Beyond barriers in studying disparities in women's access to health services in Ontario, Canada: a qualitative metasynthesis

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ABSTRACT

Women live within complex and differing social, economic, and environmental circumstances that influence options to seek health care. In this article we report on a metasynthesis of qualitative research concerning access disparities for women in the Canadian province of Ontario, where there is a publicly funded health care system. We took a metastudy approach to analysis of results from 35 relevant qualitative articles to understand the conditions and conceptualizations of women's inequitable access to health care. The articles' authors attributed access disparities to myriad barriers. We focused our analysis on these barriers to understand the contributing social and political forces. We found that four major, sometimes countervailing, forces shaped access to health care: (a) contextual conditions, (b) constraints, (c) barriers, and (d) deterrents. Complex convergences of these forces acted to push, pull, obstruct, and/or repel women as they sought health care, resulting in different patterns of inequitable access.

Key Words

Health care, access to; health care disparities; metasynthesis; women's health

Equitable access to effective health care can reduce the social and economic burdens associated with ill health, including disability and loss of income. However, many constraining, enabling, and need factors can complicate access to care, and these have been linked with socioeconomic position (Dunlop, Coyte, & McIsaac, 2000; Finkelstein, 2001), citizenship or immigration (Asanin & Wilson, 2008), health status (Kisely et al., 2007), and geographic location (Glazier et al., 2004; Lofters, Glazier, Agha, Creator, & Moineddin, 2007). Although many researchers have conceptualized gender inequities in health care as being related to various barriers, few have delved further into the converging relational forces that contextualize women's efforts to obtain health-related services. As part of the Project for an Ontario Women's Health Evidence-Based Report (POWER) study, we conducted a qualitative metasynthesis to complement analysis of quantitative indicators of women's access to health care in Ontario, Canada (Bierman et al., 2010).

The POWER study team examined a comprehensive set of quantitative evidence-based indicators identified through a rigorous modified Delphi process to evaluate gender and socioeconomic differences in access (Bierman et al., 2010). We used a community-engaged research model, and during consultations with clinical and community stakeholders we repeatedly heard that there is a need to understand the social and material contexts of women's health-related decisions and actions. Stakeholders also asked us if it would be possible to go beyond studying the quantitative indicators and seek more detailed information about what it is like for women to manage their health, seek care, and receive health services. Qualitative methods of inquiry were used to obtain detailed descriptions of access to health care in small, purposefully selected groups of women. We also recognized that qualitative metasynthesis was a novel approach to meet our need for more detailed information.

Understanding Access Disparities for Women

We were aware that, over time, conceptual approaches to access disparities have highlighted different aspects of the problem. Aday and Andersen proposed a behavioral model, arguing that actual use of health services was determined by individual health needs, the predisposition to seek care, and a range of enabling or impeding factors (Aday & Andersen, 1974; Andersen, 1995). Subsequent conceptual approaches reflected greater emphasis on the potential mismatch between available health services and the needs or expectations of distinct subpopulations (Gulliford et al., 2002; Sanmartin & Ross, 2006). More recently, there have been calls for a holistic view because, although most determinants of health and illness are situated outside the health care sector, they are deeply implicated in the need for and subsequent access to care (Bierman & Dunn, 2006; Frohlich, Corin, & Potvin, 2001; Frolich, Ross, & Richmond, 2006). Finally, Dixon-Woods and colleagues drew attention to the coordinated sequences of work and interaction associated with access, arguing that "receipt of healthcare is the outcome of many different complex processes, of which all need to be recognized if access is to be properly understood" (2006, p. 7/13). Thus, the initial focus on health-seeking behaviors has broadened into concern with the design and delivery of health services, as well as the broader sociopolitical context in which they are offered.

We also recognized that women live within complex and differing social, economic, and environmental circumstances that influence options for health behavior and health care (Hankivsky & Christoffersen, 2008; Hankivsky et al., 2010). We were convinced that inequitable conditions, such as poverty and discrimination, interact to form health inequalities in those women who already face significantly limited opportunities (Hankivsky & Christoffersen; Hankivsky et al.). Disparities in health and access to health care are intensified by gender-specific impacts of sociopolitical conditions such as (a) health policies and services that reinforce and complicate women's economic vulnerabilities, (b) the lifelong medicalization of women's reproductive health, and (c) women's unpaid work as providers of family care (Bird & Rieker, 2008; Read & Gorman, 2010; Zimmerman & Legerski, 2010).

Although many qualitative researchers have reported specific barriers to access, there have been few accounts of forces that contour the sequential and changing interplay between individual women and health services institutions (Dixon-Woods et al., 2006). In addition, to narrowly conceptualize low income as an access barrier obscures its multiple influences over health and illness at different points in women's lifetimes, because income is linked with social position as well as material circumstances and available resources (Kosteniuk & Dickinson, 2003; McDonough, Sacker, & Wiggins, 2005). For these reasons, we chose to use qualitative metasynthesis to work toward a more detailed understanding of how women access health services in the geopolitical context of the Canadian province of Ontario.

The Social and Health Services Context of Ontario, Canada

Canada's publicly funded health care system is composed of ten provincial and three territorial health insurance plans. All provincial and territorial plans are based on the principle of universal coverage for medically necessary hospital and physician services provided on the basis of need rather than the ability to pay. It is not a unified system like the National Health System in the United Kingdom (Armstrong & Armstrong, 2010; Deber, 2003). Instead, provincial systems vary in their definition of "medically necessary services" and the proportion of public funds allocated to health care expenditures (Deber). Some have argued that Canada has one of the most limited public health care systems, because in most provinces dental care is still almost entirely private and prescription drugs are only partially covered (Deber).

The economic strengths of Canadian provinces vary and, with time, fiscal pressures on provincial budgets result in cost-restructuring "reforms" (Armstrong & Armstrong, 2010). These include budget cuts for hospitals and greater pressures on health providers to increase efficiency of care to more patients (Deber, 2003). Over the past decade in Ontario, cost-cutting strategies involved changing the location of service delivery from the hospital to the community, and reducing the list of insured services, such as physiotherapy and routine eye exams (Jin, Buys, Hatch, & Trope, 2012; Landry et al., 2006). Care in the community, including home care, subsequently became subject to competitive bidding by private contractors. Community-based health services were subject to "managed competition," tendering of contracts to lowest bidders, and tightening of eligibility requirements for public funding (Baranek, Deber, & Williams, 1999; Daly, 2007). This delisting of and adoption of market competition for previously insured services has long-term health consequences for those who lack additional private insurance or have low incomes (Armstrong & Armstrong; Jin et al.; Paul et al., 2008).

Ontario is Canada's most populous and diverse province, with marked regional contrasts. The densely populated urban sprawl of southern Ontario juxtaposes with more remote conditions in northern Ontario, where only 10% of the population is spread across almost 90% of the province's land mass (Timmermans et al., 2011). Northern residents rely heavily on highway travel, amid harsh

climatic conditions and thin health resource dispersal (Sahai et al., 2000). Conversely, Ontario's capital city of Toronto is Canada's largest city and the country's major gateway for immigrant newcomers (Murdie, 2008). Toronto, like much of southern Ontario, is culturally diverse and 50% of the residents are immigrants, compared to 20% nationally (Murdie). Ontario's geographic and social contrasts increase the complexity of access disparities in the province, and many qualitative studies have been conducted to analyze how vulnerable groups "live out" these conditions.

Purpose

Recently, approaches have been developed for metasynthesis of qualitative research so that the findings can be aggregated and synthesized to refine major themes (Barnett-Page & Thomas, 2009; Noblit & Hare, 1988; Paterson, Thorne, Canam, & Jillings, 2001). Qualitative metasynthesis involves comparative, interpretive analysis of findings from several studies to identify recurrent themes (Paterson et al., 2001). Published metasyntheses of qualitative research related to health services access include experiences of primary care for people with chronic illnesses (Dubouloz et al., 2010), elders' encounters with cancer treatment (Hughes, Closs, & Clark, 2009), barriers to antenatal care for marginalized women in high-income countries (Downe, Finlayson, Walsh, & Lavender, 2009), and consumer decision making for knee replacement surgery (O'Neill, Jinks, & Ong, 2007). We were unable to find any qualitative metasyntheses that dealt with women's access to health care services in a specific geopolitical location, such as a single province of Canada.

We conducted a qualitative metasynthesis to better understand mechanisms leading to disparities in health and health care access for women in Ontario, within a sociopolitical context of retrenchment in publicly funded health services. Our metasynthesis was guided by two questions: How do the reviewed studies describe the conditions under which women engage with the health care system in Ontario? How do these studies conceptualize inequitable access to health care in Ontario? The review was conducted as part of a mixed-methods approach in which qualitative findings were used to better understand issues of inequitable health care access identified in POWER study quantitative analyses.

Methods

Systematic Search Strategy

We devised a comprehensive search strategy in consultation with a health services librarian specialist. Medline, CINAHL, PsycInfo, Social Sciences Abstracts, Web of Science, Scopus, Gender Studies, and LGBT Life databases were searched for qualitative studies published from 2002 to 2008, which was the time period covered by the POWER study analysis of indicators. The chosen search terms varied somewhat because of the structures of the different databases, but were comparable across searches. The keywords and terms were chosen to obtain a wide selection of published articles about access (e.g., "health services accessibility," "health services for the indigent," "healthcare delivery," "health services misuse," "access"), groups of women (e.g., "marginalized," "disadvantaged," "aged," "homeless," "youth," "lesbian," "immigrant"), and regions of Ontario (e.g., "rural health," "urban health," "medically underserved area," "remote"). We also focused the search by using terms that would capture articles about qualitative studies (e.g., "qualitative research," "focus groups," "ethnographic," "grounded theory," "interviews"). Besides searching computerized databases, we found additional studies by crosschecking with reference lists of relevant articles, and we acted on suggestions from POWER study stakeholders and colleagues.

Inclusion and Exclusion Criteria

A total of 194 abstracts were retrieved, 38 of which were duplicates. Cechetto reviewed and screened all of the abstracts against the following inclusion criteria: (a) use of qualitative design, (b) published in peer-reviewed journals between January 2002 and January 2008 (to sample qualitative studies that represented the time period evaluated by the POWER study indicators), (c) sample recruited at least partially in Ontario,[1] (d) women participants, (e) English-language studies, and (f) studies approved by ethical review boards. Mixed methods studies with detailed discussion of a qualitative component were eligible for inclusion. Angus and Lowndes screened any abstracts that were in question. Seventy-one abstracts met the inclusion criteria, and the articles were retrieved and appraised.

Appraisal of Included Articles

The first stage of appraisal involved reading and further screening articles to extract those with clear relevance to the questions posed for the synthesis. Thirty-four research reports were removed from the set because they (a) were based on mixed-methods studies and included insufficient detail about the qualitative methods and findings, (b) included both men and women and pooled findings so gender differences were not analyzed, or (c) did not include people from Ontario. We selected articles in which we found insights into the two research questions. Not all articles were written entirely about access to health care; rather,

some contained lengthy sections on this issue, so they were included in the set.

In the second stage of appraisal, each of the remaining 37 articles was read, reviewed, and scored independently by two of three reviewers: Angus, Lowndes, and Cechetto. We used a form based on the Critical Appraisal Skills Program (CASP) tool for qualitative research (National Health Service, 2006). Many authors have contributed to ongoing discussion and disagreement about evaluative criteria for qualitative research, and many approaches exist (Cohen & Crabtree, 2008; Eakin & Mykhalovskiy, 2003; Pawson, 2006). The CASP appraisal form is often used to assess the rigor of qualitative studies prior to meta-synthesis, and it has been favorably compared to other appraisal tools (Feder, Hutson, Ramsay, & Taket, 2006; Malpass et al., 2009). Although the form was not designed to assign numeric scores to research articles, we initially adapted it by assigning points to each section to make a total of ten. However, we eventually realized that the main advantage of this system was to generate and guide discussion of the relative substantive merits of each article.

Each article was assessed and scored by two reviewers. Scores were consistent between reviewer pairs, but like Malpass et al. (2009), we ultimately chose to assign each of the relevant articles into three groups: as a "key article" if it seemed likely to offer considerable substantive depth to the synthesis; as a "satisfactory article" if it met the CASP criteria; or as an "unsatisfactory article" if it did not meet the criteria and seemed unlikely to contribute to the analysis. Two articles were assigned to the latter category after some discussion among all three reviewers, and they were not included in the set. In one of these two articles, there was minimal description of the qualitative methods, and no supportive quotes in the results section. The second was a report of a study that included women from both Ontario and the United States; in reading the results of the study, we were unable to determine which pertained to the Ontario women. Thus, both articles seemed unlikely to yield insights into our guiding questions (see Figure 1 for a summary of article selection).

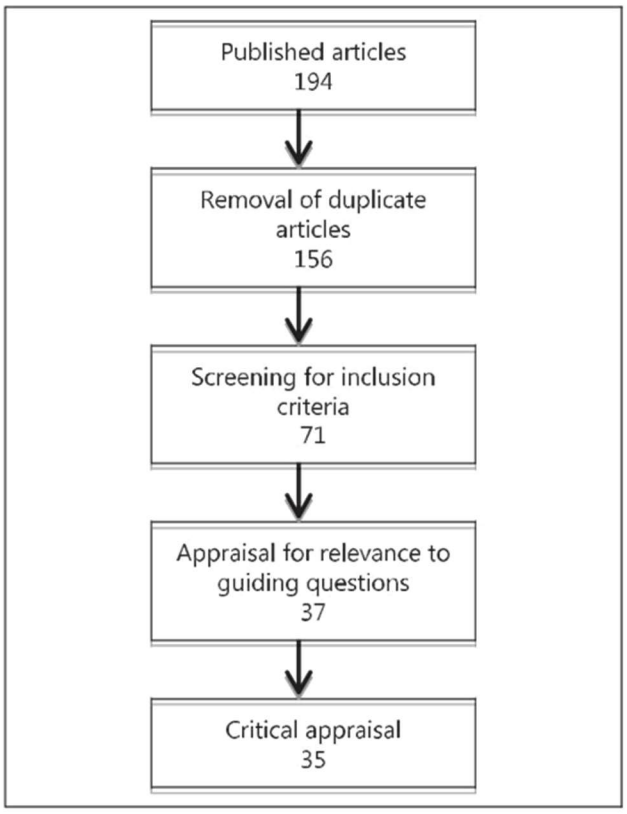

Figure 1. Identification and inclusion of studies in the review.

Description of Included Studies

Thirty-five articles were included in the analysis and together they offered a sample of 1,225 women from urban, suburban, and rural areas of Ontario. There were studies of women at various stages of the lifespan (adolescent, young adult, recent mothers, middle-aged, and older) in a range of economic circumstances (low-income, homeless, middle-class, self-employed), and who had been marginalized according to perceived social identities (immigrant, lesbian, disabled, ethnoracial membership). Women with a number of acute and chronic health problems were represented, but there were also studies of access to resources that promote health and prevent illness. Across the set of articles, most authors attributed access disparities to myriad barriers, implying that the major mechanism behind access disparities was obstruction of women's efforts to obtain care. Yet our reading of these articles revealed instances of greater complexity than could be resolved by the simple removal of any one of the identified barriers. Our synthesis of the articles proceeded from this observation.

Synthesis

Metastudy (Paterson et al., 2001) involves concurrent analysis of data, methods, and theories. In this article, we emphasize the results of one component, the metadata analysis (Paterson et al.). Each of the remaining 35 articles was carefully read, reread, and annotated to identify concepts, phrases, and metaphors that addressed our synthesis questions. During biweekly meetings, Angus, Lowndes, and Cechetto compared articles, noting how key results recurred or differed across studies. Through this process we developed a coding scheme that iteratively evolved over the process of reviewing the entire set of articles. Codes and their definitions were developed through discussion and consensus.

Ahmad, a POWER study coinvestigator with expertise in qualitative research, reviewed and verified the coding scheme and representative articles by (a) considering how it applied to the three articles in the set she had authored or coauthored and (b) using it to read and code an article she was unfamiliar with. We considered her familiarity with access disparities for immigrant women a strong basis for verification and elaboration of the evolving analysis. Following her review of our work in progress, she suggested we add two additional codes. All articles were coded using this scheme and the corresponding segments of text were collected in separate computer files for each code.

We were mindful of the assertion that metasyntheses should be "more than the sum of parts, in that they offer novel interpretations of findings" (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004, p. 1358). Despite the interpretive and constructivist philosophical foundations of metastudy (Paterson et al., 2001), we also realized that the intention to integrate studies into novel terms tacitly acknowledged our acceptance of a "shared and discoverable reality" among the set of 35 articles (Gomersall, Madill, & Summers, 2011, p. 861). As the analysis progressed, we sought to move beyond summary of the various "barriers" identified in the articles and to better understand their generative circumstances.

In numerous core team meetings we struggled to untangle within the coded excerpts the origins and influences of various mechanisms that contributed to access disparities. We noted that in many cases the same barrier could be differently implicated in women's interactions with the health care system. This convinced us to focus more deeply on how these different interactions played out. We gradually discerned four distinct and directional forces and refined conceptualization of these by diagramming them and returning to the coded excerpts as well as the articles themselves for verification. Despite our initial reservations about the recurrent term *barriers*, we eventually agreed to retain this concept by narrowing its conceptualization. We defined barriers as those systemic features of the health care system that actively barred or obstructed women's access to care. Other identified forces were predisposing contextual conditions, the restrictions imposed by situational constraints, and the deterrents posed by unpleasant or marginalizing previous encounters with health services.

In metadata analysis, data saturation is restricted by the nature of the primary data set (Paterson et al., 2001). However, we found that subgroups of studies offered rich information about specific dimensions of access. When pieced together, these rich sources formed a wide-angle view of the spectrum of access issues (see Table 1 for dimensions of access identified in each article). Furthermore, in exploring these rich sources (often, but not always, those studies rated as key articles), we were prompted to revisit and review previously coded articles with new understanding. We tried to answer the guiding questions in a way that was "faithful to the interpretations of the original data . . . that is, it accurately portrays the shared and unique findings of the included research studies" (Paterson et al., p. 65). Lombardo, who was not involved in the initial analytic process, subsequently read all of the articles. He confirmed that the metadata analysis was consistent with the content of the articles, and then conducted a further analysis that was focused on the representation of women's health-seeking activities (Lombardo et al., 2012).

Results

In the following sections we present the findings of our meta-analysis, drawing attention to the interplay between the structure and delivery of health care services and women's complex, differing life circumstances. In synthesizing themes across the 35 articles, we found that women's access to health care was shaped by four sometimes opposing forces: (a) contextual conditions, (b) constraints, (c) barriers, and (d) deterrents (see Figure 2). Furthermore, we saw that these forces acted separately and differently to push, pull, obstruct, or even repel women as they sought to access health services. The four forces could act in various combinations, as reflected in a final theme, complex convergences.

Contextual Conditions

Across several studies, participants gave accounts of stressful or unhealthful life circumstances, highlighting challenges and disadvantages that made it difficult to promote and protect their own health. Participants pointed out contextual conditions that they thought could generate, accelerate, or exacerbate health problems. Predisposing contextual conditions included competing priorities, poverty and homelessness, marginalization and vulnerability, and violence and victimization. They were described as difficult or impossible to avoid, and often related to insecurities about subsistence or social competency.

Competing priorities. A recurrent theme was the pressure on women to prioritize issues other than their own health, but two groups were identified by researchers as particularly vulnerable: rural and immigrant women. Some researchers showed that rural and small-town life was based in traditional and patriarchal norms of gendered domesticity, with women as the principal familial caregivers and homemakers (Leipert & George, 2008; Sutherns, 2004). Several authors described the lives of rural women, who balanced farm chores, domestic work,

Table 1. Description of Reviewed Articles, With Associated Themes and Subthemes.

Authors, Year	Sample	Methods	Conditions	Constraints	Barriers	Deterrents
Ahmad et al., 2004a	21 recent immigrant Indian, Hindi-speaking women	Focus groups in Hindi Thematic analysis	Competing priorities Marginalization and vulnerability	Economic hardship Opening space for health care Linguistic or cultural constraints	Eligibility for coverage Provider–patient communication	Inconveniences
Ahmad et al., 2004b	46 recent immigrant women from mainland China and India	Focus groups Thematic and comparative analysis	Competing priorities Marginalization and vulnerability	Opening space for health care Linguistic or cultural constraints	Provider–patient communication	Inconveniences
Aronson, 2003	27 women with chronic illness and/or disability, receiving home care	Longitudinal, two interviews per year Critical social theory analytic lens	Marginalization and vulnerability	Economic hardship	Limited availability, cutbacks, and funding cuts	Intensification of social vulnerability
Aronson, 2006	As above for Aronson, 2003; 22 remaining participants	As above for Aronson, 2003; later findings from same study			Limited availability, cutbacks, and funding cuts	Intensification of social vulnerability
Barnoff, Sinding, & Grassau, 2005	26 lesbian women with cancer	Participatory Interviews Thematic analysis				Intensification of social vulnerability
Bates, 2004	57 women, self-employed, Ontario & Nova Scotia	Semistructured interviews Descriptive analysis	Poverty and homelessness	Economic hardship		
Bethune-Davies, McWilliam, & Berman, 2006	8 women with disabilities, receiving home care	Semistructured interviews Hermeneutic interpretive analysis Critical feminist lens	Marginalization and vulnerability	Economic hardship	Limited availability, cutbacks, and funding cuts	Intensification of social vulnerability
Butters & Erickson, 2003	30 urban women, crack users, homeless or underhoused	Mixed methods Structured interview guide Content analysis	Poverty and homelessness Violence and victimization		Eligibility for coverage	Intensification of social vulnerability
Caldwell, Arthur, & Rideout, 2005	12 rural women, post myocardial infarction Follow-up interviews with physicians	Open-ended interviews; 2 to 3 per participant Critical ethnography	Competing priorities	Opening space for health care	Provider–patient communication Limited availability, cutbacks, and funding cuts	
Cooper-Brathwaite & Williams, 2003	6 immigrant, Chinese Canadian new mothers	Ethnographic interviews Cultural theory		Linguistic or cultural constraints		Intensification of social vulnerability
Friedman & Hoffman-Goetz, 2003	18 urban older women	Focus groups Descriptive analysis			Provider–patient communication	
Gould, 2004	14 low-income women with breast cancer	Interviews and focus groups Descriptive analysis	Poverty and homelessness	Economic hardship Opening space for health care		

(continued)

Table 1. (continued)

Authors, Year	Sample	Methods	Conditions	Constraints	Barriers	Deterrents
Gray, James, Manthorne, Gould, & Fitch, 2004	276 rural women with breast cancer (multiple provinces, three locations in Ontario)	17 focus groups Descriptive coding and thematic analysis	Competing priorities Poverty and homelessness	Opening space for health care	Provider–patient communication Limited availability, cutbacks, and funding cuts	
Ismail, Berman, & Ward-Griffin, 2007	11 adolescent and young women encountering dating violence	Group and individual interviews Content analysis Critical feminist lens	Violence and victimization	Linguistic or cultural constraints		Intensification of social vulnerability
Jack, DiCenso, & Lohfeld, 2005	20 mothers of at-risk children receiving social services Service providers	Interviews Grounded theory		Linguistic or cultural constraints		Intensification of social vulnerability
Leipert & George, 2008	65 rural women	Focus groups and interviews Descriptive analysis	Competing priorities Violence and victimization	Linguistic or cultural constraints	Limited availability, cutbacks, and funding cuts	
Mitra, Jacobsen, O'Connor, Pottie, & Tugwell, 2006	8 immigrant women from sub-Saharan Africa and the Caribbean Health providers	Interviews Descriptive content analysis		Opening space for health care Linguistic or cultural constraints	Provider–patient communication	
Montgomery, Tompkins, Forchuk, & French, 2006	20 mothers with mental illness	Interviews, theoretical sampling Grounded theory				Intensification of social vulnerability
Nelson & Agyapong, 2004	15 immigrant Black women with breast cancer	Interviews Descriptive analysis	Marginalization and vulnerability		Provider–patient communication	Intensification of social vulnerability
Odette et al., 2003	45 women with disabilities, rural and urban residents	Focus groups Descriptive, thematic analysis	Poverty and homelessness Marginalization and vulnerability		Provider–patient communication	Intensification of social vulnerability
Power, Brown, & Ritvo, 2008	30 women with ovarian cancer	Semistructured interviews Grounded theory analysis			Provider–patient communication Limited availability, cutbacks, and funding cuts	
Reid, Berman, & Forchuk, 2005	10 homeless adolescent and young women	Individual or small group interviews Thematic analysis Critical feminist lens	Poverty and homelessness Violence and victimization	Economic hardship Opening space for health care	Eligibility for coverage	Intensification of social vulnerability
Ross, Ali, & Toner, 2003	48 adolescent women with depression	Participatory focus group study Descriptive thematic analysis			Provider–patient communication	Intensification of social vulnerability
Sinding, Barnoff, & Grassau, 2004	26 lesbian women with cancer	Participatory Interviews Thematic analysis			Provider–patient communication	Intensification of social vulnerability

(continued)

Table 1. (continued)

Authors, Year	Sample	Methods	Conditions	Constraints	Barriers	Deterrents
Sinding, Wiernikowski, & Aronson, 2005	15 older women with breast cancer	Interviews Grounded theory		Opening space for health care	Provider–patient communication	
Sutherns, 2004	36 rural new mothers	Semistructured interviews Descriptive, thematic analysis	Competing priorities	Linguistic or cultural constraints	Limited availability, cutbacks, & funding cuts	
Sutton, Meizi, Despard, & Evans, 2007	11 breastfeeding mothers, Vietnamese immigrants	Interviews in Vietnamese Descriptive content analysis		Opening space for health care	Provider–patient communication	Intensification of social vulnerability
Sword, 2003	26 low-income expectant mothers	Interviews, focus groups Grounded theory		Economic hardship	Provider–patient communication	
Tarrant & Gregory, 2003	28 Aboriginal mothers	Interviews Descriptive content analysis		Linguistic or cultural constraints	Provider–patient communication	Inconveniences Intensification of social vulnerability
Uskul, Ahmad, Leyland, & Stewart, 2003	29 women, after hysterectomy	Interviews Thematic analysis Decision theory			Provider–patient communication	
Vahabi & Gastaldo, 2003	180 young women with no history of breast cancer	Mixed methods Open-ended interviews Risk theory		Linguistic or cultural constraints	Provider–patient communication	
Wathen & Harris, 2007	40 rural women	Interviews Descriptive analysis	Competing priorities	Opening space for health care Linguistic or cultural constraints	Provider–patient communication	
Woolhouse, Brown, & Lent, 2004	36 women with low income, in shelters or transitional housing	Focus groups Constant comparative analysis	Poverty and homelessness	Opening space for health care	Provider–patient communication	Intensification of social vulnerability

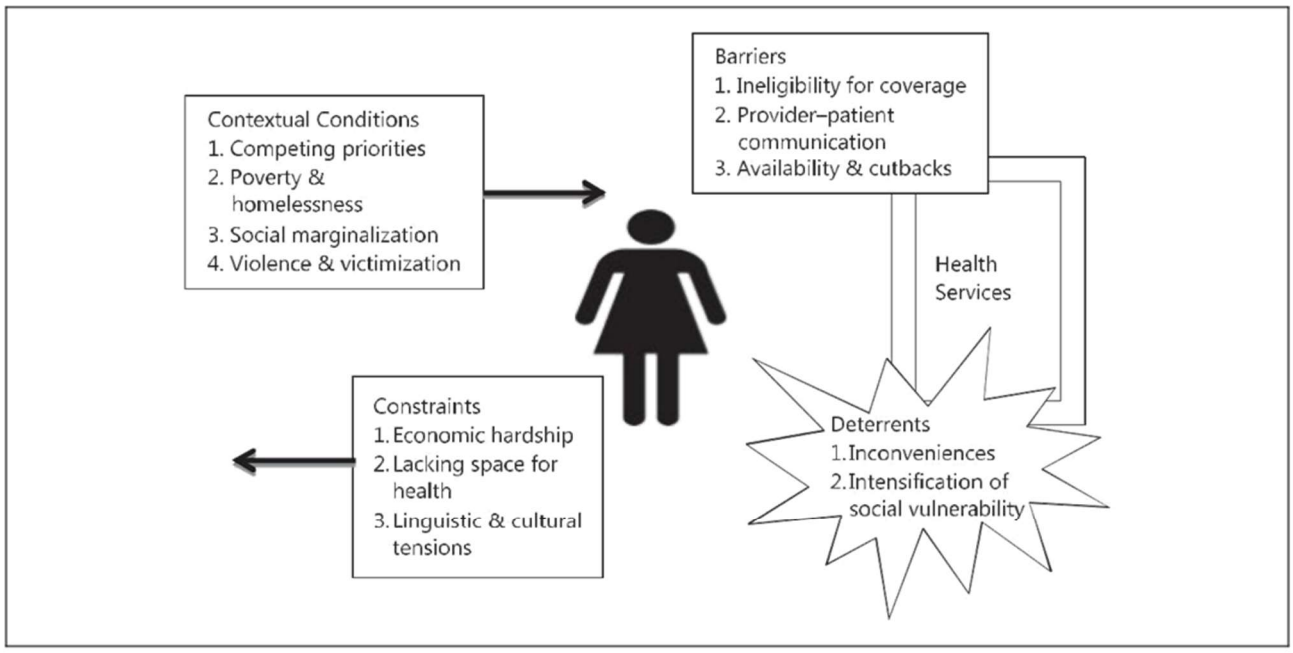

Figure 2. Forces shaping women's access to health services.

and part-time employment off the farm to supplement the family income (Caldwell, Arthur, & Rideout, 2005; Gray, James, Manthorne, Gould, & Fitch, 2004; Leipert & George). Within this context, participants explained that they had little time or encouragement to think about their own needs. Wathen and Harris (2007) also found that some participants had worries about health hazards associated with pesticide use and regular exposure to animals that could be disease vectors.

Ahmad and colleagues illustrated the pressures of resettlement for Ontario's growing population of recent immigrants (Ahmad et al., 2004a; Ahmad et al., 2004b). Women who recently arrived from India described economic uncertainty and downward social mobility, explaining that to support their families they had to remain in stressful or even harmful employment situations (Ahmad et al., 2004b). The Canadian lifestyle was viewed as extremely time pressured, with little time to relax and renew. Particularly troublesome was difficulty in balancing employment with gendered domesticity. Immigrant women described the mental and physical health implications of the chronic stress imposed by competing priorities:

> [B]ut the thing is that we are immigrants and if anyone of us complains we are afraid we will lose our job. And at home if only one person (is earning), how are you going to run your house, how will you survive? (Ahmad et. al., 2004b, p. 120)

Poverty and homelessness. Low income was identified in several articles as a potential contributor to multiple health-related issues. Women who were employed part time or were self-employed lacked access to benefits that protect and maintain health; for example, they could not afford preventive dental services (Bates, 2004; Gray et al., 2004). Women who received inconsistent income, unemployment insurance, disability pensions, or welfare payments described problems with homelessness, inadequate or unstable housing, and/or inadequate nutrition (Butters & Erickson, 2003; Gould, 2004; Odette et al., 2003; Reid, Berman, & Forchuk, 2005; Woolhouse, Brown, & Lent, 2004). Homeless women might resort to panhandling or "survival sex" to obtain food, shelter, or drugs, and were consequently at risk for violence and additional health problems (Butters & Erickson; Reid et al., 2005). Woolhouse and colleagues studied women staying in shelters or transitional housing, and found that many were mothers who had inadequate financial resources, were leaving violent relationships, and could not afford safe housing for themselves and their children.

Marginalization and vulnerability. With attention to retrenchment of social and health services, some researchers explored the emerging social predicaments of women with chronic illnesses and disabilities, illuminating challenges to health promotion and full social participation (Aronson, 2003; Bethune-Davies, McWilliam, & Berman, 2006; Odette et al., 2003). These authors found ongoing tensions for those women who valued the option to live independently in their own homes, because cutbacks in

home care services meant that help was increasingly needed from family and friends (Aronson, 2003; Bethune-Davies et al., 2006). Dependency on others for help became a source of shame and altered undesirably the nature of social relationships. Without easily available transportation, accessible buildings, and personal assistance, women described becoming isolated and unable to "get out" for recreation, shopping, and socialization (Bethune-Davies et al.). Odette and colleagues showed that when women with disabilities sought to promote their health, they encountered inaccessible grocery shelves, unreliable transportation, and inappropriately designed exercise programs, many of which were priced beyond their low incomes (Odette et al.).

Other researchers reported how the migration experience resulted in various forms of marginalization for some women. Recent immigrants described the profound loss of extended family and community support networks at a time when stresses were high (Ahmad et al., 2004a). They explained the difficulty of creating new supportive networks under conditions of isolation, time pressure, and language barriers (Ahmad et al., 2004a). Moreover, Nelson and Agyapong (2004) found that encounters with racism intensify the social losses experienced in resettlement. They described how immigrant women of color felt excluded from full entitlement to social inclusion and benefits, even after several decades of residency in Ontario. Participants described racism that was expressed through low-paying employment and during encounters with health and social services providers. Racism was particularly damaging when they were ill and needed compassionate care, as one woman explained:

> [A]fter we put in our strength, our youth into the economy, then when we are sick we would like to get something back . . . and you wonder why can't we feel like we are a part of the society here? (Nelson & Agyapong, p. 170)

Violence and victimization. Four groups of researchers identified the problems of abuse and victimization in different groups of women (Butters & Erickson, 2003; Ismail, Berman, & Ward-Griffin, 2007; Leipert & George, 2008; Reid et al., 2005). In a study of women crack (cocaine) users, participants revealed that sexual and physical assaults were common, often perpetrated by their drug dealers, customers, husbands, or boyfriends. These women reported experiences with multiple types of violence. Some explained that drug use began as a childhood response to familial discord and abuse; later involvement in the crack market placed them at greater risk (Butters & Erickson). Homeless young women who participated in another study reported that family histories of abuse drove them onto the streets, where they were vulnerable to additional risk of physical and sexual violence (Reid et al.). Ironically, leaving home and becoming homeless offered escape from physical, sexual, and emotional abuse, but gender-based violence continued to play out in their lives and relationships.

Ismail and colleagues (2007) found that young women participants experienced violence within ordinary dating and romantic relationships; without family or peer support, many remained in toxic situations as abuse intensified. Normative pressures to appear desirable and lovable compelled some to tolerate abuse rather than break off a relationship and remain single. Leipert and George (2008) identified similar social pressures as the social dynamic that locked rural women in abusive partnerships. They found that rural women were paradoxically isolated but subject to an intense social scrutiny that made it difficult for them to leave their partners. As one participant stated, "You have that luxury in the city of retreating . . . being anonymous. Here, you can be close and supportive, but . . . it can [also] be 'messy.'" (p. 213)

Constraints

During analysis, we noted that constraints to access arose from the same social, economic, and environmental contexts that contributed to disparate needs for health services among women. Constraints restricted the ability to obtain or take full advantage of health services after a health problem was actually suspected or identified. Seventeen of the articles were relevant to this theme, and they contained examples of constraints to access such as economic hardship, lacking space for health care, and linguistic or cultural constraints. The researchers focused on groups of women who experienced geographical or social challenges within Ontario's diverse population and regional contrasts.

Economic hardship. Low income prompted delays in seeking health care among women whose insecure employment made them hesitate to ask for time off work to go to appointments (Ahmad et al., 2004a; Ahmad et al., 2004b). These fears seemed reasonable, because some authors reported that loss of employment or promotion opportunities resulted from some women's prolonged absence for cancer treatment (Gould, 2004; Gray et al., 2004). Bates (2004) found that self-employed women had the lowest income levels in Ontario, and they also lacked access to health-related benefits like paid sick leave. Income loss resulted when these women took time off for health appointments and treatments. Several research teams reported that transportation to medical appointments or treatment centers presented difficulties for women who could not afford a car, taxi fare, or public transportation (Ahmad et al., 2004a; Ahmad et al., 2004b; Gould; Mitra, Jacobsen, O'Connor, Pottie, & Tugwell,

2006; Reid et al., 2005; Sinding, Wiernikowski, & Aronson, 2005; Sutton, Meizi, Despard, & Evans, 2007; Woolhouse et al., 2004).

Lacking space for health care. To attend health appointments, women had to take action or make changes in their lives by getting leave from work, organizing childcare, and arranging transportation; limited social supports made these steps difficult for immigrant women (Ahmad et al., 2004a; Ahmad et al., 2004b). These arrangements required some effort and resulted in suspension of everyday routines for varying amounts of time. Travel to treatment centers was a matter of particular challenge for women living in rural areas (Caldwell et al., 2005; Gray et al., 2004; Wathen & Harris, 2007). Gray and colleagues found that some rural women opted for cancer treatments that involved the shortest period of displacement from home (such as full mastectomy instead of lumpectomy). The alternative was to spend weeks in the city, far from home and supportive networks, while receiving radiation treatment or chemotherapy. Similarly, Aboriginal women who lived on reserves reportedly hesitated to leave abusive relationships because available services were frequently located off reserve. One woman explained the extreme displacements involved: "So, it's not like going [just] from rural to rural. [They're] leaving family, they're going to the city. And I think it's a bit of a [culture] shock for our women to go there" (Leipert & George, 2008, p. 213).

Linguistic or cultural constraints. Several authors found that immigrant women hesitated to reach out to health services in Canada because they remained uncomfortable expressing themselves in Canada's official languages of English or French (Ahmad et al., 2004a; Ahmad et al., 2004b; Mitra et al., 2006; Sutton et al., 2007). Some women were intimidated by situations in which fluency was required, and they did not always consider use of interpreter services an optimal solution, especially when sensitive health problems created worries about confidentiality (Mitra et al.). Others were intimidated by the tasks of finding the way to service sites and navigating unfamiliar health service environments (Ahmad et al., 2004a). These were described as problems of settlement.

Other authors, however, described health beliefs and expectations of distinct cultural communities that led to trepidations about seeking care. Cooper-Brathwaite & Williams (2003) found that Chinese immigrant women had unmet cultural expectations for care of the newborn, and hesitations about the use of medical technology during labor. Tarrant & Gregory (2003) noted that women weighed conflicts between opinions circulating within their cultural communities and the messages offered by health providers. More widely, fear and lack of information about cancer risks and screening procedures could prevent women from seeking appropriate services (Vahabi & Gastaldo, 2003).

Cultural constraints were not limited to immigrants or newcomers to Ontario. Normative expectations of Canadian-born women also constrained access to care. Some young women tolerated intimate partner violence because they felt peer pressure to have a romantic partner, and they thought seeking help might be construed as a sign of inadequacy (Ismail et al., 2007). Some authors described the two-sided nature of close-knit and supportive social networks of rural communities (Sutherns, 2004; Wathen & Harris, 2007). Local health providers were highly respected members of rural networks, and women feared social repercussions if they sought other sources of primary care (Sutherns; Wathen & Harris).

Barriers

We restricted our definition of access barriers to facets of Ontario health policy and the institutional organization of health care that made it difficult for women to make optimal use of services. Whereas contextual conditions and constraints to access were forces that arose from women's life circumstances and social positions, barriers were systemic features of health care policies and delivery systems that blocked efforts to obtain care and health information. Twenty-eight of the reviewed studies focused on barriers to obtaining health care, including eligibility for coverage, provider–patient communication, and limited availability, service cutbacks, and funding cuts.

Eligibility for coverage. Some women were not eligible for publicly insured health coverage in Ontario. Immigrant women reported expenses incurred during a required 3-month period of self-insurance on arrival in Ontario; the Ontario Health Insurance Plan (OHIP) did not cover them until after that period (Ahmad et al., 2004a; Ahmad et al., 2004b). However, homeless or insecurely housed women in Ontario reported occasional difficulty claiming OHIP benefits because they lived in circumstances that predisposed them to their cards being stolen, lost, or destroyed, and without a fixed home address it was difficult to replace a health card (Butters & Erickson, 2003; Reid et al., 2005).

Provider–patient communication. Many authors reported women's complaints about limited opportunities for fruitful communication during appointments with physicians. A commonly identified problem was insufficient time allotted for appointments, which truncated discussion of health issues; some women found primary care providers were unable to discuss details of specialty care and treatment (Ahmad et al., 2004a; Friedman & Hoffman-Goetz, 2003; Mitra et al., 2006; Power, Brown, & Ritvo, 2008; Sinding et al., 2005; Wathen & Harris, 2007; Woolhouse et al., 2004). Furthermore, researchers in one study noted that conflicting or contradictory advice from providers was a source of anxiety and confusion for women (Caldwell et al., 2005).

A common problem was lack of communication between various providers, especially between specialists and primary care providers (Caldwell et al., 2005; Sinding et al., 2005). Older women with multiple comorbid health conditions were particularly challenged to make cancer care decisions that took into account all their health needs (Sinding et al.). Some immigrant women remarked on the lack of control or choice in the referral process (Ahmad et al., 2004a; Ahmad et al., 2004b). Canadian-born rural women also described being positioned as "silent players" (Caldwell et al., p. 60) in a system in which access to programs was perceived as tightly controlled by physicians.

Internet and media reports were a source of information for women, but there were often contradictions among these reports and also lack of agreement with the information offered by health providers. Some authors found that women wanted specialty providers to spend more time explaining treatment options (Friedman & Hoffman-Goetz, 2003; Sinding et al., 2005; Uskul, Ahmad, Leyland, & Stewart, 2003; Vahabi & Gastaldo, 2003). Women valued providers who were culturally sensitive to and astute concerning issues of heteronormativity, ableism, or racism, and they appreciated the opportunity to use trained and confidential interpreters or teletype communication (TTY) in encounters with health care providers (Mitra et al., 2006; Nelson & Agyapong, 2004; Odette et al., 2003; Sinding, Barnoff, & Grassau, 2004; Sutton et al., 2007; Tarrant & Gregory, 2003). Some participants reported that gender, age, or class differences were barriers to ease of communication with providers (Ross, Ali, & Toner, 2003; Sinding et al., 2005; Sword, 2003; Wathen & Harris, 2007; Woolhouse et al., 2004).

Limited availability, service cutbacks and funding cuts. Participants in some studies reported wait lists to enter specialized programs such as support groups, cardiac rehabilitation, or prenatal classes, and some explained that they worried about how this would affect their health (Caldwell et al., 2005; Gray et al., 2004; Leipert & George, 2008; Sutherns, 2004). Others revealed that in their geographic areas (especially rural and remote areas), specialized programs were fewer, scattered, and distant from their homes (Caldwell et al.; Gray et al.; Leipert & George; Sutherns), and existing resources were unevenly distributed. According to one woman with cervical cancer,

> Every time I hear all these ads for, you know, supporting breast cancer and stuff, I'm thinking, "What about the rest?" And there's all kinds of other cancers out there . . . you know? Lung cancer; number one killer. Like, but every time you see a Run for Breast Cancer, . . . money's funded toward the higher profile. (Power et al., 2008, p. 375)

Many authors pointed to the barriers posed by uninsured components of health care, as well as the results of delisting specific services. Participants frequently mentioned the high cost of medications and dental care (Ahmad et al., 2004a; Bates, 2004; Gould, 2004; Reid et al., 2005) and, although private insurance could assist with these costs, many said they could not afford the premiums. Certain prenatal programs or other supportive services were available for a fee, and might not be affordable for mothers with low incomes; less costly or free alternatives had wait lists (Sword, 2003).

The accounts of women receiving long-term home care suggest that there were two separate systems of care: an intensive and relatively highly resourced acute care system and an inadequately resourced long-term home care system (Aronson, 2006; Bethune-Davies et al., 2006). One longitudinal study of women receiving long-term home care documented how, over time, hours of service were reduced; women described situations in which complaints about cutbacks were overtly and tacitly discouraged (Aronson, 2003, 2006). Women described unmet needs that went beyond the focus of home care on bathing and personal care (Aronson, 2006; Bethune-Davies et al.). For one woman, personal care had been limited to only one bath per week: "But she said 'It's the government's rule, you get one bath a week.' It felt such a comedown to explain my sweating and my hygiene—and for nothing" (Aronson, 2006, p. 547).

Deterrents

We conceptualized deterrents[2] as features of the health care system that women found sufficiently unsatisfactory to discourage full use of and participation within otherwise accessible services. Deterrents created experiences that dissuaded women from using services they knew were available to them. Twenty-four of the reviewed studies contained descriptions of issues that were grouped under this category. Although there have been attempts to increase efficiency and quality of health services across the province through the development of policies, standards of care, and evaluative benchmarks, these have not always incorporated a gender focus. Hence, these changes were not always sensitive to socially situated differences in women's health care needs. In the reviewed studies, some women became discouraged from accessing or fully participating in health services.

Inconveniences. Scheduling and referral patterns created difficulties, given the time pressures of women's situated responsibilities that discouraged continued use of existing services. Three articles contained descriptions of the effort and time involved in initiating and maintaining connections with health services (Ahmad et al., 2004a; Ahmad et al., 2004b; Tarrant & Gregory, 2003).

Scheduling and timing issues discouraged or delayed women's subsequent use of health services, especially when combined with contexts of family responsibilities, low incomes, and uncertain employment. Recent immigrant women from some countries found medical appointments surprisingly more difficult to arrange in Canada, and that attending scheduled appointments could involve lingering in waiting rooms (Ahmad et al., 2004a; Ahmad et al., 2004b). Similarly, Aboriginal mothers in northern Ontario said they encountered delays during clinic visits with their children, and some even reported that they occasionally left without being seen: "[A]nd then we come here at 2:30 and we sit here until 3:15 in the waiting room. They specifically said that your appointment is at 2:30 but you have to wait another 30 or 45 minutes" (Tarrant & Gregory, p. 69).

Intensification of social vulnerability. Numerous participants in the included studies described instances in which the design and delivery of institutional health care intensified their preexisting social vulnerabilities. The resultant discomforts silenced women during health care encounters, preventing full participation in assessment, decision making, and delivery of treatment. One longitudinal study found a lack of responsiveness to women's complaints about home care services (Aronson, 2003, 2006). These chronically ill and disabled women were socially isolated in their homes and vulnerable to cutbacks in service as well as suboptimal practice; hence, they were deeply affected by lack of interest in their concerns. Furthermore, receipt of home care services could generate feelings of shame and humiliation, because privacy was invaded and control over situations was undermined: "It makes me feel as if I've no say at all—and in my own house!" "You have strangers coming in, doing these personal things—a catheter's personal—you have no pride, no choice" (Aronson, 2003, p. 89).

Homeless or impoverished women and women who engaged in substance abuse described discriminatory treatment by providers, and some said they hesitated to seek care until they were seriously ill (Butters & Erickson 2003; Reid et al., 2005; Woolhouse et al., 2004):

> A lot of homeless people get more sick and they get actually worse because they don't go to a hospital because either they're afraid something might happen to them or, you know, they just don't want to go because of the way that people look at homeless people." (Reid et al., p. 249)

Taken together, the findings of many of the reviewed studies indicated that the programs and services offered through the health care system were based in assumptions that deterred women. Women with auditory, visual, or mobility disabilities were not always accommodated by health-promotion programs and preventive services (Bethune-Davies et al., 2006; Odette et al., 2003). Some authors cited examples of Vietnamese and Chinese immigrant new mothers who did not fully benefit from English-language programs and services that were not aligned with their cultural backgrounds (Cooper-Brathwaite & Williams, 2003; Sutton et al., 2007).

The partners and families of lesbian women with cancer were deterred from seeking psychosocial support services when they most needed them, because they feared repeating the "coming out" experience in support groups organized around a heteronormative perspective. To same-sex partners and their children, this meant that instead of receiving unconditional empathy from other group members, they might be faced with questions about their family structure (Barnoff, Sinding, & Grassau, 2005). Also, lesbian women with cancer endured social discomfort when they encountered health providers who assumed they had male partners (Sinding et al., 2004).

Other authors reported that Black women with breast cancer found it difficult to participate in or attend support groups that were predominantly attended by White women (Nelson & Agyapong, 2004). Similarly, women with low incomes reported discomfort in speaking up during prenatal education sessions attended by expectant mothers with higher incomes (Sword, 2003). Finally, Ross and colleagues (2003) described the intersection of age- and gender-related power imbalances in young women with depression; these women reported feeling intimidated by male physicians, especially when communication took place with their mothers present and the girls' input was not encouraged.

A subgroup of four articles indicated that mothers were particularly concerned about surveillance by health providers. Several authors explored women's accounts of "judgmental" encounters with physicians, nurses, and social workers, leading some mothers to lose trust, discontinue attendance, or withhold information from providers (Jack, DiCenso, & Lohfeld, 2005; Montgomery, Tompkins, Forchuk, & French, 2006; Sword, 2003; Tarrant & Gregory, 2003; Woolhouse et al., 2004). These authors documented the discomforts encountered by Aboriginal or homeless mothers, and mothers with mental illness or low incomes, highlighting the consequences of power imbalances when women feared their mothering skills might be deemed inadequate or that they could lose custody of their children. For example, mothers with mental illnesses reportedly ignored or disguised their own deteriorating health and delayed seeking help because they feared losing their children (Montgomery et al., 2006).

Complex Convergences

In six of the reviewed articles we found evidence that some women struggled to overcome complex convergences of all the forces identified during our metasynthesis: contextual conditions, constraints, barriers, and deterrents (Ahmad et al., 2004a; Ahmad et al., 2004b; Aronson, 2003; Bethune-Davies et al., 2006; Reid et al., 2005; Woolhouse et al., 2004). For example, homeless women were at risk for physical and sexual violence, unable to pay for transportation or medication, ineligible to receive a government health insurance card because they lacked a fixed address, and hesitant to seek health care after previous encounters with providers positioned them as socially inferior (Reid et al.; Woolhouse et al.). Women receiving long-term home care for chronic illnesses simultaneously contended with social isolation, inability to pay for additional assistance beyond services provided by home care, cutbacks in the amount and types of services allowed through the home care system, and feelings of shame and humiliation when complaints and requests were silenced by service providers (Aronson, 2003; Bethune-Davies et al.).

We found 10 other studies that contained evidence of women's attempts to deal with different combinations of three of the four forces (Butters & Erickson, 2003; Gray et al., 2004; Ismail et al., 2007; Leipert & George, 2008; Nelson & Agyapong, 2004; Odette et al., 2003; Sutherns, 2004; Sutton et al., 2007; Tarrant & Gregory, 2003; Wathen & Harris, 2007). For example, women with disabilities described low or fixed incomes that limited access to health-promoting activities; poor communication with providers, especially when short appointment times limited time for information exchange; and additional marginalization by services that did not accommodate their visual, physical, or auditory disabilities (Odette et al.). Women from rural communities had to satisfy many demands to meet the subsistence needs of family and community, lived within communities with gendered expectations that limited opportunities to seek care, and had fewer closely available services and providers (Gray et al.; Leipert & George; Sutherns; Wathen & Harris). These interactions contributed to health and access disparities among the affected groups.

Discussion

Our metasynthesis illuminated the range of forces that contribute to women's access disparities within the sociopolitical context of publicly funded health services within one province of Canada. Diverse subgroups of women were represented in the 35 synthesized articles; hence, the findings capture how interacting social factors can differently affect women's health-seeking behaviors and opportunities to receive equitable treatment. Gender is simultaneously a social construct and a constituent of the processes of social institutions, such as health care (Lorber, 2006). However, gender is only one of many social categories that interact with the processes of health care delivery, and it cannot be assumed that all women share the same experience. Thus, the cross-section of women represented in the synthesized articles facilitates insight into the impacts on access to health care of various configurations of conditions, constraints, barriers, and deterrents.

The finding that contextual conditions contribute to health disparities in women is not new; many authors have contributed to the literature on determinants of health, as well as the social structures that generate them (Frolich et al., 2006; Hankivsky & Christoffersen, 2008; Raphael, 2006). As early as the 1960s, some models of access to health care drew attention to the "predisposing factors" that contribute to the need for health services (Andersen, 1995). Despite continued attention across subsequent decades, major inequities persist in patterns of key health determinants such as income, housing, education, and employment; for example, food insecurity is reported by 5% of Ontario residents and 25% of those living in low-income households (Bierman et al., 2010).

Based on our results, we argue that integrated cross-sectoral approaches to assure access to effective services should be combined with efforts by health care providers to understand and address systematic barriers to care. Furthermore, we found that women's health needs could be configured not only by competing priorities of domestic responsibility and employment, but by interlocking, varying circumstances such as poverty and homelessness, social marginalization, and susceptibility to victimization. Without sensitivity to diversity, a solely gender-based analysis is therefore insufficient to capture the range of interacting circumstances that contribute to health disparities among women (Hankivsky & Christoffersen, 2008). Authors of the included studies described women's efforts to sustain personal and familial health within challenging socioeconomic and cultural contexts that seemingly "pushed" them toward ill health, exacerbation of disease, and a need for health care.

Constraints were closely linked with women's life circumstances, but they emerged as countervailing forces that impeded women's efforts to obtain available services or limited the extent to which they could benefit from health care. Unaffordable costs of medication, dental care, and transportation to health services were constraints described by several authors, and they were also documented in the POWER report (Bierman et al., 2010). Several of the synthesized articles indicated that women had to make arrangements in other areas of their lives before it was possible to obtain treatment. Women from

remote or rural areas in particular had to leave employment and family for periods of time to be hospitalized in more densely populated areas.

In addition, we saw that lack of experience with the dominant language and cultural assumptions of health care delivery created hesitations for some potential users of available services, particularly immigrant women. The POWER analysis of quantitative indicators showed that ethnicity and recency of immigration were associated with increased difficulty accessing specialist care for diagnosis or consultation (Bierman et al., 2010). Such problems are often framed in the delayed-help-seeking literature as personal preferences that shape decisions to seek care (Facione & Facione, 2006; Nelson, Geiger, & Mangione, 2002). There is no question that individual agency and responsibility are essential components in the process of accessing health services; however, these components are deeply situated within varying life circumstances that constrain and complicate formulation of care-seeking intentions (Angus, Miller, Pulfer, & McKeever, 2006; Bierman & Dunn, 2006; Downe et al., 2009). Furthermore, health care providers can mediate these barriers by facilitating linguistic access, becoming culturally responsive, and identifying and addressing institutional and provider biases.

Within the narrower confines of our definition of barriers, some of the shortcomings of health policy and service delivery were illuminated. Although some of the synthesized studies indicated that new immigrants and homeless women faced challenges and limits to their eligibility for health coverage, we were unable to find research on undocumented immigrants, who are also ineligible. That any subpopulation is excluded from the principle of universal coverage is noteworthy; however, our metasynthesis also showed that uninsured services, limited availability, service cutbacks, and funding cuts represent additional barriers, creating an inequitable policy and health service climate of implicit rationing (Lauridsen, Norup, & Rossel, 2007; Strech, Synofzik, & Marckmann, 2008).

Furthermore, there were similar barriers for recipients of long-term home care, and analysis of the POWER study indicators also suggest that unmet health care needs were higher among adults with two or more chronic conditions and those with lower incomes. These unmet needs were linked with lack of service availability, long wait times, and cost of service, and access to a specialist varied by geographic region (Bierman et al., 2010). Furthermore, according to the POWER study results, long-term home care applications could take as long as 90 days to finalize, instead of the 14 days recommended by provincial guidelines (Bierman et al., 2010, p. 115).

Deterrents emerged as factors that discouraged women from using readily available and previously accessed services. This finding resonates with the emphasis of some authors on equity or fairness in delivery as key determinants of access to health care (Gulliford et al., 2002). Gulliford and colleagues pointed out that there is a "vertical dimension" of equity in access to health care, wherein "the health problems of different groups are diverse, healthcare needs for similar health problems vary and different groups have their own priorities and values" (p. 188). We found that some encounters with health care services intensified women's experiences of social marginalization and negatively influenced their intentions to return for additional care.

We found that complex convergences of contextual conditions, constraints, barriers, and deterrents could complicate and exacerbate access disparities. Thus, as our analysis indicates, various combinations of forces can push, pull, obstruct, and/or repel women as they seek health care, resulting in different patterns of inequitable access. Perhaps this is why women who occupied intersecting, marginalizing social situations reported the greatest difficulty accessing health care (Hankivsky & Christoffersen, 2008; Hankivsky et al., 2010). Dixon-Woods and colleagues (2006) also found that vulnerable populations can be discouraged from seeking health care when the process requires extensive effort and resources. We noted that certain aspects of women's circumstances, such as inadequate income, could be differently active across two or more of the four forces. One of the strengths of examining complex convergences is the resultant illumination and explanation of contextually embedded patterns of access disparity, rather than solely linking analysis to specific identities and attributes of women. This approach incorporates a structural analysis by emphasizing the fragility and failings of the Canadian universal health care system under market pressures and economic recession; such an approach avoids constructing certain groups of women as problematically different from the general population of service users.

Conclusion

The accounts contained within our set of reviewed research reports indicate how diverse groups of women lived out health insurance retrenchments and gaps in health services within Ontario's context of geographic and social contrasts in a system often not well designed to meet their needs. Although limited to this specific geopolitical context, our metasynthesis of these accounts found that the frequently used concept of barriers obscures the complexity of disparities in women's access to health care. We found that what many authors referred to as barriers arose from four major, sometimes opposing forces: (a) contextual conditions, (b) constraints, (c) barriers, and (d) deterrents, each composed of several dimensions.

Some women encountered complex convergences of two, three, or even four of these forces when they identified the need for and sought health care. These findings indicate that many problems occur across groups of women; therefore, there are opportunities for interventions that simultaneously meet the needs of many. One of the strengths of our approach is that it avoids attributing access disparities to specific identities held by women, because it directs attention to the larger geopolitical contexts in which health seeking is embedded. Our metasynthesis provides a framework that providers, policymakers, and community stakeholders can use in partnership to identify factors that complicate access to health care. This knowledge can then inform strategies to facilitate access to care with the goal of improving health outcomes and reducing health disparities.

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Notes

1. Researchers in two studies recruited participants from at least one other province, but they were retained because each was part of a subset of studies discussing specific contexts or subgroups of women. The findings of each were consistent with those of the other articles in the subsets.
2. Lucy Costa-Nyman (of the Anne Johnston Health Station, Toronto, Canada) suggested this term by explaining that previous suboptimal, even traumatizing experience with health care or other social services "deters" women from seeking further health care.

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