

Tokenism and Mending Fences: How Rural Male Farmers and Their Health Needs Are Discussed in Health Policy and Planning Documents

Mesures symboliques et redressements de clôtures : comment les fermiers ruraux masculins et leurs besoins en matière de santé sont abordés dans les politiques et documents de planification de santé



BRADLEY HIEBERT, MSc

*Doctoral Candidate, Department of Health Information Sciences
Western University
London, ON*

SANDRA REGAN, RN, PhD

*Adjunct Associate Professor, Arthur Labatt Family School of Nursing
Western University
London, ON*

BEVERLY LEIPERT, RN, PhD

*Professor, Arthur Labatt Family School of Nursing
Western University
London, ON*

Abstract

Rural male farmers (RMFs) are an understudied population with high mortality, morbidity and co-morbidities due to preventable injury, most of which occur on-farm. This study examines how RMFs and their health needs are discussed in Ontario rural health policy documents. A retrospective analysis of policy was conducted to analyze the content of Ontario rural healthcare policy documents published since 2006. Discussions of RMFs were categorized by two themes: tokenism and mending fences. Tokenism refers to RMFs'

invisibility, except when farming stereotypes were used to describe rural areas. Mending fences captures the desire of rural communities to be included in healthcare decisions, and to position RMFs as key stakeholders for healthcare organizations to engage with to improve how they are perceived by rural communities. This study asserts that including RMFs in health policy formation can improve rural healthcare delivery and relationships between rural healthcare organizations and the communities they serve.

Résumé

Les fermiers ruraux masculins (FRM) constituent une population sous-étudiée où on observe de hauts taux de mortalité, morbidité et comorbidité attribuables à des blessures évitables, dont la plupart ont lieu sur la ferme. Cette étude examine comment sont abordés les FRM et leurs besoins en matière de santé dans les documents de politiques sur la santé rurale en Ontario. Une étude rétrospective a été menée afin d'analyser le contenu des documents de politiques sur la santé rurale en Ontario publiés depuis 2006. Les considérations sur les FRM ont été catégorisées selon deux thèmes : les mesures symboliques et les redressements de clôtures. Le terme « mesures symboliques » fait référence à l'invisibilité des FRM, sauf dans les cas où les stéréotypes fermiers sont utilisés pour décrire des régions rurales. Le terme « redressements de clôtures » exprime le désir des communautés rurales d'être incluses dans les décisions en matière de services de santé. Ce terme fait aussi référence aux FRM à titre de partenaires que les organisations de santé peuvent consulter pour améliorer la perception qu'en ont les communautés rurales. Cette étude fait voir qu'en incluant les FRM dans l'élaboration des politiques de santé, on peut améliorer la prestation de services en milieu rural ainsi que la relation entre les organisations rurales de santé et les communautés qu'elles desservent.

APPROXIMATELY 19% OF CANADIANS RESIDE IN RURAL AREAS (STATISTICS CANADA 2011b). Place, that is, residing in a rural or urban setting, is a noted independent determinant of health (Brundisini et al. 2013; DesMeules et al. 2012) that contributes to rural Canadians having an all-cause mortality rate that is 14.1% higher than that of urban residents (CIHI 2006; Ostry 2012). Additionally, compared to their urban counterparts, rural Canadians experience higher risks and mortality rates for a number of chronic conditions, including a 10.4% higher circulatory disease mortality rate, a 10.6% higher respiratory disease mortality rate, a 19.7% higher diabetes mortality rate, as well as a 125.8% higher accidental mortality rate due to injury and poisonings (CIHI 2006; Ostry 2012). When accounting for gender, injury and poisoning in men represent the greatest rural–urban disparity as rural men's injury-related mortality rate is 130.2% higher than that of urban men (CIHI 2006; Ostry 2012). Disproportionately high injury mortality rates are associated with high prevalence of motor vehicle accidents in rural areas (CIHI 2006; Ostry 2012; Williams and Kulig 2012) and high prevalence of workplace injuries associated with the agricultural industry (CAIR 2011; Morassaei et al. 2013; Turner and Gutmanis 2005).

Rural health inequities are often influenced by health policy decisions to regionalize healthcare services to larger urban centers in efforts to reduce system costs, streamline service delivery and improve healthcare providers' professional development (Fleet et al. 2015; Fleet et al. 2013). Despite such system improvement goals, healthcare centralization creates accessibility barriers for rural communities due to limited availability of most healthcare professionals (Nair et al. 2016; Pitblado 2012). As a result, 33.6% of rural men and 20.3% of rural women in Canada have no access to a regular primary care provider, and thus rely on rural hospitals as their main point of interaction with healthcare services (Pong et al. 2012). Rural health human resource shortages may also influence high rates of injury-related mortality and morbidity by limiting access to health promotion and information resources designed to prevent injury and illness (Haas et al. 2012; Hameed et al. 2010). Recent initiatives in Ontario have attempted to improve access to healthcare in rural areas by establishing collaborative care networks based specifically on the needs of the rural communities they serve (Multi-Sector Rural Health Hub Advisory Committee 2015). This approach has also been proposed in Alberta (Rural Health Services Review Committee 2015), British Columbia (British Columbia Ministry of Health 2015), and Nova Scotia (Health Association Nova Scotia 2013) as a viable means to improve access to rural healthcare in each of their provincial contexts.

Rural male farmers (RMFs) represent an appropriate target population for health policy designed to reduce high injury-related mortality and morbidity rates in rural areas as they account for 93% of agriculture-related mortalities and 83% of agriculture injury-related hospitalizations (CAIR 2011). In Ontario, there is a relatively low likelihood that patients from rural regions will receive timely specialized trauma care, which increases their risks of comorbidities or mortality (Haas et al. 2012; Hameed et al. 2010). Limited trauma care access for rural Ontarians reflects policy decisions that prioritize a downsized and centralized healthcare system characterized by a smaller rural healthcare workforce (Kaasalainen et al. 2014). Without access to local healthcare professionals, RMFs may rely on other sources for health information and treatment that have been utilized by rural communities to offset limited healthcare access, such as neighbours, veterinarians and naturopaths (Leipert et al. 2008; Wathen and Harris 2007). Furthermore, RMFs may be unaware of reporting procedures or wish to avoid reporting health and safety issues for fear of workplace sanctions and economic penalty from government workplace safety agencies (Hall 2007; Turner and Gutmanis 2005).

Despite healthcare system centralization remaining on the policy agenda, the Ontario Ministry of Health and Long-Term Care (MOHLTC) has prioritized the improvement of rural healthcare access and delivery in efforts to reduce geography-based health inequities (MOHLTC 2010). The MOHLTC's (2010) guiding rural healthcare reform policy, *Rural and Northern Healthcare Framework/Plan*, establishes provincial, regional and municipal priorities to improve rural healthcare, such as how to address the limited range of healthcare services used by rural communities and the need to engage rural communities in their own healthcare reform. Following the policy stages heuristic (Sabatier and Smith 1993), this study examines how RMFs are included and how their potentially high healthcare needs are

recognized in Ontario health policy and planning documents. In doing so, this study seeks to address the following questions: (1) How and in what contexts are RMFs discussed in health policy and planning documents in Ontario? and (2) How do health policy and planning documents in Ontario include RMFs in their recommendations?

Methods

A retrospective analysis of Ontario rural health policy and planning documents was conducted to examine how and in what contexts RMFs are discussed, and whether their health needs are incorporated into policy recommendations. A retrospective analysis of policy was conducted since this approach enables researchers to critically review and evaluate the content of existing health policy documents (Buse et al. 2012). In doing so, researchers can evaluate how health policy documents include and discuss the needs of various groups within the population, such as RMFs. This study followed Buse et al.'s (2012) definition of health policy, which holds that health policies “embrace courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health and healthcare system. It includes policy made in the public sector (by government) as well as policies in the private sector” (Buse et al. 2012: 6). Thus, health policies may include documents published by federal or provincial governments and subsidiaries acting on their behalf such as regional health authorities or local public health units, as well as non-government (private) organizations that aim to influence the arrangement of the healthcare system to benefit specific populations. Health policies may be analysed to gain an understanding of their content, their outcomes, the process that led to their creation or the actors involved in or excluded from their creation (Buse et al. 2012; Cheung et al. 2010). This study analyzed the content of Ontario rural health policy and planning documents since rural healthcare improvement is currently on the health policy agenda in that province, as evidenced by the creation of the *Rural and Northern Healthcare Framework/Plan* (MOHLTC 2010).

Document selection

Documents are often a primary source of data when conducting a retrospective analysis of health policy (Buse et al. 2012) as they can provide valuable insight into the contexts and values that helped inform policy decisions (Cheung et al. 2010); however, policy and planning documents should only be included in a study if they contain information that addresses the study's purpose (Bowen 2009). Concerns about sample size (for example, the number of documents) should be secondary to document relevance as a limited sample size may suggest that the policy issue under investigation is rarely on the policy agenda (Bowen 2009). This study included publicly available Canadian rural health policy and planning documents collected from grey literature resources including: formal databases including the Canadian Public Policy Collection, the Canadian Health Research Collection, the Canadian Research Index and the Cochrane Library; provincial healthcare websites, including those of the MOHLTC, Ontario's Local Health Integration Networks (LHINs)

and Ontario’s Public Health Units; and rural working group websites published by the Rural Ontario Institute. Following consultations with an academic research librarian, the following Boolean search query was used: “subject: Ontario AND farm* AND rural AND male”. Using an asterisk (*) ensured all permutations of a term, such as farmers, farmed or farming, were included in the search results. For the purposes of this study, a “farmer” is understood to be a person who performs agricultural labour in any capacity, including full-time, part-time or contract labour commitments on any size and type of family-run or commercial agricultural operation.

Initial search results yielded 131 documents that included: rural community profiles, economic reports, legal proceedings, agricultural planning documents published by both the Ontario provincial government and agriculture commodities groups, health policy and planning documents published by both the MOHLTC and LHINs, rural funding initiatives and reports on the status of healthcare and health services delivery in rural Ontario. To ensure the sample included recent and relevant policy issues, documents were included if they were published since 2006. Titles and executive summaries were scanned to include documents that held a primary focus on rural healthcare in Ontario. Finally, the full text of each document was scanned to ensure there was at least one reference to farm* or agricultur* in the document. A total of 13 documents were retained for the study sample after all inclusion criteria were applied. Figure 1 provides a detailed outline of the inclusion process, and Table 1 provides a list of the 13 documents retained for analysis. Of note, a single rural policy document published since 2013 was relevant.

FIGURE 1. Health policy and planning document inclusion and exclusion process

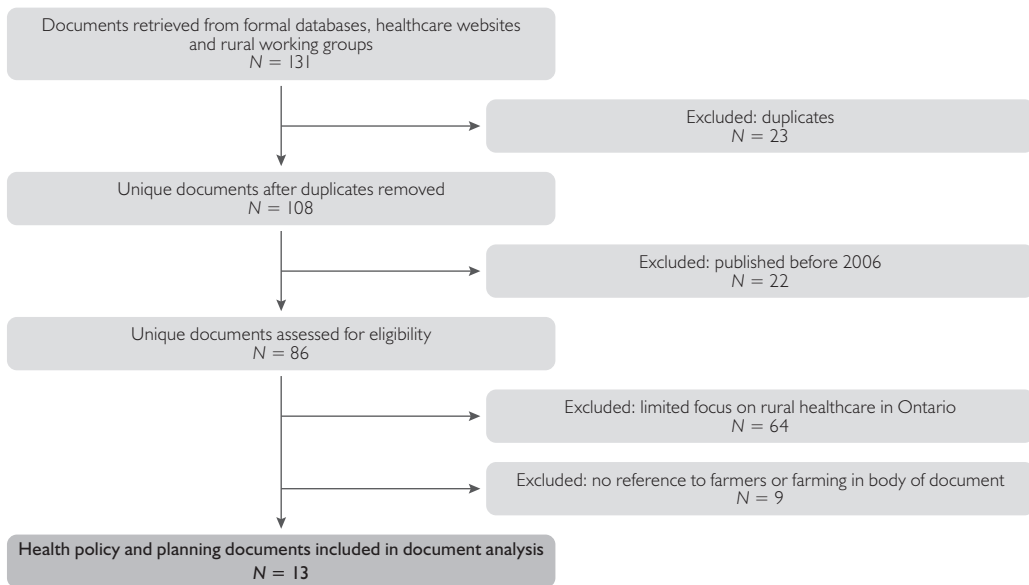


TABLE 1. Health policy and planning documents included in analysis

Document author (publisher)	Document title	Year	Document type
Caldwell, W.J., P. Kraehling, S. Kaptur and J. Huff (University of Guelph)	<i>Healthy Rural Communities Tool Kit: A Guide for Rural Municipalities</i>	2015	Public health planning report
Chase, C., R. Gallaway, F. Gelinas, T. McDonald, N. Mehra, B. Proctor and K. Tod (Ontario Health Coalition)	<i>Towards Access and Equality: Realigning Ontario's Approach to Small and Rural Hospitals to Serve Public Values</i>	2010	Healthcare service evaluation
Clark, W.F., J.J. Macnab and J.M. Sontrop (London Health Sciences Centre)	<i>The Walkerton Health Study 2002–2008 Final Report</i>	2008	Health research report
Kitty, H.L. (Haldimand-Norfolk Health Unit)	<i>Rural Health: A Qualitative Research Approach to Understanding Best Practices for Rural Health Service Delivery in a Public Health Setting</i>	2007	Public health report
Kreutzwiser, R., R.C. de Loë and K. Imgrund (Water Policy and Governance Group)	<i>Out of Sight, out of Mind: Private Water Well Stewardship in Ontario. Summary of the Findings of the Ontario Household Water Well Owner Survey 2008</i>	2010	Public health report
Mohindra, K. (Population Health Improvement Research Network)	<i>When Wildfires Burn: Towards the Development of an Appropriate Population Health and Public Safety Resource for Northeastern Ontario</i>	2013	Public health planning report
Moro, F, Z. Pasek, K. Pfaff and T. Sands (Erie-St. Clair Local Health Integration Network)	<i>Rural Emergent Healthcare: Selected Perspectives for the Erie-St. Clair Local Health Integration Network</i>	2009	Healthcare service evaluation
Rural and Northern Healthcare Panel (Ontario Ministry of Health and Long-Term Care)	<i>Rural and Northern Healthcare Framework/Plan: Stage 1 Report</i>	2010	Provincial health planning report
The Ontario Rural Council (The Rural Ontario Institute)	<i>Local Health Integration Networks (LHINs) and the Future of Rural Health: TORC Issues Paper from the Rural Health Forum Held September 25, 2006</i>	2007	Public consultation findings
The Ontario Rural Council (The Rural Ontario Institute)	<i>Summary of the Adult Working Group's Seaforth Consultations on Health and Learning with Adults Living in Rural and Remote Areas</i>	2008	Public consultation findings
The Ontario Rural Council (The Rural Ontario Institute)	<i>Rethinking Rural Healthcare: Innovations Making a Difference: Discussion and Recommended Actions Toward an Integrated Comprehensive Rural Health Strategy</i>	2009	Healthcare service evaluation
Waterloo Wellington Local Health Integration Network (Author)	<i>Waterloo Wellington Local Health Integration Network: Rural Healthcare Review</i>	2010	Healthcare service review
White, D. (Haldimand-Norfolk Health Unit)	<i>Addressing Rural Health Needs: Development of a Rural Health Framework and Application for Program Service Planning and Delivery</i>	2011	Public health planning report

Data Analysis

Conventional content analysis (Hsieh and Shannon 2005) was used to inductively code each health policy document as this process allows codes and dominant coding categories to emerge naturally from the data. The process of inductive coding enabled the researchers to immerse themselves (Hsieh and Shannon 2005) in this sample of health policy and planning documents to discover the context in which RMFs' health and healthcare needs are discussed. Data analysis and organization was conducted using N*Vivo 11 (QSR International 2016).

Eleven dominant categories of codes emerged from this sample of health policy and planning documents that help to contextualize how RMFs' health and healthcare needs are discussed. These categories include: rural healthcare service delivery, how to characterize "rural", health policy and planning recommendations, the government's role in rural healthcare, rural healthcare planning, rural health communications, rural health human resources, rural health promotion, health-related technology, farming and agriculture, and rural leadership in healthcare.

Recommendations are an important component of policy reports as they present suggested policy options to address a problem, convey government's intent to act on the problem or express the affected population's preferred methods to improve their current situation. Inductive coding (Hsieh and Shannon 2015) was also used to determine the extent to which RMFs' health and healthcare needs were included in health policy and planning recommendations. The top three categories of recommendations in this sample were: (1) improve access to rural healthcare services, (2) improve funding models that account for rural challenges, and (3) improve delivery of rural healthcare services. As part of conventional content analysis (Hsieh and Shannon 2005), the top three categories of recommendations were compared to the 11 dominant categories that contextualized how RMFs' health and their health needs were discussed to identify any relationships or overarching themes that might permeate the entire sample. Upon comparison, two overarching themes emerged to characterize the sample: (1) tokenism and (2) mending fences.

Results and Discussion

The presence of RMFs, their health and their healthcare needs in Ontario rural health policy and planning documents is limited. As such, the policy documents, coding categories and discussions of RMFs' health or healthcare needs can be described by two overarching themes: tokenism and mending fences. Tokenism refers to the general invisibility of RMFs' health and healthcare needs, except when stereotypes of a farm or farm-related injury can be used to describe rural areas. Mending fences captures both the desire of rural communities to be included in healthcare decisions, as well as the recognition by healthcare providers that improving relationships with farmers and agricultural organizations is a necessary step to improving rural health. This section will present evidence for and discuss how Ontario RMFs' health and healthcare needs are contextualized in health policy documents by the two dominant themes of tokenism and mending fences. Additionally, the limited number of documents published since 2013 will be discussed as a possible indication that RMFs and their health needs are absent from the Ontario health policy agenda.

Tokenism

Policy documents often used farming and agricultural stereotypes to symbolize rurality for a policy audience that may otherwise be unfamiliar with the complexities of the rural context. Specifically, farm-related injuries were used to highlight negative health outcomes associated with living and working in rural areas, "Another important cause of death for

rural residents is mortality from ‘external causes’ including farm accidents and traffic fatalities” (WW LHIN 2010: 40). An evaluation of hospital services in rural Ontario presents RMFs’ healthcare needs as being limited to the effects of having no workplace insurance to cover rehabilitation associated with farm injuries, “Another witness had surgery on his knee in 2008. He is self employed [sic] on farm without health insurance. His knee replacement was done in November 2009 in Toronto. He is still receiving physiotherapy” (Chase et al. 2010: 88). Additionally, an evaluation of the accessibility and delivery of rural emergency services in Ontario leveraged RMF’s farm injuries to rationalize the utility of a proposed model for emergency care (Scenario 2 in the following quote):

“A 63-year-old farmer collapses out in the field on a 38 Celsius degree summer day. His health condition may or may not require emergent care. In the event that he requires emergent care, there are three possible scenarios: Scenario 1: The farmer’s wife calls 911; Scenario 2: The farmer’s wife calls the local IRPC [Integrated Rural Priority Care] facility and asks for advice; Scenario 3: The farmer’s wife has no cellular coverage so seeks help from a neighbour and the farmer is driven by truck to the nearest hospital” (Moro et al. 2009: 84).

Relying on injury-related farming stereotypes to convey the health challenges or adverse health outcomes associated with rural communities is commonplace in government documents and presents a limited understanding of the range of the health issues faced by RMFs.

Due to the limited inclusion of RMFs in these policy documents, discussions of farmers’ health in general were also examined by the authors. Authors of government policy documents discussed farmers’ health issues in general by relying on token farm injuries and safety risks associated with the agricultural industry (Kitty 2007; Moro et al. 2009; WW LHIN 2010; White 2011). In contrast, policy documents informed by and drafted following engagement with rural communities present a full and nuanced understanding of health issues faced by farmers in general. For example, in addition to highlighting the importance of rural emergency care, bottom-up policy documents highlight that RMFs’ mental health is affected by stress, lack of sleep and prolonged bouts of isolation while working, and that limited opportunities exist for recreational physical activity (The Ontario Rural Council 2007, 2008, 2009). Despite including more health issues in the policy documents when the scope is broadened from RMFs’ health needs to the health needs of farmers in general, there was still limited discussion in health policy documents about possible policy or program solutions to address farmers’ health issues. Limited inclusion of general farmers’ health needs in the content of health policy documents suggests that, as with RMFs’ health needs, policy documents approach general farmers’ health needs as tokens that may help explicate the rural health context. For example, farmers in general only appear in lists of rural subpopulations or as a part of an example to support proposed policies and programs. The inclusion of general farmers in lists of rural subpopulations such as women, infants, children, youth, elderly,

Indigenous or Mennonites may also imply that “farmer” is synonymous with men in these documents, as men’s health needs are the only specific rural subpopulation not represented. The limited inclusion of RMFs’ health and health needs is also evident in the recommendations put forth by these policy documents.

RMFs’ health issues were rarely included in the policy and planning recommendations of the health policy documents reviewed in this study. When included, token farm injuries were used to advocate for improved healthcare service delivery to only a small number of rural communities. For example, RMFs’ injuries were leveraged to rationalize the need for improved ambulance response times in rural areas and to lobby the Ontario MOHLTC to implement and monitor response time standards:

“The panel heard that ambulance response times can be 30–45 minutes for traumas from car and farm accidents in rural areas. Thus, at optimum, baseline services should be 20 minutes from residents’ homes in average road conditions, and, at most 30 minutes from residents’ homes in average road conditions. This would allow ambulances access to a hospital emergency room within the critical ‘golden hour’ during which the intervention provided in a local emergency department can save life and improve health outcomes.” (Chase et al. 2010: 15).

In conclusion, limited inclusion of RMFs’ health needs, and general farmers’ health needs, in the recommendations put forth by rural health policy documents reinforces the proposition that farmers’ health needs are not on, and have limited ability to influence, the health policy agenda as they are either invisible or stereotyped when included.

Mending fences

To reinforce RMFs’ invisibility on the rural health policy agenda, the authors of these health policy documents did not specifically identify RMFs as a target population for community engagement. However, Ontario agricultural groups, whose membership is approximately 72% male (Statistics Canada 2011a), were identified as possible stakeholders for LHINs and rural hospital organizations to engage with to mend fractured relationships with rural communities caused by healthcare system reform and regionalization. Agricultural groups were considered “assets” to rural healthcare development due to their previous contributions to physical and social capital projects such as community health centres, local markets, hockey arenas and public water services (Caldwell et al. 2015; Kreutzwiser et al. 2010; WW LHIN 2010; White 2011).

Prioritizing improved rural community involvement in planning healthcare service delivery is a core component in the development and implementation of rural health hubs (Multi-Sector Rural Health Hub Advisory Committee 2015) and affirms recommendations put forth by Ontario’s guiding rural health policy, the *Rural and Northern Healthcare Framework/Plan* (MOHLTC 2010). Specifically, the MOHLTC (2010) recommends that

the LHINs actively engage with rural communities when making healthcare decisions about service planning, funding and delivery. In doing so, the LHINs may be able to: improve their understanding of local healthcare access needs, solve local healthcare challenges and identify methods to integrate funding across health and social services. Despite these recommendations by MOHLTC, “there have been no public consultations” (Chase et al. 2010: 84) between the LHINs and rural communities, which has contributed to rural communities’ loss of faith in the LHINs’ effectiveness and accountability to rural communities (Chase et al. 2010; Moro et al. 2009; The Ontario Rural Council 2007). Rural healthcare service removal and instatement of healthcare management personnel unfamiliar with the rural context has led rural communities to develop a “deep public anger and mistrust” toward the LHINs and rural hospitals (Chase et al. 2010: 83). Additionally, a perceived “lack of proper policy and planning ... [and] wasteful decision making” (Chase et al. 2010: 90) has further alienated the LHINs and rural hospitals from the rural communities they serve (Moro et al. 2009; The Ontario Rural Council 2009).

To restore faith in healthcare governance by the LHINs and rural hospital organizations, policy documents drafted by community-based organizations emphasized the need for LHINs and rural hospitals to provide rural communities with power and control of their healthcare services to improve community responsiveness to changes in healthcare service delivery (Chase et al. 2010). Community-based organizations suggested that LHINs and rural hospitals establish “health partnerships [that involve] faith groups, businesses, agriculture, and not-for profits” (The Ontario Rural Council 2009: 14) to transfer decision-making power back to rural communities. Authors of policy documents drafted by, or on behalf of, LHINs or public health units did not suggest methods nor identify community groups to involve in efforts to mend relationships with rural communities.

Authors of policy documents drafted by healthcare organizations and community-based organizations simultaneously recognized the challenges of engaging with RMFs since they often prefer to work in isolation and were found to avoid print materials when getting their information about local events (The Ontario Rural Council 2008; WW LHIN 2010). For engagement efforts to be effective, RMFs and healthcare organizations must establish a clear purpose and set of goals, have shared control over discussions and agenda setting, and aim to be sustainable engagements so trust can develop (Kenny et al. 2015). Therefore, despite the challenges with being reached, their community influence makes RMFs a key stakeholder group for LHINs and other rural healthcare organizations to engage with as they attempt to mend fences with rural communities.

Founded on the principle of affected interests (McKenzie and Wharf 2010), involving agricultural organizations in healthcare decision-making abilities would afford RMFs an opportunity to influence three streams that contribute to understanding the contexts that shape the formulation of rural health policy: problem, policy and politics streams (Kingdon 2010). The problem stream refers to health policy makers’ awareness of, and attentiveness to, a specific policy issue (Kingdon 2010), such as LHINs’ awareness of attentiveness to

RMFs' high mortality and morbidity rates due to agriculture-related injury (WW LHIN 2010). By consulting with agricultural organizations and RMFs about RMFs' agriculture-related injury, the LHINs may gain a broader understanding of the conditions that contribute to RMFs' farm injuries, such as fatigue, stress and other mental health issues, and thus set the rural health policy agenda to address RMFs' health needs on a broader scale than the current injury-centric approach. For example, understanding how fatigue, stress and other mental health issues affect RMFs' work behaviours may lead LHINs to include community outreach programs on the health policy agenda to provide RMFs with more community social support.

Additionally, providing agricultural groups and RMFs with power over their healthcare would enable them to influence the policy stream, which is the process of analysis and debate over how to address a specific policy issue (Kingdon 2010). Involving RMFs in the policy stream may allow them an opportunity to ensure that their, and other, rural healthcare needs are appropriately recognized and accounted for in rural health policy solutions. Due to their aforementioned involvement in rural community development projects, active and positive involvement of RMFs and agricultural groups could also influence the politics stream, which refers to the public mood on a specific policy issue (Kingdon 2010), and help improve public perception of rural healthcare organizations. Despite these possible positive policy steps, engaging RMFs in healthcare discussions may be a difficult task.

The limited sample of Ontario health policy and planning documents included for analysis may indicate that RMFs and their health needs have held a minute portion of the provincial health policy agenda (Buse et al. 2012). This portion has become smaller since 2013 as a single document (Caldwell et al. 2015) has been published that accounted for RMFs and their health needs since that time. Reduced inclusion of RMFs from rural health policy and planning documents may indicate that their health needs are not currently on the provincial health policy agenda (Buse et al. 2012), which may exacerbate existing health inequities such as disproportionately high all-cause, circulatory disease, respiratory disease, diabetes and injury-related mortality rates (CIHI 2006; Ostry 2012). Publication of a single document accounting for RMFs and their health needs may also indicate that the provincial rural health policy agenda has shifted to prioritize broader population health issues. For example, initiatives designed to improve access to healthcare for entire rural communities has remained on the provincial agenda as evidenced by the launch of rural health hubs (Multi-Sector Rural Health Hub Advisory Committee 2015; Ontario Hospital Association 2017). Such initiatives could benefit RMFs as some of their health needs may be addressed by policies that target rural healthcare improvement in general. Furthermore, since rural health hubs' guiding principles mandate community inclusion during healthcare planning (Multi-Sector Rural Health Hub Advisory Committee 2015), RMFs may have an opportunity to influence the policy stream (Kingdon 2010) by contributing to future debate regarding how to plan rural healthcare services to meet their and their communities' needs.

Conclusion

This analysis of health policy documents has revealed how RMFs' health needs were included in health policy documents and how they were included in recommendations for future policy. Policy documents predominantly relied on RMFs as tokens to symbolize rural healthcare access issues for members of the policy audience who may be unfamiliar with the diverse range of rural health needs. In doing so, authors of policy documents leveraged RMFs' agricultural injury-related needs to rationalize the need for and propose new models of rural healthcare service delivery. While this approach may improve healthcare service delivery to rural communities in general, it renders invisible other RMF health needs, such as mental health needs associated with long hours spent in isolation during farm season or chronic health needs associated with working in the agricultural industry. The authors of these policy documents also recognized the potential benefits of including RMFs and agricultural organizations in community engagement processes. Improving community engagement aligns with provincial goals established to improve rural healthcare delivery (MOHLTC 2010), and engagement with RMFs presents an ideal opportunity for impactful community participation due to their position as key stakeholders in rural communities. Therefore, sustained and meaningful consultation of RMFs by healthcare organizations may enable RMFs to ensure their healthcare needs are included on the policy agenda in the future. Sustained engagement with RMFs may also help healthcare organizations create programs and identify implementation strategies that align with the needs and preferences of RMFs, thus increasing their likelihood of accessing healthcare services.

This study is not without its limitations. Restricting the document search to include health policy and planning documents focused on rural healthcare in Ontario limited the scope of analysis to a single province within Canada and may have contributed to the small sample size. However, since each province and territory within Canada manages their own healthcare independently, restricting document analysis to a single province ensured that the findings were specific to a single healthcare context in Canada. An additional limitation is the inclusion of a single health policy document published by the Ontario MOHLTC. As previously mentioned, this limited inclusion of provincial health policy documents and small sample size may indicate that RMFs are absent from the health policy agenda in Ontario. Further research is needed to understand how RMFs and their health and healthcare needs are included in health policy and planning documents in other regions within Canada. Additionally, future research should investigate how to effectively reach out to RMFs to include them in discussions regarding the formulation of rural health policy and planning documents, and how RMFs prefer to engage with public policy makers. Doing so may enable healthcare service providers to more effectively design community engagement strategies that are better tailored to the needs and preferences of RMFs, which may improve the likelihood of sustained interactions and better health outcomes.

Correspondence may be directed to: Bradley C. Hiebert, Doctoral Candidate, Department of Health Information Sciences, FIMS & Nursing Building, Room 2050, Western University, London, ON N6A 5B9; e-mail: bhiebert@uwo.ca.

References

- Bowen, G.A. 2009. "Document Analysis as Qualitative Research Method." *Qualitative Research Journal* 9(2): 27–40. doi:10.3316/QRJ0902027.
- British Columbia Ministry of Health. 2015. "Rural Health Services in BC: A Policy Framework to Provide a System of Quality Care". Retrieved February 21, 2018. <<http://www.health.gov.bc.ca/library/publications/year/2015/rural-health-policy-paper.pdf>>.
- Brundisini, F., M. Giacomini, D. DeJean, M. Vanstone, S. Winsor and A. Smith. 2013. "Chronic Disease Patients' Experiences with Accessing Health Care in Rural and Remote Areas: A Systematic Review and Qualitative Meta-Synthesis." *Ontario Health Technology Assessment Series* 13(15): 1–33. Retrieved February 21, 2018. <<http://www.hqontario.ca/en/documents/eds/2013/full-report-OCDM-rural-health-care.pdf>>.
- Buse, K., N. Mays and G. Walt. 2012. *Making Health Policy, Second Edition*. New York, NY: Open University Press.
- Caldwell, W.J., P. Kraehling, S. Kaptur and J. Huff. 2015. "Healthy Rural Communities Tool Kit: A Guide for Rural Municipalities." Guelph, ON. Retrieved February 21, 2018. <<https://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/HealthyRuralCommunitiesToolKitcompressed.pdf>>.
- Canadian Agricultural Injury Reporting (CAIR). 2011. "Agricultural Fatalities and Hospitalizations in Ontario 1990–2008." Winnipeg, MB: Author. Retrieved May 26, 2015. <http://www.cair-sbac.ca/wp-content/uploads/2012/03/12-0814_Agricultural-fatalities-in-Ontario-FULL-REPORT-FINAL.pdf>.
- Canadian Institute for Health Information (CIHI). 2006. "How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants." Ottawa, ON: Author. Retrieved January 28, 2015. <https://secure.cihi.ca/free_products/rural_canadians_2006_report_e.pdf>.
- Chase, C., R. Gallaway, F. Gelinas, T. McDonald, N. Mehra, B. Proctor and K. Tod. 2010. "Toward Access and Equality: Realigning Ontario's Approach to Small and Rural Hospitals to Serve Public Values." Toronto, ON: Ontario Health Coalition. Retrieved May 3, 2017. <<http://www.ruralontarioinstitute.ca/file.aspx?id=ce33d262-b27e-49a1-986d-2da1b9d1c384>>.
- Cheung, K.K., M. Mirzaei and S. Leeder. 2010. "Health Policy Analysis: A Tool to Evaluate in Policy Documents the Aligned Between Policy Statements and Intended Outcomes." *Australian Health Review* 34(4): 405–13. doi:10.1071/AH09767.
- Clark, W.F., J.J. Macnab and J.M. Sontrop. 2008. "The Walkerton Health Study 2002–2008 Final Report." London, ON: London Health Sciences Centre.
- DesMeules, M., R.W. Pong, J.R. Guernsey, F. Wang, W. Luo and M.P. Dressler. 2012. "Rural Health Status and Determinants in Canada." In J.C. Kulig and A.M. Williams, eds., *Health in Rural Canada*. Vancouver, BC: UBC Press.
- Fleet, R., C. Pelletier, J. Marcoux, J. Maltais-Giguère, P. Archambault, L.D. Audette et al. 2015. "Differences in Access to Services in Rural Emergency Departments of Quebec and Ontario." *PLoS ONE* 10(4): 1–11. doi:10.1371/journal.pone.0123746.
- Fleet, R., J. Plant, R. Ness and S. Moola. 2013. "Patient Advocacy by Rural Emergency Physicians After Major Service Cuts: The Case of Nelson, BC." *Canadian Journal of Rural Medicine* 18(2): 56–61.
- Haas, B., T.A. Stukel, D. Gomez, B. Zagorski, C. De Mestral, S.V. Sharma et al. 2012. "The Mortality Benefit of Direct Trauma Center Transport in a Regional Trauma System: A Population-Based Analysis." *Journal of Trauma and Acute Care Surgery* 72(6): 1510–17. doi:10.1097/TA.0b013e318252510a.
- Hall, A. 2007. "Restructuring, Environmentalism and the Problem of Farm Safety." *Sociologia Ruralis* 47(4): 343–68. doi:10.1111/j.1467-9523.2007.00443.x.
- Hameed, S.M., N. Schuurman, T. Razek, D. Boone, R. Van Heest, T. Taulu et al. 2010. "Access to Trauma Systems in Canada." *Journal of Trauma* 69(6): 1350–61. doi.org/10.1097/TA.0b013e3181e751f7.
- Health Association Nova Scotia. 2013. "Rural Health and Service Delivery in Nova Scotia." Bedford, NS: Author. Retrieved February 21, 2018. <<https://www.healthassociation.ns.ca/sites/base/pages/mpe%20section/policydocuments>>.
- Hsieh, H.-F. and S.E. Shannon. 2005. "Three Approaches to Qualitative Content Analysis." *Qualitative Health Research* 15(9): 1277–88. doi:10.1177/1049732305276687.

- Kaasalainen, S., K. Brazil, A. Williams, D. Wilson, K. Willison, D. Marshall et al. 2014. "Nurses' Experiences Providing Palliative Care to Individuals Living in Rural Communities: Aspects of the Physical Residential Setting." *Rural and Remote Health* 14(2728): 1–13.
- Kenny, A., J. Farmer, V. Dickson-Swift and N. Hyett. 2015. "Community Participation for Rural Health: A Review of Challenges." *Health Expectations* 18(6): 1906–17. doi:10.1111/hex.12314.
- Kingdon, J.W. 2010. *Agenda, Alternatives, and Public Policies* (Second Edition). Boston, MA: Longman.
- Kitty, H.L. 2007. "Rural Health: A Qualitative Research Approach to Understanding Best Practices for Rural Health Service Delivery in a Public Health Setting." Simcoe, ON: Haldimand-Norfolk Health Unit. Retrieved August 3, 2016. <<http://www.ruralontarioinstitute.ca/file.aspx?id=b7788485-1d15-479b-8b10-13aae25ffdaf>>.
- Kreutzwisser, R., R.C. de Loë and K. Imgrund. 2010. "Out of Sight, Out of Mind: Private Water Well Stewardship in Ontario. Report on The Findings of The Ontario Household Water Well Owner Survey 2008." Waterloo, ON: Water Policy and Governance Group, University of Waterloo. Retrieved May 3, 2017. <<http://www.wpgg.ca/sites/default/files/Kreutzwisser%20et%20al%202010%20Summary.pdf>>.
- Leipert, B.D., D. Matsui, J. Wagner and M.J. Rieder. 2008. "Rural Women and Pharmacologic Therapy: Needs and Issues in Rural Canada." *Canadian Journal of Rural Medicine* 13(4): 171–79.
- McKenzie, B. and B. Wharf (Eds.). 2010. *Connecting Policy to Practice in the Human Services*. Don Mills, ON: Oxford University Press.
- Ministry of Health and Long-Term Care (MOHLTC). 2010. "Rural and Northern Health Care Framework/ Plan: Stage 1 Report." Toronto, ON: Queen's Printer of Ontario. Retrieved May 3, 2016. <http://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/report_rural_northern_EN.pdf>.
- Mohindra, K. 2013. "When Wildfires Burn: Towards the Development of an Appropriate Population Health and Public Safety Resource for Northeastern Ontario." Ottawa, ON: Population Health Improvement Research Network.
- Morassaei, S., F.C. Breslin, S.A. Ibrahim, P.M. Smith, C.A. Mustard, B.C. Amick et al. 2013. Geographic Variation in Work Injuries: A Multilevel Analysis of Individual-Level Data and Area-Level Factors Within Canada." *Annals of Epidemiology* 23(5): 260–66. doi:10.1016/j.annepidem.2013.03.008.
- Moro, F., Z. Pasek, K. Pfaff and T. Sands. 2009. "Rural Emergent Health Care: Selected Perspectives for The Erie-St. Clair Local Health Integration Network." Chatham, ON: Erie-St. Clair Local Health Integration Network. Retrieved May 3, 2017. <<http://www.eriesclairrhin.on.ca/Page.aspx?id=11328>>.
- Multi-Sector Rural Health Hub Advisory Committee. 2015. "Rural Health Hubs Framework for Ontario." Retrieved February 20, 2018. <<https://www.oha.com/Documents/Rural%20Health%20Hub%20Framework%20Ontario.pdf>>.
- Nair, B.V., R. Schuler, S. Stewart and R.M. Taylor-Gjevrev. 2016. "Self-Reported Barriers to Healthcare Access for Rheumatoid Arthritis Patients in Rural and Northern Saskatchewan: A Mixed Methods Study." *Musculoskeletal Care* 14(4): 243–51. doi:10.1002/msc.1146.
- Ontario Hospital Association. 2017. "Rural Health Hub Implementation Guide." Toronto, ON: Author. Retrieved February 20, 2018. <<https://www.oha.com/Documents/Final%20-%20Rural%20Health%20Hub%20Implementation%20Guide%20-%20May%204.pdf>>.
- Ostry, A. 2012. "Children, Youth and Young Adults and the Gap in Health Status Between Rural and Urban Canadians." In J.C. Kulig and A.M. Williams, eds., *Health in Rural Canada*. Vancouver, BC: UBC Press.
- Pitblado, J.R. 2012. "Geographical Distribution of Rural Health Human Resources." In J.C. Kulig and A.M. Williams, eds., *Health in Rural Canada*. Vancouver, BC: UBC Press.
- Pong, R.W., M. DesMeules, J.R. Guernsey, D. Manuel, A. Kazanjian and F. Wang. 2012. "Health Services Utilization in Rural Canada: Are There Distinct Rural Patterns?" In J.C. Kulig and A.M. Williams, eds., *Health in Rural Canada*. Vancouver, BC: UBC Press.
- QSR International. 2016. *N*Vivo 11*. Doncaster, Australia: Author.
- Rural Health Services Review Committee. 2015. "Rural Health Services Review Final Report." Government of Alberta. Retrieved February 21, 2018. <<http://www.health.alberta.ca/documents/>>

Rural-Health-Services-Review-2015.pdf>.

Sabatier, P. and S. Smith. 1993. *Policy Change and Learning*. Boulder, CO: Westview Press.

Statistics Canada. 2011a. "2011 Census of Agriculture." Ottawa, ON: Author. Retrieved July 12, 2017. <<http://www.statcan.gc.ca/eng/ca2011/ha#a1-1>>.

Statistics Canada. 2011b. "Population, Urban and Rural, by Province and Territory (Canada)." Ottawa, ON: Author. Retrieved July 12, 2017. <<http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo62a-eng.htm>>.

The Ontario Rural Council. 2007. "Local Health Integration Networks (LHINs) and The Future of Rural Health." Guelph, ON: Author. Retrieved May 3, 2017. <<http://ruralontarioinstitute.ca/file.aspx?id=b77a1c89-6dc2-41c7-835e-f32312097db1>>.

The Ontario Rural Council. 2008. "Summary of The Adult Working Group's Seaforth Consultations on Health and Learning With Adults Living in Rural And Remote Areas." Guelph, ON: Author. Retrieved May 3, 2017. <<http://ruralontarioinstitute.ca/file.aspx?id=524df970-8445-45fc-bcf3-4b10e5b77d49>>.

The Ontario Rural Council. 2009. "Rethinking Rural Health Care: Innovations Making a Difference. Discussion and Recommended Actions Toward an Integrated and Comprehensive Rural Health Strategy." Guelph, ON: Author. Retrieved May 3, 2017. <<http://www.ruralontarioinstitute.ca/file.aspx?id=1fb3035d-7c0e-4bfa-a8d7-783891f5c5dc>>.

Turner, L.A. and I. Gutmanis. 2005. "Rural Health Matters: A Look at Farming in Southwest Ontario Part 2." London, ON: Southwest Region Health Information Partnership.

Waterloo Wellington Local Health Integration Network (WW LHIN). 2010. "Waterloo Wellington Local Health Integration Network Rural Health Care Review: Final Report." Kitchener, ON: Author. Retrieved May 3, 2017. <http://www.waterloowellingtonlhin.on.ca/~media/sites/ww/files/forhsp/RPT_20100110_WWLHIN_RuralHealthReportFinal.pdf?la=en>.

Wathen, C.N. and R. Harris. 2007. "I Try to Take Care of It Myself.' How Rural Women Search for Health Information." *Qualitative Health Research* 17(5): 639–51. doi:10.1177/1049732307301236.

White, D. 2011. "Addressing Rural Health Needs: Development of a Rural Health Framework and Application for Program Service Planning And Delivery." Simcoe, ON: Haldimand-Norfolk Health Unit. Retrieved May 3, 2017. <<http://www.ruralontarioinstitute.ca/file.aspx?id=b7788485-1d15-479b-8b10-13aae25ffdaf>>.

Williams, A.M. and J.C. Kulig. 2012. "Health and Place in Rural Canada." In J.C. Kulig and A.M. Williams, eds., *Health in Rural Canada*. Vancouver, BC: UBC Press.

HealthcarePolicy.net