HEALTHCARE SYSTEM TRANSFORMATION IN RURAL AND INDIGENOUS COMMUNITIES

CHANGING LANDSCAPES:
IMPACTS OF HEALTH CARE SYSTEM TRANSFORMATION IN RURAL AND INDIGENOUS COMMUNITIES IN CANADA

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Abstract

This dissertation is about Indigenous and settler health, wellbeing and health policy in rural Manitoba. Across Canada, both sweeping and incremental provincial health system changes have profound effects on marginalized communities facing existing health inequities, including rural settler and Indigenous peoples. Increasingly, the centralization of provincial health care systems has led to the elimination of health services within rural settings. The research I present in this dissertation arose from advocacy efforts in a rural community in southwest Manitoba. The community sought representation and recognition in health decision-making in the midst of the largest health care system transformation in provincial history and called for local research production. The community-led study grew to the larger inquiry and analysis presented here, including a First Nation and Métis community, which were both affected by the transformation. The objectives of this dissertation were to analyze the ideas and structures used to inform provincial decisions, and to understand community experiences of rural health care before and during system transformation. As a settler researcher, I undertake an anti-colonial, strengths-based, community-engaged approach to research, developed through ongoing relationship with the community. In addition to a critical thematic analysis of key policy documents, semi-structured interviews were conducted with settler, First Nations, and Métis community members and service providers regarding their experiences within the health care system, their perceptions of change and the impacts of transformation on health and wellbeing. Arising themes include the importance of relational health care relationships in determining wellbeing, and the sense that the government undertook dehumanized decision-making in developing and implementing health system change. This dissertation concludes with policy recommendations for provincial governments, including the prioritization of community voices, and the visibility and involvement of rural and Indigenous peoples in health system decision-making.

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This dissertation begins with an acknowledgement of the lands upon which it was produced. This research was completed with communities in Treaty Two territory, in what is now southwestern Manitoba, which is the original territory of the Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, as well as the traditional homeland of the Métis Nation. Much of this work was composed on the traditional territories of the Anishinabe and Haudenosaunee peoples in what is now Hamilton, Ontario, and on the traditional lands of the Dokis in Nipissing region, on the rocky shores of Lake Memesagamesing.

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List of Abbreviations and Symbols

CER – Community-engaged research

CBPR – Community-engaged participatory research

CSP – Community-based health service provider

ED – Emergency department

EMS – Emergency medical services

FHT – Family Health Teams

FNIHB – First Nations and Inuit Health Branch of Health Canada

HBC – Hudson's Bay Company

LHIN – Local Health Integration Networks

PMH – Prairie Mountain Health, regional health authority, Manitoba

POC – People of colour

RCAP – Royal Commission on Aboriginal Peoples

SCT – Settler colonial theory

SDOH – Social determinants of health

SIT – Symbolic interaction theory

SP – Health service provider

TRC – Truth and Reconciliation Commission

Chapter One: Introduction

Canada is comprised of diverse peoples and communities, with their own histories, challenges and resiliencies. The Canadian population is spread out across this vast nation within urban, rural and remote areas of the country. The diversity of the population is considered a core value, and is established as central to the multiculturalism that makes up an important part of the Canadian identity and narrative. The image of Canada as an expansive, picturesque wilderness and as an agriculturally- and resource- rich and prosperous land is also central to the Canadian imaginary, and to the lasting pursuit of settler colonialism. These images of diverse lands and people are what sets Canada apart in the world, as a country made up of many places and peoples. The rural and remote landscape of the nation makes up over 90% of Canada's landmass, and despite a growing urban Canadian identity, rural, remote and Northern reaches within the country represent home to between 19% and 30% of the Canadian population (Williams & Kulig, 2012). Many people in Canada define themselves through a rural identity, and this collective imagination is based upon the long-standing reliance and pursuit of lands and resources across Canada since the time of colonization and contact. The country was considered an untouched, unclaimed wilderness rich with resources for harvest and consumption. A dependence on primary and agricultural industries and resources remains today, most of which is situated across the rural, remote and northern expanses of the country, on unceded Indigenous lands. This picture of the Canadian landscape is central within this dissertation, not only depicting a historical representation of what the country known as Canada was, but also as a picture of what Canada remains to many communities across the country. While rural areas across Canada are comprised of fewer immigrant and visible minority populations, these places are made up of diverse and culturally distinct peoples (Williams & Kulig, 2012). For example, rural places have greater proportions of Indigenous peoples, including First Nations, Métis and Inuit peoples, as well as unique religious groups, such as the settlements of Amish, Hutterite and Mennonites of the Canadian prairies (Williams & Kulig, 2012). In addition to unique population groups, rural population demographics include a greater proportion of younger and older adults, and a smaller population of working-age adults, when compared with urban populations (CIHI, 2006; Williams & Kulig, 2012). The presence of these populations contributes to current conceptualizations of rural places in Canada, and importantly, to the health realities and vulnerabilities faced by rural peoples and communities.

Despite the nostalgic rural image of the country, much of what Canada has become is due to more recent patterns of settlement and the urbanization of a country with a growing population. In recent decades, the visibility of rural spaces across Canada has diminished as a social and cultural preoccupation with cities has increased in the Western world as symbolic of economic and technologic success and sustainability. There has been a stark juxtaposition of the rural and remote wilderness of Canada, with a prosperous, busy urban metropolis, with cities such as Toronto, Montreal, Calgary and Vancouver becoming sites of promise and possibility for new Canadians and existing citizens alike. The Canadian city is synonymous with the notion of the ‘cultural melting pot’, and Williams and Kulig (2012) argue that this preoccupation with cities has shifted the Canadian cultural identity such that the need for research on rural places, people and health has become less pronounced in recent years.

Health and health care are also central to the Canadian identity, where universal care and access to essential health care services is a right of all Canadians. The national health care system is considered to be a model of best policy for many countries because of this perceivably non-discriminating delivery, and more than anything, because Canadian health care is ‘free’.

Equitable, timely and effective access to health care is thought of as a right to Canadians, and the right to good health is found within the social value of equality that Canada represents (Browne, 2016). However, these images and ideals of universalism and equitable access for all are misleading, as despite this structure of delivery, vast inequalities and disparities in both health status and access to care are experienced across the country, in both urban and rural settings.

The rural and remote setting itself presents numerous challenges to the planning and delivery of health care services, especially due to geographic and regional variations in health status and service needs based on population and availability of health and human resources. In Canada, the rural population is generally in decline, as people age, young people move into urban centres to seek education and employment opportunities, and economic and employment trends change (Williams & Kulig, 2012). As a result, within these communities, the rural experience of health, employment, education, transportation and many other factors is different from those in urban regions across Canada. Further, challenges to delivering on health policy include limited access to care, significant travel to reach care, a shortage of rural health human resources, and long wait times (Kulig & Williams, 2012; CMA, 2013). As a result of these challenges, and other geographic, economic and social realities, rural peoples and communities experience more disabilities, poorer overall health, and shorter life expectancies when compared with people living in suburban and urban areas in Canada (CIHI, 2006). This reality is contradictory to the conceptualization of Canada and the Canadian health care system. When planning for the health needs of such a diverse population, it is critical to reflect upon unique experiences and needs of rural peoples.

Efforts have been made across Canada to address these inequalities and continue to improve health status and outcomes. Through decades of provincial health care reform, growth of urban populations, and increasing urban and suburban settlement in Canada, health and social services have increased within urban settings, while the provision of rural, remote and Northern services has stagnated or decreased. These changes often accompany large, sweeping health care system changes or transformations on a provincial scale. Canadian provinces are responsible for the delivery of health care services under Medicare, Canada's national, publicly-funded health care system that ensures all Canadians have timely and reasonable access to medically-necessary hospital and primary care services. Changes to provincial health care systems have been ongoing in the decades following the passing of the Canada Health Act in 1984, requiring the provinces to deliver programs and services for citizens using federal transfer dollars. Recently, major changes have been made in many provinces, with Manitoba undergoing the largest health care reform and transformation in the province's history, where this research is situated.

Introducing the Researcher

It is here that I introduce myself, a white settler student of Euro-Canadian descent, with deep family roots in agriculture and early settlement in rural southern Ontario. I conceive of myself as both a colonizer and a settler seeking to decolonize myself and my research through this dissertation process. As a rural person, and a student interested in community-engaged, action-based research on health policy and addressing health inequalities, I am seeking to answer a call to contribute to rural health research. This cannot be separated from Indigenous health research, and so the aims of this research necessarily undertake an inclusive, decolonizing approach. I am fortunate to have been guided through this process by my supervisor, an Indigenous scholar with family ties to rural Manitoba and communities impacted by health system change. I provide a deeper reflexion in chapter five where I locate myself in this research further, and in practicing decolonizing research.

Research Questions and Objectives

This dissertation is about rural and Indigenous health in Canada, and the impacts of major health care system transformation on community health, wellbeing, resilience and existence. The research undertaken for this dissertation was borne out of community need. In early 2018, a rural community within Manitoba was experiencing both doubt and despair over the implementation of a complete provincial health care system transformation; one which threatened the continued delivery of emergency medical services (EMS) within the rural town, affecting not only the settler community there, but also nearby First Nations and Métis communities. The provincial health care system transformation addressed not only EMS services, but also called into question the viability of rural hospitals and emergency departments (EDs). Significantly, the majority of these proposed and confirmed changes targeted the southwest corner of the province, and the rural and remote north. For example, in southwest Manitoba, overseen by provincial health authority Prairie Mountain Health (PMH), over 20 EMS stations were listed for closure or merger in a government document produced in 2017.

This system transformation poses a policy problem, for communities across the province. In Grandview, with the pending closure of the EMS station comes a loss of staffing and fear that the hospital ED will close as a result. Further to this, system transformation fails to consider the impact to Indigenous communities, including First Nations and Métis communities that rely on provincial health services in settler towns. In this case, when access to health care services, especially positive, relational and supportive services, are withdrawn from First Nation and Métis communities, a policy problem emerges. This dissertation examines the impacts of this health care system transformation and policy change on the health and perceptions of affected rural and Indigenous communities, as well as the resulting changes to health service delivery and experience of community members and service providers.

The research questions are divided into three primary categories. The first evaluates the concept of health as it is regarded by rural and Indigenous peoples, and the ways in which health is determined and experienced. This understanding supports the second set of questions, which reflects on the ways in which health policy and reform have been developed and delivered within the rural setting. A knowledge of the factors that led to the development of a transformed health care system then allows for an examination of the personal experiences of communities within a health care system in a state of flux. Therefore, the research questions guiding this dissertation include:

- What does 'health' mean to rural peoples and communities in Canada? What are the determinants of rural health in Canada?
- How was health care policy and system transformation developed in Manitoba? What were the ideas, interests and institutions leading to this transformation?
- What are the experiences of clients and service providers before and after health care transformation? What are the barriers and strengths of health care services in the community and province?

These research questions require foundational understandings in several key areas, which are examined in the following chapters. First, in order to appreciate the policy and political setting and decisions within Manitoba, a review of health policy in the province is required, after reflecting on the Canadian health care system and national policies at large. The literature provides a background on the determinants of health of Canadians, and specifically of rural peoples, while some research provides descriptions of the determinants of Indigenous health, within local settings and communities. These concepts set the foundation on which the third research question can be applied, where community experiences of provincial health policies and systems in states of change can be expressed and interpreted while contributing to the literature.

Rural Health in Canada

The health of rural people and communities in Canada is affected by a number of significant determinants which act upon the distinct demographic characteristics of this population, contributing to numerous vulnerabilities. As noted by Williams and Kulig (2012), rural peoples in Canada experience greater health risks when compared to urban populations. Among the determinants that contribute to poorer health status, rural people in Canada generally experience lower socio-economic status due to lower rates of employment and educational attainment when compared with urban peoples (Kirby & LeBreton, 2002). Further, rural people in Canada have a shorter life expectancy, and high mortality and infant mortality than the average in Canada (CIHI, 2006). Comparative Canadian research has found that rural people have higher blood pressure, greater rates of obesity, arthritis and depression, with lower levels of self-reported health and health-promoting behaviours (CIHI, 2006; Mitura & Bollman, 2003). Further, greater rates of accidents, suicide and disability are experienced within the rural populations in Canada, linked largely with the primary forms of employment, and lack thereof in rural places (Williams & Kulig, 2012). These findings demonstrate that between urban and rural populations around the world that rurality, or geography, is a determinant of health. These findings are also demonstrative of the deficit model of rural health analysis, the overarching perspective that the risks outweigh the benefits of rural living. These vulnerabilities are present, but coexist with many strengths, resiliencies and benefits of rural living, with positive and protective effects on health. For example, rural residents report a greater sense of community and belonging when compared to urban populations (CIHI, 2006). Many of these determinants of health are examined within this dissertation, describing why so many people choose to live in rural places and experience rich, vibrant and healthy connections to their community and environment.

Rurality

The definition of rurality and what constitutes rural places has been contentious in Canada, and subject to a great many discussions and debates in both academic, political and social settings. For instance, in Kulig and colleagues' (2003) review of over 150 academic rural nursing publications resulted in no singular, universal definition of what is meant by 'rural' or 'remote'. In another Canadian study, Pitblado (2005) suggested that using geographical distance and social approaches to defining the meaning of rurality served to distinguish these terms in the Canadian context. Supportive of these findings, Williams and Cutchin (2002) found that rurality was best represented as complex, based on multiple features including socio-cultural aspects of place, demonstrable land use practices and measurable demographic characteristics, and local conceptualizations of what it means to be 'rural.' The findings from the National Study on Rural and Remote Nursing Practice, which surveyed registered nurses across Canada, found that research should aim to define rurality based on the meanings shared by rural peoples (Kulig et al., 2008). These suggestions demonstrate the precariousness of trying to conclusively define such a term, while highlighting the importance of local and community-based perspectives of rurality when conducting place-based social sciences research. A multidimensional definition of rurality is then critical, and such research on rural health calls for interdisciplinarity and holistic approaches.

For political and census purposes, there are three primary definitions for rural used in Canadian policies and research, depending on the nature of the research or issue. The term 'census rural' is used to define a population the resides outside of a settlement with 1,000 or more people with a population density equal or greater than 400 people per square kilometer (Statistics Canada, 2007). Rural and Small Town (RST) includes individuals in towns or municipalities the are found outside commuting distances (or zones) of larger urban centres with populations over 10,000 people (duPlessis et al., 2006). These larger urban areas are referred to as Census Metropolitan Areas (CMAs). Lastly, the term 'predominantly rural region' is most frequently used in conducting rural policy analysis with a regional focus, it refers to an area where more than 50 percent of the population live in a rural community with a density less than 150 people per square kilometre (Williams & Kulig, 20120). Williams and Kulig (2012) support the use of RST as an acceptable definition of rural for rural health researchers since it allows for whole towns or settlements to be defined as rural, as well as the people that live in the surrounding area, as well as it allows for the study of certain issues, such as health care access, that affects whole geographical areas. Using the RST definition, 19 percent of Canadians are rural (Williams & Kulig, 2012). One fifth of the Canadian population residing in the rural setting designates a significant need for further research and understanding of rural health needs and responses of rural communities.

In much Canadian research and policy work, the use of the terms rural, remote and Northern are used to describe those people, communities and places found on the fringe, or separated from the fringe of developed or settled areas with wide and expansive geographies. Remote and Northern places are equally as challenging to define and generally describe as rural ones. In Canadian policy literature for example, 'remote' refers to places that are considerably far-removed from the nearest community, or population centre, such that out-commuting for work or regular business is impossible (Slack, Bourne & Gertler, 2003). In remote places, there is little to no access to social and medical services (MacLeod at al., 2004; Wakerman, 2002). Remote health is defined as it relates to the level of geographical, social and professional isolation of the community, the availability of roads and transportation to health services and levels of communication between communities (Krieg, 2012). Among Indigenous communities, the federal Ministry of Indigenous and Northern Affairs (INAC) defines the geographical zone of each registered First Nation based on level of isolation, or remoteness. This geographic zone is based on each First Nation's proximity or distance to the nearest 'service centre', which is the nearest community that band members can access for government, financial, social and health-related services, as well as resources and supplies (INAC, 2020). Further to these various definitions, it is impossible to generalize health experiences and outcomes studied in one area across all others. Throughout this dissertation the term 'rural' is used as a descriptor of rural, remote and Northern places and peoples. The way that communities studied in this work come to describe themselves through this research as 'rural' is expanded upon in the following chapters.

Indigenous Health in Canada

Any work concerning the health of people living in the rural and remote reaches of Canada cannot disregard the many diverse Indigenous communities across the nation that are impacted by rural health care systems and policies. Across Canada, First Nations, Inuit and Métis peoples and communities exist in rural, remote, Northern and reserve places, as well as urban places, and experience health inequities when compared with the general population, or with urban populations (Adelson, 2005). These inequities are founded by pervasive colonial ideologies, policies and practices, many of which persist today resulting in multiple disparities in health as well as social, political and economic areas (Adelson, 2005; King, Smith & Gracey, 2009; Allan & Smylie, 2015). As an example, infant mortality rates among the Indigenous population in Canada are 1.9 – 3.6 times greater when compared to the non-Indigenous population, and chronic illness rates, like diabetes, are 3 – 5 times greater within Indigenous communities (Smylie, 2012; Harris, Bhattacharyya, Dyck, Hayward & Toth, 2013). These disparities have long been linked to pervasive poverty, food and housing insecurity, unemployment and lower educational attainment (Loppie Reading & Wien, 2010). All of which stem from an ongoing colonial history that since, from the time of contact with European settlers on this land, has contributed to the marginalization, displacement, forced assimilation and racialization of Indigenous peoples (Adelson, 2005; Allan & Smylie, 2015). Despite destructive colonial policies and practices, such as the Indian Act of 1876, the implementation of the reserve system and theft of Indigenous lands, and the residential school system, Indigenous communities and cultures resist and persist today. It is critical that from the outset of this dissertation, the diversity, resiliency and strength of Indigenous peoples be highlighted. Today in Canada, Indigenous communities are reclaiming lands, languages, identities, histories, cultures, artifacts, and stories, which were all but lost over the past hundreds of years since contact and are now being renewed and revived through processes of decolonization and self-determination.

Studying Rural Health in Canada

Considering the increasing and complex health needs of an aging rural and Indigenous population within the country, new research is required to understand community perspectives, strengths and challenges. In order to address the ongoing needs of the population, as well as strive towards fiscal sustainability and delivery of health resources, many provinces have reformed their health systems and policies. In the midst of these system changes, some communities have increased concern for representation and consideration in new health system models. Rural and Indigenous communities, which make up a smaller proportion of provincial populations, are often faced with one-size-fits-all solutions that do not address their specific health needs and concerns, or address the roots of the inequities they experience. Further to this, these communities are socially, politically and geographically isolated from urban centres where health services and decision-makers are concentrated, creating a precarious position for communities striving to be represented.

For novel and contributive research on rural health within Canada, a focus on rural and Indigenous communities facing health system and service delivery change provides a powerful setting within which to understand both the meaning of health and perceived health status of rural peoples. This setting and moment in time provides an opportunity to understand how health systems and provincial policies work on the ground, within communities, and how service providers and receivers are impacted by health system transformation.

Purpose

The purpose of this research is to examine the experiences of diverse rural and Indigenous communities, both First Nations and Métis peoples, in Canada. Specifically, this research is set within the province of Manitoba, where a complete transformation of the provincial health system is still actively taking place, and creating new situations and challenges within communities. This work provides a review of impacts and outcomes of policy change among small communities in geographically isolated places which have been historically marginalized and omitted from political consideration for myriad perceived reasons. Further, the objective of this research are to contribute to the ongoing examination of the prevalence of systemic settler colonial values and ideologies observed in structural determinants of health such as policy and health systems. This work seeks to uncover and identify the processes in place within government structures that serve to substantiate settler colonial goals, and oppose the visibility and voice of marginalized, racialized and other historically ‘problematic’ peoples. This work serves to demonstrate the complicated structures and relationships between rural and Indigenous communities and the state, but it also aims to undertake a strengths-based approach to research where systemic challenges and inequities are met and resisted by communities with established support systems, strong political voices and creative, community-based solutions.

Throughout this dissertation, the reader will be reminded of Canada’s colonial legacy, and concerted and insidious efforts to assimilate and marginalize Indigenous peoples, and rural peoples through a longstanding history of colonization, centralization and federalism. It is also important to note that much earlier work and research with such communities was done so at their expense, and that research relationships have often been one-sided and served to support state initiatives. This history is a structural determinant of health in and of itself, in the way that it has become entrenched in existing policies and practices into the 21st century. Lastly, the production of this dissertation occurred during health system transformation within Manitoba and within the communities included in this research. It is reflective of a series of moments in time during the largest health system change in the province’s history, and represents the interpretations as presented by this researcher. While representing the experiences of rural and Indigenous communities in one province, the goal of this research is to inform health decision-making across Canada. And although no single model exists that can effectively accommodate government-community collaboration in health policy-making, it is the hope of this work to empower rural and Indigenous communities in representing their challenges and strengths in addressing their health needs at the policy level.

Organization of the Dissertation

This dissertation is organized in such a way that guides the reader through the research project and process to understand the impacts of health care system transformation and centralization of health services on rural communities. In the second chapter, the dissertation sets the stage for this study, with an overview of the historical and present social and political contexts in place within rural Canada, but particularly within Manitoba where this research took place. This history is important for the reader to grasp the realities experienced through time by Indigenous peoples on that land from before contact, through colonization and today, as well as the experience of settlers and patterns of settlement which have formed Manitoba into the province that is it currently. This is an important starting point when embarking on a study of health and policy in the rural prairies. Within chapter three, the primary theoretical concepts and perspectives used in this dissertation are elaborated on. This dissertation uses settler colonial theory (SCT) as an overarching and guiding approach to understand the formation of health policy within, as well as the intentions and impacts of decision-making on Indigenous and other marginalized communities. Symbolic interaction theory (SIT) is integrated to provide a mechanism to articulate how communities come to share understandings and meanings of their experiences and the social and political context in which they live. Lastly, chapter three describes the social determinants of health (SDOH) as a framework to evaluate health inequalities and methods to address inequalities for improved health outcomes particularly among marginalized communities. These theories interact to provide a holistic analysis of the research setting, context and findings. Chapter four offers a review of the existing literature informing current and necessary understandings of rural health and Indigenous health in Canada, health policy and determinants of health. The chapter concludes by situating this dissertation within existing knowledge gaps in these areas. In chapter five, the research methodologies, or guiding principles and protocols of the project, are highlighted, with a particular focus on the importance on community-based and -engaged research when studying health among Indigenous communities, and other groups that are often vulnerable or marginalized. The chapter further iterates the processes and qualitative research methods undertaken in the production of the study along with a description of the study setting, and concludes with a self-reflection and situation of the researcher as a settler person with rural roots conducting community-based research within rural and Indigenous communities in another province. In chapters six and seven, the results of the research are presented and critically analyzed through a theoretical lens, while presenting the limitations of this study. Finally, chapter eight provides a conclusion and offers a number of recommendations for policy and practice to improve community collaboration in health policy- and decision-making. The focus of this work on rurality and Indigeneity and the impacts of these identifiers on community health will help contribute to the understanding of health policy implications and outcomes from a social and community-based perspective.

A Note on Terminology

Throughout this dissertation, several identifying terms are utilized to describe peoples that are Indigenous to the territory now referred to as Canada. While the Canadian government refers to Indigenous peoples in Canada as ‘Aboriginal’, “Indigenous Canadians’ and even ‘Status Indians’, these are not appropriate identifiers or terms. Throughout this text the term ‘Indigenous peoples’ is used to refer to all of those individuals who identify as Indigenous, including First Nations, Inuit, Métis, status, non-status, urban, and rural peoples. The first peoples of this land and their descendants are diverse and distinct, with their unique identities, histories, languages, stories, cultures and traditions. While acknowledging the fact that inclusive terms can mislead the reader into thinking they refer to peoples as single collectives, the term ‘Indigenous’ here is meant to include these multiple identities, without being used to homogenize or erase the vast, rich and various communities of peoples across this land.

Chapter Two: Setting and Context

Before embarking on this research journey, it was critical for me, as a settler researcher from out-of-province to come to understand the setting, history and context of the place where I would be studying, the political background and policies that were to be examined before I went about gathering data. This study emerged from a request for community-engaged research in a small settler community in southwestern Manitoba. A community advocacy group there had contacted my supervisor, who has family ties to the area and had grown up there, to assist them with their project. Further to this, the research presented here has occurred in large part as a response to a significant shift across Canada in the development and delivery of health care services in rural places as a result of broad health system transformation. Over the past several years, certainly over the course of the last election cycle in many provinces, provincial governments have identified a need to re-establish aging health care systems towards more sustainable, economically lean, and data-driven operations. A history of health care system and policy reform, particularly in the primary care setting has developed over the past three decades in Canada, and has been examined closely (Hutchison, Levesque, Strumpf & Coyle, 2011). Much of this research demonstrates trends in reform across Canada in which changes to produce sustainable outcomes are supported. However, citing earlier research, Hutchinson (2008) states that particular processes and attention are required at the local and regional level to actively engage key stakeholders regarding potential transformational change, especially as it relates to primary health care access and quality. The research presented here fits within this context, as an examination of these changes amidst recent policy changes.

One of the provinces to undergo health care system transformation most recently is Manitoba, a province considered by health policymakers and politicians to be long overdue for health system change. Manitoba provides a relevant stage then to examine the impacts of significant health system change on rural people and Indigenous communities. This chapter offers a short history and contextualization of the research site, and Manitoba more generally, and of the political setting within which the research took place. An opportunity is provided through transformation to understand what this will mean socially and in terms of health and wellbeing of rural communities, but an initial review of context is required.

Setting the Scene: Contextualizing Manitoba

There is a need to contextualize the setting of this research, the rural place where the work was undertaken, and why this site is significant to the critical study of rural and Indigenous health and health policy. Manitoba is the easternmost of the prairie provinces, with a longstanding economic history as an agricultural site, dating back prior to contact with Europeans. With a steadily increasing population of nearly 1.3 million, Manitoba has one of the smallest populations, however, this population is very widely dispersed across broad geographic expanses (Statistics Canada, 2016). Further, compared with other provinces, Manitoba has one of the largest populations of Indigenous peoples living there, both rurally and in urban settings. It is also home to the greatest population of Métis peoples proportional to the provincial population compared with other provinces (Macdougall, 2017). As of the 2016 Census, within Manitoba, 27% of the population lives rurally, representing one of the largest rural populations, proportional to total population, in Canada (Statistics Canada, 2019). The national average of population living rurally is 16.8% (Statistics Canada, 2016). This is one reason why Manitoba makes for an ideal place to study rural health. The research for this dissertation is situated within the southwestern corner of Manitoba, a mostly rural area of the province. The largest cities in the area are Dauphin, and Brandon, but many people within the region must travel into the largest city of Winnipeg.

Colonial Settlement

The province was and continues to be a place of Indigenous visibility, though Indigenous presence and power has shifted over time with colonial settlement. Within the province, the largest city, with the largest population and greatest population of Indigenous peoples in proportion, is Winnipeg. This area represents a major site of settlement within the province, and provides an important history of state- and settler- relations with Indigenous peoples. The city itself has a long history, as a colonial settlement, but as a critical Indigenous site long before that, as well as a place of Métis resistance. Winnipeg sits upon the traditional territory of the Anishinaabeg[1] peoples, the Cree, and Métis, where the Red and Assiniboine Rivers meet, a place where the archeological record shows people have inhabited for at least over 6,000 years (McCallum & Perry, 2018). The First Nations peoples who occupied these lands prior to contact saw to the intense agriculturalization of the area, dating back to the 1400s (Flynn & Syms, 1996). The lands surrounding the river forks were claimed simultaneously by the British, as well as the Hudson's Bay Company in 1670, one of many such moves by the colonial, imperialist system to acquire Indigenous lands and dispossess native peoples in a play for control of resources (McCallum & Perry, 2018). Despite this colonial practice, the regions surrounding Winnipeg remain Indigenous places, and lands remained primarily in the possession of the Indigenous peoples that lived there, particularly Métis communities, until the first wave of British settlers arrived around 1812 to establish a more permanent settlement (McCallum & Perry, 2018). It is within these interactive moments between peoples that Métis scholar Chris Andersen describes

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[1] Spelling utilized reflects that of the original source.

the genesis of the Métis Nation as set within the Red River Valley, where a distinct culture and lifestyle separate from Euro-Canadian and First Nations in the region was established, including a new language, laws, dress, music and policy (Andersen, 2008; Macdougall, 2017). However, even after Confederation in 1867, the vast majority of people living in the Red River area were the Métis. For example, in 1870, over half of the Manitoba legislature was Métis (McCallum & Perry, 2018). Despite this significant representation of Métis in the area at the time, settler state forces marginalized the community using policies that favoured white settlers.

Towards the end of the 19th century, a number of insidious changes and policies, such as the Manitoba Act in 1870 and 1874, led to the massive dispossession of Red River lands from Métis families, and many of those prominent members of society at that time lost their significant status (McCallum & Perry, 2018). This began in 1869 when the Hudson's Bay Company (HBC) transferred its lands and authority over those lands held in the Northwest of Canada to the Government of Canada (Smylie & Firestone, 2016). At this time of transfer, First Nations and the Métis were the largest populations residing in this area, Smylie and Firestone (2016) point out that at the time of census in 1871 in the Red River area, there were over 9,800 Métis people and only 1,600 white settlers in the area, noting that First Nations peoples were not recorded in the census. The transfer from HBC and the government did not account for the First Nations or Métis peoples who were living on the great expanse of lands that were transferred, and what resulted was significant social unrest (Smylie & Firestone, 2016).

At the time of the Manitoba Act, the Canadian government was already establishing reservation lands and systems to house Indigenous people and communities across the country. The rights of the Métis were represented to then Prime Minister Macdonald by Louis Riel and the Manitoba Act came to recognize and set provisions of land and titles for Métis and First

Nations people (Smylie & Firestone, 2016). In the case of the Métis, especially surrounding the Red River, special reservations were established for people of mixed Indigenous and European ancestry, though very little of these actual lands were held by Métis families themselves (McCallum & Parry, 2018). This was due to the failure of incoming settlers to respect Métis titles, and ultimately in 1872, the Métis community was denied central land for their collective use in the Red River area, forcing families to either apply for lands individually, or relocate (Smylie & Firestone, 2016). Simultaneously, First Nations reserves were being established around the settled areas, and in further remote tracts of land that settler communities were not interested in.

The Manitoba Act clearly did not represent Métis rights, or Indigenous rights more generally, and served as a colonial act to dispossess Indigenous peoples of their traditional lands and territories. This led to great frustration among the Métis and ultimately to the establishment of independent settlements further west in what is now Saskatchewan, with Métis-led governance system established in 1873 (Smylie & Firestone, 2016). Over the following ten years, the Government of Canada refused to recognize this settlement, resulting in armed conflict between the Métis and Canadian forces (Smylie & Firestone, 2016; Macdougall, 2017). The culminating three-day battle at the Métis settlement of Batoche ended when the Métis ran out of ammunition, and the Canadian forces destroyed the settlement; Riel was later hanged as a traitor (Smylie & Firestone, 2016). This aggressive colonial event once again left the Métis dispossessed of their lands, further marginalized within their own territory, and fearful, and many families ended up fleeing to the United States, or changing their names (Smylie & Firestone, 2016; Macdougall, 2017). This is what Chris Andersen describes as the moment where the Métis as “a collective political alternative to the Canadian state” began to fade into “political obscurity”

(2008, p. 351). The conflicts that occurred between the state and the Métis people occurred during what Métis scholar Adam Gaudry highlights as being a pivotal moment in the development of what is now known as Canada (Gaudry, 2013). As such, much of Canada's colonial history is known and understood in relation to Métis people and nationhood (Gaudry, 2013). It is critical then, that Canada's history, and the context I provide for this dissertation be situated upon the history of these lands, place and peoples, especially the Métis. The early colonial acts of persecution and dispossession of the Métis people and their traditional lands left resounding effects on the Métis through generations to today, demonstrating the influence of colonial Canadian policy, and treatment of Indigenous peoples. Danial Voth (2016) reviews one of the more recent legal and political acts of Métis resistance to the devastating processes to come out of the Manitoba Act and settler colonization in the 1981 case of the Manitoba Métis Federation v. Canada. While the ultimate supreme court ruling in that case was viewed by Métis leadership as a strategic win, Voth (2016) argues that such acts of resistance on a legal stage instigated strain between the Métis and other Indigenous peoples. Voth (2016) describes acts of resistance to settler colonialism within settler colonial spaces as in part another negative impact of the settler colonial imperative. This ongoing history is deeply rooted in the lands that make up what is called Manitoba today and contribute an important understanding of state- and settler-relations with the Métis and First Nation peoples, and between Indigenous peoples.

Settlement Relations in Southwest Manitoba

Within the Parkland region Indigenous communities and settler communities have intersected and connected within and because of rural places and spaces. Gabel (2013) notes that Tootinaowaziibeeng First Nation, located south of the Duck Mountain range is an important and abundant land base for agriculture, recreation and tourism within the province. The areas surrounding the 4,6698-hectare reserve are spaces where settlers have taken up large agricultural ventures, or have developed seasonal homes, camps and cabins today. The land has been a particular place of interaction due to its proximity to the mountains, and along the Valley River. During early settlement in the region in the 1880s through the early 1900s, logging and timber milling was an important and growing settler economy, and the largest timber mill in Manitoba was located in Grandview, operated by T.A. Burrows (Nicholson, 2000). Historians note settler logging activities throughout the Duck and Riding Mountains, along the Boggy Creek and Valley River, between larger European settlements, disrupting traditional lands and territories (Nicholson, 2000). These lands located alongside various river systems, were the settler access points to wider expansion. Following lumber, and the major economic boost that the Burrows' mill brought to Grandview, settlers arrived into the area in the early 1900's with the growing rail lines, being supplied and built with the very lumber harvested from the Duck and Riding ranges. In 1900, Grandview represented the end of the rail line out of Dauphin, making it a last stop and location to land for many settlers, and over 1,000 men gained employment at the Grandview lumber mill (Nicholson, 2000). After lumber and the closing of the mill in 1919, settlers took to clearing land for agriculture (Nicholson, 2000; Grandview Historical Society, 2009). Accounts of early settlement in Grandview list the cost per acre of homestead land at ten dollars, with the expectation that it be worked at least six months of the year (Grandview Historical Society, 2009). The first field was cleared for farming and agricultural in 1890 in the area, but settlement did not increase until the early 1900s with the rise of the logging trade and timber mill (Nicholson, 2000; Grandview Historical Society, 2009). The community had grown such that by 1904, Grandview became only the fourth place in Manitoba with an operating water works (Grandview Historical Society, 2009). Since then farming practices increased and then waned by the Second World War (Grandview Historical Society, 2009). During the course of its history, Grandview has served as a resource and service centre for the surrounding settler and Indigenous communities, based largely on location to rail, river and settler colonial economies.

Critically, these early accounts leave out the ongoing relationships, interactions and points of contact and contention between First Nations, Métis and settlers. Tootinaowaziibeeng First Nation is a Treaty Four signatory, one of the many numbered treaties made across the prairies and the west, originally signed in 1874. Ongoing interactions based on land and resources in the region brought communities into contact, with small towns and villages being established between logging operations and larger towns, like Grandview. One such community, Shortdale, was located just west of Valley River Reserve boundaries, and was established in 1903 along Short Creek to connect resources with the rail. Due to changing industries and depleted timber resources, the village diminished by the late 1930s (Lynxleg, 2019). A sign commemorating the once thriving village was erected in 2007, noting the partnership between the Métis people and Ukrainian and Polish settlers in establishing the town (Lynxleg, 2019). The sign notes the division of the town, with the Métis to the south of the rail line, and the settlers to the north, however, it does not make any mention of the First Nations peoples that undoubtedly contributed significantly to the village and industry in the area (Lynxleg, 2019). Such absences are indicative of both historical exclusion and assimilative policies and practices.

Changes in the Prairies

Changing land use and population demographics across the prairies has led to other changes as well. Notably, transportation in the prairies and across Western Canada has undergone a major shift. In July 2018, Greyhound announced that it would cease to operate western routes across Canada, effectively severing public transportation connections between small rural towns and remote hamlets across half of the county (Hutchins, 2018). This change has been seen by many people across Western provinces as a move to cut rural Canada off from the growing, bustling world of urban centres (Hutchins, 2018). More immediate than this however, this loss of service across the prairies means a lifeline to critical health and social services has been cut, preventing people who rely on public transportation from accessing necessary services that can only be accessed out-of-town in larger centres (Hutchins, 2018). The implications for an aging population are serious, with people and entire families relying on public transportation for both leisure travel, but most importantly to access care. Critically concerning is the impact that this elimination of transportation services will have on the many Indigenous communities and peoples across the prairie and Western provinces. The significance of this change is severe, especially for communities along previous routes that relied exclusively on the bus to access much-needed health care services. Very seriously, these cuts to transportation will impact communities that have long experienced isolation and vulnerability. Lack of safe travel options through rural and remote places in Canada has deeply affected many Indigenous communities and hundreds of families. The final report from the National Inquiry into Missing and Murdered Indigenous Women and Girls recommended "more frequent and accessible transportation services available to Indigenous women, girls, and LGBTQ2S people" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019) Without access to safe transit, Indigenous peoples, and especially women, girls and LGBTQ2S people will be made more vulnerable, their risk more acute, and could contribute to further violence. Such changes to rural and remote life and transportation has significant implications for health, wellbeing and importantly, Indigenous rights.

Health System and Policy Context

In order to provide an understanding of the particular political moment that this dissertation explores, I elaborate on the health care transformation initiated in Manitoba in 2017. Within Canada, and as part of the universal health care system, provinces are responsible for delivering primary and emergency health services for which the federal government issues transfer payments. The provinces are also responsible for the structuring of their health system, but must ensure continuity of care for those accessing universally insured services. For this reason, provincial health systems and policies across Canada vary, and are organized in different ways. For example, provinces like British Columbia have a regional health authority network responsible for the administration and delivery of care on a geographic basis. Health policies and programs in place in Manitoba prior to transformation were poorly designed to meet the needs of such a diverse provincial population (Moss et al., 2012). This move to transform the system by the new Conservative government at the time caused community reactions throughout the province, and ultimately precipitated the formation of a community advocacy group within the community that engaged with the research I share here.

Health Care Transformation in Manitoba

The delivery of health care services in the province of Manitoba has been under review and change over the past 25 years as the population, demographics, primary economy and provincial needs change. Beginning in 1997, Manitoba moved to regionalize the delivery of health care services with the creation of Regional Health Authorities. However, after 20 years operating in that initial structure, the provincial health care system was found to be too complex, overlapping, and in many ways, it created barriers for people to access services (MHSAL, 2018b). This regionalized structure allowed for duplication, and health care planning that operated in silos with little coordination between regions and provincial health organizations.

Various studies found that access to health care services under this model were challenged by the current system that was found to be ill-equipped to deliver health services across a region with a widely dispersed population, especially in rural, remote and Northern reaches (Moss et al., 2012). The province also saw health care funding increase by 97% between 2003 and 2016, however significant positive and improved health outcomes for Manitobans did not accompany this increase, and the province of Manitoba remained one of the lowest-ranking provinces in many health indicator areas (MHSAL, 2018b). These findings are part of the impetus for health care transformation in Manitoba.

A series of studies and reports were commissioned by the provincial government between 2012 and 2017 to evaluate the state of the health care system, from emergency departments and services, to wait times and sustainability in the health care system. Major change in Manitoba's health care system rests on the findings of four central reports, including the 2013 Provincial EMS Review (Toews Report), the 2017 Health System Sustainability and Innovation Review (KPMG Report), 2017 Clinical and Preventative Services Planning Report (Peachey Report), the 2017 Wait Times Reduction Report. I review and analyze these reports in the second half of the dissertation.

Early in 2012, the provincial government, then led by the NDP, recognized that changes were required to address the delivery of emergency medical services (EMS) including ambulance and paramedical care, and patient transfer to emergency departments. Independent consultant Reg Toews, an established researcher on health care systems, was commissioned by the Government of Manitoba to undertake a review of the state of EMS delivery across the province. The *2013 Provincial EMS Review* looked into emergency medical services in Manitoba, evaluating call and wait times, finding that a more integrated, reliable and sustainable emergency response service was needed within the province. One of the major recommendations was an investment in increased paramedic staffing across Manitoba, including nearly 30 new full-time positions across the province, and 5 new EMS stations (Government of Manitoba, 2017a). While this investment in paramedic staffing and coordination was welcome across the province, the 2013 Review ultimately recommended the closure of nearly two dozen low-volume EMS stations across the province, most of which were rurally or remotely located (Laychuk, 2017a). In an information package to rural municipalities, the province assured residents of government 'commitment to excellent patient care' where only those EMS stations with very low patient call volumes, in poor state of repair or those facing significant staffing shortages would be closed (Government of Manitoba, 2017b). At the time, the province claimed that these closures would result in a more responsive and coordinated emergency medical response service. One of the major limitations to implementing the report recommendations, included the siloed health care delivery system used across Manitoba. In the provincial health care system of 2012, numerous independent agencies undertook health care delivery, resulting in a lack of coordination, confusion and duplication of services (Toews, 2013). This lack of coordination would have to be addressed by the province in order to improve EMS services across Manitoba.

Following the election of the Progressive Conservative party into provincial leadership in 2016, the government called for a series of studies and recommendations on the present health care system, which was, and continues to be by far the most expensive provincial expenditure. Fiscal responsibility, reform and sustainability would be central to the provision of services going forward under the new government. From 2015 - 2016 a round of studies and reviews were commissioned by the government into improved health care systems delivery, improved access to quality services and increased provincial health care planning.

The result of the 2015-16 research produced by government-initiated requests called for the centralization of the health care system in Manitoba. The primary reasoning behind this restructuring and reform was to address fiscal sustainability, according to government reports. With the results of numerous studies and reviews of the fragmented and uncoordinated health care system in Manitoba, the province took the step towards transforming the system in mid-2017 with the creation of Manitoba Shared Health, a provincial health organization (PHO) that would improve planning and increase integration of health care services within Manitoba. One of the major initial changes to health care service delivery following the establishment of a single provincial health organization, was the change in the delivery of emergency medical services, leading to the recommended closure of some EMS stations across the province.

In considering health system transformation, scholars state health care providers, planners, managers and policymakers need information (not to mention resources and commitment) at the "practice, local, regional, provincial/territorial and pan-Canadian levels so that targeted programs to address disparities can be developed and implemented" (Hutchison, 2008, p. 20). The transformation of the health system in Manitoba was founded upon a regional approach, and saw to the amalgamation of several regional health authorities (RHAs), bringing a total of five RHAs into service under the umbrella and administration of Manitoba Shared Health.

Prairie Mountain Health

This research is situated within the Prairie Mountain Health Region (PMH) in Manitoba, located in the southwestern corner of the province, as depicted in Figure 1. The PMH region was officially formed in 2012 after the provincial government amalgamated three health regions serving the area, previously known as the parkland region, PMH is now one of five Regional

Health Authorities (RHAs) within Manitoba (PMH, 2019). The decision to amalgamate RHAs was done in order to reduce the number of regional bodies involved in delivering health care services across the province. The region is vast, covering over 67,000 square kilometres, running along the provincial border with Saskatchewan to the west, and along the United States border to the south. There are 55 distinct municipalities within PMH jurisdiction, ranging from small settlements with less than 1,000 residents, to larger cities, including Brandon and Dauphin, with populations of 58,003 and 8,095 people, respectively (PMH, 2019; Statistics Canada, 2016c, d). These represent two of the largest cities within the province, after Winnipeg. Outside of these urban settlements, the majority of the PMH region is considered rural, with a largely agricultural economic base. In addition to the varying settler communities and populations in Manitoba, there are 14 First Nation communities, including Treaty 2 and 4 communities, as well as 32 Hutterite colonies within the PMH region (PMH, 2019). In total, this area represents nearly 13% of the total population of Manitoba, or approximately 170,899 people as of 2018 (PMH, 2019). The demographics of the region show that this area is aging, and that there is little in-migration to these rural areas. Rather, much of the working-age population has more recently been moving into urban areas for more diverse work and education opportunities. Presently, there are 20 acute care hospitals serving the PMH region, with 38 EMS stations (PMH, 2019). Figure 2 provides an overview of the health care services and where they are offered across the PMH region. As the map depicts, there is a greater concentration of service in the most southerly half of the region, where a greater number of settlements and corresponding population is found. Conversely, the map shows the limited number of services, particularly hospitals and acute care, to the north of the Riding Mountain range.

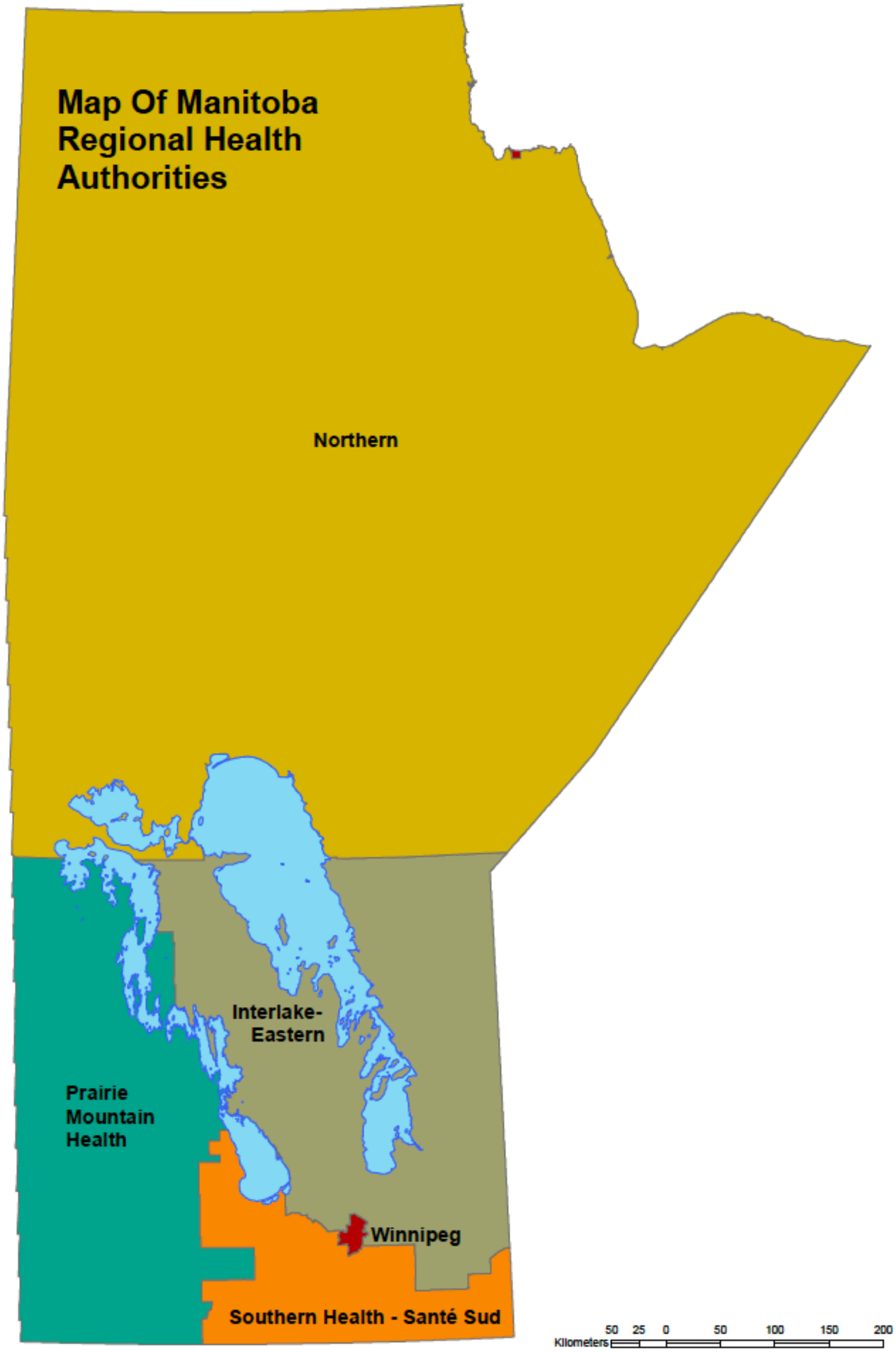

Figure 1: Manitoba Regional Health Authority Map, Retrieved from: https://www.gov.mb.ca/health/rha/docs/map.pdf

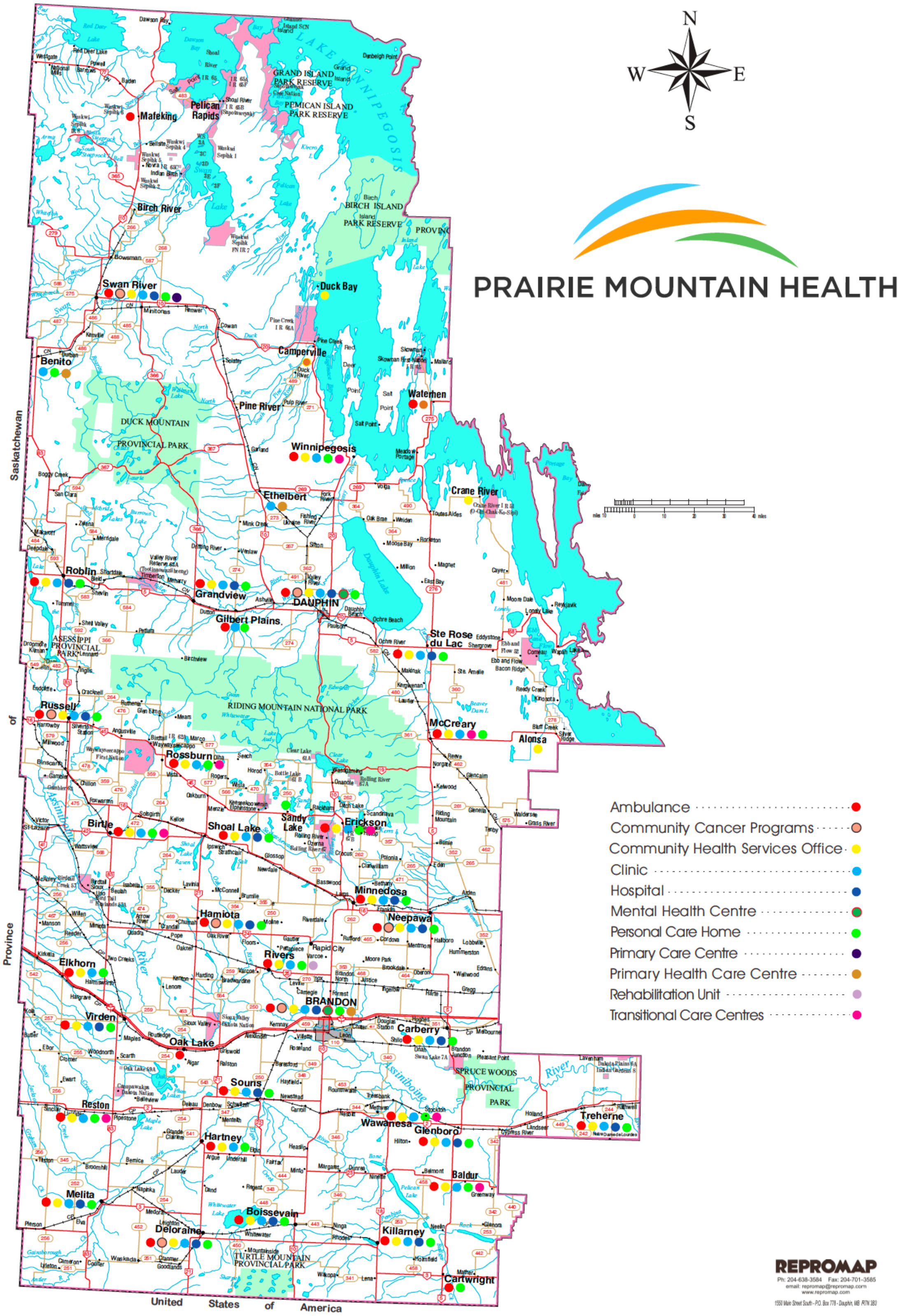

Figure 2: Prairie Mountain Health Region Community Health Service, Retrieved from: http://www.mhpnetwork.ca/files/pmh-services.pdf

Community Setting

This research is set within a small rural town in southwestern Manitoba, along a major highway route. Grandview, Manitoba is located in the southwestern corner of the province, about 375 kilometers northwest of Winnipeg in a rural, agricultural landscape. The nearest city, Dauphin, Manitoba, is about 45 kilometers to the east. The area surrounding Grandview is primarily rural-agricultural, situated between two sprawling mountain ranges and provincial parks. To the north of Grandview lies Duck Mountain Provincial Park, a popular summer destination for local residents and tourists alike, with many recreational opportunities. Located south of town is Riding Mountain National Park, another major draw of local Manitobans and Canadian tourists to the area. This scenic, picturesque prairie setting represents the idyllic rural town in the Canadian imagination. And for many residents living there, it is.

The region surrounding the community is also agriculturally rich, serving as one of the province's largest production areas of oilseeds such as canola, flax, soybeans and, in 2020 with an increased demand for birdseed across North America (in part a response to isolation amid COVID-19 lockdowns), sunflower. With narrow, single-lane roadways and highways, and with a productive agricultural economy, residents are familiar with sharing the roads and landscape with large farming implements and machinery. This is one aspect that characterizes the area, and the community living here. Economically, within the town proper, there are few primary employers, with the largest being the hospital and primary care home. Recently, much to the dismay of the community, but to no surprise, the town newspaper closed, representing a true shift in the economy of the community, where nearly one third of the town is over retirement age of seniors over the age of 65.

The community is small, with a total population in 2016 of 1,420 people (Statistics Canada, 2016b). The average age within the community is 48 years, ten years older than that of the general population of Manitoba (Stats Canada, 2016b). This aging community represents now a place of retirement, as demographics and employment areas show there has been a decline of in-migration to the community, and a population decline by 1.7% since the previous census in 2011 (Stats Canada, 2016b). It is important to note the proportion of older adults within each site, as older people utilize EMS services more often than any other age group (Kulig & Williams, 2012). The community is also one of lower income when compared with Manitoba generally, with an average after-tax household income of nearly $51,000 compared with $70,000 provincial average (Stats Canada, 2016b). This is similar to other rural communities within the region (Stats Canada, 2016a). While the majority (85%) of the community identify as third generation (or more) settlers of white/Euro-Canadian descent, 13% of residents reported Aboriginal identity within the last census (Stats Canada, 2016b). The community is located very near to one First Nation reserve, Tootinaowaziibeeng (Valley River) and the Métis settlement of San Clara, who share access to health resources within the community as the nearest health service centre and emergency services.

Community Health Care Services

The Grandview hospital, ER, personal care home and clinic serve the populations of the town itself, the nearest First Nation and Métis settlement, as well as neighbouring municipalities without their own hospital and clinic. The services available within Grandview are reputable, and known as reliable. For example, the 24-hour ER has never once closed, as there is always a doctor on call supported by nurse practitioners. This reality, in addition to others makes Grandview an outlier when compared to many rural towns across the province. The hospital, clinic and EMS station all operate out of a single site, with the EMS station attached to the hospital. The hospital features 18 in-patient beds for both chronic and acute patients, and could not function without the auxiliary laboratory and x-ray facilities, which are critical to the operation of the hospital and timeliness of services and test results. The care team includes nurse practitioners and primary care nurses, physio- and occupational therapists, lab and diagnostic technicians, dietary and housekeeping staff that have worked within the community over long-term periods, reflecting the stability and continuity of services and providers in Grandview. The entire staff team is highly skilled, qualified and experienced, for example, the collective emergency room experience of the physicians alone exceeds 40 years. Within Grandview, the practicing physicians are considered true rural generalists and also have specialized qualifications in emergency medicine, anesthesia, bedside, ultrasound and addictions medicine. In addition, the physicians have a special interest in Indigenous health and mental health service provision, which is critical to broad and diverse communities that they serve both within and outside of Grandview itself.

What makes the hospital well-known within the region, and sought by patients and families requiring care, is the relationships and personability of staff within the facility. Further, the reliability of the services delivered there, especially emergency services, is well known. As an indicator of reliability, one physician stated to local media that the only time the hospital had to close its doors and stop provision of services was during a severe snowstorm about ten years ago (Laychuk, 2017a). The Grandview hospital serves people and families outside of the community as well, and is the only hospital located within the 94 kilometer stretch of highway between the nearest communities to the east and west with their own hospital services.

The hospital service, and importantly the ER within Grandview, is further supported by the EMS station. Emergency services are staffed 12 hours a day, with on-call services overnight, but equipped to offer 24-hour services to Grandview and the surrounding area (Laychuk, 2017a). There are four full-time primary- or intermediate- care paramedics employed by the station in order to support the services it is designed to deliver, which include emergency response duties, but also community paramedicine, which includes the provision of community education, volunteering their service at community events such as sports games, BBQS and parades. Important to the operation of the hospital, the paramedics support EMS responders from other communities, and help the Grandview physicians, nurses and staff. In the hospital setting, these paramedics are key personnel in the delivery of services, assisting with triaging of emergency patients, patient transfer and administrative duties. The Grandview EMS service responds to calls within the town proper, and rural residences surrounding the community, to the east and west along the main highway through town, and between the mountain ranges and parks to the north and south. When the Grandview ambulance is on a call, a second ambulance would be dispatched to Grandview in the case of a second call from either the nearest town to the west or east, or even Dauphin, the nearest city.

According to Manitoba Shared Health, the EMS station in Grandview is considered a rural and low call-volume station, making it a candidate for closure in the province's plan to shutter several low functioning EMS sites. However, from October through December of 2018, Grandview EMS responded to more calls than 46% of the other rural and remote EMS stations under Prairie Mountain Health authority, excluding Dauphin and Brandon because these are urban EMS sites and respond to a greater volume of calls for a larger population. This call response rate varies quarterly, or seasonally, due to land use, and the agricultural and tourism economies. For example, between July and September 2017, Grandview responded to more calls than 66% of the other rural and remote stations within the region. This reflects the increase in recreational use and visitation to the Grandview area for summer tourism and activities in the two provincial parks, as well as the increase in agricultural work and activity during those peak operational months. Statistical data gathered from the Ministry of Health, Seniors and Active Living indicates that the Grandview EMS station is used more frequently by the populations that it serves, compared to other rural EMS stations in Manitoba.

Utilization of Grandview EMS includes not only emergency medical response, but also inter-facility transfers between Grandview, and the nearest rural hospital to the west, as well as transfer to larger centres and specialized care in Dauphin and Winnipeg. In 2014, Grandview EMS responded to 218 calls, 185 calls in 2015 and 245 calls in 2016, while over the same period, the Grandview ambulance and EMS staff provided 1260 inter-facility transfers within the region. Comparatively, the EMS station to the east, which is not affiliated with a rural hospital or clinic, responds to 5% fewer calls on a regular basis. Considering this, it is clear that within PMH region, Grandview is not a low call-volume station, at least not among the rural and remote stations within the region.

Indigenous Community Setting

Importantly, Grandview's ambulance also responds to calls from the nearest First Nation, located about 23 minutes from town. The First Nation is an Anishnabe[2] community, with a population of over 1,600 members, with over 600 residents living on reserve, and the remaining population residing within the surrounding region. The community identifies particular health care needs among members and operates a health clinic right on reserve, funded primarily

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[2] Term utilized reflects the preferred spelling of the First Nation community.

through federal transfer. In addition to this, many services are supported and provided by physicians and staff operating out of Grandview. This unique service relationship between the First Nation and the settler community and health providers allows for continuity of care and ensures that care needs are met.

As the nearest EMS station, Grandview responds to between 46% and 93% of emergency calls out of the First Nation, consistently arriving within 30 minutes. This is important, as the community is considered a rural First Nation, with at least two access roads in and out of the community. With Grandview's EMS responding to the majority of calls and an established health service relationship, Grandview paramedics and staff have become familiar with the reserve community. Further, the EMS staff have become familiar with the roadways through the community, and arrive on the scene of a call in the shortest wait time possible. When compared with the response time from the neighbouring stations and the number of responses to the First Nation, the EMS out of Grandview is the fastest and most consistent.

In addition to the First Nation Community, a nearby Métis settlement within the region also relies upon the services offered out of Grandview, including EMS, the ER, hospital and clinic. While the settlement is closer to another rural town with a hospital and EMS station, many community members travel further to seek care out of Grandview as it is the most reliable and consistent hospital in the region. The nearest hospital to the settlement is not open 24-hours a day, and tends to be inconsistent. For that reason, many folks from the Métis community make the longer trip, and additional 25 minutes, into Grandview, for care.

Research in this Setting

This dissertation is based within this rural community and region, offering a rich space to study and understand rural health in the prairies, and across Canada. However, the reason why I base this dissertation research here is due to so much more than that. It is the site of an intense rural health policy problem, that became exacerbated to the point that the community undertook its own advocacy and sought the help of academic researchers. In the following section I describe the actions taken by the Manitoba government to transform the provincial health care system, which began with the announced closure of several EMS stations across the province. Many of these stations were identified within Winnipeg, where their close proximity to other stations rendered them redundant. However, the majority of stations slated for closure were located in rural, remote and northern communities, justified for closure or amalgamation because of their low call-volume status.

Announced Closure of Grandview EMS Station

Despite conflicting utilization and population data that I analyze in chapter six, in 2017 the Government of Manitoba announced the decision to discontinue emergency medical services in the community of Grandview. At the time of this writing, the station has not yet closed. However, the knowledge of the impending closure has left community members reeling. The decision to discontinue services came about following the province's decision to act on the 2013 EMS Review, the Peachey Report and the KPMG Report on health sustainability. Under the new provincial health system, the closure of nearly two dozen EMS stations would take place over the course of ten years (Laychuk, 2017a). Among those slated to close, 18 EMS stations are considered rural.

At the news of the impending closure of their EMS station, a sense of concern over rural access to health care was heightened. Immediate reactions to this proposal were strong across rural Manitoba. In Grandview, the community imagined the elimination of EMS services as a precursor to the eventual closure of the hospital, and from there all of the auxiliary services and businesses that accompany, support and pair with it (Laychuk, 2017a). The community brought their concerns forward to their provincial government representative. But despite these efforts to petition the government's decision to close the station, the Manitoba government confirmed their plan to close Grandview's EMS station in December 2018, in the midst of this research. The announcement came at this time that a new station would be built in the neighbouring town located about 13 minutes east of Grandview, between Grandview and Dauphin. Under this plan, the new station will service the entire Duck Mountain region, a population of about 4,000 people (Laychuk, 2017a). Significantly though, this new station would not be affiliated with a hospital, rather a stand-alone unit, and would leave the Grandview hospital without the support of paramedics on hand to assist hospital personnel. The community felt that the level of service and the health care system as it existed in Grandview was ideal. As one service provider stated, "…we have a current model that works… Once you lose something in a small town, you never get it back," (Hutchins, 2018, p. 1). Following the announcement of their impending EMS station closure, the residents of Grandview prepared to challenge this decision and demonstrate why Grandview's EMS and hospital services should remain in place through Manitoba's health care transformation.

Policy Problem

In reviewing the setting and social context within Manitoba, and how this relates to Canada more broadly, a policy problem emerges, and it is here that the following research can be situated. Across Canada the restructuring and redistribution of health care services has been conducted as a type of reform. Unfortunately, this practice has resulted in the centralization of health care services out of many small, rural communities, or to become shared between communities, in what is determined by the government as a geographically central location.

Often, these provincial health system changes fail to recognize the strengths of community health care, and transformation occurs without appropriate community consultation. Unfortunately, what has occurred in many jurisdictions and communities, is a significant change to the level and form of health care service that many smaller communities are familiar with. In the case of Manitoba, the community of Grandview now faces the loss of their EMS station and staffing, as well as the possible closure of their ER and hospital as a result of this loss. Further to this, such provincial health system transformations fail to consider the impact to Indigenous communities as a result. Where access to health care services, especially positive, relational and supportive services, are withdrawn from First Nation and Métis communities a policy problem emerges.

Health Policy in a Post-TRC Era

Following the release of the Truth and Reconciliation Commission's (TRC) inquiry into the residential school system, and the 94 Calls to Action brought forth by the Commission, it is critical that any research or work on rural health, or more broadly health in Canada, reflect upon that of Indigenous communities and peoples across this country (Truth and Reconciliation Commission of Canada, 2015). There are seven calls to action specific to Indigenous health, calling upon all levels of government to recognize the impact of historical policies and practices on the health and wellbeing of generations of Indigenous peoples across Canada and to ensure that change is brought into the health care system to provide services appropriate to Indigenous communities by practitioners who are trained to be culturally safe. Addressing these calls to action is required to move forward in reconciliation and relationship between Indigenous and non-Indigenous peoples, settler communities and governments, and to recognize, repair and prevent further, the damage done to Indigenous peoples by the colonial state. Reading, Loppie and O'Neil (2016) state that researchers have a crucial role to play in addressing these calls of action in a critical and collaborative way, but also in making record of how their work contributes to reconciliation. By highlighting the social and political context within which this research is situated, I am contextualizing this work and writing as a response aligned with the TRC Calls to Action on Indigenous health. For rurality and rural health within this country known as Canada cannot be known as separate from Indigenous peoples, worldviews and experiences of health.

Chapter Three: Theoretical Concepts

This dissertation was conducted through and guided by a set of theoretical frameworks that were utilized throughout the research process. The theoretical frameworks that are used to inform this research include settler colonial theory as an overarching theory in which rural and Indigenous health policy can be conceived and evaluated critically. The second guiding theory includes symbolic interaction theory, borne of social interactionism, which allows for the interpretation of how communities come to have shared understandings of their experiences and the world around them. Lastly, the SDOH framework is utilized to holistically conceptualize the multiple, layered factors that affect health, and those that are most pertinent within a rural and an Indigenous context. While these theoretical concepts are often used independently of one another, they provide an important foundation upon which this research is based. Taken together, they form a holistic perspective through which I examine rural and Indigenous health and policy in Canada. In the following sections I expand on each of these theories and frameworks and illustrate how they are used in this dissertation.

Settler Colonial Theory

Settler colonial theory (SCT) can be utilized to analyze the nature of settler colonialism in the development of Indigenous health policy in Canada. It has emerged in critical response to notions of a postcolonial moment occurring within many setter states, such as Canada. Postcolonialism was problematized by critical Indigenous scholars for its forward acceptance of the idea that colonialism was a problem of the past (Macoun & Strakosch, 2013). As foundational settler colonial studies scholar Patrick Wolfe (1999) asserts, SCT views colonization as a structure, rather than a singular event. The acts and outcomes of colonization are lasting, reverberating through histories and peoples as intergenerational trauma. Rather than idealize a postcolonial future, settler colonial theorists Macoun and Strakosch (2013, p. 426) argue that "SCT is useful in dehistoricizing colonialism" and in articulating the ways in which settler discourses, structures and ideologies relate to policy and influence relationships with Indigenous peoples and lands. The active use of SCT brings forward the concept of colonial continuity into current structures within society. Using SCT, settler scholars are motivated to dismantle and disrupt persistent colonial power dynamics and contribute to a growing Indigenous resistance in settler states (Macoun & Strakosch, 2013). Importantly, SCT is used to analyze these structures, often through an analysis of policy, and while this analysis has traditionally been conducted on conservative, exclusionary policies, Macoun and Strakosch (2013) remind settler scholars that SCT is just as useful and important to apply this critique to liberal, seemingly progressive approaches to policy. By making visible the colonial structures evident even in inclusive policies, SCT dismantles the notion that postcolonialism is a present reality, and draws the similarities between overt colonizing state work of the past, and contemporary attempts to exert power.

It is in this utility that I find SCT to be critical to this dissertation, in that the theory can be applied to locate and resist settler colonial intentions within health policies and systems within the Canadian state. The work that I undertake here is concerned with the decision-making processes at play in provincial health system transformation, which operates under a federal structure, and how this change comes to affect rural residents and communities, but also Indigenous peoples and communities. Macoun and Strakosch (2013) write that non-Indigenous scholars should draw on SCT to operate as political actors, and challenge the ways in which settler colonial ideologies operate as structural forces in both visible and insidious ways through policy, education, planning, and various social and political systems.

SCT provides a critical opportunity to acknowledge and account for the embedded and explicit enactments of settler colonialism in contemporary policy (Macoun & Strakosch, 2013). SCT can be utilized for critical analysis of government policies and program, revealing partisanship on the side of the oft-presented neutral state. Macoun and Strakosch (2013) state that this neutral positioning and the superficial optics of impartiality among governments in settler colonial contexts serve to enhance and perpetuate the settler colonial policy agenda where Indigenous polity is absorbed and extinguished. SCT allows scholars to challenge and critique the superficial neutrality of the state through policy actions and underlying colonial struggle to deal with the 'problem' of Indigenous peoples (Macoun & Strakosch, 2013). This relatively recent theoretical approach can be used to expose state intentions and will serve as invaluable for the analysis of provincial health policy in this project. SCT deliberately entwines the personal and structural nature of settler control, which can be observed on all levels within society (Macoun & Strakosch, 2013). As Macoun and Strakosch (2013) state, SCT can be used to bridge connections, both visible and obscure, between "political structures, broader social contexts, and the lived experience of individuals" (p. 8). This is the goal of the proposed research within the context of provincial health system transformation, and rural and Indigenous health policies in delivery, practice and experience.

There are a number of concerns and critiques held by academics and critical Indigenous scholars regarding SCT. Macoun and Strakosch (2013) state that the use of SCT for analysis holds both political and ethical risks for settler scholars. For instance, its tendency to view colonialism as a structural inevitability can justify political stagnancy (Macoun & Strakosch, 2013). Foundational writer on SCT, the late Patrick Wolfe (2006) states that settler colonial structures appear stable and resistant to change. Yet, by acknowledging SCT as a settler discourse in itself, settler academics can properly place the theory within its political location and strive to look beyond the current social and political structures, both conservative and progressive, that continue to deny Indigenous sovereignty. By emphasizing the limited nature of SCT as a form of critical settler discourse, scholars can address the critiques and incorporate other ways of knowing (Macoun & Strakosch, 2013). This is one reason why SCT is not utilized in isolation through this dissertation.

Further, settler researcher Elizabeth Carlson (2016) suggests that when used objectively, SCT can actually serve to reproduce historical settler structures of power and authority over research matter and knowledge. For example, she states that when settler researchers disassociate themselves from their work, by writing in third person and taking an academic tone, they are enacting an arrogant power dynamic reflective of colonial attitudes and academia (Carlson, 2016). Rather, an anticolonial approach, and a (self-) critical application of SCT calls for the consistent positioning of the researcher within their work, and reflexion throughout the process, both of which are acts of resistance against traditional settler colonial approaches to research and objectivity (Carlson, 2016). Macoun and Strakosch (2013) maintain that problems arise when SCT is applied in a neutral, descriptive manner, where the settler research is effectively reciting their political authority over the research process, and controlling the narrative and space within which Indigenous communities participate. These problematics are what this work aims to avoid. SCT is one framework that I can rely on to provide me with guidance in my conduct throughout the process. Snelgrove, Dhamoon and Corntassel (2014) call for a contextual approach to settler colonial studies, in which research is place-based, accountable and conducted in relationship with Indigenous peoples and knowledges. As Elizabeth Carlson states, ethical SCT acknowledges "the foundational role Indigenous scholarship has in critiques of settler colonialism" while also recognizing that settler scholars in and of themselves are limited in expressing acts of settler colonialism without engaging Indigenous peoples (2016, p. 9). This positioning supports the use of anti-colonial methodologies in research, which Carlson (2016) argues can be utilized by non-Indigenous peoples.

Without the use of ethical SCT, this work could reproduce settler colonial histories, but without the correct application of the theory, I could do the same. This creates a precariousness, a balancing act, and a level of discomfort that drives and sustains an anticolonial approach to research with Indigenous and marginalized peoples. This is exactly the position that non-Indigenous scholar Paulette Regan (2010) describes in her work, *Unsettling the Settler Within*. In order to shake, disrupt and dismantle sustained settler colonialism in Canada, settler people must be awoken to not only learn about our collective colonial history and damages, but also to act, and act against them (Regan, 2010). In spaces both social and political, settler consciousness pervades, to the point that even following the Report from the TRC, settler ideologies, practices, institutions and policies remain dominant in Canada. In this way, settler colonialism is entrenched and played out systemically. Regan (2010) examines how this entrenchment can be undone and challenged. The solution lies not with Indigenous peoples carrying the burden of educating settlers, but rather with settler people experiencing the discomfort, guilt, shame and anger in learning for themselves the colonial history of the settler state (Regan, 2010). Moving beyond these emotions however requires action through critical self-reflection, and a re-learning and re-contextualizing of one's personal history and past. This uncomfortable act of unsettling is a first step towards reconciliation, and should be a constant practice embedded within settler learning, doing and decision-making.

It is clear that neutrality cannot exist in research, particularly where it involves settlers operating in Indigenous spaces and lands. Here, the application of critical SCT is helpful in the process of unsettling; my own unsettling as a non-Indigenous researcher, but also my approach to questioning and examining provincial health policies and systems, which historically represent settler colonial ideals and ideologies. This theory is therefore useful to the proposed research in many aspects, however it is primarily used as a way for the settler researcher to account for settler colonial pursuits through health policy in Canada, and supports the anti-colonial approach to research, as guided by Indigenous supervision and community participation in the process. SCT does not account for Indigenous lives or experiences and cannot be used to substitute Indigenous community engagement in research, though it can be used to help reach the goal of Indigenous community-engagement (Macoun & Strakosch, 2013). As such, it is crucial to this research that this theory be used in conjunction with a methodological approach that allows for Indigenous community control and authority within the project, such as community-based participatory models and community-engaged approaches guided by anti-colonial methodologies. Coupled with researcher reflexivity and community-engaged research methods, SCT is a productive guiding perspective in this dissertation.

Throughout this work, I seek to position and reposition myself, my settler history, and the ways that I relate to the research. This approach, or relational accountability, is what Macoun and Strakosch (2013) argue is imperative to SCT, in that it provides the transformative opportunity for settlers to account for their themselves in the way they negotiate relationships with Indigenous peoples and knowledges. This recognition is critical in Indigenous health research. Henry and Tait (2016) develop relational accountability in Indigenous health research, stating that such a framework provides the roadmap that scholars, both new and established, Indigenous and non-Indigenous, can follow in efforts to improve relationships between Indigenous peoples and settler nations. This process of the "four R's" – respect, relevance, reciprocity, and responsibility – allows for strengthened research relationships, calls for the decolonization of researcher thinking, and seeks to create opportunity and wellbeing for Indigenous communities (Kirkness & Barnhardt, 1991; Henry & Tait, 2016). Relational accountability is the foundational paradigm to guide ethically sound and culturally safe community-engaged research (Henry & Tait, 2016). As Snelgrove, Dhamoon and Corntassel (2014) assert, any approach that avoids relationality of settler colonialism can serve to reify and reproduce settler colonial ideals and forms of domination. Therefore, a focus on Indigenous approaches and experiences is important to the research I undertake here. I have been fortunate to have studied under the supervision and guidance of emerging indigenous scholars, and non-Indigenous settler scholars who apply relational, anticolonial approaches to settler colonial studies.

In addition to SCT, two other theoretical concepts and frameworks are woven into the approach I undertake in this dissertation. SCT can operate in cohesion with other concepts, especially those that are relational in nature and assist in critically examining structures that affect health, self-determination and Indigenous-settler relations. SCT helps to identify settler colonial ideals throughout societal structures, and interpersonal relationships, as well as position the settler research throughout their examination and analysis (Macoun & Strakosch, 2013; Carlson, 2016). By pairing SCT with symbolic interaction theory, I am able to bring focus to the interpersonal level where settler colonialism plays out in experience of health policy, and in relationship with community.

Symbolic Interaction Theory

This research is community-centred and engaged, having emerged from a study called for by a rural Manitoban community. The basis of the community-engaged project sought to understand how the community presently interacted within the health care system in place within the town, calling for a qualitative approach to the research. The incorporation of symbolic interaction theory to this work provides the necessary theoretical underpinnings to appreciate and understand the ways in which community members come to understand health and health care, and contextualize their experience of it. Further, it can be utilized to understand the ideas that contributed and continue to affect the health policies under examination in an integrated approach using SCT. The social interactions and engagements that community members have with the health care system, providers and one another inform the ways in which they live, experience and interpret their health.

Symbolic interactionism is based within social interaction theory, which covers a broad perspective emphasizing the importance of subjective meanings that are given to social actions and institutions (McDonnell, Lohan, Hyde & Porter, 2009). Here, interaction is considered to be inseparable from the wider social context of the community and individual (Morgan, 2012). As a theoretical framework, rather than an explanatory theory, symbolic interactionism assumes that society is socially constructed through the small, daily interactions that people experience (Charmaz & Belgrave, 2013; McDonnell et al., 2009). These everyday experiences are thus what contributes to society's creation of normative rules, practices and thought, rather than a simple human response to social structures (McDonnell et al., 2009). In this sense, as social actors, we are active in shaping the social spaces in which we live and operate. Symbolic interactionism finds that individual actions are rooted within the symbolic meaning that is ascribed to things, which is developed through social interactions (McDonnell et al., 2009). People construct their own social world and understanding based on interactions (McDonnell et al., 2009). These interactions between people take place through shared languages, both spoken and unspoken, shared symbols and actions that inform meaning (Charmaz & Belgrave, 2013). Blumer (1969) contends that these interactions, and all of their intricacies work to form and guide human conduct, rather than performing or expressing it.

Primary principles of symbolic interactionism are outlined by Blumer (1969) and built upon by Charmaz (1980). The first premise is that people as individuals and as collectives act towards things or others depending on the meaning ascribed to the item or situation (Charmaz & Belgrave, 2013). Secondly, the meanings that are applied to things are developed through social interactions with other individuals in society or within the community (Charmaz & Belgrave, 2013). These meanings are developed and changed through an interpretive process occurring at the individual level when people engage with things and situations within society. Charmaz (1980) adds two other points to Blumer's list, including that meanings are interpreted through the shared languages and symbols that people use in communication and engagement, and that these are constantly changing and developing through social interactions over time. Further, engagement between people occurs through a process of interaction. Here, social and collective acts are constructed through individual assessment of the situation, and the actions that make up institutions and networks are always moving and changing (McDonnell et al., 2009). Charmaz and Belgrave (2013) state that symbolic interactionism demonstrates how relationships between individuals and society are dynamic and that human life and activities are based on developing process and change. Symbolic interactionism does not assume stability and continuity in society, as interactions are subject to changing interpretations over time (Charmaz & Belgrave, 2013). In resolving this aspect of the theory with SCT and the persistence of colonialism through time in ideologies and actions within society, it can be seen that settler colonialism has changed over time and through (and by) various social movements and moments. What was explicit racism, assimilationist forces and prejudice expressed as the colonial project has shifted to insidious, implicit practices of racism and marginalization of Indigenous peoples within society and social structures.

It is important to clarify what is intended by the concept of meaning-making in symbolic interaction theory. Briefly, within this theoretical perspective, meaning is not borne of an object in and of itself, but rather meaning comes from what individuals can use the object for and what it can do (Blumer, 1969). Action, and the ability to act upon things, situations and others, is central to the theory, and to making meaning. Charmaz and Belgrave (2013) concede that much of life is routine, and therefore it may be assumed that meanings that are created and shared seldom change. Indeed, people are unlikely to change their actions, or their meanings and understandings unless their social situation has become problematic, or an unexpected situation arises, and their common response is no longer appropriate (Charmaz, 1980). One example that Charmaz and Belgrave (2013) offer is in instances where individuals are called out by others for their actions or responses to certain situations, the individual is more likely to change their behaviour, meanings and actions. Such as when a critic suggests that an individual is faking an illness by mimicking symptoms, in this case, the individual, now subject to social criticism, whether public or private, is likely to change their behaviour. But this is due to the form of engagement and interaction that the individual experiences within social settings. Along these lines, the use of symbolic interactionism is useful in this dissertation because it is applied to a moment in time where a community is facing a significant impending change to their way of life. From here, meanings of health, wellbeing, rurality and suffering may change in response.

Importantly. the concept of social structures, and the notion that they determine and influence individual or group choices, decisions and opportunities is also addressed by symbolic interactionism. Theorists Charmaz and Belgrave (2013) state that rather than deny the existence of social structures, symbolic interactionists find that people construct and reproduce social structures through their interactions. Politics, power and privilege then come into play in the way that structures are formed by people, and the ways in which social structures act upon and impact people. Importantly, symbolic interaction theory accounts for this by recognizing that the creation of society is done through social interactions, but also that people rarely operate within social, economic and historic conditions of their own choosing, such that social institutions and structures can come to equally inform or constrain human interaction (Charmaz & Belgrave, 2013). Critical to this research, this theoretical framework acknowledges that meaning-making is performed under such constraining conditions, where society, institutions and traditions restrict response in a structural way (Charmaz & Belgrave, 2013). These structures are also subject to varying contexts over time, again constructed by and constraining human actions.

Symbolic interactionism acknowledges that social, cultural and historical contexts help to shape interactions within society and that interactions occur within context, but that context does not determine interactions (Charmaz & Belgrave, 2013). Meaning is developed through experience, and is redefined when collective (or subjective) experiences call for change (Charmaz and Belgrave, 2013). Here, identity becomes a crucial concept within symbolic interactionism, and is tied to social location, cultural and group affiliations, and cultural meanings; these aspects affect the way that individuals and communities create meaning and understand it through interaction in society.

The use of symbolic interaction theory is well regarded and well used within medical sociology research, and has often been used to inform health care professionals, as well as service users, patients and their caregivers (Charmaz & Belgrave, 2013). The use of the theory has been expanded outwards from the medical setting to inform many other areas of study, including aging, social movements and health inequalities (Charmaz & Belgrave, 2013). Symbolic interaction theory is of particular use when examining individuals' experiences and navigation of social spaces, for example health care settings. It acknowledges constraining histories and collective approaches to health and healing, while focusing on the ways in which community members and service providers interact to create meaning. Within symbolic interactionist studies, researchers often begin by seeking to understand individual or community experiences, to develop an awareness of their perspectives and worldviews (Charmaz & Belgrave, 2013). This theoretical perspective goes beyond this as well, to provide researchers with an opportunity to find where contrasting experiences and meanings ascribed to certain situations arise within a community or social setting (Charmaz & Belgrave, 2013). For example, this approach can reveal where service providers and service users interpret situations, policies or services differently, and can help to explain why. For this and many other reasons, social interactionist analyses have been seen to increasingly inform the work and practice of health care organizations and providers, as well as patients and service users, and their families (Charmaz & Belgrave, 2013). For this reason, my research draws upon symbolic interaction theory when seeking to understand settler and Indigenous community members' experiences of health care services and changes within a rural community setting. It also assists in evaluating the concept of rurality and health, and the ways in which processes of marginalization occur within a ruralized and Indigenized setting, and how they are enacted in policy, practice and experience. Symbolic interaction theory then holds an important and useful place in being taken up in practical and policy settings.

The use of symbolic interaction theory in health studies research, while perceived as a dated approach, has undeniable value in the context of the research presented here. Charmaz and Belgrave (2013) argue that the use of medical sociological interpretations helps to inform theory, which can be translated into the most practical sense and made valuable within an applied setting, such as in the policy-making environment, the hospital, the emergency department, and the community at large. The goal of such research is practical in nature: to help relieve suffering, to improve life circumstances, human health, reduce inequalities, and work towards health equity across various intersections of identities and realities. By informing theory in a practical way, symbolic interactionist research can be applied to policy, or assist service providers and professionals in making decisions that best address the needs of their clients, patients or service user community (Charmaz & Belgrave, 2013).

The application of the theory can also help to move understandings of health and illness from a very individualized level, to the community level. What Charmaz and Belgrave (2013, p. 33) suggest as one of the most critical outcomes of symbolic interactionism, is the way in which the theory can be used to challenge the “blame-the-victim” narrative that is found both transparently and insidiously in settler colonial and biomedical rhetoric and disciplines, especially as they relate to health and illness among marginalized peoples. Importantly, symbolic interactionism prioritizes the experiences of people, and in social justice research, it specifically prioritizes the experiences of those who are marginalized or made vulnerable by social and structural inequalities and inequities. Symbolic interaction theory has significantly contributed to the definitions and understandings of marginalization, what it is and how it is enacted by people and communities, and given meaning in place, practice and policy (Charmaz, 2008). Important to this research, Charmaz (2008) finds marginalization to be structural. Not only do marginalized peoples and groups occupy problematic positions within society, to be considered marginalized according to symbolic interactionism, a group must be an identifiable social entity, where either implicit or explicit measures allow individuals to be part of that entity, and distance other people, the social majority from it (Charmaz, 2008). Ultimately, Charmaz (2008) concludes that the process of marginalization is inherently comparative. When thinking through the process of historical and present marginalization of Indigenous peoples, the application of SCT allows for the contextualization of contact and the colonial project to lay claim to land, wealth and resources. In order to do so, Indigenous peoples were necessarily marginalized based on identity, location and a host of other identifiable measures that persist today, for example in the identification of Indian Status with the federal government. In the case of rural marginality, the identifying factors and us-versus-them, rural-versus-urban divide is not only geographical, but also economy and employment-based, and framed around patterns of settlement.

What I appreciate about symbolic interactionism is that it is founded upon the idea that individuals and communities are active knowers that interact to create social realities. In this way, change within society, and policy, is possible from the bottom up, at the grassroots level (McDonnell et al., 2009). With respect to the methodologies and methods undertaken for this work, and described in chapter five, Charmaz and Belgrave (2013) remark on the utility of pairing symbolic interactionism with grounded theory, the approach used in the analysis of this research, as aligning with anti-colonial methodologies including community-engaged research and grounded theory analysis. For these many reasons, symbolic interactionism is a central theory to the work that is presented in this dissertation.

Social Determinants of Health Framework

The social determinants of health (SDOH) framework provides a beneficial guide and structure which can be informed by social interaction theory and settler colonial theory. The social determinants of health represent any non-medical factors, such as social and economic conditions, that both directly and indirectly impact health (Braveman, Egerter &Williams, 2011; Bryant, Raphael, Schrecker & Labonte, 2011). The framework allows for a conceptualization of health and illness due to systems and structures that individuals and communities live within, where health is intrinsically linked to social context (Marmot et al., 2008). Following the symbolic interaction framework, the SDOH provide a way to consider the structural and social constraints that fall upon individuals as they construct meaning about health, illness and health care through their experiences. This is observed structurally through the effects of settler colonialism on social realities and systems, resulting in health inequalities, observable among Indigenous communities and rural peoples in Canada. These determinants affect health outcomes, and thus experience and interactions between individuals and within communities. The following section develops the SDOH framework, and how it is utilized alongside SCT and symbolic interactionism in this dissertation.

The SDOH are a concept that has existed within health studies research for quite some time, and as such has seen considerable recognition and uptake in global settings, such as the World Health Organization's (WHO) 2007 Commission on the SDOH, and the alignment of the United Nations (UN) 17 Sustainable Development Goals (SDGs) towards addressing inequalities in the social determinants of health globally. Prior to this major uptake, the SDOH were established by health equity scholars seeking to understand disparities in health between people of varying socioeconomic status (SES) (Raphael, 2006). Because health is found to be so centrally connected to context, the SDOH can be applied to individual, community and population levels, making it an adaptable and relevant framework through which to study health inequalities, and to address them (Raphael, 2006). The framework provides an understanding of how health and illness come to be caused by both social and structural forces, and identifies some of these forces as the cause of health inequality. Further, because social and structural forces dictate the distribution of resources, they also cause the persistence of inequity, where those populations facing disparities are unable to achieve optimal health status because they simply do not have access to the necessary resources, or health determinants, such as income, housing, or education (Bryant et al., 2011). The connection between the social and the structural here in causing health, illness and disparity between peoples is what drew me to the use of this framework in this dissertation, where history, context and community interactions inform experiences of health and the health system within the rural community setting.

In the context of this research, I take for granted that social and structural factors cause health and illness, and eschew the singular, Western, biomedical view of the health-illness dichotomy. Where this approach is commonly utilized in health systems and addressed through curative methods, health promotion and disease prevention and targeting high-risk groups, many health studies scholars recognize that this does not effectively reduce health inequalities (Raphael, 2006; Braveman et al., 2011). However, especially in Western, settler colonial biomedical health system, a SDOH approach remains inferior because of its broad perspectives and shift away from curative approaches (Raphael, 2006). Over the past 20 years, some scholars, including Indigenous health scholars, are finding SDOH increasingly useful in research, and there has been more uptake among Canadian policies (de Leeuw & Greenwood, 2011; de Leeuw, Lindsay & Greenwood, 2018). In response to the overreliance of Canadian health policy and practice on Western biomedicine, de Leeuw and Greenwood (2011, p. 56) find that the SDOH moves beyond the biological, from "the cell to the social," examining the "cause of the causes" of poor health and health inequalities.

The SDOH framework differentiates between three levels of health determinants. While there are several different iterations of the framework, I provide an overview in Figure 3 of the SDOH framework as I conceptualize it, demonstrating the trickle-down effects of colonialism, systemic racism, and various settler colonial ideologies and discourses such as biomedical dominance, into health outcomes, resulting in health inequalities among marginalized populations, including Indigenous rural peoples in Canada.

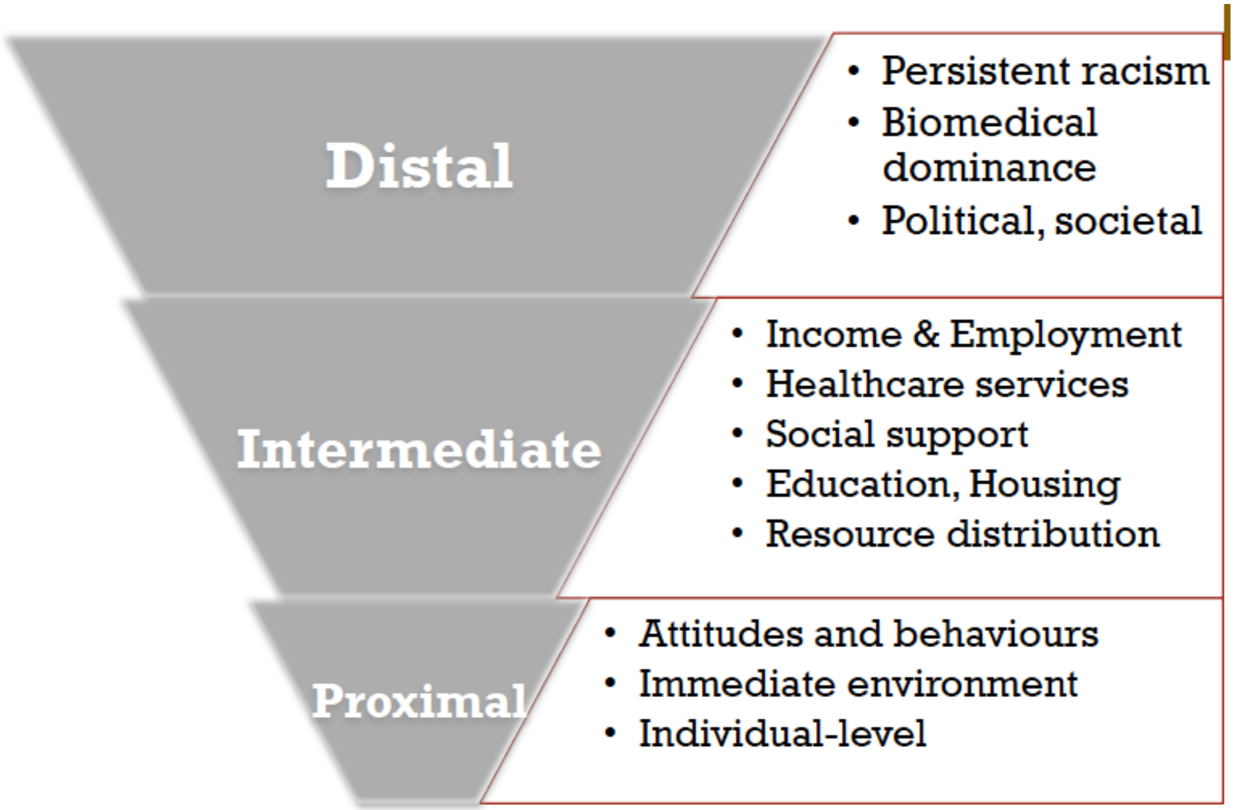

Figure 3: Social Determinants of Health Framework as deployed in this dissertation by the author.

Within the SDOH framework, I perceive the best explanation begins from the bottom up. Proximal determinants of health are the factors that influence health on the individual level.

These include personal knowledge, attitudes, beliefs and behaviours as they relate to health (Braveman et al., 2011). Proximal determinants also include the physical and social environment (Reading & Wien, 2010). Such personal determinants extend to social discourses and interactions between people, like patients and service providers, and systems and places like hospitals. These are often expressed as health behaviours and attitudes towards health-seeking practices, which under a biomedical lens would attribute behaviour to the choice of the individual. Under the SDOH framework, it is understood that choice, and behaviour, is often limited and constrained by social, political and economic contexts found at the intermediate level. The biomedical approach to health and illness falls short in many instances in addressing health issues of marginalized and vulnerable peoples with its narrow focus on health promotion and call for changes in behaviour to solve health problems (Braveman et al., 2011). Distal/structural and intermediate determinants dictate and shape the proximal determinants and health outcomes, and for this reason, health must be conceived of holistically and contextually.

Intermediate determinants are the political, economic and sociocultural structures and drivers of infrastructure, resource distribution and social systems such as health care and education (Marmot, Friel, Bell, Houweling & Taylor, 2008; Reading & Wien, 2010; de Leeuw et al., 2018). At this level, determinants include social and physical infrastructure, resource distribution, and social and health systems (Reading & Wien, 2010). These intermediate determinants are distributed as social and economic resources, often as delivered through state policy, and can either be attained by or restricted from various communities or populations. An example of this within the Canadian health care system is the delivery of Indigenous health resources, where responsibility for on-reserve resources is that of the federal government, but access to services outside of that setting is patchwork and unclear, leaving urban, non-Status and

Métis peoples excluded and, in many cases, unaccounted for (Smylie & Firestone, 2015). Access to social and economic resources regulates the opportunities, life chances and ultimate health outcomes for all people, as they dictate income, educational attainment, health and safe living and working conditions and the ability to make healthful choices (Braveman et al., 2011; de Leeuw et al., 2018). Of particular importance to this research, access to and distribution of health care resources are considered here as intermediate determinants of health, produced through policy and health systems. Health-negative intermediate determinants are difficult to change at the grassroots level and typically require systemic and institutional change at the ideological and political level; without such change, health inequalities due to inequitable resource distribution are left to persist (Raphael, 2006). The intermediate, and proximal determinants of health are subject to the overarching ideologies, discourses, policies and institutions at the distal level.

At the broadest level, the distal determinants of health are composed of the ideologies that influence political and societal thinking, and persist in common discourse. These determinants, while not necessarily explicit or visible within society, are the most influential factors that operate along social, political and economic lines (Loppie Reading & Wien, 2009). Colonialism, racism and discrimination are examples of the distal determinants of Indigenous health (Loppie Reading & Wien, 2009; Reading, 2018). Distal determinants of health are often entrenched and have the ability to persist over long periods of time, flexing with societal change. This allows such structural determinants to take effect on several generations of people and leaving lasting impacts on whole communities or populations (Reading, 2018). These factors trickle down to affect the intermediate and proximal determinants of health, often affecting the most marginalized populations (Loppie Reading & Wien, 2009). Because the distal determinants operate in structural and systemic ways, working their way from the power figures holding and promoting dominant ideologies, they come to infiltrate the thinking and behaviours of society at large, normalizing discriminatory policies, and systemic racism, for instance.

The SDOH framework presented here is extended to be applicable to and inclusive of Indigenous peoples and perspectives. While Indigenous peoples share the same SDOH as the general population, Indigenous scholars have identified more specific factors that serve to determine Indigenous health (Wilson & Rosenberg; Loppie Reading & Wien, 2009; de Leeuw et al., 2018). For example, Loppie Reading and Wien (2009), and de Leeuw, Lindsay and Greenwood (2018) include access to traditional lands, languages, kinship structures, and practice of cultural traditions within their conceptualization of Indigenous SDOH. By incorporating these cultural aspects, the SDOH framework serves to inform academic understandings and approaches to Indigenous health and health inequalities. By examining SDOH among Indigenous peoples critically, it is evident that these determinants are embedded within the power struggle and unequitable relations between settler colonial political forces and Indigenous peoples through time (Richmond & Ross, 2009; Adelson, 2005; Waldram et al., 2006). The distal determinants of health include colonialism and settler colonialism, and histories of assimilation, marginalization and discrimination of Indigenous peoples in Canada, leading to health and social inequalities and greater burdens of illness (Adelson, 2005; Loppie Reading & Wien, 2009). These ideologies and structural forces were actualized in history through the creation of the reserve system, residential schools, inadequate service provision and racism in policy and society. In the SDOH framework, colonialism has penetrated and settler colonialism persists within the proximal determinants of health, exacerbated by diminished self-determination of Indigenous peoples (Loppie Reading & Wien, 2009; de Leeuw et al., 2018). Research using the SDOH framework to study Indigenous health has been demonstrated as effective in describing these historical contexts and structural factors that have led to health outcomes presently within Indigenous populations and communities (Richmond & Ross, 2009; Graham, Stamler, Leesberg, 2010). In fact, Indigenous health scholars have indicated that the SDOH is a fitting framework for policy-makers and governments to refer to in addressing inequalities and working towards reconciliation (Graham et al., 2010; deLeeuw et al., 2010; Smylie, 2009; Richmond & Ross, 2009; Loppie Reading & Wien, 2009; Reading et al., 2007).

My interest in using the SDOH framework here comes from my previous experience using the framework and examining it in practice in the research I completed for my Master's degree (Powell, 2014; Powell & Gabel, 2018). In that work, I undertook a study to understand how health service providers within an urban Indigenous health centre conceptualized health needs and determinants of health and illness among their Indigenous clients (Powell, 2014; Powell & Gabel, 2018). There the SDOH framework helped to guide inquiry and analysis, and research outcomes showed that both Indigenous and non-Indigenous health service providers conceived of health needs as they connected to a web of other determinants of health (Powell, 2014; Powell & Gabel, 2018). In that setting, the framework was useful, and the SDOH as a concept were supported by my findings. My experience in working through research on Indigenous health inequalities using the SDOH framework supports my use of the framework here for this dissertation.

The SDOH framework cannot be utilized in isolation however, as the framework does not offer a critical explanation as to why and where health inequalities arise in the first place, though it allows for categorization, and an understanding as to how they persist and, in many ways amplify over time. As deLeeuw, Greenwood and Cameron (2010) argue, in order for the SDOH framework to be effective in in addressing health among marginalized peoples, it must necessarily incorporate a thorough understanding of colonial and settler colonial discourse, where inequalities are produced and reproduced at the intersection of ideas, institutions, people, actions and place. This is why I bring together SDOH with critical and social theories, to provide a framework through which health inequalities and determinants of health of rural and Indigenous peoples can be conceptualized. SCT and symbolic interaction theory here contribute to understanding structural and systemic social forces that act as and upon determinants of health. The use of SCT demands a critical reflection on history and context of colonialism through time and how it acts implicitly and explicitly through structures and systems today. Symbolic interactionism contributes to the study of social discourse, and particularly settler colonial discourse and power struggles, and community experiences and representations of health. The discourses that are (re)produced in policy and in everyday interactions between community members and the health care system, serve to regulate and constrain relationships (de Leeuw et al., 2010). For this research, community health experiences, and the way that communities conceive of health conditions and services can be brought together with the ways in which these are conceived by the state through policy. From here, this comparison can be critically analyzed for the ways in which colonial ideals persist through health systems. ln this way, the blending of these theories with the the SDOH framework serves to bring this research full circle: from the structural/distal level where (settler) colonial ideologies pervade, through the health system at the intermediate level, through to the proximal level where community experiences and health outcomes result.

Integrating Theories and Frameworks

The preceding theories and frameworks can be integrated to provide a greater understanding of the ways in policies and health systems are constructed and delivered to affect health and health experiences of individuals and communities. As Charmaz and Belgrave (2013, p.12) assert, in sociological health studies, the use of multiple, integrated theoretical perspectives can be "mutually enriching, and… sometimes inseparable." There are multiple pathways of study that are created in the integrated model presented here. Many potential inquiries are beyond the scope of the research I undertake here, in part due to the nature of the research that was called for by the initiating community, but also due to the focused setting of the research as embedded within a singular place and instance in time. Such projects are not intended for vast generalizations, but rather speak as examples that support the generation of larger theories. Nevertheless, the theories and frameworks that I bring together here are combined as the foundation for understanding and analyzing provincial policy, and community experiences. I do this in a number of ways. For example, in understanding individuals' experiences of health care, my analysis applies symbolic interaction theory to the ideas that are formed where community members engage with one another and with service providers within the health system. SCT is used to guide the analysis of government decision and policy-making through my analysis of the key policy documents informing health system transformation. Further, SCT allows for an analysis of the ways in which settler colonial ideals and policies become embodied and enacted by individuals, and shared between them through interactions and discourse (Macoun & Strakosch, 2013). Weaved throughput this dissertation and my analysis is the framework offered by the SDOH, where conceptualizations of health, inequalities, challenges and resiliencies of the community are considered proximal, intermediate and distal/structural determinants of health. Additionally, the SDOH framework contributes to the interests and agendas that identify the health needs of rural and Indigenous communities. This integrated approach is helpful here where both structural determinants such as political and settler colonial ideologies are used to inform health care systems and services at the intermediate level of the SDOH framework, which then act upon proximal determinants of health within the rural and Indigenous communities. Here, community members and services providers express their experiences of a health system as informed by state discourse and thought. Thinking through these interactions brought forward the need to integrate SCT, interactionism and the SDOH to inform this research.

Theoretical Alternatives

The research I undertake here may have been served by several theoretical alternatives outside of and beyond SCT, SIT and SDOH frameworks. In fact, future research in this area may seek to broaden critical understandings by purposefully selecting alternative theoretical frames. In critical health studies there are two primary examples of suitable approaches which I have not taken up in this dissertation. Much of this work has to do with the delivery of health care resources and services, and as such a political economy or critical neoliberal approach would have utility here. Political economy theory is particularly helpful in studying material disparities such as low income, employment and poor housing, as determinants of health and illness, and inequalities (McDonnell et al., 2009). It is particularly useful in approaching shifts within contemporary health care systems, in understanding that through capitalism, health care has been commoditized, and access to health care is based on class (McDonnell et al., 2009). Much of the political economy approach focuses on class-based struggles for power, organization, representation and access. While this theoretical frame can be applied to the case of Manitoba and rural settler and Indigenous communities opposing system centralization, it operates on a structural level, linking social class with health inequalities. Rather than a focus on class, my research is concerned with relational experiences in response in inequalities created by the reorganization of the health care system. As Glen Coulthard (2014) argues in his prolific *Red*

Skin, White Masks, the Canadian settler state has always been less concerned with creating an economy based on cheap, Indigenous labour, rather, it was focused on accumulating lands and resources through the displacement and erasure of Indigenous peoples and bodies. Rather than undertake a political economy approach concerned with class, I turn towards a set of theories that critically analyze both the actions of the state through policy, and the response and experience of communities, both settler and Indigenous.

Further, neoliberalism is borne from the re-emergence of economic liberalism and the development of the private, free market in order to sustain economic growth (McDonnell et al., 2009). In the new management of health care under neoliberalism, private business is often integrated into a public system to bring about cost efficiencies and quality improvements (McDonnell et al., 2009). Similar to the type of system reform underway in Manitoba, these processes are geared towards the development of patient-centred services founded on user involvement and empowerment. In this research however, directions of inquiry were developed through community engagement and involvement. Much of what the community sought to understand was the value of intricate relationships and interactions between service users and providers in the rural health care setting. While a study on health care reform rightfully calls for a theoretical application of political economy theory, the social, personal and relational nature of this study prioritized theories of relationships, experiences, settler colonialism power relations and social interactions in rural health care spaces. In proceeding from this study, and building upon findings, I suggest that a political economy approach would be beneficial.

Action Through Theory

Throughout this chapter, the key premise of each theory and framework have been articulated, with several threads that bring them together. Importantly though, in approaching and addressing health inequalities, and societal inequities, each theory calls deliberate action to bring forth transformative change. In the case of SCT, both critics and scholars clearly state the need for those who draw on the theory to position themselves and be reciprocal (Macoun & Strakosch, 2013; Carlson, 2016). There is nowhere for SCT and the findings it brings forward to go if presented without action. Similarly, the study of health and experience of health and services as examined through symbolic interactionism is useful for informing health policies and systems (Charmaz & Belgrave, 2013). Lastly, SDOH scholars indicate that the study of health inequalities demands action on the SDOH, that this work must be authentically framed as social justice work, demanding action through societal structures to begin to create equitable policy and experiences, for the sake of improving health status (Raphael et al., 2008). Each theory used in this dissertation necessarily calls for action on the part of the researcher.

Despite increasing disparities in health, poverty, income and housing, there are few Canadian policies that have taken required action on the social determinants (Pathak, Low, Franzini & Swint, 2012; Mikkonen & Raphael, 2010). Many scholars indicate that acceptable action is not undertaken in policy due to the ideologies held by those who are in positions of power and the very way that settler government institutions, decision-makers, service providers and society conceive of health, illness, and healing (Raphael, Curry-Stevens & Bryant; 2008). Dominant conceptualizations of health and illness are framed within settler colonial, biomedical discourses, denying the inclusion of personal experience, Indigenous knowledges and alternative therapies. Further, action on improving rural and Indigenous health and outcomes has been limited due to a societal reliance on quantitative studies over qualitative research that shares experience and meanings. The use of SCT as a critical theory, symbolic interactionism as a social theory and the SDOH framework allows for a holistic guiding approach to the study of rural and Indigenous health and policy in Canada. This integrated approach calls for action to improve health by reducing inequalities, and importantly striving for equity for marginalized peoples.

Chapter Four: Literature Review

In this chapter, a review of recent literature is undertaken in order to contextualize and situate this research on rural and Indigenous health in Canada, and the impacts on changing health policies and health care delivery on communities. This review provides the basis for understanding the current state of rural health, including primary and emergency care, and provides the opportunity to build on this area of scholarship, an area notably in need of development within the Canadian health context. In this chapter I provide an overview of Canadian and Indigenous health policy, and then to rural health in Canada. Guided by the SDOH framework, I provide a review of the Canadian literature on rural health, and the distinct determinants that research has identified as critical to health and wellbeing within rural, remote and Northern settings. Building upon this, I then provide an overview of the scholarship on Indigenous health and policy in Canada, as rural and Indigenous health in Canada are intertwined in many ways. I aim to undertake a strengths-based approach to describing identified determinants of Indigenous health by utilizing the works of Indigenous scholars, and drawing on examples of positive health and community resiliency. When reporting on Indigenous health outcomes, it is crucial to provide context for Indigenous health challenges observed, and highlight strengths, to avoid contributing to stigmatization in wider society (Hyett et al., 2018). It is critically important here to unpack and contextualize the impacts of an ongoing colonial history in Canada, and how this has fundamentally impacted the health and wellbeing of Indigenous peoples and communities across this land. I conclude this chapter with a section dedicated to the ways in which health inequalities can be addressed in both policy and practice and situate where this dissertation builds upon and contributes to the existing literature.

Canadian Health Policy

Canada is known for having a national-level, universal health care system, which provides access to essential primary and emergency health services. These provisions are made available to Canadian citizens through provincial and territorial health care systems that support the delivery of hospital and physicians' services under the Canada Health Act of 1984. In addition, municipalities and the private sector contribute to a rather patchwork system (Lavoie, 2013). In return for delivering services, the federal government reimburses provinces and territories through transfer payments, or block funding (Smylie & Firestone, 2015). Besides this fiduciary relationship, Lavoie (2013) states that the Canadian system is held together by complementary legislation, policies, relationships and goodwill. The national health care system is founded on five key principles, which include universality, where all Canadians have access to public health care insurance; comprehensiveness, which ensures that all medically necessary services like hospital and doctor services are covered; as well as accessibility, which calls for the elimination of financial or other barriers to ensure health care is available when needed. Lastly, the system calls for portability where Canadians are medically insured across the country, regardless of which province or territory they live in, and internationally, and the health system requires public administration where health care insurance plans are managed by a public agency (the province or territory). Together these principles form the foundation of the Canadian health care system, which adheres to two central objectives since its inception in the 1960s with the federal Medical Care Act. The primary objectives of the Canadian system include that every Canadian has timely access to all medically necessary health services regardless of ability to pay for those services and that no Canadian should suffer undue financial hardship as a result of having to pay for care. These are the criteria that all provincial and territorial health care systems must adhere to in order to receive funding from the federal government for the services they deliver. While medically necessary health care services are not expressly defined in the Canada Health Act, the provinces must provide health insurance to their residents and meet the federal requirements, as well as plan and implement public health and health promotion initiatives, and regulate physician services and compensation (Williams & Kulig, 2012). For these reasons, health care systems across Canada look different and are delivered in various ways, but all provinces must satisfy the national health policy. Here, the provinces carry the greatest responsibility for ensuring that health care services are accessible and meet the needs of the population. In evaluating eligibility under the Act, Kelly (2011) states that persons insured are residents of the province, other than members of the Canadian Forces or Royal Canadian Mounted Police (RCMP), federal inmates or non-permanent residents of the province, who fall under federal jurisdiction. The coverage of Indigenous peoples, is not stated within the Act, however MacIntosh (2008, p. 86) has argued that the provinces must deliver insured health care services "to all persons normally resident in the province, which includes Aboriginal residents regardless of whether they live on or off reserve." Varying interpretations have resulted in jurisdictional gaps, and contention over responsibility for health care provisions between federal, provincial and Indigenous governments (Jacklin & Warry, 2004; Lavoie & Forget, 2008; Kelly, 2011). Considering this ambiguity, the Canada Health Act is the central health policy across the country, but is implemented according to the discretion of each province.

The structure of provincial health systems varies across the country; however, most subscribe to a decentralized model in which the provincial government transfers authority over delivery to a group of regional health networks or authorities (Lavoie, 2013). While this is a decentralized, or regionalized approach, it is also centralized with respect to the ways that municipalities and communities must defer to health regions or authorities for system implementation. These authorities are then responsible for planning and delivering services and administering health care resources and funding (Lavoie, 2013). The concept of decentralization is intended to allow for greater community and stakeholder engagement in health decision-making and priority-setting on a geographical or regional basis (Lavoie, 2013). While over time provincial governments have increasingly shifted towards community-based health care service delivery and disease prevention, the greatest expenditures among provincial health systems has consistently been hospitals, physicians, and pharmaceutical drugs between 1975 and 2010 (CIHI, 2010). These sources of primary care are considered the most essential foundation of the health system. It is critical to note here however, that emergency medical services (EMS) and EMS systems are not considered part of the Canada Health Act, as emergency departments (EDs) and trauma services provided in hospitals are (Hameed et al., 2010). This has led to differing EMS delivery systems across the country, and varying standards and quality, as well varying relationships between EMS providers and primary care providers (Hameed et al., 2010). This point also highlights the importance of primary care in addressing health care needs and emergency health needs in hospital.

Addressing Inequalities: Primary Health Care

There is significant literature directed towards the improvement of health and reduction of health inequalities through the provisioning of equitable and effective primary health care (Starfield et al., 2005; Wong et al., 2011; Browne et al., 2012; Kyoon-Achan et al., 2019). The WHO for example notes that closing the gap in health disparities among marginalized and vulnerable populations requires that primary health care be addressed (WHO, 2008). Primary care includes the first point of access into the health care system, such as medically necessary care in the form of family physicians, preventative care, and hospital and emergency care

(Browne et al., 2012). The effective delivery of primary care and prevention services is critical to reducing demand on hospital and emergency services, and can reduce user demand and economic strain on the health care system (Starfield et al., 2008).

While many would argue that primary health care is a foundational inclusion in Canada's universal health care system, it is important to note that primary care is not always delivered equitably. Research on the delivery of primary care has consistently found problems that contribute to persistent inequities, including inverse care, where the most marginalized peoples within society experience the worst health outcomes, and have the least access to health care services (WHO, 2008; Browne et al., 2012; Raphael, 2006). Research also demonstrates that primary care delivery is often fragmented and underfunded for delivery to vulnerable peoples, and further there is little research or political interest in learning how to structure services to be responsive and effective in meeting health needs of marginalized populations (Wong et al., 2011; Browne et al., 2012). In their study on primary health care utilization by urban Indigenous peoples, Browne and colleagues (2012) found that investing in primary care is critical to addressing health and social inequities. However, in their review of service delivery and policy in Western Canada, they found that very little progress had been made to take action towards improving such care, and suggested that intersectoral collaboration and community involvement was required to effectively meet health needs (Browne et al., 2012). Further, the development of equity-oriented primary health care was identified as crucial to meeting the needs of vulnerable and marginalized populations. From their research, Browne and colleagues (2012) highlighted four key dimensions of equitable primary care, including inequity-responsive care that is focused on addressing the SDOH; trauma-informed care cognizant of structural violence often experienced by marginalized peoples; contextually-tailored care, which includes programs and services specifically designed for (and with) communities; and lastly, culturally competent care that acknowledges and responds to provider and patient histories, experiences, cultures and biases, and how these impact life and health. Researchers note that this idealized form of primary health care can only be successful if supported by multi-sectoral governments and initiatives (Browne et al., 2012). However, within Canada, the literature below shows a different approach to the design and delivery of primary care.

Reforming Primary Health Care in Canada

There have been many reviews of health care reform across Canada, most of which occurring at the provincial level where provinces are responsible for the delivery of services and programs under the federal Health Act. This dissertation is situated within a moment of health care system reform and transformation in Manitoba and speaks to the effects that this change makes on the ground, within communities. In their review of the primary health care reform in Canada, Hutchison and colleagues (2011) found that in most provinces, primary care physicians enjoyed significant control over their work and settings through a fee-for-service model, any changes to health policy would necessarily have to include physician support and avoid diminishing autonomy. Compared internationally, Canada has a low physician-to-population ratio, where few doctors for more people affords physicians more control within the health system (Hutchison et al., 2011). Despite this, in 2009, 91% of Canadians reported having a family doctor (Hutchison et al., 2011). However, earlier in the 1980s and 1990s, little reform was actualized in the Canadian health system, and as a result in the early 2000s, Canada’s health system seemed to stagnate compared with other high-income countries when it came to primary health care, including few quality improvements, little change to staffing and administration and lack of investment in technologies (Hutchison et al., 2011). As a result, in 2001 nearly half of all

Canadians reported difficulties in accessing health care during off-peak hours, on evenings and weekends, and a quarter of all Canadians felt that primary health care had worsened over the past two years (Hutchison et al., 2011). It was time then for significant change and reform to restart and rejuvenate a health system that was supposed to be a national pride, that had been for too long neglected by policy-makers and funders. From the early 2000s onwards Hutchison and colleagues (2011) state that through the actions of several provinces, Canada entered into a new era of health care reform and transformation that recognized the effects of entrenched policy legacies that limit major changes; that there is no perfect fit health care system or funding plan, each model has strengths and weaknesses; and that the renewal of the primary care system would require major investment and infrastructural changes (Hutchison et al., 2011). Reform strategies undertaken in those times had to strategically include physicians in decision-making to ensure participation within the primary care system and seamless delivery of services. In rural settings for example, health reform has sought to increase the enrolment of rural students in medical schools across Canada, and financial incentives are provided to practitioners and recent graduates to practice in rural, remote, northern and Indigenous communities (Garasia & Dobbs, 2019). Further, at this time, centralization of health services was taking place within provinces where regional health authorities undertook the delivery and organization of services, resulting in the closure of many rural EDs across the country (Fleet et al., 2015). This move led to limited health resources and health service providers in rural settings.

Research from the Canadian setting has demonstrated the dissatisfaction that primary health care providers experience in the system reform and transformation process, where physicians feel shut out from decision-making, and where their participation is invited, feel as though their presence at the provincial policy table is tokenistic (Kreindler et al., 2019). This recent finding shows the continued importance of service providers in decision-making processes and the authentic inclusion of experts and advocates of the system, and patients. The key goals and objectives of recent primary care reform include improved access to primary care, improved coordination and integration of care, better quality and prevention services (Hutchison et al., 2011). While these goals have been important, the researchers found that objectives like action on health equity, improved experiences of health providers and patients, community participation in decision-making, responsiveness to community needs and building local capacity were all lower-priority in the provinces reviewed (Hutchison et al., 2011).

In summary of their review of Canadian provincial health system reform, Hutchison and colleagues (2011) found that while major transformative change to the primary health care system in Canadian provinces was warranted after years of stagnation, existing policy legacies and the political climate, as well as the social climate, would only allow for incremental changes, or a phased approach to reforming care. Deliberate and intentional change at a steady pace may take longer to achieve results, but Hutchison and his colleagues (2011) found that this was more likely to lead to fundamental and coherent change, that acknowledged and addressed service providers' needs, those of patients, and allowed for cost efficiencies. Findings also indicated that despite a universal health care system, and despite system reform, issues of equity and access to care persist within Canada, particularly among low-income families and patients who are poorly educated (Hutchison et al., 2011). In response, these policy researchers called for inter-governmental collaboration, and involvement of service providers and local, regional and municipal governments in addressing health equity, as well as research to support decision-making and action (Hutchison et al., 2011). The study also noted several challenges to determining the effectiveness of reform, including a lack of defined evaluation measures of primary health care performance, and the participation of service providers and patients (Hutchison et al., 2011). In line with findings of health studies scholars, the need to set evaluation standards for primary health care delivery will be critical in addressing health inequalities and improving the SDOH (Wong et al., 2011; Browne et al., 2012). In all, this review of the health policy literature provides a foundation for understanding health system transformation, but it also echoes what health studies and Indigenous health researchers state with regards to system change for action on health inequalities among populations within Canada, which I expand on below.

Provincial Health System Transformations

In addition to the above findings, several provinces have undergone more recent health system transformations which may serve as examples for Manitoba as it embarks in this journey. For example, in 2012, the Saskatchewan Ministry of Health initiated the process for a Lean management plan and operating principles within the province (McIntosh, 2016). This was among the largest, transformative changes in Canadian health service delivery history, and possibly the world (Kinsman et al., 2014; Willis et al., 2014). The Lean model of reform seeks to create efficiencies while reducing waste and cost, as well as focus on continual improvements and ongoing priority setting (McIntosh, 2016). This reform was intended to empower both patients and providers within the system, through the redesign of health care service delivery and through the development of patient-centred care (McIntosh, 2016). However, key stakeholders, including physicians and service providers, as well as patients, the public and the media, challenged the provincial government on the intended goals of reform, how much it was costing the taxpayer to employee a consultant to oversee a service delivery change that was developed along an automobile production line (McIntosh, 2016; Kinsman et al., 2014). The province justified this significant change by stating that incremental policy and systems change is found to result in little actual improvement, for both the system, and for actors within it, including both providers and patients (Willis et al., 2014). The Canadian Foundation for Healthcare Improvement in 2012 called on the provinces to make large-scale sweeping changes, not only to the structure of the health system, but as an effort to change that attitudes, behaviours, and beliefs of all people acting within the system (Willis et al., 2016). In his critical review, McIntosh (2016) suggests that the Saskatchewan government was forced onto the defensive to justify that major system changes it was undertaking in response to resistance to change from across many sectors. Without buy-in and support from the public or key players within the health care system, the province needed to necessarily rethink implementation. In order to achieve success in system transformation, McIntosh (2016) states that the government must listen to the voices within the health system, including patients and the public, as they make critical inquiries and draw into question state motivations.

In Ontario, health system transformation has been in various states of implementation for many years. In the 1990s, Ontario sought to reduce hospital expenditures, which were steadily increasing, towards a more regionalized, dispersed health system that would better utilize health care resources in the province, particularly in metropolitan areas (Deber, 2006). Under a new PC government, this resulted in closures and cutbacks, including the eventual closure of the Wellesley Hospital in Toronto in 1998 despite community resistance (Goyette, Magill & Denis, 2006). Since 2002, Ontario has been restructuring the provincial system and service delivery (Marchildon & Hutchison, 2016). Significantly, between 2005 and 2009, the province introduced new primary care delivery and funding models to reimburse physicians and development of Family Health Teams (FHTs), leading to an increase in expenditures and corresponding increase in medical school graduates (Marchildon & Hutchison, 2016). Unfortunately, despite these substantial public investments, little actual improvement to access and quality of care has been realized (Marchildon & Hutchison, 2016). For example, a five-year evaluation of the FHT model found that while mechanisms of high primary care performance were improved between 2009 and 2012, patient-reported experiences and outcomes indicated no change to various aspects of patient health experience including access, care coordination, patient- and family-centeredness, and chronic conditions management (Marchildon & Hutchison, 2016; Usher et al., 2020). This lack of impact created particular strain during the recovery period following the 2008 economic recession (Hutchison & Glazier, 2013).

However, by 2015, Ontario patients were reporting having better access to a family physician than other Canadians, and Ontario doctors reporting improved ability to schedule same- and next-day appointments (Marchildon & Hutchison, 2016). Marchildon and Hutchison (2016) found that significant state investment into reform combined with high expectations for operational and performance outcomes has been met with conflict with provincial medical organizations and the public, as the provincial deficit climbed. Further tension has arisen where the Ontario government has suggested even more drastic restructuring measures (Marchildon & Hutchison, 2016). Health policy scholars have repeatedly indicated the importance and value of a clear policy and health system transformation road map, to allow for reciprocal feedback from key stakeholders, though in Ontario, this has not been taken up (Hutchison & Glazier, 2013).

A more recent review of primary health care reform in Ontario between 2008 and 2018 has revealed that most provincial reform has occurred in modifying reimbursement and payment formulas for providers (Aggarwal & Williams, 2019). Major transformative change, like the development of FHTs remain the outlier method employed by Ontario and other provinces

(Aggarwal & Williams, 2019). In 2016, the province issued the Patients First Act, which saw the amalgamation of community and home care under the regional health authorities, or Local Health Integration Networks (LHINs) due to excessive and inefficient spending (Shepperd, 2019). Arising public, health care and academic pushback highlighted the issues with this reform in addressing geographic barriers to health care access, as well as ethnocultural and linguistic differences (Sheppard, 2016). In the midst of this transition, in another significant shift, in February 2019, the conservative provincial government issued the Peoples' Health Care Act, in which the 14 regional Local Health Integration Networks would be dissolved into a singular health agency, Ontario Health (Pilon & Brouard, 2020). This move of centralization was initiated to reach spending efficiencies, eliminate operational silos, and ultimately provide more value for public investment (Pilon & Brouard, 2020). This move effectively eliminates local and regional community involvement in decision-making, as evidenced by the Ontario Health board composition, and inclusion of marginalized communities including rural and Indigenous peoples (Pilon & Brouard, 2020). In these early stages of transition in the province, the question remains as to the ability of this new system structure to address existing health inequities and regional health needs (Sheppard, 2019; Pilon & Brouard, 2020). At any rate, the Ontario example serves to demonstrate that while such shifts in primary care and system restructuring may lead to slowly arising improvements, a lack of inclusion of local voices and stakeholders at the community health care level can lead to resistance and tension.

Rural Health in Canada

The health of Canadians living rurally, remotely and in Northern reaches is in many ways profoundly different from those living in suburban and urban settings. These differences are not surprising, as the demography of rural places in Canada reflects an older population, with lower socioeconomic status, lower education attainment levels, hazardous working conditions associated with farming, logging, and mining among other industries, and riskier health behaviours (CIHI, 2006; Kulig and Williams, 2012). In addition to an aging population, rural people have a high dependency ratio, meaning there are greater numbers of younger and older people in the rural population compared with working-aged adults 20 through 59 years (CIHI, 2006). These dynamics intersect and overlap to produce unique, heterogenous health outcomes among rural populations across Canada. In a review of the 2001 Canadian Community Health Survey (CCHS), researchers found that all-cause mortality risks were higher in rural than urban areas for all age groups up to 64 years (CIHI, 2006). Conversely however, older adults over 65, did not experience greater all-cause mortality risks when compared with urban counterparts (CIHI, 2006). This was attributed to the likelihood of critically and chronically ill people to change location and seek care in urban areas (CIHI, 2006). In addition, recent research has shown that poor health among rural communities can in part to the intentional and promoted in-migration of retirees and low-income working-age people with chronic health conditions to rural areas where housing is less expensive (Rice & Webster, 2017). Overall, the literature shows that rural people in Canada experience poorer health outcomes when compared with urban counterparts, however, they also experience different health-protective factors as well (DesMeules et al., 2012; Pong et al., 2012).

While the rural population in Canada is steadily declining, and represents only one in five Canadians, rural and remote communities are culturally unique and diverse across Canada, resulting in varying health care and social service needs. For example, while fewer visible minorities live in rural places, there are greater proportions of Indigenous communities, including First Nations and Métis communities, and distinct religious colonies, such as Hutterites and Mennonites, residing rurally across Canada (Williams & Kulig, 2012). Further, people living in rural places experience different SDOH from their urban counterparts. In this section I provide an overview of the Canadian literature on rural health and its determinants in Canada.

Determinants of Rural Health in Canada

Much has been made within both academic and policy areas regarding the social determinants of health and their geographic distribution. In fact, Canada and the work of Canadian scholars serves as one of the starting places for scholarship and development to improve health via the social, economic and environmental conditions within which people live, work and develop. In the following segment, I highlight the literature on social determinants of rural health in Canada.

Structural Determinants of Rural Health

Perhaps the most important distal determinant of health for rural communities is the guiding ideology of public health and dominance of the biomedical ideology in establishing health care policies and systems. In their analysis of health status of rural Canadians, Pong, DesMueles and Legace (2009) found that due to the diversity of rural communities and the gradient of health status between urban populations, and the very most remote populations in Canada, a simple, overarching approach to health care services and systems through health promotion and disease prevention was not appropriate. Further stating that targeted programs for rural and remote communities were best suited to meeting community health needs and addressing health disparities.

In an evaluation of the provincial health system in Manitoba, Moss and colleagues (2012) found that health policies and programs delivered in the North and most rural reaches of the province were not adequate in meeting the needs of that population. Further, as these were designed within major cities like Winnipeg, by policy-makers with no experience of the North, for visible delivery in the southern half of the province, the Manitoba health system was ineffective and incapable of addressing rural needs and providing appropriate access (Moss et al., 2012). Dominant, urban-focused, settler biomedical ideologies are reflected in inequitable health care systems, representing a significant determinant of health that trickles down into every component of the provincial health care system, where in Manitoba, research has frequently indicated its bias towards supporting the majority population and non-Indigenous population living within larger cities.

Intermediate Determinants of Rural Health

The intermediate determinants of rural health are often bound to the geographies of health system and service delivery, as well as the distribution of resources through systems. While there is a notable shortage of literature on the determinants of rural health, most of the Canadian literature focuses on the systems-level, or intermediate determinants, and evaluates the disparities in access to care between rural and urban settings as a benchmark for policy and service delivery improvements.

The utilization of health care services among rural people in Canada has also been broadly studied, and reflects intermediate determinants at the distal level. Much research reflects the fact that rural people use health care services differently compared to urban populations, and there are considerable differences in utilization between rural communities (Pong et al., 2012). Rural people are found not to use fewer health services, but rather a different range of services, including greater reliance on family physicians and hospital services (Pong et al., 2012). In many rural settings, access to specialist health services is limited or non-existent, leaving rural family doctors in a position to fill in these gaps by widening the scope of their practice as rural health generalists (Pong et al., 2012). Compared with physicians in urban areas, rural practitioners are more likely to also work in EDs in addition to family or community practice, as well as provide in-hospital care and follow-up for their patients, therefore Pong and colleagues (2012) state that is unsurprising to observe different patterns of use among rural peoples. Greater use of hospitals and EDs is likely reflective of the lack of other forms of emergent care, such as walk-in clinics or urgent care centres, leading more rural peoples to report directly to the ED or use EMS services (Haggerty et al., 2007; Pong et al., 2012). Due to the fact that health inequalities have persisted among rural peoples, research indicates that rural peoples experience a disproportionate burden of disease and likely are not receiving the health care services needed to improve health outcomes (Pong et al., 2012). Naturally, utilization is based largely upon access to health care services.

Access to health care services

Access to health care services is perhaps the best-known determinant of rural heath, where one of the most significant differences between rural and urban peoples in Canada is access. For example, rural peoples are on average four times further away from primary care services than urban peoples (Garasian & Dobbs, 2019). Those rural areas that are located nearer to cities and health service centres experience better health than those who live more remotely, demonstrating the gradient of health disparity in rural Canada (Lavergne & Kephart, 2012). Importantly, in the prairie setting, regardless of geographic location and proximity to urban services, rural communities are worried about not having access to health care at all (Ramsey & Beesley, 2012). Although there have been criticisms of rural health research as being too narrowly focused on access to care in rural settings and do not delve into issues affecting other determinants of health, this literature is central to this dissertation (CIHI, 2006). There are several factors which limit access to health care among rural communities, such as geographic barriers, limited availability of health care services and service providers, cultural barriers and the detrimental impacts of health care reform and transformation (CIHI, 2006; Browne, 2016). Additionally, the literature suggests that access to health care in rural places is gradually declining because medical technology advancements often warrant delivery from specialized providers, who are concentrated in urban centres, and because rural communities are aging and getting smaller, and cannot justify or sustain broader health services and facilities (CIHI, 2006). These limitations are observed and studied across Canada.

Geographic barriers, such as distance from the community, or rural and remote settlements from the nearest hospital or clinic represent significant limitations to accessing quality health care services (Wong & Regan, 2009; Browne, 2016). Rural locations have also been found to significantly limit timely access to health care services (Wong & Regan, 2009). Rural residents must often travel greater distances to reach health care services, often on dangerous roads or single-lane highways (CIHI, 2006; Garasia & Dobbs, 2019). In some cases, rural people living in the prairies and in the north may travel over 200 kilometers to get to their nearest health care centre or regional hospital (Browne, 2016). Most people living in rural areas then rely on road and air transportation to get to and from appointments, or for emergency care access. The travelling distance to access care is compounded and creates an additional barrier for rural communities in severe weather, on hazardous roadways, and for those with limited access to vehicular transportation (Browne, 2016). Including travel for work, shopping, education and government services, national-level research shows that injuries and death due to traffic accidents are far more frequent in rural areas, leading researchers to recommend the improvement of rural road conditions and road safety awareness as methods to address rural health disparities (CIHI, 2006). Further, hazardous and dangerous conditions may leave people waiting for days at a time for an opportunity to travel, or may lead to a cancelled appointment.

Travel and commuting to seek health care services creates additional burdens on individuals, families and communities. In many cases people must leave dependents behind, or find alternative care for them, while they seek care or transport a family member or friend to the nearest clinic or centre (Browne, 2016; Garasia & Dobbs, 2019). Driving significant distances can be costly, financially and in terms of time, and may be compounded in cases requiring that people take time off from work to travel and thus must spend time and expenses on travel, while missing work and losing wages in order to access care (Regan & Wong, 2009; Garasia & Dobbs, 2019). Geographic barriers and travel take a toll socially and emotionally as well. Separation from family and community during the journey to access care places stress on family relationships and interrupts community life (Browne, 2016; Garasia & Dobbs, 2016). This case is a prime example of inequitable access and makes clear how inequalities in both health care access and health itself develop and deepen over time. Research has demonstrated that due to many of these barriers in accessing care, especially primary care emergency services and health specialists, rural settings are associated with more frequent use of hospitals and emergency departments (Fleet et al., 2015; Garasia & Dobbs, 2019).

Much of this dissertation reflects on access to emergency care through EMS services in a rural community and the subsequent access to rural EDs for emergency and trauma care. In their commentary on access to emergency care in rural Canada, Fleet, Archambault, Plant and Poitras (2013) note that little research from within the country exists on access to EMS and EDs among rural peoples, or the impact that this has on rural health. This is largely due to the fact that EMS services are not included within the universal health care system, and that provinces and health regions across the country have diverse emergency and trauma care structures in place, making evaluation and comparisons difficult (Fleet et al., 2013). Further, access to EMS varies across the country, and this geographic variability is not thoroughly examined in the literature. Emergency health research has indicated the “golden hour” of emergency care access as crucial to improving health outcomes, however only Ontario and Quebec rank as excellent in terms of access, with 85 percent and 87 percent of their populations respectively, able to access emergency and trauma care within one hour (Fleet et al., 2013). The other provinces range from 40 to 76 percent of their populations within a one-hour window to access emergency care (Fleet et al., 2013). This has led researchers to suggest that the concentration of services in urban settings, the overwhelming of rural front-line health service providers, and fear of reprisal from health authorities may lead rural physicians to under-report or avoid noting issues within the emergency health care system (Fleet et al., 2013). Other research comparing provinces across Canada has shown that rural residents are more likely to access health care services through the ED or outpatient clinics than urban counterparts (Pong et al., 2011). While this may speak to differing health needs between populations, it also indicates issues in access both to emergency care, and consistent primary care.

Across Canada over the past 30 years, there has been a shift in health care reform to devolve health care planning and services decision-making over to regional health boards or authorities by reducing hospital-based services, and turning them over to the responsibility of local boards. Provincial changes and reform to rural emergency health care services have been framed in Canada as detrimental to communities, a hazardous approach to fiscal sustainability (Soles, 2005; Fleet et al., 2013). This is problematic in many ways as rural EDs are considered safety nets for rural communities which often have greater health needs and an aging population, as well as greater risk of injury or trauma (Fleet et al., 2015). The impacts of health care system reform on rural communities have thus resulted in issues of access, efficiency and effectiveness of health care services within rural places. When these moves take place, it is crucial that provincial governments provide community-based supports to accommodate the increased responsibility to provide services (Browne, 2016). However, this is not frequently observed. For example, Moss and colleagues (2012) find that centralization puts rural, northern and indigenous communities at a severe disadvantage to accessing required care, and when residents feel as though they cannot access care, they avoid seeking it, contributing to poor health outcomes and mortality.

Further, when rural hospital-based services are eliminated, health care service providers such as community physicians, nurses and social workers struggle to keep up with the needs and demands of their community, and their emergency and acute health care needs (Browne, 2016). Because rural people access hospitals more frequently, availability is critical. Further, rural peoples utilize the services of family physicians more often than urban peoples, making access to family doctors an important determinant of health (Ramsey & Beesley, 2012). While the withdrawal of expensive hospital services is a move of decentralization of service, there is an accompanying move to centralize and mobilize services in urban centres, away from small towns and rural authorities in an effort to be cost-effective and responsible. Without the appropriate services in place to serve rural communities, health care service professionals in rural and remote regions find themselves performing additional duties (Fleet et al., 2010; 2013). Rural patients in British Columbia noted that the primary health care system became inefficient in rural communities, where increased travel, coordination, visitation and referrals were required before patients actually received the required care (Wong & Regan, 2009). Seeking diagnostic and specialty care became even more precarious for rural people, where the only place to access these services were in major urban hubs requiring lengthy and expensive travel, and interactions with unfamiliar service providers who are unaware of their health history and contexts (Wong & Regan, 2009). These impacts of reform on rural communities have created places that are not ideal to work, or receive care, due to constant flux and change, and limited support, continuity, and health human resources.

Health human resources

Many communities in rural, northern and remote areas of the country face health human resource shortages, where despite even having services and facilities available, or within a reasonable distance, there are simply not enough health care service providers to serve the community (Garasia & Dobbs, 2019). Research and public policy have long been directed towards addressing the retention of health human resources in rural places in Canada, but the trend continues (Garasia & Dobbs, 2019). While across Canada the absolute number of health care providers of various occupational groups have increased, in rural areas only 40 percent of health care professions observed an increase in workers (Pitblado, 2012). Unfortunately, these increases were not sufficient to increase patient-to-provider ratios in rural places to match that of urban settings (Pitblado, 2012).

Further, studies within the Canadian context reveal a greater number of practitioner turnover in rural and remote communities, in which trained professionals enter the community, practice for a number of months or a few years, before leaving the community to practice elsewhere (Browne, 2016). Pitblado (2012) also describes considerable rural-urban out-migration where rural practitioners often move into urban settings, rather than between rural communities to practice. This trend is observed with many different types of service providers including nurses, physicians, dentists and other specialized health practitioners. Rural communities often find it difficult to attract and retain health care service providers for a number of reasons, including challenging, and often outdated working conditions and equipment, long hours, professional and social isolation, a lack of colleagues, few opportunities for continuing education and professional development, and the perception that social and family life would suffer in a remote location (Browne, 2016; Garasia & Dobbs, 2019). Additionally, physicians and health service providers are often hesitant to uproot their families to rural places for fear that their partners will not find employment, and that there are limited educational and recreational opportunities for children (Rice & Webster, 2017; Garasia & Dobbs, 2019). Here it is important to reflect that place matters to practice for rural physicians.

These barriers for rural patients also deeply affect continuity of care and relationships with service providers. In their review of rural community use of primary health care services in British Columbia, Wong and Regan (2009) found that in total, 80 percent of participants had received health care from the same service provider for more than one year, and had two chronic health conditions on average. Rural people found that their geographic barriers created challenges in maintaining health due to the inability to form a consistent relationship with the same health care provider (Wong & Regan, 2009). Such a relationship with the same service provider is critical to people feeling comfortable when seeking or receiving care, as well as on confidence in the health provider's decisions and building a trusting relationship (Wong & Regan, 2009). The lack of consistent care, and the inability to retain physicians long term create substantial challenges for rural people managing chronic health conditions, and those that must receive routine care (Wong & Regan, 2009). These determinants reveal why many rural and remote communities experience barriers in both seeking and accessing care, as the development of trusting relationships and rapport between patients and practitioners takes time and investment. For rural people with complex health needs, the relationship with their service provider is central to addressing their treatment and their willingness to adhere to treatment plans. Without a consistent and trusting connection to their local practitioner, many people may simply choose not to seek care or follow up, and may take their treatment into their own hands. These actions may result in avoidance of health care services and contribute to inequalities in health experienced in rural and remote regions.

Aging and rural health

In addition to difficulties attaining and retaining health care service providers, as many rural and remote communities continue to age, few long-term care facilities and services exist to support the aging population. In fact, the rural Canadian population is aging on a more rapid pace than in urban settings, as reflected by Census data (Kulig & Williams, 2012). Older adults living rurally would prefer to remain in their home communities, however, without specialist, long-term and appropriate emergency care suited to the aging population, this becomes less feasible in rural communities. Browne (2016) notes that this has recently become a major strain on rural families, having to choose between relocating their elderly family member to an urban setting where appropriate services exist to support their health needs, or attempting to support their loved ones' aging at home without adequate services. As the rural Canadian population ages, it is becoming increasingly more important to establish and maintain adequate health care and human resources in such communities to assist older adults and their families to age in place.

Proximal Determinants of Rural Health

There are a number of proximal determinants of health that are significant to rural people in Canada. In Ramsey and Beesley's 2006 study of rural health care provider perspectives on determinants of rural health in Manitoba, most providers identified proximal determinants as central to their patients' health, including adequate diets and physical activity, smoking and drinking behaviours, lifestyle, relationships with friends and community, community participation and immediate environment such as housing.

Particular concern is drawn to health-related behaviours which contribute to poor health outcomes and conditions. For example, rural people in Canada are more likely to smoke and consume diets low in fresh foods, as well as engage in low levels of physical activity, contributing to greater levels of obesity (CIHI, 2006; DesMeules et al., 2012). While the CIHI (2006) study shows that socio-economic status is a determining factor of health behaviour, researchers also suggest that access to fresh foods, health promotion programs and recreational facilities may contribute to these observed rural health behaviours. In terms of self-reported health, just over 14 percent of rural peoples reported poor or fair health status, compared with 12 percent of the urban population (CIHI, 2006). Interestingly, rural peoples reported less stressful lives and better levels of self-esteem as opposed to urban-dwelling Canadians (CIHI, 2006).

Working conditions and environments are also highlighted as critical proximal determinants for rural peoples, where rural, remote and northern economies are often based upon farming and agriculture, lumber and forestry, mining and resource extraction and other hazardous industries (CIHI, 2006). As a result, unsafe working conditions and dangerous conditions lead to higher rates of accidental death and injury in rural places across Canada (CIHI, 2006). Injuries, vehicle accidents, and suicide are significant causes of mortality, all of which are determined by employment and working conditions in rural places (CIHI, 2006).

In addition to environment, ideas and attitudes about health are also key proximal determinants of health. Within a foundational systematic review of 34 articles on rural definitions of health in the United States, Canada and Australia, Gessert and colleagues (2015) found that rural definitions of health often emphasized functional aspects of health and wellbeing, such as the ability to work or be productive. Further, they found that the fulfillment of community, family and household roles was very important to rural peoples and their health, framing health in terms of ability, independence and self-sufficiency (Gessert et al., 2015). In the qualitative studies included, rural peoples tended to demonstrate stoicism and fatalism when it came to their own health (Gessert et al., 2015). Several studies reviewed indicated that especially older rural adults, would avoid seeking medical care for as long as possible for matters they deemed non-urgent, in order to avoid becoming what they believed to be a burden on the health system (Gessert et al., 2015).

Social capital is a critical determinant of health for rural peoples, with people living in rural settings in Canada reporting a very strong sense of community belonging (CIHI, 2006; DesMeules et al., 2012). This sense of community belonging and engagement results in strong social capital, which is known as a health positive determinant and supportive of good health. Social capital is defined in many ways in social science literature, but generally refers to the connection between an individual and the immediate social environment they are situated in, including their social network, mutual trust shared between community members and neighbours, participation within the community, and other community-engaged activities, such as volunteering or engaging in local civics, all of which have an influence on health (CIHI, 2006). Varying forms of social capital exist, where positive social capital are though strong and supportive relationships, where negative social capital includes isolation, racist interactions and abusive or violent interactions. While positive social capital cannot undo the damaging effects of low SES, or the structural determinants of racism and classism many rural residents experience, social capital does provide family and community support to individuals, and can result in physical and materials supports such as funding, transportation and child care or caregiving (CIHI, 2006). Interestingly, rural peoples reported less stressful lives and better levels of self-esteem as opposed to urban-dwelling Canadians (CIHI, 2006). Rural communities located closest to larger towns and cities were found to have the highest level of social capital and supportive positive health outcomes (DesMeules et al., 2012). These findings indicate a form of social buffer or protection to health afforded within rural settings. This is observed as a form of resilience, and known to be health-protective.

Community connectivity and support is an important form of rural resilience. In a study of rural Manitoban health providers definitions of health, wellbeing and community, one service provider defined a 'healthy rural community' as "one that functions together for the general good of the entire community… who can make a team work… to improve what development they have… a healthy rural community is a community that thinks that it is a positive place to live and is not afraid to say it" (Ramsey & Beesley, 2007, p. 8).

Addressing Rural Health Inequalities

Organizational and policy-based responses to inequalities in rural health in Canada have typically focused on addressing proximal determinants of health through health promotion and disease prevention strategies. As DesMeules and Pong present in the 2006 CIHI report on Rural Canadian Health, recommendations for addressing poor health status and outcomes included the development of rural-friendly public health strategies focused on smoking, obesity, and healthy eating. While such suggestions are valid and supported through the quantitative data from the Canadian Community Health Survey in 2001, they do not extend far enough to address the structural determinants of rural health, the causes of causes of disparities. Following their systematic review of the literature of definitions of rural health, Gessert and colleagues (2015) found that a better understanding of the ways that rural patients think about health and health care is needed in order to effectively activate patients towards health, but also in the design of patient-centred health care services and programs. By better understanding the unique definitions of health within individual communities, health planning can be intentional and effective, as well as relevant. Further, this research indicates that communities are unique, and the ways in which community members engage with one another, and the health care system through services and providers contributes to the construction of community definitions of health, necessitating the need for community-based solutions for community-specific health needs. Moss and colleagues (2012, p. 175) conclude their study of the Manitoba health care system by stating that rural, remote and northern health needs are unique, and require community-borne solutions, stating that “made-in-the-North solutions have the greatest potential to resolve issues to access” and health inequalities. In this case innovation from within the community, drawing on relationships with dedicated rural health care providers, must be taken up in planning and delivery to empower community members and clearly define jurisdictional responsibilities (Moss et al., 2012).

It is crucial here to consider that rural health cannot be studied without an acute and critical understanding of Indigenous health in Canada, as many Indigenous peoples and communities are themselves situated in geographically rural, remote and northern places, often as a result of colonial policy and displacement. I spend the remaining pages in this chapter reviewing the literature on Indigenous health and SDOH within the Canadian context before situating this dissertation within these bodies of literature.

Indigenous Health in Canada

There is considerable literature produced within Canada concerning Indigenous health in localized, or community-based settings over the last 20 years. However, there is a dearth of literature regarding overall health or population health for Indigenous peoples in Canada (Smylie & Firestone, 2015). Smylie and Firestone (2015) conducted a rich analysis of the availability of Indigenous health statistics literature in Canada. Their work demonstrated that the root for this lack of information stems from the absence of culturally relevant and inclusive identifiers of Indigenous peoples in datasets and that most research fails to actively and appropriately engage with Indigenous communities in research, or establish meaningful, long-term relationships which would allow communities to gather and govern health data collected within their jurisdiction (Smylie & Firestone, 2015). As one suggestion to correct for the lack of Indigenous population health data in Canada, Smylie and Firestone (2015) suggest the inclusion of self-reported Indigenous identity in Canadian census, as well as other national health and social surveys to allow individuals to define their own identity and membership, but also establish more specific population health data. The results stemming from this lack of information are numerous. As Smylie and Firestone (2015) point out, without substantial population health data, health researchers and governments end up underestimating existing health inequities and disparities along various determinants of health and health status. The following section reviews leading research out of Canada on Indigenous health inequities.

Indigenous Health Inequities

There has been substantial work in Canada and on the health inequalities and inequalities faced by Indigenous people. Disparities occur along social, political, and economic lines and within the SDOH, including under-housing, overcrowded and unsafe housing, substandard infrastructure within Indigenous communities, both reserve communities and urban neighbourhoods, lack of safe, clean water, food insecurity, under-employment and training, few educational opportunities, and lack of access to health care (Loppie-Reading & Wien, 2009; Reading & Halseth, 2013). Health scholars identify that the disproportionate burdens of illness and health inequalities experienced among Indigenous peoples across Canada can be attributed to the uncoordinated and fragmented delivery of health care services through government health systems and existing colonial structures (Kelly, 2011; Adelson, 2005; Greenwood et al., 2015; Gabel et al., 2017).

Disparities in morbidity and mortality exist between Indigenous and non-Indigenous peoples in Canada, for example, Indigenous peoples have been found to suffer from a greater proportion of infectious disease and chronic illnesses (Loppie Reading & Wien, 2009; Adelson, 2005; Wilson & Rosenberg, 2002). Within the Indigenous population in Canada, leading causes of morbidity include injury, poisoning, circulatory disease, cancer and respiratory disease, with rising rates of suicide and self-inflicted injury (Adelson, 2005). Suicide is noted by Indigenous health scholars as a key indicator of social disruption among Indigenous communities, and rising cases demonstrate the severity of the impacts of colonization and other structural determinants of health such as colonialism and racism within society (Adelson, 2005). Further, violence within families, and interpersonal violence has been a significant health concern, where various forms of abuse continue to rise in many communities, however violence does not occur within a vacuum, and must be recognized as the outcome of intergenerational trauma caused by centuries of destructive colonial policies (Adelson, 2005). These disparities in health are representative of the outcomes of inequity in structures, systems, services and society.

Determinants of Indigenous Health in Canada

Here I share an overview of the determinants of Indigenous health as identified by Indigenous health scholars and settler scholars who do health research with Indigenous peoples and communities. Determinants of Indigenous health include access to health care, colonial histories, environment, education, housing, socio-economic conditions, resulting lifestyle and health-related choices, among many other factors (Adelson, 2005; Marmot & Wilkinson, 1999; Reading & Wien, 2009; de Leeuw & Greenwood, 2011; Czyzewski, 2011; de Leeuw, Lindsay & Greenwood; 2018). Critical Indigenous health scholars argue that a SDOH approach to understanding Indigenous health is productive, but must necessarily reflect the ways in which settler colonial policies, practices and ideas have colluded to result in the poor health status among Indigenous peoples in Canada today (de Leeuw, Greenwood & Cameron, 2010). For this reason, I begin with a review of the structural determinants, the colonial history and policy context within which Indigenous health is determined.

Structural Determinants of Indigenous Health: A Colonial History

The structural determinants of health are the political, social and economic contexts within which people live and through which health and illness are constructed (Czyzewski, 2011). Considered the cause of the causes of health inequities, these entrenched structures and ideologies become engrained in political and social processes, discourses and norms operating on a societal level (Czyzewski, 2011). Canada’s history of relations with Indigenous peoples of this land has been categorized in myriad ways, as destructive, horrific, genocidal and ignorant. Many policies were implemented within the country’s infancy as a way to assimilate and erase Indigenous peoples. The first colonial policy to directly address Indigenous peoples, following some of the historic treaties in the north over land rights and resources, was the Indian Act of 1876, in which the government described who is ‘Indian’ or ‘Status’ (Kelly, 2011). This has been, and continues to be used as a tool by the government to determine who is within federal jurisdiction, and under federal responsibility, it also determines who among Indigenous peoples has certain rights as determined by the state (Kelly, 2011). The Indian Act also established Indian reservations, and delineated federal responsibility for health care for only those Indian people residing on-reserve (Kelly, 2011). Another of these policies was the development of the residential school system and mandatory attendance at Indian Residential Schools (IRS). In 1876, with the passing of the Indian Act, the Canadian government partnered with denominations of the Christian church and offered the church control over residential schools (Reading, Loppie & O'Neil, 2016; Waldram et al., 2006; Mashford-Pringle, 2011; MacDonald & Steenbeck, 2015). In fact, the Canadian government benefitted greatly from this partnership, where the state was effectively able to deny both responsibility and accountability for the atrocities that occurred within the IRS. Over the course of a century, residential schools operated, with administrators forcibly removing Indigenous children from their homes and communities, punishing parents and families who refused to send their children, and effectively eliminating all trace of Indigenous identity, language and culture among generations young Indigenous peoples (Kelm, 1998). The IRS strategy aimed to erase the history of Indigenous peoples and their claims to land and resources altogether, by dismantling identities and dissolving family, community and kinship structures (Kelm, 1998). Many scholars refer to the Indian Act and the IRS as policies of assimilation aimed to eliminate the 'Indian' from society (Kelly, 2011). The Indian Act and the IRS contributed to a colonial legacy which has informed contemporary settler colonial policies, and social constructions of Indigenous peoples. Further, these have enacted centuries of violence upon Indigenous communities, resulting in intergenerational traumas and the embodiment of inequality.

Despite destructive assimilationist policies in Canada's colonial history, scholars have also identified policies of recognition, and those of reconciliation (Kelly, 2011). Reading, Loppie and O'Neil (2016) provide an overview of the two major historical policies that reflect on equity for Indigenous peoples in Canada. First, the Royal Commission on Aboriginal Peoples (RCAP) report was issued in 1997, in part as the Canadian response to national human rights abuses against Indigenous peoples, and in following the path created by governments in South African and Chile to initiate truth and reconciliation following abuses there (Reading et al., 2016). The resulting report included five volumes and over 4,000 pages detailing issues experienced by Indigenous peoples in Canada, but also included their recognition, and highlighted future prospects through many recommendations (Kelly, 2011). Among those, the RCAP called for a new relationship between Indigenous and non-Indigenous peoples, and all levels of government (Kelly, 2011; Reading et al., 2016). Actionable areas included the need to improve housing, child welfare, education and health; all important determinants of Indigenous health (Kelly, 2011). RCAP can be viewed as the first government document outlining specifically the need to address inequalities faced by Indigenous peoples in Canada through the improvement of the SDOH. However, the Canadian federal government has followed through with very few of the RCAP recommendations. The Assembly of First Nations released a 10-year report card in 2006 and assessed the response and actions of the Federal Government. Relative to a summary of major clusters of recommendations, it reveals a clear lack of action on the key foundational recommendations of RCAP.

The second major policy response to Canada's colonial history and relationship with Indigenous peoples is the report by the Truth and Reconciliation Commission of Canada, published in 2015. Published at such a time as to disrupt the lead up and debates prior to the

Canadian federal election, the TRC Report placed Indigenous health, rights and policies in the forefront of political thought and discussion (Reading et al., 2016). Post-TRC and the resulting 94 Calls to Action, Indigenous issues, particularly disparities in health, and persistent inequalities along social, economic and political lines have become priority areas for many governments and policies in Canada. The prioritization of Indigenous issues has thus increased the expectation both within Canada and internationally, that systemic racism and marginalization of Indigenous peoples must inherently be addressed within policies and programs going forward (Reading et al., 2016). Progress in reconciliation thus calls for improved education systems, not just improved education, better outcomes, and a national awareness and condemnation for the IRS and other colonial acts of assimilation and cultural destruction (Reading et al., 2016). Despite these clear indicators, very few large-scale political moves have been made to address equity and create change to improve health and wellbeing of Indigenous peoples in Canada (Reading et al., 2016).

Disappointingly, many scholars state that action, both political and social, on the reports of RCAP and the TRC has taken longer than expected, both by communities and those critical of state response to such condemning reports, and call for Indigenous self-determination (Reading et al., 2016). Many critics view the slow pace of political and social action as the direct result of both the subtle and overt settler colonial racism that continues to pervade Canadian society, which views equity work as a form of oppression of those in position of settler privilege and power (Reading et al., 2016). Without action, disparities and inequalities will continue to exist in the determinants of health, including education, employment, and various other factors, between Indigenous and non-Indigenous peoples in Canada.

Racism and Health

Racism is considered a significant distal determinant of Indigenous health and health inequalities (Smylie & Firestone, 2016; Allan & Smylie, 2014). As a complex social construction which has arisen through colonialist ideologies and discourses, racism has far-reaching implications for racialized and marginalized peoples where colonial policy and practice has essentially legitimized racism within Canadian society (Allan & Smylie, 2024) Wayne Warry (1998) provides a distinction between racism and discrimination, where racism is viewed as an attitude and discrimination, an action leading to marginalization of a culture. Allan and Smylie (2014) extend this stating that racism contributes to unequal distribution of advantage (or disadvantage) within society. Systemic racism, often called structural or institutional racism, is an attitude inherent in institutions and organizations which becomes enacted in social processes and systems (Warry, 1998; Allan & Smylie, 2014). Paradies, Harris and Anderson (2008, p.vi) develop this, stating systemic racism is carried out through the "requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities" among racialized peoples. It is systemic racism that persists in Canadian politics and policies, the education system and health care system and beyond, where Indigenous peoples are negatively regarded, omitted from decision-making, and excluded from power and where resources and opportunities are withheld (Warry, 1998; Allan & Smylie, Smylie & Firestone, 2016). Systemic racism is often subtle and easily denied by the settler colonial state, yet it remains present in settler society, limiting the ways that government and society in general responds to Indigenous peoples, health inequalities and determinants. Systemic racism reveals itself in the ways that the state empowers and privileges settler ideals and practices, and fails to recognize Indigenous peoples and knowledges as critical in addressing health inequalities and community needs (Warry, 1998; Allan & Smylie, 2014). The continuity of such racism has been studied across aspects of society and policy, particularly within health care and health policy settings. Through this history, Indigenous-specific health policies have emerged.

Indigenous Health Policy in Canada

Indigenous health policies in Canada are patchwork and ambiguous at best with programs and services being delivered by the federal government to certain peoples, First Nations on-reserve and Inuit, and others being delivered by provincial health systems, Indigenous health authorities, or in some cases, the private sector (Lavoie, 2013; Gabel et al., 2017). Because health services for Métis, off-reserve First Nations, registered or non-registered Indians, Inuit living outside traditional territories, and urban Indigenous peoples are subject to receive health care services as administered and delivered by the provinces and territories, Indigenous peoples across Canada experience differing levels of care and service (Richmond & Cook, 2016). The federal government's jurisdiction over the health of Indigenous peoples comes from the Indian Act of 1876, however this does not outline a clear description of obligations or responsibilities, including types of services or programs, and Canada has never formally acknowledged a legal responsibility to provide health care to First Nations peoples (Lavoie, 2013; Kelly, 2011). There are strong assertions from many Indigenous health scholars that the state's actions to provide some level of care for Indigenous peoples has been wrapped in self-serving settler colonial practice of acting altruistically for social, political and economic gain, and to protect the health of settler society by controlling illness within Indigenous communities (Lavoie, Forget & Brown, 2010c; Jacklin & Warry, 2004, Alfred & Corntassel, 2005; Waldram, Herring & Young, 2006; Gabel et al., 2017). In doing so, the state continues to act in its own interest, and in the interest of settler society.

Within Canada, health care services for First Nations on-reserve are funded by the federal government and were traditionally delivered by the First Nations and Inuit Health Branch (FNIHB) of Health Canada, however much of these services are considered by scholars to be offered complementary to provincial health care services, leaving Indigenous health policies and delivery systems with gaps and failing to be seamless (Jacklin & Warry, 2004; Lavoie et al., 2010b; Kelly, 2011; Lavoie, 2013). Beginning in the late 1980s, FNIHB began to develop ways for First Nations living on-reserve to engage in health priority setting, planning and service delivery, resulting in options for communities wishing to become more involved with health care (Lavoie et al., 2010a). Three levels of community control exist, including health transfer under the 1989 Health Transfer Policy, where communities undertake the administration of community-based and regional health programs and receive the resource and funding to support their capacity to do so (Lavoie et al., 2010a; Lavoie, 2013). The second option for communities is integrated community-based health services, in which less control over programming is carried by the community, but service delivery responsibility is shared with the federal government (Lavoie et al., 2010a). Lastly, non-transferred communities have some say over the delivery of certain programs, but the federal government retains control over services, funding allocations and planning (Lavoie et al., 2010a). In addition, in Manitoba, a small number of First Nations have entered into agreement with the provincial government to receive their health care services through the provincial system, essentially eliminating the opportunity for community control over health care services (Lavoie et al., 2010a). Correspondingly, however, provincial health systems are responsible for delivering services to all residents, including vulnerable and marginalized peoples and communities, including those who are homeless or housing insecure, low income families, new Canadians, and off-reserve, urban-dwelling Indigenous peoples.

Considering this, the province necessarily must adapt programs and service to meet the needs of diverse and varying needs groups.

Interestingly but unsurprisingly, in a review of provincial and territorial health systems, Lavoie (2013) found significant variance between provinces in terms of Indigenous-specific health policy or planning. There were several provinces and territories that did not have any specific legislative provisions for Indigenous peoples' health at all (Lavoie, 2013). Two provinces had specific Indigenous health policies, including the first Aboriginal Healing and Wellness Strategy initiated in Ontario in the early 1990s, and British Columbia, entering into a tripartite framework agreement between the province, crown, and B.C. First Nations (Lavoie, 2013; Gabel et al. 2017). These, and other provincial strategies have been criticized however, for being specifically focused in improving the health of one group of Indigenous peoples over others, for example in 2005 Nova Scotia introduced a health framework to improve the health of the Mi'kmaq people, but did not address health disparities experienced by Métis or other Indigenous peoples or groups living in the province (Lavoie, 2013). The structure of provincial health systems also plays a substantial role in how Indigenous health is planned for. As mentioned above, most provinces undertake a decentralized approach to service delivery through regional health networks or authorities (Lavoie, 2013). In the cases where specific health authorities were reviewed for Indigenous health care focus, it was found that very few across Canadian provinces take any steps to ensure Indigenous representation in planning (Lavoie, 2013). In reviewing the practices and policies in each province as the relate to Indigenous health, it is difficult to find a single model that works best for all Indigenous communities and peoples. For this reason, substantial literature has reflected on the importance of community-based decision making, administration and delivery of health care services that are designed to meet the unique and specific needs of each community, while capitalizing on the distinct strengths and capacity within Indigenous communities through self-determined health care models.

Indigenous Health Governance

Recently in Canada there has been an increasing proliferation of research and academic review of Indigenous health governance and community control. This is partially in response to the TRC Calls to Action, and movement towards self-determination among many Indigenous communities and peoples across Canada. Community control is considered a determinant of health, wherein communities with strong, coordinated control over governance, service provisions and representation are found to exhibit better health outcomes (Kelm, 2004; de Leeuw et al., 2016; Reading & Wien, 2010). Correspondingly, there are a number of determinants of Indigenous health in Canada that can be addressed only through community-controlled health care processes.

Self-determination necessitates Indigenous involvement and control over policy- and decision-making. However, the engagement of Indigenous peoples in health policy decision-making across Canada has been limited and disjointed at best. Fridkin, Browne and Dion Stout (2019) demonstrate the important of Indigenous participation in such decision-making and planning, and further, point out that in order to ensure meaningful engagement, historic power imbalances and colonizing structures must first be dismantled. These policies of assimilation and mere recognition in Canada do not allow for Indigenous self-government due to their conflicting rationales and principles. As Indigenous lawyer and scholar, Pamela Palmater (2011, p. 114) asks, “how can Canada in one instance defend the …provisions of the Indian Act, while at the same time support self-government? The underlying conflict in these two policy objectives, acts as a significant impediment to progress.” Indeed, the literature is rife with the observation that settler colonial policies and ideologies loom heavy, and insidiously in some cases, over Indigenous peoples in Canada today. This has led critical Indigenous health scholars to charge the federal government with ulterior motives in the process of health transfer and shifting of responsibility to the provinces and Indigenous communities (Lavoie et al., 2010c). Having observed the shift of responsibility through health policies over the past 30 years, scholars believe that under the guise of support for community control and self-determination, the state is actually avoiding legal and ethical responsibility (Lavoie et al., 2010c). In Palmater's words (2011, p. 116), this practice of the federal government is their common strategy of "defer, deflect and deny" where the government essentially evades responsibility and one of the most critical policy issues in contemporary Canada.

In their review of outcomes of health transfer to First Nations communities, several researchers have found that costs to communities have actually increased, and benefits have been limited (Jacklin & Warry, 2004; Lavoie et al., 2010c). While community-control and self-determination have undoubtedly made strides towards the improvement of health service delivery, disparities remain between Indigenous and non-Indigenous peoples (Kelly, 2011). MacIntosh (2008) states that the government changing who is responsible for planning and delivering health services does not go far enough to improve health and social outcomes. He argues that policy legacies and problems continue to plague the health care system in general, and it should not be the responsibility of Indigenous peoples to repair the centuries of damage that state policy has done to the health and wellbeing of generations of Indigenous peoples (MacIntosh, 2008). Transformative, discursive, ideological and structural change is needed.

The impacts of such colonial destruction through policy and the breakdown of Indigenous self-governance has led to the great burden of illness and crisis found within communities today

(Ladner, 2009). Therefore, the reestablishment of self-governance is a way to address community crisis. Warry (2007) states that with the return of Indigenous control, and an improvement of mental health resources, crisis can be remedied. Through this line of thought, Indigenous scholars argue that Indigenous self-determination is part of the solution to settler colonialism. By undertaking community control over health care, communities establish a place to enact their authority and local knowledges in order to address the needs of their people in a holistic, culturally relevant and safe way. In one very well documented case of success in Indigenous-controlled health care and positive health outcomes, Kelm (2004) reviews the experience of health transfer within the Nisga'a Nation of Northwestern British Columbia. While difficulties arose in negotiating transfer with the federal government, Kelm (2004) argues that health transfer served as a decolonizing process that supported traditional Nisga'a community social structure and enhanced identity and self-esteem within the community as they took control of health care (Kelm, 2004). This example demonstrates community-control as a conduit to achieving and wellbeing (Kelm, 2004). It also shows that community control and Indigenous health governance can work to reinstate a sense of cultural identity and belonging within the community, as well as provide access to traditional forms of healing that have been excluded from the dominant, settler colonial forms of health care. In early research, Chandler and Lalonde (1998) showed that First Nations communities in British Columbia that displayed high levels of cultural continuity, or social cohesion and cultural retention through administration and control over health and social services, had lower or nonexistent rates of suicide when compared to other First Nations communities. This demonstrates the health-protective effects of community control (Waldram et al., 2006; Ladner, 2009). These examples provide support for the positive health and social effects of community-control and authority over health care decision-making and service provision.

Despite powerful criticisms, many Indigenous scholars and communities contend that the ability to self-govern and to control health care services in the community is an inherent right of Indigenous nations, and is deeply restorative. Here, indigenous self-determination is considered a foundation upon which health policies and systems can be developed to address community health needs and improve health outcomes (Warry, 2007; Minore & Katt, 2007; Gabel et al., 2017). This right must be undertaken by communities themselves however, rather than a result of government downshifting, as self-determination of health cannot uproot colonial discourses within society. Keira Ladner (2009) argues that Indigenous peoples must return to their lands and families, to their traditional ways of living and away from the harmful and colonizing ways of settler society. In doing so, many Indigenous and non-Indigenous health leaders view community control of services and health as a step towards self-determination in the pursuit to move from being colonized peoples to becoming sovereign nations, particularly in the eyes of the state (Ladner, 2009). Early approaches to Indigenous control failed to improve health because processes did not utilize local and traditional teachings and language, or operate through the guidance of community Elders. Along similar lines, Minore and Katt (2007) state that a shift towards self-determination and community control of health care services may not change or improve all of the determinants of Indigenous health, such as poverty, housing and sanitation, but this process has the opportunity to affect culture and incorporate Indigenous healing traditions into the health care setting, which will have positive effects on health and community wellbeing.

Intermediate Determinants of Indigenous Health

The intermediate determinants of health make up the structures and systems within society, including the distribution of resources, policies, and the health care and education systems, and infrastructure (Reading & Wien, 2010; Czyzewski, 2011). The intermediate determinants also include access to health care services, education, economic and legal systems, cultural continuity, and the practice of Indigenous traditions and languages (Czyzewski, 2011). The intermediate determinants of Indigenous health are similar to those experienced by the broader population, however experience of Indigenous peoples and communities here are nuanced by historical legacies and structural determinants of colonialism, racism and marginalization. The intermediate determinants are systems-based and spatially attributed. In their work on the SDOH of Indigenous peoples in Canada, de Leeuw, Maurice, Holyk, Greenwood and Adam (2012) argue that the poor health outcomes and inequalities experienced by Indigenous peoples, are historically, and geographically determined, in that colonial policies and contexts have resulted in the geographic locations, spaces, places and environments in which Indigenous peoples live today. While immediate environments are considered proximal, the geographic situation of Indigenous peoples as on-reserve, urban, or mobile, ultimately determines the resources and services available to address health at the intermediate level.

Poverty and health

Poverty is determined through factors such as income, education, housing and employment and is one of the most the most important intermediate determinants of health because it affects life chances, opportunities and proximal determinants such as health behaviours. Further, so much of what determines levels of poverty within communities and populations cannot be controlled by individuals or communities, and these factors are determined structurally and systemically. In Canada, the average household incomes of Indigenous peoples are significantly less than those of non-Indigenous people, representing 40-61 percent of the average Canadian household income (Adelson, 2005; Smylie & Firestone, 2016). Unemployment is the among the most urgent cause of poverty and low income among Indigenous people, for example in 2009, the unemployment rate among Indigenous peoples was 14 percent, compared to eight percent for non-Indigenous counterparts within Canada (Smylie & Firestone, 2016). Within the Indigenous population in Canada, unemployment is experienced differently between on-reserve and off-reserve peoples. The unemployment rate for those living on-reserve was over 23 percent, compared with 12.3 percent for those First Nations that lived off-reserve or in urban areas (Smylie & Firestone, 2016). These rates speak to the effect of geographic determinants of health, and the result of colonial policies like the reservation system, situating First Nations communities out of reach of work and opportunity to prosper.

The complex interaction between various social determinants, and the trickle-down effect of the structural determinants like racism and colonialism affect employment, and in turn poverty (Loppie Reading & Wien, 2009). These include job market discrimination, through systemic racism education and loss of authority, all of which contribute to a cycle of disadvantage (Adelson, 2005). The role of education on Indigenous health and inequalities has been discussed in the Canadian literature at length as a significant factor in determining Indigenous health (Loppie Reading & Wien, 2010; Smylie & Firestone, 2016). The education system across Canada fails to appropriately represent Indigenous peoples or include Indigenous knowledges. The 2012 Aboriginal Peoples' Survey in Canada demonstrated that 72 percent of First Nations living off-reserve, 56 percent of those on-reserve, 42 percent of Inuit and 77 percent of Métis peoples between ages 18 and 44 held a high school diploma (Smylie & Firestone, 2016). Earlier research found that Indigenous peoples who completed secondary and post-secondary schooling are less likely to report themselves as being unhealthy (Wilson & Rosenberg, 2002). Levels of education also impact health-seeking and health-protective behaviours, which are proximal determinants of health, where Indigenous peoples with a higher completed level of education have been found to be significantly more likely to seek health care through a physician then those with lower educational attainment (Adelson, 2005). The ability to seek and access care is a critical determinant of health, informed by poverty, income and education.

Access to health care services

Access to health care is an important determinant of health across all populations, and the literature reflects the same for Indigenous peoples and communities within Canada. Naturally, addressing inequalities in health must go beyond simply improving access to health care services, however this is nevertheless important, especially so for Indigenous peoples across Canada where policies are patchwork. Inequitable access to health care has long been noted as a determinant of Indigenous health (de Leeuw et al., 2012; de Leeuw et al., 2016). Geographic distribution of peoples and resources contribute ultimately to access and for the most part, First Nations reserves and Indigenous settlements, determined by colonial governments, are located in rural, remote and Northern places across Canada, distanced from settler towns and cities, and removed from concentrated health and social services. In their qualitative study with 58 members of 13 different First Nations communities in British Columbia, de Leeuw and her colleagues (2012) found that First Nations communities are both spatially and materially removed from health services. Not only is this due to patchwork policy and jurisdictional confusion on the delivery of services to Indigenous peoples, but it is also importantly attributed to the social marginalization of Indigenous peoples and the very literal social distancing and social construction of Indigenous peoples within Canadian society (de Leeuw et al., 2012). This social construction of Indigenous peoples and the spaces and places where they belong is informed by settler colonialism and the longstanding adherence to policies such as the reservation system, which dictates where Indigenous peoples should live (de Leeuw et al., 2012). These are what Indigenous scholars refer to as colonial geographies, and their social and health outcomes are stark.

Alternatively, while ill health and inequalities among Indigenous peoples are often linked to isolated geographies, many Indigenous peoples living within their traditional territories also attribute good health and wellbeing to their connection to the land and traditional land-based activities (de Leeuw et al., 2012). The health-positive aspects of land cannot be overlooked here, for resilience among Indigenous communities is deeply and profoundly connected to traditional territories (Lavoie, O'Neil, Reading & Allard, 2008). Important health-protective factors are associated with traditional territories and activities. As Wilson and Rosenberg (2002) have demonstrated, Indigenous peoples who spend more time on the land, and those that acquire food through traditional methods are less likely to self-report as unhealthy. Access to traditional lands and ceremonies are considered important and unique determinants of Indigenous peoples' health, and for many Indigenous peoples, good health includes the practice of local tradition and ceremony, learning from community Elders, and learning local language, tradition healing and reconnection to land and culture (Martin Hill, 2009; Reading & Wien, 2010; Greenwood et al., 2015).

Within Western health care systems, access to comprehensive, appropriate primary health care is considered critical to the improvement of health, and the prevention of illness. The exact role that primary health care services play in reducing health inequalities is limited, but improved access to such care has been known to improve immunization rates, decreased childhood morbidity, earlier detection of some cancers, and improved outcomes for people with diabetes, depression, and hypertension (Marmot & Wilkinson, 1999; Starfield, Shi, and Macinko; 2005; Macinko, Starfield, and Shi; 2003).

Lavoie and colleagues (2010) performed an informative study in Manitoba to understand the relationship between First Nation's community characteristics and the rate of hospitalization among community members for ambulatory care sensitive conditions, or those illnesses or conditions where hospitalization could be avoided with access to timely and efficient primary care, between 1984/85 and 2004/05. Earlier research by Martens, Sanderson and Jebamani (2005) had found that there was a disparate rate in avoidable hospitalizations among First Nations in Manitoba compared to the general population, indicating inequity in access to primary health care services among First Nation communities. The study by Lavoie and colleagues built on this, and found two significant factors in determining rates of hospitalization, including level of access to primary health care services, and the level of local health autonomy within the community (Lavoie et al., 2010a). Findings indicated that communities with access to a wide compliment of primary care services had a lower rate of hospitalizations, and as the autonomy and self-determination of communities increased over time, hospitalizations decreased (Lavoie et al., 2010a). In total however, Lavoie and colleagues (2010a) found that in 2005, 37 out of 59 First Nation communities in Manitoba that were included in their sample, had limited access to primary health care. Poorer access to primary health care services, as well as poorer health status among Manitoba First Nations compared to the general population, results in both greater hospitalization rates, and longer hospital stays (Lavoie & Forget, 2008). In their study of health system impacts in Manitoba in relation to expenditures on First Nations health, Lavoie and Forget (2008) found that per-person costs for hospital visits were at the time 70% greater for

First Nations in Manitoba than for other residents. This led the authors to recommend a concerted effort to invest in primary health care services for First Nations as a form of prevention and method to improve overall health status (Lavoie & Forget, 2008). It is critical to note here that, as mentioned earlier in this chapter, the greatest costs within provincial health care systems are attributed to hospitals. Indigenous health research, particularly these studies conducted within Manitoba, demonstrate that adequate primary care and access to care can significantly reduce avoidable hospitalizations of Indigenous peoples, thus reducing burdens associated with hospital expenditures, but additionally contributing to the improvement of Indigenous health status and outcomes (Lavoie & Forget, 2008; Lavoie et al., 2010a; Martens at al., 2002; 2005). Recent research on urban settings across Ontario as part of the exceptional Our Health Counts urban Indigenous health research project, demonstrates that Indigenous people who do not have access to a regular primary care physician, or had experienced racial discrimination when seeking care were five times more likely to report unmet health needs (Kitching et al., 2019). Often, unmet primary care needs result in health crises requiring hospitalization and greater levels of care.

In a very recent study of access and utilization of in-hospital mental health services among First Nations living in rural and remote communities in Manitoba, Lavoie, Phillips-Beck, Kinew and Katz (2020) found that mental health hospitalization rates are increasing amongst males and females across the province. Further, the length of time spent in the hospital for mental health-related conditions has also increased, and the age of individuals being admitted is steadily decreasing, indicating that younger First Nations people have significant unmet mental health care needs (Lavoie et al., 2020). Community partners that participated in the study noted that in many cases in their community, First Nations are reporting to hospital with greater acuity, and that these trends have been on the rise over the past 20 years (Lavoie et al., 2020). These partners also indicted that community-based supports would work best to help community members and avoid hospitalizations, and that innovation at the community level can best be realized with structural support through policies, which have often been the barrier to community-based healing efforts (Lavoie et al., 2020). This lack of political support from various levels of government, as well as lack of health infrastructure within First Nations communities and rural and remote communities where care is accessed contributes to this ongoing trend.

Access to health care services is also greatly affected by access to transportation services. Several studies have found that most First Nations communities, and particularly those in rural, remote and northern reaches in Manitoba have little to no access to public transportation to access health care (Lavoie et al., 2010a; Martens et al., 2002). In their study of Northern First Nations in B.C., de Leeuw and colleagues (2012) found that many participants cited hitchhiking to and from health services as the most viable form of transportation when a ride from friends or family was unavailable. This response speaks to the precariousness of remote living, but also to the violence and trauma experienced by women and families of missing and murdered Indigenous women and girls (de Leeuw et al., 2012). Consistent, reliable and safe transportation and infrastructure is needed to connect rural, remote and Northern Indigenous communities to care.

Further, location of First Nations communities with respect to municipal settings impact accessibility of health services. Lavoie and colleagues (2010a) have found that First Nations that do not have access to health services on reserve are often located near to a provincial health service centre, such as a municipal health clinic or hospital. Another startling study by Martens and colleagues (2005; 2007) found that while the prevalence of diabetes among First Nations in

Manitoba was 4.2 times greater than that for the general population, the rate of amputation due to diabetes was 16 times greater for First Nations. The greatest number of amputations within Manitoba occurred among First Nations communities in the southwest corner of the province, where the research for this dissertation is set (Martens et al., 2005; 2007). Many of the communities within this region of the province, while rural, lack supportive primary care services on-reserve, and are located within two-hour driving distance of primary care such as doctors' offices, health clinics or hospitals offered within a municipal setting by the provincial government (Martens et al., 2005; 2007). The authors suggest that geographic accessibility of primary care does not indicate Indigenous utilization, and may not be appropriate for local Indigenous communities, but even distances of two hours without access to public transportation make such services inaccessible to many peoples and communities (Martens et al., 2005; 2007). Such research, while becoming dated, calls for a re-examination of access to primary care services and health outcomes among rural and Indigenous communities. Furthermore, much of this Canadian literature reveals startling findings within the southwest region of Manitoba and justify the pursuit of research within this geographic setting.

Barriers to care

In addition to access to care and transportation, experiences within the health care system are important, interconnected determinants of health. There are multiple examples that can be unpacked here, describing the inequitable relationship, if it can be called such, between indigenous peoples and colonial institutions. McCallum and Perry (2018) offer an overview of the interaction between Indigenous peoples and health care systems and services, noting that despite longstanding depictions in popular, medical and academic writings that Indigenous notions of health and healing were always at odds with Western ways, this has not always been the case. In the early days of settlement on the Canadian prairies, and on into the later 1800's as settlers on this land moved towards Confederation, Indigenous peoples were indeed eager to access modern health care services and sites (Lux, 2001; Burnett, 2010; Drees, 2013; Kelm, 1999). In response, settler health systems turned Indigenous peoples away and set up minimal provisions within settlements and communities, in part to prevent the sharing of resources between Indigenous and non-Indigenous peoples in effort to protect settler health (McCallum & Perry, 2018). These historical experiences left resounding effects upon generations of peoples and communities.

The experiences of Indigenous peoples within the health care system and when seeking care are significant determinants of health, and determine whether individuals will choose to seek care when they need it. Negative experiences within the mainstream health care system in Canada can serve as a significant barrier for Indigenous peoples (Allan & Smylie, 2014; Richmond & Ross, 2009; Loppie Reading & Wien, 2009). In Canada, fewer than one percent of physicians are Indigenous, and as such the majority of medical care for Indigenous peoples is provided by non-Indigenous doctors, which can lead to racialized experiences (Towle et al., 2006). The attitudes and prejudice of health service providers are important when examining the interactions between providers and Indigenous clients. The experiences of racist and discriminatory treatment by health service providers serves as a barrier to accessing care when it is needed (Tang & Browne, 2008; Browne et al, 2011). Indigenous clients fear being dismissed or denied help by medical professionals based on their visibility as Indigenous, and the racist assumptions that may be applied to their identity (Browne et al., 2011). Common medical discourse and ideology places individuals that are living in poverty, homeless, or substance users as undeserving of medical assistance, and Canadian research shows that Indigenous clients perceive these attitudes among health service providers Browne et al., 2011; Baker & Giles, 2012). The unfortunate case of Brian Sinclair, a 45-year-old Indigenous man who died after waiting over 34 hours for care in a Winnipeg emergency room, is a glaring example of the fatal effects of racism within the health care system (McCallum & Perry, 2018; Allan & Smylie, 2014). Brian required routine treatment for a bladder infection, which would have taken no more than a half hour of care, but was instead ignored by countless service providers to die slowly and unnecessarily, dismissed due to his race, disability as a double amputee, and perceived poverty and class (McCallum & Perry, 2018; Allan & Smylie, 2014). Questions of responsibility and jurisdiction could not be used to explain this case. As an urban Indigenous person in need of medically necessary care following a referral from a community physician, Brian was seeking health care services from within the publicly-funded provincial health system in Manitoba. Under the Health Act, Brian deserved to receive this care, regardless of race, class, status or income. His fateful example serves to demonstrate that racism is alive and well within Canadian health systems, and racist attitudes remain among service providers.

The Canadian settler colonial context within which these racist interactions occur reduces Indigenous peoples as dependent on the state and health care system, and unworthy of the perceived benefits imparted by the state (Warry, 1998). Research has demonstrated that Indigenous peoples avoid and distrust mainstream health care settings, and fear discrimination in seeking care, where many people have experienced discrimination and stigmatization from service providers (Levin & Herbert, 2004). These perceptions reflect the persistence of colonial attitudes within the Canadian health care system.

Indigenous health services

In response to the experiences of racism and other barriers to accessing health care services within the mainstream, settler health care system, the concept of integrated health care and Indigenous health services has risen as a health-positive determinant of Indigenous health. Traditional healing has been found to be an important aspect of Indigenous health for many communities in Canada (Maar & Shawande, 2010). Recently, research has shown that there has been resurgence in the practice and acceptance of traditional healing in both Indigenous health organizations, both within Indigenous communities and within the broader primary health care system in Canada (Maar & Shawande, 2010; Powell & Gabel, 2018). In their review of access to traditional care in the Canadian territories, Redvers, Marianayagam and Blondin (2019) found that the provision of traditional Indigenous health care within culturally safe environments serves as a lasting challenge that will require a transformational change within territorial health systems. While territorial policies and approaches in the Northwest Territories of Canada have indicated the importance of reconciliation in health and health care and the development of a culturally safe health system, evaluations show that these have not been realized (Redvers et al., 2019). Nor have traditional approaches to medicine and care been integrated into the territorial health system (Redvers et al., 2019). Frameworks for integration of Indigenous healing into the provincial health care system exist, however full integration of traditional services have been proven difficult in settings where non-Indigenous service providers are untrained or unwilling to partner with Indigenous Elders healers and knowledge keepers to integrate Indigenous healing with clinical services (Lemchuk-Favel and Jock, 2004a, b; Maar & Shawande, 2010). Alternatively, research in Ontario has shown that the provincial Aboriginal Healing and Wellness Strategy (AHWS), implemented in 1994, allows for the successful delivery of integrated health services including clinical and traditional care through Aboriginal Health Access Centres (AHACs)

(Maar, 2004; Maar & Shawande, 2010; Gabel et al.; Powell & Gabel, 2018). In the AHAC setting, in both rural and urban areas, a safe space is established for Indigenous community members, including First Nations, Inuit and Métis, to seek supportive and complimentary care from both Indigenous and non-Indigenous service providers (Powell & Gabel, 2018). Through the literature reviewed, there exists is a need for integration of traditional healing into primary health care services for Indigenous peoples, however within the system today, settler, biomedical approaches are still favoured over traditional practices by policy and government funding structures (Manitowabi & Shawande, 2013). With access to appropriate and attentive, culturally safe and specific health care, improved health outcomes may become actualized among Indigenous peoples and communities.

Proximal Determinants of Indigenous Health

The proximal determinants take immediate effect on individual and community health, and are commonly considered lifestyle factors that occur on the individual level, such as health behaviour, diet, social environment, working conditions and housing (Reading & Wien, 2013; Czyzewski, 2011; Greenwood et al., 2015). Within the literature on the proximal determinants of Indigenous health and health inequalities, it is clear that the structural determinants of health such as colonialism and racism play out through policy and resource distribution to ultimately impact these immediate determinants of health. Distal, or structural determinants (re)produce negative environments for Indigenous peoples that have led to poor health behaviours, hazardous employment, low educational attainment and food insecurities leading to greater rates of obesity, diabetes, cancer, self-harm and family violence (Reading & Wien, 2013; Greenwood et al., 2015; Czyzewski, 2011). These immediate conditions create stressors for individuals, families and communities, resulting in a variety of coping mechanisms that may be helpful or harmful to health (Reading & Wien, 2013). Importantly, due to the factors that contribute to stress, individuals are constrained in making choices and therefore have little control over their responses (Reading & Wien, 2013).

Noted health-negative behaviours and responses to stressors include alcohol misuse, excessive smoking, and poor prenatal care, all which lead to increased mortality (Reading & Wien, 2013). Low self-esteem and social capital have been associated with health-negative behaviours as well, indicating the importance of effective mental health services (Kirmayer, Brass & Tait, 2000; Kirmayer, Tait; Simpson, 2009; Reading & Wien, 2013). A rise in mortality is attributed to conditions resulting from these behaviours, such as lung and heart disease and limited physical, intellectual and emotional development (Reading and Wien, 2013). These health behaviours are exacerbated by poor diet and limited exercise that is frequently experienced (Reading & Wien, 2013).

As a result of distal colonial constructs, the internalization of racism is experienced at the proximal level within Indigenous peoples (Adelson, 2005; Allan & Smylie, 2014). Internalized racism occurs where a colonized group perceives itself based on the values held by the colonizing society, taking on negative and often racist perceptions of themselves and their culture (Adelson, 2005; Allan & Smylie, 2015). Internalized racism occurs within the process of assimilation, where colonialist ideologies transcend the boundaries between colonized and settler discourse, invading the ways that racialized peoples think about themselves and act upon themselves (Allan & Smylie, 2014). This affects health-related and health-seeking behaviours through an internalized belief in racist stereotypes may affect health behaviours, and could lead individuals to avoid health care and support services.

Further, this internalization of racism results in stress that affects psychological health and coping ability, which may serve to reproduce racialized, stereotyped behaviour through addictions and violence (Bombay, Matheson & Anisman, 2009). The residential school experience of tens of thousands of children and families has resulted in collective, historical trauma, which refers to the accumulation of stress over time leading to increased risk of negative health outcomes (King et al., 2009; de Leeuw & Greenwood, 2011; Bombay, et al., 2009). Indigenous researchers have found that 64% of residential school survivors experience post-traumatic stress disorder (Bombay et al., 2009). Further, Bombay and her colleagues found that as a result of their experiences, survivors took on negative health behaviours and coping methods leading to depression, addiction and violence (Bombay et al., 2014). In addition to the IRS, other colonial policies, such as the 60s Scoop, led to the institutionalization of Indigenous children, effectively dismantling the family system to the point where traditional parenting practices have been deeply impacted on an intergenerational level (King et al., 2009). With the breakdown of traditional family and community life, and without exposure to positive, healthy, strong, supportive family relationships, survivors may pass down their negative stressors and behaviours to their children in what is referred to as intergenerational trauma (Bombay et al., 2014; Czyzewski, 2011). As an example, the children of IRS survivors have increased thoughts of suicide, rates of depressive symptoms, adverse childhood experiences and higher levels of perceived discrimination (Bombay et al., 2009). Intergenerational trauma describes the impacts of colonialism and settler colonial processes over time and through generations, manifesting itself in current health inequalities and poor health status and health behaviours experienced within Indigenous communities in Canada.

Addressing Health Inequalities Through Cultural Safety

Within the global Indigenous health literature, one of the most important arising concepts is that of cultural safety. Indigenous communities and scholars alike have repeatedly called for the inclusion of diverse local Indigenous perspectives, practices and protocols within the mainstream or conventional health care system, as a strategy to not only confront systemic racism and settler colonialism, but also to create spaces of health that Indigenous and vulnerable peoples feel safe in accessing (Reading, Brennan & Masching, 2014). Health systems that serve diverse and marginalized peoples must be free of discrimination and prejudice in policy, approach and practice in order to deliver effective, positive health outcomes. Scholars and communities alike have called for health systems delivering care to Indigenous communities to be controlled and informed by Indigenous peoples themselves (Reading et al., 2014). In public health systems, this can be satisfied through authentic cultural safety. This concept refers to a lifelong committed practice to recognizing and acknowledging colonization and the detrimental impacts that settler colonialism has had on Indigenous peoples and lands (Reading et al., 2016). It further requires that present-day power structures were socially constructed through colonization to situate white, European people and worldviews in control and power over other people and lands. Not only is this recognition required, but cultural safety also calls for skills and knowledge that incorporate respect, equity and humility into all interactions between practitioners, service providers and other people in positions of power and the Indigenous and other vulnerable peoples that they serve (Reading et al., 2014).

Cultural safety is a powerful, restorative concept in anticolonial and antiracist literature and health practice, however, a critical lens has been applied by Indigenous and settler health scholars alike. Rather than a criticism of the intent of the concept, scholars have remarked that cultural safety cannot be taught or applied in a vacuum, for the sake that without critical reflection, cultural safety runs the risk of privileging white settler colonial perspectives in the delivery of care to Indigenous, marginalized peoples, and peoples of colour (POC) (MacCallum & Perry, 2018). Instead, cultural safety must be used to address systemic and structural racism by tackling long-standing practices and traditions of prejudice in various social and political systems.

Furthering the Literature

In their comprehensive work on rural health in Canada, Kulig and Williams (2012) conclude their edited book with a significant list of recommendations on areas of future research and scholarship on rural health in Canada, organized into three themed areas, including: rural place matters to health, rural places are diverse, and rural places are dynamic. Here I find this research overlaps and intersects these three areas, as a community-engaged study set within the rural Prairies, on health system transformation effects on diverse rural and Indigenous communities that have had to innovate, collaborate and advocate for health care services that sustain the very heartbeat of community.

Since this collection edited by Kulig and Williams in 2012, there have been many additional contributions to the study of rural health in Canada, but with little integration of health policy impacts on community perspectives of health and wellbeing, inclusion of the SDOH and Indigenous health perspectives. Further, a recent issue of the University of Toronto’s Medical Journal covered broadly current issues of rural health in Canada. The 2019 issue highlighted several themes including the socioeconomic determinants of rural health, as well as the common approach in research to focus solely on the disparities and inequalities of rural health, rather than turn to highlight the resiliencies of rural communities in addressing health concerns. As Peters (2019, p. 41) writes, “rural communities should be approached through a lens of resilience rather than disadvantage." Too often the literature on rural and Indigenous health has focused too narrowly on the problems associated with rural living, rather than indicate the unique strengths, adaptations, innovations and capacities that communities demonstrate in the face of health, social and economic challenges. Rural health research reviews also suggest the importance of avoiding deficit language and rural-versus-urban narratives pitting geographies against one another in future research (Kulig & Williams, 2012; Peters, 2019). Comparisons such as these create tensions in places where health inequalities are consistently produced and reproduced, albeit differently. Many recent publications concerning rural health in Canada lack inclusion of the ways in which policy decisions made at the provincial level are operationalized and come to affect rural health and communities. Additionally, and importantly, critical perspectives and Indigenous approaches to understanding rural health and service delivery needs are required to advance the ways in which rural health policy is both used by governments towards state agendas, and ultimately experienced by rural communities.

It is within this gap that this research project is situated. The research presented here undertakes a strengths-based approach to analyzing rural health and the social determinants of rural and Indigenous health within a rural, Prairie setting in Canada. The communities involved in this research were active, engaged and sought to advocate for themselves and problem-solve towards community-based solutions to challenges arising from provincial health care system reform and service centralization. This work ultimately seeks to demonstrate how health care, and social and community services should be integrated in both policy and practice to establish equitable health services and outcomes for rural and Indigenous peoples in Manitoba.

Chapter Five: Methodologies and Research Methods

In the following section, the methodologies that guided this research are described, followed by a review of the methods that were used throughout the course of this research. This project sought to understand and uncover the impacts of significant health policy change and health system transformation on a small rural community in Manitoba, and the First Nations and Métis communities that receive primary health care services there. The research sought to understand the state of health and health care services within this setting, while also examining what makes rural health care work, and the areas where rural care is challenged by the system it operates within. In following the motivations of social sciences research, the inclusion of personal experiences of rural peoples, health care providers and Indigenous community members is necessary to answering and addressing the central research questions identified in this project. Simply, these questions could not be answered without the participation, collaboration and support of the community. Therefore, the very nature of this research required a qualitative and community-engaged framework to permit an exploratory approach to open-ended health studies questions. The qualitative approach taken here is considered the most appropriate way to undertake social science research with communities, including vulnerable and marginalized peoples. Qualitative research allows for people in real communities who are most affected by policy and service change to provide their perspectives through narrative and dialogue in the collection of data. This approach also allows for the researcher to practice cultural safety and work to undertake a decolonial approach to research, centering and privileging the experiences, voices and lives of the people and communities who are often left out of health decision making.

Historical Impacts of Research

The impacts of both state- and academia-led research projects involving Indigenous and other racialized and marginalized peoples through history have been deep and far-reaching. Often the subjects of research for political gain or authority, Indigenous communities have since necessitated a shift in research approach, calling for the end of intrusive practices used to take possession of their knowledge and assert colonial control (Brant Castellano, 2000; Smith, 2012; Porsanger, 2004). Many Indigenous scholars have examined the impacts of settler-colonial research on Indigenous peoples. As prominent Maori scholar, Linda Tuhiwai Smith, in her most popular passage states, “The word itself, ‘research,’ is probably one of the dirtiest words in the Indigenous world’s vocabulary” (2012, p. xi). This distrust of state and academic research among Indigenous and other marginalized peoples such as people who are homeless or housing-insecure, people living with HIV/AIDS and others, is widely held. Feelings of distrust are experienced further when research is carried out for white settler academics, who enter into communities to extract knowledge and experience the benefits of doing so. Countless instances of such unethical research have been reviewed, particularly in the context of Indigenous health research (Smith, 2012; Hyett, Marjerrison & Gabel, 2018). In many of these cases, both historically and more recently, research is done to assist the state in colonialist advances towards the accumulation of lands, waters and resources, and to further normalize the marginalization of Indigenous peoples. In these colonial pursuits, knowledge was stolen from Indigenous peoples and made accessible to the church, state and academia to disempower, control or coerce communities into submission. This history resonates within communities today. Scholars within Canada have remarked that research with Indigenous communities has typically been “top-down, outside-in”, indicating the significant imbalance between the researched community and the researcher, where the researcher benefits, and the community bears the risk with little or no reward (Gabel, DeMaio & Powell; 2017). As a result of negative research practices, Indigenous communities feel that they have been "researched to death" (Brant Castellano, 2000; Jacklin & Kinoshameg, 2008; Smith, 2012). This has resulted in deep-seated suspicion and avoidance of research, particularly when undertaken by settlers and government representatives.

Critically, as a deliberate effort to combat the historical legacy of colonial research initiatives a decolonizing approach and anti-colonial methodology is required. Settler researchers who work within the margins as a way to bring about social justice, must develop research strategies to build community capacity and empowerment, as well as balance the relationship between researcher and community. Therefore, settler approaches must incorporate methodologies that respect Indigenous knowledges and acknowledge the impacts of research in the past. Research with Indigenous and marginalized peoples must be inherently decolonizing, participatory, and respectful, and uphold Indigenous authority over knowledge and the production of knowledge.

Decolonizing Research

As a counter to historical impacts, research with Indigenous peoples should be decolonizing. Maori scholar Linda Smith elaborates on this practice, stating that decolonization in research calls for an understanding of the ideologies and motivations that are inherent within the research practice. This critical approach recognizes that there are ways of knowing and doing beyond those of the Western settler academic, and it denies the superiority of Western models and systems of knowledge that have been for so long claimed by academic institutions. Appropriate decolonizing research practices undertake a community-led or directed approach (Bartlett et al., 2007). This calls for research methodologies unlike those traditional to the Western academic setting and philosophy. In striving towards the practice of decolonizing research, the researcher must ask themselves several crucial questions that help to situate themselves within the research and what it means to the Indigenous community involved, such as "who defined the research problem? … for whom is this study worthy and relevant? …what knowledge will the community gain? ...to whom is the researcher accountable?" (Smith, 2012, p. 175-6). Ultimately, decolonizing methodologies explicitly call for researchers to be critical about their perspectives, and place Indigenous interests, experiences and knowledges at the centre of the research process.

Anti-Colonial Methodology

In performing research concerning Indigenous peoples' health as a settler researcher within the colonized Canadian state, it is crucial to take an anti-colonial methodology in efforts to address and resist the colonial histories of research and academic institutions and to challenge this privileged position through a rebalancing of power towards Indigenous knowledges, voices and communities. Settler researchers may counter settler colonialism and its pervasiveness in research, and social and political structures through the use of anti-colonial methodology. It is important to reflect critically on how such a methodology will be applied. In the case of this dissertation, research involved a white, settler student as researcher, and included white and non-white settlers residing within a rural community, as well as Indigenous peoples, both First Nations and Métis. Settler scholar Elizabeth Carlson (2016) writes that white settler scholars cannot practice anti-colonialism in research with other white settler people. Doing good, ethical research that honours self-determination and reciprocity with other white settlers is normative, and does not counteract the colonial pursuit. However, Carlson (2016, p. 6) states that conducting research on Indigenous lands that are currently occupied by the Canadian settler colonial state, even when it involves only white settlers, occurs in "spaces of Indigenous sovereignty”. Research in these spaces must therefore involve relationships beyond just those between white settler researcher and white settler participants (Carlson, 2016). As Carlson (2016) argues, any settler colonial work that aims to be anti-colonial must be situated within relationships and communication with Indigenous peoples, and can include the oversight of the research by Indigenous scholars, consultation with Indigenous communities and knowledge keepers, or draw upon the critical work of Indigenous writers and scholars. By doing this, Carlson states that the research will ensure an Indigenous presence and relationship, even if it involves the study by and with white settlers, and will thus require anti-colonial methodological approaches.

The research for this dissertation occurred in response to a proposed settler community-based study in rural Manitoba. In the face of health system transformation, and reeling from the announced closure of the local EMS station, the community in question initiated a community advocacy group driven to research the impacts of this government initiative on their community and beyond. The closure would have resounding effects on neighbouring Indigenous communities and peoples, and the community group included Indigenous community leaders and service providers. My supervisor, a Métis scholar with family ties to the community, was approached to support the community through a community-led study. Working alongside my supervisor, we designed a project with the community advocacy group that would involve a careful critical analysis of government policies, and interviews with community members, both settler and Indigenous people who were affected by health system changes. It is here that I reflect on the need for an anti-colonial approach. The research for this dissertation came from within a settler community which included Indigenous communities in the struggle for representation and collaboration on health care services and policies. It is derived from the existing initiative of those communities, and the guidance of an established Indigenous scholar and supervisor of my work, both within the doctoral program, but also on my previous research with an urban Indigenous community during my Master's degree. As a settler student, I was in a position of privilege and educated within a settler colonial system, but fortunate to be led through graduate studies by Indigenous advisors in academic, community and health service settings, and to study foundational works on Indigenous health and research by Indigenous scholars themselves. My journey as a settler graduate student, and the nature of the community research I was engaging with, called for adherence to anti-colonial methodologies.

In considering the methodologies required for this dissertation research, I drew upon Carlson's (2016) eight principles of anti-colonial methodology. While developed for setter researchers to use in their work with settler populations, these were useful in situating the aims of the proposed project as one enacted by a settler researcher in a multi-community-based setting. Carlson (2016, p.7) suggests "resistance to and subversion of settler colonialism" as the first anti-colonial principle, which identifies and takes issue with settler colonial histories and contemporary practices. In preparing for dissertation research, I spent time learning about Canadian colonial history and Western research intentions as complicit with the colonial pursuit. An adherence to relational and land-based accountability to Indigenous peoples is critical to anti-colonial approaches, where researchers must learn about and honour local Indigenous histories, experiences and epistemologies. Carlson (2016) suggests that this may be done through engagement with Indigenous communities, scholars and advisors and establishing relationships through the research process. In expanding on the study of rural health in Canada, I necessarily extended contemplation to Indigenous health and community settings. The oversight of my work on the community project was shared between my supervisor and the community advocacy group. In Carlson's (2016) review of anti-colonial methodologies, the importance of supporting Indigenous self-determination and autonomy through research, valuing reciprocity and collective capacity building, as well as holism are critical to performing such work. This dissertation research was undertaken to expand upon the community-driven initiative to demonstrate the importance of community control and collaboration on health policies and services to decision-makers and government. In this, self-determination is central, and identified as a determinant of health in and of itself. Carlson (2016) also discusses the importance of settler researcher acknowledgment of social location and how this affects the process of research, as well as the practice of reflexivity in identifying where settler colonialism is reproduced. Lastly, Carlson (2016) suggests the practice of egalitarian, participatory, community-based research approaches.

In the following sections, I further address Carlson's principles and the ways in which this research incorporated them towards being an anti-colonial project. This research sought to be anti-colonial throughout the research process by enacting these principles and taking up a community-engaged research (CER) approach, as well as being led and advised by the community in which the work was situated. I conclude this chapter by offering my personal reflexion and contextualization.

Community-Engaged Research

This research necessarily undertook a community-engaged approach. As described earlier, this dissertation grew out of a community-based initiative and call for academic research support in community advocacy pursuits. This project engaged with the community advocacy group established in response to provincial health system change, concerned with the impacts to the local settler and Indigenous communities. The community advocacy group, including community leaders, health service providers, and residents, guided the development of the initial study, including the research questions and objectives, as well as the interview questions and recruitment of participants. In aligning with anti-colonial methodologies, it was crucial to this research to take on a community-engaged approach.

Community engagement research (CER) is defined in Chapter 9 of the Canadian Institutes in Health Research (CIHR) Tri-Council Policy Statement II as "…a process that establishes interaction between a researcher… and the Aboriginal community relevant to the research project" (p. 108). This relationship between the researcher and community is collaborative, involving planning and approval of community leadership or advisory groups. Within the TCPS II, engagement may include the review and community approval of the research to be conducted within the community, or extend as far as the empowerment and shared leadership on the project with the community, or the community may select to permit the research to take place, or simply register no objection to it (CIHR, 2010). Importantly, CER acknowledges varying levels of community participation that may be appropriate, especially where research is conducted involving participants in their roles as professionals. This level of participation may involve a research agreement, board approval, gatekeeper or community leader guidance and dissemination of findings back to the organization. CER has been defined as "a collective approach to research that democratically involves community participants and researchers in one or more phases of the research process" (Nation, Bess, Voight, Perkins & Juarez, 2011, p. 89). Nation et al. (2011) state the CER can be divided into two models including both practical and empirical CER. In their description, practical CER occurs where dialogue is exchanged between all research partners from both the academic and community settings, on how best to develop the inquiry, interpret the findings and disseminate and act on them (Nation et al., 2011). Empirical CER promotes the examination of power differences between the researcher and the community (Nation et al., 2011). In both cases, Nation and colleagues (2011, p. 90) maintain that the purpose of CER should be to "democratize knowledge and resist oppression." Furthermore, Nation et al. (2011) identify another division in CER with community-initiation, where the community organizes itself to address a need and then seeks the involvement of researchers, and community collaboration, where the researcher extends to the community to collaborate in answering a research question. A key consideration is that engagement and participation occur along a spectrum, and must be defined by the community and the needs, capacities and desires of the community rather than a prescriptive, Western model.

Within this dissertation research, the form of CER employed was very much a practical, initiated community-engaged research model. The research involved was initiated from within the settler community by a community advocacy group with representation from within both the settler community, local health service providers, and Indigenous community members. The research questions put forward by the community were practical in nature and were developed in collaboration between the community, the research and the supervisor. The community research project expanded into a larger study for this dissertation by applying critical and theoretical lens on the research problem. This adaptation was encouraged by the community group, and a research agreement was formed between the group, the settler student researcher, and the supervisor.

Community-Based Participatory Research

Further to the CER approach, for non-Indigenous and settler researchers, community-based participatory research (CBPR) offers a decolonizing approach that inherently rebalances the power between researcher and community as it requires the community to consent and support the research under way. CBPR is defined as a partnership between the researcher and community members in which knowledge is mutually shared to develop a deeper understanding of the research topic, and to integrate knowledge and action in order to benefit the community (Israel et al., 1998). The TCPS II defines participatory research as “a systematic inquiry that includes the active involvement of those who are the subject of the research” (CIHR, 2010, p. 124). CBPR affords control and authority over the research project to community members. Thus, the community helps to guide the research process from design, through recruitment, knowledge gathering, analysis and dissemination. This method builds capacity within the community, while producing knowledge on an issue that is of interest to the community itself (Gabel et al., 2017). In this way, as an anti-colonial methodology appropriate to settler researchers, it allows for research to be conducted with communities, rather than on them (Gabel, 2012). Within CBPR, the community develops its own interests and maintains authority over the research process. CBPR is decolonizing in that it is sensitive to community values and knowledge, it empowers community ownership of the research and produces actionable results that serve to benefit the community (Bull, 2010). Within the CBPR process, decolonizing relationships include discussion of community values, conceptual frameworks, methodologies, protocols and knowledge mobilization within the research (Ball & Janyst, 2008). CBPR requires the development of strong, reciprocal relationships between researchers and communities, relationships that, as Bull (2010) states, are the precursor to ethical research.

In their review of successful methodologies used in Indigenous health research, Hyett, Marjerrison and Gabel (2018) highlight CBPR where the work is motivated and sustained by the desires and goals of the community of peoples involved. CBPR is a form of active research requiring community involvement in the process throughout the course of study, and after completion, which requires a partnership approach to research (Goodman, Bird & Gabel, 2017). Partnership through CBPR requires greater accountability and effort on the part of the researcher, however the positive outcomes and practical use of research findings by the community, and the prioritization of community needs in the process provides greater social impacts (Goodman et al., 2017). CBPR approaches can be utilized in various community-based research settings, and is especially important when engaging in research concerning vulnerable and marginalized peoples. For this reason, Hyett and colleagues (2018) indicate that CBPR is a successful, anti-colonial methodology for Indigenous health research. When used with Indigenous communities, CBPR is about restoring community control and power over the research process by privileging and centralizing community narratives and ideals (Smith, 2012).

Strengths-Based Approach

In conducting research regarding the health and experiences of vulnerable, marginalized and Indigenous peoples, it is important to undertake the process, analysis and interpretation using a strengths-based approach, rather than apply a deficit discourse. Such a discourse frames marginalized peoples and identities negatively, focusing on deficiencies, weaknesses and challenges, which contributes to the historical discrimination such communities and peoples have experienced, both within society and academic research. Indigenous peoples particularly have been subject to deficit narratives, often being described or characterized by the disparities they experience, or the historical traumas that reverberate within communities today, contributing to the collective disempowerment of Indigenous peoples, and the persistence of settler colonial visions and ideals (Hyett, Gabel, Marjerrison & Schwartz, 2019). There is harm in attributing the health and social disparities that Indigenous and other marginalized peoples experience as a result of colonization, to cultural features of peoples or communities (Browne, 2009; Smith, 2012). The deficit discourse blames those who were victimized through history and supports racist stereotypes. Any research regarding Indigenous and rural health that fails to contextualize health status and outcomes as a result of colonial history and accumulated inequality fails marginalized peoples, and works counter to anti-colonial initiatives. A strengths-based approach seeks to highlight and support the capabilities, knowledges, skills and social capital that operates within marginalized communities, especially where people facing significant barriers to health adapt to overcome such challenges as a collective (Hyett et al., 2018; Browne; 2009). It is critical to this research, focused on rural and Indigenous health in Canada, to undertake a strengths-based, community-centred approach. This work is predicated on the systemic marginalization of both Indigenous peoples and rural communities through exclusion in health decision-making, and the prevalence of settler colonial ideologies operating in health policies across Canada today. By reviewing these multiple histories, and turning to community-based research approaches as undertaken through an anti-colonial methodology, this dissertation aims to highlight the profound strengths and resiliencies that are embedded within the communities included in this work.

Integrating Methodologies

This research integrates three central methodologies in conducting studies with(in) communities of both Indigenous and settler peoples, including decolonizing methodologies, a strengths-based approach and community-engaged research practices. Indigenous scholars point out that any research with, within, or for Indigenous peoples or communities must necessarily be decolonizing (Smith, 2012; Kovach, 2009). This research must be conducted in such a way as to counter the damaging, colonizing research practices of the past. Anti-colonial methodologies, as per Carlson call for the subversion of settler colonial practices in research. For me, this included the prioritization of community needs, and the necessary involvement in Indigenous community members and health service providers, who were familiar with the community research project. This inclusion is done through the integration of a community-engaged approach to research in which community research goals inform the development of this dissertation research. Lastly, this anti-colonial approach, using CER practices are integrated with a strengths-based approach that also addressed the need for research to be decolonial in nature. Historic research has for too long been deficit-based, leading to ongoing stereotyping and contributing to systemic racism towards Indigenous peoples in Canada (Hyett et al., 2019). The integration of these methodologies allows for a decolonial approach to research, and complies with Carlson's (2016) expectations for settler researchers.

Research Methods

The following section describes the qualitative methods that were undertaken within this research and the way that the research was carried out. This dissertation brings together the findings of a community-engaged study on health care services and experiences of services within a rural community in southwestern Manitoba, with community responses to health system transformation. In order to meet the objectives of this research and for a holistic study, two methods were used, including a policy document review and one-on-one interviews with both settler residents, and Indigenous community members, undertaken through a community-based approach. In their review of qualitative methods used in Indigenous health research Wright and colleagues (2016) highlight that Indigenous methods can be used within Western methodologies, such as grounded theory. The qualitative tradition has been particularly useful and successful in integrating Indigenous ways of knowing and doing, with Western methods of research (Wright et al., 2016; Hyett et al., 2018). Qualitative research values multiple ways of knowing and conceptualizing the world and one's experience, while recognizing the subjectivity of individual experience and the diversity between collective experiences. While this research utilizes qualitative research methods and approaches such as semi-structured interviews and grounded theory analysis, it is conducted through an anti-colonial and community-based lens.

The first method employed in this research included a government document and policy review and analysis regarding health system transformation in Manitoba, and earlier government-issued studies on the state of the health system which contributed to system transformation and decision-making within the province. The second method consisted of semi-structured interviews of community members and service providers within the local rural and Indigenous community setting. The first round of interviews with rural community members and service providers was conducted as part of a community-based research project initiated by a community health advocacy group. Due to the small population of the rural and Indigenous communities involved in this research, participants will be referred to as either community members or service providers within this dissertation, so as to ensure the confidentiality of all participants. The community involved in this study was one of over 18 small rural towns that was notified by the provincial government that their local EMS station would be closing, and that emergency services would be deployed to the community from the neighbouring towns. In the case of the community involved, the revocation of EMS services would not only affect the local ambulance station, it would also significantly impact the delivery of services out of the local rural hospital and ER, out of which EMS services are deployed. Further, it would hinder the accessibility of emergency and primary health services for nearby First Nation and Métis communities. This community serves, unfortunately, as an example of many rural places across the country that experience added burden from provincial health system change in addition to the disparities they face in accessing and retaining services. It provides an ideal setting within which experiences of health system transformation can be explored through qualitative community-based research.

The findings from this project are intended to provide a critical analysis of provincial health system transformation through settler colonial theory and a social determinants of health framework, and provide an understanding of rural experiences with health care systems and services. Further, this study was founded upon an existing desire within the rural community to identify the impacts of the proposed policy and system change on the health and wellbeing of community members and impacts on service providers and existing health care services. This study was designed by the community through a local community health advocacy group, and serves to support community advocacy efforts. The study then broadened to include a critical analysis of health system transformation. Not only is this a project for and by the community, it is intended to contribute to future health policy- and decision-making efforts, to the literature on rural health in Canada and to encourage collaborative, community-based solutions for rural health challenges.

Community Advocacy Group and Advisory Committee

Importantly, this research was borne of a request issued by a community health advocacy group for community health policy researchers to assist in conducting a qualitative study on the state and current experiences of the local rural health care system, and the perceived impacts of provincial health system changes. This initiated the creation of a community-engaged project in which the researcher collaborated with the community advocacy group alongside her supervisor to develop a study that met the intentions of the community. The researcher worked with the community to establish a Research Agreement (Appendix C), which outlined the role of both the researcher and the community advisory group in the research process. This agreement also established the role of the group as an advisory committee on behalf of the community. The research agreement included both the community project, as well as the broader dissertation research. The research agreement detailed several aspects of the research process, including recruitment of participants among service providers and community members, the gathering of data through interviews, the analysis and approval of research findings, and the translation of knowledge within the community and outwards to media, policy and academia. Throughout the two-year research process, the researcher provided the committee with drafts of the findings and report taking into consideration the committee's recommendations. Ultimately, as part of the research relationship, my supervisor and I were responsible for providing a community report back to the advisory group, reflecting the findings derived from community member interviews and an analysis of decision-making that led to system transformation and the elimination of local EMS services. Moving forward with this larger, critical study, the committee will have discretion over the way in which knowledge from this dissertation is shared back with the community and guide the ways in which knowledge is shared and mobilized outward.

Document Review

Following the community engaged approach, the government documents critically reviewed for this research were recommended and brought forward by the community advocacy group to the researcher. For the document analysis within this research, six recent and imperative government documents were selected for review regarding health care transformation in Manitoba and the recommendation to close select rural EMS stations across the province. These documents all played central roles in educating government decision-making towards these changes, and are acknowledged as such by the Manitoba government and department of Health, Seniors and Active Living. The documents reviewed in this research include: the 2013 EMS Systems Review by Reg Toews for the Government of Manitoba, the 2017 Provincial Clinical and Preventative Services Planning for Manitoba (Peachey Report) by David Peachey and colleagues, the 2017 Wait Times Reduction Task Force Final Report to the Ministry of Health, Seniors and Active Living, the 2017 Health System Sustainability and Innovation Review (KPMG Report), which was not released to the public until May 2018, the May 2019 Shared Health report, Better Care Closer to Home: Planning for the future of our health care system, and the June 2019 Shared Health report Better Care Closer to Home. All of these reports and documents are publicly accessible through the Government of Manitoba, Ministry of Health, Seniors and Active Living.

These documents were reviewed and analyzed based on their effect or influence on the government decision to consolidate health care and emergency health services across rural Manitoba. The sample size for this component was small, and intentional, as these six documents were commissioned for the purpose of analyzing the effectiveness of the Manitoba health care system over the past six years by the province, and were indicated as imperative by the community. The central question addressed when reviewing these government documents was ‘how have these government reports affected rural community health and health services in Manitoba?’ in order to assist in responding to the central research questions. The review of these core policy documents provides a background to understand government decision-making around the delivery of emergency medical services across the province, but they also represent the basis for all health care service delivery in Manitoba in the future as part of health care system transformation.

Policy documents and government reports were considered very useful to developing an understanding of the health system transformation reviewed in this research, especially as decisions related to the experience of change within the community. In qualitative studies, it is important for the researcher to be clear about what such documents can be utilized for in the research and interpretation of results (Atkinson & Coffey, in Silverman, 2000, p. 826). Publicly accessible government documents and reports such as those reviewed here are considered as "social facts" because they were "produced, shared and used in socially-organized ways" (Atkinson & Coffey, 1997, in Silverman, 2000, p. 826). While such publications cannot be considered as "transparent representations" of the province, health system and decision-makes, they were written, prepared and delivered to the public as fact (Atkinson & Coffey, 1997, Silverman, 2000, p. 826). While especially useful for understanding processes, structures and research that contributed to health policy-making in Manitoba, the review of these reports cannot replace other forms of knowledge when studying the community experience of health systems and services. This methodological consideration supports and contributes to the anti-colonial and community-engaged approach of this research. Government documents that influence change and policy operate as products of the settler colonial system and politic, and because these documents have been delivered to the public to inform on their decision-making, that must be taken seriously and analyzed within the project. The community highlighted these reports as both informative and problematic and therefore, reviewing and analyzing these government documents was crucial to understanding the process of health system transformation in Manitoba.

Data Collection

In addressing the research questions, this study utilized two forms of data collection. In analyzing the impacts of policy change and health care system transformation, this project first undertook a document and policy review. The six government-issued reports studied here were recommended by the community group to the researcher, and were publicly accessible through the Government of Manitoba website. This form of data collection was selected to provide a historical background on the decision-making process, but also to provide an understanding of how the community came to understand the changes they would be experiencing as a result of system changes. Among the documents reviewed was a research report commissioned by the provincial government to analyze emergency health services and the sustainability of the system. This report laid the foundation for transformative change within the provincial health system under a new Conservative government.

The review of such documents is important to qualitative research, but in work concerning marginalized peoples, and Indigenous communities, it is critical as it provides an opportunity to critically analyze government iterations and representations, as well as the ways in which state ideologies are constructed and delivered within society. This review allows for a critical approach and the application of constructivist and settler colonial lens to government structures. In qualitative research, a review of documents is considered the least intrusive method of data collection, but it allows the researcher to develop the historical context of the research subject (Marshall & Rossman, 2006). Such a review can also be used to supplement the findings of other methods (Marshall & Rossman, 2006). In this dissertation, the document review contributes to the interpretation and context arising from community member interviews.

Analysis

The document and policy review of this project was conducted using a discourse analysis examining how provincial government policies and literature construct and describe rural and Indigenous health priorities and needs, and whether these reflect the perspectives of the local rural and Indigenous communities which participated in this study. Such an analysis allows for the examination of the processes informing government decision-making in the design, and delivery of a transformed health care system. Discourse analysis examines the use of language in practice and communication, and how shared use of language is what creates meaning of terms and concepts (Starks and Brown, 2007). Language is used to both construct and regulate understandings of social realities (Starks & Brown, 2007). In qualitative research, an evaluation of language and its use in context is useful in understanding social norms and constructed identities (Starks & Brown, 2007). For these reasons, a discourse analysis of policy documents was utilized to reveal decision-making processes and priorities in health system transformation in Manitoba, and how conceptualizations of rural and Indigenous health at the provincial policy level come to affect the experience of health care services and norms at the community level.

The research questions that this analysis sought to address were:

- *How was health care policy and system transformation developed in Manitoba?*
- *What were the ideas, interests and institutions leading to this transformation?*

By evaluating these key government documents, these questions can be answered, at least through the language and meanings that are communicated through publicly delivered literature.

The six government documents and reports were reviewed from November 2018 through June 2019. The initial review began with information seeking about provincial health system transformation to provide a foundation upon which to begin community member interviews, and evaluate the ways in which the social determinants of health, and rural and Indigenous health in particular, are addressed or omitted from consideration. This process also allowed for the generation of early themes from these documents. Themes were generated by identifying the focus, stress and repetition applied to ideas and concepts within each document, and occurred at least once in each document. The primary themes that emerged included:

- Improving health and services through centralized, integrated, sustainable care
- Matching resources with supply and demand
- Patient-centred, equitable decision-making
- Support community-based care

These themes served as a foundation upon which findings from the analysis of community interviews were applied. Further, these social facts contributed to community understandings of health system transformation, and the position of rural and Indigenous communities and health services in the provincial health system structure. It was imperative to review these documents as these have contributed to social understandings and constructs within the communities involved in this research.

Semi-Structured Interviews

The second method of data collection was semi-structured, qualitative interviews with community members in a small, rural community, and neighbouring Indigenous communities. The community advocacy group called for a qualitative approach to the research in seeking interviews to be held with community members, health service users from outside of the community, service providers, and importantly, the inclusion of First Nation and Métis communities. Semi-structured interviews were identified and agreed upon mutually by the researcher and the community group as the most appropriate, safe and effective method of data collection, as they would allow for open-ended questions and the opportunity for participants to share their stories and narratives.

Setting

This study was established to review a provincial health care system transformation as it was unfolding within Manitoba, and to evaluate the impacts of significant changes in health services on rural communities and Indigenous peoples within the province. This research was necessarily based within a small rural community, with an established rural hospital and health care services, including an active emergency department, 24-hour emergency care, and primary services. In response to the proposed changes to health care delivery within the health region, under the direction of regional authority, Prairie Mountain Health, the community established its own community health advocacy group to address community concerns and bring this forward to the local provincial government representative. The community group sought support from academic researchers in designing and completing a community-based study in response to these health system changes. This rural setting provides a holistic and representational perspective, as the local hospital and service providers also deliver services, and are relied upon by both the local First Nations community, and neighbouring Métis community.

Sample

For this research, a purposive, non-random sampling method was utilized within both settler and Indigenous communities. This style of sampling is most common in the gathering of qualitative data, where researchers seek information-rich cases from within the community or population (Malterud, 2001; Coyne, 1997). Purposive sampling allows for the strategic selection of participants, and where and how the research is carried out (Given, 2008). In this method, the sample is determined based on the research objective (Given, 2008). Further, in community-engaged research, the sample is based on community advice. The value of purposeful sampling comes from the inclusion of information-rich cases to provide significant knowledge on the subject of the research (Patton, 2001). This sampling strategy was utilized in order to include community experts, including people with personal experience utilizing health care services in both rural settings, including Grandview and specialized urban settings across the province, as well as people who represent various interest groups, such as seniors and residents of other communities seeking care in Grandview. The sampling of community experts was important to this study, where particular knowledge of the health care system and services in the community was critical to addressing the research questions.

There are several methods of sampling involved in the purposive sampling style, and these can be used in combination based on the research questions and objectives (Coyne, 1997). In this study and in working with the community advocacy group, an expert sampling strategy was employed. In expert sampling, the community or the researcher seeks the participation of individuals who have a particular knowledge or expertise on the research subject and will most likely be able to advance the study, and identify new ways of thinking (Given, 2008). Participants were selected by the community group based on their personal experiences with the health care system in Manitoba, further, local health service providers were selected based on their positions as experts on the health care system, and community health needs. The research questions and objectives for this project centred on both the perspectives of community members and health experts, supporting the selection of this method of sampling.

Snowball sampling was also utilized, whereby participants were invited to share the study with members of their social networks to encourage participation. Snowball sampling involves current research participants identifying potential participants from among their social network who may have rich information that would contribute to the research (Patton, 2001). In typical snowball sampling, the referral of potential participants is sought and intentional because individuals possess rich knowledge and information (Patton, 2001). The snowball sampling method within this research was intentional, where both the community advocacy group and expert participants referred me to other potential participants by providing either their contact information or referring potential participants to get in touch with me. As a community-based project, many community members were aware of the study taking place, and were willing to contribute to a project designed for and with the community group. Such a sampling style is helpful and common practice in community-based research.

Recruitment

Beginning in Fall 2018, members of the rural community were recruited for participation in this study through an invitation provided through the community health advocacy group, both directly, electronically through email or in personal communication, and in local newspaper media. Interested community members were then invited to participate in a 30-minute telephone interview with the researcher. The community advocacy group, made up of several community representatives had taken efforts in connecting with potential participants, and led in the recruitment of participants completely, as part of a community-engaged research strategy. The community group also had a sense of the diversity of participants, ensuring that various demographics and characteristics of participants were included.

Participants

In total 29 participants consented and were interviewed over the telephone for the study, between December 2018 and September 2020. The population included in this research is made up of Grandview community members, business owners, service providers, parents, older, middle and young adults, and residents of communities nearby Grandview who travel to the town to access health care services there, rather than within their local municipality. Table 1 provides an overview of the participant groups included in this study. This population is demographically diverse in order to demonstrate experiences and views from across the lifecourse, various socioeconomic and education levels, and employment backgrounds. While it is not possible to collect the experiences of all residents in Grandview, the population included in this sample is reasonably representative of the diversity of the community.

This population of participants was included as the result of a community-based study, but it is important to reflect that rural community members and Indigenous peoples have been frequently omitted from health service and policy research (Williams & Kulig, 2012; Gabel, 2013). It was clear from the provincial document review that rural communities were not consulted or included in health system decision-making. Further, including health service providers is important as there is a deficit in the literature and knowledge base on service provider perspectives on rural health in Canada. SDOH literature has continuously indicated the importance of service provider perspectives, due to their role in delivering care and acting on many determinants of health (Marmot et al., 2008; Raphael et al., 2008). The perspectives of service providers, as well as community members can be used to inform both the public and policymakers on the SDOH that affect the health outcomes of their clients.

Table 1: Participant sample.

Participant Descriptor	Number of Participants
Indigenous Community Member	1
Municipal Community Resident / Service User	16
Indigenous Service Provider	2
Municipal Service Provider	9
Community Leader	1
Total	**29**

The sample size included in this study was supported by the ability to reach saturation in the analysis of the findings. Saturation occurred after 25 interviews had occurred, and when subsequent interviews did not yield any significant additional information or themes to those previously compiled. This finding of saturation aligns with what Mason (2010) and Charmaz (2006) describe as qualitative saturation. While saturation is dependent on the subject, methodology, methods and participants involved, there is no required sample size for qualitative research projects (Mason, 2010). However, trends in qualitative research provide some suggestions upon which the intended sample size is based. In her review of qualitative research Dworkin (2012) suggests that the acceptable number of interviews required to reach saturation is between 25 and 30. Similarly, in his analysis of PhD research utilizing qualitative interviews, Mason (2010) found that the average number of interview participants in qualitative PhD-level research was 31 participants. While the concept of saturation to support intended sample size is contentious, and some authors argue that it is impractical, this dissertation aligns with the findings of other qualitative studies (Mason, 2010). Considering the complexity of community-engaged research and research within Indigenous communities carried out by a settler researcher from outside of the participating communities, it was expected that participant sample size would remain modest.

Data Collection

For this project, semi-structured, open-ended, one-on-one interviews were held over the phone with participants. Because the research was based within a rural Manitoba community and as the researcher, I was based in Hamilton, it was decided that interviews would take place over the telephone. This was deliberate and allowed for participants to engage with someone outside of the immediate community and was most often the most convenient and preferred interview method among participants, as video conferencing and calling was offered in addition. This was also practiced later within the data collection process out of necessity, when the COVID-19 pandemic restricted travel and research in person. The community advisory group was satisfied with my leading in data collection, as my supervisor recommended my involvement, and I had relevant experience in completing qualitative research, including in-depth interviews, gained during my Master's research. In-depth interviews were selected to gather an insider perspective of community experiences of the health care system, and response to the proposed policy and delivery changes put forward by the provincial government. As Charmaz and Belgrave (2013) note, within the symbolic interactionist research tradition, most researchers utilize in-depth interviews as their primary form of data collection, largely due to the fact that such a method allows for the evocation of experience through story-telling, personal narrative, and self-reflection. Interviews are perhaps one of the best forms of data collection for research on individual and collective experience.

An interview guide (Appendix D) was developed mutually with the community advisory group and was used to structure interviews and allow for participants to prepare for their interview in advance. The interview guide drew on theoretical approaches used in this research, by following the SDOH framework in addressing various layers of health determinants. It further reflected on the social interactions between community members and the health system, between participants as service receivers, or patients, and health service providers. The wording of questions was intentionally neutral, allowing for participants to share their narrative based on their interpretation of the question. The interview guide included experience-based questions, such as:

- What are health care services like in your community currently?
- Describe the services provided or available to you.

- Are there any important experiences that you would like to share?
- Describe your ability to access care and receive emergency care.
- Are there important relationships between service providers and sectors that affected the delivery of health services?

The interview guide also included opinion-based questions, to gauge participant feelings towards the changes to EMS delivery within the community, and how these will affect the community, such as:

- What will happen to health care in your community after the proposed change to the delivery of emergency services?
- How will you and the community adapt to this change?
- Do you feel your needs will continue to be met?
- Do you feel there will be gaps in services?
- Are there people that will be more seriously affected by this change than others?

Once the community advisory group had shared the contact information of interested participants, I shared a recruitment email including a letter of information (Appendix A) along with the interview guide (Appendix D). Participants were advised that both a community study and a PhD study were being completed, and they had the option to participate in the community study only, or both, as per the agreement developed with the community advisory group (Appendix E). Only one participant chose not to have their responses included in the community-based study, and contributed to this dissertation research only. All participants agreed to have their interviews recorded and permitted me to take hand-written notes. Consent for participation and recording was collected verbally over the phone on the day of the interview, prior to me initiating the interview questions.

Each interview lasted between 25 minutes and 2 hours, and was audio recorded with consent from the participant. Once each interview was completed, the digital file was uploaded from the recording device to my password-protected computer, and the original recording was then deleted from the device. Each interview was transcribed verbatim by the researcher, by hand.

While most interviews were typical in nature, and followed the interview guide closely, there were some that included longer story-telling, and the sharing of lengthy personal experiences. These responses are expected in such a qualitative study, where participants are asked about their experiences and personal and professional opinions and feelings. The diversity of the interviews reflects the diversity of the research participants.

Analysis

The objectives of this research were to understand the process of health system transformation in Manitoba and the impacts of this change on rural and Indigenous communities. This project necessarily placed focus on the perspectives of community members as part of a community-initiated and engaged study. In consideration of the gaps existing within the literature, the period over which this research was conducted provided the ideal opportunity to understand the response of actual communities as the province delivers on intended change. The emphasis on personal and professional experiences called for a method of analysis that acknowledges the voices and narratives of participants, without restricting or presuming the intended meaning.

This research undertook a modified grounded theory approach to analyze the data accumulated through interviews. A thematic analysis, informed by a constructivist grounded theory approach was utilized, for this reason, the term 'modified' grounded theory is utilized. True grounded theory prohibits the guidance of structured research questions and leading theories, and rather, utilizes the data to develop an answer for a non-predetermined question (Glaser, 1992). Grounded theory was first described by Glaser and Strauss in 1967, where the intention of the method is to allow new, original ideas to arise without preconceived notions of the researcher, and to allow the data to lead in discovery, rather than attempt to test an existing hypothesis

(Glaser, 1992; Charmaz, 2006). True grounded theory methods thus allow researchers to generate theories, not verify them. By relying on data for a resulting original theory, grounded theory essentially eliminates the need for a guiding theory in approaching research (Charmaz, 2000). In qualitative research, and as part of an appropriate method in Indigenous research, grounded theory is useful and encouraged for use by settler researchers (Hyett et al., 2017). It is important however, to utilize this method in a way that is inclusive and respectful of positioning and power in the research relationship.

In an effort to acknowledge the research relationship within an anti-colonial and community-engaged approach, and to conduct research in a good way as a settler, the constructivist approach to grounded theory was undertaken. The constructivist approach as developed by Charmaz (2000) acknowledges that both the participant and the researcher are active in the construction of the research data and findings. The approach seeks to draw meaning out of participants' narratives as done so by the researcher, and community advisors in the case of the CER approach (Charmaz, 2000). In this process, the researcher cannot remain a neutral, third-party observer, but very much so becomes embedded within the research. This calls for a critical reflexive process, especially in this specific research project where the researcher is a non-Indigenous settler, and where I must reflect on my situation and position within the research process. Charmaz (2006) argues that the position and experiences of the researcher are also critical in the formation of theories in addition to the data collected. In addition to this, Charmaz (2006) states that research findings are interpretations belonging to the researcher based on the engagement between researcher and participant. In the case of a community-engaged study, involvement also includes members of the community advisory group. Constructivist grounded theory methods allow for reflexive analysis, where the researcher's work is a construction based on their position related to the participants, rather than an objective product (Charmaz, 2006). This aspect of modified grounded theory is critical to research with Indigenous peoples and aligns with Indigenous methodologies where research is considered inherently relational (Wilson, 2008). Constructivist approaches acknowledge that concepts and ideas within the research come from the researcher’s interactions with participants and clearly finds that research cannot be unbiased, however it can be clear about where and why interpretations arise as a result of the researcher’s position and privilege. Within this dissertation, analysis relies on constructivist grounded theory methods, as position and power of the settler researcher must be reflected in Indigenous health research, where historically settler researchers have misinterpreted and misrepresented Indigenous and marginalized communities, perpetuating settler colonialism in research.

Importantly, the results of such research and constructivist grounded theory are not intended to be widely generalizable as they reflect a singular moment in time, within a specific community, and reflects the personal experiences and narratives of those participants included in the research (Charmaz, 2000). Constructivist approaches do not attempt to produce a single truth or theory that is applicable to all populations over time, but rather this approach addresses the realities of individuals and communities (Charmaz, 2006). This dissertation does not intend to produce a universally applicable finding; rather it was designed with a particular community to report on the conceptions and experiences of a selected group of community members, on a particular moment in health system change within one province. What is useful and applicable about this theory in CER is that it aids in the development of qualitative research traditions by studying experience through the viewpoint of those that live it (Charmaz, 2000). This makes the use of grounded theory methods appropriate for this qualitative, community-engaged study.

While grounded theory does not provide instructions for data collection, it does detail methods for data analysis and recognizes the interaction between data collection and analysis (Charmaz, 2000). The constructivist approach allows for the guidance of theory, so thematic analysis here utilizes settler colonial theory, symbolic interactionism and the SDOH framework. Interview transcripts were reviewed in search of common themes, feelings, beliefs and responses among the participants in response to each interview question. When themes became common among the first five interview transcripts, they created the basis from which the analysis developed. Two thematic areas emerged through analyses. The first reflected community thoughts and experiences of the current health care model within the community and EMS, and the second indicated the participant's views on the impacts that the proposed changes would have on health care services and the community now and in the future.

Thematic Analysis

A thematic analysis of interview transcripts was initiated during the time of transcription, which was completed by hand on a password-protected computer. Personal information and names were not included in the transcripts to further ensure confidentiality of participants. In qualitative research, the composition of transcripts is not a technical detail, but rather a critical and informative process (Silverman, 2000). Charmaz (2000) states that in grounded theory, analysis begins early in the process. In many instances, the researcher can identify themes before, during and after the collection of data (Ryan & Bernard, 2000). In following with constructivist grounded theory methods, I was able to begin to pick out themes after the first interview was transcribed, shortly after the interview was completed, while my memory was fresh.

Central themes arising from interviews were drawn from the transcripts from each participant using the process of coding. In this process, I practiced line-by-line coding and memoing as described by Charmaz (2000) and Ryan and Bernard (2000). This practice identifies the potential arising themes or concepts by analyzing examples from the transcripts (Ryan & Bernard, 2000). Coding helps to simplify the data into a consumable and simplified understanding of what is meant by the language used (Ryan & Bernard, 2000). Coding is an inductive process, finding meaning within the narrative, while limiting the researcher from applying their beliefs or assumptions to what the participant has expressed (Charmaz, 2000). During analysis I also practiced memoing, where I made reflections on sections of the transcripts based on my experience and memory of the particular interview (Charmaz, 2000). For example, I included some of my handwritten in the analysis where a participant made a pause, got emotional or shared a personal story. The act of memoing helps the researcher to reflect on their relation to the data and the participant that contributed it (Charmaz, 2000).

Once I had reviewed the first six coded transcripts, I was in a position to identify emergent themes going forward in the analysis process, paying close attention for reference to various SDOH and social interactions and power struggles in the narratives as they aligned with the SDOH framework and guiding theories. These were helpful as I moved forward in analyzing the remainder of the transcripts. Initial codes and code categories were used to guide the selective coding of the remaining transcripts. This is a helpful practice in grounded theory which allows for the development and confirmation of definitive themes and to determine if participants' responses were agreeable and would reach the point of saturation (Charmaz, 2000).

Codes were categorized and compared in relation to one another to develop final overarching themes and subthemes. The identification of subthemes is referred to in grounded theory as axial coding, where thematic codes are compared to one another to look for variations (Charmaz, 2000). Subthemes help to develop the larger theme, but deserve attention in their own right, as they are representative of the social interactions or experiences that give way to the larger theme (Charmaz, 2000). The final themes found in this research were identified through the review of the codes that arose throughout analysis, and the comparison of these. In this process I was able to conclude which codes appeared most often in response to each interview question. If certain codes appeared in the responses to several interview questions, and occurred in multiple interviews, they were confirmed as themes. The completion of analysis resulted in many additional themes and concepts that extend beyond the scope of this project. The primary themes that directly address the central research questions will be reviewed in detail in the following chapters.

In conducting qualitative research however, the researcher is never neutral. Throughout the analysis my position as a settler, a researcher and an outsider to the community became apparent. In doing research in a good way, and making efforts to perform anti-colonial work in Indigenous health research it is important for me to contextualize and position myself.

Researcher Reflexivity and Contextualization

The practice of reflexivity is ingrained in most qualitative research approaches as central to good research. In their review of methods to improve Indigenous health research, Hyett and colleagues (2018) discuss reflexivity and allyship among non-Indigenous and settler researchers conducting work with Indigenous peoples. This practice and directive is critical in all research that relates to vulnerable or marginalized peoples, where the researcher has historically held the power in an unbalanced relationship. Serving as an ally is an active role requiring the elimination of inequalities between actors in a research relationship and redistributing power (Hyett et al., 2018). Striving to undertake this role, settler and non-Indigenous researchers must acknowledge that they cannot speak in behalf or instead of Indigenous peoples on Indigenous issues and can never be considered experts on such issues, regardless of their academic or experiential past (Smith, 2012; Hyett et al., 2018).Critically, in the spirit of relationality as defined so eloquently by Indigenous scholar Shawn Wilson (2008), only Indigenous peoples and communities themselves can determine who is an ally to them. Further to this, to do research in a good way and contextualize themselves as outsiders, settler researchers striving for allyship must necessarily confront problematic histories of colonialism, and accept that they may make errors or feel uncomfortable when confronting these histories (Wilson, 2008). The process of striving towards allyship should be reflexive, requiring of the researcher to engage in critical self-reflection and awareness throughout the course of their research relationship, and before and after (Findlay, 2002). Reflexivity here fits well within the qualitative tradition and is imperative to settler engagement in Indigenous health research. Non-Indigenous researchers must position themselves as such, as their interpretations will be different from an Indigenous, or local community researcher (Smith, 2012). Through the process of critical reflexion, settler researchers can acknowledge the colonized space within which they come from (Kovach, 2010). Authentic reflexion requires a constant questioning and criticality of one’s existing worldviews, assumptions and beliefs, and how these beliefs affect and interact with every step in the research process (Findlay, 2002). Critical reflexion in research also calls for the researcher to examine and express their observations about themselves and their interpretations, and the aspects of themselves that contribute to their interpretations of their own work. I reflect on my perceptions in the section below.

Reflexion

To position myself, and the work and perspectives I have employed in this research, I am compelled to briefly share my history as a settler Canadian, rural community member and health equity researcher, while recognizing and situating my privilege and intention to live and work in a decolonizing way.

First, I am a non-Indigenous settler researcher engaging in research about rural health, Indigenous health policy, and rural and Indigenous folks' experiences within the health care system in Canada. I was educated within a colonial system, and have experienced the benefits that come from such a system, as a settler person. Here, I recognize that my own worldview was created through my early experiences in the education system. In beginning this research process, and the pursuit of doctoral studies at McMaster University, I had recently completed a Master of Arts in Health and Aging, in the same department. My previous work, and my motivation for pursuing a graduate degree, was to understand, research and write about the social determinants of health, but most centrally, health inequalities experienced by Indigenous peoples across Canada, and their resiliencies. I wanted to examine the policies in this country that help or hinder the health and wellness of Indigenous and marginalized peoples. My interests have always fallen along geographical lines. During the masters' program, I was fortunate to work within an urban, Indigenous health care organization where I learned from Indigenous Elders and health service providers; people who worked to integrate Indigeneity and Indigenous knowledges within a Western health care system. Throughout the course of my earlier academic research, through to this current work, I have been privileged to be supervised and advised by Indigenous scholars and practitioners who have helped to create pathways to understanding how to do research as a settler person and have established opportunities for me to be humbled in the learning process.

While initiating doctoral research, my studies took a pivot towards rural health through the undertaking of a community-based study and project for a rural community in Manitoba. Stepping into the research assistant role on the project, I entered with a false familiarity with rural health. Through my personal and family history, I have lived as a rural person, as the fifth generation to grow up on the same farmland in rural southern Ontario, in a small agricultural community within the heart of Ontario’s Greenbelt. While I did not grow up farming, members of my father’s family continued to do so on the same property and within neighbouring counties. Growing up rural in the 1990s and early 2000s meant spending more time outdoors than in, and an appreciation for sowing, growing and harvesting foods for our family and neighbours. My family history of community involvement led to long-term membership in the community agricultural society, from volunteer work, to a board position, to an elected senior leadership role in 2020. My experience of rurality in southern Ontario, in a town that has since been amalgamated into a much larger city in the greater Golden Horseshoe area (the most population-dense place in Canada), however, cannot be compared to prairie and Northern rurality in Canada. In those places, one can drive hundreds of kilometers before reaching the next town. That is not my experience of rurality. I can contextualize and situate myself as a person with rural roots, but geographical differences in rurality are clear, especially in a country as diverse, demographically as much as geographically, as Canada. The research process has effected a profound change in my ways of contextualizing rural identity and health.

Lastly, the research interest that I have pursued over the past 13 years of academic study has been health and health equity, I am not a health care professional or service provider. Nor am I a health care policy- or decision-maker. As a researcher I can reflect on my role as an influencer of policy, as a supporter of community interests as they relate to health, but I am not a part of the health care system, except for as a receiver. The research for both my Master's thesis and this dissertation involves the perceptions of those people who live and work within the system that is so often deemed as problematic for numerous reasons. I am an outsider to this system and recognize this in the ways that I interpret and criticize the system and the way it operates through policy and various actors including service providers.

Through the course of this research I can frame myself as moving through my academic experience as a rural, settler person, from not knowing, to knowing a little more, but always still learning. This awareness is rooted in an experience I had while presenting at a graduate student research conference on Indigenous health in British Columbia in 2018. After presenting to a full room about my proposed research, an older Indigenous woman waited for me to finish answering the obligatory questions of other students in the room. She reminded me then, "you may have an answer for all of the questions, but never forget that you are still learning, will always be learning." I thought of her words frequently throughout the following years and the research process I embarked on in this dissertation.

In order to practice decolonizing research, I prioritize my accountability to Indigenous interests and marginalized communities in an effort to decolonize my perspectives and research approach, to counter the abuse of power that research has historically upheld, to honour and maintain relationships with Indigenous communities, and to generate knowledge for the direct, actionable benefit of communities themselves. It is through this work in part that I strive for decolonization of structures and systems and research.

Chapter Six: Critical Analysis of Government Reports:

Towards Transformation

This chapter provides a review of the results and emerging themes from the critical policy document analysis. Below I review each significant government report that contributed to the health system transformation in Manitoba in 2017 under the recently elected Progressive Conservative government led by Premier Brian Pallister and build on the themes that arose. In conclusion, I provide critical application of settler colonial theory to these guiding documents and their outcomes within the rural communities participating in this research.

Transforming the Manitoba Health Care System

In order to understand the political context that provincial government decisions have been made within, it was important to review and analyze the research that influenced the transformation of Manitoba's health care system. These government-initiated reports, conducted by external firms and consultants, established the social facts upon which transformation and policy recommendations were made. The analysis of each report generated a theme that was seen to contribute to future reporting and decision-making, demonstrating the structural effects of political ideologies in created entrenched policy legacies. This analysis assists in answering the research questions posed by this dissertation: *How was health care policy and system transformation developed in Manitoba? What were the ideas, interests and institutions leading to this transformation?*

The first report I review, which was commissioned by the previous provincial government while the New Democratic Party (NDP) were in leadership in 2012, has been the basis for the substantial change to the delivery of emergency medical services in the province. The proposed changes to EMS delivery are initially what sparked the community call for research on the impacts to Grandview, the health system there, and residents of the surrounding area. This report, the 2013 EMS System Review authored by Reg Toews is critical in addressing the central research questions that the community sought to answer. This is the only report that was generated prior to the PC government leadership. The following reports, however, were all commissioned by Manitoba's current PC government, and have subsequently contributed to the largest health care system transformation ever undertaken within the province. This includes the elimination of suggested low call-volume EMS stations in rural areas. The following sections highlight these government reports in relation to the policy and health system changes that have affected the residents of Grandview, the Métis residents of San Clara, and the First Nation citizens of Tootinaowaziibeeng, and many other rural communities across Manitoba.

Theme One: Centralization for Fiscal Sustainability

The first theme that has subsequently contributed to all following reports, is focused on health system reform through the centralization of EMS services in order to reduce costs and create efficiencies.

2013 EMS System Review (Toews Report)

In 2012 the provincial government of Manitoba, led by the NDP, commissioned an external, third-party review of the EMS system across the province in order to address the development of a more "integrated, responsive, reliable and sustainable service," (Toews, 2013, p. 3). At this time, concerns regarding the rising expense of the EMS system, and the increase in call volumes across the province were compounded by the amalgamation of eight regional health authorities to the five that exist today (Toews, 2013). As I have noted in chapter four, provincial EMS systems are patchwork, and are often delivered regionally, by relying on province-wide coordination of ED, trauma and specialist care responses. When the EMS System Review study was commissioned in Manitoba, it had been years since the system had been evaluated, and there were signs of stagnation and lack of coordination realized during RHA amalgamation. Prior to the implementation of RHAs in the late 1990s, Manitoba's EMS services were delivered by municipalities, leaving many resounding service gaps across the province (Toews, 2013). With several health authorities responsible for delivery of emergency services, but with few specialized emergency and trauma care centres in the province, the EMS system had many jurisdictional failings as well, warranting a fulsome review.

The external consulting firm on the EMS review project, Fitch and Associates, had previous experience in the review of emergency systems and RHAs in Manitoba, and was led by Reg Toews, who was previously the CEO of one of the amalgamated RHAs in southeast Manitoba. The report relied on EMS call data compiled by the Medical Transportation Coordination Centre (MTCC), which records EMS and patient transport in the province, as well as with the EMS division of Manitoba's department of Health, Seniors and Active Living. The primary objective of the review was to evaluate and make recommendations on the financial, operational and service standards of EMS in the province, and resulted in the creation of service delivery models that the province was recommended to structure future emergency medical services after (Toews, 2013). The expected outcomes were to specifically include recommendations on service levels matching national response time benchmarks, enhanced integration of EMS systems across the province, public accountability, and fiscal and operational sustainability (Toews, 2013). All of which were common political buzzwords at the time.

The project scope listed a number of areas for review, including current performance standards and benchmarks for rural and urban settings, the location and number of EMS stations across the province and their relation to achieving benchmarks, and integration and collaboration across regional and municipal boundaries and available services (Toews, 2013). The EMS Review was structured around these objectives and expectations, importantly noting that this review took place at a provincial level, rather than a regional-municipal level, where RHAs are responsible for structuring the delivery of health care services to meet the needs of their diverse and distinct populations. This caveat has ultimately had important implications in terms of the findings, recommendations and ultimate impacts of the Review on health regions and municipalities.

The methods and data used by government and state consultants must be reviewed critically, as constructed data is often used by settler colonial governments to achieve self-serving agendas. The 2013 EMS Review utilized a series of methods, including a review of relevant, albeit dated, policy and government documents. Consultants held meetings with various organizational and operational stakeholders, including service providers (EMS managers, educators, medical directors and Manitoba Transportation and Coordination Centre), educational institutions (colleges and universities), paramedic associations and unions, and importantly representatives of Indigenous leadership (Assembly of Manitoba Chiefs Secretariat, Manitoba Métis Federation), as well as the Assembly of Manitoba Municipalities (Toews, 2013). It is critical to point out here however, that professionals including paramedics, emergency physicians, community leaders, and members were carefully left out of these consultations, reflecting the 'high-level' focus of such a review, and the production of knowledge based on the perceptions of institutions, organizations and people in positions of power and control over the health care and EMS systems. The review also included, but did not name or list, a series of statistical documents provided by the EMS branch of Health, Seniors and Active Living, the MTCC and "various service providers and others…" (Toews, 2013, p. 7). Therefore, the Review is based upon unknown, inaccessible documents and research provided to the consultants by the government itself, representing a lack of transparency and reliability. To justify the use of these unnamed files, the Review noted that accessing statistical and population data was difficult, stating,

> “The lack of consistent and reliable information available centrally was a challenge. Every effort has been made to make the data as accurate and complete as possible so that it can be considered reliable for the limited purpose of this review. The data should be treated with caution when used for any other purpose. The Annual Operation Plan completed by the RHAs and other service operators was a primary source of information,” (Toews, 2013, p. 7).

This disclaimer indicates that the reviewers believe the data is good enough for the sake of a provincial review, but draws attention to the fact that implementing significant changes based on this data could be problematic. This is a central concern for communities like Grandview, who perceive their community as negatively affected by the results and recommendations of the 2013 EMS System Review as they were undertaken by the province.

The report notes several positive aspects of the EMS system in place at the time, as the fact that, despite an increasing number of calls each year, with a six percent increase rurally, and an aging fleet of vehicles, the land ambulance program was meeting population needs in 2012 (Toews, 2013). An optimal EMS system would continue to meet population needs, with a rural response time benchmark of ambulance arrival within 15 minutes for life-threatening emergencies (Toews, 2013). Toews (2013) also notes that the optimal EMS system is patient-centred, with EMS services playing central roles within community settings, through health education, illness and injury prevention and early risk detection, highlighting here the importance and place of paramedics within the community health setting.

Key findings from the Review suggested that 911 calls were increasing in volume province-wide, costs and service standards varied widely, gaps existed in data collection, and services and delivery models were uncoordinated and fragmented (Toews, 2013). These indicate an EMS system with gaps which had the potential to contribute to negative health outcomes. The findings resulted in a number of high-level recommendations to be undertaken at a systems level. These included the use of primary care paramedics as entry-level standard for EMS providers, continuing the practice of two central dispatch centres to assign ambulance units to calls (one for Winnipeg, and one for rural, remote and northern settings), and to shift EMS culture from one focused on response to one of prevention and risk reduction (Toews, 2013). Important to this study, and rural communities, was the recommendation to "reconfigure land and air ambulance placement to more closely match resources with actual service demand to achieve defined response time standards," (Toews, 2013, p. 2).

In the report, Toews reviews EMS response and deployment practices, questioning the reliability and suitability of stations and their fleets, (Toews, 2013). With 92 EMS stations located across rural and northern Manitoba, many of which were deploying ambulances over 15 years old, the question arose as to whether this practice was sustainable. The report states that for the sake of providing the province with a conceptual service delivery model to align the best number of EMS stations and ambulance units where they are needed most, a computer modelling method based on national best practice, was used to design a system where all Manitobans would receive "predictable, responsible and reasonably costed ambulance services" (Toews, 2013, p. 28). The unit-hour model is highlighted by Toews, and a caution states that this model is theoretical, to provide the government with an idea of costing for EMS delivery, rather than actually determining the location of EMS stations and units,

> "This model is intended for theoretical value only… to give the… Government an order of cost magnitude and it is not intended to reflect actual station locations. A further process will need to be completed to determine the location of the stations. The location

> names identified in this report were strictly a computerized output to allow for a count of required resources," (Toews, 2013, p. 28).

The unit-hour model focuses on meeting the highest needs first in urban and suburban areas with larger populations, and builds outward to rural and remote geographic areas (Toews, 2013). Once station location is determined, the number of ambulances and primary care paramedics required to meet demand can be calculated, then the number of hours that are needed to staff those positions for appropriate coverage times are given, and ultimately a final cost is ascribed. Despite the caution that modelling was theoretical to be used for costing purposes, the 2013 Review provides a map and list of recommended EMS resource locations, as depicted in Figure 5. The Review states that the locations were determined by "minimizing risk using generally accepted response time for Urban (8:59 minutes), rural (14:59 minutes) and remote response (30 minute) times," (Toews, 2013, p. 31). But this method does not clearly describe how the reviewers arrived at these specific locations.

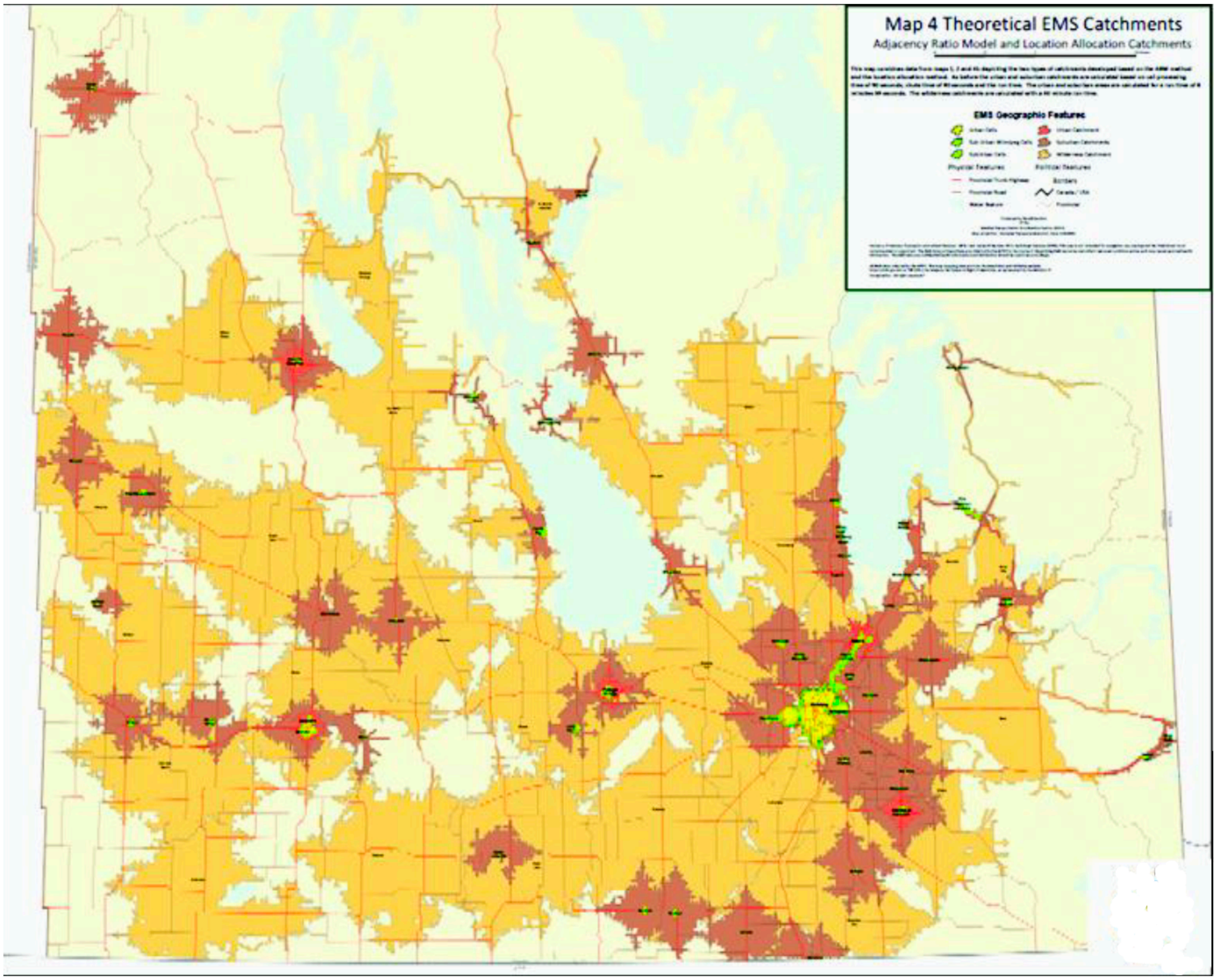

Figure 5: Recommended EMS Resource Locations. Source: 2013 EMS Systems Review (Toews, 2013).

The Review states that according to the unit-hour model and demand analysis, the regions south of the 52nd parallel will require 89 ambulances, 74 of which would be needed outside of the city of Winnipeg to ensure a response time of less than 30 minutes in rural and remote areas 90 percent of the time for 90 percent of the population (Toews, 2013). The final number of 74 ambulances for rural and remote Manitoba came from supplementary work provided by the MTCC and EMS Branch of Manitoba Health, Seniors and Active Living, utilizing "a combination of computer modelling and judgement from experience," (Toews, 2013, p. 32).

Further description is not provided within the report to explain whose experience the decision-making was based on, again reflecting a failure to be transparent.

The final count of 74 required stations represents a reduction of 18 stations, from the 92 stations that were then in use across the province's rural and remote areas. Eleven of which were situated in the Assiniboine RHA (now amalgamated into Prairie Mountain Health RHA). The RHA had previously reviewed and modelled demand versus available units and resources, finding that there were too many EMS stations within the region. Paramedics and the reviewers stated that many of these were low call-volume stations, particularly in the western edge of the region. The reviewers believed that with the recommended reduction to the number of low volume stations in the region, the RHA would still meet response time requirements (Toews, 2013).

In the Review, there were two primary reasons cited for eliminating or consolidating stations in rural Manitoba. The first states that many low volume stations are operated on an on-call basis by emergency medical responders (EMRs), rather than more skilled paramedics. EMRs are only able to respond to calls with the permission of their employers, as EMRs are not full-time EMS staff, rather they are often volunteers with careers outside of emergency response duties (Toews, 2013). The use of these health human resources was determined to be unsustainable, and limits the ability for stations to maintain standard minimum response times. Further, EMRs were found to take on EMS duties as a commitment or responsibility to their community, and this sense of commitment or volunteerism is considered a dying trend across the country. However notably, the Review did not gather any qualitative data regarding EMRs and community capacity to support services through EMRs. Ultimately, the report stated that full-time, salaried paramedics will be required to provide sustainable EMS services in the long-term, replacing EMRs (Toews, 2013). Secondly, there is concern that low volume EMS stations cannot attract, retain or sustain the employment of permanent, full-time paramedic professionals (Toews, 2013). Therefore, smaller, low volume, on-call stations will have to be eliminated or consolidated in order to sustain the highest quality paramedic staff on a long-term basis (Toews, 2013). This perceived health human resource issue contributed to the Review recommendations, and the reviewers did not present community-based solutions for this problem, again denying opportunities for community participation and innovation.

Towards the end of the report, the reviewers state that “it is becoming less helpful to think in terms of stations,” (Toews, 2013, p. 33). When it comes to the elimination of stations, the reviewers are referring to physical EMS garages and on-site staff, rather than ambulances or paramedics. For future-planning and sustainability, the report states that it is more beneficial to think of EMS services as independent of physical locations or home bases, and rather more dependent on having full-time paramedic staff that are effectively geographically positioned, or geo-posted in idling ambulances, prepared to respond to the greatest number of calls in the shortest time possible. This way of thinking is problematic however, as it does not take into consideration the local context of current EMS stations and community needs, such as proximity to a rural hospital and ED, which could have ultimately influenced decisions to close some stations, including the station in Grandview.

The 2013 EMS System Review by Toews represents an important precursor to the eventual transformation of the Manitoba health care system, and ultimately to the intended closures of 18 rural EMS stations, including the one in Grandview. The review is focused on supporting the concepts of centralization in order to establish a sustainable EMS system, however it fails to acknowledge and incorporate the local capacities of communities and EMS services that operate successfully for rural, remote and Indigenous communities in Manitoba. Critically, I raise a number of concerns with this document, including lack of clarity in recommendations, which Toews acknowledges should be understood at a provincial level, rather than prescriptive to any single RHA, especially where the majority of theoretical closures were identified within the PMH region. Further, the report relied on questionable outdated information and data, as well as unidentified 'experience', and lastly, the report was exclusionary of any form of participation from community members with a demonstrated lack of community engagement. The Review is quantitative and relied on limited, narrow resources, and reflects the provincial desire to further centralize health care services, a process that was already in place at the time of the review through the amalgamation of smaller, distinct RHAs into five broad health authorities responsible for extended populations and geographies. Lastly, the Review was commissioned in a time when centralization as a method of health system reform was crucial to establishing 'sustainable' health systems, focused on cost efficiencies and managing utilization of expensive hospital services within the province.

Theme Two: Patient-Centred Decision-Making for Fiscal Sustainability

From a focus on centralization, a theme emerged among government reports that pivoted towards patient-centred decision-making. This theme suggests that structural changes to the health system, and service delivery were framed as supportive of patients, families and caregivers, but also created cost-efficiencies. This shift in framing is viewed as strategic in gathering both stakeholder and public buy-in, while supporting government agendas.

2017 Provincial Clinical and Preventive Services Planning for Manitoba Report (Peachey Report)

Presented to the government of Manitoba in 2017 just under a year into the new Progressive Conservative leadership, the Peachey Report sought to determine where inefficiencies and duplications in health care service planning and delivery existed in an effort to improve fiscal sustainability. David Peachey, the report's author, was called in from out of province as the head of a private health care consulting firm, Health Intelligence in Nova Scotia (Geary, 2017). Valued for his contributions to health care system transformation and care reform in other provinces and territories in Canada, including Alberta, Nova Scotia, Saskatchewan and the Yukon, Peachey was intentionally selected by the previous NDP government in 2015 based on his experience in conducting broad reviews of provincial health systems (Geary, 2017). Ultimately, Peachey's various reports made recommendations on evidence-based cost-saving measures, with the Manitoba review the largest Health Intelligence had ever undertaken (Geary, 2017). Despite being hired by the NDP, Peachey's report was well-received by the new PCs government, noting the new government's willingness to change previous structures and systems (Geary, 2017).

As a follow-up to an environmental scan of the provincial health care system completed in 2016, the Peachey report was intended to explore how health care services are being delivered and how they can be improved as a first step to planning a transformational change to the provincial health care system. The report notes that while health care is a provincial responsibility, most planning and delivery is conducted by the five RHAs within the province, along with the Ministry of Health, Seniors and Active Living, CancerCare Manitoba and Diagnostic Services Manitoba (Peachey et al., 2017). This lack of centralization at a provincial level had resulted in "fragmented services, concerns over quality and access, redundancy and inefficiency, and challenges for those responsible for planning health human resources, capital investments, and digital technology," (Peachey et al., 2017, p. 5). The Peachey Report represents the first time that the province of Manitoba has gone about long-term planning for the provincial health care system and a significant reform (Peachey et al., 2017). Overall, Peachey and colleagues focused on provincial clinical governance, and how this should be structured in order to reform the health care system.

Peachey and colleagues listed a number of principles that would need to be adhered to in order to ensure the implementation of a new health system over the course of the next ten years that the researchers budgeted for total system transformation. In order for transformative change, Peachey and colleagues included principles such as transparent methodologies, patient-centred decision-making where the patient and their family are the focus of health care delivery systems, and equitable care across geographic lines within the province (Peachey et al., 2017). These principles are critical in approaching health care systems change, but are especially important to community members that would be most affected by such changes, particularly those in geographic areas that have historically had less access to quality clinical and specialized care compared to those in major urban centres like Winnipeg. However, following these and the other listed principles, Peachey (2017) states that a one-time strategic investment in health care services planning and delivery can result in wide-spread systemic change that not only improves health care services and patient experiences, but also meets government goals to improve quality and reduce costs. This report attempts to balance patient-centred approaches with fiscal sustainability, which traditionally are irreconcilable in health systems and structures.

Ten priority areas were highlighted by the researchers as critical to address when planning system reform for Manitoba, and were viewed as aligned with the goals and direction of the government of Manitoba. These included: older adults, collaborative care, consolidated services, emergency medical and health services, home care, Indigenous peoples, maternal health, mental health and addictions, palliative care, and public and population health (Peachey et al., 2017, p. 19). While these priorities are critical and must be included, residents of rural, remote and northern areas, known to utilize EMS services more frequently than urban counterparts, and as a source of primary care, and that often face diverse risks and illnesses were not specifically included on this priority list. Interestingly, within the Indigenous Peoples priority area, the report discusses the importance of First Nations, Métis and Inuit leadership in participation around planning and service delivery (Peachey, 2017). Further stating that Indigenous communities would benefit from strategic alignment with the province, to avoid increased health care service and medical transportation costs, and to bring appropriate care into communities (Peachey, 2017). With respect to the EMS priority area, Peachey (2017) concedes that there will necessarily be an urban stream of delivery, and a separate rural stream, based on available health and hospital resources. For rural areas, Peachey (2017, p. 63) alludes to the fact that some rural hospitals with EDs do not actually constitute as appropriate emergency and trauma care facilities, by quoting stakeholders as saying, "If it isn't an emergency department, then don't call it an emergency department." While this statement is not directly elaborated on, it implies the idea that some rural primary care facilities should not consider themselves as emergency hospitals, likely because ED services are not always available, or ED physicians and staff are on-call, rather than posted 24/7. Rather than support rural facilities in providing emergency services, this statement implies that they would be more effective to close or merge with a better-equipped facility in a larger municipality.

The most important priority with impact on health care services and EMS in Grandview and other rural communities, is Peachey's (2017) recommendation to consolidate services wherever possible. Consolidation described as beneficial in clinical and preventative services planning and reform as a mechanism to improve quality, centralize resources and decrease cost, and consolidation should always be considered where possible (Peachey, 2017). An important highlight that Peachey makes, however, is that "where safe, care closer to home is an equally compelling goal," (Peachey et al., 2017, p. 54). In the report, Peachey (2017) does not state which specific facilities in Manitoba should close or be consolidated, stating that that these decisions are for clinical governance and leadership positions across the province, and cautioning that this will have regional and political impacts. However, Peachey does provide a list of facts that compel the suggestion to consolidate health care services in Manitoba, including two points that have direct relevance to Grandview as a rural hospital site:

> "There are 73 hospitals in Manitoba; this is a large number for a population of 1.3 million, even if dispersed; it is not uncommon in a rural setting that patients will call before going to a hospital or emergency department to see if it is open that particular day. Many smaller, rural hospitals are, de facto, providers of long-term and personal care even though funded as hospitals," (Peachey et al., 2017, p. 54).

Citing various issues as reasons for consolidation or closure avoids the reality that rural practitioners and communities face consistently: a lack of support at regional and provincial levels to ensure consistent and effective delivery of primary and emergency medical services.

Further, in the Peachey report (2017), the authors list key concepts, or themes, that were recurring in their research and planning process. Here "rurality and remoteness" was listed as the second theme, indicating that rural health must be addressed in all areas of a clinical and preventative health plan. Peachey (2017) notes that rural and remote populations statistically experience lower health status than urban counterparts, and that this remains true in Canada, and in Manitoba, where the rural population is comparatively large. Rural and remote areas also struggle to attract and retain health care professionals, limiting access to quality, continual care (Peachey et al., 2017). In reviewing health care planning literature from across Canada, Peachey and colleagues (2017) cite the work of Kralj (2000, as cited in Peachey et al., 2017), where rural physicians and service providers listed the 10 most important factors that define rurality from a practical standpoint. These characteristics of rural medical and health care practice included: “high level of on-call responsibility, long distance to secondary referral centre, lack of specialist services, insufficient numbers of general and family physicians, long distance to tertiary referral centre, absence of diagnostic equipment, difficulty in obtaining locum tenens support, no ambulance service, inability to provide obstetrical and surgical services, sparsely populated catchment area,” (Peachey et al., 2017, p. 30). Kralj asserted through this Ontario-based study that rurality is important to health care planning decisions, and must take into consideration the rural community and lifestyle, the nature of rural health care practice as diverse and different from urban practice, and the unavoidable professional isolation and need for support for practitioners and rural places (Peachey et al., 2017). Inclusion of this research for the sake of clinical and preventative services planning indicates consideration towards rural needs, however it is mostly reflective of professional, health human resources needs rather than the perceived or actual health needs of communities themselves, otherwise community consultation, patient-led planning and community recruitment boards would have been included here. What is also problematic in this section of the report, is the failure to include and integrate the strengths and resiliencies of rural places and peoples in creating health system efficiencies. A reliance on a deficit-model in health system planning and reform does not meet the goal of patient-centeredness.

Another key concept that is relevant to Grandview, and was essential to the Peachey report was the focus on patient-centred care, where clinical and preventative services planning should be structured around the needs, contexts and limitations of patients and their families (Peachey et al., 2017). Patient-centred care calls for comprehensive-care, patient-, rather than physician-led decision-making on health, coordination and communication between patient and provider, empowerment of patients and patient autonomy, and lastly timely access to care and information (Peachey et al., 2017). Peachey (2017, p. 35) states that in primary health care reform, patient-centred care must be prioritized, quoting from the College of Family Practice of Canada, that each patient must have a "medical home", where they are able to access quality, timely and effective care. Here, a "medical home" is described as a place where:

- "Each patient has a personal family physician
- Patients have access to nurses or nurse practitioners and other health professionals, as needed, either in the practice or through formal links to other settings
- Health professionals work as well-coordinated teams; each offers unique skills to ensure optimal patient benefit
- Systems are in place to ensure timely appointments with the family doctor and other members of the care team
- Arrangements for and coordination of all other medical services are carried out through the medical home…" (Peachey et al., 2017, p. 35).

These factors are considered core elements of a collaborative care model, in which integrated health care teams address community, and patient needs and provide quality, continual care for the patient (Peachey et al., 2017). This model of care is highlighted in the report as being crucial to the delivery of quality care. Arguably, the elimination of existing reliable, community health care services would detract from this model of medical home. Further, this description of a health place, or medical home fails to integrate patient, family, caregiver, practitioner and community perspectives of what a 'medical home' or 'health home' should be and include. This definition is reflective of dominant, entrenched settler/Western, biomedical conceptualizations of health and health care.

Of relevance to this dissertation and the community of Grandview, is Peachey's recommendations concerning primary care, and public and population health. The Report makes a series of recommendations in numerous areas, and makes clear statements regarding the continuation of rural hospitals. One recommendation calls for the individual assessment of all rural hospitals in the province, how their beds are utilized, the propriety of their emergency departments, and whether they should remain serving as hospitals in the future (Peachey et al., 2017). Of concern is the lack of criteria provided in the review to determine the suitability of rural emergency departments, acute and chronic beds, and hospital performance in general. Where Peachey and colleagues (2017) recommend the consolidation of services, there is little discussion of what needs to take place in order to ensure the continuity and quality of care for people in rural and remote settings that are facing the closure or consolidation with other services or facilities in their communities. While the Peachey Report refers to the importance of patient-centred care, and the limitations and priorities of clinical and preventative services in rural areas, it does not offer clear instructions to government to determine what services are required to support health in rural communities, or how to engage with communities and local practitioners to determine what they believe is required to address their diverse and unique health needs.

2017 Health System Sustainability and Innovation Review (KPMG Report)

In 2016, the government of Manitoba commissioned private Ontario-based firm KPMG to review the current state of the health care system and consider ways in which the province could improve on fiscal sustainability within the health care system in Manitoba. The province was particularly concerned with sustainability and cost-effectiveness at the time, following reports of ever-increasing health care expenditures and lack of return in improved health status across the province and during a fiscal performance review across all provincial departments. KPMG is known for conducting sweeping financial audits, and Canadian operations are based out of Ontario. The KPMG report was coupled with the Peachey report to provide a holistic review of the system. The research undertaken for the review began in 2016 when the PC government took position, with a broad review of the health system and manner of service delivery, investigating ways in which the province could lead or manage services centrally. Again, the call for centralization through system transformation arose within the objectives of the KPMG report. KPMG (2017, p. 4) described their review as "high-level," meaning that services and delivery costs were evaluated broadly, and statistically, in order to make general recommendations for cost-effective changes. This review took place over the span of nine weeks, and included over 70 stakeholder interviews, a document review, and review of previous health system reports that KPMG had authored (KPMG, 2017).

The research, and subsequent report was warranted within the province, as Manitoba's health care system had not undergone a systemic cost review in many years, and between 2003 and 2016, health care expenditures in the province had increased by over 72 percent (KPMG, 2017). The primary objective of this report, in accompaniment to the 2017 Peachey Report on health care governance and planning, was to review and recommend on ways to restructure the provincial health care system in a cost-effective manner with the intention of reaching fiscal sustainability.

In the report, titled Health System Sustainability and Innovation Review (HSIR), KPMG reviewed current practices of budgeting and spending within the health system, stating that at the time health system budgets had been based on historic budgets, rather than population needs, with no incentives to encourage quality and efficiency among service providers and administrators (KPMG, 2017). Governing bodies, such as the provincial ministry and the RHAs had no clearly defined mandates to work within in order to make spending decisions, and health care planning was not previously evidence-based, resulting in less than optimal services and delivery methods. The system itself was poorly structured with unclear responsibilities across health care leadership. For example, with a population of 1.3 million people, Manitoba's health care system was at the time far too complex and siloed with what the report claimed were too many health authorities and administrative bodies (KPMG, 2017). Additionally, the Winnipeg Regional Health Authority (WRHA) possessed many provincial clinical and diagnostic resources, including technology, specialists and service areas, and these were not readily accessible to other regions. The authors referred to health care reform in other provinces being based on the consolidation of services, patient-centred care and funding reform, where significant improvements to the health system had resulted. This was the direction proposed for Manitoba.

KPMG made a lengthy number of recommendations for the province to incorporate into a health system transformation, with respect to the structure of the health system itself, and making health service delivery more efficient. Over 300 opportunities for cost improvement were identified in the report (KPMG, 2017). Following its review of the provincial health system, KPMG provided an overview of a preferred provincial health system structure which included RHAs to deliver health care services, the development of a centralized provincial health organization to regulate the use of province-wide resources and lead in provincial health planning, and lastly the remainder of the Ministry of Health, Seniors and Active Living to undertake planning, policy and funding of the health care system in Manitoba (KPMG, 2017). This new provincial structure was suggested to allow for a number of improved outcomes, including cost efficiencies through shared, rather than siloed services, clear roles and responsibilities of health service organizations and RHAs, improved management of provincial programs, and decreased operating costs (KPMG, 2017). The move to a central provincial health organization (PHO) with a clearly defined mandate and responsibilities, as well as clear roles assigned to the regional health authorities was recommended as an immediate change that had to come as a precursor to any additional cost-effective improvements within the Manitoba health care system. This recommendation is what the development of Manitoba Shared Health came from, as a central PHO, in 2018 to preside over health system transformation and collaborate with the RHAs in the delivery of care. Shared Health was also designed to deliver EMS and patient transport services across the province, and to participate in the transformation of emergency response services as recommended through the HSIR and the other government documents reviewed here.

Within the HSIR, one recommendation within the 11 areas of cost-saving opportunity identified was the move to shift health care services from acute, hospital-based settings to community-based settings, where diverse rural and urban patients would receive more appropriate and convenient care in community settings, rather than within hospitals, where hospitals act as hubs to connect patients with services in their community (KPMG, 2017). This hub-and-spoke method is considered a best practice in patient-centred care and the provision of integrated health care services (KPMG, 2017). In their review of documents and respondent surveys, KPMG found that rural service providers, patients, families and caregivers cited difficulty in accessing services and resources in their communities, which KPMG states could be improved through the use of technology, such as TeleHealth (KPMG, 2017). To support this recommendation, KPMG analyzed emergency department usage across Manitoba’s RHAs. Significant to Grandview, KPMG found that within Prairie Mountain RHA, patients visited the ED 3 percent more often than expected when adjusted for age, leading KPMG to state that this region was particularly suitable for changes to reduce the number of avoidable ED visits residents make. The potential cost improvement, or savings for this area were stated to be in the amount of $0.6 million dollars annually with 4,558 fewer avoidable ED visits per year through health system changes (KPMG, 2017). Again, this move reflects back to the intention of the KPMG study, and arising theme to move the health system towards fiscal sustainability by eliminating what is deemed to be avoidable, or unnecessary hospital visits, which incur the among greatest costs within the health care system. Unfortunately, this recommendation fails to acknowledge the root causes of increased hospital use and neglects the various contributing SDOH.

The KPMG report highlighted a second significant area of opportunity to reduce health system costs, as the consolidation of small, proximal emergency departments. However, KPMG's analysis showed that there were actually few cost savings associated with a decrease in the number of rural ED visits among rural and small hospitals. KPMG (2017, p. 149) states "fixed cost savings from consolidations are likely negligible compared to those associated with the potential to reduce unit costs." In other words, consolidating and eliminating rural EDs and hospitals in general will likely not result in major savings for the Manitoba health care system, rather changes should be made to lower the cost per ED visit across the province. KPMG recommended that the first priority in addressing hospitals and EDs in Manitoba should be to reduce ED visit costs, and secondly to reduce the number of ED visits in the Southern RHA, where they were found to be the greatest, 46 percent more ED visits than expected. Only once these priorities have been addressed, should the province consider the consolidation of small rural EDs (KPMG, 2017). In the prioritization of this area of opportunity (Core Clinical and Health care Services), KPMG recommends that the province undertake these steps on a medium-term basis (3-4 fiscal years) as these are considered to be highly cost-saving, but also expensive and time-consuming to implement. For Grandview, and other similar communities with rural hospitals and EDs, this provides time to address efficiencies and areas of cost-savings as KPMG results demonstrate that consolidation is not immediately cost-effective and contributive to the fiscal sustainability goal.

Throughout the KPMG report, which drew on stakeholder feedback gathered through group meetings, online surveys, and focus groups with decision-makers, health care providers, caregivers, families, and health system partners, the authors repeatedly identified the importance of collaborating with communities and stakeholders on planning. What is problematic, and representative of a settler government report, is the lack of consideration for socioeconomic drivers for structural or institutional change. Rather, the report is singularly focused on identifying cost-saving areas and establishing a framework, while utilizing other recent government reports, to transform the health system over short- and long-term phases. The KPMG report is designed to be a stand-alone fiscal performance review, providing recommendations on controlling health care spending and improving system and provider performance. Additionally, the report begins by comparing and problematizing Manitoba's health care expenditures in comparison with Ontario and British Columbia, who KPMG states have been able to constrain health care spending increases over time, without contextualizing the provinces or their health system structures. Ultimately, the KPMG report identified over $300 million in cost savings opportunities, which were attractive to the new Manitoba government, who had made campaign promises to reduce the provincial deficit, lower ambulance fees and reduce hospital wait times (Dangerfield, 2016).

Theme Three: Patient-Centred Care Close to Home

The third theme arising in the later government reports hone in on the state narrative of reforming health care services in order to provide patient-centred care close to home, which largely includes restructuring services to increase response times and receptivity to local health care needs. Below I elaborate on the 2017 Wait Times Reduction Report, which significantly impacted, and continues to impact, the delivery and provision of emergency care in EDs and EMS services in the province. Lastly, I analyze one of the most recent health system documents, the spring 2019 updates titled 'Better Care Closer to Home', issued by Manitoba's new centralized health agency, Shared Health.

2017 Wait Times Reduction Report

While the Peachey and KPMG reports were underway, the Manitoba government was also examining wait times for emergency department services within the province, as the Progressive Conservative government had highlighted wait time reductions as a central component to their campaign platform. In 2016 the Emergency Department Wait Times Reduction Committee was established under the direction of the Minister of Health, Seniors and Active Living (MHSAL) to review and analyze various reports, systematic reviews and data regarding ED use in Manitoba in order to make recommendations to improve access to emergency medical care and reduce wait times in emergency departments. The committee also sought to identify limitations in addressing these improvements, such as health system structures and governance. Not only were government reports utilized to inform this report, but the committee held extensive consultation with many stakeholders, including front-line health care providers, ED managers, hospital executives, RHA leaders, and the public, which would be most affected by recommended changes. Members of the public, as well as practitioners and service providers were surveyed regarding their use, experience and thoughts regarding emergency departments (Manitoba Health, Seniors and Active Living, 2017).

An entire chapter of the report was directed towards rural and remote emergency departments and access to care. Importantly, the authors explored areas such as availability of practitioners and services, distance to specialized services and transportation (MHSAL, 2017). There are 63 rural EDs across Manitoba, all with strengths and weakness that result in a great variation in quality, timeliness and effectiveness of services (MHSAL, 2017). The report acknowledges here that many communities rely on services offered outside of their geographic area, and as such transportation and emergency transport is critical. In reference to access to EDs and primary care, public survey participants voiced much concern over the availability of the ED in their local hospital, where in many cases, EDs operated sporadically due to staffing and service limitations, with patients unsure whether the local ED was open or closed on a given day or time (MHSAL, 2017). This supports the report's finding that a significant concern in rural Manitoba today is inequitable access to consistent, quality, primary health care services due to limited retention of service providers (MHSAL, 2017). Unfortunately, in most rural settings, the same doctors that are providing primary care through the day to regular patients and through appointments, are the same providers that are on-call for the ED, often having to cancel or reschedule appointments (MHSAL, 2017). The report states that this leads to patients having to use EMS and ED services as a first point of contact with the health care system, finding themselves under the care of the same professional that they would have seen during clinic hours (MHSAL, 2017). In these scenarios, providers are found prioritized emergent care over consistent primary care, which, conversely, is viewed as a method to offset avoidable ED visits and hospital use. Responsibility across so many domains leads to physician and provider burnout, which is one reason the report providers for the difficulty in retention of staff in rural EDs and in rural primary care (MHSAL, 2017). This leads to operational challenges, where clinic hours are cut short, and EDs are only open and available occasionally, which occurs frequently in many rural hospitals in the province (MHSAL, 2017). This cycle of staffing and operational challenges further reduces the ability of rural EDs to meet the needs of patients, and limits the improvement of rural health outcomes. While this may be the reality in many rural EDs, it does not describe the experiences of all rural hospitals and service providers, where the scenario outlined above does not fit the model of service delivery and coverage that hospitals like Grandview strive towards and ensure.

Importantly, the Wait Times Report recognizes the skills and position of paramedics in rural settings. A crucial recommendation in the Wait Times Report is that paramedics should not be confined to an ambulance. Rather, paramedics possess unique knowledge, skills, and awareness of their community and community health needs, such that they should be empowered to provide skills in other places, such as in-home care, and supportive care for frequent EMS and ED users (MHSAL, 2017). This indicates a demand for primary and advanced care paramedics, as well as the practice of community paramedicine. The report highlights the importance of emergency care in being delivered by certified paramedics, rather that EMRs, who lack advanced training to support more serious traumas, and sustain patients during longer commutes through rural and remote places to the nearest hospital (MHSAL, 2017) This suggestion supports the utilization of rural EMS service providers within rural EDs, as support to physicians, nurses and staff, and encouraging integrated, team-based service provision.

The report also briefly reviews EMS service needs in Indigenous communities within the province, stating that such a review was important, as authors highlighted that Indigenous people were more likely to utilize EMS and EDs than non-Indigenous people in Manitoba (MHSAL, 2017). Further stating that Indigenous people make up 40 percent of all ED users in the province.

Here the report acknowledges the various inequities in the SDOH that affect this use and health-related behaviours and outcomes. The report also acknowledges that it is limited in examining Indigenous use of EDs and EMS in the province, and the authors recommend a separate collaborative review of Indigenous EMS and ED use, involving community leaders and Elders, Indigenous service providers and practitioners, and Indigenous clients (MHSAL, 2017). In this section of the report the authors describe several SDOH and inequalities experienced by the growing Indigenous population in the province, while describing the jurisdictional confusion over health care and EMS delivery, justifying the increased rates of ED and EMS use among rural, remote and urban Indigenous populations (MHSAL, 2017). The chapter recommends addressing the TRC Calls to Action, as well as the importance of culturally safe emergency and primary care.

The 2017 Wait Times Reduction report also references EMS location and ambulance positioning, stating that EMS stations were previously and traditionally located near to a hospital with an emergency department, however, due to the reality of most rural hospitals and EDs, where they are frequently understaffed, temporarily closed, unable to conduct critical diagnostic processes due to a lack of technology or trained technologists to operate equipment, this positioning model is ineffective (Government of Manitoba, 2017a). Instead, the current trend and priority response research recommends the use of geo-posting, or geographical positioning, wherein ambulance units are placed in a large area of higher call volume, rather than simply nearby to a hospital (MHSAL, 2017a). The report acknowledges some of the limitations to this new model. For example, using geo-posting, ambulances would be sitting idle, waiting for calls to come in, in order to respond immediately, rather than remaining parked and allowing paramedics to perform other auxiliary duties such as administrative, hospital support and triaging, while they are not responding to an emergency call. Geo-posting supports the concept of dynamic deployment, where ambulances are placed in high call-volume areas and remain idle until a call arrives, such that paramedics perform the sole duty of emergency response where they are needed most. The downside to this recommended practice, is that the additional duties, professional development and emergency department assistance that paramedics provide when posted at or near to a hospital are no longer available. Further, this suggestion is also in conflict with the earlier recommendation to involve paramedics in community-based care.

In its final comments on rural emergency departments, the Wait Times Report states that consolidation of rural EDs is not simply about cost-saving or the closure of low-volume hospitals, but rather about a new vision, a set of standards based on population distribution and geography, infrastructure, technology and importantly, health human resources and availability of service providers (MHSAL, 2017). If a rural hospital is going to have an ED, then it must be available to patients when they need it, 24-7, when the right service providers are in the right place to meet emergency needs. Manitoba, and the rest of Canada are facing a shortage of qualified physicians and nurses, set to worsen over the next 20 years, impacting both rural and urban EDs (MHSAL, 2017). As a result, consolidation is taking place across the country to make best use of limited personnel, and provide the best possible care. Consolidation, and the transition of some EDs to urgent care centres, is something that the Wait Times report states must happen in Manitoba, but not arbitrarily, rather through a provincial restructuring, so that rural patients are not further limited in accessing quality emergency care. It is important to note here that this restructuring should be inclusive of input from service providers and communities within rural Manitoba, those communities that would be most affected by a provincial restructuring. These municipalities and people may have the capacity to resist such change, but at any rate represent diverse, heterogenous settings across Manitoba. If restructuring is going to happen, the response must be transparent; affected communities such as Grandview, were not included in this process.

2019 Better Care Closer to Home Documents

In May 2019, Manitoba Shared Health released the Better Care Closer to Home: Planning for the Future of Health Care System document. This report describes the progress Shared Health has made in implementing the government plans and it states,

> "Shared Health is leading the creation of a provincial clinical and preventative service plan that will guide improvements to access, coordination and integration of health services in Manitoba. The plan will cover a five-year timeframe and will be updated annually. It will identify improved, innovative ways of delivering care, clear provider roles and responsibilities and easy to understand pathways for patients to ensure they are able to access appropriate care as close to home as possible, with the certainty that specialized resources are available to them if they are required" (Manitoba Shared Health, 2019a, p. 2).

The document proposes a new model of health service delivery through a network of health hubs in order to meet health needs of Manitobans on local levels, and by providing a continuum of care within the community while patients await specialized services in Winnipeg. The capabilities across hubs are described as standardized within a spectrum from Local Health Hubs which provide low-acuity medicine, primary care and community-based support, through to the singular Provincial Referral Hub in Winnipeg, which provides highly specialized care for high-acuity and high-complexity health needs (Shared Health, 2019a). In between, District Health Hubs provide care for low-moderate acuity conditions, general medicine and surgery and emergency services, and Intermediate Health Hubs are responsible for moderate-acuity and some complex and critical care (Shared Health, 2019a). Health hubs must be flexible to align with population needs and resource competency, so the level of hub within each community or region must reflect its capabilities to deliver care.

In the report, Shared Health iterates the hundreds of stakeholder meetings and interviews undertaken with municipal leaders, physicians and clinical providers, in early spring 2019 to develop the Health Hub model of care, drawing on stakeholder comments that indicated the rising need of Indigenous communities and the increasing variability in rural ED operations, citing 17 long-term suspensions of rural and northern EDs due to lack of staff capacity, and over 3,500 unplanned closure days across hospitals in rural and northern regions (Shared Health, 2019a). In both the long-term and single-day closures, stakeholders stated that emergency and critical care patients had to be diverted to other regional hospitals and care facilities, causing strain on the system (Shared Health, 2019a). This strain is attributed in the report to unnecessary or avoidable ED use. The document further highlights the fact that all government-produced documentation through the development process has clearly identified the focus of the health system changes as an effort to place the patient at the bottom of the inverted pyramid with the government occupying the top and practitioners in the middle, ultimately making health care and health system decisions on a top-down basis, in the interest of the patient. The report outlines Shared Health's focus on "building up care in local communities ensuring access to primary care and community services supported by interdisciplinary teams" (Shared Health, 2019a, p. 4). Stakeholders consistently indicated the need to support the development of a robust and responsive primary health care system, to reduce the number of avoidable ED visits that people make as a response to poor primary care (Shared Health, 2019a). Other key points include the increase in use of technology, communication between health regions, hubs and providers, and health teams. Lastly, the May Better Care document states that Indigenous populations in Manitoba have poor health outcomes in many areas, making equitable access to quality services and the development of strong innovative partnerships a key priority of health system transformation, however the report fails to mention how these partnerships would be actualized.

The June 2019 Better Care document reviews the most recent district health meetings, and summarizes system changes and proposals up to that time. This document identifies the ways in which Shared Health has used all the other recent government-commissioned health system reports to guide the planning, and system changes underway in Manitoba. Most importantly there is an expanded description of the network of care across the province through a health hub delivery model. As described above, District Health Hubs are larger, community-based health care services centres that bridge local, primary- and community-care, with emergency and low to moderate acuity services to provide continuous care, and act as points of reference for patients requiring critical and complex care from Intermediate Health Hubs. This definition describes the health care system and services in place in Grandview, where primary and emergency care are delivered through a compliment of EMS and ED services from the Grandview Hospital, and are available 24/7 through effective planning and staffing. While this Shared Health update does not provide examples of hospitals or care settings that fit within the Health Hub descriptors, it does clearly indicate Winnipeg as the central Hub for specialized and complex referrals and care (Shared Health, 2019b). This model clearly centralizes and prioritizes care delivered within the largest city in the province, where service providers, specialists, diagnostic and clinical services and technologies are concentrated.

The June document also provides an overview of the strategic shifts taking place within the provincial health system as a result of the system transformation. Importantly, the first strategic category is the enhancement of local capacity within the health care system. This strategy states that the province must improve upon existing community services to meet local health needs. Therefore, the strategy then requires consideration of the efficacy of community-based services and care settings such as hospitals across rural Manitoba. The intention to retain and build upon successful community health care services and systems supports the retention and enhancement of those EMS and ED services offered in Grandview and other rural hospitals and care settings that are perceived by administrators, health care providers and community members, as successful in meeting community health care needs. These strategic shifts represent the directions that health system transformation is working towards within the province, and as a result must take into consideration the viewpoints and experiences of rural communities that have the current capacity to meet community needs. If the province continues to move towards a Health Hub model of service delivery, an inventory of health care settings, services and capacities requires the participation and consultation of rural communities.

Critical Discussion

In reviewing these recent and central government documents and reports, it is clear that the province of Manitoba has undertaken extensive research in order to improve the provincial health care system at the local community/municipal, regional and provincial levels. However, it is clear that this planning was largely exclusionary of Indigenous community participation, consultation and review, as well as an on-the-ground analysis of the rural care settings that are cited in these reports as the contributors to expensive, avoidable ED visits. Particular concern for cost-effectiveness and fiscal sustainability was taken in each report, in order to balance the budget and ultimately reduce some of the provincial deficit under the new PC government. While consideration of rural, remote, northern, vulnerable and Indigenous peoples was taken, community-based engagement and consultation was avoided. These reports do not go far enough to address the structural causes of inequalities along the SDOH, which contribute both to avoidable ED use, and ineffective primary care services and delivery in rural, remote and northern areas.

Such significant changes to the health care system will affect all people in Manitoba, and it is clear through these government-commissioned reports that changes to services and service delivery, through EMS, hospitals and EDs, and community health services will take the greatest effect on the peoples and communities that already experience inequalities, barriers and limitations in accessing care. Communities like Grandview, Tootinaowaziibeeng First Nation, Métis residents living in San Clara, and other rural peoples, who are facing changes not only to the provision of EMS services, but also the potential consolidation or closure of the local ED and hospital, are placed in a precarious position. In such a community where residents enjoy accessible primary and emergency care, timely EMS response, and consistent, patient-centred care, the thought of change and reform for the sake of cost-saving and fiscal sustainability as described in campaign promises, is particularly challenging.

Critically, this health system transformation does what so many scholars and health advocates advise against in primary care reform, which is the inevitable inversion of health care, where the most marginalized and in-need peoples are put last in decision-making and kept the furthest from accessing care (Browne et al., 2012; WHO; 2008). By eliminating critical emergency services and threatening the continuity of EDs and rural hospitals, the Manitoba government is ostracizing community health care workers and physicians, making their workplace precarious, and further restricting and eliminating rural and Indigenous peoples from accessing primary and emergency care that they need and rely upon.

In their review of primary health care policy reform in Manitoba under the previous NDP government, from 2011-2015, Kreindler and colleagues (2019) found that many primary care physicians were unsatisfied with the opportunities offered by the government to provide feedback and consideration, and questioned how meaningful their interactions were with decision-makers. In 2011, the provincial government promised that every Manitoban would have access to a primary care physician under their “doc for all” plan (Kreindler et al., 2019, p. 533). At the time, the primary care sector in the province was much-neglected, and this steep plan cause considerable pressure on physicians and primary care providers across the province (Kreindler et al., 2019). Certainly, in resource-poor areas, such as the rural, remote and northern regions in the province, this attempt to ensure accessible primary care was perceived as challenging. The study found that in this political cycle, policy- and decision-makers consistently held overreaching visions for system reform that clashed with what physicians considered acceptable and achievable (Kreindler et al., 2019). Further, a reform to primary care would be exceptionally costly, and the doctor-for-all plan would serve as a buffer to expensive, avoidable ED visits, especially in rural and remote regions. The 2013 EMS Review was important in indicating steadily rising costs of the fragmented EMS system, which could be reduced by improving access to primary care across the province.

As found in a Hutchison and colleagues’ 2011 review of primary care reform across Canada, Manitoba’s recent transformation has continued to rank the following characteristics as low priority: action on health equity, improved experiences of health providers and patients, community participation in decision-making, responsiveness to community needs and local capacity-building. In contrast, the province instead narrowly focuses on cost-savings, sustainability and accountability. This continued avoidance of community engagement and value for the expertise and experiences of both patients and providers in active rural hospitals and health care settings contributes to the persistent legacy of exclusion of marginalized peoples in Canadian health policy.

Settler Colonial Continuity in Policy

In applying a critical SCT lens to the findings of this document review, it is clear that settler colonial tendencies are rife within provincial health policy in Canada. Particularly among those provinces and territories that do not operate with any form of Indigenous health strategy, or such program that is led by Indigenous peoples and communities themselves. As Macoun and Strakosch (2013) maintain, settler colonialism is often present in both conservative and progressive state structures and policy, seeking to eliminate colonial conflict by reducing the political independence of Indigenous peoples and communities. This act is completed in various forms, through both political exclusion and inclusion (Macoun & Strakosch, 2013). These acts are strategic, and can be disguised in many ways. In the case presented here, provincial health policy and transformation in Manitoba provides broad social facts regarding the inclusion and importance of Indigenous health in addressing and improving provincial health status. However, as I find in my analysis, and through community-engaged work, this ‘social fact’ as presented in the language of policy was never acted upon through the deliberate and evidenced consultation or inclusion of Indigenous peoples and communities across Manitoba. In this way, I find the actions, or rather the inaction, of the state to maintain settler colonial continuity, through the very visible discourse of inclusion in policy, to the failure to recognize and include Indigenous peoples in decision-making. This is characteristic of the settler colonial state.

Macoun and Strakosch (2013) reflect on contemporary Australian policy structures and persistent settler colonialism on Aboriginal communities in Australia. These government strategies seek to eliminate and contain Indigenous calls for self-determination and strive to solidify settler sovereignty (Macoun & Strakosch, 2013). Here, through a critical policy analysis, and the necessary inclusion of community voices that follows this chapter, it is evident that the provincial government maintains the notion that the state knows best, for both rural people, and Indigenous communities alike. The application of SCT demonstrates, as Macoun and Strakosch (2013) find in the Australian context, that so-called progressive settler actions and policies further colonial pursuits just as effectively as conservative ones. While it may be assumed that deliberately exclusionary settler policies are more colonizing and problematic, Macoun and Strakosch (2013) caution that policies that appear inclusionary are often just as colonizing, and strive towards the same goal, to ensure settler control.

Under the new PC government in 2017, Manitoba initiated health system transformation in such a way that optically presented a progressive and sustainable step forward for the province. This was particularly important to the new government, to uphold campaign promises to reduce provincial deficit, reign in spending, and reach fiscal sustainability in a health care system that accounted for 45 percent of total provincial spending at the time (KPMG, 2017). Utilizing SCT, and engaging with marginalized communities, the actions involved in this transformation are indicative of previous settler colonial values. Actions taken to erase settler colonialism, or bury or disguise it serve only to assist the settler colonial pursuit ongoing in contemporary Canadian politics, and those of other settler states. What is apparent in the case presented here is that the provincial government has utilized conflicting discourses and strategies in the assertion of control. The process of health system centralization, paired with directives towards community-based care and health care close to home are objectively conflicting. In the case of Indigenous health, as many critical Indigenous scholars have indicated, the move towards community-based care or control can be seen as a settler colonial state attempt to transfer responsibility to Indigenous communities for their outcomes, or failures (Waldram et al., 2006; Gabel et al., 2017). In the case of Manitoba, jurisdictional issues over responsibility for Indigenous health care, while mentioned, was never resolved. Policies of recognition often include reference to the need to establish partnerships between the state and Indigenous peoples, but they are never reconciliatory if there is no action to address Indigenous self-determination and control. The Manitoba health system transformation is another opportunity for the state to control when, where, how and who has access to health care.

Further, in their SCT-guided analysis of the Northern Territory intervention in Australia, Macoun and Strakosch (2013) describe how the Australian state undertook the task of naturalizing domination over Aboriginal people through presenting its role as governing for both non-Indigenous and Aboriginal peoples. Naturalizing neutrality is among the central goals of the settler colonial pursuit, done so in contemporary governance and politics through self-designating state authority over all citizens (Macoun & Strakosch, 2013). I identify parallels here between the Australian case, and that in Manitoba, where the provincial government, and the reports that system reform are based upon, fail to address, consider or contextualize the state of rural and Indigenous health as the outcome or fallout of hundreds of years of assimilationist policy, exclusionary policy and erasure. In initiating a health system transformation that relies on settler colonial perspectives, methodologies and processes, the state creates a system that results in inequitable outcomes and fails in addressing the root and structural causes of inequality.

Noting the highlights and strategic directions of Manitoba’s health system transformation and the perspectives of community members, Grandview’s community health care system operates successfully, utilizing local capacity to deliver the suite of services including a 24/7 ED, EMS services, community paramedicine, primary care, home care and long-term care; all of those responsibilities expected of District Health Hub as described in the Better Care Close to Home documents. In the following chapter I provide an analysis of the key themes and findings resulting from community interviews in Grandview, Tootinaowaziibeeng First Nation, and Métis residents in San Clara, where EMS services are to be eliminated, and the local hospital and ED are at risk of closure or consolidation in the wake of the health care system reform based on the reports reviewed above.

Chapter Seven: Community Findings and Discussion

In this chapter I share the results of the community-engaged study, elaborating on key findings and themes emerging from semi-structured interviews with community members and health services providers in Grandview, the surrounding rural areas, and Tootinaowaziibeeng First Nation. This chapter seeks to answer the following questions, which are central to this research:

- What does 'health' mean to rural peoples in Canada? What are the determinants of rural health in Canada?
- What are the experiences of clients and service providers through health care transformation? What are the barriers and strengths of health care services in the community and province?

This chapter combines a traditional results section with a critical discussion to align these findings with the literature. Throughout the chapter, I reflect on the state of health care services that were available in Grandview at the time, sharing community experiences and interpretation of health care services and their meaning and place within the community. The narratives of the community demonstrate that the current level of health care service is crucial to the way of life and wellbeing that residents enjoy in Grandview. These sentiments contributed to the generation of themes through grounded theory analysis. I organize the chapter into themes as they answer and provide response to the research questions. The major arising themes include:

1. Relational health care and community wellbeing
2. Dehumanized decision-making: 'why fix the system if it isn't broken?'
3. 'What we've got is good': Impacts to Indigenous health
4. Centralization equals elimination and erasure
5. From vulnerable to empowered: Community resiliency through cohesion and collaboration

Throughout I undertake a critical analysis of community interpretations of health system change and government decision-making and provide participant narrative to give voice to local concerns and hopes. I conclude by detailing the limitations of this study and outlining areas for future research on rural and Indigenous health and policy in Canada.

Theme One: Relational health care and community wellbeing

In response to the first primary research question, community members clearly depicted the image and aspects of health within the community by identifying various SDOH. Most clearly, residents reflected on their health and wellbeing in terms of access to care, health and place, and healthy caring relationships with services providers. Further, community members connect place and their visible rurality to their health and wellbeing. Throughout the research, community members constructed meanings of health through social experiences and interactions with the health care system.

Access to quality care

The importance of access to quality health care services was indicated consistently by participants. While Grandview is a small, rural town, prior to transformation, the community did not experience the same barriers to accessing health care services that the majority of rural and remote towns do across Canada. The Canadian literature provides a glimpse into the inequalities that exist in rural, remote, Northern and Indigenous places across the country in accessing health care (Kulig & Williams, 2012; Browne, 2016). Barriers to accessing care such as geography, distance to the nearest health care centre, burdens associated with travel, limited health human resources, and lack of consistent, reliable services are commonly experienced by rural communities across the prairies and the country, yet these barriers are not experienced by the community of Grandview. With a 24-hour hospital and ED, three physicians who provide emergency coverage on rotation, an on-call EMS service, and reliable service, Grandview is an outlier. As one community leader stated, "... the emergency medical services are available 24/7, which is somehow unique for a small community, but when you look at it on a geographical basis, it serves a fairly good-sized area" (CL1).

Perhaps the most compelling evidence supporting access to local emergency and primary care, are the many stories, experiences and examples shared by participants about their personal interactions with emergency health care services in Grandview. For example, one community member explained at length that despite a long-term health condition over the last 30 years, they are otherwise very healthy,

> "Things are currently very good, at the Grandview Clinic where I go. I've been going [to the Grandview clinic] for probably over 20 years. I've had the same doctor in all that time… I do try and take care of myself, but still, it's under the guidance of the doctor… Two years back, I participated in a study… in Boston… the doctor there again commented on… how good I looked, well, my body… fit wise, for [having this condition] for so long. No skin problems or ya know, major bladder problems, that type of thing that people are prone to... So yeah, I guess that's just a testament to the care I've received at Grandview Clinic" (CM1).

Many participants attributed their health and life, or those of a family member or friend, to the swift response of Grandview EMS, or the fast action of community physicians in the hospital and one community member stated, "just the care with our doctors and having that emergency services here is just so vital to our people and their survival, as well as my children" (CM11). One participant, who lives over an hour away from Grandview, described her experience of a serious health emergency in which she avoided her local hospital in order to access emergency care in Grandview:

> "I just recently experienced… a minor heart attack, and um, not realizing that's what was happening, my husband drove me from our home, and I remember driving past Roblin and him saying 'do you want to [stop here at the Roblin hospital]?' and I said 'no, continue on.' And um, when I got to Grandview, it was around six in the morning I believe, and… there was nurses there, and then um, like she knew exactly what was going on, and the next thing I knew, there was like three doctors in the room… who sort of knew immediately what to do to ensure I would not receive more damage to my heart… I find that I'm just so quite fortunate that this place is [here], even though it's an hour away, I mean, I still know that if I didn't get there in time, even if I would have

> stopped in Roblin, um, by the time the ambulance got me to [the specialized urban hospital] I mean, there could have been more damage done to my heart. So, I feel um, that Grandview hospital, they have that to offer people… it's just that...whole atmosphere in there, and um, and of course also the fact that there's three doctors there. You know that there's going to be a doctor there. Where you know, at say like, a closer hospital which is Roblin, you never know if there's going to be a doctor around... and I don't mean to compare one to the other; however, the fact is that ya know, if there's going to be a review on, ya know, where the centre should be, I mean, the fact...ya know, it should go where there's physicians, and it should go where they stay. Ya know, it's almost like the government is almost making decisions based on locale, ya know, and that's not always how it works in rural areas. And it's really... I don't mean to go on and on about that, but that's the situation recently." (CM2).

Now, in light of the government decision to eliminate EMS services, community members are concerned that should they require emergency response, they will be taken to a different hospital, where they may experience care of a lesser quality. Community members have understandably come to rely upon these services, and the people providing them, not only in a professional way, but on a personal and relational level as well.

The rural caring relationship

Community members in Grandview attribute both their personal sense of wellbeing and their concept of community to the presence of a strong, supportive and effective local health care system. Community members described their own personal health achievements as resulting directly from access to the services that they received from within the local health care setting, as one participant stated, "…health care here is good, very good. I've had the same doctor here for 20 years and [over that time] people start to notice how well I'm doin.' I owe that to the care [here]" (CM2). This narrative was common, often referring back to the quality of the care relationship between community members and their physicians. For many Grandview residents, the personal connection and relationship that they are enabled to maintain with their service providers, including physicians, nurses and paramedics, contributes to their positive experience of local health care, and their good health, even with chronic conditions. For many participants, it is this caring relationship that encourages health-positive and health-seeking behaviours, and provides confidence in seeking care that will be responsive.

A common subtheme that arose within the analysis was the feeling that health care services are better within small community settings, because they are often more personal, and individualized, where patients are able to establish strong relationships with their providers, who are often community members themselves. Both community members and service providers remarked on this, with one service provider, who lives outside of Grandview stating, "it's a small community, so it has better care. Doctors have a closer bond with the people. In Grandview you are not just a number" (SP2). This comment was made repeatedly by both community members and service providers; the feeling that patients are family, rather than a number. A long-time community member who lives with chronic illness compared their experience in Grandview, with hospitals in larger cities, stating,

> "[Grandview hospital staff] do it with a smile on their face and they are just, I think they're all really incredible people, after being in like, city hospitals where you're not a name, you're a number, and the name of the game is to get you the hell out the door. And the name of the game here is to get you well so they can get you out the door and not see you again. So, there's the difference" (CM10)

Another community member reflected in the value of caring relationships with providers,

> "And the other thing that plays into... a small town, is the level of... I guess I wouldn't say care but, concern. Because everybody knows everybody. Ya know, you're almost exclusively dealing with a friend. As opposed to a stranger, someone you've never seen before. When you go to see a doctor... I had some other health issues... where I ended up in the hospital… and again, I was dealing with friends, and people I grew up with and doctors that knew me, that didn't have to look at a chart to get my background. When I walked in the door, they knew exactly who I was, and... ya know, those sorts of things not only save time but they're priceless" (CL1).

This connection with care and a strong caring relationship is important to many residents, especially to those that require additional, or specialized assistance for chronic or complex illness. One health service provider spoke about high-needs clients, who often have difficulty seeking medical assistance due to their conditions, stating that their health is absolutely dependent on their relationship and trust with service providers in Grandview. If they did not have strong, trusting relationship with their doctor, they may not be inclined to seek care or follow care instructions.

The doctor-patient relationship has a significant impact on perceived wellbeing within the community. A long-time community member stated, "…the docs here know your history… you develop a sort of 'comfort zone' and confidence in the care you receive from doctors and nursing staff" (CM6). The sense of confidence and comfort described here indicates that many of the social and interpersonal barriers to accessing health care, experienced within rural communities are not present in Grandview. It is clear through interviews with residents and patients that health care services are inclusive, comfortable and welcoming, as they are caring for their neighbours, friends, family and community. In doing so, rural service providers establish long-term relationships with the people that they serve. One community member noted, "[the doctors] share cell phone numbers with patients and [their] family in crises" (CM3). One service provider explained the value of this relationality in the ED setting,

> "The bigger value in the emerge is the patients know you. So, they're coming in absolute crisis, the worst thing that can happen to them, and they see these faces that they know, and that they trust, so even if the outcome isn't good, there's not the sense that we did something wrong or that we didn't try, they know us, they trust us. So, they know we put in our best effort, they know we have skills and do all the things necessary to keep those skills up, so the trust and the acceptance that the decisions we make are the right decisions and the best decisions. And not just the docs, that goes for the nurses too, that this team was the best thing that could have happened to me tonight. That's priceless. I mean, you can't put a value on that, right?" (SP2)

Within the hospital and clinic setting, another community member remarked, "there is a spirit of cooperation amongst the physicians… [they] take pride in the facility and how well patients are being looked after. When there is a good outcome, [they] celebrate. When there is a bad outcome

[they] grieve" (CM5). This comment supports the concept of patient-centred, relational care that is best practice in health service provision. In this rural community, health care providers maintain meaningful personal and professional connections with their patients and fellow community members, contributing to the sense of wellbeing and good health that Grandview residents experience.

Place and health

Physical place and sense of wellbeing are deeply intertwined within the Grandview community and surrounding areas. Participants often reflected on the idea that the hospital and EMS station are at the literal and figurative centre of community life in Grandview, as one service provider states "our hospital really is the hub of our community" (SP6). Having access to such services makes the town and area a good place to live. Many participants often spoke about how their family, friends or neighbours came to be residents of the town, stating that regular and consistent access to health care services, particularly hospital care and a 24-hour ED, was a major determining factor for their move into the community. This aligns with the literature where rural places become ideal places of retirement and residence due to lower housing costs, but also where health and social services are readily available to support greater needs (DesMeules et al., 2012). Interviews indicated that people with greater medical needs, that wanted to live a rural way of life outside of the city, chose to settle in Grandview because they knew about the excellent care offered there, and the regular EMS and ED services that were available. Here it is evident that the services delivered through Grandview EMS and hospital are part of the foundation for community wellbeing. A service provider described Grandview as "generally healthy, people are able to live independently here into old age" (SP2). For this service provider, access to immediate EMS services is critical to many older adults in Grandview being able to age in place at home, in their community, where many people can live in their homes until they are over 90 years old. Ramsey and Beesley (2007) reflect on rural health care service providers' perception of health, wellbeing and community in southwestern Manitoba, near to where this research is situated, finding that service providers conceive of community health within the SDOH framework, and they used these determinants and concepts to interpret and define rural community health needs effectively. The findings within this research align with those in the literature. Service providers in Grandview conceptualize the health of their rural clients within a SDOH framework, with particular concern for place, relationship, and access to care.

Similarly, many service providers in Grandview are also residents, choosing to practice there because of all of the additional opportunities. As one service provider and Grandview resident stated, "after school I chose to move to Grandview, because access to health care was good, and there is a great recreation program and education system" (SP2). Where many rural communities present barriers to a quality lifestyle for service providers, Grandview is the opposite, serving to attract service providers and their families to settle in the area (Rice & Webster, 2017; Garasia & Dobbs, 2019). One service provider, a new resident described the choice to move and work there,

> "I guess some of the reasons I chose Grandview as my home is because it does have access to health care and good education, as well as a good recreation program that they have within the community. But like I always say, the number one reason why people move to a town is if they have good health care, and if the schools and education systems are good, and that definitely played a factor in my choice of moving here and staying here" (SP4).

In addition to excellent health care services, residents reflected on Grandview as a great place to live in terms of social and recreational opportunities, which contribute to good health. As one community member stated,

> "We have a very active. [community]… for a small town, we have fantastic recreation facilities, and that plays a big role in the health and wellbeing of the community. So, I think our community is in great shape. We're definitely...tending towards the older side, but that's the case in a lot of small towns, rural Manitoba, that's a fact of life. But I think...ya know, you go out in the evening and you gotta be careful driving down the streets because there's people walking every night. We didn't see that 20 years ago, 30 years ago, but we do now. So, I think our community overall is very conscious of what they eat, and very conscious of their exercise, very conscious of all of their health habits, more so than we used to be. So, we're overall, definitely a healthier community than we used to be" (CL1).

Rural health and place are clearly very closely linked for people living in and near to Grandview, where living in a supportive recreational environment contributes to important proximal determinants of health and health-protective behaviours.

Lastly, rurality and sense of community support and social capital were established through the narratives. Small communities look out for one another, and neighbours provide help in times of need, contributing to a greater sense of wellbeing,

> "Small town living is the best life in the world, ya know. Sure, we don't necessarily have access to all the theater, and arts, and sports events that you do in an urban, city life, but we live in a community of [hundreds of] people and I can knock on anybody's door, 24/7 and can get all kinds of support. I've got 800 family members, that all know my name. That doesn't happen in Winnipeg" (CL1).

Integrated care

The final subtheme that addresses the community definitions of health and its determinants is the sense that services in Grandview are supportive and integrated. Within this subtheme, participants expressed the ways in which service provision in Grandview, particularly within the hospital, and between EMS and hospital staff was a prime example of integrated, team-based care, where service providers deliver coordinated care that puts patients and families first. Much of this theme is in relation to the logistical arrangement of health care services in Grandview, where the EMS station and staff are located adjacent to the hospital. With paramedic staff stationed in the hospital setting, complementary services and auxiliary care can be provided to support service providers within the ED, when staff capacity is low and needs are high. Health care providers including doctors and nurses work effectively and collaboratively as a team, however in times of increased need, efficiencies and support are provided by assisting on-call EMS staff. One service provider in the hospital setting describes the many auxiliary roles and supports of the paramedics,

> "…If it's unconscious patient and we're doing chest compressions and managing the airway, they have skills with that, they can do chest compressions, they're good at it. They can do IV axis, they can help us manage an airway, they can bag the patient, they can put IOs in, intraosseous devices, they can help stabilize fractures, they're a set of hands, they know where stuff is in the facility, for example… they can be runners, they can take phone calls, there's so many things that they do, they make notes sometimes, sometimes they're the record-keeper so they have many, many different functions. The paramedics, sometimes they wander down the ward, they say 'good morning, how are you?' And the way patients trust [doctors], they come to trust the paramedics." (SP2).

These supportive relationships and integration between health care providers were mentioned by community members as well. In some instances, participants noted that patients seeking emergency care in the ED would continue to receive care from paramedics after triage. In many cases, paramedics supported triage, patient transfer between wards, patient monitoring and data collection while doctors and nurses responded to other more emergent issues in the ED. A service provider with experience in the Grandview hospital remarked, "the EMS personnel help nurses and doctors, they perform crowd control… They are not just doing their EMS job, or only what's in their job description. They dig in and help" (SP1). This demonstrates the coordination of service provision between providers, where EMS personnel remain with their patient, and continue in assisting with care past the point of triage in the emergency department, and perform services within the hospital beyond and in addition to their regular duties. One service provider noted the many external duties and responsibilities that Grandview EMS personnel attend to, stating,

> "Our EMS personnel are very community-minded. They promote [hospital] services, they raise their own money, and are present at all the community events. I would say they are very high profile in the community… people have a sense of wellbeing when [the paramedics] are visible" (CM3).

Another service provider said of the Grandview paramedics,

> "I've even seen them help with transfers and that within the hospital, because a lot of time, if it's only one nurse there at the time and the other staff are busy somewhere else and you need to transfer somebody, unless you don't value your back, you're not going to do it by yourself, so yeah lots of times I had seen an EMS worker come and help. I think it's just ridiculous them trying to close it, I haven't heard something as ridiculous as that actually" (SP3).

Collaboration and teamwork in an integrated setting is related to the fact that service providers in Grandview are community members themselves, with a vested interest in the health and wellbeing of their community. One community member stated, "EMS staff are residents, they know where every little farm is, but when people are from out of the area, they don't know these things" (CM3). This sentiment expressed the idea that experienced, well-trained and invested paramedical services develop over time, with staff working within the same area and community. This is certainly a strategic advantage of Grandview EMS and hospital staff, who are community members. This belief also contributes to the concern that residents have, that without the EMS station in Grandview, EMS personnel out of another location will not be as efficient or as knowledgeable about the community and their health needs.

Health care integration in Grandview goes beyond the EMS and ED to incorporate home care, mental health, pharmacy care and other forms of auxiliary care. As one service provider described the integrated, working relationships between health service providers in the community,

> "Being a small community, you get to know lots of people who live here so lots of people also who work here... as a [service provider], we are on a first-name basis with the doctors; often if someone needs [care]… it's just a quick call to the clinic and the doctors are there to provide us with that information… so, care is not disrupted in any way. It's

> real proof of how inter-professional communication and working together can really serve the community" (SP4).

Another service provider described the intersectoral working relationships across providers in the various health care settings in Grandview,

> "What we've got in the clinic, at the hospital, in emerge with the paramedics, and even with homecare, like we're all separate, but we're all one. And we all work together, there's none of this, 'I can't do this, I can't do that.' We do what we shouldn't. We've got a beautiful group here and you're not going to get that in a bigger center. You turn into a number. Here we're not a number" (SP7).

Access and use of rural health services is complex, and depends upon how seriously rural patients perceive their need for care (Wong & Regan, 2009). For many with chronic conditions, it is a serious, daily need, and for these patients, and for aging peoples and those involved in hazardous industries, having access to quality emergency care is also critical (Wong & Regan, 2009). As Canadian research has shown, poor primary health care services and limited access to health care in rural settings increases the avoidable hospitalizations, and the need for emergency care services (Wong & Regan, 2009; Martens et al., 2002; Lavoie et al., 2010a). These all represent inequalities in the provision of health care services through a changing system in Manitoba. In their 2009 study of rural health experiences in B.C., Wong and Regan noted the importance of improving access and continuity of health care in rural settings. Further, additional funding and solutions to the existing barriers to care were highlighted as crucial to addressing health disparities (Wong & Regan, 2009). The results presented here demonstrate that rural community members define and describe their health and wellbeing in relation to the services that they access for care. Despite an aging community, with more chronic health issues, participants described their health as generally quite good. In Grandview, health care services are accessible, reliable, personal, integrated and effective. These positive descriptions and experiences of health and health care raise serious questions about the health care system reform process in place in Grandview and the proposal to do away with a well-functioning rural health service and delivery model. While the province contends that this decision will not create any new barriers to accessing regular or emergency care, and will maintain the same level of response that Grandview residents have experienced previously, community members are not so confident.

Theme Two: Dehumanized Decision-Making: Why fix the system if it isn't broken?

The second major theme to arise revealed the community's response and feelings towards health care transformation in Manitoba and locally, within Grandview. As the narrative below demonstrates, the community does not support the proposed changes to health care delivery in Grandview. Many participants expressed the sentiment, 'why fix something if it isn't broken?' With a strong and effective health system in place, community members and service providers are at a loss as to why such services would be changed or removed.

Rural intricacies ignored

Through many interviews it became clear that the community felt as though the rural setting and intricacies of place were disregarded. All of the important aspects of place that make Grandview and the area unique geographically, agriculturally and socially, also create impacts to the delivery of emergency services. Factors such as local and seasonal traffic, and seasonal living and residences were seemingly disregarded. As one community member, a long-standing resident of the town reflected,

> "One of their [government] reasons that they're putting an ambulance garage in Gilbert Plains supposedly, is that you get a faster response to the north of [East Town] up towards the Ethelbert area, uh, however, I don't think anybody's ever been on Highway …North during harvest time, or during seeding time. When guys get on them with their big tractors and combines, there's no way to get around them. So, I think what the government has done, or whoever was in charge of geolocating all these places, they have never took into account ya know, the local traffic patterns or anything. They see a highway and, "oh, well that's shorter to such-and-such a place than Grandview so it'll be

> faster for them to get up there," well they might be sitting behind a combine for half an hour… So ya know, people haven't really researched that part of the problem. Anyways, like, there's a lot of little factors like that, that come into play. And actually… we have a Provincial Park that is just north of us, which falls in our catchment area, and …people that have year-round cottages or even camping in the summer… by moving this EMS garage, the response time to them is going to be over the so-called 30-minute approach the government is taking, so it's like the research really hasn't been done to the extent that it should be." (CM1).

Concern for the ability to access care within a reasonable timeframe was central to community responses. This is not unexpected, as previous research has indicated that even relatively ordinary environmental changes within rural places, such as the daily change in weather conditions and seasons, may come to affect health and health outcomes, as well as inform decisions for patients to access care or not (Pong et al., 2002; CIHI, 2006). For these factors to have been avoided and unconsidered is irresponsible at best, and dangerous at worst. The realities of rural roads and highways through all seasons must be taken into consideration when planning emergency service delivery. The suggestion that EMS services would be eliminated from Grandview, and residents would instead be serviced by EMS out of Gilbert Plains or Roblin was problematic for participants. For some, it could make a difference between life and death. One participant, who lives over an hour outside of Grandview stated, "…time out here is crucial, it's everything. If you have a stroke, and it takes longer for the ambulance to arrive, then get 'ya to the hospital, that could make or break it for you."

Another participant raised concern regarding EMS services attending calls in the Métis community of San Clara (known also as Boggy Creek),

> "…a lot of [the Grandview paramedics] probably frequent the area because of the lakes, and the beaches like that out here, so then they know when you say 'Boggy Creek', they say okay there it is, and that would be it. Where if you had someone from Gilbert Plains or people were hired from ya know, different areas to come in to work that shift, and you said 'Boggy Creek', I mean, I can see them looking at each other...[laughs]...do you know what I'm saying? 'Do you know where is it?' 'I don't know where it is, we better look it

> up’. I could see that sort of...reaction between people that were, say, brought in from [another town or city] to work that shift. I’m using that as an example” (CM2).

Without knowledge of the surrounding areas and community needs, participants felt as though what makes this area unique geographically, was never considered in government planning.

Competing for Resources: Communities at Odds

One of the most important social outcomes of dehumanized decision-making, is the creation of animosity between neighbouring communities over access to resources and health care services. An important arising subtheme was the confusion and opposition to neighbouring communities, with fewer health care services in place, receiving a bolstered EMS services, when Grandview is perceived as an ideal, regionally central location for such services. Discussion arose during interviews about the government decision to close Grandview’s EMS in favour of a new EMS station in Gilbert Plains, 16 kilometers, or a 12-minute drive to the east. In pitting communities against one another, the state is effective in distracting residents from the realities of the cause of these inequalities.

Community members discussed the realities of the regional geography, where Grandview is located equidistant between Roblin, where ED availability has been inconsistent, and Dauphin, the second largest city in the Prairie Mountain Health Region, after Brandon, with a larger and more comprehensive health services centre. Community members stated that geographically, Grandview would be the ideal location to provision EMS for the communities located between Roblin and Dauphin, allowing for optimal service delivery. Further, participants argued that Grandview has a fully-equipped EMS station adjacent to the hospital, staffed to allow for 24-hour emergency coverage alongside the ED. Participants were very strongly opposed to services being moved out of Grandview and into a similar-sized community with fewer existing health services. With Gilbert Plains offering three days per week of physician services in its health centre, and one day of nurse practitioner services, patients are taken into Dauphin to receive hospital services. Participants expressed a clear difference in consistency and continuity of services available to residents in the area.

The shift of EMS location would also result in a change in response time for many residents in Grandview and beyond, though the province contends that the impact to response time would be minimal. In personal communications with community members, the Manitoba department of Health, Seniors and Active Living contended that response times in Grandview will remain within a 12- to 15-minute window from the Gilbert Plains station, and that Roblin and Dauphin ambulances would serve as on-call units for additional calls, should the Gilbert Plains ambulance be in service, with a wait time of 30 minutes out of those locations. As one service provider said, "there is a lot more to be lost than gained in that 10-mile stretch [between Grandview and Gilbert Plains]" (SP2). Further, based on the strong existing care relationships between patients and providers, and the familiarity of Grandview paramedics with the community, participants indicated issues not only with response time, but with new or unfamiliar EMS staff from out of town navigating through a large geographic region,

> "Sometimes ambulances have a hard time finding locations in the rural areas, and... if the paramedic is from the area, they'll generally have an idea where [the address] is or they may know the exact location, just from the person's name. But… I think they're talking about maybe centralizing… or just bringing in ambulances from elsewhere, situating them in the community, and that like, that just doesn't make sense... Well, it may be cost-wise for the government but it doesn't do a thing for the care of the patients... if they have an emergency and have to wait an extra half-hour because they can't find the location properly" (CM1).

Another significant issue with the proposed catchment area of the new station, is that residents of Tootinaowaziibeeng First Nation would now have an even longer wait for EMS response out of Gilbert Plains located 41 kilometers away, over 20 minutes of emergency-speed travel in ideal road and weather conditions. Realistically, travel from Gilbert Plains to

Tootinaowaziibeeng is closer to 40 minutes, at 90 kilometers per hour and therefore at risk of falling outside the maximum response time of under 30 minutes. Participants also expressed the concern that should EMS services be responding to emergencies in the Grandview or Tootinaowaziibeeng area from Roblin, Gilbert Plains, or Dauphin detachments, they are more likely to bypass the Grandview hospital. Even when participants lived closer to towns outside of Grandview, such as Roblin, or Dauphin, they stated that they would rather be taken into Grandview by EMS to receive emergency care there. A participant living remotely stated, "…from my residence it's an hour [to Grandview] … Roblin is actually closer, but… there are a lot of times that the emergency services are closed [in Roblin], so a lot of times, rather than guess, in an emergency situation people tend to go straight to Grandview" (CM4). Another participant, who considers themselves a member of Roblin's community elaborated, "In Roblin the services are, how do I put it… they're doubtful. You never know if there will be physician, will it ever be open? So, my experience is I bypass and will continue to bypass Roblin and go on to Grandview. I've had the same physician for over 15 years, providing excellent service… I feel like I am very fortunate to have had a family doctor for this many years" (CM7). This sentiment supports the findings of government reports, like the 2017 Wait Times Report, where in many rural and remote communities, residents have variable access to but primary and emergency care. However, it is clear from these experiences of people that live well outside of Grandview, that services within the town are reliable and worth hours of travel to receive. If people are choosing to leave their communities, even those that have their own hospital and ED, to receive care in Grandview, it is indicative that the system is effective in meeting community health needs. But one Grandview community member raises an important point, stating,

> "…Gilbert Plains over Grandview, ya know, why is Grandview more important than Gilbert Plains? I've [worked] in both places… Why, if you live in Grandview, deserve

> the ambulance in town, why does Gilbert Plains not? It's a tough argument, I don't know. If they've got a study and a rationale and a survey that says [Gilbert Plains] will offer improved care to more people, who am I to dispute that, I'm not the expert. However, it goes back to the inequalities thing" (CM12).

The notion that health care services in Grandview are meeting community needs only amplifies the animosity and competition between communities in the area over scare health resources. One service provider who lives outside of Grandview, relayed the emotional and turbulent events of a townhall meeting, where the two communities were being pitted against one another in the discussion of closing the EMS station,

> "There was a big town meeting and uh, it ended up coming out that… it was between Gilbert and Grandview [to keep their EMS station], like both towns were at the meeting… And then one lady stood up… she stood up and she was actually crying, she had had an aneurism [previously]… and she said if it wasn't for the Gilbert Plains ambulance coming as fast as they did, she wouldn't be standing there talking. And it ended up that everybody was getting so upset that they had to cut the meeting short" (SP3).

The imminent threat of the loss of services has taken a considerable impact on community members, businesses and service organizations as well. When asked to share what health care services are like in Grandview, one health service provider elaborated on how good the service is in Grandview, but then caught themselves, saying, "…it's stressful now because the future [of health care in Grandview] is in question" (SP2). This sentiment was shared repeatedly by participants, indicating the toll that government decisions have on services, but also on individuals and wellbeing.

Intentional exclusion: Lack of communication and consultation

The community expressed that prior to the government announcement in 2017, they had received no notice of the intended EMS closure. Not even service providers had been consulted. Participants repeatedly expressed that community voices were not valued or heard in the decision-making process, and that vulnerable people and Indigenous communities were not consulted or considered in this process. Community members made it clear that they felt blindsided and excluded from decision-making on their own health and health care services. After vocalizing discontent and confusion in community townhalls, community members felt ignored and, in many ways, silenced by the government regarding the impact the provincial health care transformation would have on their community. This subtheme considers the lack of community consultation that took place in production of government research initiatives and resulted in dehumanized decision-making.

Participants expressed confusion around the proposed closure of the Grandview EMS station. Without knowing all of the reasons for the decision, one service provider remarked, “It’s mind-boggling why they are closing Grandview and building new in Gilbert Plains. It’s like someone threw a dart at a map and said ‘that’s where the ambulance will be’.” For the most part, this confusion is exacerbated by a total lack of communication from government and health system administrators. For example, in 2017, during a series of community meetings regarding the newly announced EMS closures, Grandview residents and members of Tootinaowaziibeeng First Nation voiced their concerns over the time it would take for residents to arrive to a hospital in the case of an emergency (Laychuk, 2017b). As one community member stated to the CBC, “The conservative government made a big deal about being consultative before they got into office… They’ve made some major changes without asking the people who are going to be affected,” (Laychuk, 2017b, p. 1). These sentiments, voiced over two years ago in those early community meetings, were echoed again in interviews with Grandview residents. As one participant stated “The government needs to do the footwork [in the community] before making serious changes.” Another participant called this type of government change, “dehumanized decision-making" referring to the use of statistics and cost-analyses data to inform critical and life-changing decisions regarding the health care system. Another community member stated,

> "[the decisions are] based on a study that was done in 2013, by the previous NDP government. They were defeated and a Conservative Government came in. But, in that study, Grandview wasn't even considered; they weren't even mentioned in the study. That's what seems to be the foolish part about it, and yet, our MLA that came to the town meeting …he said 'oh I believe in my party, I believe in the alignment they're taking, I believe in the report that was written in 2013'. Well the report didn't even mention Grandview so how can you take that into consideration in the first place" (CM5).

One health service provider elaborated,

> "The government was looking at paper and demographics [when they made their decision], not at individual community needs. I mean, we have it all here! …they need to re-evaluate and look at the communities that are being affected. There are always variables [that get missed when relying on statistics]. They need to see the full picture... they did not make an informed decision" (SP2).

Another service provider reflected on the politics involved in decision-making,

> 'But I think a lot of that was putting a pin on a map and not taking a good [look at] the actual qualitative… features of some of the roads… So, I think that was made sort of on twofold, a computer basis without looking at the pragmatic realities of the area, and then secondly with the way that they moved the particular stations to the north of us. So, while it doesn't make a lot of sense to us on paper, and particularly with having [EMS] in the hospital, they said 'oh, brick and mortars don't count,' but I say you've got this overlay of service that when the people are there, when EMS workers are there, it's certainly relieving a bit of the load of the rest of the hospital staff. You move that to an independent location and you lose those value-added services. But if they're just looking at it from… circles on a map then well, for sure, I can see why they did. I'm hoping there's no deeper politics involved" (SP5).

It is ironic that the 2013 EMS System Review upon which the EMS closure was based, states community expectations must be taken into consideration, and that the implementation of the report's recommendations requires the provincial government to work with community leaders and stakeholders (Toews, 2013). The people of Grandview, including community leaders and service providers have not been directly consulted through the process of health care transformation. And to this date, have not been invited to discuss ways to address the potential impacts that service changes will have in their community, despite many requests to local regional and provincial government representatives. As one community member put it, “I would just like them to actually sit down and think this through, like really think it through, and really, really listen to what people are saying, like we’re not saying these things because we want some kind of drama, it’s here, it’s real, ya know like, come and spend some time in the community and actually listen” (CM10). Indeed, there has been a continued lack of communication on the part of the government, even after the community has attempted to engage, contributing to this sense of intentional exclusion and avoidance.

Aging in rural places

Community members also expressed concern that health care system changes were being made without consideration of rural communities, and their largely aging population. The literature notes that rural places across Canada are aging places, with out-migration of middle, working-age adults, and the settlement of older adults following retirement. However, aging within rural places is becoming more difficult, as a result of the inequitable distribution of health resources and other SDOH, and limited supports for families and caregivers. Community members indicated that Grandview and the surrounding region was an ideal place to retire, with affordable housing, active seniors’ programming, appealing recreational activities such as curling and golf. Aging in place, and retirement in later years are supported within the community of Grandview, with the level of health care services available prior to transformation including the EMS and ED. Additionally, Grandview hosts a 40-person personal care and long-term care (LTC) home with access to the hospital, staff and services. This supportive living option makes it possible for people with greater needs to remain in their home or preferred community as they age. As one community member described,

> "We bought our house here in Grandview because we were... thinking about retirement and we were looking for a location and we had a couple of criteria. One was a hospital, obviously, as we're getting older. We need generally better health care services. My wife does have a few health problems… [we] both love the outdoors, and … the Duck Mountains are only a few miles away from here, so they have beautiful lakes and scenery, and I like to golf, so there's one of the best golf courses in all of Manitoba; it's only 12 minutes away from here. So, in Grandview, when a house became available, it had been on the market for a while, and some friends of ours had moved down here, sent us a copy of the local newspaper with the house being advertised in it. My brother at the time was a corporal in the RCMP here, so I came to visit him one time looked at the community, and I had the opportunity to look at the house; it's an older place but it suited our needs, it wasn't that expensive for us to buy" (CM4).

Community members indicated the importance of aging in place, within their own home and community, on their family farm, homestead or property. For many, having access to consistent, reliable primary care and emergency services is crucial to their ability and confidence to age in place. In interviews, residents raised concerns about some of their aging family members, friends and neighbours, describing many of whom as reliant on the services provided by the Grandview hospital. As of the last census in 2016, one third of the population of Grandview was over the age of 65, a community that is aging. Participating community members felt that appropriate health care services for this aging population are required in order for people to continue to age at home. One community member indicated their concern that services would continue to be eliminated in Grandview, putting seniors' health at risk, "I am concerned for seniors in the community, you know, there used to be a mobile clinic… with nurse practitioners and such. That was removed recently, but the seniors loved it." The level of care that was available to residents through the research period, prior to any changes, was meeting the needs of older residents, as another participant, themselves a member of the aging community stated, "Elderly people here are not at risk [at this time] … people retire here knowing they have access to emergency care and acute care." But the threat of lost services, especially in primary and emergency care has left many residents fearful for the continued health of their elderly neighbours, family members and friends that are aging at home, many of whom live alone, or a considerable distance from the town. Additional concern was raised for individuals living with high-risk health needs and complex or chronic illnesses. One health service provider, referring to their clients, stated "I worry for my people…" as a result of the loss of EMS services in town. The failure of the government to account for the rising health needs of older adults within Grandview and the surrounding area has also contributed to the sense of dehumanized decision-making in health system reform.

Dehumanized decisions and (un)accountability

From a structural determinants of health perspective, and SCT approach, it is impossible to separate politics from health. Community members both within the municipal community and neighbouring First Nation expressed this interconnection in various ways, often concluding that government decisions are almost always exclusionary of community input and consultation. Despite efforts to engage with government, community members feel unheard. As one service provider said, "– I honestly feel we're losing battle with the government" (SP5). One Indigenous service provider acknowledged the political motivations of the provincial government, and the RHA, and the impacts on the community. "I think PMH [Prairie Mountain Health authority] is very power hungry. Even if the [provincial] government says 'change', they are always at least three weeks behind" (ISP1).

This research also reflects on lack of government awareness of community functioning on the ground, and the structural nature of decision-making and policy without consequence. Community members were acutely aware of the hierarchy in policy-making, and were reminded of the power struggles and execution of state control. One community member shares,

> "If they don't even know the community or what's in the community, how can they go and publicly state that they're aware of all the pros and cons? … it's nothing but

> laughable. But it's not them making the decisions, right, it's the [next level up] um, lifelong government folks that have no party… they're the ones that are making all these decisions and sending them up the ladder to whoever, like, the Minister says I want this much cut out of the budget, then these guys get their maps out and start cutting. Like ya know, Pallister doesn't even understand the process they went through to make these decisions. Then we had one government person that stood up for us and he lost his position a week later. And he's actually a government person doing something for the people, but because he stood up for them, he lost his position" (CM10).

In her scathing review of health care regionalization in B.C., Soles (2005) writes that important political considerations are made when governments seek to reform and dismantle existing health care systems. Importantly here, she notes that governments frequently turn to independent consultants and external researchers in order to minimize political fallout from extreme health system changes, such as hospital closures and service eliminations (Soles, 2005). Further, she states, "a properly crafted study can easily find statistical evidence supporting the desired outcome" (Soles, 2005, p. 2). This statement foreshadows the sentiments expressed by Grandview community members regarding the steps the provincial government took in determining the processes to create a more sustainable health care system, and deciding which EMS stations to close across Manitoba. One service provider describes their perspectives, stating,

> "… we've also heard down the chain in both the long-term care and the EMS movements, they say these things could be costing tens of millions more, and it was never about saving money, it's about ensuring long-term consistency or whatever the terminology is. And that's what I think is what is making us scratch our heads; if it's not meant to save money, by what means is it sustainable? What else is there to sustainability other than the financing of it? Well and control. And governments will want to control everything, whether they're of any political stripe, but health care is delivered locally, I think that phrase has been thrown around, so as you get these layers of bureaucracy on top of it – I'm not knocking them per say, because you need some level of oversight in provincial policy, but there's been a lot of unintended consequences" (SP5).

Further, it is apparent in Grandview's case, that health service providers including doctors, nurses, lab technicians and EMS personnel were not included in any system decision-making. Fleet, Plant, Ness and Moola (2013) describe their own experience as rural physicians in B.C. where services in their hospitals were eliminated through provincial health system centralization, forcing thousands of their patients and clients to seek care 74 kilometres away in the nearest large municipality. The physicians share their challenging experience advocating at the policy level on behalf of rural clients, and for rural medical practice, noting significant administrative barriers and lack of receptivity among government officials. In describing participation in medical leadership and planning within the province, one Grandview service provider states, "it's hard for us to be a group, to lobby for ourselves, the small town docs, it's also hard for us to stay involved in medical leadership because… if there's two of us and I have to go to a meeting, and [my colleague] gets sick, how do I leave the community and go to a meeting? I can't. I can't abandon my patients" (SP2). This statement speaks to the idea that even if rural service providers were included in decision-making, their position as the only emergency doctor on call, limited capacity or remoteness could prohibit them from attending and participating fully in government stakeholders' meetings and surveys. Even if rural professionals were not strategically avoided in health planning, any ability to participate is limited by their responsibility to their community on-the-ground, suggesting the importance of health system planning and consultation to be community-specific and take place in an accessible setting for stakeholders.

Another consideration is that the process of centralization has largely been approached collectively, without recognition of the differences between communities and health regions. As one community leader so aptly stated,

> "If it's not broke, don't fix it. Don't tear apart something that's serving a need extremely well and doing its job. Look at each situation individually, look at each situation in terms of geography, and how it fits...rather than just making a blanket statement. Because what applies in Southern Manitoba, doesn't necessarily apply in Western Manitoba or

> Northern Manitoba. Because every circumstance is different, and they're taking this 2013 EMS report and their painting every EMS station with the same brush. And it doesn't work that way. So, my suggestion to government is, use some common sense, what works in an ideal world doesn't always work in a realistic world" (CL1).

In addition to the need for community-based decision-making and inclusion and consultation of Indigenous communities, one service provider for Grandview and Tootinaowaziibeeng, called out the lack of accountability in the part of the government,

> "I think [government] didn't come here [to consult], cause they didn't want to answer to them [community], they just wanted to make this decision and be the people to say 'we are saving so much money'… honestly, I think it's because they are cowards, they don't wanna deal with the aspect of consequences for their actions… I think it's more of a power struggle actually, that they can make whatever decisions that they want… it's all political, it's a political game" (ISP1).

In contrast, a community member involved in health care administration shared their perspectives on system change,

> "…does health care have to change? Are the governments right to start changing, and looking for changes? Yes, they are. Are they doing it in a considered manner? I don't know; I don't know what they've really looked at, other than we get the quote about the 2013 study. It's hard to say. Do changes need to happen? I think so, I think change is inevitable. If we want to continue offering high-quality care, we need to change our outlook. Because the current system is unsupportable, I believe. Now, that doesn't mean that we close off the EMS, and close the ER in Grandview. That's not what I'm getting at, I'm getting at the way we do business needs to change some more. I don't think – and I think if we talked practically to most people that worked in health care, they'd agree with that, but I'm talking about pragmatic changes for the benefit of the community. I'm not talking about: 'close that down, close that down, save this community', ya know? Because I don't necessarily believe in that model either" (CM12).

Taken together, community members feel as though the social, structural and personal aspects of health have been largely ignored or avoided by the government. Many people felt as though Grandview, with its effective primary and emergency health care services, does not fit within the province's definition of an unreliable rural health setting, but instead of bolstering services in a successful care setting, the province elected to move ahead with a predetermined plan to eliminate EMS services there, failing to consider the human outcomes. To put it in the words of a community member, “we [Grandview] are very in-demand… Listen to people even those you have your plan in place; there are other ideas and other options and closing Grandview shouldn’t be one of them. We have the hospital, we have the doctors, we have the community support, we have everything” (CM9).

Theme Three: ‘What we’ve got is good’: Indigenous Health in Rural Places

An important theme that aligns with dehumanized decision-making is government failure to include Indigenous communities, namely the nearest First Nation and Métis communities within the local region in health care changes. Tootinaowaziibeeng First Nation, located at what is known as Valley River Reserve is the nearest First Nation community to Grandview, approximately 25 kilometers west of the town proper, with a travel time of over 13 minutes at highway speeds. Over 600 people call the community on reserve home, while another 600 people reside off reserve. The community has its own health clinic, offering diabetes and foot care, mental health counseling, public health nursing, homecare, medical transportation, and prenatal health, in addition to many other services (Gabel, 2013). In her dissertation research, Gabel (2013) describes the health clinic as the centre of community, as a social hub and meeting place for many, after the community centre was damaged badly in a fire years earlier. My earlier findings in the urban setting at an Aboriginal Health Access Centre in Ontario also reflect this, where health centres become social and cultural spaces for Indigenous clients to connect with one another, as much as the site serves to connect people with conventional and traditional health services (Powell, 2014). In addition to what the clinic provides, funded primarily through federal health transfer funds and programs, the community receives primary care services and emergency response from Grandview.

In addition to the First Nations community in Tootinaowaziibeeng, Grandview Hospital, clinic and services are also utilized by Métis residents living in and around the Métis community San Clara. Also known as Boggy Creek, the community is about 53 minutes of highway driving northwest of Grandview. Located about ten kilometers from the border shared with Saskatchewan, San Clara is actually closer to Roblin, which has its own hospital, with a 37 minutes' drive to Roblin in the south. After Roblin, and Grandview, the next largest service centre is about an hour away (87 kilometers) in Swan River to the north. While always a smaller settlement area, San Clara is nearly abandoned, with a small remaining population of mostly older adults, as most younger generations have moved to larger areas for work or school. This area is an important site of Métis settlement since 1885 following the Red River Resistance (Davey, 2017). As a small community, San Clara does not have its own health centre or clinic, and therefore, residents have relied upon provincial health services offered in larger neighbouring towns, seeking both emergency and primary care in Roblin or Grandview.

Healthy heath care relationships

Importantly, over the last several decades, strong relationships have been developed between Grandview EMS personnel and members of Tootinaowaziibeeng, resulting in twice-per-week physician services on reserve conducted by Grandview physicians at the clinic. As one service provider who works in the clinic on reserve remarked in the working relationship, "It's excellent, like they know us by our names… they respond well, they communicate well, they're very polite and respectful. They're good people to work with. And we need them, we need them for this community" (ISP2).

They went on to elaborate,

> "We work very closely with the doctor(s) in Grandview, so it's so easy to like, make a phone call and say this… client needs this, or needs a prescription for whatever it is…

> and it’s easy. If we don’t have a close working relationship with the doctor in Grandview, like, if that closes then we have to reach out to Dauphin or Russell even, and then that’s going to be a big problem for our department and our community members that need our help t advocate for them” (ISP2).

Lines of communication between service providers on reserve and staff in Grandview are critical to ensuring that community and client health needs are being met. One service provider described the ease in her professional relationship with colleagues in Grandview,

> “All the [community] has to do is call me and I advocate for them, or, ‘cause I see them on a regular basis, I do a lot of home visits, and I know sometimes they need supplies before they even ask for it because I am the one doing their health assessments. So then I contact the doctor and [they’re] like, the doctor is so good and will take my phone calls… like it’s so good right now the way things are going, that if they close [Grandview] it’s gonna cause a lot of health concerns to the community members here in Tootinaowaziibeeng” (ISP2).

The service provider went on to describe the critical support that the community receives from the physicians and staff in Grandview in advocating for access to mental health services for community members in need, elaborating,

> “You know, it takes months to get in [to Winnipeg] to see the psychiatrist… but with our good working relationship with the Grandview doctors, they can get us there the next day. Like, because mental health is an emergency as well, we can’t forget that. We have that connection through Grandview to the psychiatrist… ‘Cause if you’re not getting them in [for care] than you’re just setting them up to fail” (ISP2).

The EMS staff and paramedics out of Grandview have become familiar with the community of Tootinaowaziibeeng, as one participant who works as a service provider in the area stated,

> “I recently took part in an EMS tour of Tootinaowaziibeeng, from the back of an ambulance. I was comforted by the expertise with which the paramedics negotiated the roads. Most roads [on the reserve] are unmarked. The houses are unnumbered, and yet the crew had no trouble pointing out ‘so-and-so’s’ houses. This comes after years of driving on the reserve” (SP2).

The relationship between Tootinaowaziibeeng patients and Grandview physicians and service providers is crucial to the delivery of care, both on reserve, and in emergency settings.

Grandview physicians provide weekly medical clinics on the reserve, reaching people who otherwise would not have regular access to such service, and providing a consistent continuum of care, as well as having staff working in Grandview's hospital from Tootinaowaziibeeng, allowing for a community care connection. Grandview physicians work effectively to advocate for Indigenous clients, as one service provider from the clinic in Tootinaowaziibeeng describes,

> "[Health care] is easily accessible to the community members. For an appointment it might take one or two days, but if they're in a health crisis, an emergency crisis… like, [Grandview services] are right there, 15 minutes away where they can be seen by an emergency doctor right away, ASAP. And then [they] advocate to Brandon, to Winnipeg, [they'll] get in touch with the specialist when [they] see like the urgency. Like one of our clients suddenly got cancer [diagnosis] and [they] pushed that date sooner to be seen by the specialist, like [they] are amazing. She pushes to get the community members seen [by] the Winnipeg or the Brandon doctors. 'Cause they'll say 'okay, I'll see you in a month', well a month is too long. So [they] advocate for this community" (ISP2).

These connections and relationships have helped to establish a critical level of rapport and trust between Grandview providers and patients from Tootinaowaziibeeng. It is clear that service providers in Grandview have a strong relationship with the Tootinaowaziibeeng community, and consider the services provided in Grandview as central to the health of many people on reserve.

Breaking and making barriers to care

Of particular concern in the provision of health care services in Canada, and in Manitoba where the Indigenous population is the greatest per capita, is addressing the specific needs of the Indigenous population, whether rural, remote, reserve or urban. First Nations peoples living on reserve receive many health care services through the Federal government, however, many additional services and specialty programs are provisioned through the province. When it comes to EMS response and accessing emergency care, Indigenous peoples living on reserve often rely on emergency response from the nearest rural town. One resident of Tootinaowaziibeeng and a health service provider described rural health care as it relates to First Nations peoples,

> "Timing is everything, in the cities there's an EMS every… few blocks… when you're in a crisis, time is everything, that's the bottom line… in the city I can guarantee you, you can wait for five hours and then see the doctor for two minutes and then you're done. Um, in the rural setting, the doctor who knows you or knows your family will definitely take the time to actual figure out what is wrong with you. There's more of um, interaction… one-one-one, they care about you aspect… In all honesty, I think is just rural people are nicer [laughs]. City people are… privileged and the rural people are not" (ISP1).

This narrative highlights the importance of breaking down barriers to accessing primary care among Indigenous peoples. As one Indigenous service provider stated, "working in the [health care system], I see the important things that you need in health care, like providing… your Manitoba health card is the best thing in the world, not just your Treaty card. It sounds corny, but that's reality." (ISP1). Unfortunately, primary health care programs and services offered to the Métis community of San Clara within the community has ceased in recent years, leading community members to have to travel out to receive care. For older adults in the community this is especially difficult, as one community member reflects,

> "There's definitely a concern about [health inequalities]. Uh, there's a lot of uh, aging...ya know, senior citizens in the area also, and... Actually, they had a mobile clinic that was coming to the area here in the last few years where they had nurse practitioners on them and it seemed to be well accepted, there was a lot of people going to it, but they just recently removed those also, or they moved them elsewhere, I'm not sure where but, they don't come here anymore. And um, people seemed to like it. My mother used to go to it all the time, and um, she's a senior citizen and it saved her from ya know, going into the clinic [in Roblin]. It was just a few miles down the road where they'd set up, in the village in San Clara, they'd set up there for the day; there's nurse practitioners on there, and ya know…so yeah, and they just basically cut it for some....like, well basically after the change in government...you know how that works." (CM1)

Without access to care right within the village of San Clara-Boggy Creek, community members must travel into the nearest town. Long-term and primary health care experiences in this rural health setting have contributed to poor health outcomes, for example due to racialized experiences, and a lack of culturally safe care for Métis peoples, especially older adults in long-term care. As one community member recalls the experience of their aging parents in the long-term care home in Roblin,

> "…I was also concerned with the lack of cultural and familiar activities available to our elders. For example, they loved to be entertained by the community musicians who would try to play for them on a regular weekly basis. Yet, there was very little in the way of program enrichment services for them as individuals or groups provided by the facility… these were active people with outside interests and I can't recall one time where they were taken outdoors for a car ride, to a farm or just appreciate the fresh air. It seemed from my perspective that [care staff] were coming into do their jobs but were not looking for innovative ways to engage this unique group with cultural ties to their community and each other" (CM13)

In addition to a lack of culturally engaging and specific programming and care for Métis residents in the home, this community member reflected on the neglectful treatment of their father, a Métis resident with Alzheimer's who ultimately passed away after an injury suffered while in the facility. Despite the family's wish to raise issue and complaint within the health system, they felt constrained to do so because the long-term care home was the only such facility in the area, and older relatives feared they too would one day age within the space.

> "These complaints unfortunately did not move forward because my mom recognized that she would also be there soon and didn't want me to 'ruffle to many feathers' because she also would need to rely on their care… In other words, because they were the only facility in town they controlled how people responded to their care or lack of care or availability and simply had to 'suck' it up. Yet, people are appreciative that they have access to this facility because there is no other place available for them to go that is within driving distance to their community" (CM13).

As a result of the withdrawal of the mobile clinic in San Clara, and likely due to negative experiences in nearby towns, many community members choose to seek care from further away, within Grandview, as it is deemed more reliable and personable. The concerns raised by members of the Métis community about access to primary care were raised by service providers in Tootinaowaziibeeng as well. Unfortunately, for people living in San Clara, the mobile primary care service had already been eliminated. One service provider in Tootinaowaziibeeng reflected on what would occur if the same would happen on reserve,

> "If we didn't have Grandview doctors coming into reserve twice a week, we would be in trouble. Without the EMS, we could survive, but you're always going to have that aspect of people going to the ER all the time… I can just see a ripple effect in every area [if EMS closes], we're [the health system] going to get overrun somewhere" (ISP1).

As the literature establishes, access to emergency care is critical to the health and health outcomes of Indigenous peoples (Martens et al., 2002). The provincial ambulance data demonstrates that Grandview's EMS services the majority of emergency calls in Tootinaowaziibeeng, which has allowed Grandview paramedics to establish familiarity with the site, but also rapport and relationship (MTCS, 2013). If EMS services were no longer offered out of Grandview, the question of who would respond, and how fast would the response be to Tootinaowaziibeeng, and other Indigenous peoples. Community service providers who work in Tootinaowaziibeeng indicated concern with pending EMS service changes, with the reliance on EMS response out of Roblin, Gilbert Plains and Dauphin, where travel times and distances lead to response times far over the maximum benchmark in response time. To access Tootinaowaziibeeng, both Gilbert Plains, located 41 kilometers east, and Roblin, located 32 kilometers west, have travel times of over 15 minutes to reach the boundaries of the reserve community. As one Grandview service provider stated,

> "In emergency medicine, the 'golden hour' refers to a time period lasting one hour or less following traumatic injury sustained [through] a casualty or medical emergency, during which there is the highest likelihood that prompt medical treatment will prevent death. Tootinaowaziibeeng patients will not receive care in the golden hour if Roblin [EMS] is dispatched" (SP2).

Furthermore, these times assume consistent speed, visibility, weather and road conditions, which cannot be guaranteed. Community service providers stated that homes on the reserve are spread out and remote, presenting difficulty to visitors in negotiating the area.

Considering that many residences are difficult to locate, wait time is further increased to allow EMS to locate and arrive to the call location. EMS personnel that are unfamiliar with the reserve, community history, and geography may face difficulty in locating the call. These concerns were raised by many participants in addition to community service providers in Tootinaowaziibeeng.

> "The ambulance comes from Gilbert Plains, it takes close to an hour for them to respond to us. We just had one [emergency] about a month ago. We had to call the ambulance and it took that long… [staff in the clinic] were about 10 minutes away, so we went to the home… but we couldn't revive them. And, you know, that takes a toll on us [staff] as well… if the ambulance was [from Grandview] we would have gotten them 20, 30 minutes before, but now it's 45, an hour, to response time… if they close Grandview that's gonna be a major loss to the people of Tootinaowaziibeeng" (ISP2).

Trust and relationship are critical in emergency care, as with primary care. Grandview paramedics, who respond most often to calls in Tootinaowaziibeeng are familiar with the people and places on reserve. A service provider from Grandview stated,

> "If Grandview loses its ambulance station, Roblin will be dispatched to Tootinaowaziibeeng… I believe the Roblin crew will take longer to reach patients… they will take patients to Roblin or Dauphin [hospitals]. I believe they will not bring patients to Grandview… I don't believe there is the same trust between Roblin and Tootinaowaziibeeng residents. Roblin has had numerous physicians in the [past] 20 years… with no physician stability or leadership. The same is apparent in their difficulties in staffing their EMS station" (SP1).

For many Indigenous people living in Canada, fear of discrimination and lack of care or respect from service providers is a reality that prevents people from accessing health care services in the first place (Browne, 2016; Williams & Kulig, 2012; Allan & Smylie, 2014). To change the way residents of Tootinaowaziibeeng experience and access emergency medical services without consultation and response from the community is problematic, and may serve to create or compound barriers that exist in accessing health care when it is needed the most. For example, one service provider in Tootinaowaziibeeng stated, "If [Tootinaowaziibeeng clients] are gonna have to go out of town, you know, no one is gonna know them there. The Grandview doctors, they know them, know their history, they might know them personally… but it's not gonna be a good situation" (ISP2). Another service provider and community member reflected on how the community might respond to having seek primary care further away, in a larger town or city,

> "When it comes to reserve people, either they will adapt or they'll just say, 'this is it, this is my life and I'm going do it my way.' And they won't get the proper care, like, they'll just stop going [to primary care]. Like, 'if I have asthma, oh well, if I die, I die.'…very few of them will move away for better health care… On the reserve, it's all about availability… my people are so impatient, they want [care] then and there, and so if they cannot get it right away, they just won't get it, it's just the way they are" (ISP1).

Within this vein, many participants brought up the fact that without reasonable access to quality health care, residents may elect to take their health into their own hands, by either doing something unsafe to help themselves, or by not doing anything at all. For example, one participant simply stated, "people may come to avoid seeking help, seeking services, if they feel they cannot access them." In other words, as a result of EMS withdrawal from Grandview, or if the ED in Grandview is consolidated, rural residents may not choose to dial 9-1-1 in an emergency, or even take themselves into the hospital when it is reasonably needed, as they perceive that the level of care and compassion they would receive would not be the same as in Grandview. As one service provider in the First Nation describes,

> "I know Dauphin is so busy, we're not going to be able to get anyone in [for care] or to come here. And community members, I don't know if they'll want to go that far. Well, they'll have no choice but, you know, they're going to delay appointments, they're gonna delay being seen by a doctor, and it will create a rise in maybe, further hospital stays because of their illness getting worst, because they don't want to go in to Dauphin, there'll be more emergency visits. It'll cause, probably, cost the health care more money by closing this facility and this small community to rely on Dauphin. Like I think it's gonna cost more for the province to close down this smaller facility just to give Dauphin more [clients]. I don't think there's gonna be a good balance. If they're planning on saving money then I don't think they're going to be able to, 'cause there'll be more emergency visits, hospital visits, than doctor appointments. I know some of my clients will not want to go. They're older, they're used to their own way, you know, they're used

> to driving 20 minutes to see the doctor [in Grandview] and the wait time is not that bad, and then you go to Dauphin and they're so busy there you can't even get in" (ISP2).

Most participants felt that because these facts were not taken into consideration when the government announce the elimination of Grandview's EMS services, that Tootinaowaziibeeng, San Clara, and perhaps other First Nations and Indigenous communities across the province, were not appropriately considered or consulted as to their needs and the impacts that proposed changes would bring to their community. As one participant stated, "there are over 600 First Nations living [in Tootinaowaziibeeng], and they are put at risk if [the ambulance] is not able to arrive from Roblin within 30 minutes… clearly with the government, Toot[inaowaziibeeng] was overlooked." In many ways, community members expressed this as a significant concern. When reflecting on consultation, service providers reflected that even if Indigenous communities, like Tootinaowaziibeeng, had been included, there was likely little that the community could do or say to stop the impended changes. As one service provider and reserve community member stated,

> "I don't think they did consult us, I think we were informed, but we were not consulted about it, that's for sure. It's just like one day, the government just decided, well, we are going to do this and cut budgets. It wasn't really a choice, it was them telling you, 'oh, by the way, we're doing this.' Um, and that unfortunately is our government right now… in their minds this is a good option because it's closer to the city in Dauphin… it was a political decision that went well on someone's end and bad on everyone else's" (ISP1).

Another service provider expanded on this,

> "I don't think we could have stopped it anyway… it's probably been planned in a way that we don't know about… I don't want to be negative, but organizations or the government have to make five and 10-year plans, so what is this plan?... So this had to be planned already, and they're gonna go with it no matter how we scream and yell to stop… why couldn't they find dollars from somewhere else instead of cutting ambulance services?... and with our aging society there are more people that depend on it, and there are babies, children… that need those services as well… Send the top people, the senior managers who made these decisions, get them to visit all over and do a mock ambulance run and see how it runs. Cause on paper it sounds all perfect in a perfect world, but go

> into reality and see how these people live and see how sick they are. Cause people aren't all healthy these days, there's stress, and mental health's a big one" (ISP2).

If government planning did not consult with the communities surrounding Grandview, there are many negative implications for the health of people in the Grandview area. This failure to include Indigenous community in planning and consultation also brings participants to question if the same failure to consult may be true for other communities facing the closure of their EMS stations, or EDs. As another participant, with close ties to San Clara stated,

> "People put up with and make do with the best they have, and they rely on each other to help get to appointments... In other words, they still look after each other the best they can and do not rely on government policies and protocols to make their lives any easier. Conversely, the government has done nothing to improve the lives or wellbeing of its citizens in this region in decades if ever" (CM13).

It is unsurprising that many of the participants demonstrated some level of fear or apprehension regarding transfer to or care from an urban hospital. Such fear still resonates with rural and Indigenous peoples stemming from the prolific Brian Sinclair case at the Winnipeg Health Sciences Centre in 2008. The cautionary tale and real-life tragedy presented by MacCallum and Perry (2018) demonstrates why rural communities and Indigenous folks alike have come to abhor the idea of leaving the familiar, safe and secure setting of their community health care system for the modern, institutional, and at times, negligent, racist and traumatizing urban hospital. A service provider differentiates between city and rural health care for Indigenous people, including concern about the willingness for urban physicians to take on new, Indigenous clients, should the health services in Grandview close,

> "They don't like going to Winnipeg at all, unless we could tap into telehealth, that might help… but they like being seen by the doctor, you know, one-on-one, and no they gotta change? And get to know another doctor? And [the doctors] are so fast in Dauphin, like how do you get to know a patient in what, five minutes? That's going to be a negative transition… and how are the doctors in Dauphin going to handle a closure in Grandview? When no doctor in Dauphin is taking new patients" (ISP2).

This narrative makes clear that the intended system changes in Grandview will have rippling effects on Indigenous peoples, particularly First Nations and Métis peoples who receive and rely on primary and emergency health care services out of Grandview. While there are many ways that services and health could be further improved, it is clear through the narratives of service providers that the current system and relationships in place between the communities, health centres, professionals, and clients, is strong and positive. The imposed changes and elimination of EMS, and possibly the ED and hospital will dramatically affect health, access to care and determinants of health among First Nations in Tootinaowaziibeeng and Métis in San Clara.

Theme Four: Centralization and transformation equals elimination and erasure

The suggestion that the centralization of services has only positive effects on rural communities across Manitoba is false. Many studies across rural Canada, particularly within rural and remote Manitoba and Saskatchewan have found that the centralization of health care services put rural residents at a greater disadvantage than urban counterparts, because it leads to the elimination and inaccessibility of services that were previously available and accessible (Moss et al., 2012). This is the case in Grandview, where residents are now feeling pressure to fight for the health care services that have been working effectively to support their community health needs.

Community response to centralization: ‘Taking health into our own hands’

When the closure of Grandview’s EMS station was announced in August 2017, the community immediately felt that this government action would be the first in a series of political actions to eliminate health services completely in Grandview, leading to the ultimate demise of the community itself. They had witnessed it happen to other small towns across the region, and to the north. Several media reports expressed the community’s fears. For example, in 2017, Grandview mayor Lyle Morran commented on the community's confusion at the closure of an EMS station located within an active, 24-hour hospital capable of handling most emergency calls, especially when located almost directly between two larger city centres, Roblin and Dauphin, about 35 minutes away (Laychuk, 2017a). One community leader described the government decision-making based on the goal to create cost saving, stating,

> "They [Manitoba government] have openly stated years ago that they would like to get rid of Grandview Hospital because it's relatively small, and we are located geographically between Dauphin and Roblin, which are larger communities, so their thought process is that if you eliminate Grandview, all the patients go either 30 miles one way or 30 miles the other, and they save some money. That's been their thought process all along" (CL1).

Interestingly, analysis of recent health care system reform in other provinces that chose to further centralize their system, have shown that neither cost efficiencies, nor improved health outcomes have arisen. In a recent analysis of the centralization of all regional health authorities to a singular provincial health organization in Nova Scotia, Fierlbeck (2019) states that intended cost savings have not materialized. Further, health outcomes for Nova Scotians have not improved, wait times have worsened, a primary care shortage persists and the system remains inflexible (Fierlbeck, 2019). Similar to the process undertaken in Manitoba, the Nova Scotia case has also resulted in poor working relationships with health care professionals and organizational bodies, which has contributed to significant issues in access to all forms of care across the province, in both rural and urban settings (Fierlbeck, 2019). This case serves as an example, that centralization does not always result in cost-savings or other economies of scale.

In the narratives shared earlier in this chapter, participants have expressed the sense of community and wellbeing that the Grandview ED and EMS services provide. Community members discuss a growing fear that the move to centralize EMS and other health care services out of rural places, is a precursor to a plan to eliminate many health-related services across rural, remote and Northern reaches of the province. Participants described this as the first move in a chain reaction of elimination. As one health service provider expressed, “I feel there will be a snow-ball effect of service shut-down here…” (SP2). Residents of Grandview and the surrounding area have consistently made known their fear that with a new reliance on EMS services out of Gilbert Plains, or Roblin, that the ED in Grandview hospital will be completely bypassed and avoided for the larger hospital in Dauphin (Laychuk, 2018). This would leave Grandview hospital underutilized, although fully equipped and staffed in order to triage and treat most emergency calls. For service providers, the idea of this bypass led to the notion that the hospital would ultimately become underutilized for acute care, and end up being closed by the government as inefficient. The idea of bypassing Grandview hospital to receive emergency care out of Roblin, or Dauphin was also concerning to many participants, as they have come to expect and rely on the high level of quality integrated care delivered by paramedics, physicians and providers in Grandview.

On the basis of this fear of service elimination in Grandview, participants indicated that due to mistrust of services and lack of relationship with providers in larger hospital and primary care settings, residents may be compelled to take their health into their own hands. In doing so, community members may delay seeking care, or wait to seek care until it was too late and their condition had worsened to the point of needing ED care or admission to the hospital. This behaviour has been described in the literature as rural stoicism in avoiding care as long as possible to avoid burdening the health care system (Gessert et al., 2015). As one participant described,

> “I can see people that are ill say ‘oh, this is okay...this will be alright, I’ll get over it’, ya know, and not going [to seek care], for example, if they have to drive that extra half-hour, ‘oh I’ll wait’, and the next thing is… it’s actually costing the system more money because

> this individual is now in the hospital, ya know, taking time and costing money, as we know, if they had easier access then… all of this would not have happened" (CM2).

Participants described the scenario where instead of calling 9-1-1 to wait for an ambulance coming from Gilbert Plains, Dauphin or Roblin, people may try to drive themselves, their family members, or neighbours to the nearest hospital in an effort to save or make up for lost response time. This perceived change in health behaviour is troubling, and could result in adverse health outcomes for people in critical need of emergency medical services. One participant who lives about 30 minutes outside of Grandview shared an experience where an ambulance was needed to respond to a farming accident, "…in that emergency, without an ambulance, my [family member] would die. If it took over 40-50 minutes, like the ambulance out of Gilbert [Plains], my [family member] would die. If we have to wait that long, we definitely need to consider driving ourselves to the hospital. But I shouldn't have to make that decision to drive" (CM10). This statement indicates that community members, especially those living further away from the town proper, are considering how the change to EMS services is going to affect their family and way of life, and demonstrating their decision-making in time of crisis should they arise.

The notion that rural residents would take their health into their own hands when faced with longer than expected wait times for EMS care aligns with previous findings by Wong and Regan (2009), where, rural residents often described having to make trade-offs between using health care services, and prioritizing their own health and safety. Further, in a study of access to mental health services in rural Manitoba, Dyck and Tiessen (2012) found that residents in both the Interlake Health Authority region, and the Eastman Health Authority region (now merged around Winnipeg Health Authority as of the recent provincial reform), were more likely to delay or refrain from seeking services due to their desire to self-manage, believing their condition is not serious enough for formal care and worrying about the costs of care. Positive health seeking behaviour in these regions was supported where residents were able to call their health care provider directly, indicative of a strong relationship between service provider and client, and being able to access care within their community (Dyck & Tiessen, 2012).

The threat of emergency service closures in Grandview has a significant impact on service providers in the community as well. Many of whom also call Grandview home. Participation in a functional, efficient and supportive hospital and ED, located in a rural setting is considered ideal to service providers who have built, or are developing their careers in this setting, engaging in rural primary care as well as emergency medicine. One long-time rural service provider states, "rural medicine is a mix of exciting things and [the elimination of the rural ED] is the antithesis of that, so I personally am not interested in that" (SP2). Another service provider explains the impact on rural physicians and the ability to retain medical staff should the EMS and ED be centralized,

> "If you start removing things like the ER, that is a huge knock against one of the drawing points for doctors out here, is you're not going to be doing that emergent medicine anymore, so now having a hard-enough time drawing physicians as is, you're now saying, we want people who are only going to be doing chronic care. That is a very small subset of physicians and I think that is going to cause problems that were unexpected… no one tends to think about providers, I'm not saying myself, but for the physicians, you're now changing what their role is in the community, and if it's just not what they look for in medicine, all of a sudden you now have another, bigger problem to deal with" (SP5).

This sentiment echoes fears of the community, who has continued to work hard to recruit physicians and health care providers over many years in order to maintain access to care, and keep their hospital open. Without a complex and interesting work environment, that is truly representative of rural health, many physicians may choose not to settle and work in small communities. Further, the lack of complex work environment, or focus on chronic or palliative care in aging rural communities reduces rural places, and denies their heterogeneity, and wider population needs.

The move to centralize health care services in Manitoba to larger urban centres effectively eliminates the opportunity for physicians, nurses and other health service providers to practice in this environment. As one service provider elaborated,

> "It's just a big spiral effect and I think if those things do not stay in the community, young people aren't going to want to stay here because they won't have access to health care which is part of the Canadian Health care Act – equal access to health care and if you're not getting that in a rural community, then what's the point of staying here… because your quality of life is higher when there's emergent care and primary care and I think that's why lots of young families have chosen to remain in Grandview. So I think if those things close… I think lots of young people won't want to stay in Grandview, and they'll move to other towns or to bigger cities and then small towns as we know it will fade and unfortunately that's bad because places like Grandview have such a high quality of living because... because you know you're going to have good health care and education and you don't have to worry about those so there's less stress kind of...knowing you have those… even if you're not using them, they're there, and you can enjoy your life more, knowing that your health and your education and your safety is taken care of" (SP4).

This narrative, describing how rural places like Grandview will fade away with the elimination of health care services, and other service areas to follow speaks to the idea among community members that this is intentional. Comments like this were common, with frequent reference to the Canada Health Act and the responsibility of the province to ensure equal access to health care across Manitoba. This demonstrates community members reflection on their rights to care and highlights as well the fear that without such access, various inequalities may be furthered or arise.

Erasing Rural and Indigenous Peoples and Places

There is great fear that if hospital and health services are withdrawn from the community, all of the auxiliary services and businesses will go with them. As one service provider stated, "we can adjust, but the fear is that if EMS leaves, the ER will disappear, that means that there will be no more doctors in town. Pharmacists and others depend on the doctors being in the community" (SP1). Within the rural setting, many facets of life are intertwined and interrelated, such that the loss of one service is often to the detriment of others. This is the perceived case in Grandview, where the loss of EMS, leads to elimination of the ED and hospital, then doctors altogether, and ultimately businesses and service providers like pharmacies and home care, will all cease to exist. Effectively contributing to the demise of the small town and its economy. As one service provider elaborated:

> "If the EMS leaves, quality of care will diminish for residents, and folks in [Tootinaowaziibeeng]. If there is no ER, will the hospital stay open? Will the doctors stay? Will other health providers stay? This will have a spiral effect within the community, affecting quality of care, auxiliary care, the care home and primary services. Young people will not want to stay here. Quality of life is improved is emergent care is there in the town. If the community's needs are not met, then small towns will just get smaller, and that small-town quality of life will cease to exist… responsibility will fall to family members and neighbours" (SP2).

In San Clara, concern is raised by community members surrounding issues of transportation, community, caregiving and equitable access to health care, especially for older adults living in the small Métis village.

> "There are no bus services, no home care health services in the village and as far as I know, the Manitoba Métis Federation is not and has not done anything to ameliorate this gap either through transportation or funding initiatives to help this community of historic families maintain a connection to their families as they negotiate these final life stages. Those who will be more seriously impacted by these changes will be those in the lowest economic brackets simply because they cannot afford to pay the expenses of transportation, food and other expenses especially during winter months or other unseasonable conditions. Also, those whose families no longer live in the community to rely on for basic needs and who are otherwise alone will also experience a diminishing quality of life… I firmly believe the inequities in health and wellbeing will worsen as a result of these changes" (CM13).

Across Canada, rural communities are getting smaller, and much-needed resources are receding, becoming what is known as the resource hinterland (Skinner, Hanlon & Halseth, 2012). As services recede, it is more and more common that health care needs are provided by family members and neighbours. While this type of informal care is considered a marker of social capital, it also places additional burden on families, who often have other dependents, or who will have to make the decision to move or travel to access care. A service provider provided their outlook on the situation, should Grandview's EMS and ED be withdrawn,

> "I think if it closed, it would be very devastating to the community because a lot of people would leave the community, and Grandview can't afford that either, Gilbert can't afford that. These are small communities that are trying to stay afloat and not become a dead zone community, or ghost towns, and people that are getting older, like I'm 68 and I've got all these issues, I don't want to live in Dauphin, I want to be where the health care is, the ambulance, emergency, I want to feel comfortable where I am. I feel comfortable now even if I am a few miles from Grandview" (SP3).

Similar studies that qualitatively studied rural residents' responses to community changes in Canada, Sweden and Australia found that rural communities feel as though they are in a "perpetual state of demolition," experiencing more and more the reduction of services including the closure of hospitals and loss of service providers (Peters, 2019, p. 43; Peters et al., 2018). Further, Canadian critics have challenged provincial government moves to centralize or regionalize health care services in ways that are eerily similar, from over a decade ago. In her brief and critical commentary, rural B.C. physician Trina Larsen Soles (2005) describes the perceived insidious goals of the provincial government to eliminate rural hospital services altogether through their regionalization process initiated in 2002. Her words and suggestions are nearly the very same as Grandview residents and service providers, spoken 15 years later in the province of Manitoba. Larsen Soles (2005) charges the B.C. government with the goal of eliminating the voting rural population through the steady removal of health services in rural places. She rationalizes this plan, stating that over 70 percent of the provincial population is urban, rural populations are in decline largely due to out-migration to urban settings, rural people choose to live in such places and as such must accept the risks associated with that choice, and rural health services are expensive for governments to maintain (Soles, 2005). In response to this, provinces like B.C. can strategically eliminate rural health services, settlements, and people, by regionalizing services to larger centres, where rural hospitals and emergency services can be reasonably closed if there are services available within a ‘reasonable’ distance, and where primary care services can be framed as being bolstered to provide improved health care and disease prevention (Soles, 2005). In places where rural hospitals cannot reasonably be closed, Soles (2005) writes that services and service providers can be destabilized through government decision-making and reformed policies, where providers no longer feel supported to work in rural settings, for example through funding cuts, limited training, participation and autonomy. While such processes could potentially establish rural residents as victims of political process and ideology, Soles (2005) writes that governments, such as B.C. construct reform and closures to be to the benefit of rural communities, for example to alleviate the burden that rural communities often face in retaining health care providers. Centralization of services then, allows communities to focus on what they can effectively manage, and no longer have to struggle to maintain inconsistent health services (Soles, 2005). This description out of B.C., from over a decade ago aligns directly with the sentiments and perceptions of Grandview health service users and providers.

In another foreshadowing, Ramsey and Beesely (2007) note that in the provincial context in Manitoba, decisions on system and service delivery are significantly impacted by the dichotomy between urban and rural, where large cities, like Winnipeg, and Brandon in the PMH health region, are so dominant in relation to rural populations, that it is politically sound to centralize services. Following their qualitative study involving two Manitoba communities, one of which, Benito, was located just 133 kilometres to the northwest of Grandview, Ramsey and Beesely (2012) found that residents were fearful of the closure of services such as hospitals, schools and other businesses. Residents expressed that with a lack of services, the community will see a decrease in population, and with that will come the demise and elimination of the community completely (Ramsey & Beesely, 2012). This experience in Benito, only a few years ago, is similar to what Grandview residents are considering now. As one participant, who lives between Benito and Grandview described the impacts of the EMS and ED closure in Grandview,

> "I don't think [our community health needs] would be met...not at all. I think there'd be a great loss and um, that um, ya know, people would uh, I can see people sort of even thinking ya know, well maybe it's time to sell, ya know, they've been in their area for many years and they'll move closer to the city or move closer to Dauphin, or things of that nature, I can see that people would think that way. And why should people have to move from their homes, just to ya know, satisfy the needs of the government to receive health care? We pay our taxes, we pay for health care and um, our health care is one of the true benefits that we have in Canada, and so I mean why should we have to leave...leave our home, our properties, things of that nature, so that we can move closer to satisfy a provincial government?" (CM2).

Critically, health care centralization by the provincial government is seen by many participants to privilege white, settler communities, and contribute to the ongoing racist avoidance of Indigenous peoples in health policy and support settler colonial attempts to erase Indigenous communities. As one service provider states,

> "And the government is saying we're putting the ambulance in Gilbert [Plains] because of Ethelbert, who is a community of white people a little bit north of there, who will get a slower response [if the ambulance were to come from Grandview instead], but what about [the Valley River] community, who needs ambulances way more? …it's no different than saying we are spending billions on … people who are in their last year or two in life, but the kids on the reserve can't get dental care, or you know what I'm saying, or transport to get primary care, like how do you justify that even, ethically and politically, right?" (SP2).

They elaborate further, "but they absolutely ignore Valley River. If they even knew Valley River existed, right, and even an inkling of worrying about them, they wouldn't have done that… Um, pardon my political incorrectness, but they worry about a white, farming, [European] community, that's smaller than Valley River" (SP2). This narrative compares the willingness of the government to create additional inequalities in access to primary and emergency care for First Nations, while ensuring that another, smaller, settler community receives timely emergency care. It further reflects on the inequalities in provincial health care expenditures, where certain programs receive more funding, such as palliative care, while First Nations and Métis children and older adults across Manitoba in 2020 still do not have equitable access to even the most basic health care.

In a poignant summation, one participant with historic familial ties to the Métis community of San Clara described their hopes and concerns for responsive health care policy and inclusion of Métis peoples and leadership in health decision-making.

> "I suspect the government decision to close this region's health spaces are because they can get away with it. There are a small number of votes in the region and it is well known that… much of the political power, populace, and infrastructure stays in southern Manitoba… I would like to see a cooperative, consolidated joint effort between the Métis Nation and the provincial government to take responsibility to address these [health] concerns… It would be much more effective to have more community representation from across the board, including citizens, politicians and health care workers with the financial resources to make real changes. That won't happen because in keeping with the erasure of Métis spaces and the trope of the vanishing Indian, the colonizers and their policy actors would prefer to remove people from these traditional lands and assimilate them into the broader Canadian mosaic where [the government] can control the narrative" (CM13).

Here the idea arises that the removal of essential health care services from rural communities, especially those that nearby Indigenous communities rely upon, will lead to the removal of Métis and First Nations peoples from their traditional lands and territories. This withdrawal of services will effectively force Indigenous peoples to decide to stay and face additional barriers to accessing care, or move into larger towns and cities and lose connection to land, history and family. The community member recognizes these government decisions as deliberate acts of settler colonialism and acts of assimilation, especially of Métis people in Manitoba, who have a rich depth of history across the province from the Red Rover outwards. The traditional lands and historical territories of the Métis however are hotly contested by the government, making the act of health care service elimination another insidious move to erase and eliminate Métis from their lands and traditional homesteads.

Through these narratives from rural residents, settler and Indigenous service providers and community members, this research demonstrates the experience of health system transformation as one of erasure for rural and Indigenous peoples in Manitoba. Interviews became intense and emotional at times where participants reflected on the fate of their communities, not only in terms of health and wellbeing of community members, but also the ability for the communities to exist and survive the transformation. Participants' responses revealed the opinion that the state will always act in its own best interests, to the detriment of those peoples it deems inconvenient, or problematic to the settler colonial pursuit. While health system reform is framed to be beneficial to the large voting population located in urban settings, as a method to reaching fiscal sustainability, it is also packaged and presented to rural peoples as being community-based and patient-centred. In reality, cost savings may never be realized, but small, aging and Indigenous communities located on the fringe of quintessential Canadian society will be addressed, either by amalgamation, or elimination altogether.

Living on the fringe: Marginalization and rurality

While many provincial health systems across Canada are considered decentralized in that they are delivered through a regional network or geographically-based health authorities, the moves of the provincial government to restructure administration of the system through Manitoba Shared Health, with services delivered through five RHAs is an example of centralization wherein the significant delivery changes affect rural, remote and northern communities. Indigenous health scholars have indicated the importance of flexible, decentralized systems that account for and actively engage with communities, especially those Indigenous communities that the system services (Lavoie & Forget, 2008). Scholarly critics of system centralization note that these trends to centralize decision-making and administration out of communities is often done for the sake of "accountability", ultimately resulting in inflexible and exclusionary policies and health systems that deny collaboration with communities (Lavoie & Forget, 2008; Savoie, 1999). The end-result of this political desire for accountability, and often correspondingly, transparency, is a compromise that jeopardizes the health and wellbeing of rural, remote, Indigenous and other vulnerable or marginalized communities that would benefit from participation, or at least consultation, on health systems and services (Lavoie & Forget, 2008).

Several broad definitions exist across health studies and sociological research for marginalization. In her 2008 work, Kathy Charmaz defined marginalization as "boundaries or barriers, distance or separation, and division or difference" (p. 9). Marginalization is social and psychological (individual), but it is also structural, in that marginalized peoples are found in disadvantaged positions within society (Charmaz & Belgrave, 2013). Through this iteration, rurality is taken as a marginalizing factor, a very obvious and easily targeted one, that is clearly felt by the rural and Indigenous peoples included in this research. Charmaz and Belgrave (2013) write that not only do social acts of marginalization lead to individual and collective suffering, but they also lead to the development a certain moral status for those that experience suffering. The findings in this dissertation show that the elimination of services in rural settings serves as a social act of marginalization, acting with settler colonial intentions seen across policies through history, where rural, remote and Indigenous peoples are effectively othered in such a way that allows or justifies the rescinding or changing of services. For example, cost-efficiency and economic sustainability rhetoric used strategically to remap where emergency services are delivered, or where rural and Indigenous peoples must go to receive care. Yet, the literature reviewed for this study, and the narrative delivered in provincial policy documents indicates that rurality and Indigeneity serve as identifying factors that call for specific forms of health care services, to address inequalities and different health needs of these populations as compared to the population at large. This research shows then that these factors are used to simultaneously marginalize rural, remote and Indigenous peoples, justify settler colonial and restrictive health policies, while also indicating the need for specialized and community-based care. The narrative shared by participants of confusion and lack of trust in government consultation processes speaks to this form of active marginalization. For example, one settler community member states, "I don't understand how you can promise better health care for First Nations people and then turn around and take away their ambulance service. Like really?" (CM10).

The settler colonial act of centralization, the elimination of health care services which serve as an important SDOH, and the eventual dismantling of rural communities serves to further marginalize and other Indigenous peoples, and rural communities. However, there is resiliency and dedication amongst the community in and surrounding Grandview, as one community leader stated, "the reason Grandview has survived is because of the community involvement and the dedication of our physicians and the persistence of the community to keep the doors open" (CL1).

Theme Five: From Vulnerable to Empowered: Community resiliency through cohesion and collaboration

After the Manitoba government announced the intended closure of the Grandview EMS station, and plan to consolidate services into a new station shared with eastern neighbour, Gilbert Plains, the community expressed vehement opposition. Nearly one third of the community attended a townhall meeting in August 2017, shortly after the announcement (Laychuk, 2017b). The meeting was arranged by three physicians on staff at Grandview's hospital, as a way to provide more information to their community, while generating a call to action to oppose these government decisions. In the process, a community interest and advocacy group formed to lobby this change. Grandview Health care Solutions was formed by a group of concerned citizens and service providers from Grandview and the surrounding area, to question and petition the Government of Manitoba on its decisions. As a service provider states,

> "I know after the information that this potentially could happen, that our EMS service could close, then a few of the doctors and a few of Grandview Health care Solutions started lobbying the government a little more but already that was closed decision-making, it was more a reaction in why weren't we consulted in the first place about it… and a lot of it just depends on our elected officials that they were trying to defend their decision rather than ask the opinion of health care providers and community members" (SP4).

That petition to urge the government to reconsider its plans to close the EMS station in Grandview ended up generating over 2,660 signatures from supporters, many of whom lived outside of the town with a population just over 1,400 people (Laychuk, 2017b). Rush, Chiasson, Butterfield, Straka and Buckley (2019) write that such community advocacy groups, or citizen-led coalitions (CLCs) are often formed by community volunteers as a form of local capacity development, in response to a social problem, adversity or crisis. They state that these groups are often formed in rural settings in response to major health-related issues such as hospital closures and lack of service providers (Rush et al., 2019). The goals of such groups are often to amplify the voices of the community, and those members who are often marginalized or ignored in the policy process (Craig, Taylor & Parkes, 2004). Community coalition groups are known to be well-versed and have a high level of understanding of rural health needs and determinants, as well as the complexities facing their community (Rush et al., 2019). The Grandview community advocacy group fits within this description, in seeking to vocalize the needs of an aging, agricultural community, as well as represent the efficacy of the current rural health system in meeting those needs and that of neighbouring communities, including First Nations and Métis peoples.

Here in the face of adversity and challenge, the community rallied, and sought to amplify their own voices through a community-engaged research project and evaluation. In early townhall meetings, community leaders partnered with health care providers, vowing to do everything within their power to preserve the level and quality of health care available in the small community. The community advocacy group is an example of community members collaborating early on in the face of crisis with the very health providers whose careers were being threatened. Rush and her colleagues (2019) discuss one important strategy of community coalitions in joining forces with other key stakeholders in the health system, such as service providers and physicians, and municipal leaders. The Grandview group was made up of community members, municipal representatives and service providers, representing a strong collective to advocate for the community in the face of health system transformation. The Canadian literature on rural community coalitions finds that one of the most significant challenges and barriers to recognition for such groups, is health authority and system restructuring and centralization (Rush et al., 2019). This is due to the frequent elimination of services, resources and capacities in rural communities, as well as the lack of response or accountability that health authorities or governments provide in the process (Rush et al., 2019). Despite the difficulties facing them in advocating for their community, Grandview Health care Solutions sought to produce their own research and report to bring to the attention of government and health officials.

Despite the positive advocacy work of such groups, critical scholars highlight the burden that such efforts take upon rural peoples and communities (Rush et al., 2019). Many rural community group members are volunteers, who spend their evenings, weekends and free time focused on solving problems inflicted upon them by a failing health system, or government. Researchers note that resources for entrepreneurship and evidence-based advocacy is often limited in rural settings, where groups are often working to advocate for greater access to resources while struggling without them (Rush et al., 2019). This work of community coalitions to advocate for improve health services and outcomes to reduce inequalities faced in rural settings can be viewed as inequitable in itself. This inequality and burden placed on communities to fight, advocate and work to retain or regain health services is the product of structural determinants of health and settler colonial-neoliberal policy in Canada. The responsibility to improve rural health should not be placed on the shoulders of the community facing such challenges. A service provider outside of the hospital setting explains,

> "We certainly will have to adapt, we've already seen changes in policy in the health care region… and it's a bit of a pain but it just means more work on our part, reconciling things, making sure patients get what they need when they need it. But I can't say how we will adapt, just that we will continue to adapt as best as possible. And that I think that a lot of the other services are fairly steadfast that they are not going to move as long as humanly possible which is nice, but a lot of it is out of our hands" (SP5).

Parallel to this critique, community group collaboration indicates a strong level of community cohesion within Grandview. This cohesion represents strong social capital found within the community, and speaks to the solid relationships built between service providers in the health system, and community members and patients. The motivation and social capital required to effectively advocate is representative of community health, and is a SDOH itself. Through cohesion and partnership, the community was empowered to gather their strength in numbers and mobilize to represent mutual interests, including maintaining the level and quality of care in the community, but also retaining sought-after physicians and paramedics. This collaboration is indicative of a strong, health community rich in social capital. Where conventional power structures and imbalances are often found, community members gather at the same table as service providers and physicians to oppose the state plan to eliminate services and community life. Within this community, such power struggles are suppressed in order to respond to the potential loss of critical health care services. For rural health service providers, coming together with supportive community members to advocate the retention of services is crucial, due to their lack of capacity as over-worked and geographically isolated from other rural service providers with the same views. A Grandview service provider explains their experience at a recent gathering of rural physicians in Manitoba, an occasion that is extremely rare,

> "I was amazed to see how many of us there is… There's a lot of physicians like me who run a place with one or two or three physicians and who [are] good at it and keen and totally into this kind of [rural] medicine. So, it's not that there's just one or two people out there, there's lots of us, and part of the problem is that we're not a speciality, right? They should make rural medicine a speciality, because there are certain skills that we need to have ya know, and so I think that's a part of the issue. We don't have our own chapter at the college, so… we can never mobilize ourselves together, so we don't have a voice. When it comes to government, you can't – because all of the small facilities are so stretched, not all the docs can ever get together, because who's going to stay in the community and do things right? Like, the intensives [care physicians] can have a meeting and almost all of them can be there, you know what I'm saying? Or the surgeons, you leave one or two to take care of call… and they can have a meeting… We [rural physicians] can never get together as a group, like geographically, we can never, ever mobilize ourselves. There is our weakness" (SP2).

However, by joining forces with the local community, rural service providers establish a platform to represent rural health goals, and add their expertise and position of power and privilege to the community-based coalition.

Within interviews with many participants, people imagined what their community would be like if EMS services were withdrawn. Without an EMS, the viability of the ED, and hospital would come into question. For many, the home that they selected to raise families, town where they started businesses, retire and age would be forever changed. The source of health and wellbeing, social activity and community pride would be gone. In a moment where the provincial government is seeking to improve health, wellbeing and access to care across Manitoba, the advocacy group formed to prevent the elimination of these very aspects from Grandview.

In the literature, Ramsey and Beesley (2012) reflect on community innovations, and the sharing of capacity, capital and resources between rural communities facing collective loss of service. Within this case, two neighbouring towns in Manitoba proposed a plan to close their hospitals in order to open a new shared facility within the RHA (Ramsey & Beesely, 2012). While this joint decision may work for those towns involved, a small community to the north voiced its concern that such a move would decrease resident access to emergency and primary care and increase travel time significantly (Ramsey & Beesely, 2012). In closing, they state, “the struggles continue in the Prairies. In responding to restructuring, only one thing seems to be clear: some communities will gain services; others will not” (Ramsey & Beesely, 2012, p. 212). Though this situation was playing out years ago, the sentiments remain the same for rural communities in Manitoba.

In Grandview, service providers and community members are already considering creative innovations to ensure the town is able to maintain the same level of care, even if that means turning to community-led service provision, or the private sector. One service provider shares their vision,

> “I believe [some rural EMS] are privately run, or privately paid… which is commendable, but if it came down to why don’t we just privately fund ours? I think that’s an option the town would be willing to look at. But if it’s being completely decided [by government], I’m much more... open to private provision of services than most...so it’s one where it’s going to be make or break it for a town, I say we pull it up and figure out how to make it work. I don’t like when we are simply told ‘this is how it’s being done and sorry you’re losing that service, and we’ve changed the policy such that you simply cannot provide that service’” (SP5).

Discussion

Research Relationships Between Community and State

Historically problematic relationships between researcher or state and communities have left a noticeable impact on the ways in which marginalized communities engage in research, and policy today. Many parallels can be drawn between the findings of this dissertation and the observations of Indigenous scholars of historical impacts of settler and state research. Historically, Indigenous communities have either been left out of research and inclusion in decision-making altogether, or have had their knowledges, resources and cultures taken (and often distorted) for the sake and benefit of colonial research. The findings of this dissertation demonstrate the impacts again of exclusion from decision-making and health care planning. In this case, communities want to participate and be included, or at the very least, consulted. Health system transformation in Manitoba, as experienced by the communities in this research, failed to do so. This case provides another contemporary example of the impacts of the lack of inclusion, and both the fears and resiliencies that necessarily arise as a result.

Addressing Health Inequalities

My earlier research was focused on addressing inequalities through the provision of integrated health care services in an urban Indigenous health centre, and I find myself here in the realm of health care access years later, a province over, in a rural setting. Similar to that research in 2013 in Ontario, the rural residents and services providers in Grandview and the First Nations community of Tootinaowaziibeeng, have clearly demonstrated that access to effective and timely quality health care is of significant concern. The literature shows that this is the same for rural and Indigenous communities that live rurally and remotely across this country (Adelson, 2005, Reading & Wien, 2009; Kulig & Williams, 2012; Greenwood et al., 2015). Rural places are aging communities, with less healthy populations that often experience higher rates of chronic and complex health issues that require acute care, when compared with urban populations (Moss et al., 2012). When taken together with their physical distance from resource-dense urban settings, rural communities have fewer accessible and specialized health services needed to address the complex care needs of their residents. There are places however, like Grandview, truly rural communities that are very satisfied with the services available to them, and the providers that are delivering care. In Grandview, where over a third of the town is comprised of older adults, many with complex care needs and acute health issues such as stroke, heart attack and kidney disease that rely on EMS and the ED, people feel safe and secure, knowing that health care support and safety net is available (Laychuk, 2017a). This is expressed in the way that community members connected the 24-7 emergency care services in town with their sense of health and wellbeing. The proposal to move the EMS station over 15 minutes east down the highway created concern that timely care would not be maintained for Grandview and surrounding residents. Based on community responses, this change will affect community life in Grandview, and in turn community sense of health and wellbeing. The strong, positive sense of wellbeing in Grandview is supported by access to effective, relational and reliable care, to change this would be to change the experience and expression of health in this community.

Research from over a decade ago in Manitoba identified the need to improve and enhance access to primary health care services for First Nations living on-reserve, including services available locally on-reserve, and more generally within the provincial health system (Lavoie et al., 2010a). The reality that this need persists is concerning. When Lavoie and colleagues (2010a) identified this, not only was the enhancement of primary care services considered a method to reduce avoidable hospitalizations and illness among First Nations it would also allow for cost savings for the province. Within Manitoba, many First Nations communities that do not have health services on reserve, or have limited services within the community, must access primary health care services, including emergency care, from the nearest municipal health centre (Lavoie et al., 2010a; Martens et al., 2002). In the case of Grandview, the nearest Métis and First Nation communities depend on primary health services provided within the nearest municipal centres. For the province of Manitoba to initiate the closure of the nearest EMS station, ultimately affecting the services offered within the adjacent ER and hospital in general, the health and wellbeing of several communities are put at risk. In this particular case, Indigenous communities have worked with local municipal communities to ensure the continuity and accessibility of health care services.

Interestingly, the work of Martens and colleagues (2005; 2007) indicates that both provincial and federal governments failed to bolster or support First Nations health care services on reserve, due to the fact that many of these rural communities are located geographically near to a municipal health care centre or services. What is clear in 2020 is that further cuts to primary and emergency care services in rural communities will have potentially disastrous effects on local First Nations and Métis communities, further marginalizing communities and contributing to ongoing health disparities.

Funding cuts and system changes to EMS delivery in rural settings in Canada serve as stark examples of the impact to health and wellbeing, and mortality of rural communities. Fleet and colleagues (2013) refer to 2001 restructuring of rural health services in British Columbia, referencing the rural region of Nelson, served by the rural Kootenay Lake Hospital where the intensive care unit, general surgery unit and mental health services were closed and laboratory and radiology services were greatly reduced in order to centralize these health services in a larger community over 74 kilometres away. Due to these changes, over 1,500 rural residents required frequent, lengthy travel to reach services, and emergency hospital care outside of their region, leading to worsening health outcomes (Fleet et al., 2013). In 2001-2002, prior to rural health system cuts and changes, residents in the Nelson region ranked fourth out of 47 municipalities in B.C., for the most important hospital health quality indicator "failure to rescue", which describes mortality from complications while hospitalized (Fleet et al., 2013, p. 191). In 2008-2009, following system changes, Nelson ranked last out of B.C. municipalities, reflecting a significant increase in hospital mortality for patients, who had to travel further for emergency care (Fleet et al., 2013).

The research I present here provides a recent account of health system transformation in Manitoba and the impacts that this has had, and threatens to have on Indigenous and rural communities in the province. It echoes findings of studies that both Indigenous and non-Indigenous scholars have found across Canada over the past 25 years. Access to health care services and jurisdictional disputes have long been identified as determinants of health inequalities experienced by Indigenous peoples and rural communities. I argue that this continued lack of coordination, and further, inability and unwillingness of government to consult and actively engage communities on health care decision-making is at best, unacceptable and at worst, negligent. The health care system in Canada, while founded upon principles of equality and accessibility, has a history of policies that lack cohesion, leaving gaps through which racialized, marginalized and vulnerable peoples and communities fall, unaccounted for, unrepresented. Jurisdictional arguments over responsibility have in the past resulted in transformative policies to support Indigenous health and wellbeing first and foremost, such as Jordan's Principle. Unfortunately, however, many of these, including Jordan's Principle, have been administratively dismissed and disregarded by the state, including both the federal government and the provinces which have failed to implement such policies (Blackstock, 2012; Blumenthal & Sinha, 2015; Chambers & Burnett; 2017). With the settler colonial state failing to recognize and undertake its responsibility to Indigenous peoples, health inequalities persist. Chambers and Burnett (2017, p. 114) recount statements made by federal and provincial governments regarding action on Jordan's Principle, relaying that Canadian taxpayers would be "saddled... with a horrendously expensive tab they have no obligation to pay." Statements such as these reflect the pervasive, destructive and very much entrenched ideologies of the settler colonial state, perpetuating a legacy of colonialism by denying the very policies and obligations that were created with Indigenous peoples to counter the harm inflicted by historical racist structures (Chambers & Burnett, 2017). As Mi'kmaq lawyer and scholar Pamela Palmater states so poignantly, "today, Canada may be full of apologies and regrets, but the fact remains that federal laws and policies not only put First Nations in their current state of extreme poverty, but the same laws and policies keep them in this state" (2011, p. 113). It is clear that the policy relationship between the state and Indigenous peoples continues to be fraught with tension and distrust founded on a looming legacy of colonialism. In reviewing the relationships between Indigenous communities and government in the health policy process, Gabel and colleagues (2017) found that community members acutely aware of strain and tension when working with government representatives, and at times expressed anger and frustration when working through health transfer agreements. This tension was found to reverberate through the community as members felt the need to compete for minimal government resources and funding, described by a community consultant as a form of "internal colonialism" (Gabel et al., 2017, p. 54). By delivering minimal resources to Indigenous communities, the government creates precarious situations and restrictive, competitive relationships between communities themselves, as I have presented in this research.

It is in this vein, that I find the both the actions and inactions of the Manitoba government, through health system transformation, creating competition and tension between rural, remote, northern and Indigenous communities across the province. By utilizing old data, making seemingly arbitrary decisions as to who-gets-what, and what-gets-cut, the province creates tensions between communities that face similar struggles, health determinants and inequalities. All of which would be best addressed collectively, concertedly and through legitimate, authentic collaboration and consultation. The communities involved in this research for example have attempted at length to be included or heard by a provincial government that does not acknowledge their capacities and strengths, but rather views rurality and rural health care as an expense.

Despite these challenges and experiences, scholars, lawyers, advocates and communities have continually called on both federal and provincial governments to take action and fulfill their obligations to Indigenous peoples across Canada (Palmater, 2011; Blackstock, 2012; Blumenthal & Sinha, 2015; Chambers & Burnett; 2017). This dissertation serves to echo that call, and I suggest that this can be done through collaboration between communities, at the community-level and in relationship between communities and the provincial government on health care system decision-making. There are notable positive outcomes in the literature, for example, communities that have undertaken control of health services have reported that improvements in community health were due in part to their partnership, or the creation of a new relationship with provincial governments (MacIntosh, 2008). While partnership does not necessarily result in an equitable balance in power, the ability for marginalized and racialized communities to represent themselves, their interests, perspectives and health needs in a policy-making arena provides a platform for positive change and self-determination.

Investments in community-based or community-led primary care, consultation and self-determination have proven to support health, community resiliency and cohesion (Ladner, 2009; Gabel et al., 2017). This dissertation demonstrates the willingness of rural communities to collaborate on health care planning and delivery, and further, it showcases the lengths that communities are willing to go to in order to advocate for the services they need. Partnerships and relationships are strengthened between rural municipal/settler communities and Indigenous communities, such as rural First Nation and Métis communities, in times of adversity and struggle. But through this research and through working with the community advocacy group, I demonstrate that these relationships existed before the government of Manitoba called into question the viability and life expectancy of an existing vibrant, supportive and effective rural health care system.

As the Canadian literature on primary health care demonstrates, equity-driven care has not been the focus of health system change in recent decades (Browne et al., 2012; Wong et al., 2011; Hutchison et al., 2011). Importantly though, scholars identify a number of strategies to guide health policy- and decision-makers towards enhancing capacity in systems for equity-oriented primary health care services, including: Make an explicit commitment to equity; Develop supportive structures, policies, and processes; Revision use of time; Attend to power differentials; Tailor care, programs and services to context; Actively counter oppression; Promote community and patient participatory engagement; Tailor care, programs and services to histories; Enhance access to social determinants of health; Optimize use of place and space (Browne et al., 2012, p.5).

A recent study of Manitoba First Nations' perspectives on primary health care transformation by Kyoon-Achan and colleagues (2019) shares findings similar to what I present here. Through 183 interviews with residents of eight diverse First Nations communities across Manitoba, Kyoon-Achan and her colleagues (2019) found that primary health care improvements within communities was absolutely imperative to community wellbeing, requiring the integration of community-specific traditional Indigenous knowledge, community-based services such as health and transportation and culturally safe health human resources. Ultimately, the study found that self-determination and health are intimately linked, and that First Nations communities need to participate in determining and visioning health care within the community (Kyoon-Achan et al., 2019). Jurisdictional problems arose, making the provision of community-based care in the communities difficult, as service providers described concern over sending patients out of community to seek care in larger towns or cities (Kyoon-Achan et al., 2019). With fewer restrictions to accessing care within the provincial health system, and intentional cross-jurisdictional collaboration between Indigenous communities and municipal health services and RHAs, the primary health needs of more people would be met as seamlessly as possible (Kyoon-Achan et al., 2019). By meeting these needs, health outcomes can be improved, ED visits and hospital stays can be avoided, and cost savings will be realized within the provincial health care system.

In the research presented here, rural community members expressed concerns around their ability to maintain good health should emergency services and primary care be withdrawn. Extensive Canadian statistical literature exists demonstrating the importance of access to care and health services, especially as they relate to proximal determinants of health and promotion of health behaviours. In settler, biomedical public health and health promotion rhetoric, citizens are expected to keep themselves as healthy as possible in order to reduce burden on the health care system and to ensure that emergency services and health care resources are available as needed. The withdrawal of emergency care, and the fear that additional primary care services are to follow is counterintuitive to this settler ideology and privileging of health promotion strategies. How can communities keep themselves well when they cannot access good care? By eliminating and consolidating service between rural communities, the state is effectively denying its responsibility to health. But as community members demonstrate, there is motivation among the communities for innovation, creative problem-solving and collaboration to ensure continuity of care. Traditional power imbalances are leveled where service providers and physicians are members of the community themselves, and partner with the community to advocate for health services. While the fate of rural health care and rural life remains to be seen, communities such as Grandview continue to hold on to the hope that their positive and supportive services will survive this health system transformation in Manitoba.

Research Limitations

While this research is expansive and covers a significant landscape of themes and findings, as a qualitative study it was not intended to provide a generalized commentary on health and wellbeing within all of rural and remote areas of Canada. Rather, this research builds on the example of Manitoba, and a small rural community within the province, and the experience of people there in seeing their health care system change dramatically. This research demonstrates the ways in which rural places and the services and systems within them are impacted by policy change, which may be insignificant in urban settings, or in the broader policy documents created for public consumption. It is however, very securely set within the geographic region of study, and while it cannot reflect the experience of all rural Manitobans and First

Nations and Métis communities within the province, it does provide support for community-specific health care solutions, rather than a one-size-fits-all health policy and system.

Practically, this research was limited as a qualitative study where interviews were conducted over the telephone, and occurred during a politically-charged time in winter 2018-2019 when the Manitoba government issued a statement by Premier Brian Pallister stating that forecasted EMS closures would indeed be carried out, at a time presumably known only to government officials. Without immersion in the community in a physical way, I missed crucial experiences to see the Grandview hospital and EMS in action, and to observe the interpersonal connections between community members and service providers. I missed those nuances that do not arise in conversation or through the telephone. That is not to say that research relationships were not maintained through the process. Having developed from a community-led study, this research involved feedback and consultation with the community advocacy group, and allowed for a reciprocal relationship.

Areas for Future Research

The health system transformation in Manitoba will have resounding effects on rural, Indigenous and urban communities across the province. Health system changes, cuts to current services and programs, and the closure of services as observed in Grandview, during the time of a global pandemic will further exacerbate negative health outcomes. These must continue to be studied through community-engaged research practices. I recommend further research using mixed methods to observe the health outcomes as a result of this transformation, particularly as they relate to EMS services and ED utilization in rural Manitoba. Any further research must actively involve communities, support community visions and goals and undertake a strengths-based approach that draws on local resiliencies and capacities. A comparative approach to provincial health system reform and policy is also warranted in this time of nation-wide transition. How do Canadian provinces differ in their delivery of rural health care? While I argue that there is no single model that will work for all, there are notable failures and successes in implementing patient- and community-centred health strategies, and examples of policies and programs that support Indigenous self-determination.

Critical Questions

While this research, as I interpret and present it, depicts the collaboration between settler and Indigenous peoples and communities in actions to preserve and retain health care services that serve both communities, critical questions may arise that find tension in these acts. Future research and critical scholarship may invariably ask whether Indigenous bodies are being used to amplify and politicize settler colonial interests. Do these forms of collaboration and advocacy serve insidiously to allow continued settler control of resources and lands? This line of questioning is important, and contributes to an ongoing list of works including those by Audra Simpson and Glen Coulthard and Robert Henry, regarding the persistence of settler colonial ideals, the framing of Indigenous bodies as violent, vanishing and in/visible for the purpose of settler colonial control. Especially in such a place as the Canadian prairies where settler colonial viability depends on Indigenous invisibility, these questions bring about a new thread of scholarship. Does the visibility of Indigenous illness and death support the ongoing settler control of rural (Indigenous) places? To prevent the death of the settler rural, are Indigenous peoples and communities being framed as dying to justify the retention of settler services? A future, critical approach to research at this juncture would contribute to settler colonial and Indigenous studies in offering an appraisal of collaborative acts that are presented here as originating out of a shared vulnerability.

Chapter Eight: Conclusions

In this conclusion, I reflect on significant insights and questions that arose in the course of this study. Is it possible to improve rural and Indigenous health within Canada through policy action on the SDOH? Can health equity be addressed for rural, First Nations, Métis and other marginalized communities through health care systems and policies? And will rural and Indigenous communities find success in advocacy through relationships? The findings presented here reiterate what is known and experienced regularly by many communities, health service providers and practitioners, rural leaders, advocates, and health researchers alike. While critical issues and barriers persist within the provincial health care system in Manitoba, there is hope for positive, community-based outcomes based on the themes presented in this research. These are rooted in the healthy health care relationships that exist within the rural health system, and between service providers, community members, Indigenous health organizations and clients. Rural and Indigenous communities are passionate about place, and attribute good health to their rurality and access to traditional lands, while conversely selecting rural places to live and age because of good, relational rural health care services.

Improving Health Relationships

Through community-engaged research, this dissertation has shown that rural health systems can be effective in meeting broad community health needs. However, it is critical that such systems continue to address health needs and enter into health relationships with Indigenous communities, neighbouring First Nations, Métis communities and other Indigenous peoples to extend access to health care. Further, rural health systems may continue to operate through settler colonial and biomedical structures, which can be harmful and oppressive. Allen et al. (2020) indicate that support for Indigenous Elders, knowledge holders and healers and cultural approaches to care by settler biomedical health providers and policies can reduce barriers to accessing appropriate and effective care. This is critical in rural settings, where provincial health care systems are utilized and relied upon by Indigenous peoples and communities for emergency and primary care. Further, support and collaboration between the medical community and Indigenous communities on health care can begin to address the persistent systemic racism found with contemporary health systems in Canada (Allen et al., 2020). Here, the idea of rural collectives or community coalitions is important. As the findings demonstrate, government decision-making has resulted in competition arising between resource-poor communities. By pitting communities against one another, the state is effective in distracting communities from broader impacts and the dismantling of rural and Indigenous places, and the absorption of rural and Indigenous peoples into the broader urban and suburban population. This political act effectively and insidiously erases and removes diverse identities from lands and territories. However, as one community member described, the cohesion of communities calls for unavoidable state recognition, especially in rural and Indigenous places across the province, where erasure is experienced and resisted,

> "But if you have a collective as opposed to a singular entity, ya know, I think it was wise to involve First Nations… to bring Tootinaowaziibeeng into the equation… [without Indigenous inclusion] I think you miss the big picture that all these communities are suffering, right? Not just Grandview. Gilbert Plains is suffering, Roblin is suffering, Ethelbert is suffering. Everybody is suffering in Northern Manitoba… and I have an invested interest in making them sustainable, but if you are a - if you have a bigger voice, if it's more than just one town, you're a bigger voice" (CM12).

Improving Rural and Indigenous Health Information

This study demonstrated the frustrations that abound at the community level in response to the failure of governments to consult, engage and partner with communities on health system decision-making. It further highlights what has been long known about Canadian and other settler colonial governments and their aversion to inclusion. The sense that provincial decision-makers have dehumanized the process of policy-making and restructuring of the health care system is found across both settler community members, and Indigenous folks whose communities are directly impacted by changes in Manitoba. As Smylie and Firestone (2015) urge, governments and academic researchers alike must establish data partnerships with communities, or little progress can be expected to be made in understanding and addressing existing health needs and inequalities. While rural health statistics are lacking, Indigenous peoples in Canada face the double burden of health disparity paired with a lack of health information (Smylie & Firestone, 2015). Only with increased academic, policy and political will can an appropriate public health, health policy and systems-level response be delivered (Smylie & Firestone, 2015). This urgent need speaks directly to structural determinants of health, which require an ideological shift among governments and decisionmakers towards inclusivity of marginalized and Indigenous voices, and a focus on amplifying those voices and making visible these peoples and communities.

Rural Health Amid a Global Pandemic

This dissertation was composed during the 2020 COVID-19 pandemic in Canada, in a moment where the failures, insecurities and readiness of health care systems, policies and services became clear, affecting the ability to respond to the health crisis. It is also in this moment, that vulnerable populations and people are further marginalized, experiencing greater rates of disease and mortality. The experience of rural communities, First Nations, Métis and other remote and Indigenous communities during the COVID-19 pandemic is noteworthy across Canada. In most provinces, cases of the virus have been low in rural and Indigenous communities, reflecting their dislocation and isolation. But the protection of these communities and their health has been of significant importance in Canada, particularly because they represent vulnerable populations and peoples with existing health concerns and limited health resources. In some cases, entire First Nations have closed their access roads, to completely isolate the community, and prevent transmission of COVID-19 from urban regions where the virus has been concentrated (Grabish, 2020). One of the strengths of rural places over the course of the pandemic was the nature of their rurality, the literal physical isolation that rural towns, Indigenous communities including remote First Nations. This isolation, as this dissertation reflects, is not always viewed as a strength, especially in terms of health access and equity. However, in a time where distance is essential to protect health, the isolation afforded by rural and remote living is a defence.

During the first wave of the COVID-19 pandemic, the prairie provinces, including Manitoba, experienced low spread of the illness across the population. This limited spread led to provinces of Manitoba and Saskatchewan to be among the first places in Canada to initiate 'reopening'. Unfortunately, in late August, Manitoba saw its greatest increase in COVID-19 on record, the majority of these occurred within the Prairie Mountain Health region, where this dissertation is set (Gowriluk, 2020b). While outbreaks are occurring in urban places across Canada, the case within PMH region in Manitoba provides an example of the importance of rural, remote and Northern health resources, particularly in diverse communities. The experience of rural, remote and northern communities through the pandemic will be affected greatly by the availability, accessibility, and reliability of both primary and emergency health care services within their regions. Of all the times for a province to eliminate rural health care services, doing so in the midst of a global pandemic is unfathomable.

However in early September, in the town of Roblin, Manitoba, Grandview's neighbour 30 minutes to the west, this is precisely what occurred. With a week's notice, Manitoba Shared Health announced the closure of the ED at Roblin's hospital, referred to as a 'temporary interruption' of services. This closure was cited by the province to be due to a shortage in diagnostic staff in Roblin, rendering the ED unable to operate. However days earlier, the community was successful in hiring two new staff, who were promptly redeployed by Shared Health to a different hospital (Lam, 2020). Without any community consultation, the shutdown created great upset and upheaval for ED staff, patients, families, and the health systems in surrounding communities, namely Grandview (Lam, 2020). Some patients and their families in Roblin were given just hours' notice that they would be moved to Grandview hospital where diagnostic services would support their care needs. The closure of the ED in Roblin will have significant impact on Métis residents in San Clara-Boggy Creek, as Roblin was the nearest emergency care centre, 30 minutes away. Now, San Clara residents will have to make the decision to travel over an hour in any direction to receive emergency care.

This closure in Roblin serves as another case in which the provincial government has made a critical, community- and health-altering decision at the expense of rural and Indigenous peoples, without community consultation. Where the community has demonstrated resiliency and capability in handling arising issues in delivering health care services, the government has intervened to diminish and deny the solutions generated by communities. Such a move is perceived as deliberate and insidious by the local community. This moment represents a time of distraction, where such health system changes could easily be forgotten by the public, serving government interests further by proving the ED and hospital itself in this rural setting are unnecessary and too expensive to reopen. The closure of the Roblin hospital leaves the community vulnerable, as the president of the Manitoba Association of Health Care Professionals, Bob Moroz stated to the CBC, "This closure is the direct result of a failure to invest in rural health care. It's the culmination of a failed strategy to ignore and cut… even more services… the Manitoba government has already signaled that we can expect consolidation in rural health care services… with significant impacts to services and accessibility." (CBC News, 2020). However, what rural health in Manitoba, and across Canada, needs is revival; support and investment to allow community-based decisions to support community-based care.

This instance has caused considerable concern in Grandview, 30 minutes away, and the nearest neighbouring hospital and 24-hour ED. While the loss of health care services in Grandview has momentarily been avoided, the community is acting now in the interest of their neighbours by partnering with the community it was once pitted against, to challenge the government's decision. If anything, the examples of Grandview and Roblin serve to demonstrate the resiliency of rural communities in times of crisis, and the failure of provincial governments to respond effectively by consulting with communities and rural health care providers, and honour the dedication of these communities to the health and wellbeing of their people. In the months to follow, the coalition group aims to release a critical community health report, and continue to innovate solutions to address barriers to care.

Changing Landscapes: Equitable Health System Transformation

In order for health status among marginalized peoples in Canada, including Indigenous and rural communities, a balanced approach towards health system innovation and policy-making must be undertaken. Scholars of Indigenous rights and health confirm that in order for ideal health and wellbeing among Indigenous communities and vulnerable peoples to be achieved, the public health care system must be grounded in the social justice concepts of equality and equity (Reading et al., 2016). Not only must health systems and policies address equality through ensuring access to the level of health programs and services for all, there must necessarily be a shift towards equity where services and programs are directed to communities where they are needed most to counter existing disparities in health. Both equality and equity must be balanced as governments seek to make transformative change to both the national and provincial health care systems. To do this effectively among communities that face the greatest inequities, local, community-based, and Indigenous perspectives and approaches must be integrated into policy and practice (Reading et al., 2016). This will require community consultation, collaboration and reciprocal feedback through transformation. The experience of rural and Indigenous communities in southwestern Manitoba provide a singular example of the complexities, challenges, strengths and resiliencies of the rural health care setting in a system experiencing change. It also calls to attention the importance of integration and partnership between communities towards advancing health equity.

Health equity must be addressed at the structural level, from which all other social determinants of health are informed. In her commentary on health systems performance in Indigenous, rural and remote communities in Canada, Susan Chatwood (2018) discusses the importance and opportunity for reconciliation within reimagined health systems. As I share in this dissertation, Indigenous health and access to care in this country is unequivocally connected to rural health systems and services due to the historic health policy and delivery legacies that persist in Canada. Where there are gaps in on-reserve services for First Nations, both on- and off-reserve, provincial health care systems must deliver. Where there are gaps in providing community-based care for Métis communities, provincial health care systems must deliver. Many critical Indigenous and settler scholars heave described the opportunity to reconceptualize health policies and systems to improve performance, and act on calls for reconciliation while incorporating Indigenous knowledge systems and methodologies into the health system (Reading et al., 2016; Gabel et al., 2017; Chatwood, 2018). By doing so, settler colonial state structures can be dismantled, and health systems can begin to address the inequities that have been sustained through a focus on social determinants of health. This equitable transformation of the policy and health system landscape will require the building of relationships between and among rural and Indigenous communities, as well as with Indigenous knowledge keepers, policy-makers, health leaders and researchers (Gabel et al., 2017; Chatwood, 2018). This is a tall order in a settler nation and neoliberal political climate that has been stalling on actionable reconciliation for decades. But it is possible, with the example most recently of the First Nations Health Authority in British Columbia overseeing the delivery of health services to First Nations across the province (Kelly, 2011; Lavoie et al., 2015).

At the local level, the example of Grandview, Manitoba and similar rural and remote places across the country are beginning this transformation, through grassroots, social movements and advocacy coalitions. There is appetite and capacity in many places to initiate innovation to survive and thrive as healthy, rural and Indigenous communities. However, it is important to remember that this is not possible in all such places, where systemic barriers have diminished both capacity and will, where prohibitive policies and delivery systems limit accessible resources. These are the places where future research, investment and community partnership are needed to advance community visions for health and wellbeing, and to create a platform for people to advocate and innovate at the policy and system level. Here, ideological and structural shifts may begin to occur to unsettle settler colonial ideals and ideologies on rural and Indigenous health in Canada.

Policy Recommendations

From the analysis of guiding government documents and interviews with rural, First Nations and Métis community members and service providers, several recommendations can be made for health policy. In order to create and equitable health care systems through transformation, I suggest that provincial governments:

1. **Establish equitable relationships**
   Consult, engage and collaborate honestly and authentically with rural, First Nations, Métis and other Indigenous communities throughout the planning, development, and implementation of health care system changes.

This study has found that while government research has occurred, many of which, rural communities and Indigenous communities do not feel included, valued or remotely considered. Wide, systemic change will impact all areas across the health care system, but will affect rural and Indigenous communities most acutely. In order to create systems change and innovation, governments will require community and practitioner support. This should be gathered through equitable engagement with communities, in the manner that works best for the community. In moving forward with the provincial health system transformation process, the government of Manitoba needs to reflect on reconciliation through health, and reconsider the way it engages with communities that will experience the greatest change, especially those that believe this change will create barriers to accessing care, or eliminate critical services.

2. **Empower rural community-based health care**
   Support changes to health care services identified through community leadership, recognize the social determinants of rural and Indigenous health and draw on community-generated evidence.

Health system transformation requires strong evidence to justify and support significant systemic changes. Through analysis, this dissertation found that government research prioritized findings that supported state goals of fiscal sustainability and establishing economies of scale in the expensive Manitoba health care system. While the importance of statistical review data is clear when it comes to systems-wide shifts in service and delivery of care, social and community-based evidence and narratives are critical to making equitable change. The goal of centralization is to eliminate inefficiencies, but rural and Indigenous communities, such as those participating in this research, have demonstrated that community-based care is effective in maintaining and improving on key SDOH. Equitable health system transformation must honour community perspectives and empower community-based solutions.

3. **Honour rural and Indigenous resiliencies**
   Commit to a strengths-based approach to health system changes in rural and Indigenous communities, support diverse rural, First Nations, and Métis community life, health and innovation

By recognizing and supporting rural community strengths and capacities, governments will be in a better position to collaborate on policies and programs that enhance and sustain the effective systems that are already in place. There are successful health relationships within communities where specific health care needs exist, where common barriers to care are addressed though positive and healthy health care relationships. By further supporting and enhancing these models of primary and emergency care, community health and wellbeing can be improved, and healthy ways of life in rural and Indigenous settings can be maintained. By supporting communities in doing what works best for them, governments are empowering communities, sustaining rural and Indigenous life, and affording self-determination and control to communities to identify, address and meet their unique needs. This approach can lead to realized cost savings within the health care system by improving SDOH and outcomes.

As this dissertation demonstrates, some rural and Indigenous communities have been self-sustaining their health care services, primarily through health care partnerships between communities and organizations, and through dedicated health service providers that have strong relationships and senses of responsibility towards the people that they serve. The systems that currently exist in rural communities can be part of the solution to provincial sustainability issues, rather than problems to be dealt with. As so many participants repeated, "…if it isn't broken, don't fix it."

Final Reflection

I titled this dissertation *Changing Landscapes* initially to represent the changing space, representation and delivery of health services within a provincial healthscape and system. However, as I embarked on this journey, I realized that this title reflects so much more. Rural places and Indigenous places are often viewed socially and politically as stagnant and never-changing. There is a sense that rural peoples and Indigenous communities are homogenous, and in large part this sense is reflected in policy, or lack of policy throughout Canada. These reflect both racist and ageist undertones as rural, remote and northern places are viewed as aging and Indigenous places, leading to often intentional policy and service gaps. The rural and Indigenous health experiences that I have explored as I engaged with community members and service providers is demonstrative of a great diversity, and resilience. Settler colonial fabrications of rural, First Nations and Métis spaces have gone to lengths to diminish this. In response, rural and Indigenous communities take up a form of resistance and struggle for what they perceive as survival by seeking visibility and voice though advocacy. It is in these moments of resistance, or crisis if the COVID-19 pandemic response has taught us anything, that the importance of community-based solutions, inclusion and self-determination becomes pronounced enough to solicit political interest. I argue through this dissertation that political interest is simply is not good enough, and that while government action is required, structurally through policy, and systemically through delivery, it cannot be taken without recognition of the marginalizing conduct and settler colonial intentions of state history.

I am also cognizant of my position in this research, and realize that the journey does not end here. Rather, it is my responsibility in this place of privilege as a white, settler researcher, to act on this challenge, out of which comes opportunity to advocate for rural and Indigenous community-based health, localized approaches, Indigenous self-determination, and to critique state response through the reform process. The transformation is not yet complete in Manitoba. It is my hope that this dissertation serves to support the call for the authentic involvement of First Nations and Métis communities, rural peoples, as well as rural service providers who embody rural health practice, in health care system planning. But beyond this, it is my hope that diverse communities in rural places across this country are enabled through policy to determine community health needs and how these can be met through a responsive, accessible and community-based system.

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Appendix A

LETTER OF INFORMATION / CONSENT

Changing Landscapes: Health Care System Transformation in Rural Canada

A study about health care services and policy in rural communities.

Investigators:

Principal Student Investigator:
Alicia Powell
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McMaster University
Hamilton, Ontario, Canada
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Hamilton, Ontario, Canada
(905) 525-9140 ext. 23316
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Purpose of the Study

I am conducting this research as part of my doctoral dissertation in Health Studies within the Department of Health, Aging and Society at McMaster University. My project is titled "*Changing Landscapes: Health Care System Transformation in Rural Canada*."

Health care service delivery and organization in rural Canada has been briefly studied, however a nuanced understanding of changing policies and their impact on rural communities is required to provide a fulsome understanding of the state of perceived rural health. During a time of health system transformation across the country, the experiences of rural peoples in the province of Manitoba provide a useful example of such changes on perceived health and wellbeing outcomes, as well as the resiliency and recognition of rural communities in championing their own needs.

In Manitoba, the health care system has been under review and transition over the past 25 years, due in large part to significant changes in demographics, economy and population. Despite these changes, including a move to regionalized health service delivery, there have been few measured improvements in overall health outcomes. Due to this, a number of studies were undertaken by the Manitoba government to evaluate the state of the provincial health system. The findings of these studies resulted in the current health care system structure in Manitoba: a single, centralized provincial health organization; Manitoba Shared Health. Results of one government study specifically led to the recommended closure or amalgamation of nearly two dozen EMS stations across the province, 18 of which are rural.

This project researches the ways in which rural communities and peoples, including First Nations and Métis communities, in Manitoba respond to health system changes and how these impact the perceived health and wellbeing.

Procedures involved in the Research

If you choose to participate in this study, you will be interviewed over the telephone based on your experience with health care services in your rural community. Interviews are expected to take 30 to 60 minutes to complete. The time of the interview is flexible, and will be scheduled at your convenience to complete over the telephone. With your permission, interviews will be audio-recorded and hand-written notes may be taken. As a participant you have the right to refuse the recording of your interview, in which case only hand-written notes can be used as data. You also have the right to refuse to answer any question that you are not comfortable answering and you can end the interview at any time. All recordings and data will be stored in encrypted files in a password protected computer. All personal information will be destroyed within one year following the completion of this project.

During the interview you will be asked questions based on your experience as a member of a rural community, or on your professional experiences as a health service provider. I will ask you questions about health services in your community, such as:

1. What are health care services like in your community currently?
    a. Describe the services provided or available to you.
    b. Are there any important experiences that you would like to share?
    c. Describe your ability to access care and receive emergency care.
    d. Are there important relationships between service providers and sectors that affected the delivery of health services?

Potential Harms, Risks or Discomforts:

The risks involved in participating in this study are minimal and it is not likely that there will be any serious harms or discomforts associated with the interview. However, you might find some questions uncomfortable to answer if you or a loved one has had emotional or distressing experiences with emergency health care services.

Because the population of the community is small, there is a risk to privacy associated with participation in this study. Further, because health care is political in nature, you may experience discomfort related to your political status if you either oppose or support provincial and health system decision-making.

These risks will be managed and minimized through the protection of participant confidentiality and anonymity. Participation in the project will only be known to the you and the researcher, unless the you choose to share this information. Participants will only be referred to as members or service providers within the community.

You do not need to answer questions that make you feel uncomfortable or that you do not want to answer, and you can withdraw (stop taking part) at any time during the interview, and up until October 12, 2020. If you choose to withdraw, your personal information and any data you provide will be destroyed. I describe below the steps I am taking to protect your privacy.

Potential Benefits

It is unlikely that there will be direct personal benefits to you, however, by better understanding the importance of emergency health care services within rural places, researchers and community groups may be able to support community health initiatives.

Confidentiality

You are participating in this study confidentially. I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team unless we have your permission. However, because the number of participants involved in this study is small, and due to the fact that the community of Grandview and surrounding area is rural and has a small population, it is possible that details you provide about your experiences could be linked to you by readers of the final report. For this reason, any data from this research that will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons and no one will be named. Instead, pseudonyms (alternative names), or participant group identifiers such as "health care worker", or "community member" will be used to describe participants in the report.

Please consider this when sharing your experiences with me. You may withdraw certain experiences or phrases from your interview at any time before the final report is published in late October, 2020.

Audio recordings will be transferred to a password-protected computer within 24 hours of the completed interview and then be erased from the device. All information, including transcripts will be kept in encrypted files on the password-protected computer. Once the study has been completed, the data you provide will be destroyed if you request that this be done at the time of consent. With your permission, the researcher will maintain an archive of the data, without identifying information, in a password-protected computer indefinitely for the purpose of future research in this area.

Legally Required Disclosure

Although I will protect your privacy as outlined above, if the law requires it, I will have to reveal certain personal information (e.g., patient abuse, professional misconduct, public health risks). If legal authorities request the information you have provided, I may be required to reveal it.

Participation and Withdrawal

Your participation in this study is voluntary and it is your choice as to whether you would like to be a part of the study. If you decide to be part of the study, you can stop (withdraw), from study for whatever reason, even after verbally consenting to participating or partway through the study or up until approximately **October 12, 2020.** If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

You can no longer withdraw from this study after approximately October 12, 2020, when I expect to be finished writing and preparing to submit my dissertation.

Information about the Study Results

I expect to have this study completed by approximately October 13, 2020. If you would like a brief summary of the results, please let me know how you would like it sent to you below.

Questions about the Study

If you have questions or need more information about the study itself, please contact me at: powellak@mcmaster.ca or (905) 902-4354.

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance.
If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

You will be asked to answer or confirm the following consent questions prior to the interview:

- I have read the information presented in the information letter about a study being conducted by **Alicia Powell**, a graduate student in the Department of Health, Aging and Society at McMaster University.
- I understand that personally identifying information will not be used as data or published within the report.
- I understand that I have the right to refuse to have my interview recorded and the data that I provide will be hand-written.
- I understand that the data I provide in digital form or audio recordings will be kept secure in an encrypted file in a password protected computer and will be accessible only to the researcher and her supervisor.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately **October 12, 2020** for writing purposes**.** If I choose to withdraw, all of my data will be destroyed.
- I have been given a copy of this form.

The following will be recorded in the Oral Consent Log:

- I agree to participate in the study *Changing Landscapes: Health Care System Transformation in Rural Canada*
- I agree that the interview can be audio recorded.
- I would like to receive a summary of the study's results.
    - If yes, please send them to this email address
- I agree to allow the researcher to retain the data that I provide indefinitely for any on-going or future research on this subject.
    - If not, I would like the data that I provide destroyed after one year.

Appendix B

Changing Landscapes: Health Care System Transformation in Rural Canada

Researcher: Alicia Powell

Study Information and Verbal Consent

Introduction:

Hello, my name is Alicia Powell. I am conducting interviews about health care services in Grandview, and how this supports the community. We are hoping to learn about Grandview's health services, and why these services work best for the community. I am a PhD student at McMaster University's department of Health, Aging and Society in Hamilton, Ontario. I'm working under the direction Dr. Chelsea Gabel of McMaster's Health, Aging and Society, and Indigenous Studies departments.

Before I proceed, are you interested in participating in a short interview about health care services in your community?

Study Procedures: **What will happen during the study?**

I'm inviting you to do a one-on-one interview over the telephone that will take about 30-60 minutes. I will ask you questions about emergency health services in your community, such as:

2. What are health care services like in your community currently?
    a. Describe the services provided or available to you.
    b. Are there any important experiences that you would like to share?
    c. Describe your ability to access care and receive emergency care.
    d. Are there important relationships between service providers and sectors that affected the delivery of health services?

I will take handwritten notes to record your answers as well as use an audio recorder to make sure I do not miss what you say. We can set up a time and place that works for us both.

What date and time work best for you to speak with me over the telephone? I will call you at the time to interview you.

Risks: **Are there any risks to doing this study?**

The risks involved in participating in this study are minimal and it is not likely that there will be any serious harms or discomforts associated with the interview. However, you might find some questions uncomfortable to answer if you or a loved one has had emotional or distressing experiences with emergency health care services.

Because the population of the community is small, there is a risk to privacy associated with participation in this study. Further, because health care is political in nature, you may experience discomfort related to your political status if you either oppose or support provincial and health system decision-making.

These risks will be managed and minimized through the protection of participant confidentiality and anonymity. Participation in the project will only be known to the you and the researcher, unless the you choose to share this information. Participants will only be referred to as members or service providers within the community.

You do not need to answer questions that make you feel uncomfortable or that you do not want to answer, and you can withdraw (stop taking part) at any time up until October 12, 2020. I describe below the steps I am taking to protect your privacy.

Benefits:

It is unlikely that there will be direct personal benefits to you, however, by better understanding the importance of emergency health care services within Grandview, researchers and community groups may be able to support community health initiatives.

Confidentiality:

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team unless we have your permission. However, because the number of participants involved in this study is small, and due to the fact that the community of Grandview and surrounding area is rural and has a small population, it is possible that details you provide about your experiences could be linked to you by readers of the final report. For this reason, any data from this research that will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons and no one will be named. Instead, pseudonyms (alternative names), or participant group identifiers such as "health care worker", "community member," or "caregiver" will be used to describe participants in the report.

Please consider this when sharing your experiences with me. You may withdraw certain experiences or phrases from your interview at any time before the final report is published.

Voluntary Participation:

- Your participation in this study is voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason, or up until approximately ***October 12, 2020***
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop we will ask you how you would like us to handle the data collected up to that point.
- This could include returning it to you, destroying it or using the data collected up to that point.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- If you do not want to answer a certain question, please let me know that you would like to "skip" or "pass" that question, and we will move on.

- If you would like to stop the interview and withdraw your information from the study, please let me know you would like to "stop" and the interview will not proceed.
- If you have any questions about this study or would like more information you can call or email Alicia Powell at **(905) 902-4354** or **powellak@mcmaster.ca**

Results:

I would be pleased to send you a short summary of the study results when I finish going over our results. Please let me know if you would like a summary and what would be the best way to get this to you.

Consent Questions:

- Do you have any questions or would like any additional details?
- Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?
- Do you agree to having your interview audio recorded for the purpose of accurately gathering your responses?
- Do you agree to allow me to include the information you provide, including quotations, in my dissertation research on Rural Health in Canada, and in future publications or presentations on Rural Health?
- Would like to receive a summary of the study's results?
    - If yes, via email/mail?
- Do you agree to allow the me to retain the collected data indefinitely for any on-going or future research on this subject?

With your consent, the interview will proceed.

END

Appendix C

Research Agreement

(Adapted from CIHR Guidelines for Health Research Involving Aboriginal Peoples)

Changing Landscapes: Impacts of Health Care System Transformation on Rural and Indigenous Communities in Canada

RESEARCH AGREEMENT

July 1, 2020

I, Alicia Powell (primary researcher***)*** agree to conduct the named research project with the following understandings:

1. The purpose of this research project, as discussed with and understood in the community of _________is:

   To understand community perspectives towards the transformation of the provincial health care system and local services.

2. The scope of this research project (that is, what issue, events, or activities are to be involved, and the degree of participation by community residents), as discussed with and understood in this community, is:

   To provide a policy analysis of provincial health policy and Indigenous health policies, and an analysis of community feelings towards the transformation of health care services. This project will involve accessing community health policy documents, as well as knowledge gathering from health care service administrators, providers and community members. Community members interested in the project and in providing their perspectives on health care services within their community may participate in virtual or telephone semi-structured interviews, or focus groups (sharing circles). Those who consent to participation in the project will be asked to review and check the transcription or summary of their interview or group discussion, and approve the transcription for use in the dissertation and other outputs.

3. Methods to be used, as agreed by the researchers and the community, are:

   - One-on-one semi-structured interviews with health service administrators or providers, and community members (over the telephone)

4. Community training and participation, as agreed, is to include:

   The development of this project is based on sincere communication between community members and researchers. All efforts will be made to incorporate and address local concerns and recommendations at each step of the project.

   At the end of the project, the researchers will participate in community meetings to discuss the results of the analysis with community members.

5. Information collected is to be shared, distributed, and stored in these agreed ways:

The data collected is confidential and no name is attached to the record. Copies will be kept at McMaster University where the data will be converted to an electronic form. The data will be kept in encrypted form on a password-protected computer belonging to the researcher, as well as in the community. The researcher will be available to answer questions and assist community members should community members decide to use these data for different purposes; a final report will be distributed after approval from the community members.

6. Informed consent of individual participants is to be obtained in these agreed ways:

   An individual consent form will be read by the interviewer to the respondent. A copy of the consent form will be left with the respondent where the address of the researcher can be used at any time, should the respondent wish to contact the researchers for additional information.

7. The names of participants and the community are to be protected in these agreed ways:

   As mentioned on the consent form, the interviews are confidential. In no instance will the name of a respondent be attached to a record. Before distribution of the final report, or any publication, or contact with the media, the community will be consulted once again as to whether the community agrees to share this data in that particular way.

8. Project progress will be communicated to the community in these agreed ways:

   - The researcher will provide monthly progress reports to the Advisory Committee

   - The researcher will deliver a monthly status report newsletter for dissemination among the community

9. Communication with the media and other parties outside the named researchers and the community will be handled in these agreed ways:

   - The researcher will acquire permission from the Advisory Committee to communicate with any external parties

   - The Advisory Committee will have the opportunity to approve/recommend the content of the communication

   - The researcher will report back to the Advisory Committee with any outputs from external communication (such as newspaper articles, podcasts, radio interviews)

Research Protocol

The research project will be based upon community protocol.

The principles of OCAP® *will be upheld in the following ways:*

- *The researcher recognizes and respects the relationship between people and their information*

- *The researcher respects the collective ownership of community cultural knowledge, data and information, including that which is gathered through research*

- *The researcher respects the inherent right of First Nations to enact authority and control* *over every aspect of their lives and institutions, including information management and dissemination*

- *The community will always have access to their own information, and determine who has access to it outside of the community in the context of this research*
- *The community will have jurisdiction over their own information and will determine where it is utilized beyond the production of the final report*

FUNDING, BENEFITS, & COMMITMENTS

Funding and Support

The main researchers have acquired support for this research project from:

- Grandview Health care Solutions community group

The community group has imposed the following criteria, disclosures, limitations, and reporting responsibilities on the main researchers:

- Produce community report on impacts of health system transformation on community health and wellbeing
- Identify the strengths of community-based health system

Benefits

The main researchers wish to use this research project for benefit in these ways (for instance, by publishing the report and articles about it):

- Provide a policy analysis
- Create a localized evaluation of community response to provincial health policy and services
- Offer suggestions on health policy and impacts of provincial system change within both settler and Indigenous communities

The researchers will produce a final dissertation to the Department of Health, Aging and Society at McMaster University as required by the PhD Health Studies program. Scientific presentations in peer-reviewed conferences and publications will be made with consent and collaboration with the community. The final dissertation will be reviewed by community members prior to publication. Scientific presentations and articles will be published after discussion with the respective communities' leaders.

Benefits likely to be gained by the community through this research project are:

- Educational
- Informational
- Political

Commitments

The community's commitment to the researchers is to:

- Recommend capable and reliable community members to collaborate/be employed in this project.
- Keep informed on the project progress, and help in leading the project toward meaningful results.

The researcher's main commitment to the community is to:

- Inform the community as to the project progress in a clear, specific, and timely manner.
- Act as resource to the community for health service and policy questions.

The researchers agree to stop the research project under the following conditions:

- If community leaders decide to withdraw participation.
- If the researchers believe that the project will no-longer benefit the community

---

Signed by:

Date:	Date:
	Community:
______________________________	______________________________
(Signature of Main Researcher)	(Signature of Community Contact Person)
Name:	Name:
Position:	Position:

Appendix D

THE STATE OF EMERGENCY HEALTH SERVICES IN GRANDVIEW, MANITOBA

INTERVIEW GUIDE

GUIDING QUESTION:

Why do the health care services in place in Grandview and surrounding communities work best for the community?

Information about these interview questions:
This guide gives you an idea what this project would like to learn about the recently proposed changes to the delivery of health care services in rural Manitoba and the impacts of these changes on the communities of Grandview, Tootinaowaziibeeng First Nation, and the surrounding area.

Interviews will be one-to-one over the telephone and will be open-ended (not just "yes or no" answers). Because of this, the exact wording of the questions may change a little. Sometimes I will use other short, probing questions to make sure I understand what you told me or if I need more information when we are talking, such as "please tell me more," or "why do you think that?"

Please let me know if you have any questions for me before we begin, or feel free to stop me to ask questions as we proceed.

INTERVIEW QUESTIONS:

1. What is your role in the health care system?
    a. Are you a patient, service provider, community-member, caregiver, administrative staff, critic, etc.?
    b. If you are a service provider, please explain your position and background serving the community.
2. What are health care services like in your community currently?
    a. Describe the services provided or available to you.
        i. (Emergency care, acute care beds, long-term care, etc.)
    b. Are there any important experiences that you would like to share?
    c. Describe your ability to access care and receive emergency care.
    d. Are there important relationships between service providers and sectors that affected the delivery of health services?
3. **Health care Professionals:** Can you give an estimate of the number of people who use the Grandview ER?
    a. What the cost is for using that service?
    b. Do you have an estimate of the cost for patients to access the Dauphin ER, or other nearby hospitals?
    c. How will patients be affected by the change in EMS and ER services and the increased travel time involved?
4. What will happen to health care services in your community after the proposed change to the delivery of services?
5. How will you and the community adapt to this change?

    a. Do you feel your needs will continue to be met?
    b. Do you feel there will be gaps in services?
    c. Are there people that will be more seriously affected by this change than others? Why?
6. Do you believe inequalities in health and wellbeing may arise as a result of this change?
7. Why do you believe the decision was made to close Grandview's EMS and Roblin's hospital?
8. What changes to health care services would you recommend to government (Manitoba Shared Health) at this time?
    a. Why are these recommendations crucial at this time?
    b. Who and/or what is affected if these changes are not made?
9. Is there anything that I may have missed that you would like me to know?

END

Thank you for your participation in this study, your experience and knowledge will make an important contribution to this work. If you would like to receive a copy of your interview transcript and the final report, please let me know at this time.

Researcher: Alicia Powell, McMaster University
I can always be contacted at powellak@mcmaster.ca or 905-902-4354.

Appendix E

To McMaster Research Ethics Board,

The purpose of this letter is to state that in addition to the research agreement that has been made between Grandview Health care Solutions Group of Grandview, Manitoba and PhD student Alicia Powell from the Department of Health, Aging and Society at McMaster University, the Group grants its permission to Ms. Powell to contact members and research participants who indicated their interest in participation in future research.

The purpose of the student's dissertation research is to understand the ways that new provincial health policy and health system transformation impacts and affects community members and health service delivery, including emergency medical services (EMS) in rural Canada, specifically within the province of Manitoba. The municipality of Grandview, Manitoba and surrounding communities serve as an effective case to demonstrate the actual and perceived outcomes of policy and system change or rural communities. This research will discuss the ways that community members, stakeholders, and organizations experience health care services prior to, and during the implementation of system change.

Grandview Health care Solutions Group agrees to allow Alicia Powell to utilize research and data gathered during the 2018-2019 community report period, including interview material and to contact participants who indicated interest in participating in future, related research. Information gathered during the research period was collected from consenting participants that were recruited by Grandview Health care Solutions Group for the community report. The researcher will ensure that the identities of participants remain confidential.

The researcher will maintain correspondence with Grandview Health care Solutions Group regarding the status of the project and will provide an overview of findings following the completion of the project.

Grandview Health care Solutions

__________________________________ Date: ______________________________

Signature of main contact person

Name: ________________________ Position:____________________________