

## SELECT SASKATCHEWAN RURAL WOMEN'S PERCEPTIONS OF HEALTH REFORM: A PRELIMINARY CONSIDERATION

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### ABSTRACT

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. Of note, rural 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). The purpose of this qualitative research study was to gain insights into the perceptions of rural women on the impact of health reform in Saskatchewan and Manitoba. This paper considers preliminary findings of the perceptions of individual and communities of Saskatchewan rural women regarding health reform/renewal policy in an effort to provide a broader perspective on the impacts and implications of that province's health reform directions. By identifying the perceptions and opinions of rural women, this research potentially contributes to rural women's understanding of health policy and may encourage them to become more directly engaged in future health policy making and planning.

### 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 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.

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) added 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) stated 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). It is therefore critical to recognize this context within which rural residents interface with health reform policy.

Of specific 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). 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) stated 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. 8).

This paper considers preliminary findings of a research study, the purpose of which is to articulate the level and type of impact of health reform/renewal policy on select rural women in Saskatchewan from their perspectives. The rationale for the specific consideration of women emanated from the potential for multiple roles and challenges experienced by rural women in the reconfiguring health care system. This paper reflects a subset of a study considering this issue and further comparisons with rural Saskatchewan and Manitoba women regarding health reform policy implications.

### **SASKATCHEWAN CONTEXT**

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, it has meant exposure to a new order and emphasis within health care from treatment towards prevention and promotion; from universality to sustainability. For the residents of Saskatchewan, health care reform/renewal has meant significant redistribution of organizational entities through regionalization/district formation, uncertainties in terms of service/facility continuance, and decentralization of power.

In 1992, the government of Saskatchewan introduced health reform/renewal with the abject 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. 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 more than 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.

For some women of rural Saskatchewan, health reform/renewal was yet another policy decision impacting on the economic, demographic, and resource sustainability of “small town” Saskatchewan, the rural “family,” and the “rural” 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 laden with socially constructed roles and responsibilities. So, how have the women in rural Saskatchewan communities fared in the implementation of the health renewal/reform policy agenda? Further, what does this perspective mean for future public policy changes in rural Saskatchewan?

## DESIGN

The research study employed a multiple case study approach appropriately “investigating a contemporary phenomenon within its real-life context” (Yin, 1989, p. 13). 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, and holistic consideration of a high-profile issue such as health care reform.

## METHOD

A community-based sample of adult women (i.e., age 18 and over) occurred in two rural field settings. Women who were or had been health care providers were excluded based on the potential for a more “intimate” knowledge of the health care system. The recruitment of potential participants was undertaken by the Saskatchewan Women’s Institutes, a rural-based group committed to the promotion of leadership and community development locally, nationally, and internationally. A total of 14 women (within the age groups of 25 to 65+) participated in 2 focus groups and 3 individuals were subsequently interviewed.

The criteria for selection of the rural health districts settings, derived, in part, from the literature review, included:

- Community rurality, i.e., communities where focus group occurred were at least 30 minutes from a secondary or higher level of service center; and
- Population base, i.e., each health district did not exceed 50,000 people.

Before the focus group sessions, all participants were asked to read and sign a consent form. In accordance with ethics approval through the University of Alberta Health Review Ethics Board, all participants were assured that their participation was voluntary and that all reporting would protect their identity.

A semi-structured question guide was followed by the author. Open-ended questions and prompts were utilized to elicit descriptions and derive meaning of the women’s perceptions of health reform policy in their lives, on personal, and, more broadly, community levels. The focus groups, which lasted between 1½ and 2 hours, were captured on audiotape and transcribed. Participants were offered the opportunity to

contact the facilitator directly to arrange an optional subsequent individual interview. Of these, three individuals self-selected and participated in a follow-up interview, which were again conducted by the primary author and utilized the same semi-structured question guide.

All participants were sent copies of the focus group transcripts and, as applicable, interview transcripts for member checking purposes.

## **DATA ANALYSIS**

Data analysis for the purpose of this study included triangulation of data from multiple sources and through multiple methods. This approach potentially deepens and broadens one's understanding of the phenomenon of interest and, according to Mitchell (1986) strengthens the rigor of the study.

After reviewing the transcripts, a preliminary coding framework was developed to assist with pattern/theme identification (Krueger, 1998; Miles & Huberman, 1994). 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. This phase guided the gathering of utilization data, select statistics, critical historical documents, and related information to permit triangulation in order to validate key observations.

An extensive review of the primary and secondary data sources was undertaken to confirm or disconfirm derived themes and findings of the research. 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.

## **PRELIMINARY FINDINGS AND INTERPRETATIONS**

The key issues, within the extant research and writings on health reform in Saskatchewan and from the current research, that contribute to understanding the complexity of this issue fell into four major themes:

1. Disconnect to connect
2. Irrational to rational
3. Dys-integration to reintegration
4. Silence to voiced

Each theme is described herein and seminal findings from informants and document reviews are provided.

### ***Disconnect to Connect***

The focus of the "disconnect to connect" theme rests within the explicit objective of Saskatchewan's health reform agenda to "provide high-quality health care services to our rural residents" (Government of Saskatchewan, 1992). 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).

From the perspective of the informants, the level of disconnect with health reform 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

There was lots of confusion and rumors ... caused real problems.

According to Briere (2003), the early days of health reform/renewal led 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-ians 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, 2003, p. C3). The study participants 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, hospital personnel, and coffee row/table top discussions. The women spoke of efforts to ensure staying involved to preserve their community’s interests in statements such as:

I remember talking about how we had to fight for what we had...that everything could be lost; and 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.

Focus group participants in a Health Services Utilization Review Commission (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). It was noted by this study’s participants in one community 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.” 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’s perspective.

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. These sentiments were reflected by this study’s informants in statements such as:

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; and

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.

According to HSURC (1999), most rural respondents (82%) recalled being satisfied with health services prior to the 1993 acute care funding cuts. In 1999, more than 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, 2000). Contrary to what they anticipated (40% in 1993), 89% of respondents reported that the funding cuts had no effect on their personal health (HSURC, 1999).

Focus group participants in this study indicated that, in the initial phases of health reform/renewal, most of the citizens of one community were “scared for (lack of health access) for families and friends”. In the second community, the women 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 and taking the beds away from us;

Our doctor left because he was overworked;

We are losing our (community-raised) money ... our hospital is closing, and we are losing our health care ... there is nothing we can do about this; and

If you lose the hospital you lose so much importance.

One woman commented that “this health reform stuff is killing our small towns – maybe it’s a political move against us rurals.”

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). Rural women, in this study, indicated that “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.”

It is apparent that health reform policy has, at best, minimally achieved the desired “reconnect” from the perspective of rural women in these two communities. This insight potentially provides direction for policy makers and implementers in their strategic interactions with the community.

### ***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 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. The opposition (i.e., Saskatchewan Progressive Conservative Party) 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, 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 universal budgeting and accounting processes to “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 health care employment of the districts. Under a needs-based funding allocation, a global budget was provided to district health boards by broad service areas. Boards had 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 women in one community indicated dissatisfaction with the approach, stating "(we are) sick of having to beg for a dollar to keep our (health) services."

Respondents from one community 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." Most women believed that health reform had more to do with cost-cutting than wellness and that its pace had been too fast, and many felt that the health reform agenda was all about money.

The focus group participants indicated concern with the locally acquired funds, both from spending and acquisition perspectives. For example, before health reform, it was perceived that "the community generosity was great. Now it's not" and that "huge sums of money have disappeared." Further, respondents 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.

**Utilization.** Until recent years, 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 centers 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, 1994; DeCoster, Peterson, Kasian, & Carriere, 1999).

Participants in this study stated "(we were not) sure whether we were going to be getting health services if we need them." While 60% of 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).

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 1,000 population (yielding a reduction of 1,200 acute-care beds between 1991 and 1995) and new long-term care bed targets of 120-140 beds per 1,000 population aged 75 years and over (Health Planning and Policy Development Branch, 1995). This targeting was partially addressed by a reduction in

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 centers and/or special care homes; 13 were replaced with another facility in the same community.

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. Focus group participants emphasized that their aging population have special needs and that they “feel strongly about our older population being able to stay here” for services. In this study, 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 than before.”

Generally, when asked the women feel that the irrational has persisted with the decisions not reflecting their personal and community needs and conditions; however, they have articulated that the health services have remained stable through the health reform process.

### ***DYS-integration to Reintegration***

The focus of the “dys-integration to reintegration” theme rests within the explicit objective of the health reform agenda to “encourage communities to come together...to co-ordinate and integrate their health care services” (Government of Saskatchewan, 1992). Honourable Louise Simard, Minister of Health in Saskatchewan, stated that reform will take place in a spirit of “... mutual aid, partnership and cooperation ... the Saskatchewan way” (Government of Saskatchewan, 1992). 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 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.

The Canadian Hospital Association’s Director of Policy Development stated that “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.

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 one community, “you never know who’s in charge...no one seems to know anything (about health care services).” According to some study participants, “(reform) 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, 2000).

“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 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, p. 4). 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). Women informants in this study indicated that the elderly and the chronically ill (i.e., dialysis clients) and their families/support network were experiencing 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;

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;

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; and

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.

According to Lewis and Fooks (2002), “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 one community 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 reformed health care system in Saskatchewan has allowed for more joint or intersectoral planning; it has fallen short of its ‘wellness’ potential in 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 reform agenda to increase citizen participation in the reconfigured health system. According to Simard (Government of Saskatchewan, 1992), the renewed health system would emphasize the community input, community values, community involvement, and a community-driven health care system. 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.” 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).

According to study participants, it was imperative in the health reform process to have “a good spokesperson...a local (person) so then everyone buys in.” 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.”

Clearly the current study’s participants indicated that they were not listened to during health reform introduction or implementation phases. For example:

Government should have listened to our ideas before acting; they would have made better decisions if they would have listened to us;

We were treated like children...no choices, no options; and

They (government) made you feel as if you don’t know anything any more. They make you feel as if you have no voice in anything.

Also, the women felt 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.”

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. “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).

Study participants 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.” It was obvious that they felt it was imperative for members of the public to “stay informed ... and don't get hung up on the rumor mill.” The participants in one 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.”

Generally, the women indicated that they personally and communally found voice in the health reform process through a variety of informal mechanisms. Clearly, they continue to perceive themselves as lacking the formal voice to affect policy direction and implementation.

## SUMMARY

This paper considers preliminary findings on impacts and implications of health reform/renewal policy as perceived by rural women in two Saskatchewan communities. In undertaking such a study, there is recognition of the unique voice and interaction of this group with health care services and providers. This study's findings yield four dichotomous thematic couplings (i.e., “disconnect to connect”; “irrational to rational”; “dys-integration to reintegration”; “silence to voiced”), which further highlight the variability in responses to health reform by rural women in Saskatchewan.

This study provides insights into the need for government, health policy makers, and health providers to consider the unique roles and needs of rural women in future policy directions. It further emphasizes the need for ongoing research with rural women regarding the health care issues and challenges affecting their personal, familial, and community well-being. Clearly, the need for inclusiveness of rural women in health policy formulation and evaluation was articulated in this study. Finally, the need to study health reform implications for rural women in other provinces is strongly suggested given the unique manner in which each jurisdiction approaches this policy.

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