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EXPLORING HEALTH CARE REGIONALIZATION AND COMMUNITY CAPACITY

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FOREWORD

The HEALNet Regionalization Research Centre was established in July 1999 with a goal to provide an avenue for regional health authorities to meet their research needs in relevant and helpful ways. The Centre also promotes the study of regionalization as an innovation. The Centre's research program is designed in collaboration with decision makers in regional health authorities and other health care planners.

In 1998-99, HEALNet Regional Health Planning, the precursor to the Regionalization Research Centre, carried out qualitative studies in two Saskatchewan health districts to explore questions of health board interaction with community. This report presents an overview of the findings from those studies, drawing out the implications for regionalization and community capacity. Supplementary reports present the data in more detail for the case studies, which were in Moose Jaw-Thunder Creek and Northwest Health Districts. There is also an appendix to the overall set of documents, which presents additional detail on study methods.

Indications from this exploratory study will perhaps come as no surprise to many. We found that health reform, at least in rural areas such as in these studies, has been limited by decreased community capacity in social and political interaction. However, we also found that health reform has potential for increasing such capacity. Further, we were led to the question of whether health reform can itself succeed only if it also succeeds in increasing community capacity. Perhaps effective social and political interaction is a precondition for both health reform and community health. These questions await further examination.

We would like to thank the two health boards involved, the Moose Jaw-Thunder Creek Health Board and the Northwest Health District Health Board. Their cooperation and support was essential to the research. We also thank the interviewees of the case studies for their participation. We appreciate their time and thoughtfulness.

I would like to acknowledge Lori Hanson, co-author of the overview report and principal researcher for the case studies. Thanks also to Lynda Lee, who provided editorial and research assistance, to Harley Dickinson and Steven Lewis for reviewing earlier drafts of the report, and to Barbara Crockford and Joanne Barry for technical support.

Please note that these studies were exploratory and we consider these reports to be working documents. I encourage readers to communicate to us your comments and opinions.

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I. INTRODUCTION

A. PURPOSE OF THE STUDY

Regionalization of health care began in Saskatchewan in 1992. The provincial government created 30 health districts and devolved to them authority for delivering health care services. Regionalization was also introduced in most of the other provinces in Canada. There were several reasons for introducing health reform, in particular the need to increase coordination and integration among the different health care services being delivered. Fiscal pressures were also an important underlying theme – regionalization was expected to decrease expenses, or at least in the view of some critics, deflect opposition to health care cuts from the provincial government to regional boards. More emphasis on population health goals was another theme.

One of the other principal themes justifying the devolution of power, the one that is most relevant to this paper, was that geographically smaller authorities would be closer to the people. The public would be more involved in the decisions about their health care. This democratic intention was supported by the way health boards were to be composed: two thirds of board members were to be elected in their district, through a ward system. The remaining third was to be appointed.

The idea of increasing public participation in health care decisions was reinforced by the ideas emerging from the population health literature about the connection between empowerment and health. Although the specifics of how these ideas would be implemented within regionalization was never clear, the general principle was to increase the ownership of health care by the people. The expectations about the relationships between community members and their health boards were very high. However, little was known about what would result from these ideas, especially in a time of fiscal restraint and limited health care expenditure.

In 1998-99 HEALNet Regional Health Planning, a research group interested in questions of health care regionalization, carried out an exploratory study about the question of health board relationships with their communities. We selected two health districts for investigation, and interviewed a group of residents and board members in each district. We were interested in obtaining a better understanding the social environment within which regionalization was taking place in each district. We believed an in-depth study of relationships and interactions between health boards and their communities would shed light on the following questions: What social resources, networks and tools do rural residents have in place to solve problems and meet challenges in their communities? Do these mechanisms for processing change present obstacles or aids to regionalization? Is health reform seen as an answer to some of those challenges, or as a further challenge added to existing social change? How does the evolving relationship between health boards and communities influence the way residents or board members view the health reform process? What obstacles remain for health boards and managers, and what future do residents see for health reform and regionalization in Saskatchewan?

B. BACKGROUND OF CHANGE

1. Devolving Authority

There were originally 30 health districts established in 1992, and subsequently an additional two northern districts and one health authority. Districts were allowed to declare their own boundaries, based on population distribution, existing trading patterns, and where health facilities were located. Two important criteria were a contiguous land mass and a population of at least 12,000. This process led to a larger number of health districts than in previous attempts to regionalize, but these self declared regions were seen to have more legitimacy than externally imposed boundaries (Kouri, 1999).

Regionalization encompassed both devolution and centralization of power. Decision making power was devolved down from the province to the region, and centralized or 'devolved up' from local hospital boards to the regional level (Lewis, 1997). Accompanying this shift in authority were the two principles of wellness and community participation. One of the goals behind devolution was to bring health care decision-making closer to the people, so they could have an influence on policy decisions. It was also hoped that the community's input would help move funding initiatives into population health and wellness directions, toward preventive health care interventions, and away from a strictly medical model. A third principle, certainly not the last in the list of regions' priorities, is a move to greater efficiency in an attempt to deal with the scarcity of health care resources. However, a democratic perspective can often be in direct conflict with the managerial efficiency perspective (Rasmussen, 1997).

District health boards have the authority to plan, provide and evaluate the health services in their district as outlined in the *Health Districts Act*. The boards have the responsibility and authority to coordinate all the health services provided in their district including those provided by affiliates. The Act also gives powers to the boards for the management, investment and allocation of funds and property belonging to the health district, with several restrictions[1]. Governance of the health districts is the jurisdiction of the health boards. However, funding decisions are dependent on the budgets allocated to the district by Saskatchewan Health (Saskatchewan Health, 1998).

Funding from Saskatchewan Health is provided to the districts in an aggregated way (i.e. global vs. line-by-line budgets), permitting variation on funding allocation as per local needs. The decisions for funding allocation are made by the boards in consultation with the district CEOs and health care managers (the administrators of the system). Under the *Provincial Health Districts Act*, district health boards do not have the authority to tax. However, they are able to approach municipalities if provincial funding fails to meet their needs (Saskatchewan Health, 1998).

Funding arrangements have been shifting from historically-based funding (allocating funds to institutions and providers as per past patterns of usage) to population needs-based funding, based on relative population size, demographic characteristics, patterns of service flow and variations in service delivery costs. Because of the new funding system, accurate demographic and socio-economic data gathering has become increasingly important.

Saskatchewan directly elects a portion of district health board members. The first province-wide elections for health board members were held in October 1995. Based on a ward system, voters elect 8 members of their boards. The remaining 4 members are appointed (with the exception of Saskatoon and Regina Health Districts, where there are six appointed members). Terms of office have varied for the first term. Half of the wards elected members after two years (in 1997) and half in 1999. Health care

[1] For example, districts cannot re-allocate funds destined for community-based care to acute care or for capital expenditures.

providers are allowed to serve on boards, as are district employees, with the exception of the CEO and top managers.

2. Rural Transformation

There were two major demographic trends in Saskatchewan in the 1980s and 1990s, both of which have a significant impact for health care reform. First, the province experienced migration of its population. Residents were leaving the province, and leaving rural areas to move into cities and larger towns within Saskatchewan. Second, the composition of the province's population was changing. Residents' average age is still increasing in many communities. Of the provinces, Saskatchewan has the highest proportion of its population in the 65 and older age group, at 14.7% (Statistics Canada, 1996). This proportion is due to the out-migration of the younger population. However among Aboriginal groups, population levels are increasing and getting younger. In Saskatchewan, half of the First Nations population is under 20 years of age (Elliott, 2000). The two districts examined in this study represent these two directions in shifting population composition: Moose Jaw-Thunder Creek has an aging population and Northwest has growing numbers of Aboriginal youth.

The most significant economic trend in the province over the last several decades is change in the agricultural sector. Over the last decades, there have been decreases in the market price of agricultural commodities, wheat in particular. Commodity prices in general tend to fluctuate, contributing to boom and bust economic patterns in the province.

Grain and transport subsidies that protected farmers from extreme climatic and economic conditions have disappeared, due to international trade arrangements and national pressure against high federal debt loads. There have been major changes in the modes of transportation for agricultural commodities and other materials (i.e., shift from railways to roadways, and shifts from some roadways to others) and in the location of commercial and industrial enterprises both in the agricultural and non-agricultural sectors (e.g., elevators, industries, major department stores). While the prosperity of the 1960s and 1970s postponed a major economic crisis in agriculture, international and federal political factors in the 1980s and 1990s have contributed to economic and social hardship in rural Saskatchewan.

Certainly the number of farms is decreasing and farm size is getting larger. The size of the agricultural labour force is diminishing. Agriculture lost almost 10,000 jobs over the ten-year period from 1988 to 1998 (Elliott, 2000).

However, there is uneven development among Saskatchewan communities and different potential. For some Saskatchewan communities, the economic base is large and expanding; for other it is small and stagnant, or shrinking. People are moving to an increasingly smaller number of large urban communities and particularly the largest towns and cities. The trend is increasing in scope over time. The population in rural Saskatchewan is getting smaller. It is also getting relatively sparser. It is no longer a question of whether people leave; it is a question of where they go. Whereas some communities have an expanding population base, others have a small and shrinking or stagnant population base (Garcea, 2000).

Imbalances in economic and population bases create, in turn, major imbalances in the communities' organizational capacities and taxation abilities. The people who leave are relatively younger. Their out-migration has negative implications for community resources and school enrolments, because these are the people more likely to have incomes, energy and younger children.

However, the change in age distribution is not uniform. Although the average age for the population in some communities is increasing substantially with each passing year, the average age in others is either staying the same or decreasing substantially.

Saskatchewan's population is better educated than ever before. The number of Saskatchewan people with university degrees is rising and the number with less than a high school education is shrinking. However, although the overall educational level is increasing, many of Saskatchewan's young and educated people leave the province. Census data show that in spite of a higher high school completion rate in Saskatchewan, the education level of the population remains lower than the Canadian average for all adult age groups.

Regional reorganizing to deal with these problems has been one of the challenges, particularly in rural areas. As well as regionalization of health care, there have been proposals in the last few years to amalgamate school divisions and municipalities. Whether one perceives them as positive or negative, these strategies are intended to bring disparate resources together to create a larger and thereby more effective pool. The problem is that the strategists have not succeeded in obtaining enough agreement among the residents about their benefits. As a result, rural communities have remained somewhat discontented and underdeveloped.

There is an atmosphere of crisis in the province. Many rural communities are struggling against what are seen as outside forces eroding their services, their culture, and their way of life. This sense of emergency among struggling communities affects how they experience change, including health care regionalization.

C. CONCEPTS OF COMMUNITY AND COMMUNITY RELATIONSHIPS

To address questions about how health districts experience regionalization, we focused on community social structures and processes. A brief review of literature about community capacity provided several key concepts that shaped the interview questions and the data analysis. These concepts provided a guide for describing how the districts function, how they react to change, and how the relationships between health boards and communities have influenced the implementation of health reform.

We present the literature first by author, describing in brief form the main ideas from each analyst. We then present our application of the literature, in a synthesis of the concepts most relevant to the study.

1. The Literature

Sociological literature about the concept of *community* is roughly divided into two categories: geographic communities and communities of affinity. In this project, 'community' is used in both ways. The case or unit of analysis in each study is a geographically defined health district, but the districts are also influenced by the various communities of interest that compose them. Geographic communities (towns and villages) within the boundaries of the district are considered a form of community of interest for the purpose of this project. However, for the interviewed informants, their home towns were the most commonly understood meaning of *communities*.

The concepts of community capacity, competency, and resiliency are all useful for understanding the dynamics of communities. *Community competency* (Cottrell, 1983) is defined as a means by which individuals, groups, and aggregates work together to identify problems and needs in the community. The process requires agreement on goals and priorities, as well as ways of implementing specific strategies to meet the identified problems and needs. Cottrell proposes that if a community can provide the conditions and generate the capabilities required for this type of problem solving, it will be able to cope with the problems of collective life. There are eight essential elements that contribute to competency (Table 1).

TABLE 1: ESSENTIAL ELEMENTS CONTRIBUTING TO COMMUNITY COMPETENCY (COTTRELL, 1983)

commitment	self-other awareness
articulateness	effective communication
conflict containment and accommodation	participation
management of relations with larger society	machinery for facilitating participant interaction and decision making.

Community resiliency was first used in the fields of human development and psychology. This concept began as the idea of an individual's ability to bounce back from adversity, and evolved into a community's capacity to respond to or assimilate changes or negative events. A methodology subgroup at the Lethbridge Think Tank Workshop on Community Resiliency (1992) concluded that the elements of community resilience included seven points (Table 2).

TABLE 2: ELEMENTS OF COMMUNITY RESILIENCE (LETHBRIDGE THINK TANK, 1992)

residents' knowledge of their own history	social networks and interactions
residents' ability to develop better or different strategies	informal and formal organizations and linkages between them
residents' ability to transform how they understand things	economic and political power arrangements within the community
local interpretative frameworks (includes strategies to understand, share, and integrate certain kinds of events and may contain a spiritual or moral world view	

The academics and activists who took part in the Lethbridge Think Tank agreed that rather than deciding whether a given community is resilient, the point is to understand how the community dynamics and relationships work.

Coleman (1994) is attributed with developing the idea of *social capital* at the family or family-community level. For him, social capital differs from other forms of capital as inherent in the structure of the relations among community actors. Social capital is valuable because it can ultimately contribute to the creation of a higher-level human capital. He observes social capital in intra-family relationships and family-community relationships. He concludes that using the construct of social capital can aid in understanding the micro-to-macro transition in social structures. He identifies three forms of social capital: 1) obligations and expectations, which depend on trustworthiness of the social environment; 2) information-flow capability of the social structure; and 3) norms, accompanied by sanctions. He also identifies a unique property of social capital, called the 'public good aspect,' which leads to a situation in which "the actor or actors who generate social capital ordinarily capture only a small part of its benefits, a fact that leads to underinvestment in social capital" (p. S119).

Robert Putnam's study of civic traditions in Italy (1993) is another major contribution to the study of social capital. His 20-year study focuses on regional government's efficacy in such areas as agriculture, housing and health services. Putnam emphasizes the importance of considering patterns of association, trust and cooperation in understanding successes and failures in different regions. He uses the term social capital to mean "features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions." Social trust, in turn, is dependent upon norms of reciprocity and networks of civic engagement. Generalized reciprocity generates extensive social exchange. Networks of civic engagement are formed through organizations and associations that bring people together. Where there are primarily persons with equal power and status they are called horizontal networks; those linking people of unequal status are known as vertical networks.

Several Canadian authors have considered the importance of social capital for understanding certain aspects of health and health care. Lomas (1997) analyzed data from six public health programs with differing emphases on social and individual changes. He concluded that public health interventions should aim to strengthen social cohesion and to generate social capital, rather than expanding access to traditional, more individualistic public health programs. Belanger (1998) reviewed recent research, which indicated the effect of the social gradient is largely mediated by levels of social capital. He argued that public health workers should act to improve the overall level of health and well-being in a community by acting on those factors that directly increase the level of social capital in a community.

Flora (1995) developed a social capital framework that examined the nature of community or district level social capital, rather than individual or aggregate family-individual levels, or state levels of social capital. Flora's work is valuable because she uses community data similar to this study. She uses the concept of social capital in her examination of the impact of sustainable agriculture on the social fabric of rural communities in four American states. Expanding on Putnam's work on indicators of social capital at provincial and national levels, and Coleman's work on measuring social capital at the individual and household level, she identifies basic social structures within and between communities useful in identifying and assessing social capital in communities. In particular, she adds important elements about diversity and acceptance of controversy. She identifies as important the extent to which the people in a community can disagree with each other, while maintaining respect for each other and differences of opinions are regarded as valid. Indications of the acceptance of controversy are when there is public discussion of alternative solutions and implications; people do not avoid taking a public position; problems are raised early and alternative solutions discussed; problems are separated from solutions; and people who raise issues are not accused of causing the problem.

Themes

In summary, the following themes can be identified in the literature, forming what we regard here to be the important elements of community capacity (Table 3).

TABLE 3: ELEMENTS OF COMMUNITY CAPACITY: SYNTHESIS OF THEMES

❑ Networks and interaction
❑ Community articulateness
❑ Openness to new ideas and members
❑ Acceptance of political controversy
❑ Resource distribution and mobilization
❑ Trust and commitment

Networks and interaction. The theme of networks is one of the principal themes. Several analysts include the number and quality of social networks, and networks of civic engagement in a community, as an important attribute of community capacity. The Lethbridge group identifies "the existence of informal and formal organizations and linkages between them" and "social networks and interactions." Networks, especially more active ones, are correlated with participation, which is an attribute stressed by Cottrell. Cottrell also identifies the "machinery for facilitating participant interaction and decision making." A diverse system of *networks* generates or reflects the existence of community capacity. Linkages to other communities are expressions of *horizontal networks*, and are seen in visits to and participation in each

other's events and multi-community organizations. Linkages that extend to regional, state or national centres are called *vertical networks*.

Community articulateness: A second group of attributes is what we have called community articulateness, or expressiveness. The effectiveness of communication among the residents, the information-flow capability of the social networks, and the general level of articulateness in the community are components of a community's capacity to develop a shared understanding of the problems and issues it faces. These important attributes of community capacity are part of what Flora calls symbolic structures. The Lethbridge group also identifies as important the presence of strategies to understand, share, and integrate certain kinds of events, possibly containing a spiritual or moral paradigm. Residents' knowledge of their own history is important.

Openness to new ideas and members: The Lethbridge group identifies as important the community's ability to transform how they understand situations, and the related ability to be open to new ideas and members. This is linked to the point about community articulateness but introduces an additional dimension about openness and change. Cottrell addresses this dimension to an extent in identifying the community's ability to manage relations with the larger society. Flora's notion of *permeable boundaries* is also about how wide and open are the community boundaries -- who is seen to belong in the community.

Depersonalizing controversy: Flora identifies as an important attribute the ability of communities to accept and depersonalize political controversy. Cottrell refers to *self-other awareness*, pointing to a community's ability for conflict containment and accommodation.

Resource distribution and mobilization: Resource mobilization is a term used by Flora. She identifies the "collective and individual investment in local development efforts." The Lethbridge group takes the concept of investment further and identifies the economic and political power arrangements within the community as a factor in community resiliency, implying that arrangements that result in greater development represent a better mobilization of resources. This is linked to Putnam's attribute he calls *norms of social reciprocity,* or values and behaviours which emphasize more social interaction and more shared use of resources.

Flora argues that the more broadly resources are defined, the greater the number of people who are considered to be positive contributors to communities, and the greater the number of activities and skills that are recognized as community assets. This idea would link the attribute of networks to that of resource mobilization: networks are a type of community resource. Cottrell argues that a component of good resource mobilization within a community is that community's management of relations with the larger society.

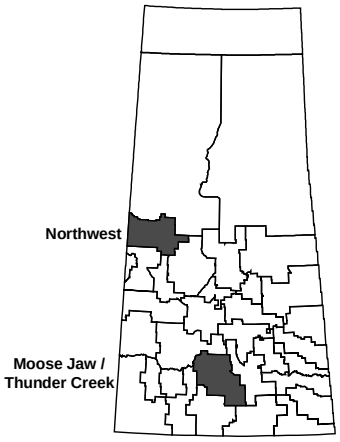
Trust and commitment: Putnam identifies trust as a key component of community capacity. Cottrell identifies commitment. Trust and commitment are treated as resources for community improvement. However, Putnam makes the point that they are themselves consequences, which depend on the trustworthiness of the social environment. The strength of community networks, and a shared understanding and vision of the community are evidence of such trustworthiness.

We used this literature to inform our understanding of community capacity as we carried out the study. However, we did not structure the study to address the specific elements. Instead we asked open questions about community relationships and interactions and allowed the key informants to raise the issues in their own way.

D. STUDY METHODS

The two districts chosen were Moose Jaw-Thunder Creek (MJTC), a large southern district near a major urban centre, and Northwest, a smaller, northern health district. Figure 1 illustrates their relative size and their location within the province. Moose Jaw-Thunder Creek is located in the southern part of the province. It contains the province's fourth largest city, while also having a large rural component, composed of typical Saskatchewan agricultural communities. As in much of the province, the district's rural population is decreasing and its residents are aging. Northwest Health District, on the other hand, is a northern district, within the geographic area known as the Parkland. It has a more diversified economy, due to logging, fishing and tourism, and the proximity of the mining industry further north in the province. The population is younger and growing, mostly in the Aboriginal sector. Northwest District has a high proportion of First Nations and Metis residents. Some reside off reserve and others reside on reserves located geographically within the Northwest's boundaries, but not falling under its jurisdiction. Taken together, Northwest and MJTC present trends and issues typical of rural Saskatchewan.

FIGURE 1: SASKATCHEWAN HEALTH DISTRICTS, SHOWING THE LOCATION OF THE OF CASE STUDY DISTRICTS



We focused on the two main topics of (1) community capacity and relationships and (2) health district board interaction with community (ies). We examined the contemporary health care issues in each district. We also asked about any tensions or major issues that may have existed in the past and whether these crossed over to health debates. We explored questions of relationships and networks, and of community action.

The study was based primarily on interviews with community members, but it included some analysis of existing district documents and observation of board meetings and workshops. The study was organized through the Regional Health Planning office in Saskatoon. Field visits were conducted on a regular basis during the summer of 1998 to gather information, to meet with the boards and CEOs, and to interview informants. During the analysis of the data, field visits, e-mail correspondence, follow up phone calls and feedback committees in each district verified the project's findings.

There were 29 persons interviewed (key informants) in the study. They included community leaders (official and unofficial), health board members and managers. The informants were not intended to compose a representative sample of the communities at large. Rather they were selected to provide a good cross-section of informed contributors. Leaders had a "recognized" history of local community involvement, included people from both "formal" political organizations and "informal" community groups, and included community members active in working with marginalized populations. District

health board members and managers were a deliberate mix in terms of their time and position with the district and their geographic area. The appendix provides more details about the criteria for selection of informants and about their characteristics.

Analysis of the interviews was done using standard qualitative techniques to create a picture of each health district. In the literature on qualitative case studies, such a *picture* is referred to as a *thick description* (Denzin, 1994). Gathering the data, triangulating it, interpreting it, and verifying the findings using member checks enabled the production of a thick description of these two health districts.

We used the themes from the community capacity literature, as we described above, to inform the analysis of the interview data. The categories that we use to present the data in this report are consistent with the themes from the literature, while emphasizing those features specific to our context and emerging from the interviews.

Additional information about the study methodology is provided in the appendix.

II. FINDINGS AND DISCUSSION

In this section, we describe the principal issues that emerged in the study. We discuss the issues in themes corresponding to the concepts of community capacity discussed earlier, and around themes of interaction between health boards and community members. At the end of each subsection, a table provides a summary in point form of the interview data for each case study. More detailed findings for each of the two study districts are reported in separate documents.

A. COMMUNITY CAPACITY AND RELATIONSHIPS

1. Resource Definition, Community Mobilization

The more broadly resources are defined, the greater the number of people who are considered to be positive contributors to communities, and the greater the number of activities and skills that are recognized as community assets. Rural Saskatchewan has traditionally relied on a large volunteer sector to mobilize community resources. Many community service organizations, such as the Lions, Rotary, Kinsmen and Kinettes have groups in both the rural and urban areas of the districts. There are also numerous community specific groups, such as hospital auxiliaries (where facilities exist), agricultural organizations, seniors committees, youth groups, etc.

Both districts define their resources and their resource users in similar ways. Generally, the poor, youth, Aboriginal people and seniors are considered in need of resources, when resources are defined as services and programs, or recreation and economic opportunities (i.e., jobs). Seniors, more so than youth, are seen to provide resources in the volunteer sector, but to draw on community resources at the same time. When resources are defined as the human capital communities possess, seniors, in particular, are considered among the most important human resources. They are an essential group of volunteer leaders in communities and are viewed as some of the most effective organizers. Volunteer resources, when described in terms of functions, are defined broadly such as donations of time, labour or money.

Health board members and managers, when they consider health and health care resources, most often see a dichotomy: resource providers and resource users. When they comment on their own community's resources, however, their perspective is similar to the description above: a broader and more complex definition. Techniques such as community assets mapping may enable boards to consider alternative views of community resources (Kretzsmann & McKnight, 1993). It may be worth exploring techniques and methods to define resources as a precursor to allocating resources. A broad examination of existing community resources, such as volunteers, leaders, skills and capacities of the population, appears to offer a complementary perspective to current notions on resources and may be worthy of further pursuit.

Most respondents expressed concern that the volunteer pool for organized activities in all of the communities of the district is aging, and that the available resources are waning. This lack of participation in community events extends into the health sector. Two respondents noted that the opportunities for community influence over health decisions are growing, but that it is a "sign of the times" that people choose not to participate or exercise influence. Due to an increasing need to occupy their time with their family's economic survival, people are less able to participate in community organization of political processes and social issues.

A number of respondents associate a lack of attendance at public meetings with a general lack of interest in health care matters. They sense that opportunities exist, but people will not directly participate until a personal stake in the issues is established. Most were at a loss as to how to foster the motivation needed to create a "buy-in" beyond the personal. Many see the issue as a wide and pervasive theme in society,

defining it as motivation for volunteer activity of any kind. A shrinking volunteer pool presents an obstacle to public participation, public knowledge and acceptance of health board activities.

Concern was also noted over the taxation resources available to communities, which dwindle as populations grow older. This situation is exacerbated in MJTC by the trend of youth emigrating from the area (urbanization) and the province (out migration). Unemployment among youth in the Northwest also contributes to a decreasing tax base.

When asked to comment on the political nature of their communities, explicitly political organizations were mentioned less frequently as resources in MJTC. There appears to be a sentiment that communities more often rally around single political issues than actively promote a specific political agenda, such as threats to community services.[2]

For example, in two instances in the small village of Briercrest, the extent of community mobilization achieved when physical resources were threatened was considerable. In the first instance, the community was successful in changing a decision by Canada Post. In the second instance the community rallied to save a store when it closed. The extent of individual and collective investment was considerable and included financial donations by individuals to the 'collective good', an important indicator of investment in increasing community capacity.

In the Northwest District as well, facility issues (whether health care or other facilities) generally appear to be the most emotive, stirring communities into mobilizing strong responses, such as the threatened school closure at Makwa in 1997. Some of the strongest indications of citizen investment were in the area of healthcare. With the current fund-raising drive for the Meadow Lake health care facility, for example, tens of thousands of dollars have been donated to the building by local businesses, individuals, and groups. The drive has involved a great deal of organizing, networking, and outreach, with a significant number of donors.

In earlier years, a similar fund-raising drive took place in Goodsoil, which involved widespread community mobilization. A diversity of community actors were involved in a variety of tasks, indicating the breadth of the resources available to the community for the drive and the importance placed on contributions by all. Both factors are important indications of collective investment in the community. Interestingly, again, health care was the motivation for the drive. Yet another important example of mobilizing around health care occurred in Loon Lake, where various groups mobilized to ensure that physician services remain part of the care provided at the health centre.

This pattern of protecting dwindling community assets and services is important in regionalizing health care. Community capacity may serve the interests of individual towns or villages, helping to rally support for conserving institutions, but it may not serve the interests of health care organized at a regional level.

[2] However, Moose Jaw itself does appear to be more political in nature than the rest of the district, housing offices for political parties, labour organizations and volunteer groups such as the Health Coalition.

TABLE 4: RESOURCE DEFINITION, COMMUNITY MOBILIZATION; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ The most common definition of resources identified by respondents is people and organizations. The most prevalent view is that the volunteer base is shrinking, aging, that younger families are "too busy" to volunteer or get involved. ♦ Financial contributions and donations are recognized as a community resource. There were numerous examples of collective investment, such as opposing post office closure in Briercrest. Individual donations also supported the campaign to save a local store. ♦ However, financial contributions and donations are not considered as significant as volunteering time. ♦ Political organizations were not suggested as community resources.	♦ Respondents provided a broad definition of resources: people, organizations and financial support. ♦ Examples of individual and collective investment include the fundraising drive for new health facility in Meadow Lake and a similar fund raising initiative in Goodsoil. ♦ A core of dedicated volunteer leaders organizes most of everything. There is a reduced volunteer base; the younger generation is not getting involved. ♦ Some encourage Aboriginals to be viewed as resource providers, not just resource users (space should be given to them on committees, etc.). ♦ Non-Aboriginal groups did not tend to identify political organizations as types of community resources, whereas Aboriginal groups did mention their political organizations as important to their communities. ♦ An issue like the threat of a school closure will mobilize non-Aboriginal communities (e.g., a school closure in Makwa in 1997 rallied people to oppose it.)

2. Personalizing Politics

Personalizing politics is a negative aspect of social interaction discussed in the community capacity literature. It refers to a tendency to identify individuals and/or their reputation rather than issues as problematic or politically controversial. Depersonalizing political controversy, on the other hand, is a positive indicator of community capacity and refers to the extent to which public discussion of alternative solutions is encouraged and stances on political issues do not become personal. Most respondents believe differences exist in the way that rural and urban people experience controversy. In the Northwest, rural people are considered less willing to deal openly with controversial issues, particularly those created by changes in their villages. Avoiding controversy and an inability to depersonalize politics represent obstacles to health reform. A culture of avoiding controversy may lead to leaving issues unresolved, especially when addressing change in communities.

In the MJTC District, rural people are considered more politicized and more apt to deal effectively with controversy. However, looking at examples offered by MJTC respondents, contradictions emerge regarding responses to controversy in rural areas. In dealing with facility issues, sometimes there is a tendency to personalize the issue or hide opinions from public scrutiny. Thus, in a town that responds to the threat of a health facility closure by mobilizing hundreds of people to protest conversion plans, community members blame the local health board member for the changes.

One board member related an incident in her town, which illustrated the obstacles presented by communities who personalize politics. When threatened with hospital closure, the town mobilized hundreds of people to back a proposal created by town leaders to "save their facility". The strategy proposed by the community was eventually accepted, but the board member was held personally responsible for some of the negative outcomes associated with the changes.

How a community handles controversy and whether it can be dealt with openly, influences how health reform is experienced. Regionalization aims to involve the public in the consultation process, but responding by personalizing issues can result in negative and long-lasting relationship difficulties and the deterioration of community capacity. People mobilizing around a health care concern may seemingly create a conundrum for the board, but may also be viewed as an opportunity to foster community capacity.

TABLE 5: ACCEPTING CONTROVERSY, NOT PERSONALIZING POLITICS; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Region is considered by its residents to be highly politicized; some issues are highly divisive (e.g. Wheatpool). ♦ Can people separate issues from personal attacks on individuals? Sometimes. It's easier to depersonalize politics in the city (Moose Jaw) than in the rural areas, although newspaper editors seem to be the exception (some wanting to instigate controversy).	♦ Informal approach to agencies and institutions is encouraged. The positive result of this is an open and friendly community. The negative side is that difficult issues may remain un-addressed, un-debated, and left to "simmer." ♦ In print media, community members usually did not notice an exploitation of controversy, with the notable exception of one newspaper editor. ♦ There was some evidence of personalizing politics, people being reluctant to take stands publicly. ♦ There was some evidence of personalizing politics, people being reluctant to take stands publicly.

3. Inter-Community Networks, Open Boundaries

What obstacles to district identity (and regionalized health care delivery) exist in traditional views of belonging to a community or town? How open or permeable are the boundaries of that community?

In both districts, community identities or loyalties are often defined by "natural" or historical boundaries. Beyond a certain distance or a certain circle of communities, there is a qualitative change in the nature of social relationships among communities. People and institutions from outside those limits are considered outsiders. Town icons or village historical structures and symbols are particularly well protected by town or area loyalties. Outsiders are not trusted when they tamper with those icons. Rural or isolated towns and villages, in particular, have borders difficult to permeate, in part because open boundaries might mean losing scarce resources. In that context, board members and managers who are unknown to residents can be faced with historical or traditional social barriers. Particularly at the outset of health reform, they were sometimes viewed with suspicion, since they were given the difficult mandate of changing those exact structures that help to define local identity and boundaries. Even now, for those board members from towns where facilities may be destined for change, they continue to have the difficult task of convincing the locals that "opening boundaries" is acceptable and even desirable. These social barriers address the issue of trust found in the community capacity literature, and how a lack of trust can present obstacles to a community solving problems effectively.

In the Northwest, villages were reportedly more likely to compete for resources than cooperate, based on historical patterns. Even job creation programs, can lead to other problems of access such as rivalry between communities (because of the location of a business, for example) or unequal access to other community resources in short supply, such as housing.

In the MJTC District, historical rivalries between towns are easing and cooperative partnerships becoming the norm. This cooperation may be a result of communities facing serious rural depopulation. In this case, rural depopulation is having a positive effect on community capacity– helping to form

intercommunity boundaries, and perhaps shift the emphasis off single town or village identity, and on to broader regional identity. Are health boards and health regionalization reflecting this trend, or furthering it? Or both?

Respondents did not mention specific formal multi-community partnerships among villages in the Northwest district. They suspected there were few for several reasons, including geographic issues (for e.g., roads, distances, common resource bases) and historical patterns. Racial boundaries are also significant in this district. Typically communities close to each other compete for scarce economic resources (jobs). Thus when local opportunities arise, multi-community efforts become easily blocked. In the recent past, the communities of the Beaver River R.M. experimented with multi-community partnerships (in tourism), which failed for unknown reasons. However, the inter-agency committee out of Meadow Lake that recently fund-raised for a new health facility made some strides here. This is discussed more fully below.

Traditional rivalries and competition between towns and villages create obstacles to regional identity, and consequently influence the reception of health reform. Lack of trust in outsiders also presents problems for board members who may be representing many other communities than those in which they reside. However, there is some evidence of communities acting together to meet the challenges of the future. Some of this evidence is taken up in subsequent sections.

TABLE 6: OPEN BOUNDARIES; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ People identify most with the towns where they use services (schools, shopping, recreation). ♦ Allegiances stretch to a radius of about 20 to 30 miles around one's hometown, about two communities. ♦ Historical rivalries between towns are easing and cooperative partnerships becoming the norm.	♦ Racial boundaries are the most significant factor in this district. ♦ Respondents mentioned few formal intercommunity groups. Obstacles identified by interview participants included distance, historical patterns and the fact that communities are more likely to compete for scarce resources than cooperate.[3] ♦ Some recreational interactions go on between communities (seniors, youth, etc).

a) Links Among Similar Organizations

Horizontal links are described in the literature as networks of organizations of equal stature, often characterized by diversity and inclusiveness. Inter-agency organizations appear to be one of the newest and most promising enablers both districts possess for the development of community capacity. In MJTC, multi-community partnerships and organizations are increasing in number and in breadth of community involvement. Interestingly, health boards appear to be integral in fostering the development of the inter-agency organizations. Health care (facility) issues are among the main reasons cited for rural communities to form multi-community partnerships.

As described earlier in this report, informal linkages among communities and groups are numerous in MJTC. Inter-community participation in events still appears to be considerable, though diminishing. Such linkages are fostered through sport, school, church and seniors' activities. Respondents gave many examples of multi-community activities.

[3]Since the study was done, the interagency group in the Northwest has developed and has recently applied to have some of the Regional Intersectoral Committee funding come directly to the interagency providers in the district; also the Primary Health Centre in Loon Lake has brought together a dynamic group of people.

In MJTC several new networks or multi-community organizations work collaboratively on social and economic issues affecting rural communities. Respondents illustrated the growing capacity of these groups to organize responses to political situations affecting rural communities. The multi-community organizations cited by respondents include the "Building a Better Community"[4] committee, consisting of towns along Highway 42 from Marquis to Tugaske; the Midlakes Community Coalition, which takes in communities linked by Highway 11 along the corridor between Lake Diefenbaker and Long Lake; and an organization of municipal leaders in villages and rural municipalities surrounding Central Butte.

In the MJTC District, multi-community organizations are growing and strengthening in their resolve to "save" rural communities from extinction. These are positive forces, with the potential for substantially altering the nature of community capacity, particularly if the groups can successfully expand in the size and diversity of their memberships. (At present, it appears that groups are often characterized by a small number of already active leaders).

Several respondents in MJTC noted difficulties and weaknesses in community networks and collaborative structures (horizontal linkages). According to them, there are tenuous or non-existent linkages (especially formal horizontal linkages) between the urban community groups and the rural organizations. It is also unknown to what extent marginalized sectors of the population are included as partners or members of multi-group efforts. There also do not appear to be formalized multi-community structures in certain parts of the district such as the southeast corner of the district, partly due to its proximity to Regina or to differing community values within the area.

In the Northwest, an important change has recently taken place in the work of the main inter-agency group. With their expanded mandate, which includes joint problem identification and sharing of solutions, the groups have moved beyond information sharing into joint programming. The organization involves a diverse group of leaders, who have managed, relatively quickly, to agree on goals for the organization. The inter-agency network works only in and around Meadow Lake, and no formal horizontal linkage of this type was reported for other communities. However, inter-community agreements on service provision do exist, such as fire protection or emergency evacuation. The data were insufficient to fully show the reasons why linkages with other communities/groups outside of the town, and within other areas of the district, are slow to develop, both in terms of inter-agency work and in terms of multi-community partnerships. However, the data did suggest that the independence and isolation of more rural communities in the district contribute to a "historical way of doing things" that inhibits networking.

Efforts at collaboration between communities offer the opportunity for districts to develop a regional identity, which may facilitate the transition to regionalized health care. Inter-community agencies also provide a chance for meaningful public participation in health care decision-making.

[4] An interview respondent explained The Building a Better Community group in the following way:

> *"We got this local government group together. It used to be that all the places around were fighting to get something for themselves. Now we're all working together to maintain things in the area that we have and try and get other things into the area you know…we're the only town in this and [there are] village councils and the RMs… it was from Riverhurst, Elbow, Lorburn, Tugaske, Eyebrow, Chaplin, Brownlee, and then there was the RM of Maple Bush, Enfield, Huron, Eyebrow, Chaplin, and we had just got it formed before this health care crisis hit and I think we'd had one meeting and thank God we had because then we got all ready to go and total cooperation to maintain something at Central Butte then and we did it cooperatively and it worked well."*

TABLE 7: LINKS AMONG SIMILAR ORGANIZATIONS; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Multi-agency groups exist in Moose Jaw (local chapter of SK Health Coalition). ♦ New groups are forming to deal with rural depopulation issues, such as "Building a Better Community". ♦ Inter-community participation in events is considerable, though diminishing. ♦ Links include diverse groups within communities. ♦ Multi-agency groups seem to be geographically patchy (some areas of district are not covered). They exclude marginalized groups, and have trouble making connections between urban and rural organizations.	♦ The Meadow Lake inter-agency group (formed of the different human service agencies) is evolving and turning to problem solving, which is making a difference in the community, but is only active in and around Meadow Lake, not with other communities.[5] ♦ Examples of links cited at the local level included service agreements for fire protection and emergency evacuation. ♦ Economic development multi-community agencies were not in evidence, except those involving the Meadow Lake Tribal Council. ♦ Recreational links between communities are numerous (sports, rodeos, bingos, seniors' groups).

b) Links to Government Organizations

In the community capacity literature, vertical networks refer to community groups' links to public resources at regional or federal levels, and to the visibility of public officials in the communities. There was little data available to explore vertical linkages in any detail, but one significant though rather obvious finding emerged. There are differences in: the ways that rural and urban people relate to public offices, the frequency of contact with public officials, and rural and urban views regarding the necessity for vertical linkages. Given the geographic layout and concentration of populations in the two regional centres in each district, it is perhaps not surprising that vertical linkages, indicated by the visibility of public officials, are more common in the urban centres, and are viewed with a certain resentfulness by rural residents.

Rural respondents claim, more often than not, that 'urban outsiders' do not understand their reality, that politicians have an urban bias and do not care about their communities, and that therefore provincial and federal politicians are not to be trusted[6]. As well, as is perhaps endemic in Canada's political system, there are tensions between the three levels of government. Municipal leaders expressed how the downloading of responsibilities from federal to provincial and provincial to municipal levels of government is unfair and burdensome. At the same time, respondents noted that rural towns depend on the resources located in urban centres (especially those provided through government offices). As a result, in the rural communities, formalized vertical linkages with higher levels of government are problematic, viewed almost as an evil necessity. However, in the city, provincial political offices are accessible and vertical linkages, at least up to provincial levels, appear to be more common and easier to form.

[5] See Footnote #3.

[6] This tendency to distrust urban dwellers is not new. Lipset remarks on its appearance at the beginning of the 20th century: "External business controls tend to make farmers hostile – the degree of hostility varying with the price of wheat – to the entire urban world, including the cities and towns of Saskatchewan… This cleavage between farmers and the urban middle class is accentuated by the fact that the organized community life of the rural population is carried on independently of social activities in the neighboring towns and cities. There are very few institutions which bind farmers and townspeople together in a common enterprise." (Lipset, 1959).

In the Northwest, provincial or federal agencies and institutions and their representatives have a low profile in the district outside Meadow Lake. With the exception of an occasional visit of an MLA near election time, villagers reported feeling mostly ignored by the provincial political system. As a result, it would appear that vertical linkages to provincial or federal governments are either too few or too rare to be considered significant by most villagers. Local politics are considered more accessible and more important.

The situation differs somewhat in Meadow Lake, where regional offices of various government agencies are located, and public employees make up a significant number of the local population. But while regional importance lends itself to vertical linkages upward to higher levels of government and commerce, it can also breed resentment. Meadow Lake (as associated with the town, the school board, the health board, or the office of social services, etc.) was often described as being the most privileged community in the district. The visibility of public offices or institutions in Meadow Lake were sometimes reported as symbolic of the political hegemony of the town over the district villages.

For the First Nations communities in the Northwest, vertical linkages have been historically established with federal levels, but seldom provincial. The MLTC also has vertical linkages internationally through their economic ventures.

Trust is one of the key concepts behind community capacity and social capital, enabling communities to deal with change effectively. A suspicion of outsiders, at the urban, provincial and federal levels, makes the centralizing aspect of health regionalization a challenge for many rural residents, and for board members alike.

TABLE 8: LINKS TO GOVERNMENT ORGANIZATIONS; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Rural resistance to urban organizations makes rural use of provincial and district resources (available in larger centers) more difficult. ♦ Links to the province and Ottawa seem easier in the urban setting (provincial offices).	♦ Weak links exist with provincial or federal institutions. Meadow Lake has more provincial and regional offices, but while this improves vertical links, it seems to breed resentment or envy from other communities who feel Meadow Lake has a privileged position. ♦ Vertical links to federal institutions have a long history in Aboriginal communities, but not with provincial institutions.

c) Within-district divisions

There were two issues that emerged from the findings that had to do with within-district divisions. One of the significant boundaries between populations in the province is between Aboriginal and non-Aboriginal residents. These relationships remain a significant factor in decision making and health outcomes for those districts with a significant proportion of Aboriginal residents.

Demographic differences in ethnic make-up, age composition and economic classes between the districts are quite striking and they help to explain some of the findings around community capacity. While comprising only 1% of the population of the MJTC District, people of Aboriginal ancestry make up more than one-third of the Northwest District's population. As well, there are 3.3% more elderly people in the MJTC District than the Saskatchewan average; while in the Northwest there are 7% more youth (from 0-14 years) than the province as a whole. The numbers of low-income families in the Northwest is also substantially higher than the MJTC District, particularly among the First Nations populations.

The Moose Jaw-Thunder Creek district is relatively homogeneous ethnically. Therefore, tolerance and valuing of diversity in the district, with respect to ethnicity, do not emerge as issues. When asked, respondents considered the district to be tolerant about ethnic differences. At the same time, they also recognized that the relative absence of minorities (or their invisibility) in the district might mask intolerant attitudes or structural discrimination. Some indicators of structural discrimination, for example, include minorities disproportionately using the Food Bank in Moose Jaw, more often living in poverty or being otherwise "marginalized". At present, the health board's main access to some minorities appears to be through their formal organizations or associations. One or two members who have regular contact with groups representing marginalized people, such as mental health groups, bring their concerns to the board table. Board members consider current strategies for accessing such "high risk" groups inadequate, and have indicated the need to find more appropriate mechanisms for improving services for these constituents (Long Term Strategic Plan, 1998). Improved services for high-risk groups will, theoretically, assist in developing relationships with marginalized groups and increase tolerance in the district. However, the quality of the interactions that take place will be an important determinant.

In the Northwest, issues related to diversity and tolerance are complex. People from villages and First Nations communities interact on a daily basis, but principally for the exchange of goods and services. On the surface, relationships between villages and First Nations communities appear amicable, and many examples exist of the two cultures exhibiting interest in and respect for each other. However, deeper issues of power and privilege remain. The historical pattern of the reserve system perpetuates the existence of two separate and distinct cultures. There are limited kinds of current interactions, and there are historic negative relationships between First Nations and white government and residents. Racial and cultural barriers must be taken into account when assessing attempts to establish relationships between Aboriginal communities and health boards. Existing and emerging linkages, such as the inter-denominational church group, or the inter-agency network, are thus to be celebrated as significant achievements. Expanding the existing links between organizations and individuals, including more leadership opportunities for First Nations people, and further cross cultural educational opportunities, could serve to develop further community capacity in the district. The district health board may have an opportunity to be a leader in forging links between the two cultures.

It was the general view of interviewed leaders that controversy, created by change, is especially difficult to accept in smaller communities. Changes that involve perceived economic threats to communities are the most controversial. In that context, despite the proximity of many district villages to reserves, moves toward self-government and self-reliance of First Nations people are poorly understood and often resented by surrounding communities. For several non-Aboriginal respondents, the construction of schools and facilities on reserves were cited as controversial issues for them and for other residents of the surrounding villages and towns.

Given the legislated mix of board members, opportunities for fostering cultural dialogue are more immediate for the health board than they are for many other local organizations. Opportunities may exist for the Northwest Board to explore decision-making processes unique to Aboriginal cultures, creating the chance for strengthened consensual decision-making forms to emerge. As well, dialogue could enable the Tribal Council to expand their linkages to leadership within the non-Aboriginal community.

The other tolerance issue that emerged is the division between rural and urban. In the preceding sections, we noted that rural respondents claim, more often than not, that 'urban outsiders' do not understand their reality, that politicians have an urban bias and do not care about their communities, and that therefore provincial and federal politicians are not to be trusted. This is one of the more divisive and unyielding boundaries that continue to pervade residents' attitudes to each other. In Saskatchewan, rural-urban tensions are as old as the province itself. However, in the current period of rural decline, the tensions have increased. Accusations have become more bitter and more blaming. Residents have become more

inflexible in finding solutions to existing problems. These are indications of rigid boundaries and a weak ability to depersonalize and accept controversy.

B. BOARD-COMMUNITY INTERACTIONS

1. Interaction and Relationships

Health boards and communities interact in similar ways in both districts, both formally and informally. Informal communication takes place in coffee shops, and other community groups in which board members are involved on a personal basis. Informal interactions are a key source of board members' local recognition, and are essential in creating and maintaining relationships with individual communities and groups. However, informal discussions are also the source of role conflict, causing potentially divisive tensions between members of the board, and between management and the board. While there were examples of this problem provided confidentially in the MJTC District, the problems created by multiple community roles and competing loyalties was especially apparent in the Northwest.

Various community leaders, management and First Nations respondents described tensions that periodically arise when board members represent differing interests in the community. However, with the exception of one member, health board respondents themselves did not see a conflict in representing various interests and levels of citizenry (i.e., group, community, district).

Formal communication takes the form of written submissions to the board or oral presentations at board meetings. The two district boards' formal interactions with community constituencies, while similar in content and format, differ in process. In the Northwest, all groups of respondents stressed the importance of informality and openness as a way of being accessible to the district's population. Protocols of access, per se, were not discussed by any group of respondents, although managers suggested that interactions among board and community groups take place within a community development model. In the MJTC District, formal processes and protocols appeared to be more established. Patterns of interactions with district constituents were clearly outlined by managers, and were recognized by board members. Accessibility was still highly valued by the board, but caution about being "swayed" by special interest groups was of equal concern. As a result, there appeared to be more guarded access to board agendas.

Interactions in the Northwest District also involve direct interactions with First Nations communities through their governing structures such as the Meadow Lake Tribal Council (MLTC). Because of the relationship between First Nations and the health district, the board and management have an indirect relationship with the federal government. Interactions with First Nations communities occur mainly at the level of management on both sides. They interact in two ways: 1) two First Nations members are appointed to the board, who attend board meetings and convey information to the governing structures of the Tribal Council and individual band leaders and 2) senior managers meet with the MLTC Health and Social Development Authority and Joseph Bighead band officials, regarding specific health service agreements between the board and First Nations communities.

There were notable differences in interactions between boards and communities among rural, urban, reserve and village populations. Rural board members in both districts are more visible in their wards due to small community populations or to the numerous leadership roles that most board members have in those settings. As a result, there are generally more opportunities for community members to interact with rural board members than there may be in an urban setting. In both districts, this trend may be changing somewhat. In the case of the Northwest, the visibility of the board increased considerably recently, due to the extensive fund-raising efforts for the new health care facility in rural and urban communities and on reserves. In Moose Jaw, the board recognized their relatively low profile, and the

Long Term Strategic Plan (1998) outlined strategies for increasing board visibility and improving public relations.

There is a general sense among health board members and management that community members' knowledge about the way the district health board functions is limited. Several of the community leaders interviewed for the study were unable to answer questions related to the health board because of their own lack of knowledge of who was on the board, what the board's role was, or what had changed in health care governance. There continues to be confusion in public perceptions regarding who the boards are, what exactly the boards do, and what decision-making powers they have. The confusion appears to be related to defining and understanding terms. In a related way, problems also occur around the boards' concept of the "public". The confusion affects the perception of relationships between communities and the board, and is thus worthy of mention.

In general, the district health board enjoys a relatively high profile in the Northwest communities. Most respondents suggested that the majority of local citizens know of the existence of the board and also know their ward's representative. In Pierceland, creation of the health board is credited with making health services and issues visible to the community, where they were not before.

In the MJTC District there is a considerable number of citizens with little or no knowledge of the health board at all. In several cases, community leaders blurred the lines between senior management and the board. Examples given of interactions with the board were clearly examples of *management* interactions with communities. When considered simultaneously, these findings suggest that some examples of interactions between the board and the "public" may not be accurate, and that the "board/public" relationship may need re-definition.

Concurrent with other literature, particularly in the field of community development, this research suggests that relationships with communities are essentially built on trust, mutual agreement about goals, and a sense of power sharing. In the studies, certain strategies that have assisted in developing relationships emerged, as did the recognition of particular personal or group capacities.

Capacities emphasized in the MJTC District that were considered essential in developing relationships included: citizen access to the board; board receptivity to communities and constituents; board members' openness in addressing issues; willingness to take a public stand on those issues; and board flexibility in working with a variety of groups.

In the Northwest, the skills and capacities noted were similar, especially the capacity to communicate with communities and to involve stakeholders in the process while simultaneously balancing their differing interests.

Difficult relationships with particular communities have existed in both districts. Often time consuming and frequently frustrating, these relationships test board resolve. In one case, they even led to the board chair's resignation. Difficult relationships also offer opportunities to learn lessons and to establish standards or protocols for future use. Examples of relationship-building strategies which were born out of difficult relationships in the districts include opening board meetings to directors of affiliates and vice-versa (in Moose Jaw), and the use of written agreements with affiliated or amalgamated agencies and First Nations political structures. These agreements outlined rights, responsibilities, expectations, and obligations of the relationships.

TABLE 9: BOARD-COMMUNITY INTERACTIONS; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Board members interact with community members officially, during board presentations, meetings, newspapers, and unofficially during social and recreational encounters. They also encounter their community residents as representatives of special interest groups, in the more formal board consultations exercises. ♦ Board members reported that the personal communications they may receive from individual community or interest group members have to be weighed against evidence, e.g.: a specific institution claiming to be understaffed, compared to the percentage of resources they are allocated against other institutions. ♦ Board members' multiple roles in the district and in their communities can create tensions, even though they generally prefer to represent the district as a whole rather than their own ward's interests. They can have associations with interest groups or communities outside the health sector, which may sometimes conflict with their board roles. Conversely, these multiple roles may give board members credibility as community leaders. ♦ Capacities that were considered essential in developing relationships included: citizen access to the board; board receptivity to communities and constituents; board members' openness in addressing issues; willingness to take a public stand on those issues; and board flexibility in working with a variety of groups.	♦ Board seems to have high profile in the district– although some confusion exists between who is management and who is board. The board is well known because of its role in building the Meadow Lake health facility. ♦ Having multiple roles in the community (other than board member) contributes to board members' visibility, but can also contribute to tensions between roles. However, most board members seemed to think they were able to handle any tensions their roles created. ♦ There are open board meetings. Groups make formal submissions. There is an emphasis on board flexibility, allowing diverse groups to involve themselves in board meetings upon request. ♦ There are public, community meetings at which board and interest groups make educational presentations. There are educational or fund-raising meetings with groups (outreach). There are door-to-door campaigns and fund-raising events. ♦ Two First Nations members are appointed members of the board. Senior managers meet with the Meadow Lake Tribal Council Health and Social Development Authority and Joseph Bighead band officials. ♦ There are informal interactions, such as with community members in unrelated organizations (coffee row and other networks or groups). ♦ Capacities to communicate with communities and involve stakeholders in the process while simultaneously balancing their differing interests were emphasized as essential to developing relationships.

2. Perceptions of Community Control

Some respondents suggested that there is increased community control under regionalization, because board members are more accessible to local citizens than former hospital board members. Another reason some respondents thought community control increased was the existence of public meetings for expressing opinions. A few people expressed the notion that the electoral process ensures accountability and community control, while tempering their observation by noting low levels of participation in elections and the existence of acclaimed and appointed members[7]. Many acknowledge that while local control over institutions has diminished, there is increased potential to influence health board decisions (especially programming decisions) at a wider level.

[7] In 1995, there was 14% turnout for elections, and a 10% turnout in the 1999 elections. 84 of 127 positions in the 1999 elections were filled by acclamation. ("Health Boards Need to be Fixed" editorial, Star Phoenix, Oct 16, 1999).

There were a substantial number of respondents who felt that the establishment of district health boards has decreased the opportunities for local input and control over decisions made. Often these respondents associate the former hospital, ambulance or other boards with times when they had more local say over the institutions in their towns.

Community control was also discussed in terms of sizes and kinds of bureaucracy and decision-making powers. For some managers and board members, the move to regional boards has decreased bureaucracy, because especially the CEO can make decisions more quickly at the local administrative level. However, people perceived this as both liberating and dangerous, as CEO's could move quickly and make relatively big decisions without passing through many obstacles. Management tended to describe these changes as positive and enabling. But for some community people, boards and management are also described as being endowed with great powers to make swift and painful decisions, such as closing rural facilities in the face of a disempowered local community.

In the Northwest, many see proximity of community members to the boards or decision-makers as a relevant factor. Various respondents note that people in rural communities, whose health facilities formerly had hospital boards, feel their power to control decisions has diminished, because their local board no longer exists. Community members often express this concern as their own or as one that they hear often in their communities. Board members and management, on the other hand, recognize that the concern exists, but do not necessarily share it.

Some Northwest respondents stated that local people view the establishment of the boards as evidence of the trend toward centralization, closing rural facilities, or decreasing rural services. As a result, the health board is feared or mistrusted because it appears endowed with powers to close local facilities in the face of a disempowered community. Another aspect of community control noted by respondents related to the composition of the board in terms of appointed vs. elected board members. A few respondents wondered if the current composition of the board allowed sufficient control over decisions by the elected members.

Other Northwest respondents, both First Nations and Non-Aboriginal, expressed concern about the composition of the board in terms of the number of First Nations Board members. These people wondered whether the First Nations citizens in the district had sufficient voice on the board, given that there were only two members.

TABLE 10: PERCEPTION OF COMMUNITY CONTROL; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Perception about community control over health care decisions varied depending on the issue. ♦ Some say boards listen to the community more closely now than before health reform began. Some say local control over issues has been reduced, compared to previous local hospital boards. ♦ Others suggest that lower local control may result in greater chance of impact on wider district decisions, more influence on the big picture, but less influence on facility issues; ♦ Some imply that there is scope for community involvement, but that community members are not taking it up or are not interested in it. There is a decreasing volunteer force. ♦ Decreased bureaucracy means that the health boards and managers can act more quickly. This has positive and negative effects for community control. Things can be accomplished quickly, with or without community input. ♦ Many interviewees were unable to suggest ways to increase interest in community meetings, etc., which only seem to be well attended if the community members have a personal stake in the issues.	♦ Communities that have lost local hospital boards (under regionalization) feel that they've lost control or input into decisions – again fear of facility closures, fear of *centralization*. ♦ Conversely, the *devolution* of power was characterized by some as positive, control closer to rural areas rather than being in Regina (e.g.: hiring a mental health social worker). ♦ For management, control over issues has increased because they can act much more quickly; ♦ Some people preferred totally elected boards, with no appointed members. ♦ Some Aboriginal interviewees wondered if there was adequate Aboriginal representation on boards. ♦ Two respondents pointed to financial control as an indicator and noted that control over finances still rests outside of the hands of the boards.

3. Issue Definition

In MJTC, board members report hearing anecdotes and concerns about the health care system in informal ways such as a conversation at church, or a phone call from an irate neighbour. This type of access is particularly common in rural areas, where board members have higher public profiles. Occasionally, a board member thinks that a concern warrants examination, and she/he brings it directly to the board, where it may or may not get defined as an issue and examined further by management. In a less direct way, the knowledge and experience they have accumulated through their multiple roles in the community are believed to influence what gets attention in board meetings and potentially what gets defined as an issue.

In the Northwest management describes the decision-making process as adequately adapted to the district's population. That is, the process is informal, accessible, and emphasizes the involvement of stakeholders in prioritizing and acting on issues. Several times it was referred to as a community development process. One manager envisioned the role of the board members within this process as catalysts to getting the community involved.

First Nations respondents' view of the decision-making process was more critical than other groups. While acknowledging that there is more room for their issues to be brought forward in the present structure than there were in the past, they still have a sense that First Nations processes and issues are sometimes excluded.

In the Northwest, populations on Reserves had few direct interactions with board members, and it was unclear whether such interactions are expected. The lack of clarity of expectations for the elected

members may have been exacerbated by the existence of appointed members from the MLTC.[8] In some wards with First Nations communities within their borders, the elected board member has established relationships with people on reserve, particularly where both populations share concerns over facilities. In other wards, elected board members do not appear to have any regular contact with First Nations communities within the borders of their wards.

TABLE 11: ISSUE DEFINITION; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Managers and board members seem to approach the definition of issues and the decision processes differently. They both try to avoid being "swayed" by interest groups, although they want to listen to the community. ♦ Managers believe they take a rational approach based on gathering appropriate evidence. ♦ Boards tend to think more in terms of political and ethical reasons for identifying issues.	♦ Issues are defined by public opinion; personal values and experience; Saskatchewan Health's strategic and political directions; and board goals and missions. ♦ Information sources include formal submissions from groups; demographic and other information forwarded from management (particularly the CEO); and board-generated documents such as needs assessments. ♦ Informal discussion between members of the public and board members can bring issues forward for board consideration, but only if backed up with other information sources. ♦ Management views the board as part of a community development process, involving the public, stakeholders in defining issues, information gathering, etc. ♦ Aboriginal interviewees were more critical of decision processes, feeling more excluded from issue definition and decision making.

4. Communication Strategies

Information from the health board is given regularly to official health leaders in the First Nations communities by the MLTC board members. Direct contact between other board members and people on reserves in their wards is sporadic, however, and there is reportedly only occasional use of informal strategies, such as the "moccasin telegraph," for disseminating information in First Nations communities.

First Nations respondents concurred in their opinion that residents of most First Nations communities are poorly informed on issues related to the health board and health service delivery. As well, various respondents from all groups suggested that First Nations health issues are not well understood by board members and management. No respondent was sure whether the lack of knowledge was considered an issue in need of action, however. Nor were respondents sure whose role it would be or what strategy could be employed to initiate and facilitate direct communication.

[8] First Nations communities are located within wards of the District, and First Nations people have the right to vote for candidates of those wards or to put forward their own candidates for elected positions. They do not vote for their own candidates apart from this arrangement. However, the Memorandum Of Understanding signed with the province established the MLTC's right to name two board candidates that are then appointed to represent the interests of the First Nations people in the district.

Information dissemination strategies directed at the general public and at staff from the district board (as a whole) include newsletters, newspaper articles, advertisements and press releases. Informally, individual board members disseminate information through face-to-face encounters, writing letters to the editor on health care issues, periodically attending "coffee row", and generally being accessible to people to speak with them on health care matters or to hear and channel concerns.

Information gathering strategies mentioned include the 1994 needs assessment, group submissions at public board meetings, face-to-face encounters with staff and community members, and feedback forms attached to newsletters.

The print media play a large part in creating or deflecting attention from controversy, and informing people about local health issues. Several media issues emerged worth consideration, including: 1) without one print medium to reach all parts of the district, information can be unevenly distributed; and 2) relationships between the board and the principal print media in both districts appear to be somewhat more positive than in the past. Given the pattern of relating to the media, particularly in the MJTC District, where more antagonistic relationships with the board have existed in the past, the redefinition of media relationships is an emergent challenge. Theoretically, a lack of attention to the board's relationships with the media will continue to contribute to the media's tendency to personalize politically complex health care issues.

While many information strategies exist, all respondents feel that there are problems with the information flow and usage, both to and from the health board and communities. Respondents offered many reasons and explanations for the lack of information and concurrent lack of knowledge about district health boards and health care matters. Some of these reasons relate to access, quality, and presentation of mail-out information. For example, many respondents questioned the effectiveness of newsletters. Newsletters are reportedly sent to all households, but it is questionable whether all residents receive them, and likely that few read them, according to many respondents' views.

Communications strategies were almost universally considered to be ineffective in both districts. Stated objectives of information gathering and dissemination were not met, and neither were longer-term goals of relationship building. However, lessons were learned and strategies began to change. Particularly in the Northwest, communication strategies that were found to be most effective were those that brought board members face-to face with constituents. Outreach was singled out as the most effective mode of sharing information and interacting with constituents. The multitude of fund-raising meetings between the board and community groups over the past few years also had a spin-off effect of securing trust with communities and groups which was a first step in building relationships.

Although communication strategies were not often discussed in terms of their functions, other than information exchange, they produce other effects. Certain strategies actually appear to be as important for relationship building as they are for educational purposes or information exchange. Two strategies, which are used extensively in the Northwest, appeared most effectively to foster positive relationships between the boards and community groups and individuals: face-to-face encounters, and meeting people on their own territory (i.e. outreach). Use of these strategies potentially affects relationships in two other ways. They appear to increase motivation to become involved or maintain involvement in health care matters, and they simultaneously create a sense of proximity to decision-makers, which respondents considered essential in fostering a sense of community control.

TABLE 12: COMMUNICATIONS STRATEGIES; SUMMARY OF INTERVIEW DATA

Moose Jaw-Thunder Creek	Northwest
♦ Information *dissemination* methods included newsletters, newspaper articles, advertisements and press releases. Informally, there were face-to-face encounters, letters to the editor. ♦ Information *gathering* methods included the needs assessment, group submissions to board meetings, feedback forms attached to newsletters, and face-to-face interactions in community. ♦ All sectors acknowledge problems with the flow of information both ways. Managers and board members think community knowledge of the board is limited. ♦ Reasons for lack of knowledge in the community included the newsletters being ineffective at communicating and ineffective advertising of public meetings. ♦ Rural board members are believed to be more in touch with their communities as they see and interact with their constituents more frequently. However, no evidence of such a disparity in knowledge between rural and urban residents was found in this project (interviews). ♦ The print media is seen as not contributing to community awareness of boards. Only negative aspects of health reform have been covered in newspapers. Lack of a district wide newspaper (a number of community newspapers are needed to reach a whole district). ♦ Community suggestions to improve communication included: a door-to-door campaign with pamphlet; the web page; outreach to captive audiences; better/different publicity on public meetings; getting community input through committee work (e.g. ethics committee); setting up advisory boards from the community; changing the focus of public meetings to make them more proactive; and creating a process and instruments for ongoing needs assessments.	♦ Information *dissemination* methods included newsletters, newspaper articles and advertisements, information in school bulletins, advertisements on the local television cable channel, outreach and public meetings. On an informal basis, there were face-to-face encounters with citizens in community settings. ♦ Information *gathering* methods included program evaluations, advisory committees, submissions from community groups, the needs assessment process and outreach meetings. ♦ Health board documents should be more accessible, say interviewees, perhaps in the public library. Newsletters and mail outs were generally considered to be ineffective, with low readership rates. Public meetings were also ineffective communication tools, as they were poorly attended if a major facility issue wasn't being discussed. ♦ Most effective were face-to-face encounters (outreach). ♦ Meadow Lake Tribal Council keeps aboriginal community leaders informed of health board issues, but generally Reserve residents are unaware of the health board's activities. Aboriginal interviewees suggested that the board did not fully understand Aboriginal health issues.

III. BARRIERS AND OPPORTUNITIES

The issues that emerged from the study represent both barriers and opportunities for health reform. In this section, we present a summary of the findings, reorganized slightly to highlight their implications.

Inter-community networks, open boundaries	
Barriers	**Opportunities**
Rural communities have borders difficult to permeate, in part because open boundaries might mean losing scarce resources. Traditional rivalries and competition between towns and villages create obstacles to regional identity, and consequently influence the reception of health reform. In that context, board members and managers who are unknown to villagers can be faced with social barriers. Particularly at the outset of health reform, they were sometimes viewed with suspicion, since they were given the difficult mandate of changing those exact structures that help to define local identity and boundaries. Links with government organizations are more common in the larger centres within these districts, and are viewed with a certain resentfulness by rural residents. There are differences in the ways that rural and urban people relate to public offices, such as the frequency of contact with public officials, and rural and urban views regarding the necessity for vertical linkages. Vertical linkages can present obstacles to regional identity in that uneven distribution of vertical links (more in urban areas) contributes to competition and rivalry between villages and towns. In Saskatchewan, rural-urban tensions are as old as the province itself. However, in the current period of rural decline, the tensions have increased in residents' attitudes to each other. These are indications of rigid boundaries and a weak ability to depersonalize and accept controversy. Personalizing politics can take the form of overt hostility or an avoidance of controversy, refusing to deal with issues openly.	Multi-community partnerships and organizations are increasing in number and in breadth of community involvement. Interestingly, health boards appear to be integral in fostering the development of the inter-agency organizations. Health care issues are among the main reasons cited for rural communities to form multi-community partnerships. In the MJTC District, multi-community organizations are growing and strengthening in their resolve to "save" rural communities from extinction. These are positive forces, with the potential for substantially altering the nature of community capacity, particularly if the groups can successfully expand in the size and diversity of their memberships. In the Northwest, an important change has recently taken place in the work of the main inter-agency group. With their expanded mandate, which includes joint problem identification and sharing of solutions, the groups have moved beyond information sharing into joint programming.

Community and resource mobilization	
Barriers	**Opportunities**
Issues that quickly mobilize communities have often included some type of facility closure. While mobilizing people for health care issues can be positive, it can also become an obstacle when communities vigorously oppose health board decisions. The volunteer pool for organized activities is waning. This lack of participation in community events extends into the health sector. Lack of attendance at public meetings seems linked with a general lack of interest in health care matters. Respondents say opportunities are there, but people will not directly participate until a personal stake in the issues is established.	In earlier years, a fund-raising drive took place in the Goodsoil, which involved widespread community mobilization. The current fund-raising and community mobilization for the new facility in Meadow Lake is a more recent example. Diverse community actors were involved in a variety of tasks, indicating the breadth of the resources available to the community for the drive and the importance placed on contributions by all. Both factors are important indications of collective investment in the community. Defining community resources broadly, including collective and individual investment in local development efforts, promotes the development of community capacity. Health board members and managers, when they consider health and health care resources, most often see a dichotomy: resource providers and resource users. When they comment on their own community's resources, however, their perspective is similar to the description above: a broader and more complex definition. A broad examination of existing community resources, such as volunteers, leaders, skills and capacities of the population offers a complementary perspective to current notions on resources.

Board-community interactions and relationships	
Barriers	**Opportunities**
Difficult relationships with particular communities have existed in both districts. Often time consuming and frequently frustrating, these relationships test board resolve. In one case, they even led to the board chair's resignation. The speed of change can precipitate difficult relationships, affecting board members' view of the health reform process. For board members, multiple roles as representatives and community members can be the source of role conflict and competing loyalties. There is a general sense among health board members and management that community members' knowledge about the way the district health board functions is limited. Several of the community leaders interviewed for the study were unable to answer questions related to the health board because of their own lack of knowledge of who was on the board, what the board's role was or what had changed in health care governance. First Nations respondents agreed that residents of most First Nations communities are poorly informed on issues related to the health board and health service delivery. As well, various respondents from all groups suggested that First Nations health issues are not well understood by board members and management. No respondent was sure whether the lack of knowledge was considered an issue in need of action, however. Nor were respondents sure whose role it would be or what strategy could be employed to initiate and facilitate direct communication. Communications strategies were generally considered to be ineffective in both districts. Stated objectives of information gathering and dissemination were not met, and neither were longer-term goals of relationship building.	Difficult relationships also offer opportunities to learn lessons and to establish standards or protocols for future use. Examples of relationship building strategies which were born out of difficult relationships in the districts include opening board meetings to directors of affiliates and vice-versa (in Moose Jaw), and the use of written agreements with affiliated or amalgamated agencies and First Nations political structures (in the Northwest). These agreements outlined rights, responsibilities, expectations, and obligations of the relationships. Rural board members in both districts are more visible in their wards due to small community populations or to the numerous leadership roles that most board members have in those settings. As a result, there are generally more opportunities for community members to interact with rural board members. For example, the district health board enjoys a relatively high profile in the Northwest communities. Most respondents suggested that the majority of local citizens know of the existence of the board and believe that many local citizens in the villages also know their ward's representative. In Pierceland, creation of the health board is credited with making health services and issues visible to the citizenship, where they weren't before. Communication strategies that were found to be most effective were those that bring board members face-to-face with constituents. Outreach was singled out as the most effective in sharing information and interacting with constituents. In Northwest, the multitude of fund-raising meetings between the board and community groups over the past few years also had a spin-off effect of securing trust with communities and groups which was a basic step in building relationships. Capacities considered essential in developing relationships include: citizen access to the board; board receptivity to communities and constituents; the capacity to communicate; board members' openness in addressing issues; willingness to take a public stand on those issues; and board flexibility in working with a variety of groups.

IV. CONCLUSION

Effective public participation in health care matters has been slow in coming, as seen in poor election turn-outs, inadequate communication between health boards and communities, and widely publicized controversy over facility closures. Communities that have lost local hospital boards under regionalization feel that they've lost control or input into decisions. However, some study participants remarked on the increased possibilities for community control, based on the wider picture of health provided by centralization. The *devolution* of power was also characterized by some as positive, bringing control closer to rural areas, rather than residing with the province. The fact that many of the board members in rural communities play multiple leadership roles in their communities can also provide residents with greater access to decision makers. Health reform is seen as a catalyst for inter-agency groups fighting to preserve their rural way of life. Health boards have the opportunity to take advantage of this new trend in regional cooperation and community participation to communicate their goals, receive input from the community, and educate the public about the complexity of the decisions they make.

Saskatchewan residents, especially in rural areas, have been faced with change on a large scale over the last several decades. Declining communities have reacted by mobilizing resources to oppose change, and to protect local services and industries. Health care regionalization is yet another change, which has meant further facility closures in many small communities. Reaction to health reform is consistent with the history of resisting change in rural areas where traditional ways of life are eroding.

Health status and system efficiency are not the only values to be considered when reviewing the health reform process, to the exclusion of social, economic or political factors. The controversy over facility closures reflects the fact that residents live in complex societies, not only in health systems. The challenge remains how to harness the community participation precipitated by health reform to get the public more fully involved in health-care decision making. While the pace of administrative change in health care may be rapid, the pace of social change in rural and urban Saskatchewan is struggling to keep up. Health care regionalization is still in its infancy, and only time will reveal whether communities take the opportunities to become more involved in their own health care decisions. The current moves toward regionalizing other administrative structures, including municipalities, may make regional identity more inevitable, if not easier to implement.

This study was exploratory. However, the findings indicate that community capacity in rural Saskatchewan, as defined within the framework of community resiliency and social capital, is very uneven. Traditional networks of interaction are eroding. There is mistrust between rural and urban residents, even within a single health district. Trust and commitment, while sometimes expressed by residents, are operative in a narrow sense only, within the boundaries of specific town or areas. These factors undermine effective resource mobilization and political efficacy – there is a diminished capacity for communities to organize themselves for positive change. These factors are not the results of health reform. However, they form the context for it.

On the other hand, there are examples of communities working together across traditional boundaries to mobilize resources. The inter-sectoral imperatives of health reform are creating new networks around health and other initiatives. New visions of health are being articulated. New mechanisms are being created to link First Nations with other residents.

In their interactions to date, health district leaders appear to have carried out numerous activities intended to communicate with residents about health needs and programs. However, such efforts have not been met with huge success from residents' point of view. Efforts considered more successful appear to be those that strengthen interactions and create new networks and relationships.

Indications from this exploratory study point to the following hypotheses:

- health reform in rural areas has been limited by decreased community capacity in social and political interaction;
- health reform has potential for increasing such community capacity; and
- health reform can only succeed if it at the same time succeeds in increasing such capacity, because it may be a precondition of both health reform and community health.

POST SCRIPT

Further changes proposed for the province in 1999, such as amalgamation of municipalities have created more controversy in rural Saskatchewan (see the Task Force on Municipal Legislative Renewal's *Issues and Options Workbook,* (April, 2000) or Stabler & Olfert's *Functional Economic Areas in Saskatchewan: A Framework for Municipal Restructuring* (March, 2000)). The Saskatchewan Medicare Review (Fyke Commission) was announced in June 2000, with further facility closure on hold until the review has been completed. The Commission's final report expected within a year.

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