from the inception of health reform to the time of conducting the field research. The focus of these types of data collection sources was primarily Canadian sources with the consideration of private and public sector perspectives in order to explore the potential multiple realities of the issue.

In mid to late 2001, three focus groups and resultant interviews were conducted to *gather* field data. This interaction included the environmental scanning of the communities and health districts/regions as well as the securing of relevant health authority materials (i.e., annual reports, health plans). In addition, the member checking process was completed by early 2002.

After reviewing the transcripts, the selection of vignettes and initial interpretations of the transcriptional data were undertaken. A preliminary coding thematic framework was developed to assist with pattern/theme identification (Krueger, 1998; Miles & Huberman, 1994). The initial coding framework was derived from the review of the transcripts of the first Saskatchewan focus group and an interview (see Appendix G-1). Theme identification involved several steps: each transcript was reviewed line by line to elicit key words and concepts; from these initial analyses, broad patterns emerged. During this phase, each case was considered individually for transcriptional analysis. The establishment of broad themes was achieved through a collective review of all transcripts. This phase guided the ongoing gathering of utilization data, select statistics, critical historical documents, and related information to permit consideration of multiple sources in order to *validate* key observations.

The *analysis of data* entailed an extensive review of the primary and secondary data sources in an effort to establish reported themes and findings of the research. Stake (1995) suggests 3 to 4 themes are generally adequate in a case study. Strategically, meaning is derived through "direct interpretation of the individual instance (and/or)... through (categorical) aggregation of instances until something can be said about them as a class" (Stake, p. 74). Direct quotes and observational data from the interviews and focus groups, and all other documents were then analyzed for congruence with resulting themes and sub-themes. Through use of multiple sources, confirmation and disconfirmation were enabled.

The study produced three extensive instrumental case studies suitable for the *target audiences.*

Confidentiality

Although it is incumbent upon the researcher to protect the identities of those interviewed, given the nature of this research, many individuals and their circumstances are known to townsfolk and had unique roles in the events that could not easily be obscured. According the Newman (2002) this is more than an ethical question for this researcher, as it poses analytic challenges: The individuals identified in these case studies, knowing that they might be recognized, may adjust or extrapolate their reporting to affect the perceptions of their experiences. Hence, I sought strategies to mitigate such dynamics entering into the process and evaluation of data. For example, no names were attached to specific comments within the transcription process, thereby reducing the linkage of contributions to specific individuals. Further, communities were referred to by pseudonyms.

Managing, Recording and Protecting Data

All the focus groups and interviews were tape recorded in this research. The telephone interview was recorded manually as this fell outside the original protocol, but on consultation with the committee chair this information was included for consideration. The tape format was convenient, reliable, and only slightly intrusive in the focus group and interview interactions. At the onset of each focus group session and interview, the participants were told that the tape recording was for review and transcription purposes. All participants were given the option to refuse to participate or withdraw at any time. In addition, they were told that, if at any time anything was relayed on tape that they wished removed, the researcher would respect this request in the transcription and analysis.

Each recording was transcribed verbatim. Each participant received a copy of her transcribed focus group and, if applicable, interview and was asked to read the transcription and to make any changes that she wished to make. The amended transcriptions were used as the final data for analysis. Interim analysis was done with the available (unamended) transcripts. Five individuals returned their transcripts with few amendments, and those that were received reflected mostly grammatical or typographical alterations.

All tapes of the focus groups and interviews, copies of signed consent forms, field notes, returned amended transcripts, and preliminary thematic findings have been labeled and stored in a secure location. Copies of the amended paper transcripts were provided to the committee chairperson. Two electronic copies of the transcripts have been stored in two different locations for data protection.

Trustworthiness

Trustworthiness for studies in the naturalist paradigm must be considered. According to Harrison, MacGibbon, and Morton (2001), trustworthiness refers to the ways researchers work to meet the criteria of validity, credibility, and believability of the research – as assessed by the academy, the communities, and research participants. The four factors generally related to trustworthiness or rigor in both qualitative and quantitative research are: truth value, applicability, consistency, and neutrality (Deyhle, Hess, & Lecompte, 1992; Guba, 1981; Lincoln & Guba, 1985; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Punch, 1986). These align with the criteria for qualitative research of credibility, transferability, dependability, and confirmability (Lincoln & Guba). Deriving from these criteria are specific strategies that are used to attain trustworthiness in qualitative research including audit checks, peer debriefings, member checks, negative cases, and prolonged engagement (Lincoln & Guba; Morse, et al.). Morse, et al. state that strategies for attaining rigor in qualitative research must be built into the process, rather than being retrospective, and should include investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance, and saturation.

More recently, Lincoln (2001) provided a series of eight commitments or standards of quality for qualitative and interpretative research. Creswell (1998) and Morse et al. (2002) refer to these developments as social action commitments. The use of these eight elements within this research is based in the pre-eminence of relationships and community in this study. According to Lincoln, the emergent research trend is relational research – "research grounded in the recognition and valuing of connectedness between researcher and researched, and between knowledge elites and the societies and communities in which they live and labour" (p. 343). The relational perspective is highly valued and aligns with this research.

The eight elements or emerging criteria for quality in qualitative research are addressed herein as they relate to this study.

Diverse Inquiry Communities

Communities exist with traditions of research with their own standards of rigor. Within qualitative research, the diverse inquiry communities are exemplified in such approaches as phenomenology, ethnography, and grounded theory. In this study, consideration of the case study approach has been undertaken to ensure an extensive understanding and incorporation of its "traditions of rigor, communication, and ways of working towards consensus" (Elliott, Fischer, & Rennie, 1999). Adherence to guidelines and strategies addressed within the literature strengthens the utility and rigor of the case studies within this research. This was demonstrated through the strategies for data collection, templating for case study presentation, and data analysis with each of the emergent cases.

Positionality

Positionality or standpoint judgments refer to a balanced and honest reflection of the participants' and the author's stance. According to Lincoln (2001), this criterion recognizes "texts are always partial and incomplete; socially, culturally, historically, racially, and sexually located" (p. 333). This criterion was addressed through the methodological approach of case studies which acknowledges the contextuality of the issues involved in health reform/renewal and embraces multiple sources and perspectives on the topic. It was also addressed through the extensive integrated literature review which provided various perspectives on the critical concepts and relationships explored within this study. In addition, the provision of assumptions by the researcher further contributed to achieving clarity in positionality.

Community as Arbiter of Quality

According to Lincoln (2001), this criterion recognizes that "research takes place in, and is addressed to, a community . . . (to) serve the purposes of the community in which it was carried out, rather than simply serving the community of knowledge producers and policymakers" (p. 334). The recognition is that there is a "close connection between knowledge and the community from which it springs, and in which it is intended to be used" (Lincoln, p. 335). This study's design and methods are designed to elicit information about the community's experience of health reform/renewal from the perspective of the community of rural women. The focus remains with recognition of the (present and potential) capacity of the community and its members throughout the research.

Voice

"Attention to voice – to who speaks, for whom, to whom, for what purposes – effectively creates praxis, even when no praxis was intended" (Lincoln, 2001, p. 336). Further, Lincoln states that "the extent to which alternative voices are heard is a criterion by which we can judge the openness, engagement, and problematic nature of any text" (p. 337). Presentation of negative or contrary exemplars as applicable strengthened this study's holistic and empowering approach. The research design and analysis of this study fully embrace this criterion in an attempt to reveal voice "as resistance against silence . . . disengagement . . . and marginalization" (p. 337). Essentially, the inclusiveness of the perspectives of rural women was paramount in this study.

Critical subjectivity

Reflectivity or critical subjectivity, according to Lincoln (2001), "enables the researcher to uncover dialectic relationships, array and discuss contradictions within the stories being recorded, and move with the research participants towards action" (p. 337). This research is essentially exploratory and is somewhat limited in the last aspect of this heightened awareness. However, the multiple case study approach and iterative analysis undertaken serve to recognize subtle differences and opportunities to mobilize research participants toward future action. Efforts were made to be inclusive of materials from various sources and perspectives in the individual cases, in an effort to strengthen the critical subjectivity of the study.

Reciprocity

All research takes place in a community which is replete with relationships including the relationship of the researcher and the researched. This criterion is critical given the intense person-centred nature of interpretive research (Lincoln, 2001). Generally, the need in this research was to establish trust and rapport in a fairly short timeframe, although the relationship with the Women's Institutes has been longstanding, the individual communities were seen as unique. In this study, reciprocity is seen in the trust and mutuality of the relationship between the researcher and the Women's Institutes. It is noted that this relationship has developed over time and continues to exist. Also, the willingness of individuals to voluntarily participate in a follow-up interview indicates a trust relationship which contributes to the quality and rigor of this study.

Sacredness of the relationship

This criterion is rooted in the concern for human dignity, justice, and interpersonal respect. Resultantly, researchers "create relationships that are based not on unequal power, but on mutual respect, granting of dignity, and deep appreciation of the human condition" (Lincoln, 2001, p. 339). The collaborative approach used in recruitment of the participants, and remuneration of incurred expenses with the Women's Institutes were critical in this regard. Further, strategies to ensure confidentiality, to gain informed consent, and the creation of safe focus group environment (i.e., an egalitarian platform for sharing) demonstrated a cognizance and embodiment of the sacredness of the relationships within this study.

Sharing privileges

Lincoln (2001) emphasizes that we must try to understand and in some way compensate those "lives to which we have access...which account in no small part for the prestige we enjoy in the worlds we create and sustain via our research" (p. 340). This research undertook to ensure various validation strategies throughout the focus groups and interviews, as well as to provide member checking opportunities through the circulation of transcripts for comment and critique. Further, a commitment has been made to share the final document with the individual participants who requested it.

Ethics Approval

Ethics approval for this project was obtained from the University of Alberta Health Sciences Ethics Board (See Appendix E).

Lessons Learned: Method of Inquiry

Based on a consideration of the method selected, this study was significantly strengthened by its comprehensive, multi-source approach. The method goes beyond traditional sources of policy analysis (i.e., facts; statistical data) by accessing the community directly to gain insight into their ideas on policy impacts of the health reform/renewal policy. This connotes respect and value for the knowledge and interpretations of these informants which, in more typical analysis, would be undervalued or absent.

The choice of the research questions, interview guide, research sites, and participants was an essential aspect of the data collection, data analysis, and data synthesis. The involvement of the provincial Women's Institutes in the preliminary stages of the research was seen as congruent and empowering to the community of rural women which they represent. This approach also aligned with the conceptual framework's strong pillar of ethics and trustworthiness through all phases of the research experience.

Simultaneous collection and analysis of data and information sources (i.e., documents) were important features of this research, enabling me to focus variably on the research questions and to direct the overall research process more effectively. This process also enabled me to assess the textual sources for relevance, and authority which contributed to the quality of the document capture. This strategic decision aligned with Merriam's (1988) comments that decisions must be made concerning scope and direction, or researchers may be left with data that are unfocused, repetitious, and overwhelming in the sheer volume of material needing to be processed.

CHAPTER IV

DATA ANALYSIS

Qualitative research analysis has been described as "calculated chaos" (Lofland & Lofland, 1995). The chaotic confusion of a complex data set with multiple potential interpretations is superimposed on an emerging knowledge set. The researcher is charting unknown territory in the pursuit of discovery and understanding. This sense of chaos was experienced within this research study with over 400 documents, and more than one hundred of pages of primary source transcripts and field notes. Further the chaos was evident in the need to be respectful and cognizant of all the stakeholders (i.e., policy makers, policy implementers, and community) at all stages of the process.

Despite the multi-source, multi-level approach, the process adhered to the proposed course of action indicated in Figure 2 with data collection, analysis, and synthesis occurring simultaneously in accordance with the case study method. According to Zucker (2001), this means that that researcher is constantly moving between the literature and field data. The analysis and synthesis aimed to generate a greater interpretive understanding of the meaning of the data set respecting select rural communities, such as rural women and their experience of the health reform/renewal policy.

Stake (2000b) states that researchers report their cases as cases rather than for the purpose of comparisons. Further, his contention is that "concentration on the bases for comparison, uniqueness, and complexities will be glossed over (if we do formal comparisons). A research design featuring comparison substitutes the comparison for the case as the focus of the study" (Stake, p. 444). Others, such as Merriam (1998) and Creswell (1998), prefer to present data analysis for comparative/collective case in two distinct levels – within case and cross case.

To facilitate analysis in this study, a brief presentation of within and cross (or between) case analysis will be proffered.

Within Case Analysis

For within case analysis, each case is treated as a comprehensive, self-contained report. Data are gathered in an effort bring forward the contextual variables that assist in depicting the setting and chronology of the case and provide the reader with the particulars of the case (Creswell, 1998). Within case analysis consists of both "description and thematic development" (Creswell, 2002, p. 486). Essentially, this involves a consideration of descriptive data (i.e., environmental scans, focus groups/interviews, document reviews) in this study giving a better understanding of the specific case within the larger context of health reform/renewal.

In this study, within case analysis informed the first three research questions. What were the intended (articulated) impacts of the policy changes proposed under the health reform/renewal agenda? What have been the short-term impacts of health reform/renewal on rural women in Saskatchewan and Manitoba? What are the perceptions of rural women regarding the impact(s) of health reform/renewal policy initiatives in Saskatchewan and Manitoba?

To frame this discussion, the individual cases will be considering through the considering two distinct models – the policy cycle model presented earlier; the second to be described as the Integrated Community Policy Uptake Model.

Cross Case Analysis

Once within case analysis is completed, thematic analysis across all cases as well as assertions or interpretation of the meaning of the cases is possible. Creswell (1998) describes cross case analysis as the "qualitative, inductive, multiple case study seeking to build abstractions across cases" (pp. 194-195). During this phase, the researcher considers whether the thematic analysis is supported for all the cases involved. Hence, the emphasis for cross-case analysis for this research will be on the similarities and differences between the three cases. In this study, the cross case analysis informed the final research question - What are the key learnings from this experience? How do the key learnings inform future public policy decisions/directions?

Case Study Overview

The work in this study illustrates the unique stories and experiences of diverse women in Saskatchewan and Manitoba and provides evidence for policy makers to consider regarding the effects of policy change on the health of rural women. The determination of what a case is has generally been under-theorized in the social sciences (Ragin & Becker, 1992). However, Ragin (1997) noted that cases are often purposefully selected because of their political and historical significance.

The format reflects a modification of Stake's (1995) seven components of the case study report, which are described in Table 8. The modifications reflect the opportunity to integrate and synthesize a number of common aspects of the three cases. As well, this format provides the opportunity for the audience to consider the case at the level (i.e., national, provincial, regional) that is most appropriate to its needs and interests.

Accordingly, the format will address the key elements of each component. The vignettes will be aligned with the individual cases (i.e., communities). The assertions will be presented in the final chapter of this document.

Table 8

Components and Key Elements in Stake's (1995) Case Study Method

Component	**Description/Key Elements**
Entry vignette	Embraces the context of the case
Issue identification, purpose, and method of study	Explains history of study, such as salient aspects of rationale, method, and issues
Extensive narrative description to further define case and contexts	Provides the body of relatively uncontestable data with limited interpretation
Development of issues	Expounds on key issues to assist with understanding the complexity of the case (may draw on other research or cases)
Descriptive detail, documents, quotations, triangulating data	Provides experiential data – indicates efforts to confirm observations
Assertions	Summarizes researcher's understanding about the case
Closing vignette	Offers a brief experiential note reminding the reader that the case is just one person's encounter with the event

Issue Identification

National

Policy problems are identified through situations that produce needs or dissatisfaction for which relief is sought (Anderson, 1990). Policy problems must be brought to the policymakers' attention. Once there, the policy issues and theoretical perspective to policy making are influenced by many factors (Brooks, 1998). "Problem definition develops as values, beliefs, and societal attitudes towards a policy concern are delineated and policy approaches considered" (Clark, 2003, p. 74).

Over the past decade, rapid and significant changes in health care delivery, technology, and public expectations have challenged Canadian and provincial governments to re-construct a health care system which balances current and future political, legal, economic, and social realities. For many involved, health restructuring has remained an amorphous, resource consuming policy approach. To most Canadian consumers of health service, this has meant exposure to a new order and emphasis within health care from treatment towards prevention and promotion; from universality to sustainability.

Provincial

Saskatchewan

In 1992, the Government of Saskatchewan introduced health reform/renewal with the stated objectives of introducing a wellness (non-treatment oriented) philosophy for health services and enhancing the individual communities' control of health care delivery, including devolution of authority to partially-elected district health boards (Saskatchewan Health, 1992). It created the mechanism for formation of health districts with expansive planning, capital, operational, and administrative roles and responsibilities for most aspects of health care services in the province. In addition to dissolution of over 400 previous health care service boards, the initial phases of health reform/renewal in Saskatchewan entailed closure or conversion of 52 small, primarily rural hospitals and establishment of 32 geographically defined districts.

In Saskatchewan, the inceptional policy position in 1992 was articulated by the Saskatchewan government document entitled *Saskatchewan Vision for Health* (Saskatchewan Health, 1992). The document emphasized the government's position to foster healthy people, health families and health communities using the following principles:

- increased community involvement in the health system;
- emphasis on disease and injury prevention, healthy lifestyles, and population health;
- improving the balance between institutional services and home or community-based programs, to provide the right service at the right time in the right place – as close to home as possible;

- coordinating and integrating health services for a more responsible, efficient, client centred system; and
- ensuring a financially sustainable, publicly funded health system.

Manitoba

In Manitoba, the Manitoba government's policy position on health reform appeared in *Quality Health for Manitobans - the Action Plan: A Strategy* to assure the future of Manitoba's health services system (Manitoba Health, 1992). This health policy document, derived through an extensive consultation process, called for a renewal of the health-care system in Manitoba and outlined the following goals:

- improve general health status of all Manitobans;
- reduce inequalities in health status;
- establish public policy that promotes health;
- foster behaviour that promotes health;
- foster environments that promote health;
- provide appropriate, effective and efficient health services;
- develop mechanisms to assess and monitor quality of care, utilization and cost-effectiveness;
- foster responsiveness and flexibility in the health-care delivery system;
- promote reasonable public expectations of health care; and
- promote delivery of alternative and less expensive services.

This document provided the framework for the establishment of the Northern and Rural Health Advisory Council which reported to the Minister of Health on issues related to renewal of health services in rural and northern Manitoba (Manitoba Health, 1992). It also framed the configuration of 13 regional health boards from the existing 180 plus local health service boards (Manitoba Health, 1993). Prior to the health reform/renewal agenda being introduced to the public, in 1991, the government undertook to restructure Manitoba Health by integrating the Manitoba Health Services Commission and the Department of Health with the intent of implementing a strategic management plan for Manitoba's health care system (MCPH, 2003).

Context

For the women of rural Saskatchewan and Manitoba, health reform/renewal was yet another policy decision impacting on the economic, demographic, and resource sustainability of 'small town' Saskatchewan/Manitoba, the rural 'family', and the individual. Consideration of the consequences for rural women of restructuring of health service delivery and redistribution of resources under the policy is critical for individuals who are already overburdened, multi-tasking, economically marginalized, and ladened with socially constructed roles and responsibilities. So, how have the women in rural Saskatchewan and Manitoba communities faired in the implementation of the health renewal/reform policy agenda? Has this Saskatchewan and/or Manitoba approach to health reform/renewal contributed to democratization of health care through creation of greater citizen awareness of and participation in health and health care issues and decisions from the perspective of select rural women? Further, what does this perspective mean for future public policy changes in rural communities in these two provinces?

As described previously, data for this study were obtained through a series of focus groups, and individual interviews, as well as extensive document reviews, and environmental scans (i.e., windshield surveys). The cases presented herein provide the contextual overviews of three rural communities resulting from these sources. Community A, in rural southeast Saskatchewan, is a community which experienced the conversion of their health centre, with a reduction in facility-based acute care capacity. The second community located in east central Saskatchewan retained its rural hospital in the form of a health centre with a reduction in beds and service capacity. Community C in west central Manitoba is a community which has had no direct changes on their facilities but was absorbed under the Parkland Regional Health Authority.

Narratives

The following three chapters consider the national, provincial, health district/region, and community narratives. Through the narrative section of the case studies, I focus on the reasons for the policies including consideration of the data on which they were based. It is recognized that sometimes there are no data, just someone's idea of what should be. Ideally policy depends on data – data gathered from existing information and summarized and synthesized with a particular question in mind. Existing sources of data used in the policy process include published and unpublished reports, briefs, and research as well as public, stakeholder, or member communication.

CHAPTER V

CANADIAN HEALTH SYSTEM NARRATIVE

This chapter provides a brief history of the Canadian health system with emphasis on the Canada Health Act. In addition, a consideration of the regionalization pattern across the nation and current health system challenges is offered to set the stage for the provincial, regional, and community narratives to follow.

Overview

Canada has a population of approximately 29.5 million people widely distributed over nearly 10 million square kilometers. Consideration of key health development indicators, such as life expectancy, educational levels, and infant mortality rates demonstrate that Canada has attained a level of international excellence. Overall life expectancy is 79 years with women at 81.4 years and men at 75.7 years which is third highest in the world (Canadian Health Services Executives, 1999). The average schooling for adults 25 to 54 is 13.2 years (Statistics Canada, 1996). Infant mortality rate (IMR) is 6 per 1,000 live births, which is second only to Japan's 3.8 per 1,000 (Statistics Canada).

National Context

Three distinct periods in the early (pre 1980s) development of Canada's health care system, as outlined by Weller and Manga (1983) will be used to present key formative elements. In addition to the historical perspective, a more recent consideration of the federal health care environment to the year 2002 is included, and where appropriate statistics are provided o further the understanding of the national context.

According to Weller and Manga (1983), the period up to 1945 is referred to as the period of benign neglect. It was this period that was guided by British North America (BNA) Act of 1867, in which the Fathers of Confederation set forth the division of federal and provincial responsibilities for health care.

The **federal** responsibilities were delineated in the BNA Act Section 91 as:

> It shall be lawful for the Queen, by and with the advice and Consent of the Senate and House of Commons, to (have) the exclusive Legislative Authority

> of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say . . .
>
> 6. The Census and Statistics;
> 11. Quarantine and the Establishment and Maintenance of Marine Hospitals; and . . .
> 24. Indians and Lands reserved for the Indians (Health Canada, 2003b).

In Section 92, the **provinces** were entrusted with

> . . . any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces, (including)
>
> 7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals (Health Canada, 2003b).

Despite the BNA Act, federal and provincial responsibility for health remained blurred during this era. Essentially the provinces were and are the primary deliverers of health care services with the federal government, which remains unchanged, both Constitutionally and historically, having involvement in public health, regulations of water and food, and similar jurisdictions.

For the period of 1945 – 1976, a number of developments lead to an era of shared cost arrangements between federal and provincial governments for health care. In 1948, the National Health Program was introduced which, along with a 50/50 provincial/federal cost share arrangement, precipitated the creation of over 45,000 hospital beds across the nation by 1953. The Hospital Insurance and Diagnostic Services Act (1957) placed emphasis on hospital based, acute care. Between 1961 and 1972, a Royal Commission, the Hall Report, and the Medical Care Act (1966) created significant inroads in terms of the provision of medically necessary services to all Canadians.

In 1997, the Established Federal-Provincial Fiscal Arrangements Act and regulations pursuant were fundamental in changing the method of financing health care in Canada. These were foundational for direct tax transfers and special transfers to the provinces along with the Canadian Assistance Plan.

Canada Health Act

The next major phase, beyond Weller and Manga's (1983) review of health care in Canada, introduced the Canada Health Act, 1984 (CHA) as the cornerstone of the Canadian health system, affirming the federal government's commitment to the five pillars of the health care system – universal, accessible, comprehensive, portable, and publicly administered. It is essentially a federal health insurance legislation which articulates the goal that all residents of Canada have access to necessary health care on a prepaid basis by establishing criteria and conditions for the provinces and territories to satisfy in order to qualify for their full share of the federal transfers for health care services (Fortier, 1995). Hence, the Act sets out the primary objective of Canadian health care policy ". . . to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Health Canada, 2002a).

According to Romanow (2002),

> The principles of the CHA began as simple conditions attached to federal funding for Medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. However, this rests on federal interpretation of the legislation and political rhetoric, both of which vary depending on the context. The principles have stood the test of time and continue to reflect the values of Canadians."(p. 95)

The CHA amalgamated the principles of the Acts of 1957 and 1966 with the augmentation of the element of accessibility. Each of the principles, as articulated in the CHA, is discussed below. Further, the CHA established criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The *public administration* principle of the CHA applies to provincial and territorial health care insurance plans with the intent of ensuring these entities are operated on a not-for-profit basis by a public authority. This principle also entails the accountability and auditability of the decisions and service levels offered by the respective provincial or territorial government.

According to the CHA *comprehensiveness* principle, there is a requirement of the provinces or territories to maintain eligibility for federal cash transfer payments. Such eligibility is based upon the expectation that all insured health services as delineated by the CHA and provincial or territorial legislation will be provided under the health care insurance plan of that jurisdiction.

Under the *universality* principle, all insured and registered residents of a province or territory must be treated equitably in terms of entitlement to the insured health services provided by the provincial or territorial health care insurance plan. Further, this principle provides parameters for a waiting period for non-residents to obtain entitlement to health coverage.

Portability under the CHA recognizes the mobility of Canadians from one province or territory to another by providing for inter-provincial coverage. This aspect allows for emergency access throughout the country and beyond, plus offers in-transit coverage for those relocating within Canada.

The *accessibility* principle aims to establish reasonable access to appropriate and necessary hospital, medical, and surgical services without barriers or charges (i.e., user fees). This principle of accessibility also puts forward that residents of a province or territory are entitled to "reasonable access in terms of physical availability of medically necessary services" which is usually interpreted as the "where and as available rule" (Health Canada, 2002b). This interpretation provides a significant amount of latitude in terms of provision models within the individual provincial and territorial jurisdictions.

It is recognized that, although the CHA discusses coverage of medically necessary hospital and physician services, the individual jurisdictions may provide programs and services beyond these. For example, at the provincial or territorial government's discretion, ambulance, chiropractic, dentistry, optometry, and prescription drug services may be covered. The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children, seniors) and coverage may range from partial, pro-rated, to full coverage.

Current federal role

There are four key areas of responsibility for the federal government at the present time. Firstly, in terms of delivery, the federal government has retained responsibility for health care services to target groups including on reserve First Nations people, Veterans, Correctional Services, Armed Forces, and RCMP. Secondly, protecting the health of Canadians is a primary responsibility in which the federal Minister of Health serves as a health advisor to Canadians on issues of health status concern; establishes standards and guidelines; and provides accurate and essential health information for protection and decision making. Thirdly, the federal government supports the health care system through legislative, fiscal (i.e., transfer payments), and strategic (i.e., policy, research) instruments. Finally, the promotion of health and prevention of illness within the population aligns with the federal responsibilities for health.

In response to a continually high deficit and rising debt level, the federal government unilaterally announced significant cuts to its transfers to the provinces since the late 1980s. The result of these successive reductions in federal transfers yielded a cumulative loss in revenues to the provinces of about $30 billion for health services from 1986-87 to 1995-96 (HSURC, 1999). An obvious consequence of the changes in federal transfer payments for health is added pressure on the provinces to contain health care costs. The reduction in funding for health care services in recent years has rendered the federal government's authority to enforce the principles somewhat suspect.

Current challenges

"Many experts have diagnosed Medicare in Canada as an ailing system in need of treatment . . . under pressures of an expanding and aging population, and of growing demands for new technologies and prescription drugs (Cooper, 2001, p. i). In Canada, it is now abundantly clear that "to preserve our much cherished Medicare, it is absolutely essential for governments to undertake bold health care reform to contain and, if possible, to reduce health care expenditures" (Manga, 1994, p. 58).

Although there has been a paradigmatic shift, in rhetoric, from medical or illness care to health care, from curative to preventive, from traditional to evidence-based practice in Canada, there is little clear evidence that this has occurred in practice. Challenges facing health care in Canada at the present time include sustainability of universal public health care, health care funding/delivery models, accessibility, and accountability. These challenges, according to Kouri (2000), have been motivational in the cross-country transitions to regional models with the objectives of:

- integration of services (regional based) along a wider continuum of care; greater focus on upstream strategies such as health promotion and prevention;
- meaningful public participation; and
- more appropriate governance.

According to Rasmussen (1996), of the various reform ideas to emerge across Canada, the two most frequently evidenced involve regionalization of management and delivery of health services and community participation and control of the regionalized entity. Together they "embody a spirit of co-ordination and rationalization that will allow for the achievement of local needs, the inclusion of regional or local levels of participation, and the reduction of expenditures" (Rasmussen, p. 3). Every province has made major changes to restructure the health care system through regionalization (see Table 9).

Costs of the health care system have continued to grow exponentially. For example, in 1999, the total health system expenditures exceeded $86 billion which was a 5.1% increase from the previous year (CCHSE, 2000) and, by 2000, this had increased an additional 7% to $95 billion (Cooper, 2001).

Over the past few years, numerous reports and commissions have highlighted the issue of financing perspectives within the Canadian health care system. Both the Mazankowski Report in Alberta (Premier's Advisory Council on Health, 2002), and the Kirby Senate Committee (Standing Senate Committee on Social Affairs, Science and Technology, 2000) described the issue of expanding the role of private financing and for-profit delivery. These and other proponents maintain that the system needs more money; that it is impossible to control costs and meet the demands of the public and

Table 9

Provincial Health Region Profile

Province	**Health regions**
Newfoundland and Labrador	6 Community Health Regions
Prince Edward Island	4 Health Regions
Nova Scotia	6 Health Regions (Zones)
New Brunswick	7 Health (Hospital) Regions
Quebec	18 Régions sociosanitaires (RSS)
Ontario	37 Public Health Units (PHU) 16 District Health Councils (DHC)
Manitoba	12 Regional Health Authorities
Saskatchewan	33 Health Districts/Authorities
Alberta	9 Regional Health Authorities
British Columbia	20 Health Service Delivery Areas
Yukon Territory	1 Entire territory
Northwest Territories	1 Entire territory
Nunavut	1 Entire territory

Adapted from Canadian Institutes for Health Information (CIHI) (2003).

providers; that raising taxes to cover the costs is unacceptable; and therefore, non-governmental revenue sources are essential (Lewis & Fooks, 2002). In contrast, the Fyke Commission in Saskatchewan (Commission on Medicare, 2001) and the National Forum on Health (1997) concluded that there is enough money in the system, but better management, an emphasis on evidence-based decision making and quality improvement, and enhanced information systems are the keys to long-term sustainability.

Nearly 1/3 of these expenditures were private sector funded, which is a significant growth from the 1975 level of 25% (CCHSE, 2000). Federal funding covers 15% of health care funding compared to 50/50 funding at inception of CHA (CCHSE). Table 10 provides a historical and comparative recount of the total expenditure of health care as a percentage of gross domestic product (GDP) for Canada and three other developed nations.

Table 10

Total Expenditure on Health Care as Percentage of GDP

Country/Year	**1970**	**1980**	**1990**	**2000**	**2001**
Canada	7%	7.1%	9%	9.1%	9.7%
United States	6.9%	8.7%	11.9%	13%	13.9%
United Kingdom	4.5%	5.6%	6%	7.3%	7.6%
Sweden	6.9%	9.1%	8.5%	8.0%	8.7%

Adapted from OECD (2003).

Despite the increased funding, regionalization, and numerous reports/commissions, the Canadian public has continued to voice concerns about the 'health care crises' with 37% indicating they feel Canada has a poor health care system (Buske, 1999). Further, nearly two-thirds (64%) of Canadians stated that the quality of health care services had declined in the last five years (CCHSE, 2000). According to a Pollara survey (2000a), health care (22%) topped the listing of the top ten issues facing Canada, as perceived by the public – followed by unemployment (9%) and economy (8%). A further Pollara survey (2000b) indicated that the top ten health care issues facing Canada today (see Table 11).

Summary

Canada has a legacy of a health care system recognized and emulated internationally. It has a rich history rooted in social justice, innovation, and responsiveness. The Canadian health care system is, in fact, not a singular system, but rather a loose amalgam of independent provincial and territorial insurance plans. It is replete with differences in client coverage, fee structures, and uninsured practice lists, which reflect regional nuances and challenges. The following two chapters consider the health care programs of Saskatchewan and Manitoba with emphasis on their recent experiences of health reform/renewal.

Table 11

Top Ten Health Care Issues in Canada in 2000

Health Care Issue	**Percentage**
Lack of funding/cutbacks	9%
Lengthy waiting periods	6%
Aging population	5%
Cancer/AIDS	5%
Doctor/Specialist Shortage	5%
Lack of staff/work overload	4%
Shortage of nurses	4%
Hospital Care	3%
Quality of Care	3%
Hospital closure/restructuring	3%
Bed shortages/more long term care	3%
Accessibility	3%

Adapted from Pollara (2000a).

CHAPTER VI

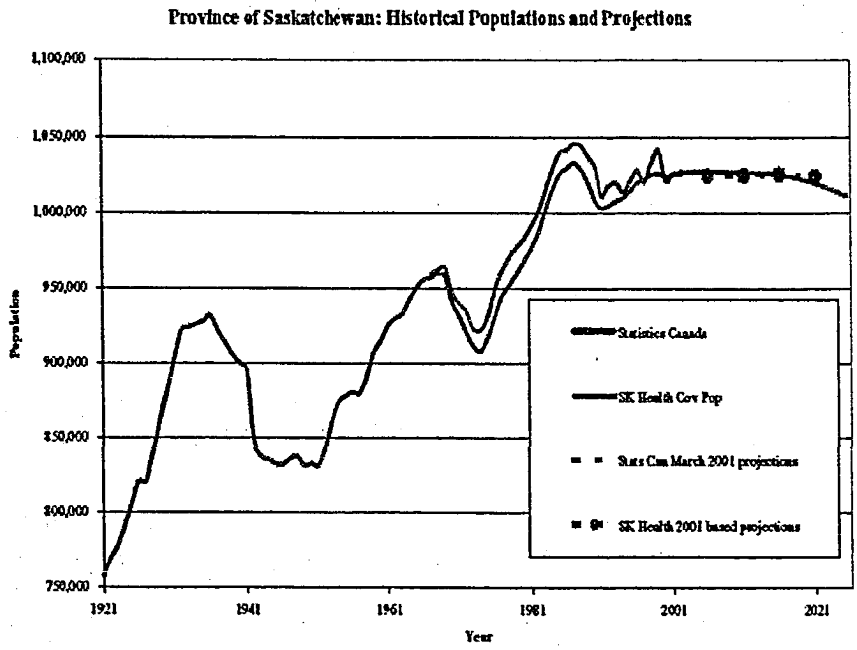
SASKATCHEWAN PROVINCIAL, REGIONAL, AND SELECT COMMUNITY NARRATIVE

Saskatchewan is a province with a unique health care history. In 1944, Saskatchewan led the way, being the first of the provinces to introduce universal hospital insurance. In 1962, despite physician strikes, Saskatchewan introduced universal medical coverage. This chapter considers the health status of Saskatchewan people, health reform/renewal efforts, and emerging directions. In addition, two Saskatchewan health districts and two communities of interest will be profiled in this chapter.

Overview

According to Statistics Canada (2000a), Saskatchewan's population in 1998 was slightly over 1 million with a fairly equitable male/female representation (504,632:509,540). Saskatchewan's recent and projected population trend is for a minimal increase (less than 1%) to a slight decline in the near term (see Figure 3). Saskatchewan's population is widely distributed over some 650,000 km^2. Compared to the Canadian population density of 3.07 persons/km^2, Saskatchewan is significantly more dispersed at 1.59 (Statistics Canada). The percent urban population in Saskatchewan is 63.3% which is significantly less than the federal level of 77.9% (Statistics Canada, 2003). Although Saskatchewan's population has remained stable over the past 50 years, the geographic distribution of the population has changed significantly. In 1951, the proportion of Saskatchewan people living in urban settings was 30%; in 1991, 63% of the population resided in urban settings. Conversely, in 1951, almost 50% of Saskatchewan residents lived on farms; in 1991, only 16% lived on farms; by 1996, less than 14% (Saskatchewan Interactive, 2002). This urban-rural shift is further exhibited in the decrease in the number of farms accompanied by an increase in farm size. Between 1986 and 1996 the number of farms dropped from 63,431 to 56,995 with an average acreage increase of 100 acres per farm (Saskatchewan Bureau of Statistics, 1999).

Figure 3. Saskatchewan population: Historical and projected.



1: Statistics Canada[i,ii,iii] and Saskatchewan Health[iv] historical and projected populations for the province of Saskatchewan

Adopted from HSURC (2000)

According to Kouri (2000), intra-provincial migration is at least as important as out of province migration in terms of the effects on communities. The migration of people from rural and small urban areas to larger urban areas continues to be a major trend in this province. Indeed, it seems to be a trend that is increasing in scope over time and will likely continue to do so in the near and more distant future. The population in rural Saskatchewan is getting smaller and sparser. The Saskatchewan trend is different from the Canadian trend. At the national level, Canada's rural and small town population grew (Mendelson & Bollman, 1998). More importantly, as stated by Kouri, a larger share of younger people is leaving rural areas, which is significant in terms of incomes and community sustainability. In Saskatchewan, proportionately more elderly live in smaller centres and rural areas with the younger adults from these communities moving to the larger centres or out of the province (Elliott, 2000).

Saskatchewan people – health conditions

In both Saskatchewan and Canada, circulatory diseases account for the greatest number of hospital days. Nationally, they also account for the most health expenditures overall (11.6% of total) (HSURC, 2001).

Arthritis, pain, and high blood pressure are the three most common chronic conditions in Saskatchewan. In 2000-01, Saskatchewan's prevalence of arthritis (18.5%) was higher than the Canadian figure of 15.2 %. Our prevalence of pain (13.1%) was slightly above the Canadian average (12.0%), while our prevalence of high blood pressure (12.6%) was the same as that for Canada (Health Quality Council (HQC), 2003).

Saskatchewan people – health outcomes

In terms of life expectancy, Saskatchewan residents average 78.5 years, approximately half a year below the Canadian average and 1.5 years shorter than the best performing province (Statistics Canada, 2002b).. This deviation may be affected by the large Aboriginal population(11.4% in Saskatchewan; 2.8% nationally) which tends to have a life expectancy five to six years less than the Canadian average (HQC, 2003). In general, Saskatchewan's population is aging with 14.6% of the residents being over 65 compared to only 12.7% nationally (HSURC, 2001).

In terms of education levels the average number of years of schooling for individuals 25 to 54 is 12.8 in Saskatchewan and 13.2 nationally (Statistics Canada, 1996). Only 63.2 % of Saskatchewan residents aged 25 to 29 were high school graduates in 1996, compared to 71.8 % in Canada overall (Statistics Canada, 1996).

In 1999, Saskatchewan's infant mortality rate was 5.6 per 1,000 live births, compared to 4.4 for Canada (HSURC, 2001). Further, low birth weight babies in Saskatchewan grew significantly in 1999 to 6.1 nearly mirroring the Canadian level of 6.0 (Statistics Canada, 2002a).

Another indicator of health outcomes, according to Statistics Canada (2002c), is the review of premature deaths from any cause which is referred to as potential years of life lost (PYLL). The overall provincial PYLL rate is 6322.7 per 100,000 in comparison to the Canadian level of 5695.9 (Statistics Canada, 2002c). The leading causes of PYLL for both Saskatchewan and Canada overall are injuries, suicide, and lung cancer in

1999. Saskatchewan's rate of PYLL for injuries was the highest of any Canadian province at 1 054 PYLL per 100,000 population compared to 707 in Canada (HSURC, 2001). This source notes that, for all three leading causes of death, males accounted for a greater proportion of PYLL than females.

Finally, in terms of self-rated health, Statistics Canada (2002d) stated that in 2000-01, 56.7% of Saskatchewan people rated their health as excellent or very good, compared to 61.4 % of Canadians (see Table 12). Gender differences in self-rated health status were small, with a slightly larger percentage of men than women reporting excellent or very good health. Age related variance in self-rated health status was significant with over 70% of youth indicating excellent or very good health as opposed to seniors reporting 36.5% at this level.

Table 12

Self-rated Health Status, Aged 12 or Over, in Saskatchewan

Saskatchewan, highest and lowest provincial rates, and Canada by gender and age, 1994-95 and 2000-01

	1994-95			2000-01		
	Excellent/ Very Good	Good	Fair/Poor	Excellent/ Very Good	Good	Fair/Poor
Saskatchewan	56.6%	32.7%	10.7%	56.7%	30.3%	12.8%
Highest[a]	67.4%	19.6%	13.0%	66.2%	21.3%	12.5%
Lowest[b]	56.6%	32.7%	10.7%	55.5%	28.4%	16.0%
Canada	63.1%	23.8%	9.0%	61.4%	26.6%	12.0%
Males	65.5%	23.1%	7.8%	62.9%	25.8%	11.2%
Females	60.8%	24.5%	10.1%	59.9%	27.4%	12.7%
Aged 12-19	72.6%	23.4%	4.0%[I]	70.8%	24.3%	4.9%
Aged 20-64	65.6%	25.8%	8.5%	64.6%	25.6%	9.8%
Aged 65+	39.7%	33.7%	26.6%	36.4%	33.8%	29.7%

[a] 1994-95: Prince Edward Island; 2000-01: Newfoundland and Labrador (province with highest percentage reporting excellent/very good health).

[b] 1994-95: Saskatchewan; 2000-01: New Brunswick (province with lowest percentage reporting excellent/very good health).

[I] Interpret with caution, due to extreme sampling variability.

Saskatchewan health care –overview

Saskatchewan has long been known as the "birthplace of Medicare" where, in 1947, the CCF introduced a public program of universal hospitalization insurance for the residents of Saskatchewan. In more recent history, a number of strategies have been undertaken to improve the health system in order to fulfill Douglas' vision of a 'second phase of Medicare (Willson & Howard, 2000). In 1992, the Saskatchewan NDP government embarked on a process of health reform outlined in *Saskatchewan Vision for Health: A Framework for Change* (Saskatchewan Health, 1992). The issues within the health system, according to the government, were an overemphasis on treatment of disease with inadequate resources devoted to health promotion, an overemphasis on institutional care, a lack of doctors in rural areas, fragmented service delivery governed by too many separate boards, and escalating health costs in a time of fiscal crisis.

Expenditures

In 2001-2002, 38.4 % of the provincial budget was spent on health (Saskatchewan Health, 2002). According to the Canadian Institute of Health Information [CIHI] (2002a), the 1999 Saskatchewan per capita health expenditures ($2,907) was slightly below the Canadian level of $2,936; Manitoba had the highest per capita health expenditures, at $3,205, while Quebec had the lowest at $2,710 (see Table 13). Further, the CIHI (2002b) indicated that Saskatchewan was below the national average in per capita expenditures on hospitals, drugs, physicians, and other professionals, but above average on long-term care costs and other health expenditures (i.e., public health and administration, capital, home care, and health research).

Table 13

Per Capita Health Expenditures by Category in Current Dollars (Saskatchewan, highest and lowest provincial figures, and Canada, 1999)

Health Expenditure	**Saskatchewan**	**Manitoba**[a]	**Lowest**[b]	**Canada**
Total	2907	3205	2710	2936
Hospital	773	978	1009	936
Pharmaceuticals	379	373	448	437
Physicians	353	385	320	400
Other Professionals	266	314	304	356
Other	725	734	387	528

a Manitoba has the highest overall expenditure
b Quebec has the lowest overall expenditure
c Expenditures on prescribed drugs and non-prescribed products purchased in retail stores
CIHI (2002a).

Using constant 1997 dollars, total health expenditures for both Saskatchewan and Canada increased by 10 % between 1991 and 1999 (HQC, 2003). According to the HSURC (2000), the largest cost centres in Saskatchewan's health care services are physician services, pharmaceuticals, and long term care. It is noted that Saskatchewan's supply of general/family practitioners is just under the Canadian rate (91 per 100,000 population compared to 94), but, at 62, is significantly below the Canadian specialist level at 93 per 100,000 (HQC, 2003). In 1997-98 seven prescriptions per beneficiary were filled compared to six prescriptions in 1991-92 (HSURC, 2000) and the exponential growth of drug expenditures are reflected in Table 14. The number of long term care beds in Saskatchewan decreased from 10,405 beds to 8,878, or from 158 beds per 1,000 aged 75 or older to 118 beds per 1,000 (Government of Saskatchewan, 1993; 2002). Despite this decrease, Saskatchewan still had the second highest number of LTC beds per 1,000 population aged 75 and over in 2000-01; the Canadian average was 101 beds per 1,000 aged 75 and over (HQC, 2003).

Table 14

Total Drug Cost Expenditures for Canada and Saskatchewan, 1995-96 and 1998-99

	Drug Costs (millions $) 1995-96	**Drug Costs (millions $) 1998-99**
Saskatchewan	104.2	127.2
Canada	6 600.0	8 900.0

Adapted from CIHI (2002c).

Utilization

The total number of acute care beds in the province decreased between 1991-9211 and 2000-01 from 5,800 to 2,802 beds, or from almost six beds per 1,000 population to less than three beds per 1,000 (HQC, 2003). Between 1992-93 and 1998-99, the number of acute care days in Saskatchewan fell by over 30%, from 1.41 million to 0.92 million (HSURC, 2000). Despite this decline, Saskatchewan residents accounted for more hospital days per capita than Canadians overall. In 1998-99, females accounted for 54 % of hospital days in Saskatchewan and 55 % of hospital days in Canada overall (CIHI, 2002d). In 1998-9, the three diagnostic categories that accounted for the greatest number of hospital days in Saskatchewan were circulatory diseases, respiratory diseases, and mental health diseases. Circulatory diseases accounted for the greatest number of hospital days both in Saskatchewan (1992-93 and 1998-99) and in Canada as a whole (1998-99). Further, Saskatchewan reports the lowest use of emergency services at 151 per 1000, compared to the national average of 433 per 1000 (CIHI, 1996).

Women's roles

During the 1990s one of the cornerstones of health care reform was the shift from institutional to home and community based care.

Hospital expenditures account for a major portion of provincial health care budgets, so the reduction in hospital services has been an important strategy to control health spending. Several provinces have closed hospitals, reduced the number of hospital beds, and shortened the length of hospital stays as described previously. As hospital spending declined, nurses and other hospital workers raised concerns over job losses, understaffing, higher workloads and increased levels of stress. The public expressed concern about access to services, patient safety, and quality of care.

Generally, health care reform has promoted home and community-based care as less costly and more client-focused alternatives to institutionalization. The shift towards more ambulatory care has had the effect of transferring delivery of certain services to the private sector – that is, to family members, mainly women, who are called on to provide increasingly difficult and complex care as caregivers, without protection or adequate support; or to community organizations, who often have the impression that they serve as overflow channels to meet needs that the public network cannot absorb (Bernier & Dallaire, 2000). Home care programs are based on the assumption that caregiving is a family responsibility and that women are available to take on caregiving roles. Shifting care from institutions to private households transfers care work from paid health care workers to unpaid family caregivers and reinforces traditional gender roles. Women continue to perform most of the unpaid caregiving work within the home, often at a cost to their own health or economic security.

Blakley and Jaffe (1999) state that health system policies in Saskatchewan appear to be "based on myths and assumptions about rural women, families, and communities" (p. 41). In terms of the impact of health care reforms on rural women informal caregivers, they found that nearly 50% felt that their personal health had deteriorated since taking on the role; most feel that they received some support from their community and/or family in their role; and health care restructuring had affected their communities.

Saskatchewan reform/renewal

Health reform and regionalization in Saskatchewan is not a new idea — the Sigerist Report (as cited in Lewis, Kouri, Estabrooks, Dickinson, Dutchak, Williams, Mustard, & Hurley, 2001) recommended full-scale regionalization in 1944, but its implementation was limited to public health services and had limited impact on the development of the province's health care system. In 1946, the CCF government created the first regional health council in Canada in the Swift Current Health Region (Rasmussen, 1996). By 1961, the province was organized into 13 health regions, which were later reduced to 10 (Rasmussen). These regional entities primarily undertook an advisory role with the local boards (i.e., hospital, ambulance, special care home) retaining health service delivery responsibility and the province issuing staffing, budgeting, and programmatic direction.

The Murray Commission report (Saskatchewan Commission on Directions in Health Care, 1990) was the formative document in the next wave towards the full regionalization model in Saskatchewan, although the proposed 15 regions or divisions to manage the system was significantly exceed in the health care restructuring which ensued. In this report, it was stated that

> only a regional health care system can empower local people and create a strong and unified system with equal emphasis on all services and make it easier for people to find out what services are available and get quick access to those they need. (p. 117)

In Saskatchewan, the health reform agenda was officially launched in 1992, with two inter-related components: (1) devolution of authority to partially-elected district health boards; and (2) a wellness approach to health rooted in population health concepts. Ultimately health reform/renewal policy in Saskatchewan has yielded regionalization, devolved authority from the provincial government to district health boards, and altered emphasis on upstream health care delivery.

Saskatchewan's Health Minister, the Honorable Madam Louise Simard, introduced the reforms on August 17, 1992 by stating that

> this (is the) first major updating of our health system since Medicare was pioneered. There are two main principles underlying this new approach to

> health: the concept of wellness as the goal of health services, and the community control of health care delivery...invite communities and health boards to begin thinking of how they can integrate and deliver services under their own control...apply the Saskatchewan spirit to revitalization of our health system. (Government of Saskatchewan, 1992)

Thirty-two health districts (see Figure 4) were established through a community development process in which local residents developed the health district boundaries. The number and size of health districts were based on location of communities, population distribution, geographic barriers, trading and commuting patterns, and location of current health facilities.

Health system restructuring resulted in assignment of scopes and exclusions of services for health districts. In addition, Saskatchewan Health (1993) experienced significant changes, retaining many of its traditional programs (as reflected in Table 15) and assuming responsibilities "to provide resources for health promotion and education, setting and monitoring standards, developing and implementing a funding formula, developing policy, creating a province-wide health information system, and monitoring disease patterns" (p.16).

District health boards are funded by the provincial government. They do not have the power of taxation. Global budgets were established for each district health board based on a *needs-based* formula implemented over five years, beginning in 1994-95. The needs- based funding approach followed by Saskatchewan Health directed funds to those populations with the greatest need. Population was adjusted for age and gender, health needs of the district, and broad variations in service delivery costs (Saskatchewan Health, 1993).

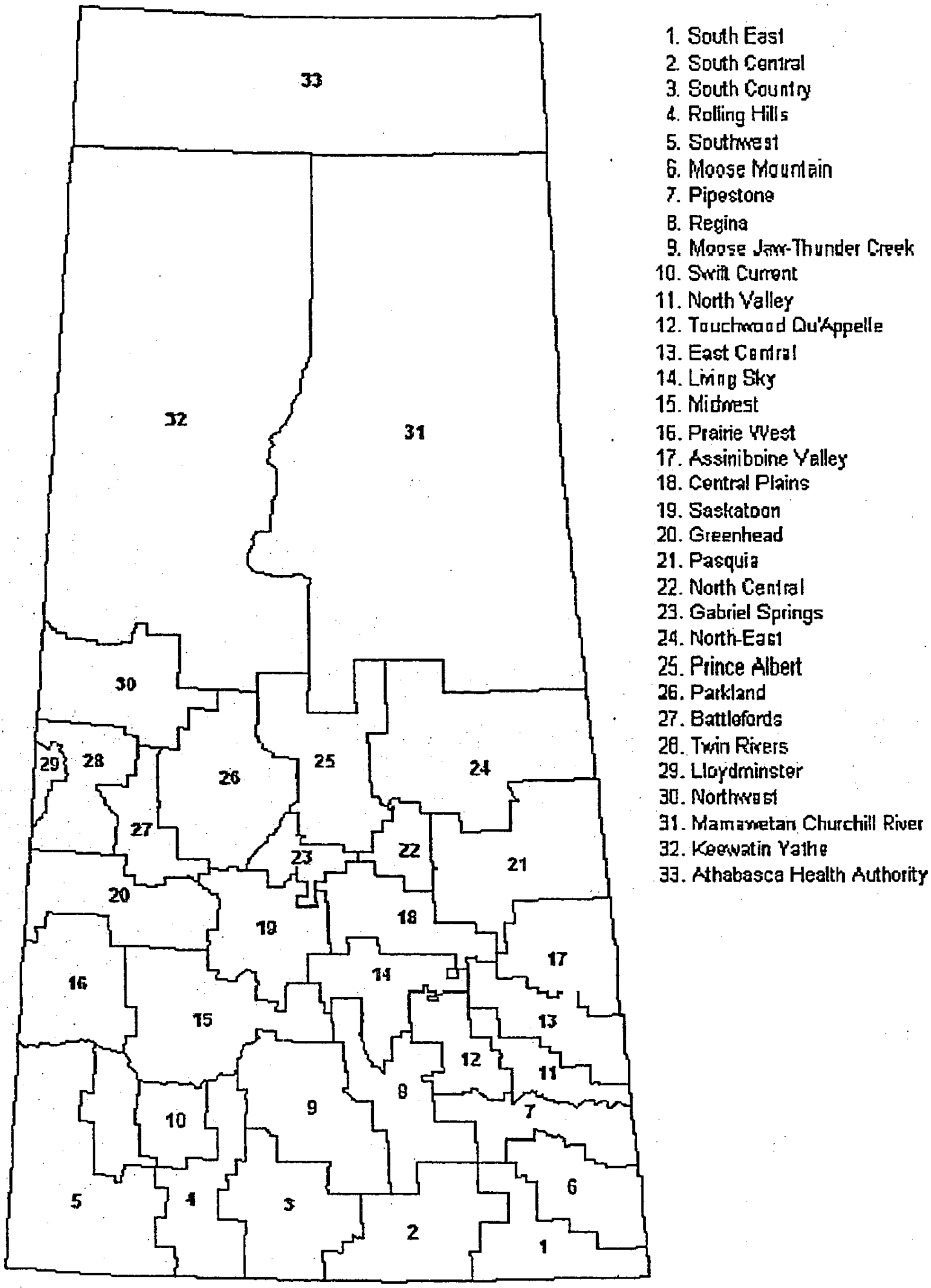
According to Saskatchewan Health (1993), the roles and responsibilities of the districts include determining health needs, promoting, and supporting the health of the people of the district, providing a range of health service in the district; shifting the balance of services from institutions to the community, ensuring the appropriate allocation of funds required to support health, and representing all segments of the community (see Table 15). These obligations are to be carried out in accordance with the concept of *wellness*, the goal of which is "to improve the health, in its broadest context, of both individuals and society within a financially sustainable framework" (Saskatchewan Health, 1996, p.1). With health reform, there is a new mandate: community involvement; population health; and an integrated client-centred system.

Recent challenges

The province's latest round of health reform, announced in December 2001, includes the amalgamation of 32 health districts into 12 regional health authorities, creation of primary health care teams across the province, formation of Canada's first Health Quality Council, and a major increase in health research funding. Saskatchewan Health released its new health action plan in December 2001, which included the following key actions:

- replacement of 32 health districts with 12 regional health authorities. *The Regional Health Services Act* was proclaimed on August 1, 2002, which establishes the regional health authorities and outlines their roles, responsibilities, and accountability requirements;
- province-wide network of community, northern, district, regional, and provincial hospitals;
- formation of primary health care teams across Saskatchewan;
- introduction of a 24-hour toll-free health advice telephone line;
- more training seats for health providers;
- formation of a health quality council, which was proclaimed in November 2002; and
- increased health research funding. (HQC, 2003)

Figure 4. Saskatchewan health districts, 1993-2002.



Source: Statistics Canada (2000b).

Table 15

Delineation of District and Provincial Responsibilities in Saskatchewan

District Responsibilities	**Provincial Responsibilities**
Acute services (hospitals) Supportive (long term care) services Health centres, wellness centres, and social centres Home based services Health improvement initiatives Community care initiatives (respite, quality of care coordinators) Emergency response services (ambulance) Community/local health services (public health, speech pathology) Mental health services Rehabilitation services Alcohol and drug services	Provincial drug plan Medial care insurance plan (physician services) Vital statistics Air ambulance Saskatchewan Cancer Agency Provincial public health and environmental laboratory

South East Health District

The South East Health District (SEHD) is the seventh largest health district in the province with a land mass of 10,533 square kilometers (1.85% of provincial land area) with the eastern and southern boundaries being the borders of Manitoba and U.S. respectively (SEHD, 2001). Refer to Figure5, Health District # 1 for a geographical location of the SEHD.

Profile

The SEHD has about 25,000 residents or 2.44% of the provincial population served by one hospital (53 bed), five community health centres, and nine nursing homes (SEHD, 2002). This district has a population density of 1.76 as compared to the provincial density of 1.59 (Statistics Canada, 1996). The urban percentage of the Weyburn Service Area is 43.3% which is significantly lower than the provincial average of 63.3% (Statistics Canada, 2002b). Projections are for a decline in population with an approximate 7% reduction in the SEHD by 2015 (HSURC, 2001).

According the health district's annual report, over three-quarters of the district residents live within 30 minutes of a hospital (SEHD, 2002).

Health conditions and outcomes

Due to the small size of the health districts in Saskatchewan many statistics are provided in terms of services areas; SEHD is merged into a larger service area referred to as the Weyburn Service Area. This distinction will be noted throughout the ensuing discussion as appropriate.

In terms of life expectancy, SEHD residents average 79.1 years, approximately half a year above the Saskatchewan average (Statistics Canada, 2002b). The population of the SEHD is comprised of nearly 16% of persons over the age of 65 which is well above the provincial average of 14.2% and the national level of 12.7% (HSURC, 2000).

In terms of education levels the average number of years of schooling for individuals 25 to 54 is 12.4 years in SEHD compared with 12.8 in Saskatchewan and 13.2 nationally (Statistics Canada, 1996). In SEHD, 61.3% of residents were high school graduates compared to the 63.2 % of Saskatchewan residents aged 25 to 29 (Statistics Canada, 1996).

In 1997, the SEHD infant mortality rate was 3.62 per 1000 compared to Saskatchewan's infant mortality rate at 8.9 per 1,000 live births (note this rate dropped significantly in subsequent years provincially) (SEHD, 2001). Further, low birth weight babies in Saskatchewan in 1997 occurred at the rate of 4.9 per 1,000, with SEHD fairing slightly better at 4.2 (SEHD, 2001).

Another indicator of health outcomes, according to Statistics Canada (2002c), is the review of premature deaths from any cause which is referred to as potential years of life lost (PYLL). The overall provincial PYLL rate of 6322.7 per 100,000 exceeds the Weyburn Service Area level of 6185.0 per 100,000 (Statistics Canada, 2002c). The leading causes of PYLL for the Weyburn Service area are unintentional injuries, lung cancer, and circulatory diseases (Statistics Canada, 2002b). In SEHD, as in provincially and nationally, circulatory diseases account for the greatest number of hospital days (HSURC, 2001).

Finally, in terms of self-rated health, Statistics Canada (2002d) stated that in 2000-01, 56.5% of Weyburn Service area residents rated their health as excellent or very good, compared to 61.4 % of Canadians. Gender difference in self-rated health status was significant with only 51.7% of women as compared to 61.2% of men reporting excellent or very good health.

Long term care beds utilization rate in SEHD (2001) in 1999 was 136.3 beds per 1,000 population compared to the provincial average of 118. It is further noted that hospital utilization in the health district is nearly 35% higher than the national average.

Reform/renewal

The SEHD Board, a 12 member board, oversees the delivery of a wide range of health care services. In most cases, these services had previously been operated by separate organizations with individual boards of directors. With the formation of health districts theses individual boards either amalgamated or affiliated with the Health District. Non-denominational hospitals and ambulance services were not given the option of affiliation. Denominational hospitals, long-term care facilities and home care services were given the option of affiliation. The Board is responsible for providing the overall direction for the Health District for establishing policy, for setting outcome targets and for evaluating the effectiveness of services.

Renewal of the Saskatchewan health care system in 1992 resulted in the conversion of 3 facilities in the SEHD – two alternate communities and Community A. All three facilities at that time were experiencing acute patient average daily census (ADC) of less than 8 which was an element of the criteria used for conversion/closure decisions in Saskatchewan (HSURC, 1994a). Of the three conversions, Community A maintained 24 hour physician and nursing presence, sub-acute inpatient services (i.e., short stay, observation/assessment, rehabilitation, and respite beds), and basic emergency services. This was a reduction from the previous status as a health centre with 12 acute care beds. The 2 alternate communities retained 24 hour registered nursing services and retain services as a clinic. The communities and their respective health care services are listed in Table 16.

According to the SEHD (2001), the health district's raison d'être was "to promote and enhance the individual's health and well-being by making available comprehensive, high quality, health care services and programs, within the (available) resources, which are responsive, accessible, coordinated and sustainable" (p. 4). The board priorized its efforts towards improving the health status of the people of the district. The SEHD delivered a wide range of health care services as delineated by Saskatchewan Health (refer to Table 15). The SEHD provided these services cooperatively with affiliated agencies, various professional bodies, other health districts, and the Department of Health.

Recent challenges

The province's latest round of health reform, announced in December 2001, resulted in the dissolution of the SEHD as an organization and its amalgamation with a new entity known as the Sunrise Regional Health Authority (Sunrise RHA). The Sunrise RHA consolidated facilities, personnel, services, and governance of three health districts – SEHD, Moose Mountain Health District, and South Central Health District.

Table 16

SEHD Health Care Services by Community

Community	**Health Care Services**
Carnduff	Clinic Long term care facility
Estevan	3 Medical Clinics/Centres Hospital Long term care facility
Alternate Community	Health Centre Medical Clinic
Alternate Community	Health Centre (24 hour nursing only)
Alternate Community	Health Centre (24 hour nursing only) Medical Clinic
Midale	Long term Care Facility Medical Clinic
Community A	Health Centre (24 hour sub-acute * no acute admission capacity) Medical Clinic
Stoughton	Medical Clinic Long term Care Facility

Community A

Early Vignette

> I remember (the health reform announcements) - people were calling in from all over the place and they were mad – damn mad about what was going on. They were afraid about the closures and how they were going to keeping getting cared for. You know it's pretty lonely out here

> in the country and sometimes the hospital is the only place you can go for help. When you are 50 miles from anywhere what do you do?

Profile

In 2001, the population of Community A was 1,132 people nearly equally distributed by gender (Statistics Canada, 2003). This reflected a decrease of nearly 3% from 1996 and clearly mirrors the general trend for rural communities throughout Saskatchewan. In terms of age distribution, the majority of persons in this community are in the 30-64 age group (Table 17).

Table 17

Age Distribution of Community A

Age Group	**Percentage**
0-14	22.2
15-29	21.3
30-64	40.5
65 plus	15.8

Adapted from Statistics Canada (2003).

The community is located approximately 70 kilometers from Estevan which is the nearest secondary service centre. The major economic engines in the community are primary industries and utilities and trade related industry (Human Resources Development Canada, 2002). In terms of educational levels, nearly 72% of the residents have a Grade 12 education or greater.

Environmental scan

The community is well-serviced and paved road accessible. The main street houses a wide array of financial, commercial (i.e., telecommunication; courier; hotel), and professional enterprises (i.e., law firm; accounting/insurance company). Maintenance of the external building facades is generally poor – with evidence of weathering and disrepair in a high percentage of the sites.

In terms of health and education services, the community had a hospital with 18 beds, nursing home, 2 physicians, a pharmacy service, plus a one unit ambulance service. Notably absent from the service mix are dental, chiropractic, and optometric services. There are three schools located in the community offering the range of programs from elementary to high school with a school for children with special needs also available.

Community safety is addressed through a policing mechanism offered through a Royal Canadian Mounted Police office and a volunteer fire department. There is an extensive telecommunications network and cellular telephone coverage is available.

Housing within the community is a mixture of low cost and primarily single family dwellings. There are a significant number of houses for sale with very few empty lots noted. The houses and landscaping are generally simple and minimally manicured. The properties are all aged – likely of the 1960s era.

The community has 5 churches, a small historical museum, and a public library. There is a significant number of posters and placards indicating the presence of a local theater production, numerous service clubs (i.e., Rotary, Kinsmen), and local auction services. Recreation facilities are primarily outdoor sites such as a baseball field, outdoor swimming pool, and tennis courts.

Summary

Community A is a rural community within South East Health District (a primarily rural health district) which experienced significant health services changes through the implementation of the health reform/renewal policy in Saskatchewan. Table 18 highlights key community and district attributes.

Table 18

Community A Overview.

- South East Saskatchewan community of 1100 people -70 kilometers from nearest major centre
- Conversion of hospital to a 24 hour health centre – loss of acute care services – major change in facility
- Maintained 24 hour physician and nursing presence, sub-acute inpatient services (i.e., short stay, observation/ assessment, rehabilitation, and respite beds), and basic emergency services. Essentially retained the health centre component of the facility and lost 12 acute care beds
- The district population is more rural and older than the provincial trend
- In terms of premature deaths, infant mortality, and low birth weight rates the district faired better than the provincial norms
- Long term care and acute care utilization rates surpassed the provincial norms

East Central Health District

Profile

The East Central Health District (ECHD) is the ninth largest health district in the province with a land mass of 8,911 square kilometers (1.35% of provincial land area) with the eastern boundary being on the Manitoba border (ECHD, 2000). Refer to Figure 4, Health Region # 13 for the East Central Health District geographical location.

The ECHD has slightly less than 30,000 residents or 3.18% of the provincial population served by one hospital (108 beds), three community health centres, and six nursing homes (ECHD, 2000). This district has a population density of 2.50 as compared to the provincial density of 1.59 (Statistics Canada, 1996). The urban percentage of the Yorkton Service Area is 50.1% which is significantly lower than the provincial average of 63.3% (Statistics Canada, 2002). Projections are for a decline in population with an approximate 10% reduction in the ECHD by 2015 (HSURC, 2001).

According the health district's annual report, over 90% of the district residents live within 30 minutes of a hospital (ECHD, 2002).

Health conditions and outcomes

Due to the small size of the health districts in Saskatchewan many statistics are provided in terms of services areas; ECHD is merged into a larger service area referred to as the Yorkton Service Area. This distinction will be noted throughout the ensuing discussion as appropriate.

In terms of life expectancy, Yorkton Service Area residents average 78.2 years, slightly less than the Saskatchewan average (Statistics Canada, 2002b). The population of the ECHD is comprised of nearly 20% of persons over the age of 65 which is well above the provincial average of 14.2% and the national level of 12.7%; the projections are for this sector to rise to 21% by 2015 (HSURC, 2000).

In terms of education levels the average number of years of schooling for individuals 25 to 54 is 12.2 years in ECHD compared with 12.8 in Saskatchewan and 13.2 nationally (Statistics Canada, 1996). In ECHD, 59.1% of residents were high school graduates compared to the 63.2 % of Saskatchewan residents aged 25 to 29 (Statistics Canada).

In 1999, the Yorkton Service Area infant mortality rate was 7.1 per 1000 compared to Saskatchewan's infant mortality rate at 8.9 per 1,000 live births (note this rate dropped significantly in subsequent years provincially)(Statistics Canada, 2002a).

Another indicator of health outcomes, according to Statistics Canada (2002c), is the review of premature deaths from any cause which is referred to as potential years of life lost (PYLL). The overall provincial PYLL rate of 6460.6 per 100,000 exceeds the Yorkton Service Area level of 5696.6 per 100,000 (Statistics Canada, 2002c). The leading causes of PYLL for the Yorkton Service area are circulatory diseases, unintentional injuries, and cancers (Statistics Canada, 2002b). In ECHD, as in provincially and nationally, circulatory diseases account for the greatest number of hospital days (HSURC, 2001). It is further noted that ECHD has the highest provincial PYLL related to cancer at 1797.9 per 100,000 (Statistics Canada, 2002b).

The issue of chronicity was significant in the ECHD. With respect to arthritis, the provincial reporting rate was 18.5% as compared to 25.4 % in the health district (HQC, 2003). This significant higher reported chronicity is exemplified with respect to pain at 18.8% in the district (13.1% provincially) and hypertension rates at 19.1% compared to 12.6% provincially (HQC, 2003).

Finally, in terms of self-rated health, Statistics Canada (2002d) stated that in 2000-01, 48.8% of Yorkton Service Area residents rated their health as excellent or very good, compared to 61.4 % of Canadians. Gender difference in self-rated health status was significant with only 45.7% of women as compared to 49.9% of men reporting excellent or very good health.

Long term care beds utilization rate in ECHD in 1999 was 161.2 beds per 1,000 population compared to the provincial average of 118 (HSURC, 2001). It is further noted that hospital utilization in the health district is 41% higher than the national average.

Reform/renewal

The ECHD Board, a 12 member board, oversees the delivery of a wide range of health care services. The Board is responsible for providing the overall direction for the Health District for establishing policy, for setting outcome targets and for evaluating the effectiveness of services.

According to the ECHD (2000), the health district's raison d'être was "to improve and promote the well-being of individuals and communities through leadership, collaboration, and the provision of high quality health services". The board priorized its efforts towards improving the health status of the people of the district. The ECHD delivered of a wide range of health care services as delineated by the Saskatchewan Health (refer to Table 15). The ECHD provided these services cooperatively with affiliated agencies, various professional bodies, other health districts, and the Department of Health.

Renewal of the Saskatchewan health care system in 1992 resulted in the conversion of three facilities in the ECHD –Community B and two other communities (see Table 19). In the alternate communities, there was an ADC of less than 8 and thus met the conversion/closure criteria (HSURC, 1994a). None of these communities retained 24 hour service, therefore no sub-acute or admission beds were retained. The Community B health care facility experienced conversion resulting in the shifting to 4 sub-acute care beds plus 11 beds for rehabilitation, respite, long term care, and palliation. Essentially, the facility went from being a 16 bed hospital to a health care centre with no approved acute care capacity. In Community B, HSURC reported that their 1991-92 utilization reflected 20.9% of their admissions being acute, and 24.7% of their patient days meeting acute care criterion. The communities and their respective health care services are listed in Table 19.

Table 19

ECHD Health Care Services by Community.

Community	**Health Care Services**
Community B	Health Centre (24 hour sub-acute & admission services *no acute care) Long term care facility Medical Clinic
Alternate Community	Health Centre (non-24 hour service)
Yorkton	Hospital Long term care facility (3) 7 Medical Clinics
Saltcoats	Long term Care Facility
Alternate Community	Health Centre (non-24 hour service) Long term Care Facility Medical Clinic

Recent challenges

The province's latest round of health reform, announced in December 2001, resulted in the dissolution of the ECHD as an organization and its amalgamation with a new entity known as the Sunrise Regional Health Authority (Sunrise RHA). The Sunrise RHA consolidated facilities, personnel, services, and governance of three health districts – ECHD, Assiniboine Health District, and North Valley Health District.

Community B

Early Vignette

> Health reform is not only about a (hospital) building. No, it is about the people. I think it is about what is happening to the (community) people. Too many People in the area have horror stories about what had or could happen to either their mothers or their aunts and father and grandfathers…it leaves us feeling helpless, betrayed, with no choice.

Profile

In 2001, the population of Community B was approximately 1,200 people nearly equally distributed by gender (Statistics Canada, 2003). This reflected a population decrease of nearly 6.5% from 1996 and clearly mirrors the general trend for rural communities throughout Saskatchewan. As Table 20 demonstrates the majority of persons in this community are in the 30-64 age group.

Table 20

Age Distribution of Community B

Age Group	Percentage
0-14	15.2
15-29	23.8
30-64	30.0
65 plus	31.0

Adapted from Statistics Canada (2003).

The community is located within 60 kilometers of Yorkton which is the nearest secondary service centre. The major economic engines in Community B are primary industries and utilities and trade related industry (Human Resources Development Canada, 2002). In terms of educational levels, nearly two-thirds of the residents of Community B have a Grade 12 education or greater.

Environmental scan

The community is located in a pristine, rustic locale surrounded by farm and ranch properties. The environment is exceptionally clean and generally appears well maintained. The community skyline is replete with the profile of grain elevators (including 3 closed traditional units and an ultramodern United Grain Growers condo complex) and church spires. Main Street appears as the business hub with law, accounting, and financial offices surrounded by grocery stores and dining establishments. Generally, the community appears to be well-serviced with a selection of businesses, professionals, and agencies. The telephone book and the tourist booth personnel provided a wide ranging list of companies and services ranging from agricultural to veterinary.

Housing is primarily single family dwellings, which are generally very well maintained. Many homes are 1950s genre with occasional new construction (post-1980s). Notably approximately 1 in 3 homes within 5 blocks of Main Street are for sale. In addition, there is a small 10 or 12 unit seniors' complex.

In terms of recreation services, the community has a large hockey arena, a curling complex, and an outdoor swimming pool. Local businesses provide a range of activities including a fitness centre, bowling, theatre, video stores, and a golf driving range. Four service stations, restaurants, grocery stores, hardware stores, and visitor accommodations (hotel and motel) are seen as centres of activity.

Culturally, Community B has a museum, library, and an historical property dating to the early 1900s which capture the primarily Slavic heritage of the community. Postings and billboards indicate a wide variety of community service groups such as the Royal Canadian Legion, Masons, Knights of Columbus, and Lions/Lioness Club.

Educational facilities in the community include both an elementary and a secondary school which provide kindergarten through Grade 12 classes. In reviewing the local paper, it was learned that post-secondary programs through a provincial College are offered either through distance or in Yorkton for residents of Community B.

Health and protection agencies include a health centre (1990s genera), nursing home, pharmacy, physician's office, and ambulance base. The senior and disabled residents of Community B can access transportation via a Handi-van bus service. In addition, an enriched senior citizens housing unit provides accommodation for 8 persons. There is an RCMP (satellite) detachment and volunteer fire department within the community which are widely advertised as being accessed by calling 911.

Summary

Community B is a small rural town within East Central Health District which has experienced many new challenges resulting from the emerging health reform/renewal initiative. Table 21 highlights key community and district attributes.

Table 21

Community B overview.

- East central Saskatchewan community of approximately 1200 individuals
- 60 kilometers from the larger centre
- Retained health centre capacity (as before health reform) with reductions – moderate change in service capacity
- 4 sub-acute care beds plus 11 beds for rehabilitation, respite, long term care, and palliation. Essentially, went from being a health centre with attached 16 bed hospital to a health care centre with no approved acute care capacity
- District has one hospital, 3 community health centres, & 6 nursing homes
- Significantly less rural & much older population
- Infant mortality & premature death rates are less than provincial norm
- Long term care & hospital utilization both exceed provincial trend

CHAPTER VII

MANITOBA PROVINCIAL, REGIONAL, AND SELECT COMMUNITY NARRATIVE

Manitoba's health system has developed into an extensive network of programs and services. It is framed within the principles of The Canada Health Act and upholds the mission to promote, preserve, and protect the health of Manitobans. This chapter considers the health status of Manitobans, health reform/renewal efforts, and emerging directions. In addition, one Manitoba regional health authority and one community of interest will be profiled in this chapter.

Overview

According to Statistics Canada (2000a), Manitoba's population in 1998 was slightly less than 1.2 million with a fairly equitable male/female representation (560,099/569,672) respectively. Canada's population is not expected to grow significantly over the 1996-2016 period (about 1.2% annually). Manitoba's population is expected to grow even less at about 0.5% annually (Statistics Canada, 2001).

Manitoba's population is widely distributed over some 640,000 km^2. Compared to the Canadian population density of 3.07 persons/km^2, Manitoba is significantly more dispersed at 1.95 (Statistics Canada, 2000a). Of note, Cox (2000) stated that in 1999 farmland in Manitoba occupied 85 times more space than urban land.

Although Manitoba's population has remained relatively stable over the past 50 years, the geographic distribution of the population has changed significantly. In 1951, Cox (2000) stated that the proportion of Manitoba people living in urban settings was 22%; in 1991, 63% of the population resided in urban settings. Conversely, in 1951, almost 58% of Manitoba residents lived on farms; since 1991, approximately 7% of Manitobans have lived on farms.

Manitoba people – health conditions

In Manitoba and Canada, overall, circulatory diseases account for the greatest number of hospital days. Arthritis, asthma, and high blood pressure are the three most common chronic conditions in Manitoba. In 2000-01, Manitoba's prevalence of arthritis (16.5%) was higher than the Canadian figure of 15.2% (CIHI, 2002b). Prevalence of pain in Manitoba (9.3%) was slightly above the Canadian average (9.1%), while prevalence of high blood pressure (13.4%) slightly higher than that for Canada (CIHI).

Manitoba people – health outcomes

In terms of life expectancy, Manitoba residents average 77.9 years, approximately a year below the Canadian average and 2.3 years shorter than the best performing province (Statistics Canada, 2002b). In general, Manitoba's population is aging with 13.5% of the residents being over 65 compared to only 12.7% nationally (MCHP, 2002a).

In terms of education levels the average number of years of schooling for individuals 25 to 54 is 12.8 in Manitoba and 13.2 nationally (Statistics Canada, 1996). A total of 77.5% of Manitoba residents aged 25 to 29 were high school graduates in 1996, compared to 71.8 % in Canada overall (Statistics Canada).

In 1999, Manitoba's infant mortality rate was 8.4 per 1,000 live births, compared to 5.3 for Canada (Statistics Canada, 2002a). Further, low birth weight baby rates in Manitoba were fairly stable between 1990 through 1999 at approximately 5.1% slightly less than the Canadian level of 6.0 (Statistics Canada).

Another indicator of health outcomes, according to Statistics Canada (2002c) is the review of premature deaths from any cause which is referred to as potential years of life lost (PYLL). The provincial PYLL rate is reported as 6261.9 per 100,000, which is significantly higher than the Canadian level of 5696.6 (Statistics Canada). The leading causes of PYLL for both Manitoba and Canada overall are injuries, suicide, and lung cancer in 1999. Manitoba's rate of PYLL for injuries at 961.2 was significantly higher than the Canadian rate of 707.

Finally, in terms of self-rated health, Statistics Canada (2002d) stated that in 1998/99, 65.8 % of Manitoba people rated their health as excellent or very good, compared to 66 % of Canadians. Gender differences in self-rated health status were small, with a slightly larger percentage of men than women reporting excellent or very good health.

Expenditures

Manitoba has consistently been above the Canadian level for per capita health expenditures in the early years of health reform/renewal. In 2001-2002, 34 % of the provincial budget was spent on health (Regional Health Authorities of Manitoba (RHAM), 2000a). According to CIHI (2002a), Manitoba had the highest per capita health expenditure of $3,205 compared to the Canadian level of $2,936; while Quebec had the lowest at $2,710. Further, CIHI indicated that Manitoba was below the national average in per capita expenditures on drugs, physicians, and other professionals, but above average on hospital costs and other health expenditures (i.e., public health and administration, capital, home care, and health research) (see Table 22).

Using constant 1997 dollars, total health expenditures for Manitoba increased by 14% compared with a Canadian level of 10 % between 1991 and 1999 (CIHI, 2003). After 1998, both federal and provincial governments increased funding and by 2000, Manitoba increased health expenditures by 20% (CIHI, 1996).

Table 22

Per capita Health Expenditures by Category in Current Dollars (Manitoba, highest[a] and lowest provincial figures, and Canada, 1999)

Health Expenditure	**Manitoba[a]**	**Lowest[b]**	**Canada**
Total	3205	2710	2936
Hospital	978	1009	936
LTC	420	242	280
Pharmaceuticals[c]	373	448	437
Physicians	385	320	400
Other Professionals	314	304	356
Other	734	387	528

a Manitoba has the highest overall expenditure

b Quebec has the lowest overall expenditure

c Includes expenditures on prescribed drugs and non-prescribed products purchase in retail stores

CIHI (2002a).

It is noted that Manitoba's supply of general/family practitioners is just under the Canadian rate (100 per 100,000 population compared to 94), but, at 76, is significantly below the Canadian specialist level at 93 per 100,000 (CIHI, 2003). The exponential growth of drug expenditures in Manitoba and Canada are reflected in Table 23. The number of long term care beds in Manitoba in 2001 was 9,791 resulting in a 126 beds per 1,000 persons over 75 which is the highest in the country (nationally 101 per 1000)

(MCHP, 2002b). It is noted, however, that the projected growth of this age group is 12% by the year 2020.

Utilization

The total number of acute care beds in the province decreased between 1991-1992 and 2000-01 from 5,677 to 4,559 beds, or from almost 5 beds per 1,000 population to 3.4 beds per 1,000 (Health Canada, 2002b). The first major cuts occurred in 1992, 306 (or 10.2%) of the acute hospital beds in Winnipeg were closed, with most of these closures at the two teaching hospital. In 1993, a further 209 (7.7%) beds were closed, with an additional 118 (4.7%) beds closed in 1994 and 1995 (Brownell & Roos, 1998). Bed and budget cuts have been less severe in Manitoba than in most other provinces. Tully and St. Pierre (1997) report that, between 1986 and 1994, Manitoba had the smallest reduction in the number of hospital beds (13%) of all provinces. Despite a drop in hospital beds per capita, hospital separation (discharge) rates remained steady at around 170 hospital separations per thousand residents (MCPH, 2000a). In fact, between 1994-95 and 1999-2000, the number of hospital separations in Manitoba increased slightly from 1.92 million to 1.95 million (MCPH, 2002a). This separation volume means that there has been a slight increase from 167.9 to 170.3 per 1000 in the five year period. The hospital days used in 1994-95 in Manitoba were 1.234 million versus 1.18 million in 1999-2000(MCPH, 2002b).

Table 23

Total Drug Cost Expenditures for Canada and Manitoba, 1995-96 and 1998-99

Province	**Drug Costs (millions $) 1995-96**	**Drug Costs (millions $) 1998-99**
Manitoba	122.8	167.1
Canada	6 600.0	8 900.0

Adapted from CIHI (2002c).

In 1999-2000, the three diagnostic categories that accounted for the greatest number of hospital days in Manitoba were circulatory diseases, respiratory diseases, and unintentional injuries. Circulatory diseases, as a specific condition grouping, accounted for the greatest number of hospital days both in Manitoba (1999-2000) and in Canada as a whole (1998-99). Further, Manitoba's emergency room utilization is 502.1

per 1,000 population making it second only to the Yukon at 527.8 and well about the Canadian average of 433 (CIHI, 1996).

Women's roles

During the 1990s, one of the cornerstones of health care reform was the shift from institutional to home and community based care. Hospital expenditures account for a major portion of provincial health care budgets, so the reduction in hospital services has been an important strategy to control health spending. Several provinces have closed hospitals, reduced the number of hospital beds, and shortened the length of hospital stays as described previously. As hospital spending declined, nurses and other hospital workers (primarily women) raised concerns over job losses, understaffing, higher workloads, and increased levels of stress. The public expressed concern about access to services, patient safety, and quality of care.

Generally, health care reform has promoted home and community-based care as less costly and more client-focused alternatives to institutionalization. The shift towards more ambulatory care has had the effect of transferring delivery of certain services to the private sector – that is, to family members, mainly women, who are called on to provide increasingly difficult and complex care as caregivers, without protection or adequate support; or to community organizations, who often have the impression that they serve as overflow channels to meet needs that the public network cannot absorb (Bernier & Dallaire, 2000). Home care programs are based on the assumption that caregiving is a family responsibility and that women are available to take on caregiving roles. Shifting care from institutions to private households transfers care work from paid health care workers to unpaid family caregivers and reinforces traditional gender roles. Women continue to perform most of the unpaid caregiving work within the home, often at a cost to their own health or economic security.

Regionalization

Prior to the formation of the regional health authorities, Manitoba was divided first into 7 administrative regions (prior to 1989) and then into 10 (post-1989) regions. After 1989, Winnipeg was partitioned into 3 zones, hence, the creation of 10 regions. In June 1996, Bill 49 (*The Regional Health Authorities and Consequential Amendments Act)* was released for public comment and came into effect on April 1, 1997. It sets out the conditions under which the RHAs are incorporated, as well as defining duties and responsibilities of the RHAs and the Minister of Health. Both parties are responsible for policy, assessment of health status, and ensuring effective health planning and delivery.

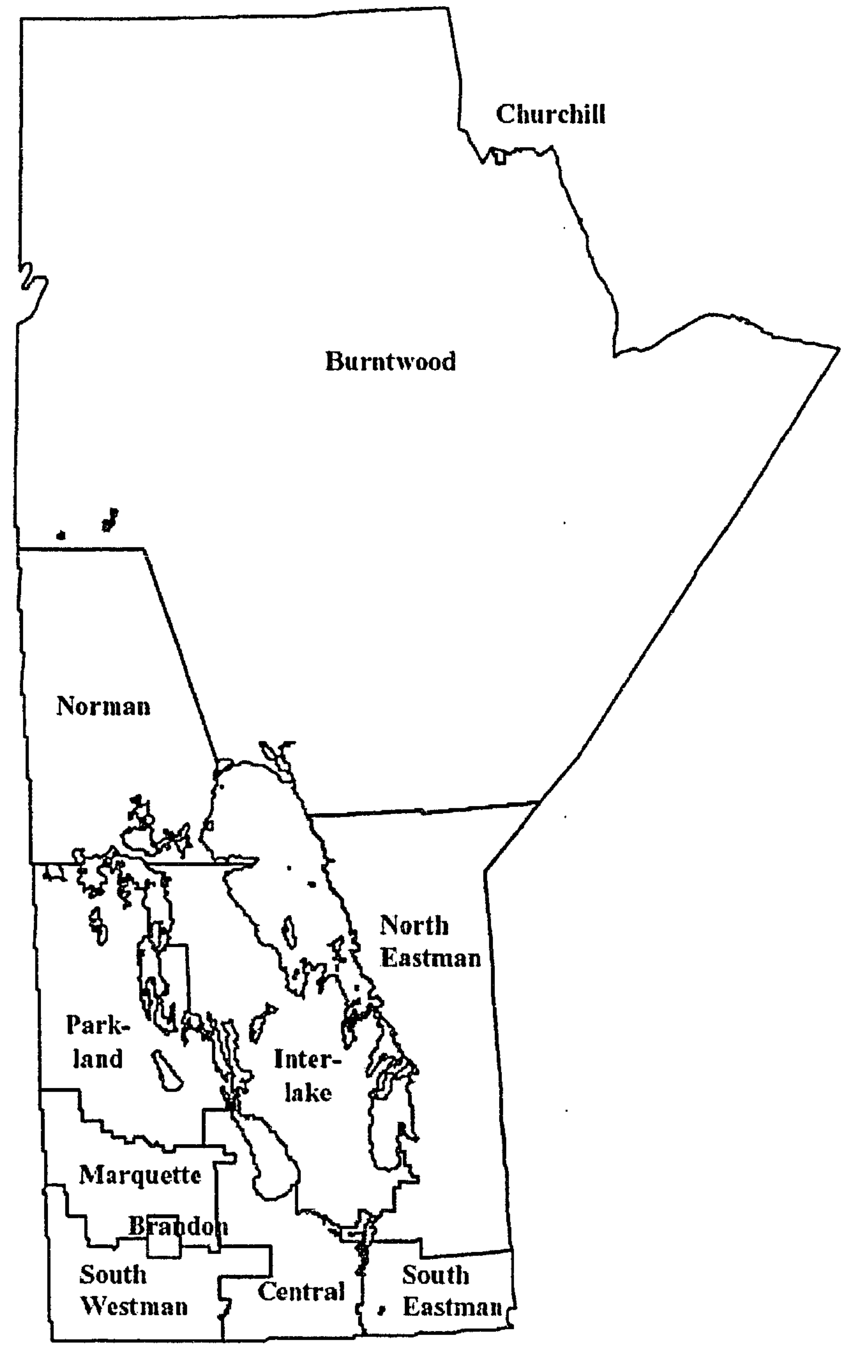
There are 12 regional health authorities (RHAs) in Manitoba as depicted in Figure 5. Each RHA is responsible for the planning, integration, and monitoring of health care services. Boards may have up to 15 members, with the exception of Churchill, which has a maximum of nine. Of these, three are optional appointments, two chosen by the Minister of Health and one as recommended by the RHA. Board members provide leadership in addressing the health needs of the population within the defined geographic boundaries of the region.

Each RHA may have up to four District Health Advisory Councils (DHACs). The Councils are representative smaller geographic areas within each region. They enable grassroots input to the RHA board. RHA boards determine the number of DHAC members and requirements for Council membership.

RHAs are accountable to the ministry. In August 1999, the province government released a document entitled *Achieving Accountability* that defines the accountability relationships between the Minister of Health and RHAs. This document also indicates that accountability must shift from its past focus on finances to being increasingly measured in terms of outcomes, health of the population, and overall benefits.

Health system restructuring resulted in assignment of scopes of services for the health districts and exclusions. Under the emergent system, Regional Health Authorities are responsible for collecting and analyzing information about the health of their population, conducting regional planning, and maintaining accountability to their residents and the government for fiscal and resource allocation decisions (Manitoba Health, 1996). Manitoba Health will continue to provide a number of traditional programmatic offerings (as cited in Table 24) plus will emphasize policy and program development, and consultative input on a provincial level (Manitoba Health, 1996). These new roles and responsibilities are reflected in Table 18.

Figure 5. Manitoba's health regions.



Source: Regional Health Authorities of Manitoba (2000b).

Table 24

Delineation of Regional and Provincial Responsibilities in Manitoba

Regional Responsibilities	**Provincial Responsibilities**
Public Health Services	Provincial drug plan
Treatment (acute and chronic)	Cancer Care Manitoba
Developmental and Rehabilitation Support Services	Addiction Foundation
Home-based services	Dialysis
Long term care	Oncology
Mental Health Services	Selkirk Mental Health Centre
Substance Abuse/Addictions	Fee for service physician services
Palliative Care	Some Northern nursing services
Salaried Physicians	Some grant and pilot projects

In addition, the restructuring of health care in Manitoba was framed within the emphasis to embrace community participation. According to Manitoba Health(1996), community participation is a fundamental value which will ensure the involvement of communities "in assessing and ranking needs, determining and implementing strategies, and evaluating their effectiveness" (p. 11).

Parkland Regional Health Authority

Profile

Parkland Regional Health Authority (PRHA) is situated in west central Manitoba. Approximately 25,000 km^2 (3.9% of the provincial land mass), the region is bounded on the west by the Saskatchewan border, on the North by the 53rd parallel, on the South by Riding Mountain National Park and on the East by Lake Manitoba and Lake Winnipegosis (PRHA, 2001). Refer to Figure 5 for PRHA's geographical location.

The PRHA has about 43,000 residents or 3.89% of the provincial population served by five hospitals, two community health centres, and eleven nursing homes (PRHA, 2001). This district has a population density of 1.34 as compared to the provincial density of 1.95 (Statistics Canada, 1996). The urban percentage of the PRHA is 35.4% which is significantly lower than the provincial average of 71.8% (Statistics Canada, 2002). Projections are for a decline in population with an approximate 8% reduction in the PRHA by 2015 (Manitoba Health, 2001b).

Health conditions and outcomes

In terms of life expectancy, PRHA residents average 77.4 years compared to the Manitoba average of 77.9 (Statistics Canada, 2002b). The population of the PRHA is composed of nearly 19% of persons over the age of 65 which is well above the provincial average of 14% and the national level of 12.7% (MCPH, 2002a; PRHA, 2001). Further approximately 14% of the PRHA's population is Aboriginal as compare to 7% of the provincial population (PRHA, 1997).

In terms of education levels the average number of years of schooling for individuals 25 to 54 is 11.7 years in PRHA compared with 12.4 in Manitoba and 13.2 nationally (Statistics Canada, 1996). PRHA has the highest percentage of persons with less than grade nine education of all Manitoba regions (PRHA, 1997).

In 1998/99, the PRHA infant mortality rate was 4.3 per 1000 compared to Manitoba's infant mortality rate at 6.94 per 1,000 live births (note this rate dropped significantly in subsequent years provincially) (PRHA, 2001). Further, low birth weight babies in Manitoba in 1999/01 occurred at the rate of 33.6 per 1,000 population, with PRHA fairing slightly worse at 51.6 (PRHA, 1997).

Another indicator of health outcomes, according to Statistics Canada (2002c), is the review of premature deaths from any cause which is referred to as potential years of life lost (PYLL). The overall provincial PYLL rate of 6261.9 per 100,000 is significantly less than the PRHA level of 7124.7 per 100,000 (Statistics Canada, 2002c). The leading causes of PYLL for the PRHA are circulatory diseases, respiratory diseases, and cancer (Manitoba Health, 1998). In PRHA, as in provincially and nationally, circulatory diseases account for the greatest number of hospital days (MCPH, 2002a). It is noted that all regions within Manitoba showed overall health status improvements between the first and second halves of the 1990s (MCPH, 2000a).

Finally, in terms of self-rated health, Statistics Canada (2002d) stated that in 2000-01, 51.9 % of PRHA residents rated their health as excellent or very good, compared to 58.4% of Canadians. Gender difference in self-rated health status was similar with 48.8% of women as compared to 50.8% of men reporting excellent or very good health.

Long term care beds numbers in PRHA are 534 in 1999/00 and 529 in 2000/01 (PRHA, 2001). The long term care utilization rate in PRHA in 1999 was 12.51 beds per

1,000 population compared to the provincial average of 8.35 (Manitoba Health, 2001b). The acute bed number in the PRHA remained stable at 216 to 215 between 1999 and 2001(PRHA, 2001). It is further noted that hospital utilization in the health district has fallen slightly by 6.2% between 1999/00 and 2000/01 (Manitoba Health, 2001a).

The supply of general/family physicians in the PRHA is 42% higher than rural average, however consultations with specialists is slightly lower than rural average by approximately 4% (PRHA, 2001). Prescription administration is significantly higher in PRHA at 3.69 per individual versus the provincial rate of 1.87 (Manitoba Health, 2002).

Reform/renewal

The governance structure in Manitoba's reformed system has at its centre a Regional Health Authority (RHA) board responsible for the overall planning and integration of services for a geographically-defined population. Each board may have up to 15 members. Of these, three are optional appointments, two chosen by the Minister of Health and one as recommended by the RHA.

The PRHA's Board of Directors is composed of up to 15 members including the Chairperson. According to the PRHA (2001), the directors "bring to the board a varied expertise and a keen awareness of the need for change to the present method of delivery to the health care system". The communities and their respective health care services in the PRHA are listed in Table 25.

The PRHA has 263 beds serving the population (yielding 5.87 beds/1000 population) which manages 78% of the hospital separations for the region (Stewart, Black, Martens, Peterson, & Frieson, 2000). The region is rated as a high needs area based on demographic and socio-economic indicators outlined by Stewart, Black, et al.). All but two of the hospitals in the region are being utilized at the expected rates, one of which is located in the community of interest (in fact was significantly underutilized).

According to the PRHA (2001), the health district's raison d'être was to assist "individuals, families and communities achieving the best possible health and wellness...through treatment of ill and injured; healthy lifestyles; health environments; and optimal quality of life."

The board priorized its governance role in a manner which moves towards fulfillment of the Vision statement while emphasizing an outward, future-oriented perspective, encourages diversity, demonstrates strategic leadership efforts, and exhibits proactivity (PRHA, 1999). The PRHA delivers a wide range of health care services as delineated by the Government of Manitoba (refer to Table 18). The PRHA provided these services cooperatively with affiliated agencies, various professional bodies, other health districts, and the Department of Health.

Table 25

PHRA Health Care Services by Community

Community	**Health Care Services**
Dauphin	Hospital Long term care centre (2)
Community C	Hospital Long term care centre
Roblin	Health Centre Long term care centre
Alternate Community	Hospital Long term care centre (2)
Gilbert Plains	Health Centre Long term care centre
Alternate Community	Hospital Long term care centre
Alternate Community	Hospital Long term care centre
McCreary	Long term care centre
Benito	Long term care centre

Community C

Early Vignette

> I don't think health reform really changed (things). Even the term "health reform" what the hell is that? You know, to some people health reform means that you're going to do something to make it better; (but that's) not what actually happened. What's actually happened is the nurses are more stressed, the patients are more stressed, and the families are stressed with all the changes.

Profile

In 2001, the population of Community C was 814 with females representing nearly 60% of the population (Statistics Canada, 2003). This population reflected a decrease of 4.9% from 1996 and clearly mirrors the general trend for rural communities throughout Manitoba. Table 26 demonstrates that the majority of persons in this community are in the 65+age group.

Table 26

Age Distribution of Community C

Age Group	**Percentage**
0-14	9.8
15-29	10.4
20-64	23.9
65 plus	55.9

Adapted from Statistics Canada (2003)

Nearly two-thirds of individuals in Community C between the ages of 20 and 44 have at least a Grade 12 level education (Statistics Canada, 2003).

The community is located within 70 kilometers from Dauphin which is the nearest secondary service centre. The major economic areas in Community C are trade related industry and health/social services (Human Resources Development Canada, 2002).

According to Stewart, Black, et al. (2000), the hospital has 18 beds, combining medical and rehabilitative services, with a 51% occupancy rate which is below the provincial average of 59%. It accounts for 1/3 of the hospitalizations for residents of the area which is a middle third ranking provincially. Both service intensity and discharge efficiency are rates as low (ranking in the lowest quartile of the province). The facility in Community C was ranked 53rd out of 68 rural hospitals in terms of efficiency (Stewart, Black, et al.).

Environmental scan

The community is located off the Yellowhead Highway via a paved access. The surrounding area appears as a sparsely populated agricultural and ranching area.

The Main Street houses a wide array of financial, commercial (i.e., bakery, florist, appliance outlets), and professional enterprises (i.e., law firm; accounting/insurance company). The buildings and the road are well maintained and clean.

Generally, the community appears to be well-serviced with a selection of businesses, professionals, and agencies. The telephone book and the tourist booth personnel provided a wide ranging list of companies and services ranging from agricultural to veterinary.

Housing is primarily single family dwellings, which are generally well maintained. Most homes appear to have been built in the 1960s. There are a few homes available for sale and additional postings are available on bulletin boards in the local restaurants.

Educational facilities in the community include both an elementary and a secondary school which provide kindergarten through Grade 12 classes. A number of programs are offered through a regional college as evidenced by brochures available at the local Public Library. The Public Library also serves as a Community Access Point under the Government of Canada's program to improve the access to information and communication technology to rural and remote residents.

In terms of health and education services, the community has a hospital, nursing home, 3 physicians, a pharmacy service, plus a two unit ambulance service. The senior and disabled residents of Community C can access transportation via a Handi-van bus service. In addition, a special needs housing and employment project provides accommodation and gainful employment for a number of mentally and developmentally challenged individuals. There is a Royal Canadian Mounted Police detachment and volunteer fire department within the community.

The community has 9 churches and a small historical museum. In addition, there are advertisement and posters at the local restaurant and library regarding community events (i.e., sporting activities), and service clubs (i.e., Kinsmen, Rebekahs). There is also a curling complex and an outdoor swimming pool.

Summary

Community C is a small rural community situated within Manitoba's Parkland Regional Health Authority. Table 27 highlights key community and region attributes.

Table 27

Community C – Overview.

- Community located in west central Manitoba with 800 plus residents
- About 70 km to larger community
- No acute care facility change
- All but two of the hospitals in the region are being utilized at the expected rates, one of which is located in the community of interest (significantly underutilized)...ranked 53/68 in efficiency
- Region has 5 hospitals, 2 community health centres, and 11 nursing homes
- Extremely rural region with nearly double the % of rural residents compared to provincial and significantly older
- Infant mortality, premature deaths, and occurrence of low birth weight babies were all slightly worse than provincial norm
- Long term and acute care beds numbers have remained stable throughout the health reform process
- Significantly higher bed utilization rate in the region than provincially

CHAPTER VIII

DATA SYNTHESIS AND FINDINGS

This chapter considers the multiple data sources and provides a synthesis of the information obtained in this study in preparation for bringing forward the themes contained within the primary and secondary data sources considered in this study.

The key issues, within the current and extant research and writings on health renewal/reform within the two provinces and from the current research, which contribute to understanding the complexity of this case fall into four major themes:

1. disconnect to connect
2. irrational to rational
3. 'dys'integration to integration
4. silence to voiced

Each theme will be considered with respect to the focus of the theme, followed by the provincial, regional, and community perspectives as applicable.

Disconnect to connect

The focus of the 'disconnect to connect' theme rests within the explicit objectives of the health renewal/reform agenda in each province. In Saskatchewan, the stated objective was to "provide high-quality health care services to our rural residents" (Government of Saskatchewan, 1992, p. 1). This objective was rooted in the promise of public meetings and public consultation in order to attain and gain confidence in the health renewal/reform agenda. This commitment by the Government of Saskatchewan appeared in the inceptional legislative debates (Government of Saskatchewan, 1992), and health renewal/reform documents (Saskatchewan Health, 1992; 1996). In Manitoba, the health renewal/reform agenda was posited to "reduce inequalities in health status" (Manitoba Health, 1992) for all Manitobans. It is noted that the original documents from Manitoba Health regarding the restructuring of health care focused on the renewal of health services in rural and northern Manitoba. Hence, in both provinces, there was evidence of recognition of the uniqueness of rural areas with respect to health and health care by government.

The level of disconnect, which was exhibited both prior to the inception of health reform/renewal and created by the initial phase of health reform/renewal in

Saskatchewan, was articulated in the legislative statements such as "(we) saw the type of input people could have when you (i.e., government) send bureaucrats to do your bidding in a public meeting" (Government of Saskatchewan, 1992). This disconnect was further encapsulated by the leader of Saskatchewan Progressive Conservatives statement that he had "never experienced, in my lifetime in the legislature, such an overwhelming and universal expression of seething anger, fear, and frustration" (Swenson, 1992, A2). In the legislature, the division bells rang for nearly three full days in April 1993 as opposition politicians filibustered to protest the funding cuts and the government's decision to limit the debate on the Health Districts Act (Briere, 2003). According to Kouri (2000), Saskatchewan community representatives surveyed indicated the manner in which the cuts to acute care funding were handled unnecessarily increased fear, anger, and instability in most of the affected communities and today health districts still have to deal with this lingering bitterness and disillusionment of health reform.

This experience was paralleled in Manitoba. At the inception of health reform/renewal in Manitoba, the political debate highlighted the level of disconnect. Opposition member, the Honorable Dave Chomiak, queried "how can the Minister see improvements in a system which takes away the tradition role of rural boards and municipalities?" (Government of Manitoba, 1995). Further, the opposition accused the government action as foreboding a "use it or lose it" philosophy for rural hospitals and health centres (Government of Manitoba).

From the perspective of the participants in Community A, the level of disconnect was reflected in comments such as:

- It's pretty lonely out here in the country and sometimes the hospital is the only place you can go for help;
- People were calling (into the radio show) from all over the place and they were mad - damn mad about what was going on (regarding closures); and
- We sensed (the government) had a master plan.

From the perspective of the participants in Community B, the level of disconnect was reflected in comments such as

- We were isolated;

- There was lots of confusion;
- Rumours . . . caused real problems; and
- More pressure on those of us at the bottom of the totem pole.

From the perspective of the participants in Community C, the level of disconnect was reflected in comments such as

- Having to go even to (larger centre) means ¾ hour from here, so people were worried;
- We thought we were going to lose the hospital and the ambulance;
- It's all about the government – they're imposing their beliefs; and
- Health reform means closure of the hospital or sending people out of the hospital as soon as possible.

According to Briere (2003), the early days of health reform/renewal lead to thousands rallying in Regina and in their own communities. Most communities actively lobbied Saskatchewan Health and local politicians by writing letters, attending rallies, and holding town meetings; many making their case by researching local needs; negotiating with local health districts; forming advisory committees; and participating on district committees (Kouri, 2000). The media was replete with the concerns of rural Saskatchewan residents that "their needs were not going to be met . . . (and) that people would die before ambulances arrived, or on the way to the hospital" (Briere, p. C3). HSURC (1999) stated "upon hearing of the cuts, about half of those surveyed anticipated that all existing physician and health services would be lost and their local hospital closed completely" (p. 13).

According to a survey conducted by the SEHD, over 50% of the residents indicated that they felt that all health services and/or the hospital would be lost through health reform (SEHD, 2001). The participants from Community A indicated that a number of individuals/stakeholders (i.e., former hospital administrator; doctors) became involved in advocating or "being vocal" on the pending changes. Information about the pending changes to their health services were gleaned from newspapers, radio, board members, women's auxiliaries, nurses, and coffee row/table top discussions. They spoke of efforts towards ensuring their voices were heard and staying involved preserving their community's interests in statements such as

- I remember Mr. C talking about how we had to fight for what we had...that everything could be lost; and
- We got some people together and, well, they just didn't let anything go.

The participants from Community B indicated that "doing it as a community" was the imperative in challenging the health reform/renewal initiatives. Information about the pending changes to their health services were gleaned from newspapers, town hall meetings, board members, hospital personnel, women's auxiliaries, information from district, and coffee row/table top discussions. Information provided by local people was felt to be the strongest by study participants. They spoke of efforts towards ensuring their voices were heard and staying involved preserving their community's interests in statements such as

- We had big crowds – cause we all care about what was going to happen here . . . it showed that so many people out there really cared when the hall was packed.

Despite these efforts, some focus group participants in Community B expressed concern that the efforts fell short of the desired level

- I don't think we fought hard enough; and
- We just let them (government) go on (with the process).

Unlike the major cuts in Saskatchewan, health reform/renewal in Manitoba took less dramatic steps. However, the responses from the public and media were significant and generally negative (IMS Health, 1997). Of interest, the faith-based organizational voice was dominant in the early discussions regarding the reforming health system (Catholic Health Association of Canada, 1995; Government of Manitoba, 1995). Further, the reports of pending closures of rural hospitals (Reston Recorder, 1997; Steinbach Carillon, 1997) reduced funding to the rural health authorities (Dauphin Herald, 1998), and cancellation of "promised" capital projects for health facilities in rural areas (The Pas Opasquia Times, 1997) were the focus of many headlines in the inceptional days.

The participants from Community C indicated information about the pending changes to their health services were gleaned from newspapers, media, former board members, health workers (i.e., doctors, nurses), local politicians (i.e., mayor, reeve), local women's Advisory Council, and town hall meetings. They spoke of efforts to lobby for their community in statements such as

- People felt they had things to say and had to do something to make sure the government knew that we didn't want to be closed down.

Focus group participants in a HSURC study expressed a number of concerns about how Saskatchewan Health handled the cuts to acute care funding in 1993. Their primary concern was that *before* the announcement of the cuts, people living in rural communities had not been made aware of any overall long range plan for local health services that included alternative service arrangements for primary and emergency care (HSURC, 1999). According to CCARH (2002), those community members closely associated with making the changes indicated their frustration due to the lack of guidance about communicating with the rest of the community.

It was noted by this study's participants in Community A and C that the lack of certainty and inconsistent information was problematic as "you were never sure whether you were going to be getting health care services if you need them" and "there is always that feeling that you don't know what's around the corner – (the question remains) 'When is it all going to be taken away from you?'. Comments such as "(misinformation like) all of us were going to lose our hospitals and there were only going to be 6 or 10 in all of the province" represent the pre-reform information gaps from this Community A's perspective. Of note, one participant from that community stated that the "best" information was obtained at a public meeting.

In both Community A and B, a major issue was control of the outstanding issue of residual community raised funds.

Participants from Community C indicated that they were concerned that "one day like it happened in Saskatchewan all of a sudden it's over with and you have no control." Further, a stated concern from that Community was that

- We didn't want the town to die either...if there is the loss of the hospital then the town would die because in a lot of (cases) people move to communities that are close to a hospital to have certain services, like ambulances and personal care homes.

In order to "reconnect" with the rural peoples of Saskatchewan, the government invoked a community process (Simard, 1997) as

> Saskatchewan moved to smaller districts because they did not want to lose community involvement and input because community ownership of health is so important in achieving population health. There was concern that if the districts were too large that small communities would be left out. (p. 77)

Further, "the district boundaries were not defined. We deliberately stayed away from defining boundaries and districts because in our experience defining boundaries caused people to focus on whether the boundaries were accurate" (Simard 1997, p. 80). Many participants in a Saskatchewan study by Kouri, Dutchak, and Lewis (1997) indicated that the community consultation processes did not appear to be legitimate – believing the outcomes were prearranged and the process was disrespectful to Saskatchewan's health care pioneers.

In a similar manner, the government of Manitoba's reconnecting messaging was clearly focused on a proposed reform/renewal agenda to make rural hospitals/health centres relevant in their communities (Government of Manitoba, 1995). With respect to the regional formations proposed under the policy, then Minister of Health, the Honorable Darren Praznik, stated "we need the benefits of large numbers and regions in order to ensure the delivery and expansion and betterment, I think, of health care in rural Manitoba" (Government of Manitoba, 1998).

One interviewee in Community A stated:

- There were people from the Health Department out a couple of time . . . really just carrying the political message . . . telling us all these lies about how much better everything was going to be after we become a district.

Participants in Community B stated that

- By the time we got to the meeting, the decisions had already been made . . . really (we) had no say...all the decisions were made in the city and we live with it;
- the city people (from the Department of Health)came out here that haven't got a clue about what goes on in these small communities and they're making decisions for us that they don't even have any idea about what it does to us; and
- the British Columbia consultant (sent by the Government) had a preconceived idea about what was going to happen.

From the perspective of the participants, Communities A and C choice of health district/ region was more an automatic than a community process. In the former case, the decision appeared driven by proximity to a larger centre where residents already accessed care; in the latter the government assigned regional bodies. During the focus group in Community A, it was stated that in deciding on which district the consensus was that "we are closest to (largest centre) so there was no decision". During the focus group session in Community C, it was stated that

- We were told this is how it is going to be (regarding the areas for the RHAs); no body had a say or a discussion about how the RHA was formed.

Additionally, the persistently flailing relationship with the RHA in Community C was further compromised by the use of some terms like RHA, clients, and health centres. One participant stated that

- You can't even look up hospital anymore because it's not listed there.

According to HSURC (1999), most rural respondents (82%) recalled being satisfied with health services prior to the 1993 acute care funding cuts. In 1999, over half (54%) were dissatisfied with current health services, mostly relating this dissatisfaction to reduced availability of doctors, emergency, and hospital services.

Only half (49%) of public respondents felt that, overall, Canadians were currently receiving quality health care; down 18% from 1999 (Pollara, 2000b). Contrary to what they anticipated (40% in 1993), 89% of Saskatchewan respondents reported that the funding cuts had no effect on their personal health (HSURC, 1999). According to a Dimark Communications Group poll (2000), 57.8% of Manitoba respondents believed that the health care system is staying the same or getting better, with no significant difference reported between rural and urban respondents.

Focus group participants indicated that, in the initial phases of health reform/renewal, most of the citizens of Community A were "scared for (lack of health access) for families and friends". The consensus appeared to be that they were less at risk for losing their health services as they had a newer facility and permanent physicians, giving them some sense of stability of their community's health services. In terms of satisfaction with health services prior to the health reform/renewal agenda, 83% of SEHD residents indicated their satisfaction as opposed to 34% reporting satisfaction with the present level (SEHD, 2001). Of note, 89% of participants in the district's survey indicated that there have been no direct impacts on their personal health (SEHD, 2001). The general sense of the current health services in this particular community is encapsulated in the quote "it could have been worse for us ... at least we kept something".

Focus group participants indicated that, in the initial phases of health reform/renewal, most of the citizens of Community B were concerned about the "closing or downgrading of the hospital." The participants indicated that "if you lose the hospital you lose so much importance". The general sense of the current health services in this particular community is encapsulated in the quote "they've done the worst so hopefully we don't have to be worried." The sense of community identity and involvement in the health reform/renewal process was further reflected in comments such as

- We have lots of experience and lots of community spirit, so we'll do everything possible, we will try hard to keep this...even become pioneers again;
- people are our strength...when things go wrong we always come together; and
- important to stand for your community as a whole.

Further, in Community B, the respondents stated that the health reform/renewal process was replete with losses for their community. For example,

- The district didn't affect us that much, not as much as losing our hospital status;
- taking the beds away from us;
- our doctor left because he was overworked; and
- We are losing our money...our hospital is closing, and we are losing our health care . . . there is nothing we can do about this.

In Community C, focus group participants indicated that, in the initial phases of health reform/renewal, many of the citizens in their community were hurt, angry and frustrated about the government's actions. The consensus appeared to be that they had a newer facility, a personal care home, and ambulance service that gave them some sense of stability of their community's health services. Hence, the philosophy appeared to be "everything is still here and everybody, for a while, feels good." There was a concern that apathy would set in regarding health services and health reform in this community.

In the early days of health reform, over half of the survey participants anticipated a decrease in population size and in the number of jobs in their town as a result of cuts to acute care funding (HSURC, 1999). This HSURC study reported that most respondents reported that the overall population size, number of jobs, and personal income either stayed the same or somewhat decreased after health reform/renewal commenced, with only 10 % attributing the changes to health policy.

A study done by the SEHD (2001) found that 60% of participants thought the cuts would result in population decrease with 81% anticipating job loss. Just over 20% of respondents stated that they believed health reform/renewal lead to changes in community population. Women in Community A stated that "this health reform stuff is killing our small towns – maybe it's a political move".

It was noted by this study's participants in Community B that their community was impacted significantly in that "loss of the hospital…threatens the community". The participants indicated that

- (Lack of a hospital and an unstable health care system) doesn't draw people to our area, it scares them away;
- We lost four businesses…nobody's going to come and take over"; and
- I remember people talking about leaving the community (if the hospital closed) because of their own health not being good.

Kouri (2000) stated that clearly the strategists and politicians have not succeeded in obtaining enough agreement among the rural residents about their benefits of health reform/renewal. There is a significant component of the rural community that has become increasingly distrustful. Rural communities continue to be discontented and community health care services capacity is uneven (Kouri, 2000, p. 47).

In Community B, participants clearly articulated distrust and discontent in statements such as

- We are just waiting because they're talking about new changes, so I guess some of those old feelings are coming back again;

- It is hard to cope with something like this... (we were) afraid and angry... frustrated; and
- health is always on our minds ... the (health reform/renewal process) has put an edge on health care in rural Saskatchewan.

Irrational to Rational

The focus of the "irrational to rational" theme rests within the often cited, yet seldom acknowledged, objective of the health renewal/reform agenda to reduce costs and alter health service utilization patterns. According to Kinross (1992) and Kouri (2000), regardless of the form of regionalization (and vicariously the health reform/renewal policy), the primary aim is to contain or cut health costs and service utilization.

Funding

Cost containment, and variations on this objective have become the touchstone of virtually all health care policy decisions and dominates the health care reform agenda of all provinces. During the early days of the health reform/renewal agenda in Saskatchewan, the Minister of Health indicated that there will "no doubt be cost efficiencies created in the system because there will be duplication removed and increased coordination of services" (Government of Saskatchewan, 1992). The health budget was to be realigned "for programs like home care and community therapies . . . family planning and an AIDS (acquired immune deficiency syndrome) strategy . . . SADAC (Saskatchewan Alcohol and Drug Abuse Commission). The opposition envisioned that . . . this fiscally driven wellness model is designed to save money for the treasury" without consideration of the impact on the people of Saskatchewan (Government of Saskatchewan, 1992).

The governmental funding process, prior to health reform/renewal in Saskatchewan, had always required the submission of annual budgets and periodic actual and budgeted statements from all the health care facilities. However, with the inception of health reform and with the immediate interest to curb the ever increasing health care costs, Saskatchewan Health shifted its attention from the universal budgeting and accounting processes to the "needs-based funding allocation"

(Saskatchewan Health, 1993). In doing so, Saskatchewan Health ignored the importance of the overlapping economic and social relationships of historical health services, historical funding, and historical level of healthcare employment of the districts. Under a needs-based funding allocation, a global budget was provided to district health boards by broad service areas. Boards have the responsibility to allocate funds in a manner consistent with local needs, as identified in their needs assessment. Saskatchewan Health provided direction to boards in terms of expectations, for services to be delivered, and guidelines around reallocations among services through the Program Management and Expenditure Plan Guidelines" (Saskatchewan Health, 1993, p. 3). The respondents in Community A indicated dissatisfaction with the approach stating "(we are) sick of having to beg for a dollar to keep our services".

In contrast, the governmental funding process, prior to health reform/renewal, has remained in place in Manitoba. The budget is based on historical precedent, and requires the RHAs to plan, integrate, and deliver a core group of health services within the dollars allocated (Mustard & Derksen, 1998). Mustard and Derksen suggested that a new method of delivering health care requires a new methodology for funding, however, this has yet to occur in Manitoba. Respondents from Community C indicated that "finances were a big part of reform", yet there did not appear to be any significant change in their context related to money allocations.

According to Simard (1997), Saskatchewan's 1993/94 health budget showed a 3% annual reduction, mainly attributable to acute care funding eliminated for hospitals with average daily census of under 8 (Health Planning and Policy Branch, 1995). The Health Planning and Policy Development Branch (1995) indicated that overall budget changes in subsequent years were -2.9% (1993/94); +0.9% (1994/95); +3.4% (1995/96). Of note, Pacholik (2000) reported that between 1990 and 1997 hospital expenditures dropped by 7.5% while home care and community based expenditures rose by 6.2% in the province (p. A3).

In Manitoba, the government expenditures on health are 17.4% higher per capita than the Canadian average (CIHI, 2002d). In comparison with Saskatchewan which has a similar demographic and economic environment, Manitoba is spending 12.2% more per capita on health care (CIHI). This disparate pattern identified by Edmonds (2003) showed the health spending growth rates, which in 2002/03 were 2.5% for Canada, 0.5% for Saskatchewan, and 5.3% for Manitoba (which was the largest increase nationally).

Despite the ongoing high expenditure pattern in Manitoba, the system continues to be replete with lengthy waiting lists, cancelled surgeries, and hospital crowding. Despite the move by the government (Government of Manitoba, 1998), "to ensure that there are adequate dollars to provide the services that they need to provide...through a funding model which is more needs-, population-, I would say, usage-based as opposed to strictly funding on sort of the same basis all across the province" it remains obvious that the funding strategies in the reformed/ renewed Manitoba health system are problematic. For example, more than 50% of the health regions have reported deficits in each of the last 5 years (Manitoba Health, 2002). Despite this seemingly disappointing result, the Minister of Health indicated that "a flexible funding approach is the goal which will recognize the differences across the province" (Government of Manitoba, 2002).

The Canadian Medical Association (1995) analyzed and diagnosed the current situation in Canada and declared Medicare to be suffering from an "affordability crisis". According to Lewis and Fooks (2002), it is not Medicare policy which is no longer affordable, but rather its inefficient manner of implementation. Despite major increases in provincial health care expenditures in recent years ($1.92 billion in 1999-2000 compared to $1.52 billion in 1991- 92 and a low of $1.49 billion in 1993-94), the majority of residents in communities that lost acute care funding continue to be dissatisfied with the current state of health services (HSURC, 1999). Most respondents in the HSURC study believed that health reform had more to do with cost-cutting than wellness and that its pace had been too fast. Few saw the need for extensive health reforms, nor did they believe the changes made in the past five years had been for the best (HSURC).

Respondents from Community A referred to the entire process as "hellness and wealth reform". According to them, health reform has come to mean "bad things for our town. It means less things for our town".

Willson and Howard (2000) indicated that there has been a shifting responsibility for the costs of health care to individuals in Saskatchewan and Manitoba, not through bold initiatives, but through a subtle form of "creeping privatization". This trend has been operationalized in both provinces by moving health care costs gradually into the private sphere through strategies such as increasing levels of co-payment or deductibles; de-listing of services; narrowing the definition of "medically necessary" service; and shifting acute and chronic care into the community. In addition, major reforms have occurred within the Manitoba Pharmacare Program was changed from a universal deductible format to an income-based drug insurance program which was accompanied by formulary restrictions and exclusions, often for the highest-priced drugs (Russell, 1999). "While not overtly identified as a privatization initiative, this trend has shifted responsibility for health services out of the public sector and onto the shoulders of families and individuals, who have, in turn, utilized private health services to meet some of their needs" (p. 54). This shift has resulted in greater than doubling of spending on home-based services between 1991 and 1997 in Saskatchewan (HSURC, 1998). This spending pattern resulted in one in four home care clients receiving care which might otherwise have been provided in hospital (HSURC).

In addition, major reforms occurred within a variety of programmatic areas such as the Saskatchewan Prescription Drug Plan. Originally, a fixed co-payment scheme, in 1993 a semi-annual deductible plus 35% co-payment scale was introduced (Saskatchewan Health, 1997). This action, along, with other strategic initiatives (i.e., delisting of chiropractics, discontinuation of dental health) altered the traditional health cost split between public and private.

The NFH (1995) reported that, in 1995, approximately 72% of the total health expenditures in Canada were publicly-funded. Nationally, the percentage share of public and private expenditures went from 75.9% in 1979 to 70.8% by 1999 (CIHI, 2001). Table 29 shows the public/private breakdown of expenditures in 2001 forecasts.

Private financing figures for health care in Saskatchewan indicate a steady and dramatic increase since 1990. Between 1990 and 1996, private health care expenditures increased by 43%, whilst public financing of the health system increased by only 3.2%

Table 28

Total Health Care Expenditures, Manitoba, Saskatchewan & National ($000,000)

Jurisdiction	Total Expenditure	Public Expenditure	Private Expenditure
Manitoba	4,174.4	3,132.7	1,041.8
Saskatchewan	3,347.2	2,619.5	727.8
National	102,511.9	74,465.0	28,046.8

Adapted from CIHI, 2001.

(CIHI, 1999). In Manitoba, in 1995, similarly to Saskatchewan the figure for public funding percentage was slightly higher than the national average at 74.5% (CIHI, 1999). Data on private financing of health care Manitoba indicate a steady and dramatic increase since 1990. Between 1990 and 1996, private health care expenditures increased by 33% in Manitoba. In contrast, between 1990 and 1996, public financing of the health system increased by 7% in Manitoba. More recent figures showing the breakdown of the private expenditures (see Table 29) demonstrate that hospital and other institutional costs are the most significant constituents of private sector costs.

Table 29

Private Sector Expenditures, Manitoba, Saskatchewan, and National ($000,000)

	Hospital	Other Institutional	Physician	Professionals	Pharma ceuticals	Public Health & Admin	Other
Man	1,142.4	430.7	482.8	49.1	177.5	403.9	446.2
Sask	902.3	405.6	425.1	56.7	155.0	322.9	351.8
Canada	29,853.2	7,175.6	13,662.6	1,281.7	6,054.3	6,650.4	74,465.0

Adapted from CIHI, 2001

The focus group participants in Community B indicated concern with the locally acquired funds, both from spending and acquisition perspectives. For example, before health reform/renewal, it was perceived that "the generosity was great. Now it's not" and that "huge sum of money has disappeared." Further, respondents from Community B referred to the loss of community autonomy in the use of health care funding dollars. Participants stated that

- Now to spend our own money we have to fill out forms and get grants to get your own money back;

- Now when we do give a donation to the health centre, we have to stipulate what we want to do for (our community); and
- (The health district) has us over a barrel because they have the money and what they decide goes.

Clearly, not all cost cutting is health care reform (Kouri, 2000; Lewis & Fooks, 2002). Some of these cost cutting actions constitute health care reform in that they promote efficiency, reallocation of resources, and improved equity of the system. Other actions merely cut the government's obligation to pay for services and are not rooted in the health care reform policy. Manga (1994) noted that most cost-cutting changes occurred without adequate public debate.

Without a doubt there continue to be disparate opinions on how to adjust the funding on local, provincial, and federal levels. The National Post (2000) posited that health care reformers in Canada divide themselves up into two schools of thought, the magicians and the spendthrifts. The magicians believe any problem with our health care system can be "magically solved" with an appropriate balance of government management and regulation. The spendthrifts envision more money as the sole balancing agent. It would appear that in Saskatchewan and Manitoba, a blended approach has been attempted with somewhat inconclusive outcomes.

Utilization

Until recently, the most common diagnosis for the problems in the Canadian and other health care systems was lack of money. Amid the funding turbulence of the 1990s was a growing awareness of quality problems and utilization anomalies quite unrelated to absolute levels of funding. The growing capacity to undertake health services research (including the establishment of provincial centres in British Columbia, Saskatchewan, Manitoba, and Ontario in the 1990s) began to generate findings that could not be attributed to resources alone. For example, a number of provinces documented the widespread use of hospitals for non-acute care—an expensive utilization pattern that contributes nothing to improved health (HSURC, 1994b; DeCoster, Peterson, Kasian, & Carriere, 1999).

In a Pollara (2000b) survey, the majority of Canadians called for fairly major repairs to the system. Only a small percentage supported a complete rebuilding from the ground up. Among the general public, calls for complete rebuilding were strongest in British Columbia and the Territories, at 21%, and in Québec, at 19%; only 7% in the Prairies saw such a need. In all regions, roughly half advocated "some fairly major repairs," from 49% in Ontario and the Prairies to 56% in the Atlantic provinces.

According to HSURC (1999) about half of respondents reported seeking health services locally prior to the 1993 funding cuts (doctor, 59%; drug prescription, 57%; emergency, 62%; and overnight hospital stay, 47%). Hospital data confirmed that, for residents of the 52 affected communities, 50% of hospital visits were to the local community hospital prior to the 1993 acute care funding cuts. Table 30 further presents utilization trends pre and post health reform/renewal in 1993 in Saskatchewan.

While 60% of Saskatchewan people surveyed had anticipated their health would be harmed by the changes, 89% reported the funding cuts had in fact no effect on their health status. Similarly, while 57% had expected the changes would limit their access to health services, 74% said their service use had stayed the same or increased (Harrison, 1999).

Participants in this study in Community A stated "(we were not) sure whether we were going to be getting health services if we need them".

In Community B, the women stated that health reform had affected their access to services in that

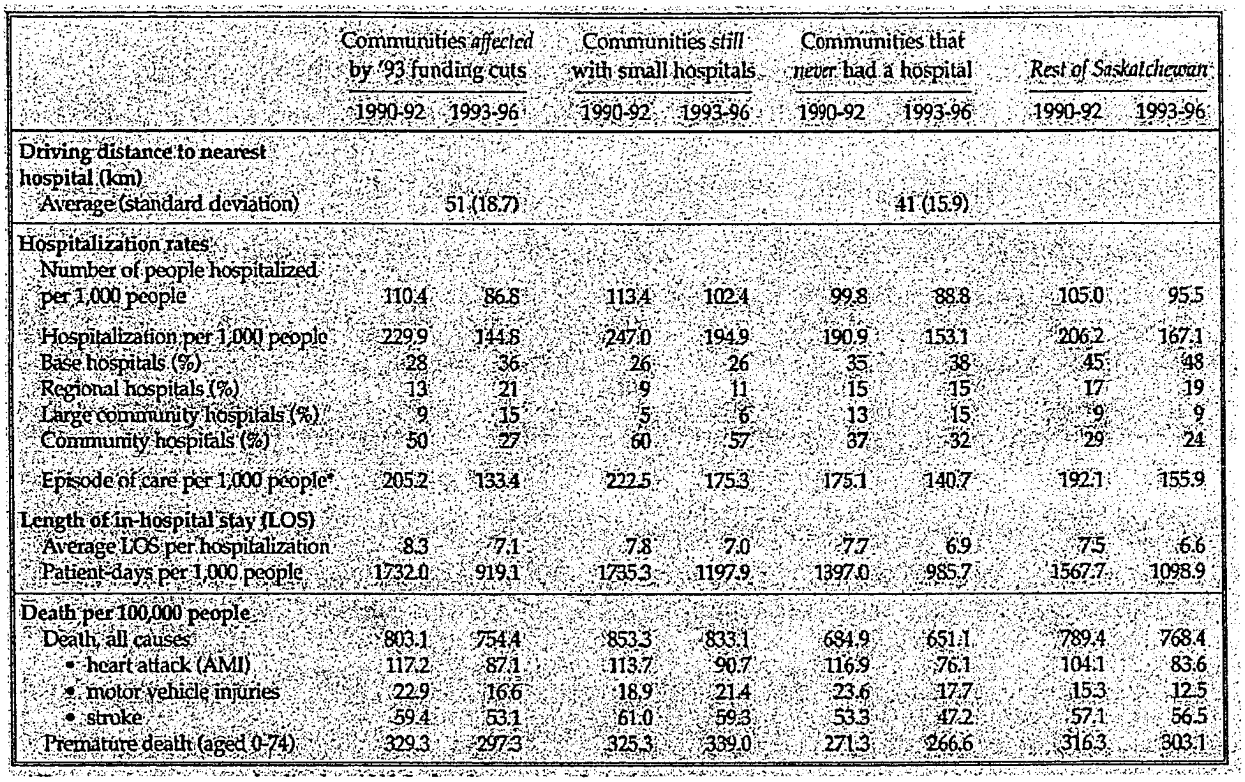
- We have longer waiting lists, we're driving farther, and getting less services; and
- The (health) system gives us less now that before.

This group also acknowledged that prior to health reform/renewal there had been hospital bed closures in their local facility.

So, with the introduction of health reform policy, what significant utilization related strategies were introduced in Saskatchewan? New provincial acute care bed guidelines established targets of 2.5-3.0 beds per 1000 population (yielding a reduction of 1200 acute care beds between 1991 and 1995) and new long term care bed targets of 120-140 beds per 1000 population aged 75 years and over (Health Planning and Policy Development Branch, 1995). This targeting was partially addressed by a reduction in

Table 30

Hospital Utilization and Health Status (before and after 1993 acute care funding cuts)



	Communities *affected* by '93 funding cuts		Communities *still* with small hospitals		Communities that *never* had a hospital		*Rest of Saskatchewan*	
	1990-92	1993-96	1990-92	1993-96	1990-92	1993-96	1990-92	1993-96
Driving distance to nearest hospital (km)								
Average (standard deviation)	51 (18.7)				41 (15.9)			
Hospitalization rates								
Number of people hospitalized per 1,000 people	110.4	86.8	113.4	102.4	99.8	88.8	105.0	95.5
Hospitalization per 1,000 people	229.9	144.8	247.0	194.9	190.9	153.1	206.2	167.1
Base hospitals (%)	28	36	26	26	35	38	45	48
Regional hospitals (%)	13	21	9	11	15	15	17	19
Large community hospitals (%)	9	15	5	6	13	15	9	9
Community hospitals (%)	50	27	60	57	37	32	29	24
Episode of care per 1,000 people*	205.2	133.4	222.5	175.3	175.1	140.7	192.1	155.9
Length of in-hospital stay (LOS)								
Average LOS per hospitalization	8.3	7.1	7.8	7.0	7.7	6.9	7.5	6.6
Patient-days per 1,000 people	1732.0	919.1	1735.3	1197.9	1397.0	985.7	1567.7	1098.9
Death per 100,000 people								
Death, all causes	803.1	754.4	853.3	833.1	684.9	651.1	789.4	768.4
• heart attack (AMI)	117.2	87.1	113.7	90.7	116.9	76.1	104.1	83.6
• motor vehicle injuries	22.9	16.6	18.9	21.4	23.6	17.7	15.3	12.5
• stroke	59.4	53.1	61.0	59.3	53.3	47.2	57.1	56.5
Premature death (aged 0-74)	329.3	297.3	325.3	339.0	271.3	266.6	316.3	303.1

HSURC (1999), p. 5

hospitals to 69 hospitals, from 131 in 1993 (HSURC, 2000). In the 52 communities affected by funding cuts, as of May 2003, Briere (2003) reported that 49 continue to have health facilities - 36 operate as health centres and/or special care homes; 13 were replaced with another facility in the same community.

Since 1993, utilization data has shown that residents of affected communities have nearly halved their use of hospitals (Harrison, 1999). Further, according to an HSURC (1999) study, there is no data that would indicated the residents of affected communities have suffered in terms of either access or quality as a result of the 1993 acute care funding cut. In this study, health status, as measured by death rates, improved throughout the province during the study period, but communities that experienced the 1993 acute care funding cuts had the largest overall improvement in mortality rates. For example, the death rate (per 100,000 population) from motor vehicle accidents declined by 28 % in affected communities, but increased by 13 % in communities that kept their small hospitals. Similarly, the heart attack death rate declined more in the affected communities than in the communities which retained rural hospitals.

In Saskatchewan, hospital closures, although high profile when instituted, were limited when compared to other provinces and, for the most part, the hospitals were converted to health centres (Kouri, 1999). Roos (2000a, 2000b) contends that all of the headlines about hospital downsizing and bed closures exaggerate the negative effects of health care reform. A recently published report by the Centre for Health Services and Policy Research in British Columbia reached similar conclusions about the effects of hospital downsizing on elders' health care utilization and mortality rates (Sheps, Reid, Barer, Krueger, McGrail, Green, Evans, & Hertzman, 2000). These researchers concluded that there have been minimal adverse effects associated with the reduction in acute care services, that the reductions in acute care services coincide with public policy goals of (and citizen preferences for) shifting care "closer to home," and that longer term hospital stays are being reserved for those who are sicker.

In addition, the focus group members in Community B indicated that the new manner of health care provision had affected their community's ability to attract a new doctor. However, one participant stated that "we still have the problem (of no doctors), so I guess it's no different."

Despite the apparent lack of empirical evidence of negative effects of rural hospital conversions on the health of residents, the majority of rural residents are dissatisfied with current health services. The proportion of rural respondents from Saskatchewan satisfied with services dropped from 82 % before 1993, to 34 % in 1999 (Harrison, 1999). Those individuals most discontented with the current health system were young, perceived their use of health services had greatly decreased, or anticipated harmful effects on their health from the funding cuts (Harrison).

Long term care was also affected by the 1992 reform/renewal agenda in Saskatchewan with the discontinuation of direct funding to long-term care facilities for persons requiring light (Level 1 and Level 2) care. This was part of a larger trend toward encouraging people to live at home or outside government-funded long-term care institutions. Between 1985 and 1994, 94% of the Level 1 beds and 69% of the Level 2 beds were removed from the health system (CCHSE, 1997). While deinstitutionalization may indeed have benefits, the decision to stop public funding may have been driven by the desire to reduce expenditures, as much as it was based on evidence of the health benefits. Between 1996 and 1999, the number of personal care home beds in the province rose 28%. Health care unions, operators of smaller personal care homes, and members of the Liberal opposition all criticized the government for opening the doors to larger, private, for-profit facilities and transferring responsibility for light level long-term care to the private sector (CUPE, 1999; Mandryk, 1996).

Participants in Community B expressed concerns that there would be future downsizing of the community's nursing home. This group emphasized that their aging population have special needs and that they "feel strongly about our older population being able to stay here" for services.

Further, although recognizing that rural hospitals handled a lower volume of cases, at a higher than expected utilization level per capita, with longer stays, the Manitoba government attempted to acknowledge and address some of the root causes of these differences. For example, the government of the day established rural physician recruitment and retention strategies, and emergency services payment structures in order to address physician departures or under-resourcing in rural areas (Lyttle, 1997). Participants from Community C stated that

- With more changes within the health care system, there's always the worry about trying to get a doctor; and
- We still struggle to get doctors and we always will...I don't think health reform really changed that at all.

Data on the current state of hospital crowding, waiting lists, delays, and denials of medical procedures do not yet indicate a significant increase in health-care outcomes, despite significantly higher spending levels for health care in Manitoba (CIHI, 2002d; Roos, 2000a). As of 1998, there was a net reduction of 1317 acute care beds (reducing the ratio of acute care beds from 4.8 per 1,000 persons to 3.6 per 1,000) and an addition of nearly 500 new and replacement long term care beds. In addition, acute psychiatry beds were reduced and replaced by a wide range of community-based services in the reformed health care system. (Manitoba Health, 1993; 1998). Of note, the participants from Community C stated that the personal care home (long term care) was a significant feature in their community as it enables "people who are working and can't care for aging parents" to have them remain in the community and be taken care of.

Undeniably, the closures and service reconfigurations were reflected in the Manitoba media under headlines such as "We're at breaking point,' HSC doctor warns" (Oswald, 1994) and "City braces for ER crisis: Patients will likely suffer winter bed shortage, Government admits." (Jacques, 1994). As stated previously, Sheps, Reid, et al. (2000) concluded that there have been minimal adverse effects associated with the reduction in acute care services, that the reductions in acute care services coincide with public policy goals of (and citizen preferences for) shifting care "closer to home," and that longer term hospital stays are being reserved for those who are sicker. Brownell and Hamilton (1999) report that hospitals cared for the same volume of patients with fewer beds by delivering care in different ways (e.g., by shifting care from inpatient to outpatient settings). As well, they report that the quality of care (measured rather crudely by hospital readmission rates) and the health of Manitobans (measured rather crudely by premature mortality, that is, deaths before age 75) were unaffected by the bed closures. Grant (2000) refutes this argument by stating that the data collection methods are not eliciting the imperatives dictated by the requirements of the system – reliance on the health care system.

A generally decreasing pattern of hospital utilization over the eight fiscal years was observed by Carriere, Roos, and Dover (2000), with decreases greater in the post-reform period ($p<.001$). In addition, these researchers reported that short stays rates were significantly reduced in the reform years (1992-1996) compared to the previous three years ($p< .0001$), for the entire population. Overall, rates of individuals hospitalized, hospital discharges, and length of hospital stay for all Manitobans declined more in the post-reform period than in the pre-reform period (the largest p-value < .001).

Hence, according to Carriere, Roos, and Dover (2000), health reform markedly accelerated declines in in-hospital utilization. According to these authors, prior to the cuts, all institutions were operating at occupancy rates greater than 75 percent, and these have not significantly changed despite reduction in bed numbers. Comparing the 1996 to 1989 ratios and the pre-post health reform rates, the reduction in days of hospitalization were found to be more dramatically lower in the post reform period, despite a less dramatic reduction in the number of admissions and discharges (Black, Roos, Francoo, & Martens, 1999). Lix, Newburn-Cook, Roos, and Derksen (2002) reported that, between 1985 and 2000, hospital admissions and physician visits in Manitoba remained stable despite major bed closures and an aging population with a decrease in hospital days per capita observed in all regions. This finding was further supported by these authors through evidence that days of hospitalization decreased by an estimated 24% between the pre and post reform time periods. Despite bed closures, there were dramatic increases in the numbers of high-profile surgical procedures, such as angioplasty, bypass, and cataract surgery (Roos, 2000a). Additionally, no increase in readmissions, and in emergency department or physician office visits in the 30 days after hospital discharge were noted.

The picture in rural Manitoba in the mid 1990s was one of small facilities with occupancy rates of less than 50% of which over two-thirds were admissions for non-acute care purposes (DeCoster, Peterson, & Kasian, 1996; Government of Manitoba, 1995). Participants acknowledged that in Community C's hospital, some service areas (i.e., operating room and obstetrics) were never used to capacity, even prior to health reform.

Despite the apparent lack of empirical evidence of negative effects of health reform in rural Manitoba on the health of residents, this study's participants in Community C displayed wide variability in their satisfaction with current health services. For example,

- It (health reform) just isn't working well; and
- I think there's been some improvements...you're going to get positives and negatives with anything.

And, regardless of the service mix or board structure, there was a cognizance of the pervasive meaning of living in small town Manitoba with the comment

- (People) might know when you flush the toilet, but they know when you need help and they're there.

DYS-integration to Reintegration

The focus of the "DYS-integration to reintegration" theme rests within the explicit objective of the health renewal/reform agenda to "encourage communities to come together . . . to co-ordinate and integrate their health care services" (Government of Saskatchewan, 1992, p. 4). Honourable Louise Simard stated that reform will take place in a spirit of ". . . mutual aid, partnership and cooperation . . . the Saskatchewan way" (Saskatchewan Health, p. 4). According to Simard (1997), "restructuring (health renewal) was only the vehicle to bring us closer to a revitalized, better co-ordinated and integrated health system" (p. 83). Some have referred to this inclusive and expansive continuum of health care services as "upstream service" (Kouri, 2000).

One participant in the current study from Community B indicated that "the nice part – the concept we liked out of the whole package (was) the wellness model . . . (but) nothing happened". Rather, some participants indicated that there has been "a loss of control of our health care" as a result of health reform/renewal.

According to Tregunna, Canadian Hospital Association's director of policy development, "by linking the various services...there will be a better flow of patients and clients through all types of health care services" (Kinross, 1992, p. 5). A recurring message focused on getting people both inside and outside the health care system to stop thinking only about beds and hospitals and start thinking about services and resources for health. To the extent that the early focus on attention was almost by necessity on producing financial reductions, the ability to shift rather than just reduce resources was identified as key (Casebeer & Hannah, 1996). However, Leatt and Nickoloff (2001) suggested that regional health organizations may have reduced some of the problems of uncoordinated care, but it is not clear whether it has improved integration of many patient-care processes. Focus group participants from Community C recognized that under the regional model, the RHA administration and board "can look at things in a broader picture...not just focusing on (our town)".

In *A Planning Framework*, Manitoba Health (1992) describes the need for a shift "from reliance on government to partnership with the community." *Quality Health for Manitobans: The Action Plan*, includes the following as goals of health reform: "to promote reasonable public expectations of health care . . . [and] to promote delivery of alternative and less expensive services" (p. 2).

One of the basic tenets of regionalization is that the health system will become more effective when a broader range of health services falls under a single governance structure. The thinking is that the wide range of healthcare services and providers will work together instead of competitively, thus avoiding duplication and making the system more accessible. In 2001, the CCARH (2003) carried out a survey of board members and CEOs of regional health authorities across Canada. The survey indicated there is continuing widespread support for the direction health reform has taken, including the incorporation of a broadened definition of health care.

Within the reformed system in Manitoba, a number of initiatives were evident as demonstrating the integration of services under the new model. The Physician Resource Committee, which was established in 1994, remains key in the recruitment of physicians and specialists to Manitoba and, specifically, to rural centres (MCPH, 2003). The establishment of extensive outreach programs (i.e., breast screening; dialysis) and Telehealth (i.e., 21 sites) between 1994 and 1999 have also been linked to the evolving health care system (Government of Manitoba, 2003). In 1997, rural health authorities assumed responsibility for Home Care Services delivery further facilitating regions in their efforts to integrate their acute and community services (MCPH, 2003). In Community C, participants felt that public health services benefited from the regionalization approach. However, there continue to be difficulties with access in the community to mental health services and physiotherapy.

Although the integration of services is perhaps the least contentious aspect of regionalization, its implementation has not been without problems. In some cases, changes have been brought in without adequate planning so the stress associated with the resulting role changes has caused formal and informal provider dissatisfaction and labour conflict in many jurisdictions (Kouri, 2000). In other cases, the issue of target groups such as women as active participants within the new board structure has been at issue. In Saskatchewan, where health board members are a combination of elected and appointed officials, the number of women directly involved in the decision making has increased substantially (Willson & Howard, 2000).

Rural women clearly perceive problems with the way the health care system is organized and managed, under the guise of integration, especially in light of the shift from the institutions into the community and the home (Fast & Keating, 2000; Roberts & Falk, 2001). According to participants from Community A, "you never know who's in charge…no one seems to know anything (about health care services)". According to participants from Community B, "(reform/renewal) has made us aware of how much the need is for care here". The shift from institutional to community and home care has created new demands on informal caregivers" (Willson & Howard, 2000). The implication was that by freeing up health resources from institutional care, these other health needs could be addressed. Research on the impact of health reforms, and in particular the shift of health care from institutions to the community and the home has not, for the most part, examined how lay providers (many of whom are women) are directly affected by policies such as early release from hospital and the shift toward outpatient care (Fast & Keating).

Eighty-two percent of district budgets in 1996/97 went to institutional services, such as hospitals and nursing homes, compared to 89% in 1991/92 with the difference redirected to home and community services (Saskatchewan Health, 1996). In 1997/98, the Saskatchewan government spent $67.8 million on home care, which represented 4.2% of the total provincial health budget (Saskatchewan Health, 1998). Saskatchewan Health (1998) notes that between 1991/92 and 1997/98, the amount of home care services have increased by 44%. Although there are no fees for certain services (i.e., nurses, case managers, therapists), fees are charged for homemaking, meals and home maintenance services. In Community A, the participants found no significant change in the number of professionals or health services offered except a slight increase in home care and public health. In Community B, the participants found that physicians were leaving, and there were only minor increases in specialists such as a diabetes educator. It was a further concern of this group that the job description given to home health care workers prevented people "from staying in their homes and being taken care of".

Manitoba was the first province to introduce a comprehensive system of continuing care in 1974. The Home Care Program is part of a continuum of services that include respite services, day programs and personal care homes. Previously operated under the

Office of Continuing Care within Manitoba Health, RHAs took control of the Home Care Program in 1998. Between 1989/90 and 1996/97 home care clients increased by 23% (Health Canada, 1997). Table 31 presents the trends in home care between 1994/95 and 2000/2001. While the number of home care clients is increasing, there is also a continuing trend toward the provision of more acute care in the home. Since 1996/97 the provision of nursing services in the home increased by 15% and the provision of personal services, such as assistance with bathing, has increased by 22%. In 1997/98, home care expenditures totaled $123,942,100 or about $4,000 per client (Manitoba Health, 1998).

Table 31

Home Care Trends in Manitoba 1994/95-2000/01

Year	**1994/95 – 1995/96**	**1999/2000 – 2000/2001**
New Cases (per 1000)	14.8	16.3
Open Cases (per 1000)	30.8	42.7
Closed Cases (per 1000)	12.1	15.8

Adapted from MCPH (2002).

In Manitoba, the provision of home care services is mostly provided by the public system, without additional user fees. This system includes case coordinators, managers, nurses, home care attendants and homemakers. There are also a number of private, for-profit companies that provide home care services, such as nursing, companionship, meal preparation, personal care and cleaning. These services are paid for by the consumer and may be covered by private insurance.

"Unpaid caregivers report feeling that the responsibilities and pressures of care frequently had been transferred to them, with little recognition of, or value for, the work they were engaged in on a daily basis" (Payne, Grant, & Gregory, 2001, p. 4). According to Lees (1997), Hillman (2000), and Donner, Busch, and Fontaine (2000), it is critical that the health care system recognize that unpaid caregivers (mostly women) have multiple roles: spouses, children, careers, friends, and other relatives. With little or no guidance, teaching or follow-up, the work these women did often exacted a high price. Reduced personal physical and emotional well-being, social isolation, and financial hardships were directly attributed to their work as carers (Lees, 1997; Payne, Grant, & Gregory, 2001). According to the Women and Health Reform Working Group (1997), when government health reforms emphasized "partnerships with the community, women are often the partners . . . expected to provide more care at home doing so without sufficient support services (p. 8). Community A participants indicated that the elderly and the chronically ill (i.e., dialysis clients) were concerns regarding frequent trips for health care services in statements such as

- I know if he (the patient) was my dad, I could not take him that much (to the city). I cannot take that much time off; and
- My mom is getting more and more frail. She is needing to get to a doctor more often and I don't mind helping, but it takes time and we all know that the cows don't feed themselves when we get stuck in the city. Even our kids suffer, because we are away with mom.

Participants in this study in Community B reflected on the changes resulting from the health reform/renewal changes experienced. For example,

- We have to drive to (larger city) to see a foot doctor . . . she used to come here . . . so 20 of us can drive (to the services) instead of one of them driving here;
- Sometimes the hospital will not give you drugs. We had to go to (larger community) to buy drugs and come back to get the hospital to administer them; and
- You have to hire other people to come in to do (home care).

According to Donner (2001), in one rural health region in Manitoba, 70% of women reported their lives were stressful with the three major causes of stress reported being money (35.2%), health of others (33.0%) and personal health (19.5%). Community C participants indicated that for some "it's been a bit more driving into (larger community) and there's lots of widows in this town, so we do the driving for appointments".

Lewis and Fooks (2002) state that "the jury is still out as to whether (the reformed health environment) has achieved the goals of better integration and improved population health" (p. 7). Lewis (1997) indicated that "conceivably boards could reallocate major portions of their budgets towards determinants such as economic development, educational upgrading . . . (but this is) in practice entirely unrealistic given the expectation that sickness care services will be maintained and improved, and in light of the roles of others in the determinants realm" (p. 2). Women in Community A stated that they have "learned to move on...because in rural Saskatchewan you are always unsure about things . . . so what else could we do?" At best, the renewed/ reformed health care system in Saskatchewan and Manitoba allows for more joint or intersectoral planning; it falls short of being able to address issues such as employment, economic policies, and many of the broad determinants of health.

Silence to Voiced

The focus of the "silence to voiced" theme rests within the explicit objective of the health renewal/reform agenda to increase citizen participation in the reconfigured health system.

In Saskatchewan, the vision was for a renewed health system emphasizing the community input, community values, community involvement, and a community-driven health care system (Government of Saskatchewan, 1992). So, the government's charge to the communities was to ask them to "organize on a district basis, to coordinate and integrate their health services" (Government of Saskatchewan). The Saskatchewan Vision for Health (Saskatchewan Health, 1992) encapsulated the proposed changes associated with health reform/renewal in the statement that "a community-based and community directed health system is being developed to place health decisions in the hands of Saskatchewan people" (p. 4).

Participants from Community A emphasized the need, in the health reform/renewal process, to have "a good spokesperson . . . a local (person) so then everyone buys in". This emphasis for good leadership was also reflected in comments from Community B participants who stated that "a leader . . . strong individuals that are community minded" are essential. In the case of this community, Mrs. C and her son were seen as filling this role. These individuals were seen as "fighting for us". Also, these individuals felt that it was important that the community "speak out . . . and send out lots of information . . . because the more you challenge, the more the district and the political people back off". From the perspective of participants from Community C, it was imperative in the health reform/renewal process to include lots of talk about what was going on. Further, they felt that their community action was important. This finding is in contrast to the experience of the participants from Community B who indicated that they were not listened to during health reform/renewal introduction. For example,

- We were treated like children...no choices, no options;
- Government should have listened to our ideas before acting; they would have made better decisions if they would have listened to us; and
- They (government) made you feel as if you don't know anything any moreThey make you feel as if you have no voice in anything.

Also, it was expressed that the community had to be mobilized, inclusive, and focused "on one or two things (really needed) – not everything". Community mobilization was encompassed in comments such as

- (Town hall meetings) wouldn't have happened if it weren't for the people in the area; and
- (People should) attend – nothing happens if you don't get people out – whether you are for it or against it go to the meetings.

Inclusiveness was further addressed in the comment that

- We have a wide range of ages (in our community)...we all have a voice.

Lomas (1990) pointed out that more attention to public beliefs and participation in both the context of health policy and the structure of research use required. Health board efforts to inform and obtain input from their communities can be seen as attempts to create and interact with an informed and involved citizenry. However, there does not appear to be a clear direction as to the most appropriate methods for effective public participation. Clearly, there is a difference between involving the public in their role as current or potential users of the system, such as through satisfaction surveys, and fully involving them as citizens participating in priority-setting for the system (Casebeer & Hannah, 1996). The latter objective requires methods that allow more deliberation, using a wider range of information and is the more difficult to achieve. In 2002, the CCARH (2002) surveyed regional health authorities in most provinces about their public-participation practices and found that merely one quarter involved the public in resource allocation decisions. Of note, in a survey of Saskatchewan health board members, only 19% indicated improved communication with the community is a sign of success (Kouri, Dutchak, & Lewis, 1997).

Among the political goals of regionalization is to create greater citizen awareness of and participation in health and health care issues and decisions (Lewis, 1997). The question remains whether or not health reform/renewal has led to achieving this goal in Saskatchewan.

Study participants in Community B indicated that they lacked "power over government to change things" and often felt that what was needed was "discussion not them (government) preaching to us". In addition, the participants felt that they were balanced in their approach to government in statements such as "we didn't just go there (to public meetings) to criticize but we also told them how they could make it (health care) better".

"Although some communities continue to struggle with changes to health care delivery, others appear to have adapted as a result of strong community leadership, the development of widely accepted alternative services, and local support and voice in creating innovative solutions" (HSURC, 1999, p. 1). In a survey of Saskatchewan health board members it was clear that they envisioned "their desired relationships and communication with residents more in the direction of education than of political interchange" (Kouri, 1999, p. 139). Sixty three percent of health board members state the level of local control in Saskatchewan's health system has increased (Kouri, Dutchak, & Lewis, 1997); and 69% state that their board decisions are affected by the people in their community.

Despite this Saskatchewan board perspective on the focus on citizen participation, Pollara (2000b) found that, in Canada, 64% of the public voiced dissatisfaction with their level of input on decisions about the future of health care. In addition, the majority of decision makers felt that residents had a tendency to bypass health boards and present their concerns to the respective provincial ministry (CCARH, 2003).

Residents of the affected communities and their district health boards differ considerably in their opinions about the need for and benefits of health reform in Saskatchewan. District health board members indicated that health reform/renewal outcomes had been positive and that both decision making processes and health status had improved (Kouri, Dutchak, & Lewis, 1997). In contrast, community members continued to express concerns that resources will continue to be inappropriately allocated, and that real issues of health care will remain mired in rhetoric and fallacy (HSURC, 1999).

Participants in Community B indicated that it was imperative for members of the public to "stay informed…and don't get hung up on the rumour mill".

In 2001, the CCARH carried out a survey of board members and CEOs of regional health authorities across Canada, the majority of respondents contend that regional health authorities are still unduly hampered by government restrictions. For them, the devolution of authority has not been fully realized. The results also show considerable and growing dissatisfaction with the uncertainty about authority and accountability. Within Community C participants, individuals indicated that accountability lacks. According to deSantis (1998), "something terribly wrong has happened since the implementation of health reform. Health reforms were supposed to empower the community owned health districts, instead, today there is the realization that such districts have become instruments of the centralized and autocratic health policies of the Government" (p. 1).

Participants from Community C indicated ongoing frustration and confusion related to the RHA and board decisions in statements such as

- (We should not) have to go all the way to the top guy in our RHA when it's something really simple that should have been handled at the local level; and
- There's no local board, so if anybody's got a problem, who do we have to go to?

Rasmussen (2001) argues that the devolution of authority to smaller authorities makes the health care system more vulnerable to local interest groups. In fact, one third (32 %) of board members feel that public pressure sometimes forces the board to make decisions they would not otherwise make (Kouri, Dutchak, & Lewis, 1997). In Manitoba, the regional health authorities are charged with responsibilities for assessing and prioritizing health needs of local residents, ensuring effective health planning and service delivery, and managing an integrated health care system within their own regions (Roberts & Falk, 2001). According to Community C participants, their opinion is that "we'll never really be successful unless we have a board from our community".

They state that there is a need for more local input into the RHA boards, however, "appointments to the board should have been able to find people who were there to help us, not just because they belong to the right party".

Pollara (2000b) found that, in Canada, 64% of the public voiced dissatisfaction with their level of input on decisions about the future of health care. In addition, the majority of decision makers felt that residents had a tendency to bypass health boards and present their concerns to the respective provincial ministry (CCARH, 2003). Community C participants indicated that "politicians need to listen to the people who know (i.e., nurses, local representatives). Further, the study participants clearly indicated that communication with the RHA was extremely problematic. They stated that

- The 'higher ups' (i.e., RHA) don't listen to the people ... there is lots of administration, so communication up or down is difficult; and
- (We need) some kind of local organizations, it's too big of a jump from a local hospital or personal care home to the RHA.

Among the political goals of regionalization is to create greater citizen awareness of and participation in health and health care issues and decisions (Lewis, 1997). However, there is no specific provision for gender equality in board appointments. Women are under-represented on these governance structures in Manitoba with less than 40% of board members being female (Boscoe, 1999); whereas, in Saskatchewan, 188 out of 367 or 51% of board members are female (Saskatchewan Health, 1999). Despite this fact, the Saskatchewan participants in the Community A focus group felt that there were not many women on the new health board, and it was important to "get more women involved in the decisions, since we are out there caring for everyone in our community". In the case of the PRHA board, there was 33% female representation at the time of initial appointments (PHRA, 1997).

In 1999, Manitoba Health announced the formation of a Women's Health Unit within the department with the responsibility to establish an effective mechanism for women to influence the health care system...through the representation and participation of women in decision making roles in health care and health policy (Women's Directorate, 2001). According to Donner (2001), the recently endorsed

Women's Health Strategy formalizes the government's commitment to work with regional health authorities to promote gender-based analysis, planning, and awareness.

Closing vignettes

Community A

> No government policy ever looks at (rural women) us. After all we don't get looked at for the work we do, we don't exist for loans and special programs, so why worry about us? Am I being cynical – you bet. It's the way of the land if you are a rural woman, always a silent partner and not entitled, so they think.
>
> We are people and unless you start to talk to us about these changes you are missing out. We have ideas about the direction and goals, so it's wrong not to include us. But do they care? Not on your life. Besides how could they meet our needs if they don't even know what they are? Yeh - like we count!

Community B

> Here in our rural communities we don't have all the services and programs you do in the city. So, if a family member is sick you have to do the driving, home care, feeding, and sometimes even making appointments. There isn't anyone to do all that for us. So you spend more time than ever doing these things just because you live in the rural area. Doesn't seem fair does it? Meanwhile the rest of the world goes 'round we're dying here in rural Saskatchewan – maybe even rural Canada. We do lots of things to make ends meet in our family and some experience in the other areas seems as screwy as in health care. I guess the biggest concern is where the future is. It's pretty scary right now but everything we keep hearing is it's going to get worse and tighter.

Community C

> Depending on what is on the political agenda...when you live in a small town as soon as you start hearing rumors and rumblings you immediately panic because small towns (they come up) with whatever kind of statistics they need to come up with (to fulfill the agenda). It

> seems we're the first ones to get hit in the rural areas – in the rural small towns. We're the first ones to get hit and the last ones to get services.

Within Case Findings

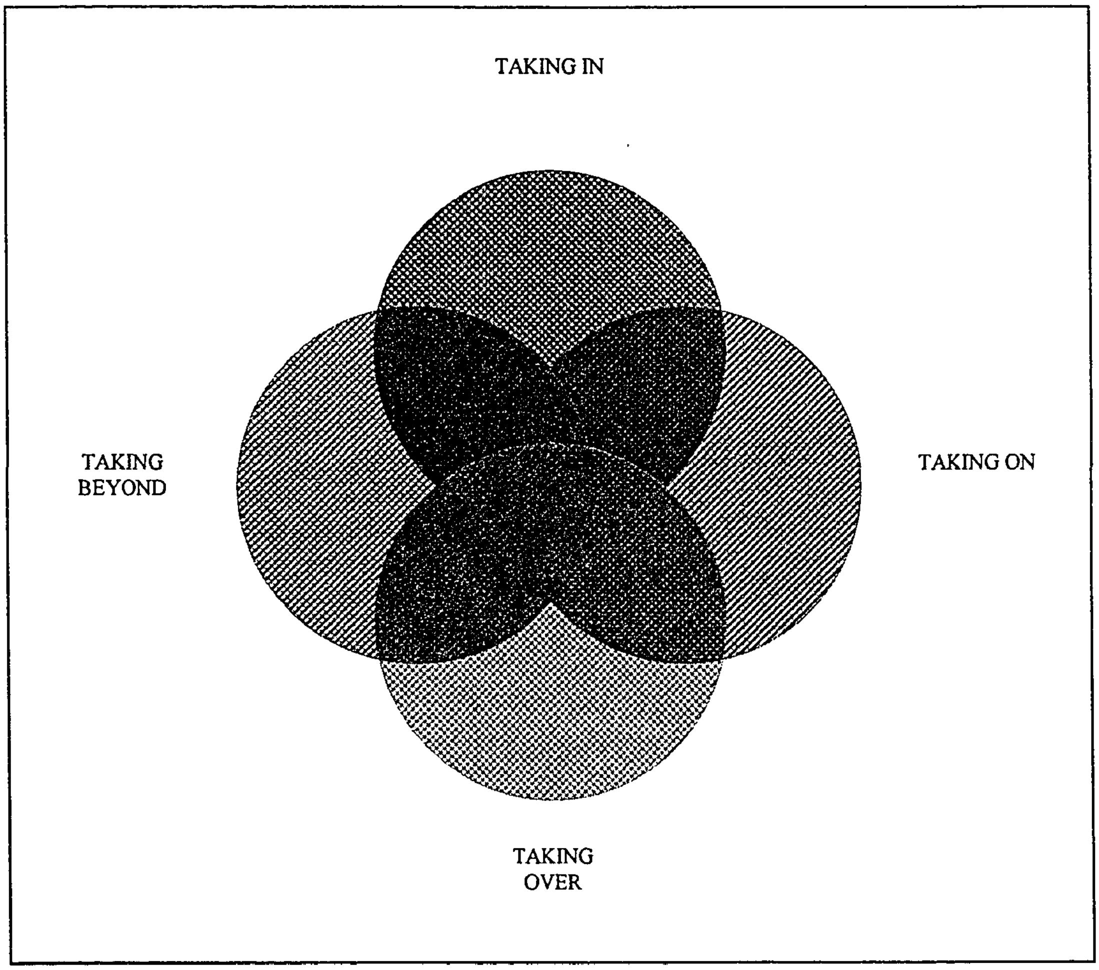
The within case assessment will be analyzed using two strategies. The first strategy is a focus on the synthesis of the data by considering the source (i.e., policy maker, policy implementer, and community) and the nature of the impacts (i.e., intended or unintended). In this study the policy maker source is government; policy implementer is the health district or region; and community is one of the three selected communities. The second strategy is a four phase model grounded in the data, entitled the Integrated Community Policy Uptake Model (see Figure 7) which reflects the stages rural women in the three communities of interest experienced during the health reform/renewal policy operationalization. Many of the attributes of this model align with the policy cycle literature referred to earlier in this document.

The four phases are entitled 'Taking In', 'Taking On', 'Taking Over', and 'Taking Beyond'. Diagrammatically, the Integrated Community Policy Uptake model is depicted in Figure 7. Each phase will be described below; including key activities and comparisons with the policy cycle. The overlapping of the various phases are critical as they demonstrate that each phases informs or impacts the others – creating an integrated model of community experience of policy change. Following the descriptions, a matrix of review and potential applications of the both models to the cases is included (see Tables 29, 30, and 31). Finally, a brief comment on the elements of the emergent model which potentially merit ongoing research will be provided.

'Taking In' Phase

There was a consistent and clear indication that at the onset of the health reform/renewal process there was a phase referred to, in this model, as 'taking in'. Taking in is the interval during which the community collects information about the policy change from all sources (i.e., formal and informal). This phase focuses on the initial awareness or suggestion of a pending change as experienced by the community. This phase aligns primarily with the communication of policy phase in the policy cycle, which intimates that the community has been 'left out' of the initial stages (i.e., issue identification, exploration of policy options, policy adoption).

Figure 7. Integrated community policy uptake model.



In the case of Saskatchewan, the participants indicated this phase began with the government's announcements of health reform and renewal. In Manitoba, there was evidence that the taking in phase began when the Saskatchewan movements occurred. The latter was attributed to the concern that the proximity and similarities in the provinces would likely lead to a similar policy pathway.

During this phase, the women involved in this study indicated that they felt they were getting information from a variety of sources – both formal and informal. It was apparent that all information, regardless of source, was taken under consideration. This phase was critical, according to the participants, in bringing the issues and pending changes to the fore in terms of discussion, and debate. It raised attention and attuned people to the possibilities of future information on this issue.

From this study, it appeared that the taking in phase was fairly short in duration and of high intensity (i.e., plenty of community involvement), although participants were not specifically requested to report on the duration of events but rather on sequencing. It appeared to be a period of separating the wheat from the chaff of information. In this case, it was typified by the women as an emotional and highly charged time period replete with confusion and frustration. Key activities in the taking in phase include listening, talking, and seeking information from various sources which reflects what Kulig (1999) discusses respecting the need for issues to be identified by all individuals and groups within the community.

'Taking On' Phase

The participants in this study indicated that community mobilization and challenging the policy makers was imperative. The taking on phase appeared to bring about the first efforts in mobilization and challenging. It was typified by community meetings, rallies, extensive media activity, and meetings with government officials both in the community and beyond. During this phase, the women suggested that the 'fight' was on to preserve whatever elements of health care services they could. This phase continues to align with the communication phase of the policy cycle.

The taking on phase was critical in determining the scope and range of changes in the particular community. It was emphasized that the taking on phase potentially posited the community as being tenacious and yielded community leaders. Conversely, one community felt that they fell short in this phase and gave up more than should have been yielded.

From this study it appeared that the taking on phase persisted as long as the community could sustain the effort. Even as some elements of the health policy were implemented, some communities continued to take on subsequent or unresolved issues. In this study, the taking on phase was typified by anger, frustration, and fear. The communities, which sustained their taking on, emphasized the importance of community leadership and full community support/ participation (i.e., town hall meetings). Key activities in the taking on phase include clarification of the proposed changes, remaining vocal, aggressively challenging proposals, seeking community leadership, and mobilizing the community at large to react.

'Taking Over' Phase

In the third phase of this model, there appeared to be a level of resolve to take the situation presented and individualize it to the specific community. The 'taking over' phase, according to the women, began when the community undertook to move forward. In this phase, the community identified the "non-negotiables" and the "needs" for their health care and worked on preserving those elements. The participants spoke of coming together as a community and working together.

The taking over phase was critical to establishing a sense of ownership and control by the respective community regarding their health and health care. It was the period in which a community individualized the resulting programs and services to be responsive to the specific community. This phase aligned with the implementation phase of the policy cycle, although the emphasis in the traditional model is on bureaucratic and formal implementers (i.e., health district/regional authorities).

From this study, it was apparent that some communities and individuals remained in this phase, especially in light of future/pending health reform/renewal initiatives. Despite these efforts to affect the implementation of the policy, all communities felt it was "too little, too late". No community indicated achievement of what they wanted in the implementation process, and, more significantly, no community indicated a sense of control (real or perceived) in the policy process.

Key activities in the taking over phase include formal and community sanctioned representative participation in decision making mechanisms, active community generated proposals and initiatives, and independent collection and control of community generated interests (i.e., funds). Formal participation included ensuring participation on the district or health board of a local representative. Community sanctioned participation included activities on advisory boards or retention of local committees to ensure the continued presentation of the community's perspectives. Of concern to the community was retention of control of community donations to support health related activities.

'Taking Beyond' Phase

In this phase there is evidence of a depth of understanding of the learnings and experience of the health reform/renewal process which the participants were able to anticipate or extrapolate to future changes (within health and beyond), as well as to other groups or communities. The taking beyond phase was evidenced in this study as a broader application of lessons learned from this encounter with policy change.

This phase aligns, in part, with the evaluation phase of the policy cycle. Both seek to consider what is working and what is not working within the new policy in order to inform future policy initiatives.

In this phase, the community identified that the various rural sectors (i.e., schools, agriculture) are all potentially facing policy evolutions given the rural contextual challenges addressed earlier in this document. The participants spoke of anticipating reforms in other sectors and other communities and working together to respond quickly and decisively. The communities suggested that getting involved early is critical, ensuring full community participation, and finding a local champion/ spokesperson were key elements. Of note, taking beyond was seen as part of the community's existing or developing capacity.

From this study, it was apparent that not all individuals or communities achieved this phase. For the individuals and communities still fighting the singular policy issue of health, it was evident that they were not ready to move into other domains. Whether this was due to their immersion in their present reality, or other factors, is unclear and beyond the scope of this study.

The taking beyond phase was critical to establishing a future visioning for community and rural sustainability for health care and other services. It was the period in which participants were able to see beyond the current policy change and predict future areas of vulnerability to change. Key activities in the taking beyond phase include participation in other forums or seeking opportunities to extend learnings to new areas, brainstorming, willingness to share learnings and experiences with others confronted with similar challenges, and evidence of using strategies and techniques learned from the present experience in new applications.

Application

The following matrices (Tables 32, 33, and 34) provide examples of the responses by various participants and health districts/regions in each community that represent the phases of the integrated model.

Table 32

Matrix of Within Case Assessment – Community A

Phase	Potential Actions	Community A	Impacts	Themes
Taking In	Ask questions, seek clarification; Communication; Seek out person(s) or agencies with the correct information	**Policy Maker (Government)** Introduction of Act within the context of CHA; Delineation of health renewal principles; Cognizance and clarification of demographic & health statistical trends **Policy Implementer (District)** Media (print, TV); SARM convention; Access to Government consultant; Review/Implement Government documents/Hansard directives; Public meeting with government health officials **Community** "lots of phone in (shows) on the radio" "lots of misinformation" "best information came at the public meetings" "Not much (information) coming to us – just them putting their master plan into action" "coffee row talk" Over 50% felt health services would be lost in the process (survey)	**Intended** **PM** – Clear messaging; Compliance with CHA (principles & financial); 'Second phase of Medicare' vision **PI** – Clear Messaging; Clarification of mandate and timelines **C** – Open dialogue and opportunity for input and direction setting for the community **Unintended** **C** - Public disillusionment & uncertainty with health reform agenda Distrust of the message regarding health reform Articulation of fear, anxiety, and uncertainty regarding health reform Preference for traditional sources of information	**Disconnect** **Dys-integration**
Taking On	Identify and priorize community needs and gather information to support these needs; Select spokesperson(s)	**Policy Maker (Government)** Debate of Act; Provision of inceptional documents; Health region boundary negotiations; Appoint district health board; Delineation and	**Intended** **PM** – Facilitate community participation – place decisions in the hands of Saskatchewan people; Vision	**Disconnect** **Silence** **Irrational**

	who are knowledgeable and facilitative	uptake of government responsibilities; Establish needs based funding **Policy Implementer (District)** Media; 12 member appointed board; Board Meetings; District Needs Assessment; Consider demographic and health statistics of district; Assemble management team; Enact closures/conversions; Delineation and uptake of district responsibilities **Community** "people were mad – damn mad about what was going on" "Dr A. was appoint to the board – so we had a good spokesman for our town" "many became involved – being vocal" "a few (former) board members were pretty vocal" "Health reform – right (we are) sick of having to beg for a dollar to keep our services" "we came out to all the meetings and public stuff (about the district)" "health reform means bad things for our town. It means less things for our town" "It does not happen just overnight – time for us to get together and plan. Everyone got together and put ideas out" "hire a (local) spokesperson...someone to talk for you and keep your interest in the (fore)front" 56.5% of residents rated health as very good to excellent (National 61.4%) 83% of residents indicated satisfaction with health services pre-reform versus 34% post-reform Community consultations	of wellness supplants illness model; Gain public confidence in health reform agenda **PI** – Establish overall direction for health district (outcomes; effectiveness) Conversion of 3 facilities C – Retain health services **Unintended** **PM** – Emergence of 32 small health regions C – Significant public activities to protect community interests Perception of prearranged process Dissatisfaction with health service level and funding arrangements Perception of predominance of losses due to health reform Emergence of informal or non-sanctioned mechanisms to act on community's behalf	

		not legitimate (prearranged outcomes)		
Taking Over	Build consensus within the community as to the ‘acceptables’ and work on maximizing these for the community’s overall well-being; Demonstrate a community willingness to move forward on key issues in partnership with the other stakeholders	**Policy Maker (Government)** Bed targets (acute and long term); Reporting responsibilities articulated **Policy Implementer (District)** Advisory Committee; Community based district meetings; Annual reports; Accreditation teams: Addressing policy and funding expectations - accountability **Community** “formed a couple of groups – one to deal with the district and the other to keep our money in the community” “we got some people together and well they just didn’t let anything go” No significant change in the number of professionals or health services – except increase in home care and public health 89% of Saskatchewan people felt health reform had no effect on their health status 74% of Saskatchewan people felt their service use had stayed the same of increased since health reform 50% felt reduction in personal health	**Intended** **PM –** Appropriate service mix Different solutions in different communities based on needs **PI** – Operational and programmatic efficiencies Accountability in program and finance plans Ability to respond to communities in accordance with unique health needs **C** –Retention of professionals and health services with change in types of professionals and health services offered Services continued to exist and meet needs of the community **Unintended** **PI** –hospital utilization and long term care bed numbers continue to exceed standards **C** – Dissatisfaction with health services and lack of supports (i.e., caregiving, job losses)	**Reintegration** **Voiced**
Taking Beyond	Participate with other communities and other sectors in	**Policy Maker (Government)** *The Regional Health Services Act*	**Intended** **PM** – Further consolidation of health reform;	**Connect** **Reintegration**

	linking, sharing, and strategizing for overall rural well-being; Provide presentations at rural forums highlighting unique and successful strategies	**Policy Implementer (District)** Intersectoral and interdistrict services **Community** "we have ideas about the direction and goals of policy, so its wrong not to include us" "learned to move on...because in rural Saskatchewan you are always unsure about things"	Address issue identification (i.e., sustainability of regions) **PI** – Recognition and fostering of non-traditional relationships **Unintended** **C** – Frustration with the lack of inclusiveness; Continued uncertainty leading to potential complacency.	

Table 33

Matrix of Within Case Assessment – Community B

Phase	**Potential Actions**	**Community B**	**Impacts**	**Themes**
Taking In	Ask questions, seek clarification; Communication; Seek out person(s) or agencies with the correct information	**Policy Maker (Government)** Introduction of Act within the context of CHA; Delineation of health renewal principles; Cognizance and clarification of demographic & health statistical trends **Policy Implementer (District)** Media; Government press releases/Hansard; Meetings with the health department; District formation meetings; District Annual Reports **Community** "People were so unhappy and wanting to know more information" "really no say, it was too far gone by then (when we had the first meetings about health reform)	**Intended** **PM** – Clear messaging; Compliance with CHA (principles & financial); 'Second phase of Medicare' vision **PI** – Clear Messaging; Clarification of mandate and timelines **C** – Open dialogue and opportunity for input and direction setting for the community **Unintended** **C** – Isolation and alienation from the process Reliance on traditional sources of information	**Disconnect** **Silence**

		“lots of confusion … rumours” “we were isolated” “we were scared, uncertain” “Looked to former hospital board members” “Mostly word of mouth” “Newspaper (had) some things about health care”	Perceptions of negative emotions related to health reform	
Taking On	Identify and priorize community needs and gather information to support these needs; Articulate needs; Select spokesperson(s) who are knowledgeable and facilitative	**Policy Maker (Government)** Debate of Act; Provision of inceptional documents; Health region boundary negotiations; Appoint district health board; Delineation and uptake of government responsibilities; Establish needs based funding **Policy Implementer (District)** Needs Assessment documents; public meetings; delimiting boundaries and services; new board process; District Annual Reports; Media **Community** “Mr. A ran around to meetings galore” “Mrs. C. & her son…headed a kind of committee (to get) information out to everyone” “Talking about what district it was smartest to go with” “The district didn’t affect us that much – not as much as losing out hospital status” “Everyone was talking…No one was going to sit there and lose our health care – not just the hospital, but everything was going to	**Intended** **PM** – Facilitate community participation – place decisions in the hands of Saskatchewan people; Vision of wellness supplants illness model; Gain public confidence in health reform agenda **PI** – Establish overall direction for health district (outcomes; effectiveness) Conversion of 3 facilities **C** – Retain health services Anticipation of a wellness based health system **Unintended** **PM** – Emergence of 32 small health regions **C** – Significant public activities to protect community interests Dissatisfaction with health service level and funding arrangements Perception of predominance of	**Voiced** **Disconnect** **Irrational** **Dys-integration**

		go" "(confronted) Minister of Health and some government bureaucrat...in the community hall" "the city people came out here...making decisions for us" "presentations by local people ...were very positive" "this health reform stuff is killing our small towns – maybe it's a political move" "the concept we liked out of the whole package (was) the wellness model...(but) nothing happened" "by the time we got to the meeting, the decisions had already been made"	losses due to health reform Perception of preconceived process Perception of urban perspectives dominating health reform policy	
Taking Over	Build consensus within the community as to the 'acceptables' and work on maximizing these for the community's overall well-being; Demonstrate a community willingness to move forward on key issues in partnership with the other stakeholders	**Policy Maker (Government)** Bed targets (acute and long term); Reporting relationship established **Policy Implementer (District)** Needs assessment documents; public/board meetings; district newletters & annual reports; selected location of district office (not in Community B); Accountability and report to stakeholders and government **Community** "started a (local) committee to get everyone coming to (meetings)" "we held on to more status than we would have otherwise (i.e., had we not had the committee)" "they reopened some rooms at the nursing home (after we	**Intended** **PM** – Appropriate service mix Different solutions in different communities based on needs **PI** – Operational and programmatic efficiencies Accountability in program and finance plans Ability to respond to communities in accordance with unique health needs New accountability to stakeholders and government **Unintended** **PI** –hospital utilization and long term care	**Integration** **Rational** **Voiced**

		convinced them not) to move offices over there" "Organized a committee ... to give donations in our area indicating it on Donors choice (for local health care needs)" "we didn't just go there (to public meetings) to criticize but we also told them how they could make it (health care) better" "loss of the hospital... threatens the community" "I don't thing we fought hard enough" 161.2 LTC beds/1000 versus provincial average of 118 41% higher acute care utilization than national average	bed numbers continue to exceed standards **C** – Residual sense of failure or inability to affect change in the process for the community Awareness of people as community strength Emergence of informal or non-sanctioned mechanisms to act on community's behalf	
Taking Beyond	Participate with other communities and other sectors in linking, sharing, and strategizing for overall rural well-being; Provide presentations at rural forums highlighting unique and successful strategies; Recognize linkages to future policy developments	**Policy Maker (Government)** *The Regional Health Services Act* **Policy Implementer (District)** No evidence found **Community** "harder to get people to move into your community because of the unstable health care system" "inclusion...and attending....nothing happens if you don't get people out" "(government bureaucrats) should listen to our ideas before acting; they would make better decisions if they would listen to us" "we are just waiting because they're talking about new changes"	**Intended** **PM** – Further consolidation of health reform; Address issue identification (i.e., sustainability of regions) **Unintended** **C** – Perception of need to protect and advocate for your community constantly Perception of absence of true inclusion in the policy process	**Voiced** **Reintegration** **Reconnect**

Table 34

Matrix of Within Case Assessment – Community C

Phase	**Potential Actions**	**Community C**	**Impacts**	**Themes**
Taking In	Ask questions, seek clarification; Communication; Seek out person(s) or agencies with the correct information	**Policy Maker (Government)** Introduction of Act within the context of CHA; Delineation of health renewal principles; Cognizance and clarification of demographic & health statistical trends; Immediate configuration of 12 regional health boards **Policy Implementer (Region)** Department of Health; Government documents; Media **Community** "concern that, like in Saskatchewan, all of a sudden its over with and you have no control (of your health care)" "fear that more will be taken – afraid for our citizens" "people form the health department were out a couple of times" "on TV by politicians that "oh its so good; its better for you…imposing their beliefs" "got information from newspapers, media, former board members, health workers and…at town hall meetings"	**Intended** **PM** – Clear messaging; Compliance with CHA (principles & financial) Reduce inequalities in health status for Manitobans **PI** – Clear messaging; Clarification of mandate and timelines **C** – Open dialogue and opportunity for input and direction setting for the community **Unintended** **C** – Reliance on traditional sources of information Perceptions of alienation from the health reform process Perceptions of fear for health and well-being	**Irrational Disconnect**
Taking On	As a community priorize your needs and gather information to support these needs; Select spokesperson(s) who are knowledgeable and facilitative	**Policy Maker (Government)** Government documents/Hansard; **Policy Implementer (Region)** 15 member appointed health authority board; Regional newletters; Media; Government mandate to shift health	**Intended** **PM** – Facilitate community participation; Gain public confidence in health reform agenda; make rural hospitals/health centres relevant in their communities **PI** – Establish	**Dys-integration** **Voiced** **Silenced**

		reliance on government to partnership to the community **Community** "leaders (were) counselors, rural municipality people, the mayor" "people wrote down their feelings and sent (the papers) to Manitoba Health" "had to say and had to do something to make sure the government knew that we didn't want to be closed down" "if loss of hospital then the town would die because ...people move to communities that (have services)" "its all about the government - they're imposing their beliefs" "you never seem to know who is in charge" "the 'higher ups' (i.e., RHA) don't listen to the people...there is lots of administration, so communication up or down is difficult" "no local board...who do we go to (if anybody's) got a problem? 51.9% of region residents rated their health very good to excellent compared to 58.4% of Canadians	overall direction for health region (integration; outcomes; effectiveness) **C** – Retain health services **Unintended** **PM** – Perception of removal of traditional roles of boards and municipalities **C** – Resistance of faith-based organizations to health reform Significant public activities to protect community interests	
Taking Over	Build consensus within the community as to the 'acceptables' and work on maximizing these for the community's overall well-being; Demonstrate a community willingness to move forward on key issues in partnership with the other stakeholders	**Policy Maker (Government)** **Policy Implementer (Region)** District Health Advisory Councils; Interprofessional and inter-regional programs; Accountability relationship with stakeholders and government Use of terms like RHA, clients, and health centre **Community**	**Intended** **PI** – Operational and programmatic efficiencies New accountability structure to respond to government and stakeholders **C** – Enhanced community visioning for health care solutions **Unintended** **PI** – Alienation of	**Connect**

		"we thought of the community as a whole…there were solution on what could be done" "need to find an accountable local group (to advise) the health authority" "People felt they had things to say and had to do something to make sure the government knew that we didn't want to be closed down" 12.51 acute beds per 1,000 compared to provincial average of 8.35 Community facility has 51% occupancy rate (below provincial average of 59%)	the public due to formal and unfamiliar terms Inability to bring bed and service utilization to meet standards C – Emergence of informal or non-sanctioned mechanisms to act on community's behalf	
Taking Beyond	Participate with other communities and other sectors in linking, sharing, and strategizing for overall rural well-being; Provide presentations at rural forums highlighting unique and successful strategies	**Policy Maker (Government)** No evidence found **Policy Implementer (Region)** Participation in provincial RHAM **Community** "Health reform lets (health planners) to look at things in the broader picture" "there's always that feeling that you don't know what's around the corner – (the question remains) when is it all going to be taken away from you?" "everything is still here and everybody, for a while, feels good"	**Intended** **PI** – Recognition and fostering of inter-regional relationships C – Enable all participants to see health in the broadest perspective **Unintended** C - Continued uncertainty about future ability to effect policies Perception of risk for apathy regarding future health agenda	**Reintegration**

Limitations to integrated community policy uptake model

Three limitations of the proposed integrated model are noted:

1. The duration of each phase appears to be highly variable. More extensive consideration of the relative lengths of the phases might be meritous in relation the overall policy process.

2. In this study, the first three phases were recognizable in all three communities under consideration. In the case of Community C, there was limited evidence of the "Taking Beyond" phase. It is unclear whether the timing of the study or other aspects contributed to whether or not a community moved into the "Taking Beyond" phase.
3. It would be preferable to undertake extensive research to validate these phases with the participants, and stakeholders.

Cross Case Findings

The three case studies sites were very similar in their demographic and health status indicators. All communities met the criterion for inclusion as discussed previously. Variations in health service mix and program offerings were minimal across the cases. The two Saskatchewan communities were more similar in term of the district size and catchment, but when contextualized within the service areas the differences with PRHA were minimized.

Extensive government directives and documents were provided to health districts/ regions to guide formation, board development, core services, and needs assessments in each province. Both provinces undertook to delineate roles and responsibilities for the districts/ regions and government. Accountability models and reporting mechanisms were clearly articulated in both jurisdictions.

In terms of provincial approaches to health reform/renewal, the major variations between the Saskatchewan and Manitoba approaches rested in the closure/conversion of facilities, regionalization approach, and the funding structures. The Saskatchewan government took a strategic stance respecting the acute care bed capacity prior to the onset of the policy by closing or converting 52 hospitals. This action was not mirrored in the Manitoba context. In Manitoba, regions were constructed by the government whereas in Saskatchewan local communities participated in determining boundaries. This latter approach led to formation of 32 districts in Saskatchewan which have since been mandatorily reduced to 12 due to concerns for sustainability and integration. In terms of funding, Saskatchewan Health provided a complex needs-based formula for district funding which was partially rooted in traditional funding formulas, but considered population health indicators (i.e., gender, age, culture, etc.). Manitoba's approach to regional funding remained with a traditional funding process. A minor variation occurred in the Saskatchewan vision for health renewal in that the policy was often described as the "second phase of Medicare". This is linked to the historical and political legacy of Tommy Douglas and therefore has strong Saskatchewan ties.

The impacts of the policy are considered in Table 35. Intended and unintended impacts are aligned with the applicable stakeholder groups (i.e., policy makers, policy implementers, and communities). The intended and unintended impacts are further subdivided into whether they occurred consistently or differentially across cases.

Four thematic couplings which emerged from the data were seen consistently in all three cases. Those relationships were clearly outlined in Tables 32, 33, and 34.

Table 35

Summary of impacts by stakeholder and research incidence

Stakeholder	**Intended**	**Unintended**
Policy Makers	***Consistencies*** Clear messaging Compliance with CHA (principles & financial) Facilitate community participation Gain public confidence in health reform/renewal agenda Services appropriate and available (i.e., reduce inequalities, make rural hospitals/health centres relevant in their communities)	***Consistencies***
	Differences Saskatchewan Sites Only Conversion of facilities Decisions in hands of public Vision of wellness supplants illness Further consolidation of health reform initiatives Address issue identification (district sustainability)	***Differences*** Saskatchewan Sites Only 32 districts in Saskatchewan Manitoba Site Only Perception of removal of traditional roles of boards and municipalities
Policy Implementers	***Consistencies*** Clear Messaging Clarification of mandate and timelines Operational and programmatic efficiencies Establish overall direction for health services Accountability mechanisms	***Consistencies*** Continued utilization and bed levels exceed norms

	Differences Saskatchewan Sites Only Ability to respond to communities in accordance with unique health needs Community B and C Recognition and fostering of new relationships	***Differences*** Manitoba Site Only Alienation of the public due to formal and unfamiliar terms
Communities	***Consistencies*** Open dialogue and opportunity for input and direction setting for the community Retain health services	***Consistencies*** Emergence of informal or non-sanctioned mechanisms to act on community's behalf Reliance on traditional sources of knowledge Distrust/alienation from the health reform process Significant public activities to protect community interests All three expressed concern about the ability to respond to future changes – ranging from complacency/apathy, lack of inclusiveness in policy process, need to stand ready (guard) Perception of negative emotions regarding health reform
	Differences Community A only Retention of professionals and health services with change in types of professionals and health services offered Services continued to exist and meet needs of the community Community B only Anticipation of a wellness based health system Community C only Enhanced community visioning for health care solutions Enable all participants to see health in the broadest perspective	***Differences*** Saskatchewan Sites Only Predominance of sense of losses related to health reform Perceptions of preconceived health reform processes Dissatisfaction with health service level and funding Community B Only Perception of urban perspectives dominating health reform policy Residual sense of failure or inability to affect change in the community process Awareness of people as community strength Community C only Resistance of faith-based organizations to health reform

Lessons Learned: Analysis, Synthesis, & Findings

This section of the research affirmed the appropriateness of the multiple sources and methodological approaches to the data. The analysis and synthesis required significant immersion in the texts (i.e., transcripts, documents, field notes) to ensure capture and reasonable representation of all stakeholders in the process. This synergy with the data collection phase contributed to the identification of consistencies and inconsistencies across data types, within cases, and between cases.

Extensive consideration of each case individually and as part of the collective provided a more in-depth and contributory set of findings than would have existed in a single case approach. The high level of congruence between the learnings in the ‘cross case’ assessment suggest that, despite nuances in the policy implementation, variances in the contextual environs, and other influences, policy makers, implementers, and communities experience this type of policy change in similar ways. These similarities and the differences are critical in informing future directions for each of these stakeholders in policy process in health and beyond.

CHAPTER IX
SUMMARY AND RECOMMENDATIONS

This research on the health reform/renewal policy impacts for rural women in select Saskatchewan and Manitoba communities considered the meaning, impacts, and implications of this policy direction for rural communities, generally, and rural women, specifically, as entities which are frequently overlooked in such discussions. By considering the perspective and ideas of those experiencing the policy's implementation, it is possible that future policy decisions might be more responsive and attuned to the needs of this population, and potentially more inclusive in future policy planning and decision making. The research findings emphasized the interest and desire by rural women to be active participants in their own health, including involvements in the policy and governance aspects. This chapter is an encapsulation of theoretical and applied learnings of this study.

Theoretical learnings

The relevance of the work of Michael Foucault in the context of this study is meritous of discussion. Two areas will be briefly addressed – power and change.

Power

Foucault suggested the need for explore the shifting patterns of power within society. defining power as "directing the conduct of others through . . . processes like surveillance and normalization in which individuals are made objects of control who are submitted to certain ends or objectives" (Foucault, 1989, p. 11). Foucault (1982) stated that power relations are "rooted deep in the social nexus" (p. 208) necessitating the analysis of these relations, their contexts, their historical formations, and the conditions needed to transform some or to abolish others. Perdue (2004) stressed Foucault's thematic of power is not a traditional one of domination, but rather is one which constructs power as "capillary, found everywhere, and in daily interactions" (p. 3).

Foucault was "concerned with the ways in which people's experiences are controlled by others and the ways in which individuals control themselves" (Nettleton, 1991, p. 99)

In this research the former is seen in how the policy makers and the policy implementers invoke "tactics, strategies, techniques, programmes, dreams, and aspirations of these authorities who shaped beliefs and control of the population" (Nettleton, 1991, p. 99). The latter is in the efforts (i.e., rallies, local action groups) that rural women and their communities undertook in response to the former.

Further, Foucault's position on the relationship between power and knowledge is relevant to this study. Foucault states that the goals of power and goals of knowledge are inseparable – in knowing we control and in controlling we know.

Change

"Foucault's conception of change... ultimately supports localistic forms of resistance and specific forms of democratic incrementalism, rather than revolutionary or totalistic strategies as the basis of transforming society" (Olssen, 2004, p. 454). Flyvbjerg (2001) emphasized that the actual content of political action, according to Foucault, must be defined by the participants themselves. Foucault questioned if policy change yields new subjectivies how are the people (recipients) responding? And, more importantly, do these subjects of the policy realize what is occurring or are they oblivious to these new subjectivites? Do they resist? This perspective aligns with the emphasis in this study on the potential role of rural women and their communities in informing and effecting policy change.

It is noted that one major criticism of Foucault's work was that his work was on power was too 'localistic' or 'regional' failing to take into account national and international hegemonies (Olssen, 2004). Resulting from this debate, Foucault coined the terms "governmentality" and "reversibility of power relations" which addressed how individuals can challenge and change the very systems which defined them and socially ascribed their status. Again, this situates the present research within the localistic framework articulated by Foucault.

Applied learnings

The applied learnings from this study were presented primarily in Chapters V through VIII. In summary, this section will consider the learning respecting the four research questions and the four dyads.

Research Questions

Intended (articulated) impacts of the health reform/renewal agenda

The first research question which guided this research was "what were the intended (articulated) impacts of the policy changes proposed under the health reform/renewal agenda?" Despite inter-provincial differences in health reform/renewal policy strategies, consistent findings respecting the impacts and themes regarding the experience of the rural health policy were found within and across the two provinces. Although some of the participants indicated that the principles of health reform/renewal were attractive, most participants indicated that the process became primarily a fiscal exercise rather than a philosophical or "health motivated" change. Ultimately, political rather than health motivations were seen as dominating the health reform/renewal agenda. The political motivations appear to be motivated by more immediate fiscal and objective outcomes, as opposed to longer term social and philosophical change.

The comparison between Saskatchewan's and Manitoba's pursuit of health care reform/renewal highlighted a number of fundamental similarities in the policies. Both looked at regionalization of services, promotion of health through alternate service mixes, and community involvement as imperatives in the redefined health system. The research highlighted the articulation of these policy efforts primarily through policymaker and policy implementer sources (i.e., documents, archival information). Major differences noted in the implementation of the health reform/renewal agendas in the two provinces were the funding approaches, closure/conversion/retention of facilities, and regional boundary formation mechanisms. The commonalities and variances between three communities of interest were exposed in this study through document reviews, environmental scans, and participant input.

Impacts on rural community of the health reform/renewal agenda

The impacts on rural communities reflect the findings related to the second and third research questions guiding this study which are "what have been the short-term impacts of health reform/renewal on rural women in Saskatchewan and Manitoba?" and "what are the perceptions of rural women regarding the impact(s) of health reform/renewal policy initiatives in Saskatchewan and Manitoba?" They were identified through the individual case studies using the combination of all data sources.

Rural communities continue to feel isolated, ignored, and disempowered with respect to health renewal/reform policies. As both provinces undertook health reform/renewal, there was an articulation of the intent of community inclusiveness in the process and community empowerment. Participants, in this study, generally felt that health reform/renewal policies were and continue to be done 'to them' rather than 'with them'. This inclusiveness has resulted variably in the two provinces with respect to gender representation of the health boards. In addition, communities reported the board and management structures were such that they were distanced, physically and practically, from the rural settings. The extreme and persistent levels of uncertainty and instability respecting health and health care are seen by these participants as problematic and disempowering.

Community involvement and adequate (or correct) information in responding to health reform/renewal policy is viewed as paramount by rural communities for the survival of their communities. Effectively managing change can be facilitated by open, ongoing, and informed communication. Informed communication, however, not only involves sharing information with those potentially affected by the change but also listening to and gathering information from these individuals, with the intent to consider their input. Failing to acknowledge past community efforts and local expertise is a potentially fatal flaw in any such effort and will limit shared solutions and decision making. Further, the more profound the change, the greater the need for an effective process for communicating the intent and expected outcomes to those directly affected.

Participants clearly indicated the need for a rural perspective in discussions and recommendations regarding health care policy and health care quality. It was apparent that rural women did not feel that this type of input was either sought or desired by government or health authorities in health reform/renewal initiatives in either province. Rural women in this study provided a consistent messaging that being vocal community advocates was imperative in addressing this type of policy process. Clearly, the sense was that there was a requirement for the community to speak out and become involved rather than remain passive in this process.

Consistently, women felt that the policies and decisions were preconceived in government offices by individuals with little knowledge of rural environments and needs. There is a need for solutions to be generated locally with "an intimate knowledge of the context, the culture, the people, and the need" (Rowley, 2003). Government and other policy makers can no longer do 'to' but must do 'with' the rural stakeholders for the policy process to be successful.

Further, the participating rural communities felt that health reform/renewal has generally meant losses not gains in their communities' health and health care services. Rural women in this study described a multitude of real and perceived losses related the health reform/renewal process. Consensus was evident on the increased travel by rural residents to access care in urban centres. Further, participants from all communities expressed concerns regarding loss of community status with changes in the hospital services. Issues of loss further ranged from business closures to loss of autonomy on community raised health care funds.

Despite these many stated perceptions, there was evidence that what was stated or anticipated often was not reality. For example, many felt that health reform/renewal would lead to loss in population and services, yet this was not evidenced, according to both the participants and other data sources. It remains unclear if and how these discrepancies can be reconciled within these communities but this is an obvious potential area of interest.

Impacts on current and future policy

The focus is on the final research question "What are the key learnings from this experience? How do the key learnings inform future public policy decisions/directions?" This question was reflected upon in the cross case analysis. The consistent learnings across all three sites were categorized according to policy maker, policy implementer, and community perspectives and intended (articulated) or unintended (incidental) outcomes.

Policy makers in both provinces emphasized two intended impacts - the need for clear messaging in an effort to gain public confidence and service capacity which is appropriate and compliant with enduring principles. No unintended outcomes were addressed. In terms of the differences, the intended impacts were Saskatchewan specific emphasizing the ongoing momentum of health reform/renewal towards community involvement in health planning and continuation of the efforts (i.e., sustainability).

Unintended impacts at this level appear to be structural such as a large number of health districts in Saskatchewan relative to the population size. The key learning for future policy directions is that consistent and clear articulation of parameters and expectations are essential.

Policy implementers (i.e., health districts/regions) consistently articulated the intended impacts of a clear agenda for overall programmatic and systemic directions in the reformed/renewed health system. Despite the intended streamlining, the two jurisdictions continued to experience high utilization rates. In terms of intended impacts some communities felt that the process had led to new relationships/partnering for health services with some opportunities for customizing of such services to particular communities. An unintended outcome in Manitoba was a perception of alienation through use of jargon. As in the case of policy makers, a key learning is the need for clarity in the policy process in order to more fully engage the stakeholders.

Communities (i.e., rural women) consistently described the intended outcomes of the health reform/renewal policy as being more community driven policy setting and direction of health services capacity. What was seen, but unanticipated, was primarily a raised profile of community based action in response to high negativity towards health reform/renewal and concerns about the policy process. The various communities expressed unique nuances in terms of their experiences of the policy. One community emphasized the retention of services and professionals; another indicated their anticipation and positive view of a wellness based system; and the third community saw community based solutions as the outcome. Differences in terms of unintended outcomes included the Saskatchewan communities highlighting the preconception of the health reform/renewal agenda and the high level of discontent with the health system post-policy. One Saskatchewan community also indicated that other unintended outcomes of this policy included perceptions of urban-centric decision making, a sense of community failure in resisting the policy changes, and a heightened awareness of community capacities. The Manitoba participants indicated that the resistance by faith-based organizations was unanticipated in the policy process. The key learning from this stakeholder group was that community action (either through involvement or resistance) is valued and valuable in the inclusiveness of community in the health reform/renewal policy process.

Research dyads

Four dyads were presented as reflecting the integration of the various data sources. These themes reflected the experience of the health reform/renewal policy from the inception through application. The dyad terms were not discrete (present or absent) characteristics, but rather represented a range or continuum. For example, it is not implied that a community can be total 'disconnected' or 'connected', but rather there are incremental levels of connectedness.

Disconnection was exemplified by emotional outpourings, distrust, and resistive actions by the communities throughout the health reform/renewal process. Whether connection has been achieved remains questionable. Communities expressed high levels of connection within the community through meetings and mobilization events. However, in terms of connectedness to the health districts/regions or to the provincial policy makers, all communities indicated concerns with communications, an inability to feel secure in health service levels, and discontent with personal health status. Despite these beliefs, in both provinces, numerous communication strategies were invoked; minor changes in services were shown; and over 50% of respondents indicated stability or improvement in health and health services.

The second dyad is irrational to rational, which highlights the tangible policy aspects of funding and utilization. Neither province emphasized inefficiencies and inadequacies in the pre-reform rhetoric, but rather stressed the opportunities for streamlining and reconfiguring. What has been seen, according to the various sources, is increased perceptions of losses in terms of public services, autonomy, and resources (i.e., beds, professionals); reallocation of resources to home care and community; and a failure to reduce wait times and case backlogs. The level of achievement of rational decisions is challenged by the persistent perception of negative effects of health reform despite a lack of empirical data for either perspective.

Dys-integration to re-integration was the dyad which showed the least amount of controversy. Pre-reform/renewal health services were seen to be somewhat disjointed, hence, the promises of co-ordination and restructuring were appealing. Many expressed disappointment in the failure of health reform/renewal policy to fully realize the potential to integrate and to shift to a broader, "wellness" based health care system. Participants expressed concern about the lack of consistency and, at times, absence of managers or locus of control. However, as pointed out by Lewis and Fooks (2002) indicated "the jury is still our whether ...the goals of better integration and improved population health (have been achieved)" (p.7).

The final dyad considers the level and type of community involvement in the health policy process. The policy makers and implementers suggested that the reformed/ renewed health care environment would lead to a community based and community directed health system. Community participants expressed concern that the local model that had existed pre-reform/renewal had actual provided a direct community link. All three communities felt that the due to their non-inclusion in developing and implementing the policy agenda led to the emergence of community spokespersons. Disparate views on the achievement of giving voice to the communities were evident.

As shown, each thematic presentation highlighted the incongruity in perceptions of communities with the stated intentions of the policy and its manifestation. It remains unclear why these mis-perceptions have persisted within the communities of interest. One might assume that this relates to the clarity and success (or not) of communications from all stakeholders.

Limitations

Identified limitations or difficulties in achieving optimal research conditions in this study are described below:

- Access to participants

This limitation may result from lack of awareness of the research, distance, and travel considerations, shut-in status, and various isolating factors (i.e., abuse). In order to mitigate this limitation, efforts to ensure accessibility (i.e., wheelchair accessible venue; child care; accessible community locale) were built into the research design. Further, the contributions by the Women's Institutes in gaining access to potential participants served to minimize this concern.

- Distance

In order to complete the research in a timely and efficient manner, it was necessary to limit sites studied which included a restriction on the number of individuals and communities. Due to the issue of spatial diversity, selection of participants was constrained by distance and travel requirements. As above, efforts to accommodate participants and their distance challenges were integral to the research design. Hence, the sessions were held in local communities and follow-up interviews were conducted in a location of the participant's choice.

- Diversity of women

It is recognized that the selection of participants did not reflect all sub-groups of the community of rural women. However, the participants were recruited independent of the researcher and met the criterion established (i.e., non-health care worker; resident of the community), which strengthened the likelihood of participants being representative of the community under consideration. The generalization of the research findings beyond the context of the specific case is limited, which aligns with the nature of case study research. Again, one must be reminded of the obligation of case study research, not to understand other cases, but to fully understand this particular case (Stake, 1995).

- Multiplicity of issues

Rural environments have experienced a wide array of economic, social, and political challenges in recent years. Hence, consideration of adjunct and/or historical changes in the study environment was reflected through the use of multiple sources and open ended questioning which enabled broader discussion.

- Disempowerment of participants

Potential participants may not feel that they are able to contribute or alter the course of events, hence, there may be complacency, resistance, and/or withdrawal for the research process. Every effort must be made to promote inclusiveness, valuing, and importance for each participant. This research was structured to encourage participation through a supportive and collegial environment with clear commitment of the researcher to protect identities. Further, the opportunity for individuals to confidentially participate in follow-up interviews served to mitigate internal (focus group) disempowerment.

- Access to information

There may be a lack of information or a reticence of certain parties to provide the available information if this research is perceived as threatening or critical of the initiatives undertaken. Efforts to convey value, respectfulness, and truthfulness in this research was paramount to addressing this potential limitation. The assurances of confidentiality and the member checking strategy afforded the participants to contribute or withdraw comments at various stages of the research.

- Gender related issues

This study considered females only. This limits the ability to extrapolate the findings more generally to all members of the community.

In addition, the use of multiple sources was seen as a strategy to reduce this limitation. It is critical for health care policy researchers, especially those working in rural communities or in areas of community development, to pay attention to the development of data-gathering systems and research methods to maximize sources and bring meaning to the policy process for the informants.

Recommendations

A number of recommendations arise from this research. These are considered under two major areas – health reform/renewal policy and practice.

Health Reform/Renewal Policy

The findings of this study document the process of policy change and its impacts on a select target group. This study's findings inform health reform/renewal policy and promote the need for policy alternatives at different levels of policymaking, and with different stakeholder groups. According to Porter O'Grady (1995), "health reform as we know it is the reduction of health care to functionalism in its rawest form. Much of the change is mechanistic: a clear understanding of what must occur if society is to be healthy is missing" (p. xvi). The challenge of identifying what must occur was addressed in this research.

Individuals/Communities

The research findings emphasize the need for public participation in all phases of the policy process. This is reiterated in the work of Ramp (1999) who states that

"Public participation in health care decision making, development and provision is especially necessary in rural areas, for 3 reasons:

1. The particular, diverse, and local nature of rural communities entails that standardized, cookie-cutter administrative strategies will be faced if not tailored to the needs of a particular community;
2. Effective public participation generates the collective will that ensures that services are not curtailed or withdrawn in unhelpful ways; and
3. Health of individuals within a community is affected by the health of the community as a whole. (p. 9)

In addition, the research emphasized the potential to capitalize on existing community assets – especially the people – in embracing the policy process. The communities all indicated that traditional mechanisms for information sharing, looking to former board members and rural councilors, and finding leaders within the community were paramount in their approach to the policy process. All these resources are existing and should not be undervalued or under-estimated in their potency to affect the community's experience of the policy process.

Health districts/regions

This research may provide health districts/regions with information and insights on the implications of health policy and decision making processes for select populations. First, the findings may emphasize the need for communication with its stakeholders. The health districts/regions may choose to utilize this information for building new linkages with this specific target population. Second, the governance body or administration of a health district/region may choose to expand, focus, or alter some elements of the research in order to gain necessary information for their purposes in order to enhance health services and their governance structure. Upon reviewing the findings, the health district/region may find elements or suggestions that will lead to future considerations in order to assist in future delivery of health services and/or to build enhanced governance.

Government/policy makers

The research findings potentially have application for government and other policy-making bodies. The potential development of a model as discussed in Chapter

VII through which community-based health policies may be developed, implemented, and evaluated is seen as potentially relevant to government and policymakers.

Integrative policy areas – health and social policy

The research study identified many of the positive and negative features of a specific health policy directive. It is potentially possible to consider the extrapolation of such findings to related social policy initiatives. Most notably, it is likely this study will inform the features (strengths and weaknesses) of regionalization, emerging health organizations (district/regional boards), and health/social service portfolios.

Practice

This research potentially has significant implications for health policy and health program/service planning and evaluation.

Health care providers/community developers/professionals

As health care providers reflect upon the findings of such research, it is possible that a better understanding of the community/client needs will be achieved. It is also possible that innovative, client-focused strategies to the development, introduction, implementation, and evaluation of health policy will be enabled through the research findings.

In the words of Buresh and Gordon (2000), nursing has the potential to be a profession of consequence taking advantage of openings provided by media interest in health issues. Nurses are well positioned to bring forward issues such as the health of rural women and rural communities. Nurses have invaluable information and insight to contribute to the most pressing health issues of our time and to the public debate over what kind of health care systems will be effective.

Related Research

I believe that there are two key areas, which may lead to future research. The first area of related research is replication or expansion on the nature of this research. The possibility to use this research as a template for future studies is offered at this time, especially with respect to investigating the utility of the conceptual framework and the integrated community policy uptake model. The second area of potential future related research is to consider other target groups (i.e., children, disabled, mental health clients) regarding the implications of health and social policy reforms. Thirdly, replication with other communities should be extended to be gender inclusive.

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Appendix A

Selection of Researcher Field Notes

The field notes serviced throughout this study to capture periods of self-reflection, understandings, conflicts, and pathways of thought. These notes also served to highlight methodological decisions at various times in the research process. A wide range of excerpts are provides as exemplars of the field notes and audit trail invoked in this study.

April 11, 1999 – Conceptual work

What will be my working definition of rural? I thought that would be simple – hey am a farm girl after all. But the literature is all over the place – may be am just looking in the wrong spot. Or maybe rural is actually in and of itself a variable???? (degree of rurality). Does this intimate some kind of a dichotomy – rural vs non-rural – don't want to got there yet!

Think that I should go back and look at the work by Chinn and Kramer from MA's class that might help – all the concept clarification stuff. But this one is important must be sure that I am talking about the real rural – not other wanna-bes.

Look into the work of Lee et al out of ?Montana – should help. But how far am I supposed to go beyond nursing – will have to as VP about that?

September 12, 1999 – Research question formulation

Follow-up to note from 02/09/99

What are the reactions of select rural women in Saskatchewan and Alberta to health reform policy initiatives?

> Strengths – open – a 'what' question – therefore aligns with preferred methods
>
> - simple – easily definable – has all the elements of a research question
>
> Weaknesses – perhaps too simple – lots of assumptions about knowledge of these groups, that there were reactions (huge risk), and doesn't clarify if the method is a plicy analysis or something else.

Go back to LJ's notes about research questions writing.

January 7, 2000 – Conceptual work/committee meeting

Conceptual framework – eclectic – HBM, Resiliency, Community Capacity

?Is it possible that an adequate rationale for the work will supplant the need for a conceptual or theoretical framework. JC indicated that it is likely grounded theory and prefers conceptual model.

If this is to be ground theory, I would likely focus in the HBM framework and relate to principles and assumptions there using case study approach.

... when looking at rural health care policy issues need to look at economics – equity – rural specific health concerns (i.e., farm stress, suicide, accidents, injuries, chemicals) – what do these mean in the overall context of health and well-being? What are rural indicators of health? Do these exist – look at the literature.

<u>August 22, 2001 – Working group with Saskatchewan Women Institute board</u>

Key Learnings:

need to let MWI know immediately because of time lines to completion
women are significantly affected in rural areas ... MO will take care of this
women want to say their peace
it is different in rural than urban - so what if one hospital out of 3 is closed?
we are dying out there and no one cares

tool - the women suggested that many rural women are familiar with focus groups and that will work well. But you will have to have a baby sitter available because they may not be able to get one.

The topic is great - no concerns - in fact the group felt that the topic was a universal or broad one that most rural communities in Canada would be interested in.

The timing is a bit bad because you might hit a late harvest - but who knows?

we need to ask women what they knew about the changes - how the changes were conveyed - lack of information was a big big problem; we need to ask women what they saw going on in their community - it was a mishmash of anger and despair - but let's see what they saw; we need to ask women who they got help from? or did they?; we need to ask women where they are at right now? how are they doing? how is the community doing? what are the impacts that they saw?

query from me - do you think rural women would be willing to share their experiences with other communities undergoing health reform changes - thoughts???

yes it would be useful - might actual be a purification - debriefing for some communities. Might not have the skills to do that - I don't know?

<u>January 12, 2002 – Coding critique</u>

I decided today I would brave the first cut of my coding. What a mess...all these categories and classifications. I had started out with a provisional start list like they suggest in the literature. The main ideas on the provisional list were Policy Context, Perspective, and Impacts for each of the sectors (federal, provincial, local, health district/region, and individual). Surely there is an easier way to do this. I will have to spend some time giving a clear definition of what each code means.

Found I was adding to this list – almost 2 to 1. That can't be good. Revisions are one thing but I am not sure what this is all telling me about the meaning. Something is also amiss when so many adjustments have to be made to what I thought were the main ideas. Or may be is should have tried to stick to that preliminary list. Will go back to the literature and see what Miles and Huberman say.

But maybe it will be better to do another transcript. Before I go any further with the coding, I will talk to MW.

<u>May 2, 2002 – Member checking feedback</u>

I was disappointed that after sending out the preliminary codes to 5 participants only 2 responded and one was the board member (she signed it). Only the board member had written anything of direction on her copy. I guess that is to be expected. Maybe they really don't understand. Or is it because they feel a difference in power? Or do they just not care? In the future I would like to look at the success or impact of member checking in this type of research. NO TIME THIS TIME!

Not to lament – VK's feedback was interesting because it might actually allude to a theme around the sense of disconnect women felt from the health district and government during the process. She highlighted that women are being faced with many challenges in rural Saskatchewan and this was just another issue.

<u>June 19, 2003 – Futility</u>

This is not making sense. Thought that another read of the transcripts would help me get back into this research. I had really thought the different communities would be 'more' different in their comments – but they are not. Maybe that is why I am so

discouraged – did I do something wrong in my approach. Is this just poor research? I feel so inexperienced. Nothing valuable
here!

January 18, 2004 – Decision point – themes

There are some obvious dichotomies here – when I read the transcripts, especially the focus group ones. A new thematic couple was identified today – this is actually exciting. I realized that the women felt very strongly that there was so much happening that was irrational yet the government and health district were presenting the policy as a rational and paced implementation. Wow – the different perspectives – I know as a rural woman I often struggled in the government because of the variance in what I believed (and thought I knew) and what the government believed was appropriate and acceptable. Guess that is a good thing – to always question.

Now have 3 thematic couplings – it really is a question of how I layer them – because even in this emerging theme do we see a need to separate out ideas such as funding which has a significant emphasis – not sure??? Also, is there a priorization of the themes – initial reaction is no – just an emergent pattern. Does placement of the themes in the discussion imply priority??

Appendix B

Focus Group/Interview Guide

Research Questions	ORID Framework	Goals
Can you tell me about how you and your community first learned about health reform/ renewal? **Probes:** Could tell me about how you first learned about health reform? What were the strengths and weaknesses? Did all women learn about it in the same way?	Objective Level	Information gathering – descriptive and factual Opinions and anecdotal recollections of events A historical 'recount' of what happened at the onset of the process.
What were reactions of the women in your community during the early phases of health reform/ renewal? **Probes:** What were the concerns? Can you provide specific examples? Have those feelings changed?	Reflective Level	
What were some of the features of your community that influenced your response to health reform/renewal? What do you feel were the impacts of health reform/renewal in your community? **Probes** Changes in services? How has your community coped with health reform/ renewal impacts? **Probes** What is happening now?	Interpretive Level	Elicit a community perspective on how and why things happened a particular way in the process. Identify community specific resources that facilitated or inhibited the process Develop a sense of current status of the process within this community
What advice you might give another community undergoing health reform/renewal? So, if another province a community came to you and said, we are facing health reform – what do you advise us to do?	Decisional Level	Focuses on lessons learned and potential to share beyond the community or beyond the sector Provides insights into future vision and strategies to respond to the evolving policy context

Appendix C
Selected Excerpts of Environmental Scan

Element	Components	
Community Core	a. Boundaries b. History c. Demographics d. Ethnicity e. Values and Beliefs	2 grain elevators Signage indicates – H, Police, Swimming Pool, Services (i.e., food, gas, accommodations) Car graveyard on edge of town Churches – Family worship centre; Free Methodist, United; Anglican; Ukrainian Catholic; Roman Catholic murals depicting cultural variations of the community (ab, uk, german)
Subsystems	a. Physical Environment b. Health and Social Services c. Economy d. Transportation and Safety e. Politics & Government f. Communication g. Education h. Recreation	Closed (non-functional) service station Railroad – cars available Recreation & Agriculture Bed and breakfast Community Centre Post office Curling Rink Campground Rodeo Grounds District Office (Municipal) Tourist information building Museum – pioneering Schools – K-12 Health – PCH; H (18 bed new); manor (seniors home)
Perceptions	General summary statements about the community's health, strengths, potential weaknesses	Recycling depot Water reservoir

Comments: Lots of cars on the street – not too many people – close to lunch time –… post office is locked – thought maybe I would see what types of ads on the community bulletin board – but no one there…etc.

Appendix D
Sample Letter to Women's Institutes

May 5, 2001

Madam:

Re: Research Partnership with Manitoba and Saskatchewan Women's Institutes

My name is Pammla Petrucka and I am a PhD student from the University of Alberta. I have been associated for approximately 2 years with the Saskatchewan Women's Institute on a variety of interests with health reform and hospital closures in Saskatchewan. I am from rural Saskatchewan and teach at the University of Manitoba in the Faculty of Nursing. Both my BscN and MN are from the University of Saskatchewan.

I am writing to request the involvement of the Manitoba Women's Institute in the next phase of my dissertation work. As of July 2001 my research project entitled IMPACT AND IMPLICATIONS OF HEALTH REFORM/RENEWAL POLICY FOR RURAL WOMEN IN SASKATCHEWAN AND MANITOBA should be through the ethics review process which means I will be at the stage of beginning to gather my data. Once the final version of my proposal is accepted I would be willing to share it with your group for their consideration.

As we discussed on the telephone, the research will require one focus group in a primarily rural health region including between 10 and 12 rural women who are non-health care providers. The purpose is to discuss health reform issues and ideas with the intent of informing policy makers on how to better involve and engage rural women in policy decision making.

I would be willing to further discuss this opportunity at your convenience. I can be reached at (204) 474-8315 in Winnipeg.

Respectfully,

Pammla M. Petrucka, RN

cc Saskatchewan Women's Institute

Appendix E
Ethics Approval

Health Research Ethics Board

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HEALTH RESEARCH ETHICS APPROVAL

Date: October 2004

Name of Applicant: Ms. Pammla Petrucka

Organization: University of Alberta

Department: Faculty of Nursing

Project Title: **Impact and Implications of Health Reform/Renewal Policy for Rural Women in Sask. And Manitoba**

The Health Research Ethics Board (HREB) has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information letter and consent form, if applicable.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form, which will be sent to you in your renewal month. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval. Written notification must be sent to the HREB when the project is complete or terminated.

Dr. Glenn Griener
Chair of the Health Research Ethics Board
(B: Health Research)

File number: B-120701-NSG

UNIVERSITY OF ALBERTA

Capital Health

CARITAS HEALTH GROUP

Appendix F
Selected Transcript Recordings

This appendix contains selections from 1 focus group and 1 interview transcript. The identity of participants and communities has been altered in order to retain confidentiality.

Focus Group Transcription (selection)

Facilitator: Obviously your community felt quite passionate about the pending changes. You have spoken about anger, fear, and worry. Were there any other emotions that you or the people in your community were feeling?

Respondents: Most people were afraid. It's pretty bad when you aren't sure whether you are going to be getting health care services if you need them. How would the politicians feel if they lived out here? I bet if it was their family this wouldn't have happened.

I don't know, I guess, there were some people who thought this was an okay way to go. But, they weren't the majority. Most of us were just scared for our families and friends. What was going to be there if you have a heart attack? I know I was worried, but not as bad as places where they lost everything. God that would have been bad – I bet lots of us would move to (larger centre).

Facilitator: You said that some people may have been in favor with the changes. Could you tell me more about this?

Respondent: Maybe I'm wrong, but there were some people, at least a couple that seemed to support the government's ideas. I guess that was their right. Mrs. A. was really pro-reform but she was appointed to the new board and (inaudible) made changes.

Facilitator: Were they any other features of your community that you think were important in the early health renewal times?

Respondents: Our hospital was newer only 2 or 3 years old so it had all the bells and whistles. So maybe cause we had no costs the government left us alone. One of the doctors said because we had 2 permanent doctors we stayed open. Lots of places with just one doctor were shut down like (nearby community). I'm not sure maybe we just in the right place. Who knows the government doesn't seem to have rhyme or reason when they make these changes – do they?

Facilitator: Were there other things going on at the time that may have affected your community?

Respondent: (name of participant) Wasn't that the time when we closed (name of community) school? (Nods) Like we had just closed a school in (smaller community) so we were aware of how these kinds of changes do in a community. We had to work together on that. So I guess we didn't want to go through that again – not with our hospital.

Respondent: We also lost our rail line and we are going to have 2 of our 3 elevators closed within the next 2 years – they're telling us. So we are losing everything.

Facilitator: Could you tell me a bit more about how you dealt with the closing of the school as a community?

Respondents: (name of participant) should talk about that cause she was the chair of the school board. Well, that's a while back, but it was hard. (name of community) had always had a small school but enrollments had dropped and well we just couldn't keep it going. So about 2 years before we started planning to move students and close the school. The teachers were moved to (name of community) or (larger centre) as we could, so really few jobs were lost. I guess that's the good part of it. But it was hard and lots of people were pretty teary the last day of school there. I don't know is there anything else you want to know?

Facilitator: I guess what I would like to know is what went well and what didn't. You said that you gave a couple years warning and people kept jobs – were those important to get the community to accept the change? Or is there anything else you would identify?

Respondents: Well probably the timing was the big thing. We had time to get together and plan – it didn't happen just overnight. Everyone got together and put ideas out, that was good. Really that was the important thing just talking it out. (nods)

Facilitator: Thanks, its important for me to understand how a community gets through a change, so that was important for my learning. So now I can go back to health reform, how do you and your community feel about the changes now? Have your feelings changed from the beginning?

Respondents: Well we are still worried almost daily that something will change. There is nothing in writing promising us that we will stay a hospital so it's day to day. Yeh, our district board comes out here what once or twice a year to tell us how it's going. But it's not like when we had our own board – we all knew what was happening. I guess I feel the board is doing an okay job, like we are not in budget problems like some of the other districts, so that's good.

Facilitator: How do you think the women of your community, in general, feel about the changes now? The same or different than you just described?

Respondents: I think most of the women don't think about the changes any more. We've learned to move on because in rural areas we're always are unsure about things. I don't know does that answer your question.

Facilitator: Yes, I think it does. I would like to know if you feel women in the community have changed their feelings towards health renewal.

Respondents: Not really, we really just wish it was back to the way it was.

Individual Interview Transcription (selection)

Facilitator: If you are okay with it, I would like to follow up on some of the questions we used at the meeting group the other evening. So tell me about the start of health reform policy in Manitoba? In (your community)? How did you first learn about the policy changes?

Respondent: Well, it was really what was going on in Saskatchewan that gave us the fear that this was going to happen to us. Like what was going to prevent them from closing our hospital? Yeah, it wasn't going to be far behind was it?

Facilitator: Can you tell me what you thought health reform meant? Tell me about your understanding of health reform?

Respondent: I don't know, well it meant a new board for sure. Not our local people, I guess (name) who you met the other night was local, but she is also from the right party if you know what I mean. Our old board wasn't about politics it was about people. And, is there anything else you wanted?

Facilitator: There's really nothing specifically that I am looking for – just your ideas and recall of the events when health reform started in Manitoba.

Respondent: I guess we were always hearing about something happening in Saskatchewan but we heard the government promising that nothing was gonna happen here so we were stupid and believed that it was okay here. Then bang one day it was all upside down and we were going to change the health care business all together. No warning, just do it. You know I really struggle with that because we were doing just fine. But that's government, right?

Facilitator: So at the start you are saying that you got most of you information from who? Community or government?

Respondent: Really I don't know. Probably from people I know in the community – I don't really remember government giving us much information other than telling us to change. So I guess that's information but kind of after the fact.

Facilitator: (name of participant) when the information started to come out how did people react?

Respondent: Well we talked a lot about it but I think we were pretty sure nothing was going to happen. They told us no hospitals would go so it was more a reducing of administration, or so we thought? Then we got it with less people, less services, and everything else.

Facilitator: Then are you telling me that people didn't react until changes started happening?

Respondent: I really don't remember, I guess it was about that time that everything went haywire and we realized there were going to be problems if we didn't watch out. You know its like with your kids everything seems fine and then all of a sudden someone's doing drugs or whatever. I guess we were just not too concerned until things started to happen.

Facilitator: So once things started to happen, how did you feel or women in your community?

Respondent: There seemed to be some angry yes real angry people out there. It was like you're not going to get away with this and we are going to fight to the end. I mean, on one day they tell us nothing is going to change and then the next day it is – so how would you feel? It was too much of a swing and people were hopping mad. So we fought them – kind of took them on so to speak. We weren't going to let them get away without having to face us.

Appendix G-1

Initial Draft Coding Framework

This appendix contains the codebook developed based on the coding of the first focus group and one interview. The codes are derived from the actual data in the transcripts. This list was superceded by a second coding scheme identified through the inductive analysis (see Appendix A-2).

EXTERNAL CONTEXT	
EC – DEMOGRAPHICS	EC-D
EC – POLITICAL	EC-P
EC – ECONOMIC	EC-E
EC – OTHER	EC-O
INTERNAL CONTEXT	
IC-CHARACTERISTICS	IC-C
IC-HISTORY	IC-H
IC-LEADERSHIP	IC-L
IC-SERVICES CHANGE	IC-SC
IC- SERVICES NO CHANGE	IC-SNC
IC- SERVICES POTENTIAL CHANGE	IC-SPC
IC-OTHER	IC-O
POLICY CONTEXT	
PC-FEDERAL	PC-F
PC-PROVINCIAL	PC-P
PC-LOCAL	PC-L
PC-DISTRICT/REGION	PC-D
PC-OTHER	PC-O
LOCUS OF CONTROL	
LOC-INTERNAL	LOC-I
LOC-EXTERNAL	LOC-E
EMOTIONS	
EM-FRUSTRATION	EM-FR
EM-ANGRY	EM-A
EM-FEAR	EM-FE
EM-PRIDE	EM-P
EM-OTHER	EM-O
INFORMATION SEEKING BEHAVIORS	INFO-SB
INFORMATION RENDERING ACTIONS	INFO-ACT
SOURCES OF INFORMATION	
SOI-NEWSPAPERS	SOI-N
SOI-MEETINGS	SOI-M
SOI-GOVERNMENT	SOI-G
SOI-DISTRICT/REGION	SOI-D
SOI-INDIVIDUAL	SOI-I
SOI-JOURNAL	SOI-J
SOI-OTHER	SOI-O

PERSPECTIVES

PER-FEDERAL	PER-F
PER-PROVINCIAL	PER-P
PER-LOCAL	PER-L
PER-DISTRICT/REGION	PER-D
PER-INDIVIDUAL	PER-I
PER-OTHER	PER-O

IMPACTS

IM-EXPECTED FEDERAL	IM-EF
IM-EXPECTED PROVINCIAL	IM-EP
IM-EXPECTED DISTRICT/REGION	IM-ED
IM-EXPECTED LOCAL	IM-EL
IM-EXPECTED INDIVDUAL	IM-EI
IM-HARMFUL FEDERAL	IM-HF
IM-HARMFUL PROVINCIAL	IM-HP
IM-HARMFUL DISTRICT/REGION	IM-HD
IM-HARMFUL LOCAL	IM-HL
IM-HARMFUL INDIVIDUAL	IM-HI
IM-NEUTRAL	IM-N

Appendix G-2

Final Coding Framework

This appendix contains the final coding framework developed for the research project. The codes are derived from the actual data in the transcripts, literature review, and document reviews. This list replaced the initial coding framework in Appendix D-1.

POLICY CONTEXT

PC-FEDERAL GOVERNMENT	PC-F
PC-PROVINCIAL GOVERNMENT	PC-P
PC-HEALTH DISTRICT/REGION	PC-D
PC-COMMUNITY	PC-C
PC-INDIVIDUAL	PC-I

POLICY IMPLEMENTATION

PI-FEDERAL GOVERNMENT	PI-F
PI-PROVINCIAL GOVERNMENT	PI-P
PI-HEALTH DISTRICT/REGION	PI-H
PI-COMMUNITY	PI-C
PI-INDIVIDUAL	PI-I

IMPACTS - ANTICIPATED

IMA-FEDERAL GOVERNMENT	IMA-F
IMA-PROVINCIAL GOVERNMENT	MA-P
IMA-HEALTH DISTRICT/REGION	IMA-D
IMA-COMMUNITY	IMA-C
IMA-INDIVIDUAL	IMA-I

IMPACTS – UNANTICIPATED

IMU-FEDERAL GOVERNMENT	IMU-F
IMU-PROVINCIAL GOVERNMENT	IMU-P
IMU-HEALTH DISTRICT/REGION	IMU-D
IMU-COMMUNITY	IMU-C
IMU-INDIVIDUAL	IMU-I

LOCUS OF CONTROL

LOC-INTERNAL	LOC-I
LOC-EXTERNAL	LOC-E

Definitions of Codes

POLICY CONTEXT

PC-FEDERAL GOVERNMENT	Refers to policy articulation and definition by federal government bodies or agents.
PC-PROVINCIAL GOVERNMENT	Refers to policy articulation and definition by provincial government bodies or agents.
PC-HEALTH DISTRICT/REGION	Refers to policy articulation and definition by health district or health region or agents.
PC-COMMUNITY	Refers to policy articulation and definition by community (i.e., rural women or local representatives <non-government>)
PC-INDIVIDUAL	Refers to policy articulation and definition by individual

POLICY IMPLEMENTATION

PI-FEDERAL GOVERNMENT	Refers to ways in which the policy was put into action by federal government or its agents
PI-PROVINCIAL GOVERNMENT	Refers to ways in which the policy was put into action by provincial government or its agents
PI-HEALTH DISTRICT/REGION	Refers to ways in which the policy was put into action by health district or health region
PI-COMMUNITY	Refers to ways in which the policy was put into action by the community (i.e., rural women or local interests <non-government>)
PI-INDIVIDUAL	Refers to ways in which the policy was put into action by individual

IMPACTS - ANTICIPATED

IMA-FEDERAL GOVERNMENT	Identifies effects or outcomes which were expected/planned/ anticipated in relation to the policy from the perspective of the federal government or its agents
IMA-PROVINCIAL GOVERNMENT	Identifies effects or outcomes which were expected or planned in relation to the policy from the perspective of the provincial government or its agents
IMA-HEALTH DISTRICT/REGION	Identifies effects or outcomes which were expected/planned/ anticipated in relation to the policy from the perspective of the health district or health region
IMA-COMMUNITY	Identifies effects or outcomes which were expected/planned/ anticipated in relation to the policy from the perspective of the community (i.e., rural women or local <non-government> interests)
IMA-INDIVIDUAL	Identifies effects or outcomes which were expected /planned/ anticipated in relation to the policy from the perspective of the individual

IMPACTS – UNANTICIPATED

IMU-FEDERAL GOVERNMENT	Identifies effects or outcomes which were unexpected/ unplanned/unanticipated in relation to the policy from the perspective of federal government or its agents
IMU-PROVINCIAL GOVERNMENT	Identifies effects or outcomes which were unexpected/ unplanned/ unanticipated in relation to the policy from the perspective of provincial government or its agents
IMU-HEALTH DISTRICT/REGION	Identifies effects or outcomes which were unexpected/ unplanned/unanticipated in relation to the policy from the perspective of the health district or health region
IMU-COMMUNITY	Identifies effects or outcomes which were unexpected/ unplanned/unanticipated in relation to the policy from the perspective of the community (i.e., rural women or local interests <non-government>)
IMU-INDIVIDUAL	Identifies effects or outcomes which were unexpected/ unplanned/ unanticipated in relation to the policy from the perspective of the individual

LOCUS OF CONTROL

LOC-INTERNAL	Describes those policy related activities which the stakeholder group or individual identifies as having direct ability to manage or influence

LOC-EXTERNAL	Describes those policy related activities which the stakeholder group or individual identifies as having no ability or limited ability to manage or influence

Appendix H
Reference Capture Sheet

CITATION REFERENCE -

DATE REVIEWED - -

BIBLIOGRPAPHIC INFORMATION

AUTHOR(S) ____________________

YEAR ____________________

TITLE ____________________

SOURCE ____________________

KEY CONCEPTS

KEY WORDS ____________________

OTHER ____________________

CONTENT

STATISTICS DATA DEFINITIONS

REMARKS ____________________

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METHODOLOGY

QUALITATIVE QUANTITATIVE MIXED METHODS

REMARKS ____________________

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ANALYSIS & FINDINGS

REMARKS ____________________

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REFERENCES NOTED

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OTHER

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RELATIVE IMPORTANCE 1 (LOW) 3 (MOD) 5 (HIGH)

DATE OF FINAL REVIEW - -

DISPOSITION RETAINED

FILE AS NOT USED

RETURNED