'It Starts at the Door': Environmental Factors & the Quality of Care for Women

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for Women and Health Care Reform

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Formerly the National Coordinating Group on Women and Health Care Reform

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- **Disclaimer**:
  - The opinions and conclusions expressed here are those of the authors, and no endorsement by the funders, including Health Canada, is implied.

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Research Objectives

- To understand what quality of care means to women based on their everyday encounters with the health care system.
- To develop empirically-based, gender-sensitive indicators of quality, based on the personal accounts of women in their interactions within the health care system.

Methods

- Focus groups were conducted in several regions and cities in Canada in 2003/2004.
- A semi-structured guide tapped into various dimensions of quality.
- Interviews lasted 1½ to 2 hours.
- All interviews were transcribed verbatim, and then coded and analyzed using N6.

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Province or Region	Number of Focus Groups	Number of Participants
British Columbia	4	17
Saskatchewan	4	24
Manitoba	3	20
Ontario	5	25
Quebec	6	36
Atlantic Region	3	23
TOTAL	25	145

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Women’s Perspectives on Quality Health Care

- Care that is woman-centred.
- Care that is comprehensive in nature.
- Care that involves a preventive focus.
- Care that is integrated, involves continuity, and has a long-term focus.

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Women's Perspectives on Quality Health Care (cont'd)

- Care that is accessible.
- Care that is culturally competent.
- Care that involves a range of providers who have the necessary skills.
- Care that is holistic & recognizes the changing nature of women's roles in society.

Step 1: Getting In

- Getting to care
  - "Accessibility means being able to get there."
  - "The greater the distance, the fewer the visits, the less care."
  - Challenges for all women in relation to:
    - Social responsibilities (work; family care)
    - Social locations
    - The structure of care and limited services (esp. in rural/remote areas)
    - Transportation as integral to care.

Step 1: Getting In

- "**It starts at the door.** When my arms were really bad, I could not open that door without wedging my elbow into it and grabbing it and yanking it and pulling it. There's no wheelchair button on the door and the handle is not friendly for people who have rheumatoid arthritis or a whole bunch of other conditions..." (NS) "Universal access has not even been in the plans or the thoughts of the designers of new clinics." (NS) "We have to have appropriate, accessible and functional caregiving facilities, whether they be for extended care or in a hospital or in a doctor's office so that people can get in and take advantage of those facilities and use them properly."

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Step 1: Getting In

- "Just because it has a button on the front door does not make that location physically accessible."
- "To get in, I couldn't. The secretary had to come to open the door."
  - Assumptions about "what a body is supposed to be able to do."
  - Assumptions about accommodations being made, but to what standard?

Step 1: Getting In

- The unique challenges of street-involved women:
  - Lack of health card
  - Need for the basics: “You shouldn’t be in a back alley…we’re not allowed to use washrooms… we’ve got our necessities. You can’t just drip dry… it’s a lot about safety, and in the end, that’s about your health too, right?”

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Step 2: Staying In

- Getting in is also linked to the social dimensions of care
  - The importance of social locations (age, class, ethnocultural background, area of residence, sexual orientation) as well as health issues and experiences.
  - "Attitude is the biggest barrier."

Step 2: Staying In

- **LGBTT women's experiences dealing with heteronormativity**.
  - The rainbow flag as a welcoming sign.
  - "There would be more accessibility if there was more education relieving the heterosexism that we have." (NS) "When people are talking to other people, don't assume anything about who you are. And whatever you are, whatever your sexuality is, it's your own damn business. Everyone should be included."
- Inclusion and non-discrimination are at issue. This is also about safety.

Step 2: Staying In

- **Overweight/Obese Women**
  - "Being overweight my whole life, the only thing the doctors wanted to do was put me on a diet. So that's been my experience. That was my first real experience, not caring or you know, not being looked after positively." (NS) "When I was 10, our family doctor put me on speed. My mum was thrilled to pieces because I had cleaned the whole house within an hour, because I was this bloody whirlwind, right?! But, to think, (laughing) how a doctor would put a 10 year old child on that?"

Step 2: Staying In

- "You're treated I like you're a second-class citizen." (NS) "Because of the way I look. Shouldn't I get health care? Like everybody else should get?"
- "I've gone to the dentist and the doctor with dandruff, and he said, 'You need to lose weight.' But it's not funny; you're very definitely treated very differently when you're overweight. It's almost as if every single issue that you go to the doctor with, the weight is going to impact it."

Step 2: Staying In

- "The thing for me, that it comes down to, is I need to feel that I have been respected. My beliefs, my lifestyle, I need as a person to feel respect. I need to feel as though I'm being treated like he would treat the next patient that came in; with as much concern, and thoughtfulness, and so on, as anybody else."

One Size Does Not Fit All

- Quality is easily and structurally compromised when people are othered in their encounters with the health care. The impacts include:
  - Compromised health status.
  - Avoidance of health care.
  - Increased marginalization.

Conclusions & Implications

- The care that women want vs. the care that the system seems to think is important.
  - Developing a relationship vs. providing a service.
  - The values feminists articulated in the second wave are still important today.
- Not only care should reflect these values, so should the accountability measures.

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