

BARRIERS TO PRIMARY HEALTH CARE

Barriers for Women in Accessing Primary (Family) Health Care in Nova Scotia

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Dedication

For all Nova Scotians. If this project works to inform change in health care that helps even just one person access the care they need . . . it will truly be worth it.

Abstract

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By Lillian Claire Latter Stratton

This thesis explores the barriers that women face in accessing primary (family) health care in Nova Scotia, Canada. Specifically, this study is concerned with the barriers that Indigenous women, women of colour and immigrant women face in accessing primary care. Twenty-eight Nova Scotian primary care physicians completed an online survey regarding their perspectives on barriers that women may face in accessing primary care (numerous other physicians answered part of the survey but did not complete it). One-hundred-ninety-three Nova Scotians who have experience accessing primary care services completed a separate online survey regarding their experiences with family medical care in Nova Scotia, and the barriers that they have faced in accessing care. Quantitative and qualitative data analyses revealed that Nova Scotian patients and physicians alike believe there are barriers to primary care access (especially for women). Indigenous women, women of colour and immigrant women populations identified particular barriers not expressed by participants who belonged to other groups.

July 15, 2020

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This work would not have been possible without the help of the amazingly supportive people in my life. They say it takes a village . . . to write a thesis!

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Chapter One: Introduction

Context

Primary health care refers to basic (i.e., not specialized) care, which includes the diagnosis and treatment of illness and injury through providing first-contact services by family physicians (Government of Canada, 2012). Primary care also provides health promotion services, and connects patients to secondary care (Montesanti, Robinson-Vollman, & Green, 2018).

Primary health care access is currently of concern in Nova Scotia. Due to the severe and persistent shortage of family physicians in Nova Scotia, access to care is limited for all patients (Bradley, 2018; Lord, 2019). However, it is evident that accessing primary care is especially complicated for individuals with existing barriers to health and/or health care. Indeed, a recent study about Canadian access to health care determined that increasing the number of family practitioners in an area may not reduce patients' unmet health care needs due to specific barriers (i.e., women's precarious employment and traditional gender roles) to accessing care (Hwang et al., 2017). This finding emphasizes the importance of social conditions in shaping health and health care access. Accordingly, as increasing the number of physicians in Nova Scotia may not mitigate barriers to accessing primary health care, it is pertinent to investigate other factors (e.g., social conditions) that may be useful in addressing Nova Scotians' need for primary care access.

Social determinants of health are economic and social conditions that are central to the well-being of Canadians (Hobbs & Rice, 2018). Gender, race, socioeconomic status, immigrant status, and Indigenous ancestry are some of the characteristics that have been recognized as determinants of health for Canadians (Angus et al., 2012; Raphael, 2016). Other social determinants of health include disability, geographical location, occupation, and many others. Understanding the impact of social determinants of health through an intersectional feminist lens

enables a critical analysis of the distribution of health, illness, and care services amongst Canadians. Research has shown that gender, race, socioeconomic status, immigrant status and indigeneity (independently and/or in interaction with each other) impact health care access (Raphael, 2016). While other social determinants of health also impact health care access, gender, race, socioeconomic status, immigrant status, and Indigenous ancestry, as social determinants of health, will be the focus of this study because it is apparent that these characteristics may produce some of the barriers that minority women face in accessing health care (Hobbs & Rice, 2018).

Research Relevance

It is evident through an intersectional feminist analysis of the social determinants of health that marginalized populations such as women of color, Indigenous women, and immigrant women may have lower overall access to health care. Factors such as income distribution, food (in)security, and reliable housing are of particular concern for marginalized populations. These factors intersect with race, immigrant status and Indigenous ancestry to complicate health care access. The particular focus of this project is primary health care because the unequal distribution of this type of health care access demands attention. Indeed, the World Health Organization (WHO) identified weak primary health care as one of the top ten threats to public health in 2019 (WHO, 2019). Moreover, it is evident that access to primary care is of significant concern for Nova Scotians currently.

In an effort to understand the inequity of health care access for women¹ in Nova Scotia, it is pertinent to investigate the barriers that members of this population face in accessing primary

¹ For the purposes of this research project, the terms *woman* and *women* refer to any person aged 18 or older who self-identifies as a woman.

care. For the purposes of this project, *barriers to health care* refers to any external factor that restricts access to health care services, and which makes it harder for some individuals to access the care they need. Through developing a grounded, evidence-based understanding of the problems that Nova Scotian women (specifically Indigenous women, women of colour, and immigrant women) face in accessing health care, while considering the perspective of physicians who provide primary care, I aim to suggest changes at the interpersonal (i.e., between physician and patient) and provincial (i.e., health care policy) levels. I am hopeful that my research findings have the potential to inform future directions and allocations of primary health care in Nova Scotia.

Thesis Statement

I will use a critical intersectional feminist lens to investigate and describe the barriers that immigrant women², women of colour³, and Indigenous women⁴ face in accessing primary health care in Nova Scotia. I will consider barriers in two general phases: (1) barriers which prevent physical access to care (e.g., inability of a patient to transport themselves to a doctors' office), and (2) barriers experienced when engaging with care providers which prevent appropriate or effective care (e.g., cultural bias of a physician). I will compare physicians' and patients' perceived barriers to primary care as demonstrated by the quantitative and qualitative analysis of data gathered from online surveys.

Research Questions

Through this research project, I intend to explore the following questions:

² The term *immigrant women* will be used to reference women who have immigrated to Canada.

³ *Women of colour* is a term that will be used to reference any woman who self-identifies as a person of visible racial minority (i.e., not Caucasian).

⁴ The term *Indigenous women* will be used in reference to women Indigenous to Canada with a particular focus on Mi'kmaq women who are people from Mi'kma'ki, the traditional and unceded territory of the Mi'kmaq people.

1. What are the barriers that immigrant women, women of colour, and Indigenous women face in accessing primary health care in Nova Scotia?
2. How do the perspectives of patients (specifically immigrant women, women of colour, and Indigenous women) and family physicians differ concerning the barriers that women face in accessing primary care (i.e., family medicine) in Nova Scotia?

My initial hypotheses were that research results will demonstrate that physicians and patients have different ideas about women's barriers to health care (e.g., physicians may not be aware of the barriers that women patients face in accessing care). Further, I hypothesized that the three populations of interest (i.e., immigrant women, Indigenous women, women of colour) would report some barriers in common, but that each group would have unique barriers. I understand that my predictions are formulated from my perspective as a white researcher, and are informed by academic research, rather than lived experience.

Objectives

The main objective of this study is to understand the social characteristics that intersect to restrict women's ability to access meaningful and effective primary health care services in Nova Scotia, from the perspectives of patients and primary care physicians. Specific objectives are: (1) to understand how Nova Scotian physicians address women's barriers to health care by examining the impacts of physician gender, minority group status and years practising; (2) to understand the experiences of women from varying cultural and social backgrounds, including women of colour, Indigenous persons, and Canadian immigrants, while acknowledging that these categories may overlap.

Researcher Positionality

My interest in health care and social justice has inspired this research project. In response to noticing contemporary issues in health care services and accessibility, I have considered possible solutions that have the potential to make positive change for patients. I believe that access to health care is a fundamental human right, and that further research is required to enact change in health care accessibility for marginalized populations in Nova Scotia.

Through this research project, I maintained my commitment to engage in ethical and meaningful relations with the communities with which I have worked, while acknowledging the different social locations and power dynamics between myself as a privileged white researcher and the research participants. I recognize the long history of research related violence that Indigenous, immigrant and persons of colour communities in Nova Scotia have endured. I engaged in this research project with a goal of working towards reconciliation rooted in empathy and understanding.

Summary & Layout

This thesis contains eight chapters. The initial chapter, Chapter One, outlined the significance of the research study, including background information about primary health care, barriers to care, and social determinants of health in the Canadian context. The first chapter also provided explanations for the relevance of this research in the context of Nova Scotia, the thesis statement, research questions and objectives.

Chapter Two is a literature review. In this chapter, I provide an overview of various bodies of literature relevant to this research project. First, I explore health as a feminist issue through drawing on research about women's health and analyses of health issues from feminist perspectives. I then provide a historical and contemporary overview of women's health activism.

Finally, I provide a thorough review of literature concerning the social determinants of health in the Canadian context.

Chapter Three is about health care and policy in Canada. This chapter provides an overview about health care policy in Canada, including national, provincial, municipal and First Nations provisioning and funding of care services. In this chapter, I also critique the current health care system in Canada, as relevant to my research. This chapter has been included because it is imperative that I provide background information about Canadian health care policy to contextualize policy change suggestions following the discussion of research results. The section about health care policy follows the literature review as some concepts (such as social determinants of health) are introduced in Chapter Two and explored further in Chapter Three.

Chapter Four provides an overview of intersectionality, the theory employed in this thesis. I outline why intersectionality, as a theory, is suitable for this project and analysis. Additionally, I explain the work that intersectionality does as a theoretical basis for this thesis. Further, I provide an overview of feminist theoretical critiques of contemporary Western medicine (i.e., medical techniques practiced in the Western hemisphere of the world, not including traditional Indigenous medicines). Finally, I outline some health care applications of feminist theory.

Chapter Five is the methodology and methods section. In this chapter, I provide an overview of intersectionality as a methodology. I then provide detailed descriptions of the methods used in my research study. An overview of methods for data analysis is also provided in this chapter.

Research results are presented in Chapter Six. Graphical representations of research results for both physician and patient surveys are provided. Demographic information, statistical analyses (correlation values, t-table results) and thematic analyses are presented and explained.

In Chapter Seven, research results are discussed in the context of relevant literature. The physician and patient surveys are discussed independently and compared to each other in this chapter. Insights and speculations about the research findings are detailed in this chapter.

Research results from this study are linked to those found in previous studies and outlined in the literature.

Chapter Eight concludes the thesis. Conclusions about the research project are presented. Limitations and contributions of the study are explored. Recommendations for action based on the results of the research study are presented, as well as recommendations for future research directions.

Chapter Two: Literature Review

Health as a Feminist Issue

Historically, feminists have played a role in studying and advocating for women's health. In particular, women's reproductive health, health policy, health access and the role that medicine plays in women's lives have been central to women's rights activism and feminist movements, historically and contemporarily (Bourassa et al., 2017). The first public and community health care systems in Canada were, in part, the result of the work of feminists who advocated for the legalization of birth control out of concern for women's health outcomes and because of the inherent link between poverty, education, housing security, gender and uncontrolled population growth (Bourassa et al., 2017).

Some feminists are interested in how gender and sex are central to dominant societal understandings and treatment of women's health issues. In general, many modern feminists hold the view that health and illness manifest in a subjective way, influenced by different cultures and environments (Bourassa et al., 2017). Moreover, the social determinants of health and consequential health outcomes for women are central to an intersectional feminist perspective of health. Gender-specific impacts of sociopolitical conditions faced by women (e.g., the medicalization of women's reproductive health, women's unpaid and undervalued work as care providers, women's economic vulnerability) further complicate their ability to access primary health care (Angus et al., 2012).

Women's Health Activism

Women's health activism has been central to feminist movements for centuries. Indeed, women's health activism dates back to the early 19th century in the Western setting (North America, Europe), with distinct waves of activism that coincided with women's rights

movements (Sobonsky, 2013). Each wave of women's health activism had important impacts on women's health care and policy (Sobonsky, 2013).

Women's health activism was first apparent in an organized manner during the popular health movement of the 1830s and 1840s (Sobonsky, 2013). This period involved questioning medical authority and urged individuals to understand the functional elements of health care (Sobonsky, 2013). The medical women's movement of the late 1800s followed the popular health movement and focused on women's struggles to be involved in medicine (e.g., to practice midwifery and to be accepted into medical schools; Sobonsky, 2013).

Historically, abortion has been central to women's health activism. Indeed, abortion has given rise to gender conflict throughout history (McBride Stetson, 2001). Though women are predominantly affected by abortion (compared to men), policy debates about abortion have long been focused on the rights of the unborn fetus or doctor who would hypothetically perform the abortion, rather than on the rights of the women who seek abortions (McBride Stetson, 2001). Women's health movements have worked towards the goal of gendering policy discussions about abortion. Indeed, women's movements worked to make women's rights central to abortion debates, rather than the focus of fetal or doctors' rights (McBride Stetson, 2001). The idea was that a gendered debate about abortion would improve the status of women; therefore, when the issue of abortion was brought to public attention, it would surface primarily as a women's rights issue. The work of feminists concerned about abortion and policy debates led to the liberalization of abortion laws in many countries across the globe (McBride Stetson, 2001).

The most popular wave of women's health activism was the women's health movement, which began in the 1960s and 1970s, with the rebirth of the feminist movement, and focused largely on women's rights to adequate health care (Boscoe et al., 2004). The women's health

movement was distinct from previous waves of women's health activism temporally and thematically (Sobonsky, 2013). This movement involved the recognition of gender as a social determinant of health. Additionally, there was a realization of the impact of social issues (e.g., sexism, racism, etc.) on health outcomes (Boscoe et al., 2004).

The women's health movement of the 1960s was born out of widely shared experiences of sexism that women encountered in medicine (e.g., sexist, patriarchal, and judgmental behaviour; lack of provision of necessary information from predominately white male physicians; Sobonsky, 2013). With a focus on a woman-centered vision of health and wellness (Boscoe et al., 2004), women began to challenge their experiences with the health care system: sexist attitudes of health professionals, over-prescription of mood-altering drugs, limited access to contraceptives, and structural inequality in health institutions (Sobonsky, 2013). Some women began to strongly critique the structure of the health care system (Sobonsky, 2013) and pushed to make medical information more accessible to women, enabling women's agency over their own health care (Boscoe et al., 2004).

The women's health movement of the mid- to late-twentieth century focused on three main goals: improving the health care delivery system, addressing the social determinants of health and increasing women's participation in all aspects of health care (e.g., as professionals and as participants in decisions about their own health care; Boscoe et al., 2004). The movement involved a critique of the Western health care system that was dominated by white male professionals, and of the power dynamic between care providers and patients (Boscoe et al., 2004). Indeed, power oppressions such as sexism, racism, and paternalism make it difficult for women to question and/or refuse medical treatment, which causes many women's health issues

to go unresolved (Boscoe et al., 2004). Ultimately, the women's health movement called for women – instead of white male health care providers – to center women's health.

The feminist health classic *Women and Their Bodies* was born out of the 1969 Female Liberation Conference in Boston, Massachusetts, during the women's health movement (Wells, 2008). *Women and Their Bodies* later became *Our Bodies, Ourselves* and went on to influence the women's health movement worldwide. The book was written as a (then highly controversial) sharing of frank information about birth control, abortion, women's bodies, sexuality, and frustrations with medical professionals (Our Bodies, Ourselves, 2020). The goal of the book was to change the health care that women received through the authors' sharing of what they had learned about their bodies with other women, communication of their findings with doctors, and through challenging the patriarchal and sexist elements of the medical institution (Our Bodies, Ourselves, 2020). The book informed much of the women's health movement throughout the United States and the world. The *Our Bodies, Ourselves* project continues to participate in and influence women's health activism worldwide, through the authors' many contemporary editions of the book, the most recent of which was released in 2011 (the ninth edition; Our Bodies, Ourselves, 2020). The authors have maintained their commitment to sharing reliable information about health in language that is accessible to most women (Wells, 2008).

In the 1970s and 1980s, Canadian feminist groups began discussions about creating a formal women's health network, which eventually led to the 1993 commencement of the Canadian Women's Health Network (Boscoe et al., 2004). The Canadian Women's Health Network continues to provide accessible and reliable health information to women. Similarly, they work to adapt health policies to be more equitable, and to make visible women's health issues in Canada (Canadian Women's Health Network, 2012).

Contemporarily, women's health continues to be central to some feminist movements. Gendered divisions in health and access to health care are issues of concern for many feminists today (Pederson et al., 2014). Moreover, the power dynamic between patients and physicians continues to affect women's health, and this issue demands attention from feminist researchers.

Power and agency have been central to feminist discussions, including those about women's health, for a long time. Indeed, many feminist theories incorporate power and agency in their conceptualizations of women's health and access to health care. As many feminist scholars (e.g., Defenbaugh, 2008; Edley & Battaglia, 2016; Hinnant, 2009) suggest, the male-oriented nature of the Western health care system may negatively affect women's access to adequate and appropriate care. Similarly, other feminist scholars (e.g., Lombardo et al., 2014; O'Connell & Zampas, 2018) explore the power dynamics involved in the patient-physician relationship and argue that women's autonomy in health care is limited by even subtle projections of patriarchal ideas evident in their interactions with physicians.

In an effort to understand the unequal distribution of health and inequity in health care access for Canadians, it is imperative to investigate feminist conceptualizations of power and agency in health care. Indeed, feminist theoretical perspectives may contribute significantly to an overall understanding of barriers in health status and health care access. Accordingly, an intersectional feminist investigation about social determinants of health may provide solutions to problems of access and equity in health care in Canada.

Social Determinants of Health

Overview

In general, social determinants of health, as discussed previously, influence individuals' and communities' states of health and illness. More specifically, the social determinants of health

define a person's ability to satisfy their needs and desires, and to cope with their environments, based on the social and physical resources they are able to access (Hobbs & Rice, 2018).

The social determinants of health model offers an alternative to the traditional biomedical understanding of health and illness. The traditional biomedical model focuses on patients as independent individuals (rather than acknowledging how people are affected by their social and physical locations) for whom physical and biological agents are the exclusive causes of disease (Borrett, 2013). Though the biomedical model is not incorrect, it is not complete. The social determinants of health model does not deny the biological and genetic influences of illnesses; instead, it acknowledges the complexity of health and illness through describing the impact that social factors have on physical and biological health (Bourassa et al., 2017). Within Canada, systemic barriers such as socioeconomic position, immigration status, health status and geographical location have been demonstrated to complicate health and access to health care (Angus et al., 2012).

Social determinants of health are the "causes-of-the-causes" of health and illness (McGibbon & McPherson, 2011, p.1). Thus, social factors *cause* physiological events that *cause* illnesses. For example, food insecurity is well understood as a social determinant of health (Raphael, 2016). In their study, Papan and Clow (2015) found that food insecurity may cause Atlantic Canadian women to become overweight or obese. Indeed, food insecure women noted that they tend to eat food rich in carbs and low in protein, because this type of food (i.e., junk food) is cheaper and more accessible than healthier options (Papan & Clow, 2015). Continuous intake of foods high in carbs and low in protein can lead to over-consumption of calories, which can ultimately lead to obesity. Moreover, participants noted that the stress associated with living with food insecurity contributes to overconsumption of unhealthy foods (Papan & Clow, 2015).

This phenomenon is referred to as the food insecurity-obesity paradox (Dhurandhar, 2016; Papan & Clow, 2015). In this example, it is evident that the social determinant of health (i.e., food insecurity) is *the cause of* over-consumption of unhealthy foods/excessive calorie intake, which is *the cause of* the disease (i.e., obesity). This model illustrates a comprehensive approach to understanding how social determinants of health function in causing illness.

The causes-of-the-causes model is also helpful in understanding how various social determinants of health often intersect to further complicate the health of individuals with multiple oppressions. For example, in their study, Bowers et al. (2019) noted that Inuit individuals residing in Inuit Nunangat (the Inuit homeland in Canada) often experience more severe social and economic disparities than the general Canadian population. Consequently, food insecurity greatly impacts the health status of Inuit communities (Bowers et al., 2019). Evidently, many social factors (in this example: Inuit status, geographical location, poverty, food insecurity) intersect and contribute to individual health outcomes.

Though this example does not highlight all of the possible factors that interact to determine individuals' and communities' health, it does demonstrate that the social determinants of health are pervasive and intersecting. Indeed, as Razack (1998) suggests with her model of interlocking oppressions (i.e., many oppressions that are interconnected and affect individuals' lives) and which McGibbon and McPherson (2011) concur, oppressions in society do not operate independently, rather, they intersect in complex ways centered around power and privilege.

The content of the following sections of this literature review have been divided into general subgroups of social determinants of health, in an effort to facilitate comprehension of the complex social factors at play. However, it is important to note that social determinants of health do not act independently; rather, they are intersecting factors that impact health through their

complex interactions with each other. The breakdown of the social determinants of health presented in this paper is not meant to suggest that various causes of health and illness can be easily categorized and manipulated in the real world. Instead, the breakdown of the content of this literature review reflects an organizational decision intended to help readers unpack the complexity of factors that contribute to health and illness.

Gender as a Social Determinant of Health

Women's health is impacted in complex ways by a number of intersecting variables, one of which is gender. As the social determinants of health are intersectional by nature, women's access to health care is limited by a number of obstacles including cultural differences in perceptions of health between patients and physicians, discrimination, and poverty, amongst others (McGibbon & McPherson, 2011).

Moreover, inadequate income combined with care responsibilities, primarily experienced by women, impact women's health. Indeed, access to employment, sufficient income, stable housing and social benefits, which are shaped by legal codes that frame structural relationships, such as marriage and divorce, affect the social relations between men and women. Similarly, childcare and subsequent child custody, responsibilities that primarily fall on women, further impact gender relations (Pederson, Raphael, & Johnson, 2010). The gendered division in access to health care is a consequence of the gendered power differential created by the unequal distribution of responsibilities and access to services between men and women. Social practices that cause gendered divisions in access to resources and opportunities contribute to states of physical and mental health and illness (Pederson et al., 2010).

In their study, Davidson et al. (2001) found that the top three reported health concerns amongst women in Nova Scotia (aged 18 years and older; sample: 17.7% aboriginal, 16.3%

Black, 65.7% European decent; surveyed via telephone) were psychosocial issues (e.g., stress, depression, anxiety, etc.), specific illnesses and cancer. Specific illnesses of major concern to Nova Scotian women were osteoporosis, migraines, asthma, diabetes and arthritis (Davidson et al., 2001). The study by Davidson et al. (2001) demonstrated that the implementation of health promotion techniques was successful in decreasing stress amongst women. Their motivation was rooted in the idea that directly addressing health concerns was the most effective method of improving care access for women, considering the scarcity of health resources in Nova Scotia. This research is useful as it demonstrates health concerns that have existed in Nova Scotia over the past 20 years and can be compared to health concerns that persist today.

MacRae (2015) conducted a similar study to Davidson et al. (2001); however, she focused on the health care- and physician-related concerns of older women (average age of 69 years) in Nova Scotia. In her aim to identify what is most important to older women in receiving health care, MacRae (2015) found that older women were most concerned with their perception of physicians' competency, physicians' bedside manner, assertiveness employed by physicians, physicians' ability to compromise with patients, physicians' gender and physicians' age. In general, the older women in this study prefer young, female family physicians (MacRae, 2015).

The above cited studies regarding Nova Scotian women's health concerns are useful in gaining an understanding about specific health concerns that women have in Nova Scotia. However, they predominantly present the views of white women, and they do not report on barriers specific to different geographical locations or socioeconomic positions of racialized women in Nova Scotia.

Socioeconomic Status as a Social Determinant of Health

Socioeconomic status, a thoroughly researched social determinant of health, has been identified to affect primary care utilization in Canada. Specifically, individuals with lower socioeconomic status visit family physicians less often, but have more frequent emergency room visits, than individuals with higher socioeconomic status (Begley et al., 2011; Manos et al., 2014). Socioeconomic status affects health care utilization due to physical barriers that prevent individuals from accessing care facilities (e.g., inability to secure transportation, etc.; Syed, 2013). Further, low health literacy is often associated with low socioeconomic status (Yin et al., 2012). Limited understanding of medical terms and treatment plans may make patients less inclined to seek primary care (e.g., patients may feel intimidated, uncomfortable or incompetent discussing medical concerns with physicians; Yin et al., 2012).

Income determines a person's ability to access housing, food, and other necessities. Income and housing may be especially important issues for women, as women typically have lower income than men, and they are predominately responsible for childcare. As such, women are most affected by changes in social assistance, employment insurance, and housing policies as well as the provision of social services (Bryant, 2009). Women earn lower wages and are more likely to have part-time employment compared to men; as such, women are more likely than men to live in poverty in Canada (Bryant, 2009). Further, women's role as primary care givers makes them especially vulnerable to economic instability (Bryant, 2009).

Housing

In his study on housing and income as social determinants of health, Bryant (2009) examined the vulnerability of Canadian women to public policy changes. According to his research findings, poor housing and precarious income for single-parent families in Canada are

predominately women's issues (Bryant, 2009). Single-parent families struggle most economically, and subsequently with securing safe housing situations, as compared to families with two parents. Though men in single-parent families experience similar economic and housing concerns as women in single-parent families, women make up the majority of single-parents (Bryant, 2009). There are direct physiological effects of poor housing conditions (i.e., the effects of mould, overcrowding, etc.); however, poor housing also affects health through its intimate ties to income, insecure employment, and food insecurity (Bryant, 2009). Similarly, Bryant (2009) noted that urban housing conditions are often closely associated with violence against women.

Moreover, in their study Charkhchi et al. (2017) found that housing and food insecurity led to worsened health outcomes and reduced access to health care services. Indeed, the results of the study by Charkhchi et al. (2017) showed that chronic illness is often associated with food and housing insecurity. Additionally, food insecurity and housing insecurity, as independent factors, increased barriers to accessing health care, and led to poorer health status. Charkhichi et al. (2017) did not find a direct interaction between food and housing insecurity.

Food Insecurity

Food insecurity is often a result of low income and impoverished living (Papan & Clow, 2015). Food insecurity and subsequent health complications are a significant issue for women in Canada. In their study about the effects of food insecurity and obesity on women's health in Atlantic Canada (noted above), Papan and Clow (2015) found that women's health is impacted by a vicious cycle of poverty, food insecurity, and illness. Particularly, poverty can lead to nutritional deprivation, which can cause stress, weight gain, obesity, and chronic illness.

Papan and Clow (2015) identified themes important to women who experience food insecurity. Of concern to Atlantic Canadian women in relation to nutrition is poverty, particularly not having enough money to afford healthy food. Similarly, women struggle with access to nutritious food; many of the women noted that they live in food deserts (i.e., far away from grocery stores/healthy food), and their lack of reliable transportation makes it difficult for them to access nutritious food. Additionally, the gendered constructs of maternal deprivation were highlighted by participants as a theme in food insecurity. In an effort to adhere with social expectations about mothering, women often eat less food, and serve themselves last, to provide for their children (Papan & Clow, 2015). As noted previously, healthy food is expensive compared to calorie-dense, nutrient-poor foods. Therefore, unhealthy food is much more accessible to low income individuals; continuous consumption of unhealthy food leads to weight gain, and obesity often ensues (Papan & Clow, 2015). Obesity leads to myriad other health issues and complications. Moreover, as noted above, Charkhchi et al. (2017) also found causal links between food insecurity, worsened health outcomes, and increased barriers to care.

It is evident, based on the relevant literature, that socioeconomic status as a social determinant of health impacts women in Canada significantly. Socioeconomic status impacts other factors that contribute to health, such as food security and housing conditions. Socioeconomic status is not distributed equally amongst Canadians. Particularly, race is closely linked to socioeconomic status and health. Moreover, previous/existing health conditions can effectively lower an individuals' socioeconomic status (e.g., due to an inability to work, costly prescriptions, etc.) which may then further worsen their health outcomes (i.e., the two-way interaction between health and income; Smith, 1998). Indeed, the relationship between socioeconomic status and health is complicated.

Geographical Location as a Social Determinant of Health

Health care accessibility differs based on geographical location. In general, it is typically more difficult for rural-residing individuals to access care compared to urban dwelling individuals (Haggerty et al., 2014). In their study about health care in Nova Scotia, Harrold and Jackson (2011) similarly noted that accessing care in a rural setting is difficult; additionally, they found that wait times are longer and cause a greater negative impact for rural-residing women compared to urban-residing women.

In their study about the barriers and facilitators of rural access to primary health care Haggerty et al. (2014) revealed themes concerning barriers and facilitators in health care-seeking including: the source of care, preparation for receiving care, and geographical location in relation to the care-giving resource. Particularly, Haggerty et al. (2014) identified distance as a greater barrier in urban settings than rural settings. According to their findings, distance is a “fact of life” (p. 96) for rural residents, so it was not reported as a barrier to care (Haggerty et al., 2014). Distance was reported as a greater issue for elderly and underprivileged people seeking health care. Distance as a barrier to care access is also dependant on the nature of the health problem and the age of the individual seeking care (Haggerty et al., 2014).

Though travelling distance may not be a significant barrier for rural residents, rural women in Nova Scotia face other unique barriers accessing health care. Harrold and Jackson (2011) analyzed the experiences of young, rural Nova Scotian women (age 18-39 years) in the South Shore District Health Authority enduring wait-times for physician services. Women in rural settings experience a unique burden: the challenge associated with prolonged waiting times for health care services is amplified by their role as caregivers, and the lower socioeconomic status experienced by many (Harrold & Jackson, 2011). Harrold and Jackson (2011) identified

strategies to deal with long wait times, such as resorting to private care (e.g., privately sourced – rather than publicly available – psychological care), “the next best thing,” (referring to alternatives to physician-provided health care, p. 86) and social/emotional support. Perceived effects of long wait times include deteriorated health and negative emotional effects (Harrold & Jackson, 2011).

As Wanless et al. (2010) note in their article about the impacts of geography on women’s health, rural versus urban impact on health is more complicated than geographical location alone. Following their investigation on geographical location, Wanless et al. (2010) proposed that social capital should be added as a social determinant of health. Indeed, they found that increased social support leads to increased health outcomes for women, regardless of their geographical location. Decreased income often results in decreased health, also regardless of patients’ geographical location (Wanless et al., 2010).

As a social determinant of health, geographical location is often significant in reference to the accessibility of services and supports available in particular areas, rather than something inherent about the physical location where people live. Though there are specific qualities of certain geographical regions that may impact health (e.g., natural essential minerals available, weather, fertility of the land, etc.), it is evident that the social characteristics of geographical location are also significant in determining health.

Furthermore, certain groups of people are located in specific geographical locations for particular reasons. Income often determines where people are able to reside. Similarly, there are historical reasons that explain why certain people live in certain areas (e.g., family histories, colonial reasons, and geographical racial segregation). Evidently, geographical location, as a

social determinant of health, intersects with other factors such as race, socioeconomic status, and ancestry, amongst others, to affect the health of individuals and communities.

Race as a Social Determinant of Health

Race, as a social determinant of health, significantly impacts the well-being of racialized (i.e., not white/Caucasian) patients in a Eurocentric health care setting. For example, studies throughout Canada and the United States have identified that Black women are significantly less likely than white women to receive appropriate breast cancer therapy (Hobbs & Rice, 2018). One study noted that Black Canadian women are significantly less likely than white women to be screened for breast cancer in the first place (Nnorom et al., 2019). Similarly, Black individuals are less likely than white individuals to receive surgical treatment, to be admitted to the hospital, and to be treated for pain. Black individuals are also more likely to be under-medicated, and are reported to have a shorter life-span compared to their white counterparts (Hobbs & Rice, 2018).

Racism has been shown to severely effect mental and physical well-being (Goffin, 2017). In an interview for the Toronto Star, Dr. Onye Nnorom, a public health and family physician from University of Toronto's Dalla Lana School of Public Health, noted that Black Canadians suffer worse health outcomes than non-racialized Canadians (Goffin, 2017). Dr. Nnorom reported that Black Canadians often have low levels of education, poor employment conditions and unhealthy physical environments, which can result in poor health. She emphasised that medical advice, such as a healthier diet and regular exercise, is not feasible for many racialized Canadians due to their low-income conditions (Goffin, 2017).

There is limited research about barriers to access to health care for Black Canadian women (Nnorom et al., 2019). Therefore, it is difficult to ascertain what element of race is responsible for hindered health and care access. However, I predict that, much like the other

social determinants of health discussed thus far, race is a determinant of health for various intersecting reasons. Institutional and structural racism are undoubtedly responsible for health disparities between Black and non-racialized persons (Nickel et al., 2018; Ramaswamy & Kelly, 2015). Moreover, the geographical location of racialized Canadians may be different than that of non-racialized Canadians, which may cause poor health outcomes. There may also be other social factors and forms of discrimination that effect the health of racialized persons that have not yet been identified or studied in depth.

Indigeneity

Indigenous women's health is complicated by the multiple oppressions they face in Canada. Various research studies indicate that Indigenous women (e.g., Dion Stout & Kipling, 1998; Varcoe et al., 2017) and Indigenous persons more broadly (e.g., Bowers et al., 2019; Nickle et al., 2018) experience lower overall health than their non-Indigenous counterparts. Specifically, these authors report that chronic mental and physical illnesses are more prevalent amongst Indigenous populations compared to non-Indigenous populations in Canada. Many Indigenous women in Canada experience low socioeconomic status, food insecurity, and increased domestic violence which contribute to diminished health and increased stress (Varcoe et al., 2017).

Indeed, the life span of Indigenous women is noticeably shorter than that for non-Indigenous people in Canada (Pederson et al., 2010). These authors reported that the average life span for Indigenous women in Canada is approximately five- to six-years shorter than for non-Indigenous women (Pederson et al., 2010). This statistic is significant in signaling particular health and health care access problems experienced by Indigenous women in Canada.

In a research study about the social determinants of health and substance use for Indigenous women in Canada, Shahram (2016) discussed potential causes and consequences of substance use. Shahram (2016) noted that the Indigenous population in Canada has lower rates of formal education, higher rates of unemployment, and lower incomes than non-Indigenous Canadians. She explained that subsequent economic and social problems often lead to substance abuse and psychological issues for Indigenous women (Shahram, 2016). Indigenous women are affected by, and inseparable from, the complexity of their histories; the multiple losses experienced because of various effects of colonization (e.g., loss of traditional lands and culture, forced removal from families, historical trauma) affect many generations, and can lead to severe health and behavioural consequences (Shahram, 2016).

Moreover, the isolated geographical locations of many Indigenous communities may have harmful effects on their health. In their study, Bowers et al. (2019) identified barriers to care access for some Indigenous persons, such as living in isolated geographical locations. Moreover, substance abuse problems, and the fear of subsequent punishment (e.g., reports to police or child services), may make Indigenous women less likely to seek medical care (Shahram, 2016). The fear that they might be judged for their substance-use problems, treated disrespectfully, or punished in a care setting may be identified as a barrier to health care. To date, there is limited research about Indigenous women's access to care in Nova Scotia, which further emphasizes the need for such research.

Canada's colonial history is responsible for the poor health of Indigenous populations. The intergenerational impacts of colonialism (particularly violence, assimilation and residential schooling) for Indigenous families has led to poverty, social immobility and continued violence against Indigenous women (Murdocca, 2017; Nickel et al., 2018). Though the research

concerning Indigenous women's access to primary care, specifically, is limited, I hypothesize that Indigenous women may have a greater need for medical attention due to their multiple oppressions. Recall Crenshaw's (1991), Razack's (1998) and McGibbon and McPherson's (2011) theories and applications of theoretical understandings about the complicated, interconnected causes and consequences of social determinants of health. In light of these theories and applications, I predict that the multiple oppressions Indigenous women face may limit their ability to access primary care. Consequently, restricted care access may be more detrimental for Indigenous women than for their non-Indigenous counterparts. Importantly, as Lewis et al. (2016) note in their study about the health of Indigenous people in Nova Scotia, Indigenous people often view their health as more than physical and mental wellbeing. Rather, the authors explain that Indigenous health involves the balance between physical, mental, emotional, spiritual, and emotional health as well as connections with the environment, culture, family, and community (Lewis et al., 2016).

Immigrant Status

Factors such as language barriers, unfamiliarity with local health care systems, and a lack of family doctors accepting new patients make it difficult for immigrants to access and benefit from primary health care in Nova Scotia (Kohler et al., 2018). In her study on immigrant women's health in Nova Scotia, Weerasinghe (2012) found that skin colour, body weight, and foreign accents act as unfavourable characteristics which negatively affect interpersonal dynamics between immigrant women patients and health care providers. Weerasinghe's (2012) findings highlight barriers that patients experience upon contact with health care providers.

In contrast, Bourassa et al. (2017) focus on barriers that immigrant women face before they have the opportunity to access health care at all. Specifically, Bourassa et al. (2017) note the

structural inequalities that are often associated with immigration, such as low socioeconomic status and residential segregation, may restrict physical access to health care providers (e.g., difficulty accessing transportation may inhibit an individual from visiting the doctor). Further, immigrants often experience culture shock, low social support and/or social isolation, which can further hinder their ability to access health care (Bourassa et al., 2017). Immigrant women also experience domestic violence and have particular difficulty accessing victim services as compared to non-immigrant women who experience domestic violence in Canada (Holtmann & Rickards, 2018; Shirwadkar, 2004; Souto et al., 2019). Finally, as the typical primary care giver in a family unit, women take on more care responsibilities than men, including supporting parents who do not speak English (Bourassa et al., 2017). These factors intersect to make access to health care difficult for immigrant women to achieve (Bourassa et al., 2017).

Comprehensive and appropriate health care is critical for immigrants to feel settled and integrated into a new cultural setting (Kohler et al., 2018). However, access to care is limited, and understanding and navigating a new health care system could be difficult for recent immigrants (Kohler et al., 2018). Difficulties with language, health literacy, and transportation can be significant barriers to health care for immigrants. Similarly, many immigrants arrive to Canada without their medical histories (or, if they do possess their medical documents, they may not be in English or French), which can further complicate their care (Kohler et al., 2018).

In their study about immigrant women's access to health care in Canada, Weerasinghe et al. (2000) identify the same barriers as those mentioned above. They also note that physicians' cultural incapacity (i.e., the perpetuation of cultural and racial biases in the health care setting) is a severe barrier to health care for immigrant women. Moreover, studies have identified that

specific mental health issues experienced by immigrant women make it more difficult for those individuals to access health care (Guruge et al., 2015; Weerasinghe et al., 2000).

In their study about immigrant women's access to and utilization of health care, Guruge et al., (2009) strongly emphasise the importance of fluency of English and French in facilitating access to health care in Canada. Immigrant women face unique challenges accessing services to help them learn English, which consequently affects their ability to access health care services. Such challenges include financial barriers, limited transportation, limited information about language services, household duties, family expectations, and a lack of childcare (Guruge et al., 2009). Indeed, many immigrant women noted that they want to learn English, and it is important to them that they become fluent in English, but it is not their first priority, as family responsibilities take precedence (Guruge et al., 2009). Evidently, language proficiency is central to accessing health care, as a patient's inability to verbally communicate with their physician will complicate their ability to share their symptoms and understand medical advice. As such, barriers to accessing the tools to learn English and/or French severely impacts access to health care for immigrant populations, and women in particular, in Canada.

There are many reasons why immigrant status is a social determinant of health in Canada. Extensive research concerning primary care access for immigrant women in Canada demonstrates that factors such as language, race, social isolation, and culture shock intersect to cause health problems for immigrant women. Similarly, these factors affect immigrant women's access to health care services in Canada, and in Nova Scotia in particular.

Considering immigrant status as a social determinant of health offers valuable insight into the experiences of patients, while allowing the opportunity to critique the Eurocentric nature of

health care in Canada. Evidently, there are systemic issues central to health care institutions in Canada that make it difficult for immigrants to seek appropriate health care.

As noted previously, the severe and persistent shortage of family physicians in Nova Scotia makes access to care difficult for all patients (Bradley, 2018; Lord, 2019). However, it is evident that accessing primary care is especially complicated for individuals with existing barriers to health and health care. Significant barriers include the social determinants of health such as gender, socioeconomic status, food and housing (in)security, race, Indigenous ancestry, immigrant status, and geography.

Though there is extensive research concerning the social determinants of health for Canadians, further research on specific barriers to primary care in Nova Scotia is required, as there are significant gaps in the current literature. Specifically, there is a gap in the research concerning access to primary care for Indigenous and women of colour in Nova Scotia. Furthermore, it is unclear which elements of the social determinants of health are particularly significant in understanding barriers to primary care in Nova Scotia.

It is necessary to develop a greater understanding of the problems that Nova Scotian women face in accessing health care in order to make suggestions about more effective ways to address the health care needs of our population. Ideally, through understanding the unique experiences of immigrant women, women of colour, and Indigenous women in accessing primary health care in Nova Scotia, policy changes regarding health care can be made to improve access to care for all patients.

Chapter Three: Health Care and Policy in Canada

Background

Health care access is critical for all Canadians. Though Canada proudly boasts a universal health care system, access to care is not distributed equally amongst the population (Sociás et al., 2016). Evidently, it is pertinent that all Canadians have access to the health care services and resources (e.g., pharmaceuticals, assistive devices, etc.) they need, not only to maintain a productive society, but because health is a fundamental human right (WHO, 2017).

Understanding the policies which regulate health care funding and allocation in Canada is important, as the regulation and distribution of care determines accessibility. Analyzing health care policy fosters an understanding of barriers, from a policy perspective – i.e., why barriers exist, and what actions can be taken to mitigate harm for individuals who have the most difficulty accessing health care services. Though not all barriers to health care are at the policy level (e.g., interpersonal patient-physician barriers may prevent effective care), it is evident that policy informs accessibility. As such, considering social determinants of health through analyzing health care policy from an intersectional feminist lens bolsters a thorough understanding of health care access in Canada.

To provide context for my critique of the Canadian health care system and policies relevant to the social determinants of health, I will provide an overview of the Canadian governmental structure and the responsibilities of the different levels of government concerning health care. I will also outline the involvement of the private, public, and voluntary sectors in health care in Canada.

Tiers of Health Care Responsibility in Canada

Federalism and Health Care

Federalism is a term that denotes a multi-level government structure, such as the system in Canada. The Canadian government consists of a federal (national level), ten provincial/three territorial, and many municipal and First Nations governments. According to Canada's constitution, each level of government has a different role and set of responsibilities concerning health care (Findlay & Johnson, 2017).

The Canadian federal government provides funds to the provinces, territories, and First Nations governments to be used for health care spending (Findlay & Johnson, 2017). The federal government contributes funds to the provinces on a per capita basis through Canada Health Transfer (Canada, 2016). Health Canada, a federal government organization, is responsible for the regulation of food and drug safety (Canada, 2008; Findlay & Johnson, 2017). The federal government also provides direct health care services to some groups, such as members of the Canadian armed forces, inmates in the federal prison system, and communities on Indigenous reserves (Canada, 2016).

The Canada Health Act (CHA), Canada's federal legislation for publicly funded health care, mandates that provincial insurance plans provide universal coverage for health services without copayments for all insured persons and insured services (Deber et al., 2014). The principles of the CHA mandate that, in order to qualify for cash entitlement under the Canada Health Transfer, provinces and territories must adhere to five principles: public administration (i.e., health care is administered on a not-for-profit basis), comprehensiveness (i.e., all insured services provided by hospitals/physicians are covered), universality (i.e., all insured residents of a province/territory are entitled to the same health care terms and conditions), portability (i.e.,

residents who move from one province to another must continue to be covered for health services), accessibility (i.e., insured residents in any province/territory have reasonable access to insured services; Health Canada, 2015).

The insured services mandated by the CHA include only care given in hospitals/clinics by physicians; however, individual provinces often provide health insurance beyond this (e.g., public health expenses; Deber et al., 2014). As federally mandated universal coverage is limited to medically necessary services provided by physicians, several other subsectors of health care services are not funded publicly. Depending on the province, patient, and service, care from other institutions (e.g., dental services, vision care, prescribed drugs, home care, ambulance services, medical devices, etc.) are paid almost entirely through out-of-pocket expenses or private health insurance plans (Deber et al., 2014).

In Canada, health care is under provincial jurisdiction (Deber et al., 2014); provincial governments provide funds (some of which are from the federal government) to individuals, hospitals, and municipalities for health care expenses (Findlay & Johnson, 2017). Provincial governments are responsible for health care delivery, administration, and for some regulation of drug costs (Findlay & Johnson, 2017). Provincially run insurance plans reimburse independent health care providers (Deber et al., 2014).

Municipal governments have minimal involvement in health care provision in Canada. In some areas, municipal governments provide funds for hospitals and public health expenses (Findlay & Johnson, 2017). Some long-term care facilities are municipally owned (Findlay & Johnson, 2017). Services that are indirectly related to health, such as water/sewage treatment and garbage removal are under municipal jurisdiction (Findlay & Johnson, 2017). Finally, First

Nations governments are involved in some of the planning and delivery of community-based services, through self-governing agreements, in Canada (Findlay & Johnson, 2017).

Public, Private and Voluntary Sectors

Though Canadian governments (federal, provincial, municipal, and First Nations) are responsible for some of the allocation and associated costs of health care, private and voluntary sectors also provide much of the health care Canadians receive. Health care allocation in Canada is not always simple; there is often overlap between the care provided by private, public, and voluntary sectors (Findlay & Johnson, 2017).

Defined narrowly, the public sector is the central government (Levac & Cowper-Smith, 2016). More broadly, the public sector is the division of the government responsible for the provision, production, distribution, and allocation of public goods and services. This definition includes public services that are provided directly by the government and para-public services (i.e., services that are publicly funded but not necessarily provided by the government; Levac & Cowper-Smith, 2016).

In Canada, physician and hospital visits, funding for health research, hospital funding, and some drug coverage are provided by the public sector (Findlay & Johnson, 2017). However, privatization and outsourcing of services complicate how the public sector is defined, as they affect how services are funded, administered, and delivered (Levac & Cowper-Smith, 2016).

The private sector involves for-profit organizations and services, along with family-provided services, that are not under direct governmental control. As noted above, in Canada, pharmaceuticals, dental services, vision care, for-profit clinics, for-profit home/elder care, ambulance, among other services, are paid for by out-of-pocket expenses and private insurance plans – hence, these services are provided by the private sector (Findlay & Johnson, 2017).

The voluntary sector, also referred to as the third or non-profit sector, involves charities and other not-for-profit organizations. In Canada, the voluntary sector is involved in health care provisioning through organizations that provide not-for-profit home and elder care, and charitable funds for hospitals (Findlay & Johnson, 2017).

Social Determinants of Health and Social Policy

As Raphael (2009b) argues, it has been difficult to have broad social determinants of health addressed by policy makers in Canada. The problem is not that social determinants of health have gone unnoticed in Canada; in fact, many public health, health care, and social organizations engage in research and policy implementation which support the impacts of social determinants on health (Raphael, 2009b). There are many organizations in Canada that are concerned with the social determinants of health (e.g., the work of the Canadian Council on the Social Determinants of Health (CCSHD) involves the creation of tools to support action on social factors that shape health through working with a range of sectors such as urban planning, public health, Indigenous organizations and municipalities; CCSDH, n.d.). However, there is still limited public health attention regarding social determinants of health. Canadian public health promotion in Canada continue to focus on individualized (i.e., behaviour, lifestyle) approaches to health and disease prevention (Raphael, 2009b). Indeed, Raphael (2009b) notes that public policy that incorporates social determinants of health is virtually non-existent in Canada. Currently, over ten years after Raphael's (2009b) finding, though the Public Health Agency of Canada has made a promise to support policies that align with the Rio Political Declaration on Social Determinants of Health (Government of Canada, 2015), Canadian public health policies still focus minimally on the social determinants of health for Canadians.

In arguing for the importance of research concerning policy change, Raphael (2009b) presents and explores the idea of the phantom zone: a community of people who are concerned with raising issues of social determinants of health in policy agenda, but who have limited impact on public policy and the world around them. He explores the role of the public health sector in the Canadian context in arguing that public health policy should be centered around discussions about the social determinants of health (Raphael, 2009b).

Similar to Raphael's (2009b) argument, Gore and Kothari (2012) determined that the majority of healthy living programs in Canadian provinces were lifestyle- and environment-based. The programs did not incorporate or address the social and structural determinants of health. As Gore and Kothari (2012) note, this trend is problematic because individual behaviour changes are typically not sufficient to make lasting health improvements. Moreover, provincial suggestions of individual lifestyle changes can lead to victim-blaming when barriers prevent individuals from accessing physician-suggested interventions. From an intersectional feminist perspective, the implementation of health care solutions which address the social determinants of health would be more sustainable. Such solutions would target the root cause of many health problems, rather than superficially attempt to resolve health issues.

Evidenced by the work of Raphael (2009b), it is vital to study social determinants of health in Canada in the context of barriers that women face in accessing care. Indeed, as Raphael (2009b) suggests, social determinants of health are central to research concerning barriers to health and health care. Undeniably, access to health care is not distributed equally amongst the Canadian population (Socías et al., 2016). Within the context of Nova Scotia, rural versus urban location impacts individuals' ability to access the health care services they need (Harrold & Jackson, 2011). The results from studies such as Harrold and Jackson's (2011) – which suggests

that women in rural locations face complicated barriers to access health care – add to the body of literature which suggests that social characteristics are central to determining health care access, and subsequent health, for Canadians.

Moreover, gender, as a social characteristic, impacts access to health care. Particularly, women are more likely to experience barriers to health care services based on individual and community characteristics than are men (Hwang et al., 2017). Indeed, women's precarious employment and traditional gender roles may explain why they are more likely than men to have unmet health needs related to barriers to care access (Hwang et al., 2017). Hwang et al. (2017) also noted that increasing the number of family practitioners in an area may not reduce unmet health care needs due to specific barriers to accessing health care, emphasizing the importance of the social nature of health and health care access. Indeed, as increasing the number of physicians does not equate increased access to care for patients, it is evident that there are other barriers (i.e., social determinants of health and barriers informed by health care policy) that affect access to health care. Accordingly, social and structural barriers must be addressed to effectively ameliorate women's access to health care.

Certain groups of women may be more likely to experience barriers to accessing health care than others. Indeed, immigrant women may experience unique barriers to accessing health care, which are not experienced by non-immigrant women. Jennings, et al. (2014) researched the impact of immigrant status on access to health care and examined the social support needs of immigrant mothers and their disabled children in Canada. Through analyzing systemic and other barriers for migrant women, which act to inhibit their ability to access health care and related services, they found mothers of children with disabilities face increased challenges accessing care. For example, immigrant mothers of children with disabilities experience limited support for

their children, which may lead to mental health challenges (e.g., depression), limiting their ability to access care further (Jennings et al., 2014).

Moreover, racism has been identified to severely affect mental and physical well-being (Goffin, 2017). Notably, Black Canadians suffer worse health outcomes than non-racialized Canadians (Goffin, 2017). Individualized medical advice, such as the promotion of healthier diets and regular exercise, is not appropriate for many racialized Canadians as their low-income conditions may prevent them from adhering to such advice (Goffin, 2017). Evidently, social and systematic solutions for health problems (i.e., policy-level solutions) offer greater potential for ameliorating health for Canadians than individualized solutions.

Critique: Canada's Health Care System

Though there are advantages to the universal health care system that currently exists in Canada, undoubtedly, the system is not perfect. Indeed, as Burke and Silver (2012) discuss, though Medicare has fostered many successes (e.g., decreased infant mortality rates in Canada following its implementation), challenges of decentralization, commodification and relegation of services persist (Burke & Silver, 2012).

Privatization of health care is fueled by the neoliberal political climate in Canada (Burke & Silver, 2012). Indeed, neoliberal political and economic frameworks emphasize private responsibility of health care over public distribution of care. Inevitably, in the neoliberal framework, health care becomes a commodity, as health services are moved from areas where care is publicly provided (i.e., hospitals) to spaces where care is privately financed (i.e., home care, out-of-hospital prescriptions). Privatization includes shifting publicly funded services to for-profit provision, and (re)familialization (i.e., becoming the responsibility of individual families) of services. Moreover, the neoliberal regime identifies efficiency as the primary goal of

public health policy evaluation (Burke & Silver, 2012). This assessment threatens to disrupt the quality and equity of care services, which may exacerbate health disparities for Canadians (Burke & Silver, 2012) as economic efficiency over publicly available health services may result in lessening expenditures purely for economic value while disregarding the health impacts that may follow. Indeed, in a neoliberal framework, in which many health care services are provided only by the private sector, individuals who are economically advantaged will be able to access care, while those with lower socioeconomic status will suffer (financially and/or physically).

The problems with the Canadian health care system may present more challenges for some individuals than others. The provision of health care and service funding in Canada determines who is able to access care, and who is not. For example, as noted previously, most pharmaceuticals are paid for by patients' out-of-pocket expenses, or through private health insurance providers (Deber et al., 2014). Understandably, the cost of pharmaceuticals prescribed by physicians may be a barrier to effective health care for some (e.g., if a patient does not have a private health insurance plan and cannot afford the out-of-pocket expense). Indeed, even a patient who is able to access health care physically (i.e., they are able to acquire and attend an appointment with a physician) may not receive adequate care (i.e., effective treatment) if they are unable to afford what the physician prescribes. Similarly, many Canadians are unable to access dental services, optical care, and other care services as they are not covered by many provincial health insurance plans; therefore, limited public health insurance may be a barrier to care (Deber et al., 2014).

Concerningly, Canadians who hold positions in precarious or part-time employment often do not have health care insurance plans through their employers (Newman et al., 2020). Moreover, in Canada, women are more likely than men to hold part-time/precarious working

positions (Newman et al., 2020). Therefore, it is reasonable to have concern about women's ability to access effective health care in Canada. As such, it is necessary that social determinants of health, including those that inform women's barriers to care access, are addressed in Canadian health policy.

As Dutton et al. (2018) discuss, the current allocation of budgets for health and social spending in Canada, dictated by the Canada Health and Social Transfers (CHT and CST, respectively), does not work to optimize the health of all Canadians. In their study, Dutton et al. (2018) measured the ratio of provincial government spending on social services relative to the spending on health care while controlling for demographic and economic factors. Their results demonstrated that increased social spending was positively associated with population health measures, though health spending did not have the same association. Dutton et al. (2018) concluded that redirecting provincial budgets from health to social spending may be an effective way to improve population health without changing the overall government spending on health and social services; this result demonstrates the importance of the impact that social determinants have on health. Indeed, much like the finding that increasing the number of physicians in an area does not increase access to care (Hwang et al., 2017), increasing resources for health spending does not necessarily increase population health (Dutton et al., 2018). However, it is important to note that Dutton's et al. (2018) suggestion of a redirection of government health expenditures to social expenditures, rather than simply suggesting that governments invest more in social spending, accepts the idea of limited government resources – a neoliberal ideal. Evidence that increased resource allocation for social programs is most effective at improving population health demonstrates that social conditions are inseparable from health and must be prioritized in policy planning.

It is critical to consider the social determinants of health when analyzing health care access from an intersectional feminist perspective. As previous research has shown, social characteristics (e.g., gender, age, race, socioeconomic status, indigeneity, immigrant status, etc.) intersect and shape the health status of Canadians, and their ability to access care (Raphael, 2009b). It is evident, through an analysis of literature on social and health policies in Canada, along with research concerning the social determinants of health, that social and structural factors must be considered in health and social policy provision. Barriers to health care, and subsequent health, for marginalized populations may be mitigated through adjusting health care policies (i.e., federal and provincial spending on health care and social programs) to reflect the importance of social determinants of health.

Chapter Four: Theoretical Framework

Intersectional Feminist Theory

I will adopt an intersectional theoretical framework grounded in the work of Kimberlé Crenshaw (1991) and Sherene Razack (2008). Informed by the work of theorists in the field of intersectionality, I will analyze the inequities in health care accessibility as a form of racialized and gender-based discrimination. Further, I aim to critique the androcentric and neoliberal nature of health care policies in Canada.

Intersectional feminist theory is most useful for my thesis, as compared to other feminist theories, because it offers useful tools to engage in critical analyses about the complicated interactions of individuals' and communities' social characteristics. Intersectionality works to uncover how inequalities, such as racism and sexism, work together to disadvantage and marginalize groups of people (Crenshaw, 2015). My interest in social determinants of health has fostered my interest in intersectionality as a feminist theory for this project. Though in health research, the *term* intersectionality is not always used when discussing social determinants of health, from my perspective, the two *concepts* are inseparable. Essentially, social determinants of health are characteristics that facilitate or inhibit individuals' health and access to health care. Indeed, social determinants of health are the multiple and intersecting factors determined by social characteristics (e.g., gender, race, socioeconomic status, etc.) – the same characteristics considered when analyzing phenomena from an intersectional perspective.

Intersectionality as a feminist theory works to highlight the “interaction between gender, race, and other categories of difference in individuals lives, social practices, institutional arrangements, and cultural ideologies, and the outcome of these interactions in terms of power” (Davis, 2008, p. 68). Because health and health care access are feminist issues, I will utilize a

critical intersectional feminist theoretical framework to analyze gender, class, race, immigrant status, and indigeneity as intersecting structures that create health inequities (Thorton Dill & Kohlman, 2012).

Intersectionality is often used to examine social justice issues within culture and health (Dagkas, 2016). Particularly, equitable access to health care is an issue of concern to intersectional feminists. Indeed, according to Bowley (2012), the central principles of intersectionality are very relevant to public health. The social determinants of health model and intersectionality work (both independently and together) to highlight the roots and impacts of social inequalities in societies.

Intersectionality is useful as a theoretical framework for understanding how social identities at the micro level (e.g., race, gender, socioeconomic status) intersect with macro level structural factors (e.g., poverty, racism, sexism) to illustrate and produce disparate health outcomes amongst populations (Dagkas, 2016). Social identities reflect oppressions and inequalities inherent to interlocking systems of hierarchies, domination, and oppression (Dagkas, 2016). Intersectional feminists posit that inequalities, including those that exist in access to health care, are not the result of a single factor. Rather, such inequalities result from the intersection of social locations, experiences, power dynamics, etc. (Dagkas, 2016).

Intersectional feminism frames agency (i.e., the freedom and flexibility to make choices; Kockelman, 2007) as influenced by the multiple intersecting oppressions that individuals face. Feminist agency is defined not simply as women's ability to make choices, but more precisely, women's ability to formulate choices (Maitra, 2013). Feminist agency is complicated because the diverse experiences and intersectionalities (e.g., race, class, religion, ethnicity, etc.) of women across the globe constitute different conceptualizations of agency (Maitra, 2013). Indeed,

multiple layers of identity must be involved in the consideration of how the social world is constructed (Crenshaw, 1991) including examinations of women's ability to access effective health care.

Themes in Feminist Critiques of Western Medicine

Though feminist theoretical perspectives about agency and power in health care vary according to the school of thought employed, there are some underlying themes common to analyses about women's health care in feminist literature. Specifically, many feminist scholars (e.g., Defenbaugh, 2008; Ellingson, 1999; O'Connell & Zampas, 2018) engage in critical feminist analyses related to Western medicine and inequalities in health care through exploring concepts such as hegemony and gender stereotypes.

Patriarchal constructions of society and medicine are apparent in interactions with medical professionals, according to Defenbaugh's (2008) examinations in her qualitative narrative research. Through outlining her own doctor-patient encounters, and what she has learned through her experiences as a chronically ill patient, Defenbaugh (2008) argues that the inherent hegemonic structures of medicine disempower patients, especially for female patients in relation to male physicians.

Moreover, gender non-conforming persons face unique challenges in the health care setting. In their research, O'Connell and Zampas (2018) identify gender non-conforming persons as facing pervasive and persistent harmful stereotypes that impact their ability to access health care. Specifically, they assert that gender stereotypes exert control over women and gender non-conforming persons (O'Connell & Zampas, 2018). Indeed, gender stereotypes are caused by and perpetuate discrimination. Moreover, gendered power relations, which are often substantiated by

gendered stereotypes, result in some women's decreased agency in the health care setting (Hawkey et al., 2019).

Patient-Physician Relationships

The concept of the patient-physician relationship has been explored thoroughly in feminist theory; these theoretical explorations are useful for my analysis of women's access to health care. Indeed, the interpersonal relationships between physicians and patients impact the quality of care provided. Patient-physician relationships may be complicated for many women – as Lombardo et al. (2014) note, some groups of women experience mixed feelings regarding medical information, as they may want to be informed about their health care but may not necessarily want to feel responsible for making care decisions for themselves.

Moreover, the physician-patient relationship is complicated by the concepts of authority, power, and control (Hinnant, 2009). Hinnant (2009) posits that the Western conceptualization of physicians as all-knowing leaves patients with little authority. This power dynamic is intensified by Western societal conceptualizations of certain groups of women as subordinate to certain groups of men (Hinnant, 2009). Historical unequal power relations between men and women impact the physician-patient relationship in a way that can harm women's experiences accessing effective health care (O'Connell & Zampas, 2018). Women may experience limited autonomy and agency in relationships with male physicians as social discourses reinforce male authority over female bodies.

Indeed, Defenbaugh (2008) explores the power relations between patients and practitioners in her analysis of her own years-long experience waiting to receive a diagnosis for her chronic illness. Physicians have power in relation to patients because of their specialized health knowledge and control over medical information that allows physicians the opportunity to

assert paternalistic control over their patients (O'Connell & Zampas, 2018). Defenbaugh (2008) explains that the authoritative position of male physicians, in relation to their female patients, makes it difficult for women to question health advice, even when they feel the advice is not appropriate or does not reflect what they are feeling in their own bodies (e.g., a diagnosis of stress for symptoms that a woman is confident are not psychosomatic; Edley & Battaglia, 2016).

According to Ellingson and Buzzanell (1999), traditional research ignores the element of gender in analyses of the physician-patient relationship. Moreover, race and class are also often ignored in traditional research in this area. However, Defenbaugh (2008) highlights that the patient-physician dynamic is founded on existing patriarchal structures in society. Moreover, the traditional relationship between male physicians and female patients works to reinforce women's gender roles in society (e.g., women as subordinate, less knowledgeable, etc.) and to diminish women's fears, concerns, and opinions in health care discourse (Defenbaugh, 2008; Edley & Battaglia, 2016).

Health Care Applications

Theoretical feminist analyses of health care may offer practical solutions to mitigate barriers that individuals face in accessing the care and supports they need. Indeed, as is apparent through analyzing contemporary feminist literature concerning health and health care access, there are many theories about why inequity in health care access exists in Canada. These theories offer an opportunity to address various factors that impact the health of Canadians in a practical (e.g., policy oriented) approach.

Improving interpersonal relations between physicians and patients can make health care experiences better for women. As results from Ellingson's and Buzzanell's (1999) study showed, participants identified respect (i.e., respecting the patient as an intelligent and autonomous

person), straightforwardness, care, and physicians' reassurance of their expertise as the most important aspects of their relationships with physicians. Evidently, how a patient is treated in their interactions with their physicians is critical to forming a trustworthy relationship.

Edley and Battaglia (2016) urge health care providers to pay attention to subtle metanarratives within the dominant discourse of health care. Similarly, O'Connell and Zampas (2018) note that international medical federations (such as the International Federation of Gynecology and Obstetrics) have acknowledged that stereotypical thinking has permeated health care, and directly affects women's health; this acknowledgement is paramount to enacting meaningful change in health care.

Researchers such as Lombardo and colleagues (2014) have demonstrated that women modulate their behaviour in health care settings to avoid confronting situations that they predict will result in diminished quality of care. Indeed, women reported engaging in impression management (e.g., purposefully failing to disclose their sexual orientation, masking mental illnesses, etc.) in an attempt to represent themselves favorably towards physicians (Lobardo et al., 2014). It is evident that without important personal health-related information of their patients, physicians may provide poorer quality of care. However, it is also evident that women may (appropriately) feel uncomfortable sharing personal information that may lead to their judgement by physicians. This discomfort is inflated in situations that involve disparate power dynamics, such as the relationship between a patient and their physician. Accordingly, it is pertinent to address the interpersonal relations between patients and physicians in order to overcome barriers to effective care that exist at the interpersonal level.

Moreover, feminist theoretical analyses of Western health care may offer useful perspectives about inequities in medicine that may be addressed at the policy level. Indeed,

intersectional feminist analyses demonstrate that individuals with multiple, intersecting oppressions are more likely to experience challenges accessing health care and maintaining good health as compared to individuals in more advantaged social positions. In line with an intersectional feminist approach, the body of literature concerning the social determinants of health focuses on individual characteristics that intersect and have known effects on individuals' and communities' health (Raphael, 2016).

An intersectional feminist analysis of the unequal distribution of health care across a population requires a thorough understanding of the social characteristics shaped by power relations and individuals' multiple intersecting oppressions. Indeed, understanding the impact of social determinants of health through an intersectional feminist lens enables a critical analysis of the distribution of health, illness, and care services amongst Canadians. Social factors, such as those used to predict health are also predictors of crime, educational attainment, social problems, quality of life (Raphael, 2009a) and are central to feminist intersectional analyses.

Feminist Health Promotion

Often, women are empowered when they are able to take action regarding their health (MacDonnell et al., 2012). Feminist health promotion works to build community capacity for health care, address social inequalities in health, and understand the complex interactions of power and privilege in health care (MacDonnell et al., 2012). Social action (e.g., social policy change, etc.) is the ideal outcome of feminist health promotion research (MacDonnell et al., 2012).

As a field, health promotion has historically paid little attention to problems of gender inequity (Pederson et al., 2014). As feminist health research works to understand gender as a determinant of health (Pederson et al., 2014), it provides valuable solutions for problems of

gender inequity in health care. Moreover, feminist health promotion techniques address the causes of gender-based health inequalities and work to transform harmful gender roles, norms, and relations (Pederson et al., 2014).

Conclusion

Agency and power are important concepts to consider when analyzing gender disparities in health care. Indeed, many feminist theoretical perspectives incorporate such concepts into their discussions about women's autonomy and rights relating to health care. As we move towards more gender equitable health care delivery and access in Canada, it is imperative that we rely on feminist conceptualizations of power, agency, and interpersonal dynamics to guide practical implementations and changes that may be introduced to the health care system. I am confident that critical feminist analyses, such as that employed in the current thesis, offer substantial opportunities to make positive change in institutions, such as health care, to benefit all members of the population.

Chapter Five: Methodology & Methods

Methodological Framework

Throughout this study, I employed a descriptive and explanatory feminist inquiry to investigate the barriers to primary care experienced by women in Nova Scotia. Online surveys were used to collect data for this research project. All research was approved by the Mount Saint Vincent University Research Ethics Board prior to commencement.

Qualitative analytic techniques were used to unpack the themes in responses to open-ended survey questions, using an intersectional approach. Intersectional analytic tools, such as thematic analysis, were also used to interpret and contextualize qualitative results from multiple-choice based survey questions.

Justification: Physician Survey

The goal of the online survey for physicians was to gain an understanding of the barriers that family medical practitioners *perceive* to exist in women's access to primary health care in Nova Scotia. The survey was comprised of 33 questions and was estimated to take approximately 10-minutes to complete. The survey was created in collaboration with and validated through a pilot study by physicians currently practicing in Nova Scotia. Suggestions from the pilot study were implemented and the survey was amended accordingly.

Justification: Patient Survey

The goal of the online patient survey was to gain an understanding of the *actual* barriers to primary health care that Nova Scotians experience. The survey was comprised of 17 questions and was estimated to take approximately 15-minutes to complete. The survey underwent a preliminary pilot study, involving a small group of participants with diverse demographic backgrounds. Pilot study participants did not offer any suggestions for changes to the survey.

Though, in general, surveys provide relatively superficial data, the majority of the questions for this survey were open-ended. Open-ended questions allowed participants to elaborate on their responses, which created a rich data set. Moreover, using surveys as a method allows for the quick collection of a large quantity of data. The original plan was to collect data from patients through focus groups (see Chapter Five page 55, Modifications due to COVID-19; Chapter Seven, Impacts of COVID-19 on the Current Research Project). However, due to the COVID-19 pandemic, in-person data collection was not permitted; accordingly, we changed the method of data collection to an online platform. The online patient survey was designed to replicate an environment similar to that of a focus group. As such, conversation prompts originally designed for the focus group were modified into open-ended questions which were used in the online survey. The survey does not include specific questions about participants' socioeconomic status; rather, we chose to probe factors such as this with open-ended question prompts as we would not have asked these personal questions in a focus group.

Methods

Physician Survey

The physician survey was open to any family physician practicing in Nova Scotia (see Appendix A for complete survey). The survey was created with LimeSurvey and was available online through the Mount Saint Vincent University LimeSurvey domain. The survey link was advertised in a bi-weekly e-newsletter distributed to Nova Scotian physicians by Doctors Nova Scotia. Similarly, the link was distributed on social media platforms (Twitter and Instagram). In total, 29 surveys were submitted via the link distributed on social media, 24 were submitted via Doctors Nova Scotia. Fifteen surveys were also distributed to doctors' offices (family and student medical clinics) in Halifax. These responses were manually entered into the database of

survey responses ($r = 3$). The survey link was coded so that participants were only able to access the survey once per electronic device. Data for the physician survey was collected beginning in December 2019 until early March 2020, prior to the COVID-19 pandemic.

The survey included 33 questions. There were 29 multiple choice questions with a five-point Likert scale or “yes/no” answer option set. There were an additional two multiple choice questions with an option to elaborate in a textbox (e.g., “if you chose yes, please explain why”). There were four open-ended questions. One of the open-ended questions was a demographic question, which asked participants to name the town in which they practice. Two additional open-ended questions asked physicians to elaborate on how they are inclusive of patients with diverse cultural backgrounds and of patients in same-sex partnerships in their practice. The final open-ended question allowed participants the opportunity to share anything else they would like researchers to know that may be relevant to the study.

The survey was divided into two sections. The first section of the survey includes 23 questions which ask about physicians’ experience providing care (e.g., do you think that women (in particular) face barriers in accessing primary health care in Nova Scotia?). The second section of the survey includes 10 demographic questions about physicians’ gender identity, geographical location, minority group status, and number of years practicing.

Patient Survey

The patient survey was open to anyone (aged 18 or older) who has experience accessing primary care services in Nova Scotia (see Appendix B for complete survey). The survey was created with LimeSurvey and was available online through the Mount Saint Vincent University LimeSurvey domain. The survey link was advertised to Nova Scotians on social media platforms (Twitter, Instagram, Facebook, LinkedIn); some diverse student groups were targeted for

recruitment specifically (e.g., MSVU Aboriginal Student Centre, MSVU Feminist Collective, etc.). The link was also distributed to individuals via email by myself and my research supervisor. Individuals who received the survey via email were encouraged to share the link with their friends, family and community members; as such, snowball sampling was also employed. The survey was open for four consecutive weeks. The survey link was coded so that participants were only able to access the survey once per electronic device.

The survey was comprised of 17 questions. There were three multiple-choice questions about patients' primary care access options (e.g., "do you have a family doctor," "in which area do you access family primary health care services," etc.). There were an additional seven multiple-choice questions which asked patients about their demographic information (e.g., "what age group do you belong to," a question about gender identification, etc.).

There were five open-ended questions which asked patients about their experiences accessing primary care services in Nova Scotia. These questions asked participants to elaborate on anything that has inhibited their ability to access effective primary care services. Patients were probed to discuss transportation issues and perceived unfair treatment due to their gender, culture, or socioeconomic status. Patients were also asked if there are any changes which they would like to see to primary health care services in Nova Scotia. Since this survey was available during the COVID-19 pandemic, there was one additional open-ended question that asked patients if they believe their responses were impacted by COVID-19.

Data Analysis

I employed an intersectional analysis, including the use of thematic and discourse analytic techniques, to analyse qualitative data from open-ended questions (via Microsoft Excel

for Mac, Version 16.37 and MAXQDA Analytics Pro Version 20.0.8) for both patient and physician surveys.

Qualitative data (responses to open-ended survey questions) were analyzed thematically and coded accordingly. Two physician survey questions were analyzed using this method: one question about cultural inclusivity of patients, and one question about inclusivity of patients in same-sex partnerships. For the question about cultural inclusivity, responses were given a score of zero if participants do not make an active effort to be inclusive of various patients (i.e., chose the “no” option for the multiple-choice question). Responses indicating minimal effort were given a score of one (e.g., “I do actively support this”). A score of two was attributed to responses that indicated moderate effort to be inclusive (e.g., “we talk about their culture and beliefs around illness, treatment and managing psychological and non-psychological issues”). Responses that indicated the physician exerts substantial effort to be inclusive were given a score of three. An example of a response that scored 3 (substantial effort) for cultural inclusivity:

“Learn basic phrases in their language (hello, thank you, would [you] like an interpreter); being cognisant of differences in health philosophy, being aware of our colonial past, overtly and often discussing body autonomy and ensuring patients know they have choice in their medical care.”

The same scoring system described for the question about cultural inclusivity was used for the question about inclusivity of patients in same-sex partnerships. Participants who demonstrated no effort to be inclusive (i.e., chose the “no” option for the multiple-choice question) were given a score of zero. Among those who answered “yes,” their responses were categorized into three groups: minimal effort, moderate effort, and substantial effort. Minimal

effort (score: 1) responses included answers such as “I am very comfortable with same sex couples”. Responses that indicated moderate effort to be inclusive (score: 2) included answers such as “I reduce gendered language or heteronormative language”. An example of a response that scored 3 (substantial effort) for the question about inclusivity of patients in same-sex partnerships:

“Attending continuing education on HIV-Prep and prescribing it to appropriate patients. Avoiding assumptions about aspects of care like whether they need birth control. Having gay/trans symbols up in my office to signal that this is a safe space.”

The majority of the data from the patient survey was qualitative. These data were analyzed for themes across responses, with a particular focus on barriers expressed by participants who identified as women of colour, immigrant women, and Indigenous women.

Quantitative data (demographic information, Likert scale questions) from the physician survey were analysed with SPSS software (IBM SPSS Statistics for Mac, Version 26). Specifically, I analyzed the responses to the physician survey questions, considering the demographic information shared by participants. Quantitative data from the patient survey consisted only of demographic information (all other questions were analyzed qualitatively); quantitative data from the patient survey were analyzed with Excel (Microsoft Excel for Mac, Version 16.37).

Pearson and t-table correlation analyses were used to determine whether there were significant associations between physicians’ demographic indicators and perceived barriers that women face in accessing primary health care in Nova Scotia. Correlations were considered significant if the probability value (p-value: the probability that the correlation is due to chance

alone) was less than 0.05. Correlations with a confidence level of 95% ($p < 0.05$) are indicated with a single asterisk (*) following the correlation coefficient (r-value). Stronger correlations are signified with a double asterisk (**) following the correlation coefficient, indicating the confidence level is 99% ($p < 0.01$). Similarly, the various survey questions that probe physicians' perception of barriers to primary care were analyzed for correlations.

A score was created for physicians' responses to questions about physical barriers (i.e., transportation, childcare, and work) for both male and female patients. The score was created by adding the numerical value of physicians' responses to questions about female patient transport, childcare, and work together to create a female patient physical barrier score. Similarly, a male patient physical barrier score was created by adding the numerical values for physicians' responses to questions about male patients for the same three categories as the female patient questions described above. Likert scale answer options (very rarely, rarely, occasionally, often, very often) were assigned numerical scores of 1, 2, 3, 4, and 5, respectively. The lowest possible score for any complete-survey participant was zero (if they did not answer any of the questions). The highest possible score was 15, if the participant answered "very often" for all three questions.

Following data analyses of both patient and physician surveys, I compared the barriers to care highlighted by physicians to those discussed in responses of patients in order to obtain a clear picture of health care barriers for women in Nova Scotia. These comparisons were made qualitatively, as statistical comparisons were unfavourable due to the nature of the questions asked in the patient survey (predominately qualitative) versus the physician survey (predominately quantitative).

Ethical Considerations & Dilemmas

The research team (Dr. Tamara Franz-Odenaal and Lillian Stratton) completed the Tri-Council Policy Statement (TCPS-2) training in preparation for working with human participants. Ethical approval for the project from the University Research Ethics Board at Mount Saint Vincent University was obtained (#2019-039) with multiple amendments prior to commencement of data collection. The project was also reviewed and accepted by the Mi'kmaw Ethics Watch Council in January 2020.

Participant Withdrawal & Confidentiality

Online survey participants were able to withdraw from the study at any point. Personal identifying information was not collected from participants. Any information that could possibly identify participants (e.g., names of specific hospitals/clinics visited, etc.) that was shared in open-ended survey responses was replaced with letters as place holders (e.g., X Hospital) in the thesis manuscript to ensure confidentiality of participants.

Modifications due to COVID-19

The COVID-19 (Corona Virus Disease 2019) global pandemic caused significant changes to the originally proposed thesis research project I intended to complete. The initial research plan involved the inclusion of four focus group sessions. Ethics approval was obtained from the university to conduct these focus groups. However, due to significant public health measures enforced by the Government of Nova Scotia during the time of the COVID-19 pandemic, Mount Saint Vincent University was required to halt all research which included in-person (face-to-face) data collection. Accordingly, amendments to my project to allow for the online patient survey were proposed and approved by the University Research Ethics Board in March 2020.

We intended to conduct one initial and one follow-up focus group session for two participating communities (Indigenous women and women of colour groups). No focus group for immigrant women was planned because 1) there is recent literature (e.g., Guruge, et al., 2015; Kohler et al., 2018, Weerasinghe, 2012; Weerasinghe et al., 2000) about primary health care access for immigrant populations in Nova Scotia and 2) in itself, this group would be very diverse and potentially challenging to tease apart different emerging themes without an extensive effort with a series of focus groups and 3) MA degree time constraints would not allow for a third focus group. Focus group/sharing circle sessions were intended to be approximately 90-minutes in length, with the option to extend the time if participants indicated they would have liked to continue. Sessions would have been manually transcribed and electronically audio recorded.

Focus group participants would have been encouraged to share their experiences accessing primary care (e.g., has there ever been anything that has prohibited you from accessing health care when you needed it?). Focus group facilitators would have provided minimal input but would have provided some discussion topics to lead the conversation. These discussion topics were used to guide the creation of questions for the online patient survey.

Though we would have made a wide recruitment effort, we aimed to have approximately 10 participants per session. Participants would have been invited to engage in an “off the record” debrief following the session to discuss any residual concerns, and to provide an opportunity to ask researchers any questions.

All focus group sessions were to be held in locations decided in partnership with participating communities to aid in convenience for participants. Participants would have been offered bus tickets or reimbursement for travel costs. Children (i.e., any person whom requires

care from a potential participant and/or cannot be left without the participant) would have been welcomed to attend all focus group sessions. It is important that participants were able to bring their children to focus group sessions, as I did not want to restrict study participation to those who can afford childcare and/or those who can leave their children alone for a period of time. Light refreshments (e.g., coffee, tea, snacks) would have been provided.

The focus group that was intended to be held for Indigenous participants was designed in partnership with the Mi'kmaw Native Friendship Centre (MNFC). All of the research suggestions from members of the MNFC were implemented into the proposed plan. The focus group for this population was planned to be held in the form of a sharing circle, facilitated by Elders from the MNFC. As a researcher, I intended to be present for data collection purposes, but due to the sensitivity of the subject matter, I would not have engaged in asking participants questions. An honorarium was intended to be provided to the Elder(s) who facilitated the sharing circle in recognition of their time and energy spent. At the request of the MNFC, all audio recordings of sharing circle sessions were to be deleted immediately following data analysis. Mi'kmaw Ethics Watch approval was obtained to conduct these focus groups.

Chapter Six: Results

Physician Survey Results

A total of 56 individuals accessed the physician survey while only 28 primary care physicians completed the survey (complete responses: participants viewed all survey questions and answered most or all questions). Nine participants answered some of the survey questions (incomplete responses: participants did not view or answer all survey questions). Nineteen individuals viewed the survey but did not respond to any of the questions (responses without answers: participants viewed some or all questions but did not answer any). On average, incomplete-survey participants responded to 8.6 questions. Most incomplete-survey participants responded to the first few survey questions (i.e., questions about years practicing and some specific questions about barriers for women in accessing health care) before exiting the web-browser.

The recruitment methods that resulted in the most complete survey responses were the Doctors Nova Scotia bi-weekly e-newsletter and direct in-person recruitment in family medical clinics (see Figure 1). Specifically, 66.7% (16/24) of participants recruited through Doctors Nova Scotia and 100% of those recruited in-person (n=3) who returned surveys provided complete responses. Other surveys distributed in-person may have been partially completed and not returned, or not completed at all. In contrast, only 31.0% (9/29) of the participants recruited via social media (Twitter, Instagram) provided complete responses. Of participants recruited from the latter method, 48.3% (14/29) viewed but did not answer any survey questions compared to only 20.7% (6/29) who completed some of survey. Comparatively, 20.8% (5/24) of participants viewed but did not respond to any survey questions for the Doctors Nova Scotia. Three participants recruited via Doctors Nova Scotia (3/24, 12.5%) provided incomplete survey

responses. According to the response rate data from the current study, the method for recruiting physicians that yielded the highest response rate was through Doctors Nova Scotia. The best method for obtaining complete surveys from physicians is through in-person distribution of surveys; however, the response rate for this method was low (3/15, 20%).

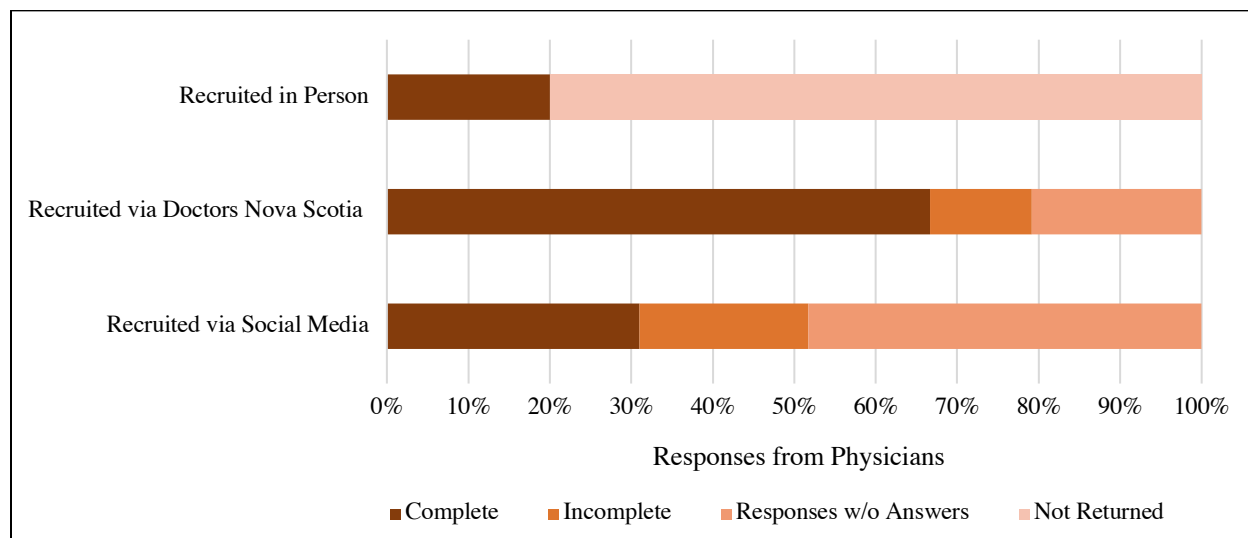


Figure 1. *Responses to physician survey by recruitment method.*

Of the 56 total survey engagements, 19 did not include any responses. The majority (14/19, 73.7%) of the no-response survey engagements were from the links shared on social media platforms. Many of these individuals viewed only one or two questions. Some of the no-response engagements from social media may have been from individuals who are not physicians; as such, these individuals may have viewed the survey questions (e.g., out of interest, curiosity, etc.) but refrained from answering any of the survey questions. Some of the no-response engagements were from the link shared by Doctors Nova Scotia, which was accessible only by physicians; however, it was accessible to all physicians in Nova Scotia (not exclusively primary care physicians). These no-response survey engagements may indicate a lack of interest or a lack of time to complete the survey (from primary care physicians) or engagement with the

survey from non-primary care physicians. The average amount of time that no-response survey participants engaged with the physician survey was 41.53 seconds.

Unless otherwise noted, all of the following correlation data and graphs represent complete survey responses only (28 total complete responses).

Demographic Information

With respect to gender, 24 (out of 28) complete-survey participants identified as women (86%) and four complete-survey participants identified as men (14%) (question 23, Appendix A). No individuals identified as trans-women, trans-men, two-spirit, non-binary, or other. There are no demographic data for incomplete survey responses.

Data concerning the age of physicians who completed the survey is summarised in Figure 2. With respect to age, two (out of 28) complete-survey participants belong to the 25- to 30-year age group (7.1%), 10 participants belong to the 31- to 40-year age group (35.7%), five participants belong to the 41- to 50-year age group (17.9%), six are in the 51- to 60-year age group (21.4%), and five are in the 61- to 70-year age group (17.9%). No participants were above 71 years of age. In summary, most of the physicians that responded to the survey were 31-40 years old.

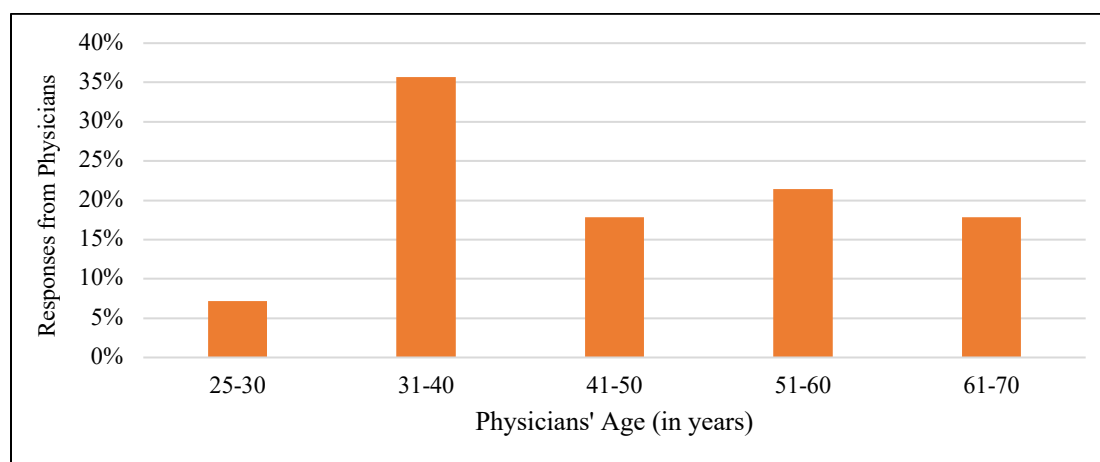


Figure 2. *Age of physicians who completed the survey in years.*

Participants were also asked questions about their cultural/racial identity and immigration status through a series of three questions (questions 25, 26, 27 Appendix A). Two (of the 28) participants identified as persons of colour (7.0%) and two preferred not to answer (7.0%). Zero participants identified as Indigenous persons with one preferring not to answer (4%). Four participants identified as Canadian immigrants (14%). These demographics are summarised in Figure 3. In summary, most respondents (86.0%) did not identify as persons of colour, Indigenous persons, or Canadian immigrants.

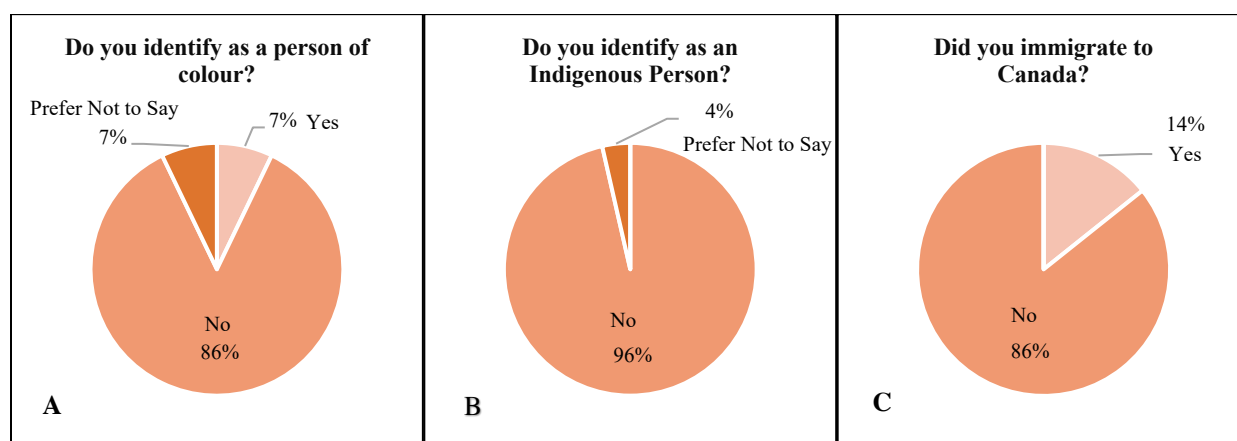


Figure 3. *Physician group identity. A) Person of Colour identity. B) Indigenous person identity. C) Immigrant identity.*

Because physicians' perspectives about barriers that women may face in accessing health care may be different based on their geographical location (e.g., rural versus urban settings), the survey also asked physicians to name the town/city in which they practice (open-ended answer field; question 31, Appendix A). Physicians' responses were then matched to zones described by the Nova Scotia Health Authority (Nova Scotia Health Authority, n.d.). Three participants did not respond to the question about area of practice. Among the 25 who responded, 18 (72.0%) identified themselves as practicing in the Central Zone (Halifax, Eastern Shore, and West Hants areas). Four participants (16.0%) practice in the Western Zone (Annapolis Valley, South Shore, and South West areas). Two participants (8.0%) practice in the Northern Zone (Colchester-East

Hants, Cumberland, and Pictou areas). One participant (4.0%) practices in the Eastern Zone (Cape Breton, Guysborough, and Antigonish areas). See Figure 4 for a summary of these data. In summary, most physicians who responded to the survey were in Central Zone (mostly urban/suburban areas).

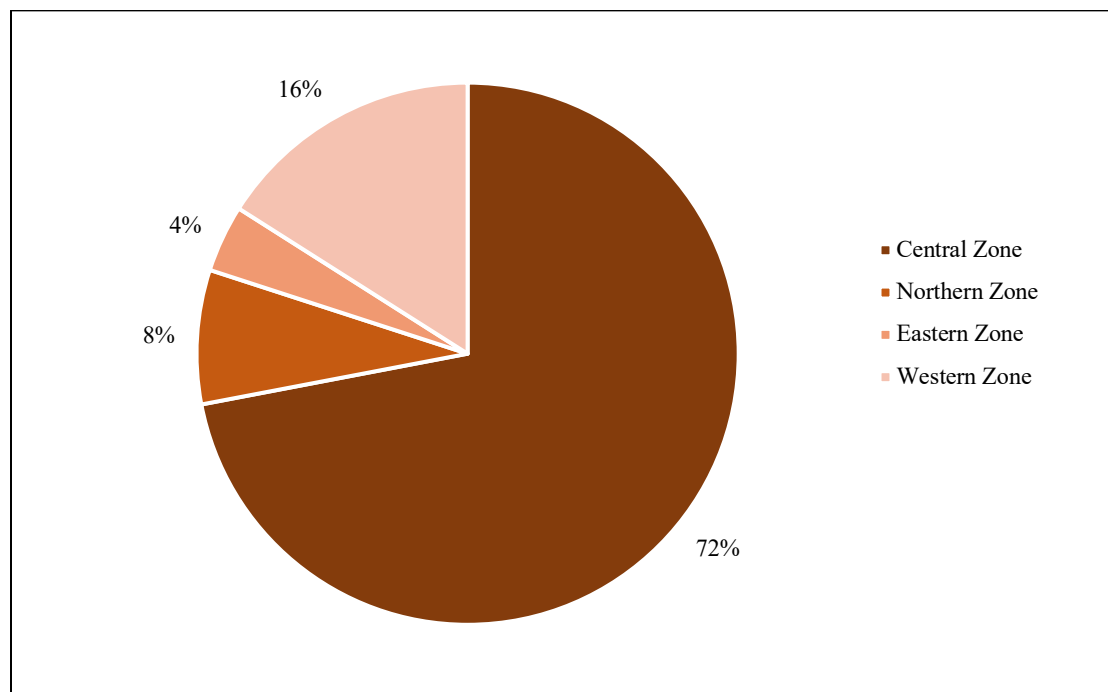


Figure 4. *Physician area of practice based on Nova Scotia Health Authority Zones.*

Overall, the physician survey participants represented a wide range of individuals from varying demographic backgrounds, with the exception of Indigenous participants, of which there were none. Most of the physicians who responded to the survey practice in Central Zone, are women, belong to the 31-40-year age group, and do not identify as persons of colour, Canadian immigrants, or Indigenous persons. Few participants identified as persons of colour, or immigrants, while none identified as Indigenous persons.

Physicians were also asked questions about the demographics of the patients they treat, in order to gauge if physicians' responses were relevant to the population groups of interest (i.e., women of colour, Indigenous women, and immigrant women). Specifically, physicians were

asked to estimate the number of patients they treat per month who are women of colour (question 18, Appendix A), Indigenous women (question 19, Appendix A), and immigrant women (question 20, Appendix A). It is evident based on the current data that most physicians who responded to this study treat low numbers of women of colour, Indigenous women, and immigrant women. However, there are few physicians who treat large numbers of the patients who belong to these categories (>21 patients per month). These data are summarised in Figure 5.

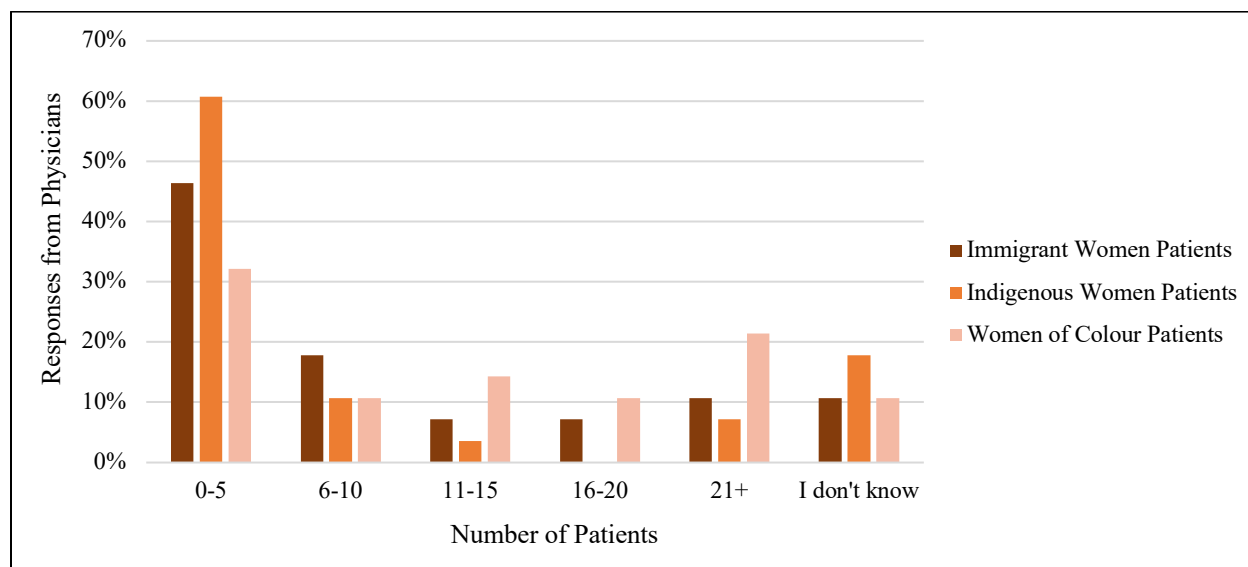
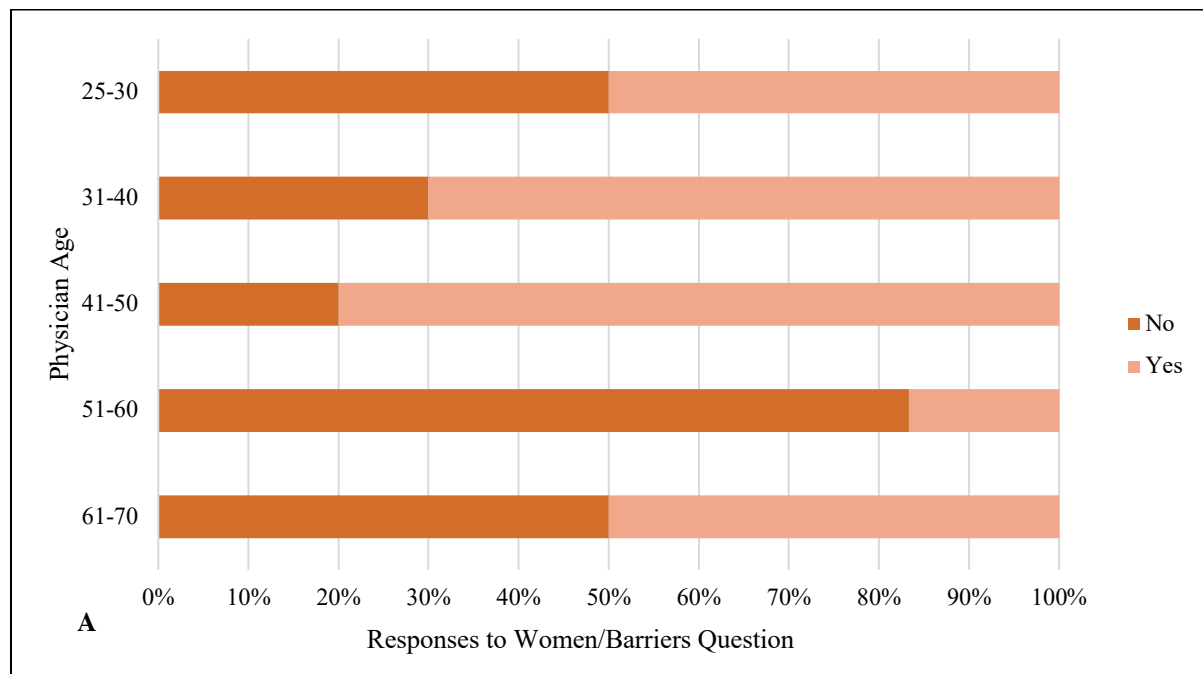


Figure 5. *Physicians estimated number of patients per group/identity.*

Physicians' Perspectives on Barriers to Primary Health Care

In order to explore physicians' perspectives of barriers to primary health care in Nova Scotia, physicians were asked a series of questions about potential barriers to care that they perceive patients may experience. Physicians were asked to rate to what extent these phenomena occur in their practice according to the Likert scales provided (e.g., very rarely, rarely, occasionally, often, very often). The responses to all survey questions were then analyzed using SPSS to explore significant correlations for participants' responses to various questions. Refer to Appendix C to review all significant correlations in tabular form.

Significant correlations were found between age, years practicing, and the question “do you believe women (in particular) face barriers in accessing primary health care in Nova Scotia” (questions 24, 1, and 2 respectively, Appendix A). Older physicians (>51 years) were significantly more likely to answer “no” to the question of women facing barriers to health care access ($r = 0.487^{**}$, $p < 0.01$, $n = 27$); however, the second most common age group to answer “no” were younger physicians (<40 years; 4/12, 33.3%) (see Figure 6A). Similarly, physicians who have been practicing longer (>21 years) were also significantly more likely than physicians who have been practicing fewer years to indicate that they do not think that women face barriers accessing primary care ($r = 0.497^{**}$, $p < 0.01$, $n = 27$). These data are summarised in Figure 6B. Expectedly, there was a significant correlation between physicians’ age and years practicing ($r = 0.948^{**}$, $p < 0.01$, $n = 28$).



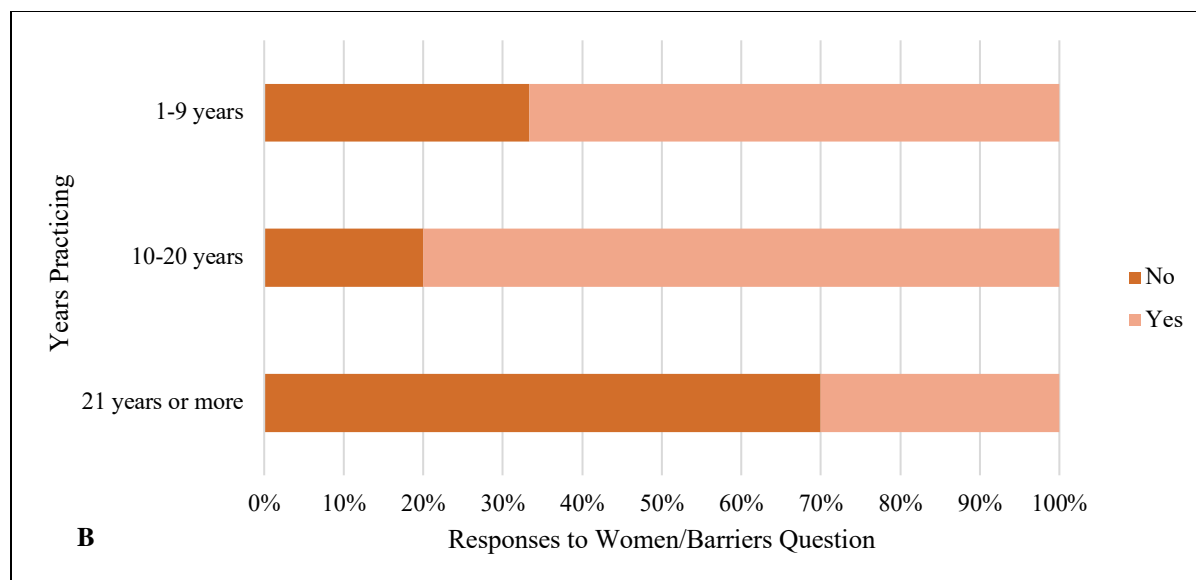


Figure 6. A) Responses to “Do you think women (in particular) face barriers accessing primary health care?” evaluated by physicians’ age. B) Responses to “Do you think women (in particular) face barriers accessing primary health care?” evaluated by physicians’ years practicing.

Physicians were also asked whether they make an effort to be inclusive in their practice, with respect to culture and same-sex relationships of their patients (questions 21 and 22 respectively, Appendix A). Significant correlations were found between physicians’ age, years practicing, and their practices of patient inclusivity (questions 24, 21, and 22 respectively, Appendix A). Physicians’ age and inclusivity of patients of other cultures were significantly positively correlated ($r = 0.374^*$, $p < 0.05$, $n = 28$). Response data for these questions are summarised in Figure 7. Indeed, younger physicians (<50 years) were significantly more likely than older physicians (>51 years) to indicate they make an active effort to be inclusive of patients from other cultures. Results also show physicians’ number of years practicing and inclusivity of patients in same sex relationships were significantly positively correlated ($r = 0.392^*$, $p < 0.05$, $n = 27$). Indeed, less experienced physicians (<10 years) were more likely than more experienced physicians to make an active effort to be inclusive of patients in same sex partnerships. These data are summarised in Figure 8. Physicians’ responses to the questions about cultural inclusivity

and inclusivity of patients in same-sex relationships were positively correlated ($n = 0.500^{**}$, $p < 0.01$, $n = 27$). Accordingly, physicians were likely to respond with similar answers to the question about effort to be culturally inclusive and the question about being inclusive of patients in same-sex partnerships (i.e., respond “yes” to both or “no” to both). These data are summarised in Figure 9. Overall, these findings indicate that the older the physician is, and the more years they have been practicing, the less likely they are to make an active effort to be inclusive of patients from cultures other than their own and of patients in same-sex partnerships in their practices.

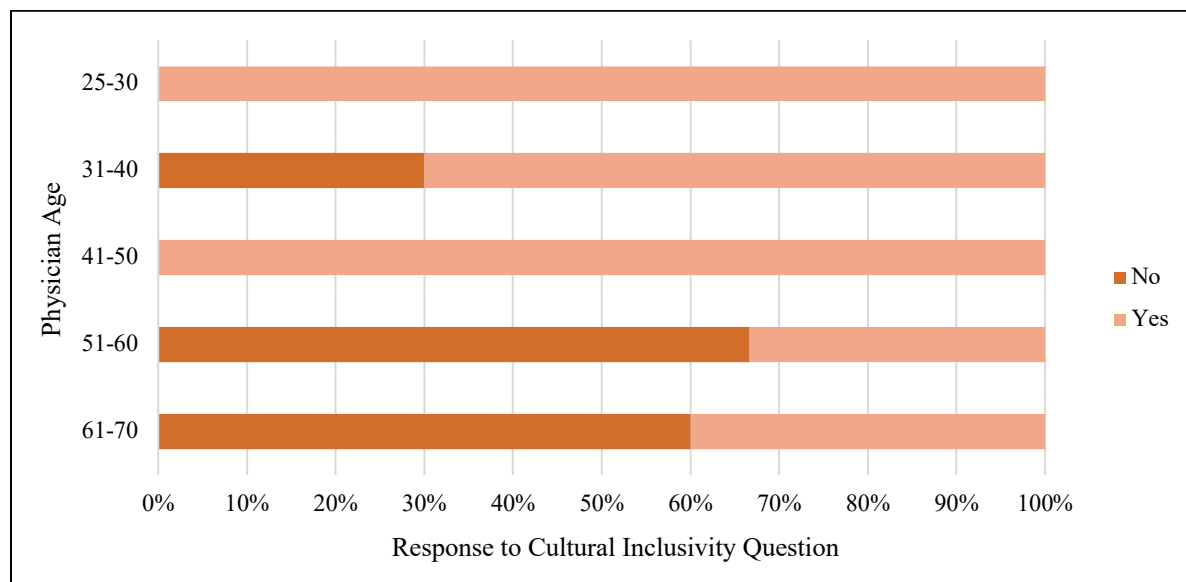


Figure 7. Responses to “Do you make an effort to be inclusive of people of cultures other than your own in your practice?” evaluated by physician’s age.

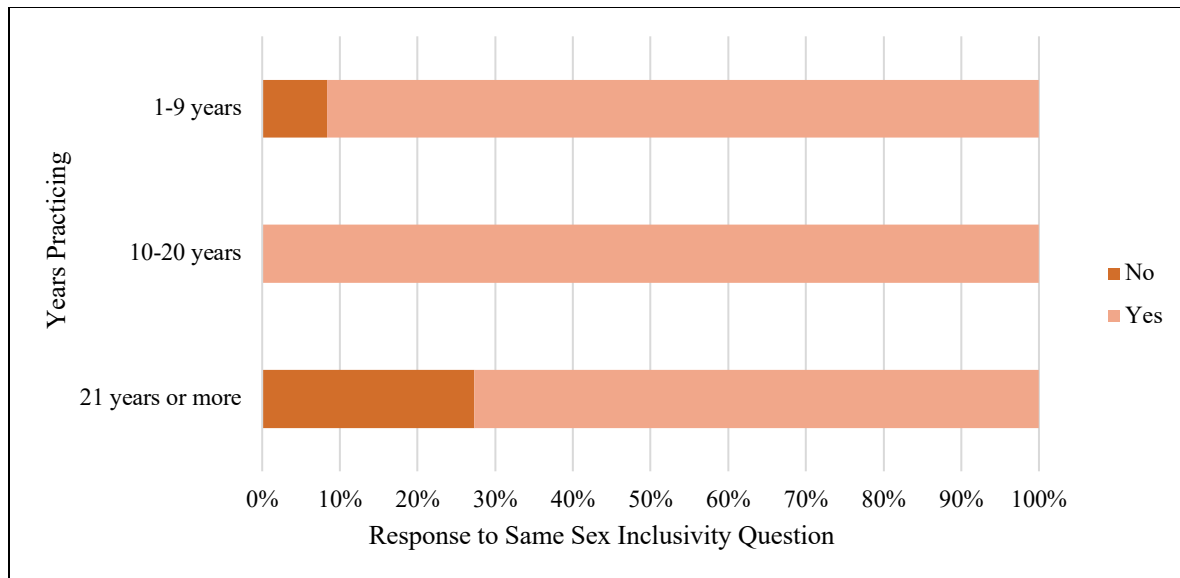


Figure 8. Responses to “Do you make an effort to be inclusive of people in same sex partnerships in your practice?” by number of years the physician has been practicing.

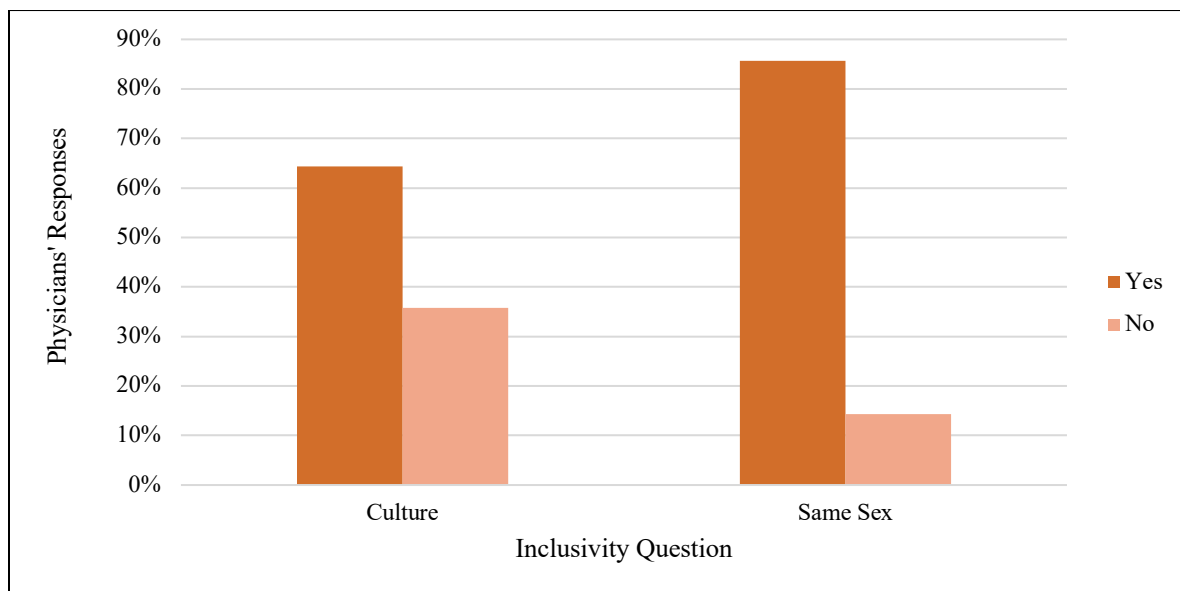


Figure 9. Physicians responses to questions about being inclusive in their practice.

Physicians were given the option to elaborate on their responses to the questions about inclusivity of patients from cultures other than their own (question 21, Appendix A) and of patients in same sex partnerships (question 22, Appendix A). Open-ended responses provided in the elaboration field (prompted with “if yes [to question 21 and 22], please elaborate”) were

scored based on physicians' indication of effort to be inclusive, as described in the methods section of this thesis (see Figure 10 for scored response data).

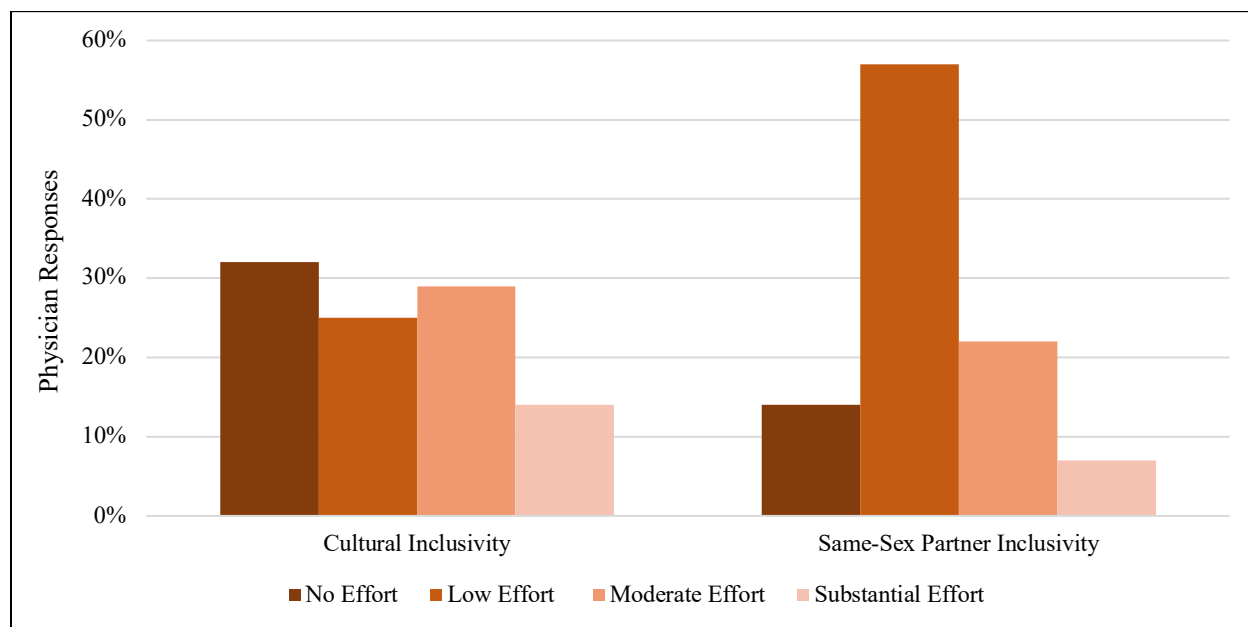


Figure 10. *Scores for open-ended inclusivity questions.* Note: Graph shows the number of physicians that indicated different scores in their answers for cultural and same-sex partnership inclusivity questions. No effort (score: 0), low effort (score: 1), moderate effort (score: 2), substantial effort (score: 3).

Nineteen physicians (67.9% of complete responses, 19/28) indicated that they make an active effort to be inclusive of patients from other cultures (i.e., responded “yes” to question 21, Appendix A) while nine physicians (32.1%) indicated that they do not make any efforts to be inclusive of patients from other cultures (i.e., responded “no” to question 21: score of 0). Of those that make an effort, seven physicians indicated they exert minimal effort (low score: 1), eight physicians indicated they exert moderate effort (medium score: 2), and four physicians indicated they exert substantial effort (high score: 3). According to the analysis of results from this study, less than half (12/28, 42.6%) of physicians make a moderate to high effort to be inclusive of their patients from cultures other than their own. Of the 12 physicians who indicated

moderate to substantial effort for this question, 100% identified as women. These data, along with the data presented in the following paragraph, are summarised in Figure 10.

Twenty-four physicians (85.7% of complete responses) indicated that they make an effort to be inclusive of patients in same-sex relationships; four physicians indicated that they do not make an effort to be inclusive of patients in same-sex relationships (score of 0). Of those that do make an effort, 16 physicians indicated they exert minimal effort (low score: 1), six physicians indicated they exert moderate effort (medium score: 2), and two physicians indicated they exert substantial effort (high score: 3). These data are summarised in Figure 10. According to these results, only one third of physicians make a moderate to high effort to be inclusive of their patients in same sex relationships (8/28, 33.3%). Of the physicians who indicated moderate to substantial effort for this question, 87.5% (7/8) identified as women and 12.5% (1/8) identified as men.

Physicians were also asked about specific barriers (transportation, childcare, work) they perceive male and female patients face in accessing primary care appointments. Most of the participants who responded “yes” to the question “do you believe women (in particular) face barriers accessing primary health care in Nova Scotia?” (question 2, Appendix A) also responded “occasionally” or “often” to the question regarding transportation issues affecting female patients’ ability to attend appointments (question 3, Appendix A) while most of the physicians who responded “no” to the former question responded “very rarely” or “rarely” to the latter question about transportation (see Figure 11). That is, the responses to these questions were significantly negatively correlated ($r = -0.406^*$, $p < 0.05$, $n = 27$). Similarly, most physicians who responded “yes” to the question “do you believe women (in particular) face barriers accessing primary health care in Nova Scotia?” also responded “occasionally” or “often” to a

question about specific childcare issues affecting female patients' ability to attend appointments (question 4, Appendix A), while most physicians who responded "no" to the former question responded "very rarely" or "rarely" to the latter question about childcare (see Figure 12). Again, the responses to these questions were significantly negatively correlated ($r = -0.525^{**}$, $p < 0.01$, $n = 27$). In summary, physicians who responded to the transportation and childcare questions with higher value responses (e.g., often, very often) were more likely to respond "yes" to the question about women facing barriers to care. Not surprisingly, physicians who believe women, in particular, face barriers to accessing primary health care also identified their female patients as likely to experience specific barriers to care such as a lack of transportation and a lack of childcare.

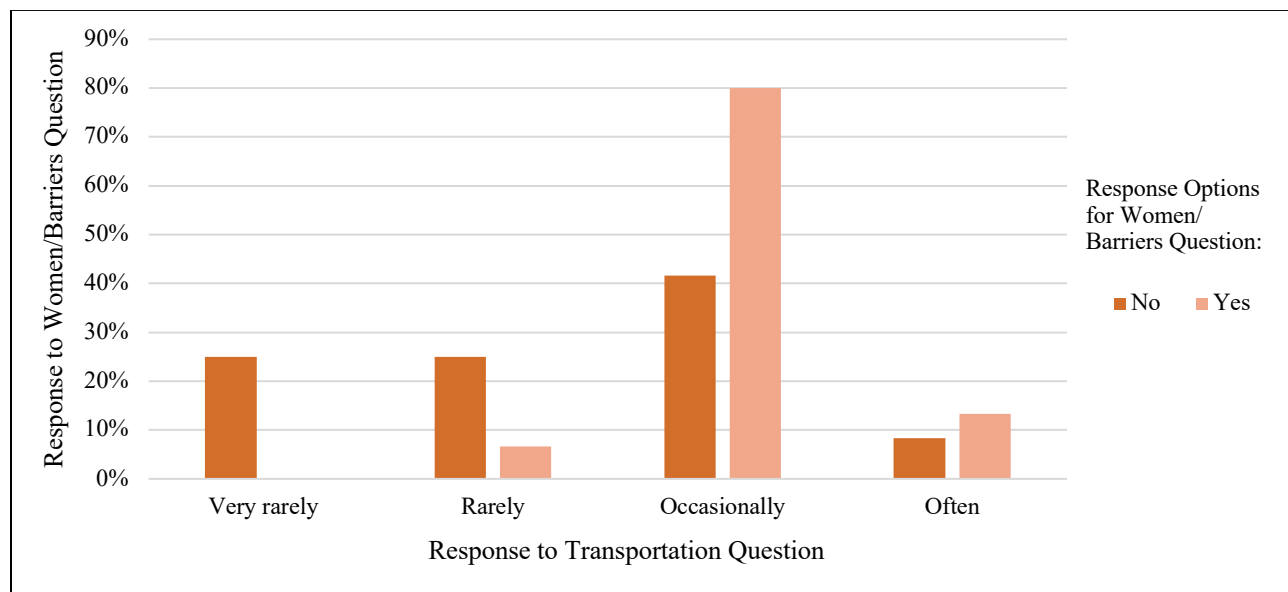


Figure 11. *Physicians responses to questions "Do you think women (in particular) face barriers accessing primary health care?" and "Do your female patients ever note difficulty attending doctors' appointments due to transportation difficulties?"*

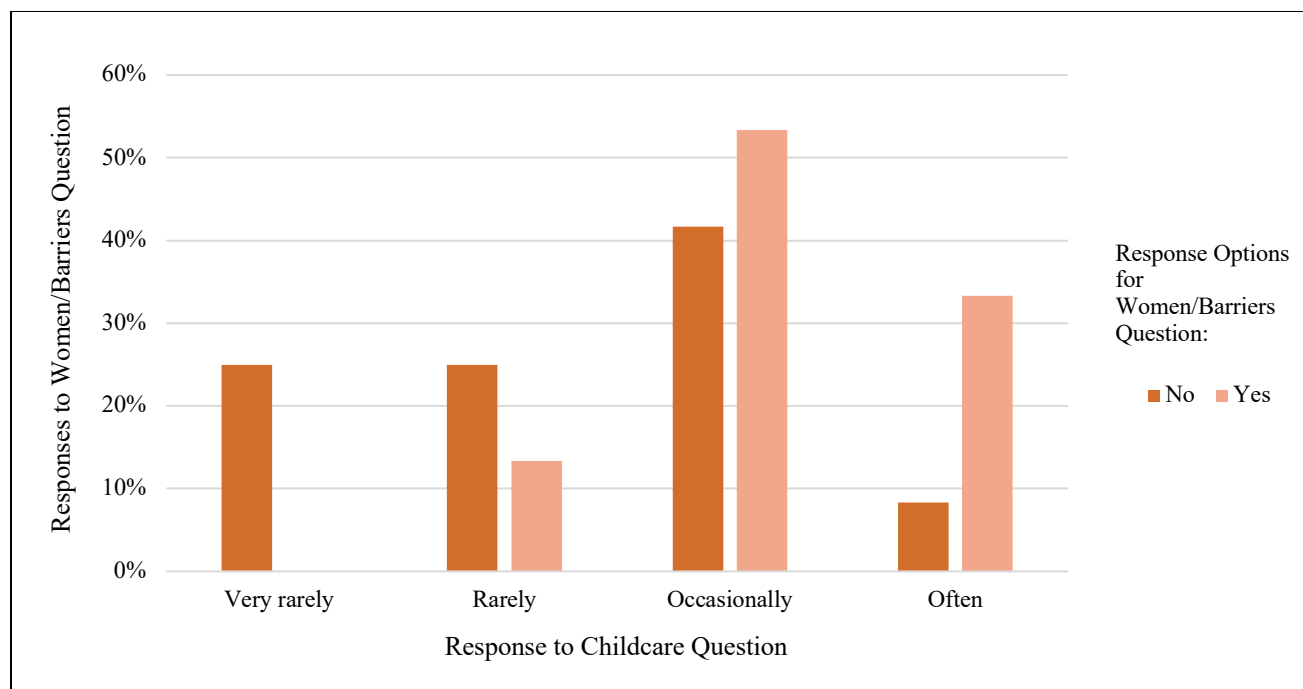


Figure 12. Physicians responses to questions “Do you think women (in particular) face barriers accessing primary health care?” and “Do your female patients ever note difficulty attending doctors’ appointments due to difficulties securing childcare?”

Correlation analyses between the previous two question responses (transportation and childcare) were conducted. Physicians’ responses to the question about specific transportation issues affecting female patients’ ability to attend appointments were significantly correlated with physicians’ responses to the question about specific childcare issues affecting female patients’ ability to attend appointments ($r = 0.832^{**}$, $p < 0.01$, $n = 28$). Similarly, there was a positive correlation between physicians’ responses to the question about specific childcare issues affecting female patients’ ability to attend appointments and physicians’ responses to the question about specific issues about time off work affecting female patients’ ability to attend appointments (question 5, Appendix A) ($r = 0.0575^{**}$, $p < 0.01$, $n = 28$). These data are summarised in Figure 13. These findings indicate that physicians who perceive their female patients as experiencing transportation barriers also perceive their female patients to experience barriers to accessing health care due to a lack of childcare. Similarly, physicians who perceive

their female patients as experiencing a lack of childcare as a barrier to accessing health care also tend to perceive their female patients' inability to take time off work as a barrier to health care.

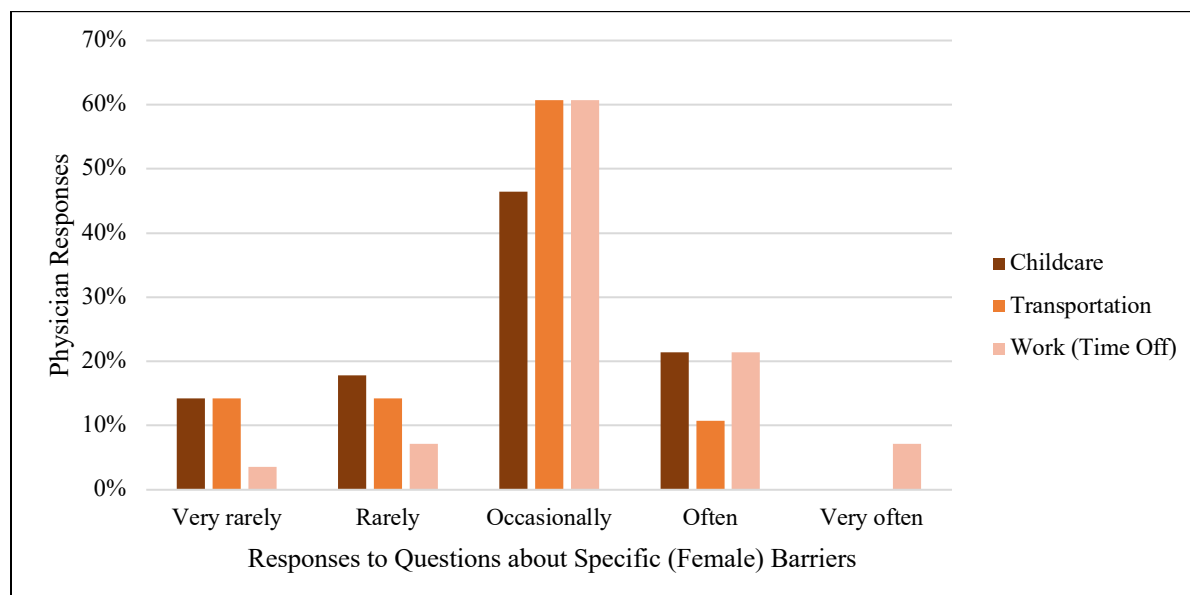


Figure 13. *Physicians responses to questions about specific barriers (childcare and time off work) for female patients.*

There were also significant correlations for questions about male patients' difficulty accessing appointments due to lack of transportation, lack of childcare and an inability to take time off work. Specifically, physicians' responses to the question about specific transportation issues affecting male patients' ability to attend appointments (question 6, Appendix A) were significantly correlated with physicians' responses to the question about specific childcare issues affecting male patients' ability to attend appointments (question 7, Appendix A) ($r = 0.559^{**}$, $p < 0.01$, $n = 28$). Similarly, there was a positive correlation between physicians' responses to the question about specific childcare issues affecting male patients' ability to attend appointments and physicians' responses to the question about specific issues about work affecting male patients' ability to attend appointments (question 8, Appendix A) ($r = 0.0519^{**}$, $p < 0.01$, $n = 28$). Response data for these questions are summarised in Figure 14. These findings indicate that physicians who perceive their male patients as experiencing transportation barriers also perceive

their male patients to experience barriers to accessing health care due to a lack of childcare.

Similarly, physicians who perceive their male patients as experiencing a lack of childcare as a barrier to accessing health care also tend to perceive their male patients' inability to take time off work as a barrier to health care.

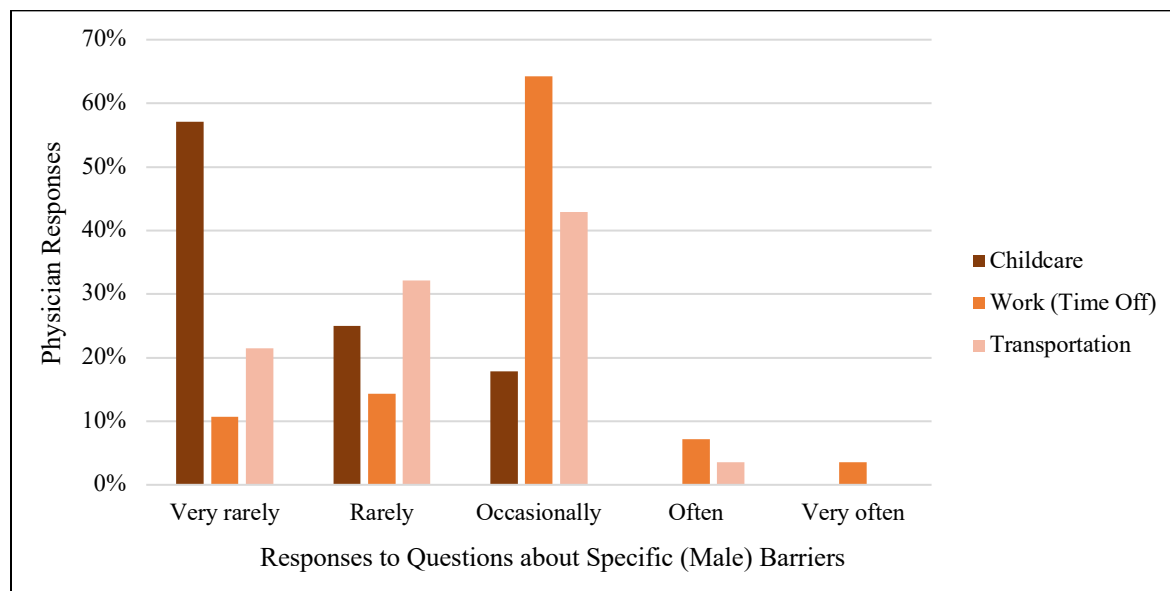


Figure 14. *Physicians responses to questions about specific barriers (childcare, transportation, and time off work) for male patients.*

Similarly, regarding barriers that male patients face when accessing to primary health care, there was a significant correlation between physicians' responses to the questions "do your male patients have difficulty accessing appointments due to lack of childcare" (question 7, Appendix A) and "do your male patients bring their children to appointments with them" (question 11, Appendix A) ($r = 0.416^*$, $p < 0.05$, $n = 28$). These results indicate that physicians' who perceive their male patients to experience barriers to health care due to a lack of childcare also tended to indicate that their male patients bring their children to appointments with them to the same degree (i.e., physicians tended to provide low responses such as very rarely, rarely, for both questions or high responses such as often, very often for both questions).

Scores for physicians' responses to questions about barriers involving transportation, childcare, and work for male and female patients were created (refer to the methods section for details about how these scores were created). The average physical barriers score for answers about male patients was 6.6 (range is 1-low to 15-high) while the average physical barriers score for answers about female patients was 8.6. This finding indicates that, on average, physicians felt female patients experienced physical barriers which affected their ability to access primary care slightly more often than for male patients. However, responses about female patients and male patients' barriers to primary care were significantly positively correlated ($r = 0.406^*$, $p < 0.05$, $n = 28$). The significant correlation indicates that physicians were likely to have similar scores for male and female patients regarding physical barriers to care; therefore, physicians were likely to provide similar responses to questions about physical barriers to care (i.e., transportation, childcare, and work) regarding both their male and female patients.

In order to analyze physicians' perceptions of male symptom amplification and female symptom amplification, correlation tests were run on relevant questions. There was a significant positive correlation between physicians' responses to questions about male patients amplifying their symptoms (question 17, Appendix A) and female patients amplifying their symptoms (question 15, Appendix A) ($r = 0.520^{**}$, $p < 0.01$, $n = 27$). The t-test for these data also showed a significant correlation between physicians' responses about male and female symptom amplification [$t(26) = 2.082$, $p = 0.047^*$, $SD = 0.832$]. This finding demonstrates that physicians were likely to provide similar responses to questions about male and female symptom amplification, indicating that physicians generally think their male and female patients amplify their symptoms to the same extent.

In order to analyze whether physicians' gender identity affected their perceptions of barriers that patients face in accessing primary care, questions about physician gender, and barriers to care were analyzed for potential correlations. Significant correlations were found between physician gender identity and perspectives about barriers that patients may face in accessing primary care. There was a significant positive correlation ($r = 0.496^{**}$, $p < 0.01$, $n = 26$) between physicians' gender (question 23, Appendix A) and the question about male patients downplaying their symptoms ("to what extent do your male patients downplay their symptoms?"; question 16, Appendix A). This finding indicates that male physicians were more likely to suggest that male patients downplay their symptoms compared to female physicians.

The final open-ended question in the physician survey asked if participants had anything else they would like to share with the research team (question 32, Appendix A). Seven (out of 28) individuals responded to this question. Of the responses, some physicians emphasized how they are inclusive of individuals in their practice because they are aware of issues concerning gender, race, and care access. One physician noted that they try to be mindful and always screen their patients for signs of domestic violence. Some physicians noted that they may not be aware of issues to care access due to lack of transportation, etc. simply because those individuals do not access medical services at all and/or patients may not share information about experiencing barriers with their physician.

One physician noted that women and men may experience similar barriers to care due to work and transportation, but that women face unique barriers accessing health care due to child and elder care responsibilities. Moreover, this physician (and one other) emphasized that women may face barriers to effective health care that men do not face, even when they are able to access care from a physician:

“I have had some patients come to me saying they haven't had pap tests because their male doctors don't do pelvic exams (this is rare, but it happens) and often people have trouble accessing cervical cancer screening if they don't have a primary care provider. [...] I have not heard a man say they couldn't access prostate exams if needed because their female physician doesn't do rectal exams (as an imperfect comparison).”

One physician noted concern and interest for the future of family medicine. Particularly, they referenced how changes to medical care delivery (e.g., tele-health) may mitigate some current barriers to primary health care while creating others.

Patient Survey Results

A total of 264 individuals accessed the patient survey. Most participants (193/264, 73.1%) who accessed the survey completed the survey entirely (complete responses: participants viewed all survey questions and answered most or all questions). Sixty-eight (25.8%, 68/264) additional participants answered some of the survey questions (incomplete responses: participants did not view or answer all survey questions). Three individuals (1.1%, 3/264) viewed the survey but did not respond to any of the questions (responses without answers: participants viewed some or all questions but did not answer any).

All patient survey participants were recruited via social media (Twitter, Instagram, Facebook, LinkedIn), direct email, and through snowball sampling (i.e., survey participants forwarded the survey link to friends/community members for their participation). All of the survey participants accessed the survey via an identical link; therefore, it is unclear what percentage of participants engaged with the survey from each specific recruitment method.

All demographic and thematic data and graphs represent complete surveys only. On average, incomplete-survey participants responded to 5.4 out of 17 questions. Most of these participants answered or looked at questions which asked patients about how they access primary care services in Nova Scotia.

Demographic Information

One-hundred-sixty-seven (167) complete-survey participants identified as women (86.5%) and 20 complete-survey participants identified as men (10.4%). One individual identified as two-spirit (0.5%); one individual identified as non-binary (0.5%), and one individual identified as other (specifically, gender fluid; 0.5%). Zero individuals identified as trans-women or trans-men. Three complete-survey participants chose not to answer this question (1.5%). Demographic data for incomplete survey responses were not analyzed.

The participants ranged in age from 18- to over 71-years (Figure 15B). Thirty-nine participants belong to the 18- to 24-year age group (20.2%). Twenty-four participants belong to the 25- to 30-year age group (12.4%), 31 participants belong to the 31- to 40-year age group (16.1%), 27 participants belong to the 41- to 50-year age group (13.9%), 48 participants belong to the 51- to 60-year age group (24.9%), 19 participants belong to the 61- to 70-year age group (9.8%) and three participants belong to the 71+ age group (1.6%) – one of which identified herself as “94-years young”. Two participants chose not to disclose their age group.

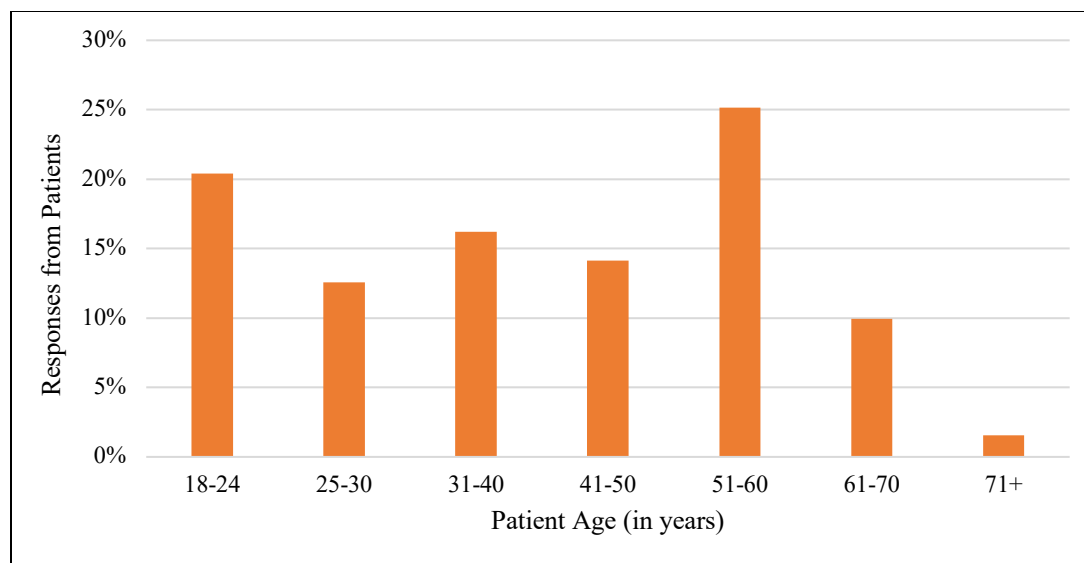


Figure 15. *Age (in years) of patients who responded to the survey.*

With respect to race, ethnicity, and immigration status (summarised in Figure 16), 12 participants identified as persons of colour (6.2%); two preferred not to say (1.0%) and four chose not to answer the question (2.1%) (question 11, Appendix B). Five participants identified as Indigenous persons (2.6%), one preferred not to say (0.5%), and three chose not to answer the question (1.6%) (question 12, Appendix B). Fifteen participants identified as Canadian immigrants (7.8%); two chose not to answer the question (1.0%) (question 13, Appendix B). Additionally, 25 participants (12.9%) indicated that they belong to “[an]other minority group” (group not specified); three participants (1.6%) preferred not to say (question 16, Appendix B). In summary, most participants were not persons of color, not Indigenous, and not immigrants to Canada.

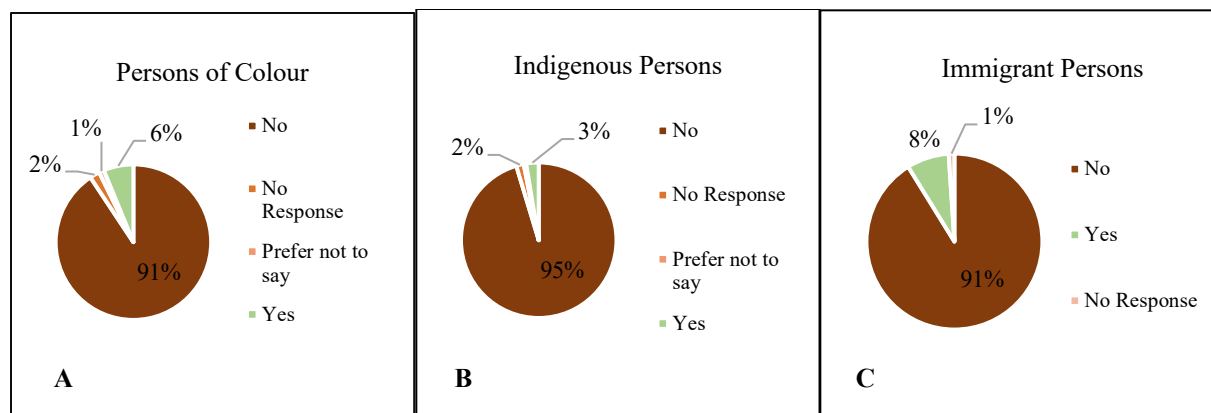


Figure 16. *Patient participant group identity. A) Person of Colour identity. B) Indigenous identity. C) Immigrant identity.*

Overall, the participants for the patient survey represent a wide range of Nova Scotians from various demographic backgrounds. There was representation from all age groups, diverse cultural/racial backgrounds and from women, men, non-binary, gender fluid, and two-spirit people, though representation from the latter three categories was small. However, while age was widely represented, most participants were non-Indigenous, Canadian, and not persons of colour.

Themes in Family Medical Care Access from the Patient Survey

While the survey focused on how patients access family care and how they have been treated by family physicians, it was important to note in which area they received their care. This data is summarised in Figure 17. One-hundred-seventy-four (174) participants (90.2%) indicated they have a family physician in Nova Scotia (question 1, Appendix B). Three participants (1.6%) indicated they do not have a family physician in Nova Scotia, but they are on a waitlist to be assigned a family physician. Sixteen participants (8.3%) indicated they do not have a family physician in Nova Scotia and they are not on a waitlist.

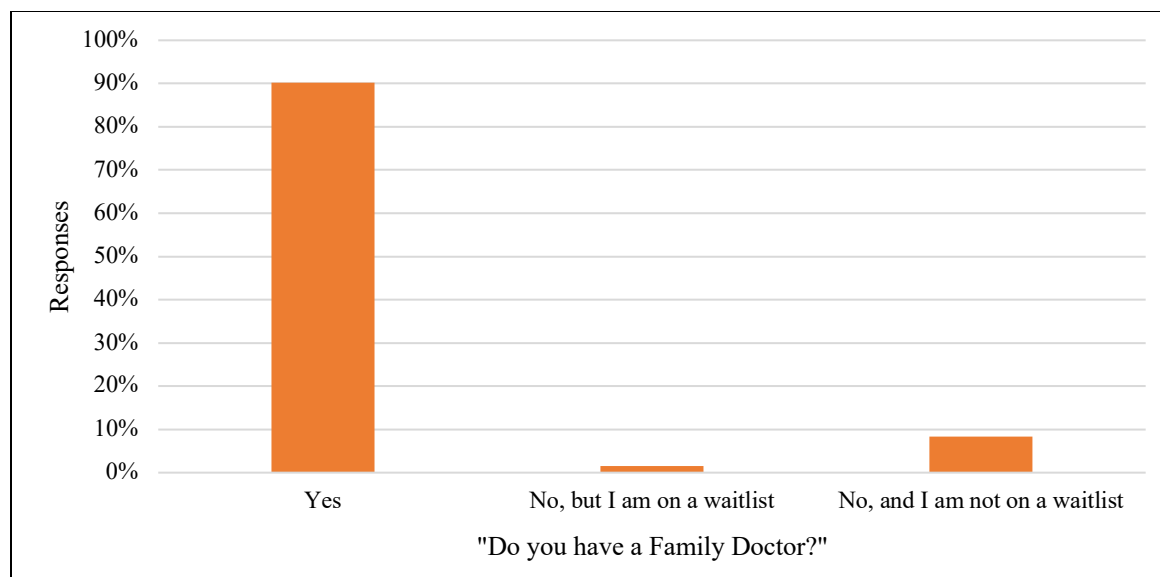


Figure 17. Patient responses to question “Do you have a family doctor?”

Participants were asked to indicate how they access primary care services if they do not have a family physician (question 3, Appendix B). Participants were able to choose from four multiple-choice answer options (listed in the legend of Figure 18), or they were able to select a fifth multiple-choice option: “other,” which required them to elaborate on their response. Though there were only 19 participants who indicated they do not have a family physician in question 1 (Appendix B), there were 33 participants who responded to question 3 (Appendix B) with answers *other than* “N/A (I have a family doctor)”. Therefore, it is evident that 14 participants who indicated that they have family doctors also indicated other methods for accessing primary care services (besides appointments with their family doctor). Sixteen participants (16/193, 8.3%) indicated they go to walk-in clinics. Two participants (2/193, 1.0%) indicated they go to the emergency room, even when it is not an emergency, because they do not have an alternative option available. Two participants (2/193, 1.0%) indicated they primarily use alternative medical services (e.g., naturopathic medicine, homeopathy, osteopathy, etc.). One-hundred-sixty (160) participants (160/193, 82.9%) selected the option “N/A (I have a family doctor)”. Thirteen

participants (13/193, 6.7%) selected the option “other” for this question. These data are summarised in Figure 18.

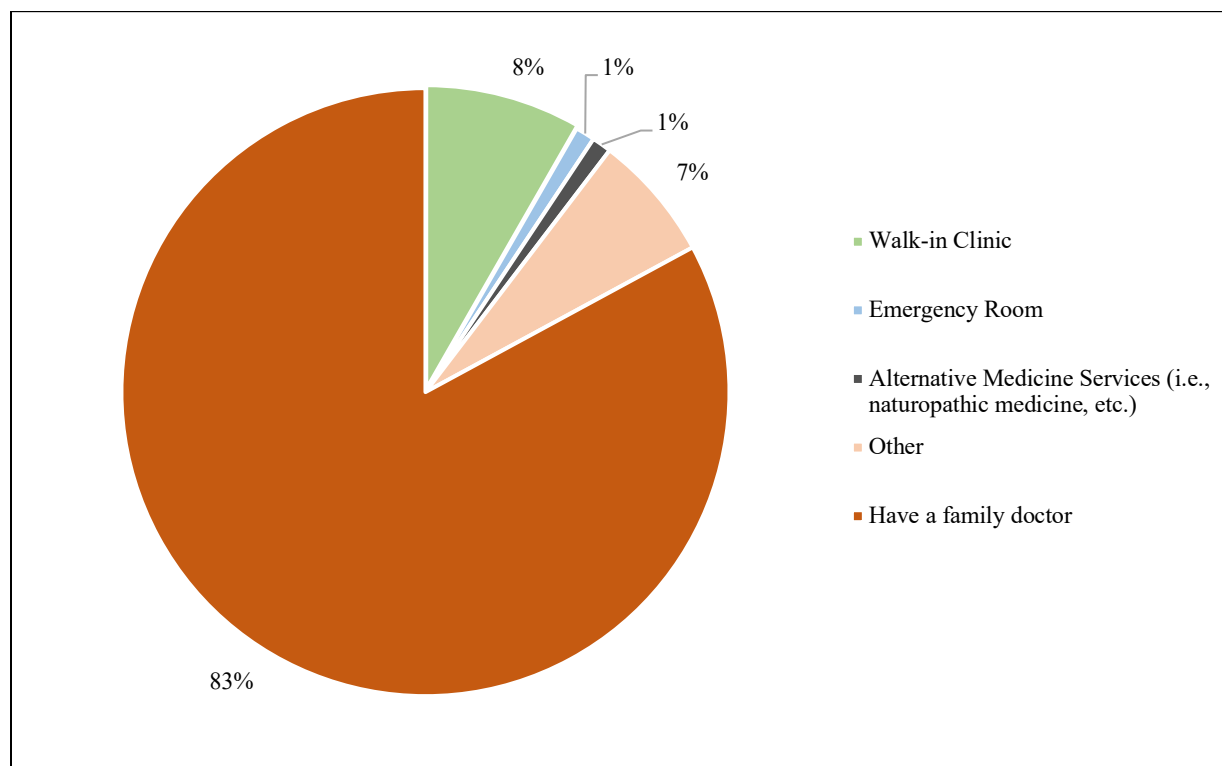


Figure 18. Patient responses by multiple-choice answer option for the question “If you do not have a family physician, how do you access health care services?”.

As noted above, 13 participants selected the multiple-choice option “other” for the question “if you do not have a family physician, how do you access health care services?” (question 3, Appendix B). Participants were prompted to elaborate (in an open-ended answer field) if they selected “other” as their answer for this question. Open-ended responses associated with the “other” option were analyzed for common themes amongst responses. Of the 13 participants who selected the option “other”, four participants (2.1% of all complete-survey participants) indicated they use walk-in clinics *and* visit the emergency room (participants were unable to select more than one multiple choice option – i.e., “I go to a walk-in clinic” *and* “I go to the emergency room” – this technicality may explain why some participants provided this response in the “other” option). Two participants (1.0% of all complete-survey participants)

indicated they access primary health care services through a nurse practitioner. One participant (0.5% of all complete-survey participants) indicated they see a pharmacist for their primary care needs. One participant (0.5% of complete survey participants) indicated they use out-of-pocket expenses to pay for tele-health services. Five of the participants (2.6% of all complete-survey participants) who selected “other” indicated that they actually do have a family doctor, but they choose to use walk-in clinics instead. Reasons given for choosing to use walk-in clinics despite having a family doctor include extended wait-times to book an appointment and unavailability of the physician. In summary, these results indicate that patients who do not have family doctors rely mostly on walk-in clinics and emergency room services for primary health care. These results also demonstrate that even patients who do have family doctors rely on alternative services to access primary health care (primarily due to the inadequacy/inconvenience associated with the care provided by their family doctors).

It was important to know where participants from the patient survey access their primary care services, in order to understand if particular barriers are associated with specific locations, or if they exist across the province. As such, patient participants were asked to indicate the Nova Scotia Health Authority Zone in which they access primary care services (question 2, Appendix B). Results are summarised in Figure 19. One-hundred-fifty-nine (159; 82.4%) participants indicated that they access primary care in the Central Zone (Halifax, Eastern Shore, and West Hants areas). Ten (5.2%) participants access primary care in the Western Zone (Annapolis Valley, South Shore, and South West areas). Sixteen (8.3%) participants access primary care in the Northern Zone (Colchester-East Hants, Cumberland, and Pictou areas). Eight participants (4.1%) access primary care in the Eastern Zone (Cape Breton, Guysborough, and Antigonish areas).

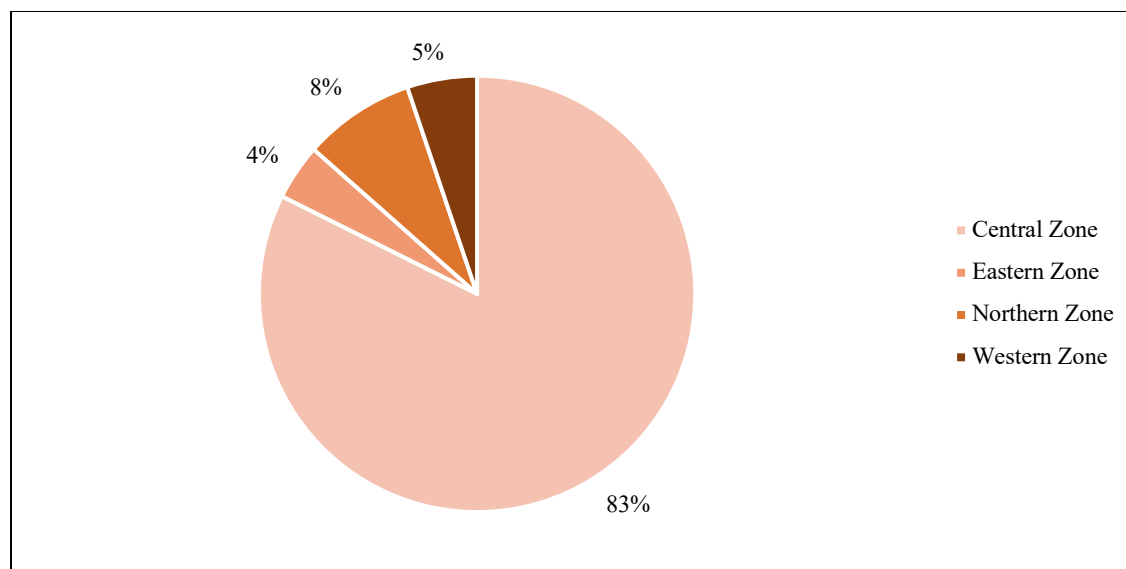


Figure 19. *Area in which patients access primary health care services.* Note: Figure refers to Nova Scotia Health Authority Zones.

Patient-Identified Barriers to Primary Health Care

Participants were asked “has there ever been anything (e.g., lack of transportation or money for transport, lack of childcare, inability to leave work, etc.) that has prohibited you from accessing primary care when you needed it?” (question 4, Appendix B). One-hundred-thirty-eight (138) complete-survey participants responded to this question. It is valuable to know the age, gender, cultural/racial status of the patients who identified barriers, in order to understand if specific barriers are associated with particular demographic groups. Therefore, barriers identified in the responses to this question are summarised in Table 1 by participants’ age, gender, and cultural/racial status (these results are specifically discussed on pages 90-92). Of the 138 participants who responded to the question, eight participants indicated more than one theme. Sixty-five participants (65/138, 47.1%) indicated they did not face barriers in response to this question. Some participants who felt they do not face barriers of this type recognized that other patients may face these particular barriers (e.g., “no ... I am one of the lucky ones”). Thirty participants (30/138, 21.7%) noted that their physicians’ unavailability was a barrier to care (e.g.,

“difficulty getting an appointment due to doctor unavailability,” “I have had to wait up to three months to get an appointment,” “my family doctor is extremely difficult to get a hold of to make appointments”). Nineteen (19/138, 13.8%) participants indicated their inability to take time off work made it difficult/impossible to access care when they needed it. Fourteen participants (14/138, 10.1%) indicated that the long wait times in physicians’ clinics were a barrier to their care access. Twelve participants (12/138, 8.7%) shared that lack of transportation is a barrier to care for them. Two participants (2/138, 1.4%) indicated their inability to afford out-of-pocket expenses associated with health care appointments acted as a barrier to care (e.g., “lack of money to pay for prescriptions, no health coverage”). Two participants (2/138, 1.4%) indicated that a lack of childcare is a barrier to health care that they experience. Two participants (2/138, 1.4%) indicated that they feel unheard in the health care setting. In summary, though most participants felt they do not experience barriers of this type, the most common theme for patient identified barriers to care identified in this question was the physicians’ unavailability. Several other barriers were also identified.

Table 1. Numbers of participants for each response theme from the question “has anything prohibited you from accessing primary care?” by age, gender, and group identity (person of colour (POC), Indigenous and immigrant). The total number of barriers identified by participants as well as the total number of participants who did not identify barriers are provided.

Barrier	Age							Gender					Group Identity		
	18-24	25-30	31-40	41-50	51-60	61-70	71+	Man	Woman	Two-Spirit	No-Binary	Other	POC	Indigenous	Immigrant
Unable to take time off work	6	4	3	4	2	0	0	2	16	0	0	1	1	2	2
Lack of childcare	0	1	0	1	0	0	0	0	2	0	0	0	0	0	0
Lack of transportation	1	4	3	0	1	1	1	2	8	0	1	1	1	0	0
Long wait times	3	2	2	6	0	0	1	1	13	0	0	0	1	0	0
Unavailability of physician	5	3	7	5	9	1	0	3	26	1	0	0	3	1	3
Unable to afford out-of-pocket expenses	1	1	0	0	0	0	0	0	2	0	0	0	0	0	0
Feels unheard	0	0	1	0	1	0	0	0	1	0	1	0	0	0	0

Note: The values amongst each demographic category provided in this table may not each add up perfectly to the total number of responses identified per theme in the text above, because some participants did not answer all demographic questions.

In order to understand how participants are treated by family physicians, participants were asked “have you ever felt as though you have been treated unfairly in a health care setting because of your gender?” (question 5, Appendix B). Participants were also probed to answer the question with examples: “e.g., spoken down to, not explained treatments fully to you, etc.”. One-hundred-forty-five (145/193, 75.1%) complete-survey participants responded to this question. Similar to the previous question about barriers, it is valuable to know the demographic information of the patients who identified barriers, in order to understand if specific barriers are associated with particular groups (these results are specifically discussed on pages 90-92). As such, barriers identified in the responses to this question are summarised in Table 2 by participants’ age, gender, and cultural/racial status. Ninety-seven participants (97/145, 66.9%) noted they did not experience this type of barrier in the primary health care setting. Some participants who felt they do not face barriers of this type recognized that other patients may face these particular barriers (e.g., “No. While I identify as a woman, I’m highly educated and work in the health care field, so that likely influences greatly my interactions with the health care system”). Twelve participants (12/145, 8.3%) indicated their concerns are not taken seriously by the primary care physicians. Ten participants (10/145, 6.9%) indicated they felt their physician was not informed about female-specific health issues such as menopause, menstruation and pregnancy. Nine participants (9/145, 6.2%) felt they were spoken down to in appointments with family doctors. Eight participants (8/145, 5.5%) indicated they felt rushed and/or as though their physicians did not listen to them during appointments. Seven participants (7/145, 4.8%) noted a general gender bias experienced in interaction with primary care physicians. In summary, though most participants

felt they do not experience barriers of this type, the most common theme for patient identified barriers to care based on gender was feeling as though the physician did not take their concerns seriously. Several other barriers were also identified.

Table 2. Numbers of participants for each response theme from the question “have you ever been treated unfairly because of your gender?” by age, gender, and group identity (POC, Indigenous and immigrant). The total number of barriers identified by participants as well as the total number of participants who did not identify barriers are provided.

Barrier	Age							Gender					Group Identity		
	18-24	25-30	31-40	41-50	51-60	61-70	71+	Man	Woman	Two-Spirit	Non-Binary	Other	POC	Indigenous	Immigrant
Concerns not taken seriously	0	2	5	0	5	0	0	0	12	0	0	0	0	0	1
Physician uninformed about female-specific issues	3	2	4	0	1	0	0	0	10	0	0	0	1	0	2
Felt rushed/unheard	4	1	0	0	1	2	0	0	6	0	1	0	0	0	7
General gender bias	0	0	2	1	3	0	1	0	7	0	0	0	1	0	2
Spoken down to	2	1	1	2	2	1	0	0	8	0	0	0	0	0	1

Note: The values amongst each demographic category provided in this table may not each add up perfectly to the total number of responses identified per theme in the text above, because some participants did not answer all demographic questions.

The final question about barriers to primary care access in Nova Scotia that participants were asked to answer was: “have you ever felt as though you have been treated unfairly in a health care setting because of your culture or socioeconomic status?” (question 6, Appendix B). One-hundred-thirty-nine (139/193, 72.0%) complete-survey participants responded to this question (question 6, Appendix B). Again, it is valuable to know the demographic information of the patients who identified barriers, in order to understand if specific barriers are associated with particular groups (these results are specifically discussed on pages 90-92). Therefore, barriers identified in the responses to this question are summarised in Table 3 by participants’ age, gender, and cultural/racial status. One-hundred-twenty-six (126/139, 90.6%) participants indicated they do not experience this type of barrier in the primary health care setting. Some participants who felt they do not face barriers of this type recognized that other patients may face

these particular barriers (e.g., “I am socially very privileged (white, anglo [English speaking person], educated, moderate income), so I have not personally had this experience. I am aware that this is an issue for many.”). Four participants (4/139, 2.9%) indicated age as a barrier to effective care (e.g., concerns were not taken seriously due to their age, either young or old). Three participants (3/139, 2.2%) felt they were spoken down to because of their culture/socioeconomic status. Two participants (2/139, 1.4%) felt they were judged by physicians based on where they lived, while two others felt they were not taken seriously in the primary care setting because of their disabilities. One participant (1/139, 0.7%) felt as though their lack of medical literacy is a barrier to effective care, one other felt they experienced general cultural bias in the primary care setting, an additional participant felt they were not taken seriously because of their pre-existing health condition, and one other felt they were not taken seriously because of their culture/socioeconomic status. In summary, though most participants felt they do not experience barriers of this type, patients identified several barriers to care associated with culture and/or socioeconomic status.

Table 3. Numbers of participants for each response theme from the question “have you ever been treated unfairly because of your culture and/or socioeconomic status?” by age, gender, and group identity (POC, Indigenous and immigrant). The total number of barriers identified by participants as well as the total number of participants who did not identify barriers are provided.

Barrier	Age							Gender					Group Identity		
	18-24	25-30	31-40	41-50	51-60	61-70	71+	Man	Woman	Two-Spirit	Non-Binary	Other	POC	Indigenous	Immigrant
Age	1	1	1	0	0	0	1	0	4	0	0	0	1	0	0
Location	0	0	1	0	0	1	0	2	0	0	0	0	1	1	0
Lack of medical literacy	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1
Cultural bias	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0
Concerns not taken seriously	0	0	1	0	0	0	0	0	1	0	0	0	1	1	0
Not taken seriously (disability)	0	1	1	0	0	0	0	0	2	0	0	0	0	0	1
Not taken seriously (pre-existing health condition)	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0
Spoken down to	0	0	0	0	2	1	0	0	2	0	1	0	0	0	0

Note: The values amongst each demographic category provided in this table may not each add up perfectly to the total number of responses identified per theme in the text above, because some participants did not answer all demographic questions.

Barriers Expressed by Participants Who Identified as Indigenous Persons, Persons of Colour, and Canadian Immigrants

As the focus of the current research project is to identify barriers that immigrant women, Indigenous women, and women of colour face in the primary health care setting in Nova Scotia, the following section focuses on the barriers identified by these populations specifically. Also included are some of the barriers identified by men and non-binary individuals who belong to the three populations of interest (Canadian immigrants, Indigenous persons, and persons of colour) because there are limited numbers of participants for each of these populations. As such, the data from men/other gendered persons who belong to the populations of interest are valuable in the analyses of results from the current study to provide context for the results of women from the populations of interest (i.e., to help discern if barriers may be due to gender or racial/cultural group status). It is important to note that while the three populations of interest are discussed

separately below (for organizational reasons), some participants identified themselves as belonging to more than one of the populations of interest. Importantly, the intersectional framework used in the current project informs us that the barriers experienced by the participants below are not due to any single defining factor; rather, they are caused by the cumulation of oppressions experienced by any given individual.

Concerning immigrant participants, almost half of the total number of participants who identified as Canadian immigrants (7/15, 46.7%) noted that they felt rushed and not listened to in appointments with primary care physicians (see Table 2). All of the immigrant participants who identified this barrier were women, with the exception of one participant who identified as non-binary. Three immigrant women participants (3/12, immigrant participants who identified as women, 25.0%) noted that their physicians' unavailability was a barrier to their primary care access (Table 1). Two immigrant women (2/12, 16.7%) identified the following barriers to primary health care: inability to take time off of work as a barrier to primary care (Table 1), felt their physicians were uninformed about specific women's health issues (Table 2), or felt a general gender bias against them in the primary care setting (Table 2). The following barriers were identified by one immigrant woman participant each (1/12, 8.3%): felt spoken down to by her primary care physician (Table 2), felt her concerns were not taken seriously by her physician (Table 2), a lack of medical literacy (i.e., difficulty understanding medical jargon) as a barrier to effective primary health care (Table 3), felt her concerns were not taken seriously because of a pre-existing disability she has (Table 3). Two of the barriers identified in Table 1 (inability to take time off work, unavailability of physician) were reported by immigrant participants. In Table 2, both immigrant participants and non-immigrant participants identified all barriers ("felt unheard" was expressed most by immigrant participants, followed by "physician uninformed

about female-specific issues,” and “gender bias”). In Table 3, immigrant participants identified distinct barriers that were not expressed by non-immigrant participants (such as lack of medical literacy, and not being taken seriously). All five of the barriers presented in Table 2 were expressed by immigrant participants. In contrast, only two barriers from each of Table 1 and Table 3 were identified by participants from this group. In summary, the barriers identified by immigrant women in the current study are diverse.

Concerning participants who identified as Indigenous persons, two people (2/5 total Indigenous participants, 40%), one of whom was a woman, identified the inability to take time off work as a barrier to primary care access (Table 1). One additional Indigenous woman identified the unavailability of their physician as a barrier to primary care access. One Indigenous man noted he felt judged in health care settings based on the reservation (location) from which he came (Table 3). One Indigenous woman noted her health concerns were not taken seriously in the primary care setting (Table 3). None of the themes of barriers from Table 2 (about being treated unfairly in the health care setting due to gender) were identified by Indigenous participants. In contrast, two barriers from each of Table 1 and Table 3 were identified by participants from this population. In summary, none of the barriers expressed by Indigenous participants in Tables 1, 2, and 3 were unique to this population. That is, all of the barriers expressed by Indigenous participants were also noted by participants who did not identify as Indigenous. None of the Indigenous participants noted how primary health care may intersect with their traditional methods of health care.

Concerning participants who identified as persons of colour (12 in total), one person (1/12, 8.3% who identified as a man) felt judged in a health care setting based on where they were from (Table 3). The following barriers were identified by one participant each, each of

whom identified as women of colour (1/12, 8.3%): inability to take time off work (see Table 1), lack of transportation (Table 1), the physician was not informed about specific women's health issues (Table 2), felt a general gender bias in the primary care setting (Table 2), age as a barrier to effective care (Table 3), concerns were not taken seriously in the primary care setting (Table 3). Three participants (two women, one man) who identified as persons of colour noted their physicians' unavailability as a barrier to primary care (Table 1). All of the barriers noted by person of colour participants were expressed also by participants from non-marginalized groups. That is, no barriers were expressed only by participants who identified as persons of colour. In summary, only two of the barriers from Table 2 were identified by person of colour participants, four from Table 1, and three from Table 3. All of the other barriers presented in Tables 1, 2, and 3 were not expressed by participants from this group.

Participant-Identified Necessary Changes to Health Care in Nova Scotia

Because the aim of the patient survey was ultimately to understand what factors contribute to some Nova Scotians' difficulty accessing primary health care, participants were given many opportunities to provide details about their experiences and difficulties with the health care system in Nova Scotia. Accordingly, participants were asked "what changes would you like to see in health care in Nova Scotia?" (question 7, Appendix B). The majority of the complete-survey participants (175/193, 90.7%) responded to this question. Seventeen general themes were identified amongst the responses to this question. Approximately half of those participants (83/175, 47.4%) had answers that corresponded to more than one theme about changes to health care in Nova Scotia. The themes are summarised in Table 4. The most commonly cited theme in the responses to the question about change in health care in Nova Scotia was "more family physicians". An example of a response that was included in the theme

of general improved access to health care is “improve[d] access” or “more accessible health care”. The 12 participants who noted the need for increased support for health care workers had answers such as “Better treatment of nurses and doctors. Better working conditions for both to keep doctors and nurses in the province”. Examples of responses that corresponded to the theme of overall change in health care delivery are “a full structure change that recognizes the ableism, misogyny, racism and socioeconomic privilege and eugenic attitudes towards disabled and elder persons,” and “we need to think differently and innovatively about our systems and how we deliver care”. Three individuals indicated reduced stigma in health care as a necessary change with responses such as “Less weight based. There’s a lot of fat shaming and bias [against] overweight people. I can’t get adequate medical care because I am overweight”. Two participants (2/175, 1.1%) included improved queer health services in their answers. In summary, the responses for this question varied widely, indicating that there are many changes that Nova Scotians would like to see to health care in our province.

Table 4. Themes for responses to the question “what changes would you like to see in health care in Nova Scotia”.

Theme Identified (Change to Health Care in NS)	Number of Participants who Identified the Theme	Percentage of Participants
More Family Physicians	75	42.9%
Shorter Wait Times	52	29.7%
General Improved Access to Health Care	19	10.9%
More Nurses, Nurse Practitioners, and Other Health Care Providers	19	10.9%
Increased Focus on Preventative and Holistic Medical Care	18	10.3%
Improved Tele-Health Services	14	8.0%
Improved Mental Health Services	13	7.4%
Increased Support for Health Care Workers	12	6.9%
Improved Access to Specialists	11	6.3%
Longer and More Comprehensive Appointments	11	6.3%
Coverage for Dental and Pharma-Care	8	4.6%
Overall change in health care delivery	8	4.6%
Improved Care for Older Adults	6	3.4%
Improved Emergency Room Services	3	1.7%
Improved Walk-In Clinics	3	1.7%
Reduced Stigma in Health Care	3	1.7%
Improved Queer Health Services	2	1.1%

Note: The percentage of participants is out of the 175 who responded to Question 7, Appendix B.

Because the survey was active during the COVID-19 pandemic, it was important to understand if participants’ responses were informed by the temporary changes in health care delivery implemented during the pandemic (question 8, Appendix B). One-hundred-thirty-eight (138/193, 71.5%) complete-survey participants indicated that their survey answers were not affected by the current COVID-19 pandemic. Twenty-three complete-survey participants (23/193, 11.9%) indicated that their responses are or may have been affected by the COVID-19 pandemic. Thirty-two (32/193, 16.6%) complete-survey participants did not respond to the question about COVID-19 and their survey responses. Therefore, it appears as though the majority of patient survey responses were not affected by the current global pandemic; as such, the majority of patient responses reflect pre-existing barriers to and concerns with primary health care in Nova Scotia.

At the end of the patient survey, participants were asked: “is there anything else you would like to mention to the researchers?” (question 17, Appendix B). Forty-five participants (23.3%, 45/193) responded to this question with comments other than “no”. One-hundred-forty-eight participants (76.7%, 148/193) total participants responded “no” to the question or did not respond to the question at all (also indicating that they did not have anything else to mention). Nineteen participants (19/193, 9.8%) emphasized further needs for health care in Nova Scotia (either by re-stating previously noted comments, or stating new thoughts; e.g., “we need more full-time family physicians in Nova Scotia”). Nine participants (9/193, 4.7%) shared insight about health care in Nova Scotia (e.g., “health care is important, all health care practitioners should work together”). Seven participants (7/193, 3.6%) noted their appreciation for the study. Five participants (5/193, 2.6%) acknowledged the importance of studies about barriers to health care in their responses; an additional five participants stated general comments about the status of their own personal health (e.g., “I have numerous health concerns”). The responses to this question indicate that most participants felt they were able to provide relevant information about primary health care in Nova Scotia to the researchers through answering the preceding questions. However, some participants felt the need to emphasize previously stated comments or share thoughtful insights.

Chapter Seven: Discussion

Discussion of Physician Survey

Demographic Information

Statistics Canada 2016 Census Report (Statistics Canada, 2016) shows that the total number of general practitioners/family physicians in Nova Scotia is 1565. This is the most current Statistics Canada data. Doctors Nova Scotia reports a lower number: 1185 of their current members (who include all Nova Scotian doctors and medical students) are family physicians (pers.comm. Kim Nakhaie from Doctors Nova Scotia, 2020). According to Statistics Canada, of the total number of primary care physicians in Nova Scotia, 51.4% (805/1565 individuals) are male; 48.6% (760/1565 individuals) are female (Statistics Canada, 2016). Doctors Nova Scotia reports the same percentages as Statistics Canada: 51.4% (609/1185) of Doctors Nova Scotia's current members who are family physicians are male, while 48.6% (576/1185) of their current members who are family physicians are female (pers.comm. Kim Nakhaie from Doctors Nova Scotia, 2020). Based on this data context, the participants for the physician survey (86% female, 14% male) are not representative of the gender of primary care physicians in Nova Scotia. That is, the survey either appealed more to women-identifying physicians or recruitment methods favoured these physicians. The former is more likely as the title of the survey included the word "women".

At a quick glance, it may have appeared that the survey was intended for physicians who are women even though language in the recruitment message encouraged "all family physicians" to respond. Alternatively, the subject matter may have intrigued physicians who are women more than physicians who are men. Similarly, a survey-based study by Aerny-Perreten et al. (2015) about primary care in Spain had a higher response rate from women than men. These authors

note that there is no consensus in the literature on response rates according to gender; however, other similar studies have also noted trends of higher response rates from women than men (Aerny-Perreten et al., 2015). They also note that surveys targeted at health professionals typically have very low response rates, and response rates are even lower for web-based surveys (Aerny-Perreten et al., 2015). Women-identifying physicians may have answered the survey with a higher response rate than men-identifying physicians because women may face barriers themselves (at work, in their careers as physicians, etc.) which may have made them feel more inclined to answer the survey than men (who may have limited experience facing these types of barriers). This may be especially true in the current study, as all of the male physicians who responded to the survey did not identify as Indigenous, persons of colour, and only one identified as a Canadian immigrant. Thus, the men who participated in this study may experience male- and white-privilege in their careers as physicians. As such, they may not be acutely aware of the barriers that exist for patients in accessing medical care.

Physicians were asked to estimate the number of patients they see per month who are women of colour, Indigenous women, and immigrant women. For each of these three populations, physicians estimated low numbers of patient (0-6) visits per month. This result may suggest that physicians see many more patients per month who are not persons of colour, Indigenous, or immigrants. Alternatively, the result may suggest that physicians do not know if their patients belong to these groups (most likely a plausible case for Indigenous and immigrant patients, as these minority groups may not be as visible as persons of colour). Thus, these results from the physician survey discussed below mostly represent physicians' perspectives of their patients whom are not Indigenous, persons of colour, or Canadian immigrants.

Physicians' Perspectives on Barriers to Primary Health Care

Physicians' age and their reported number of years practicing family medicine were significantly correlated; this result was expected, as older physicians have likely been in their careers for a long time, whereas younger physicians have not accumulated as much work experience. Due to the relation between age and years practicing, it is expected that physicians' responses to the question about women facing barriers to care would be significantly correlated with both measures. Indeed, this was the case. Interestingly, older/more experienced physicians were less likely to report that women face unique barriers in accessing primary health care in Nova Scotia than were younger/less experienced physicians. No other research studies could be found that assess physicians' perspectives on barriers that patients face with respect to primary care; as such, the data from the current study are novel.

Similar to the data trends regarding physician age/experience and perceived barriers to primary care, older physicians were more likely than younger physicians to indicate that they do not make an active effort to be inclusive of patients from cultures other than their own. Moreover, physicians who have been practicing longer were more likely than physicians with less practical experience to indicate that they do not make an active effort to be inclusive of patients in same-sex partnerships. The significant correlation between responses to questions about cultural inclusivity and inclusivity of patients in same-sex partnerships indicates that physicians were likely to provide similar responses for questions about cultural inclusivity as inclusivity of patients in same-sex partnerships (i.e., many physicians answered "no" to both or "yes" to both). In their study, Vistorte et al. (2018) found that older, more experienced physicians had more stigmatizing attitudes towards patients with mental disorders than younger, less experienced physicians. The findings from Vistorte et al. (2018) are similar to those of the

current study, which indicates that older/more experienced physicians are more likely to have less inclusive attitudes in their practices as compared to younger/less experienced physicians.

Responses to questions about female patients having difficulty accessing appointments due to transportation issues and about women facing barriers to primary health care were significantly negatively correlated; the same relation was noted between the questions about female patients having difficulty accessing appointments due to lack of childcare and women facing barriers to primary health care. Indeed, these findings demonstrate that physicians who perceive women as particularly vulnerable to barriers to primary care access were also aware of specific barriers (e.g., a lack of transportation, childcare) that women face in accessing primary health care. These results may indicate that physicians who are informed about women's unique barriers to health care access are also aware of the ways in which these barriers often manifest, and/or, these same physicians may make an effort to inform themselves about the barriers that their female patients face in attempting to access their care. Furthermore, these results may be apparent because the majority of respondents for the physician survey were women; perhaps, women physicians were able to draw on their first-hand knowledge and experience of these barriers.

The significant correlations for physicians' responses to questions about female patients' barriers to primary care access due to transportation issues, lack of childcare, and the inability to take time off work indicate that physicians were likely to perceive barriers for their female patients to the same degree for all three categories (transportation, work, childcare). These results may indicate that physicians perceive female patients who experience one type of barrier as more likely to experience another type of barrier. Or, these findings may indicate that physicians who

are aware of one type of barrier that their female patients face are more likely to be cognisant of other barriers that their patients experience.

Findings about physicians' perceptions of physical barriers to care access for their female and male patients were significantly correlated, meaning physicians tended to provide similar answers for questions that probed at barriers experienced by female patients to those experienced by male patients. This finding suggests that, on average, physicians did not think that their female patients had more difficulty accessing primary care appointments than their male patients did. The literature suggests that women face increased barriers to accessing health care as compared to men (e.g., McGibbon & McPherson; Pederson et al., 2010; Pederson, Raphael & Johnson, 2010). However, there is limited research about physicians' perceptions of these barriers for male versus female patients. Indeed, other studies focused only on the barriers that patients face, rather than physicians' perceptions of these barriers, which makes the current study unique, and provides an important perspective about barriers to primary care. Physicians' perspectives about barriers that patients face in accessing primary care are valuable, as physicians are an important link between health care policy and the patient experience.

Other correlations in responses to questions from the physician survey were found. These correlations include those between measures of physician's gender identity and their perceptions of male patients downplaying their symptoms, male patients' difficulty accessing appointments due to childcare and their likelihood to bring children to their appointments, and male and female patients amplifying their symptoms. Moreover, similar relations between male barrier data (e.g., physicians perspectives of transportation and childcare affecting male patients' ability to access health care) and female barrier data about the same topics showed similar correlation trends (i.e., data about male patients were correlated with other data about male patients and data about

female patients were correlated with other data about female patients from the physician survey). These results are interesting because data from the physician survey also showed that physicians provided similar responses to questions that asked about their perception of barriers experienced by female and male patients. As such, these results suggest that physicians tend to think there are minimal differences between the barriers that women and men face in accessing primary health care. It is important to note, however, that this conclusion does not mean there are not differences in the barriers that men and women face in accessing health care; rather, it indicates that physicians may not be aware of the differences in barriers between men and women.

Overall, the physician survey demonstrates that physicians have a general understanding of barriers that patients may face in attempting to access primary care services in Nova Scotia. Moreover, most physicians agree that women, in particular, face barriers to accessing primary health care. On average, it is evident that physicians believe that male and female patients face some of the same barriers (e.g., transportation, childcare, work), but that female patients also have some unique barriers of their own (e.g., limited access to female sexual health care). Recommendations about changes to primary care developed in response to survey data are presented in a later section (Chapter 8). Physicians' perspectives will be compared to patients' perspectives about barriers to primary health care following the discussion of the patient data.

Discussion of Patient Survey

Demographic Information

The data for demographic information for the patient survey are representative of demographic information about Nova Scotia residents with respect to race/status. According to Statistics Canada 2016 Census Report, 6.35% of Nova Scotians are persons of colour, 5.58% of Nova Scotians are Indigenous persons, and 6.03% of individuals in Nova Scotia are immigrants

(Statistics Canada, 2016). The demographic information for the participants from the current study are comparable to provincial statistics: 6.2% persons of colour, 2.6% Indigenous persons, 7.8% immigrants, indicating that the recruitment methods were successful. Regarding the low response rate of Indigenous persons in Nova Scotia, Lewis et al. (2016) note that there is no “typical response rate” (p. 199) for Indigenous survey participants; however, there are historical reasons why response rates for this population are low (indicating lower engagement in research), such as feeling as though they are an over-researched population. Though efforts were made to collaborate with this group of individuals to gather statistically meaningful data, more time and the absence of the COVID-19 global pandemic may have increased their response rates.

With respect to gender, considerably more women than men responded to the patient survey (86.5% and 20%, respectively). Only three individuals who do not identify as women or men responded to the survey. Though the response rates for men and women identifying participants are not representative of the population of Nova Scotian residents, women may have been more interested in the survey subject matter if they felt more connected to the idea of facing barriers to primary care access than men did. Indeed, Saleh and Bista (2017) showed that individuals are more likely to respond to surveys that are interesting and meaningful to them. And, it is evident that women face more barriers in accessing primary health care than do men (Hwang et al., 2017). Therefore, this gendered response rate was not unexpected.

The data set for the patient survey adequately represents perspectives from a wide range of Nova Scotians. However, while age was well distributed, most participants were women, from Central Zone, and did not identify as persons of colour, Indigenous persons, or Canadian immigrants. Therefore, the results discussed below are most representative of non-Indigenous,

non-immigrant, non-persons of colour women from the Central Zone of Nova Scotia. However, results from diverse participant groups are discussed.

Themes in Family Medical Care Access from the Patient Survey

The vast majority of participants who expressed their experience facing barriers to primary care access in the patient survey were women. This finding is consistent with the literature about social determinants of health, which suggests that gender impacts health care accessibility; in general, women have a more difficult experience accessing health care than their male counterparts (Hwang et al., 2017; Pederson et al., 2010). Pederson, Raphael, and Johnson (2010) note that childcare predominately falls on women and this responsibility may impact women's ability to access care when they need it. The findings of the current study are consistent with the literature in that some women noted that a lack of childcare has prohibited them from accessing primary care services when needed.

While the majority (64.8% of women who answered the question about barriers to care due to gender, question 5, Appendix B) of women felt they did not experience barriers because of their gender, many women (35.2%) do feel as though they experience barriers to effective care based on their gender. The current study showed that some women felt their concerns were not taken seriously in the health care setting, and that physicians were not adequately educated about women-specific health issues (e.g., menopause, menstruation, pregnancy, etc.). Some women also felt rushed and as though their physicians did not listen to them in appointments. Some women also noted general gender biases in the health care setting. Though the numbers of participants who felt they were treated unfairly in the health care setting based on the reasons listed above are low, it is important not to dismiss the experiences of minority cases, as these challenges have great impacts on the women who experience them. These findings are all

consistent with research and attitudes that have historically informed women's health activism. Indeed, the current research findings are consistent with research by Defenbaugh (2008), Hinnant (2009) and O'Connell and Zampas (2018) who suggest that there are unequal power dynamics between physicians and patients, and that this causes problems (e.g., disempowerment, paternalistic treatment, difficulty accessing effective care) for women. Based on previous research findings, and the fact that women continue to face issues associated with gender bias in the health care setting (as indicated by current research findings), there is more work that needs to be done to promote gender equality and fair treatment in health care in Nova Scotia. Indeed, it is imperative that women have unhindered access to health care, not only from a moral standpoint of wanting good health for all people, but also because women's health is important to the functioning of society. Indeed, many women play a central role in families, communities, and the economy (Newman et al., 2020); as such, their health is critical to the sustainability of these social institutions.

Further, as Syed (2013) notes, an inability to secure transportation is a barrier to health care access that individuals in low socioeconomic situations may experience. Concordantly, a lack of transportation as a barrier to primary care access was a theme that was identified in the current study. Participants in this study commented on the far distance that their family practitioners are from their home, and the difficulties they have accessing their doctor without a car. Many participants noted they rely on public transport and have to take multiple buses to access their family doctor's clinic. Some of these participants noted they book their health care appointments based on their ability to access public and transit schedules, which may be unreliable. Similarly, some participants who noted they do not have their own vehicles also noted that there are not public transit routes that can take them near their doctor's offices; many of

these participants indicated they rely on others to drive them to appointments, and when this is not possible, they do not access primary care services at all. Again, this finding highlights the need for additional support measures (e.g., transportation support) required in Nova Scotia for those who have difficulty accessing health care services.

More than one participant noted that their inability to afford out-of-pocket expenses is a barrier for them in accessing primary health care. Notably, Deber et al. (2014) report that most pharmaceutical expenses are paid for by patients (out-of-pocket) or through private insurance plans. Prescription drugs can be highly expensive, and the requirement to pay for them out-of-pocket by patients without private insurance plans – as indicated by participants in the current study – is a barrier to care. Moreover, eight participants noted that coverage of pharmaceuticals and dental care (also mostly paid for by out-of-pocket expenses and private insurance plans) are important changes they would like to see in health care in Nova Scotia. These findings suggest that the costs associated with health care in Nova Scotia (such as prescriptions and dental care) are of concern for some Nova Scotians currently, and must be addressed to ameliorate care access and health status of the province's residents.

In the survey question about what changes participants would like to see in health care in Nova Scotia, the majority of respondents noted that they believe Nova Scotia needs more family physicians. This finding was interesting as it is in contrast to Hwang et al. (2017) findings that increasing the number of family physicians in a particular area may not effectively make primary care more accessible to the residents of that area. In fact, one participant from the current study (who identified themselves as a person who works in health care administration in Nova Scotia) noted the same idea:

“Personally, I feel that our physician shortage in Nova Scotia is not as ‘dire’ as it is made out to be compared to the rest of Canada. I do feel the media makes it seem that we are worse off compared to other provinces. From the Canadian Institute for Health Information 2018 ‘Physicians in Canada’ report, it showed that Nova Scotia had one of the highest physicians per capita in the entire country. This number alone I think points more to issues around how we allocate our resources, rather than how many physicians we actually have.”

Perhaps this finding indicates that many Nova Scotian’s ideologies about how to increase primary care access across the province are misinformed (i.e., that we need more family doctors rather than an improved system of resource allocation). While it is unclear based on the findings from the current study if an increase in the number of family physicians in Nova Scotia will improve access to primary care, or not, several patients noted that the unavailability of their physicians is a barrier to their care. Moreover, it is very clear based on the current study that barriers to primary care do exist, with reference to transportation, language, physicians’ knowledge about specific women’s health issues, amongst others. These findings suggest that there may be underlying problems with the way that health care is delivered in Nova Scotia that require specific attention. As such, further research in this area is required.

Findings from Participants Who Identified as Indigenous Persons, Persons of Colour, and Canadian Immigrants

As the specific research questions for this thesis research study were concerned with the barriers that women of colour, Indigenous women, and immigrant women face in accessing

primary health care in Nova Scotia, the following section outlines relevant survey responses and themes from the populations of interest.

In response to the question about barriers to care due to culture and/or socioeconomic status, only one participant who was a person of colour identified the barrier of feeling as though their concerns are not taken seriously by their physician. This participant also identified as a woman and an Indigenous person. Particularly, this participant noted “Yes. I feel like my issues are never taken seriously”. Details about exactly why she felt her concerns are not taken seriously were not provided; however, in a separate question, the same participant noted that in “almost every appointment [,] nothing is ever explained fully, and my questioning is always met with resistance”. As previous authors have noted, there is limited research about barriers to health care access for racialized Canadian women (Nnorom et al., 2019). Though it is unclear whether the comments from this participant can be attributed to their status as a woman of colour, or as an Indigenous woman, it is possible that this is the case, as similar comments (specifically about questioning being met with resistance) were not expressed by any participants who did not identify as persons of colour. Moreover, there may be myriad complicated reasons (based on the multiple intersecting oppressions this participant may face) why this participant experienced particular barriers in the health care setting. The results discussed here are from a single person of colour participant (though there were 12 total in the current study); as such, it was not the consensus from all participants who identified as persons of colour. Regardless of the causes or quantity of barriers such as these, these results are troubling and urge further investigation into the experiences of women of colour in health care in Nova Scotia, as institutional and structural racism are responsible for health disparities between racialized and non-racialized persons (Nickel et al., 2018; Ramaswamy & Kelly, 2015). It is plausible that

women of colour feel as though their concerns are not taken seriously in the health care setting (such as the woman in the current study noted) because they do not see themselves represented in the field of medicine (i.e., it is likely that there are limited physicians of colour in Nova Scotia, based on the low response rate from this group in the current study). Therefore, it is unclear whether or not person of colour representation in medicine impacts the patient experience; however, if it does, it is evident that there is work that must be done to address this problem in Nova Scotia.

In order to address the potential problem of low numbers of physicians who are persons of colour in Nova Scotia, it is pertinent to have a clear understanding of physician racial demographic information. It is currently unclear how many Nova Scotian physicians are persons of colour, and how many of those are women, as Statistics Canada does not report specific occupations by racial group. Doctors Nova Scotia also does not capture statistics concerning the cultural/racial identity of physicians in Nova Scotia (pers.comm. Kim Nakhaie from Doctors Nova Scotia, 2020). Further, though Dalhousie University Medical School has an affirmative action statement, which suggests that they are committed to increasing the number of medical graduates from underrepresented groups, the university does not report race data in their class statistics (average age, number of male/female students, and province of residence are the only demographic data shared publicly; Dalhousie University, 2019). These findings are concerning. Indeed, Canadian medical students (and thus the physicians they graduate to become) are not representative of the Canadian population (Khan et al., 2020). Specifically, Black and Indigenous students are vastly underrepresented in Canadian medical schools (Khan et al., 2020).

None of the barriers expressed by persons of colour participants were *only* expressed by participants in this population. This finding suggests that patients' status as persons of colour

may not be the only factor which contributes to specific barriers experienced in the primary care setting. Indeed, an intersectional feminist analysis would suggest that myriad oppressions experienced by persons of colour (and other individuals) contribute to the barriers they face in accessing services, such as primary health care. Future research is required to further investigate these phenomena.

One Indigenous participant, who identified as a man, felt judged based on where he lives and highlighted this as a barrier to his health care access in response to a survey question. Specifically, this participant noted that their unfair treatment was due to bias based on the reserve from which he comes: “At the [X] hospital, I was automatically assumed that I was a drug user after being admitted again. The nurse was looking at the IV marks from being in the hospital a few days before. She said they can’t be too careful because of the reservation I come from. I was mortified.” It is evident that the participant in this scenario was judged based on their status as an Indigenous person and the reserve on which they live. This finding may be similar to those from studies by Bowers et al. (2019) and Nickle et al. (2018), that identified that Indigenous persons experience lower overall health as compared to non-Indigenous persons for myriad reasons. Concerningly, studies have also shown that the intergenerational impacts of colonialism also contribute to the injustices faced by Indigenous persons (Murdocca, 2017; Nickel et al., 2018).

Similar to the scenario described above (in which a participant felt judged in a health care setting based on where they were from), one participant who identified as a person of colour noted that they also felt judged in a health care setting based on where they are from: “I went to [X location] to see a specialist. When she found out I was from the [Y location] area, her attitude seemed to change and she was not as friendly (smile went away, short abrupt answers, didn’t tell me the appointment was over – just walked out of the examining room)”. Though the quotation

from a participant shared here is about care received from a specialist, rather than a primary health care provider, it is concerning that patients accessing health care in Nova Scotia feel judged based on where they come from in any capacity. Indeed, it is unclear the exact context for which the patient felt unwelcomed in the interaction with the physician (e.g., if it had to do with the patient's race or not); however, instances such as this urge further investigation into the medical care Nova Scotians receive.

As presented in the results section, several participants who identified as Canadian immigrants (all but one of whom were women, the other was non-binary) indicated they experienced many barriers in the health care setting (felt spoken down to, felt rushed/not listened to in appointments, felt a general gender bias). It is unclear if the immigrant participants in this study are familiar with their local health care systems. However, as Kohler et al. (2018) note, factors such as this often contribute to the difficulty that immigrants face in accessing primary health care in Nova Scotia specifically. Further, as Weerasinghe (2012) notes, skin colour, body weight, and foreign accents may contribute to adverse interpersonal interactions between patients and physicians. Though it is unclear whether the factors Weerasinghe (2012) highlights in her study caused the barriers expressed by immigrant women in the current study (i.e., feelings of being rushed, spoken down to, and biased against), it is plausible that these factors may have contributed to the unfavourable health care experiences of immigrant women in Nova Scotia.

Furthermore, low health literacy is often associated with low socioeconomic status and may make patients uncomfortable in a primary care setting, which may make them less likely to access care altogether (Yin et al., 2012). In the current study, one Canadian immigrant woman noted that she feels uncomfortable in interactions with her primary care physician because she does not understand the medical terminologies/medical language used to describe her and her

children's conditions. It is unclear if her status as an immigrant was at all associated with the barrier she identified. This situation describes a barrier to effective care: the patient is able to physically access her primary care physician, but the care received is not meaningful or effective due to the difference in language sets used by the patient and physician. As Yin et al. (2012) suggest, this type of interaction may make the patient feel intimidated and lack confidence discussing medical concerns with their physician. While this concern was only raised by one participant, it does highlight the need for more mediators/translators in the health care system for some immigrant families. Moreover, it is unclear based on the results from the current study if the immigrant women participants face language barriers (based on language spoken, rather than particular words used) in the health care setting; as such, this topic requires further investigation.

Overall, some of the barriers identified by participants who identified as Indigenous, immigrants, and/or persons of colour were also identified by participants who did not belong to these groups. However, some other barriers identified by these groups of interest (i.e., Indigenous, immigrant, and person of colour participants) were unique to these populations (e.g., feeling judged based on where one comes from as a barrier to care, low health literacy). Some barriers were not expressed in relation to the participants' culture/race (i.e., patients did not always specifically state that they believe the barriers they experience are due to their cultural/racial group identities). Further research would be required to determine if there is a substantial link between these barriers and individuals' status as immigrants, Indigenous and/or persons of colour.

As noted above, many of the participants from the current study belong to more than one of the populations of interest and experience other socially determined barriers to health/health care (e.g., based on geographical location, socioeconomic status, etc.). As such, there is not one

single reason as to why any individual experiences particular barriers in health care that can be reduced to the product of any one characteristic of the individual. Rather, barriers to health care result from the cumulation of multiple oppressions that a given individual experiences.

Indeed, as explained by Crenshaw (2015), intersectionality, as a feminist theory, works to uncover how inequalities work together to disadvantage groups of people. In the current study, inequalities have been characterized by the social determinants of health that were probed in the patient survey (i.e., socioeconomic status, immigrant status, indigeneity, race, gender, geographical location). It is evident based on the results of the current study that these factors do, indeed, effect patients' ability to access health care in Nova Scotia.

However, the goal of intersectionality is not to attribute inequalities experienced by individuals to specific characteristics (such as, a patient experiences X barrier because of Y characteristic *only*). Rather, intersectionality works to uncover how oppressions overlap – or, intersect – and helps to explain why some groups of people are more disadvantaged than others in some ways (e.g., in terms of access health care). Therefore, the results of the current study are important in highlighting that the myriad oppressions experienced by various patients in Nova Scotia have cumulative negative effects on their ability to access health care services. Particularly, the experiences of Indigenous women, women of colour, and immigrant women may be different than experiences of individuals outside of these groups, not only because of the their cultural/racial/group status, but also because of their other characteristics which intersect to create disadvantages in accessing health care. These results demonstrate problems that exist in the health care system in Nova Scotia that require attention.

Physician & Patient Survey Comparison & Discussion

Due to the nature of the survey styles (i.e., physician survey as predominantly quantitative, patient survey as predominately qualitative) it was not suitable to compare the two surveys in a statistical manner. Instead, themes from each of the surveys were compared and are discussed in the following section. No previous study in Nova Scotia has addressed both physicians' perspectives and patients' lived experiences in this way; therefore, the current study provides a new and valuable analysis of health care in Nova Scotia.

Some trends noted in the responses from physician surveys were similar to the themes found in responses by participants from the patient survey. For example, both physicians and patients noted that physical barriers such as a lack of transportation, lack of childcare, and the inability to take time off work complicated (and in some cases, prohibited) women from being able to access primary care services when they needed them. This indicates that there is substantial work that needs to be done in Nova Scotia to address physical barriers that prevent patients from accessing health care when they need it.

Intentionally, the patient study provided more details about barriers to effective care (e.g., feeling rushed, unheard, judged in the health care setting) than the physician survey did. That is, the physician participants were not asked to explain interpersonal barriers to care experienced by their patients. Some physicians vaguely touched on the subject of barriers to effective care caused by interpersonal relationships; however, not many physicians mentioned this type of barrier. That result may be due to the fact that physicians do not want to admit they contribute to the barriers their patients experience or, they may not even be aware that they contribute to their patients' barriers to care.

Notably, physicians did not note major differences in barriers to health care between male and female patients, despite the fact that most of the physicians are female. In contrast, the vast majority of patient participants who reported barriers to care were women. This could be because more women responded to the patient survey than men. Alternatively, this result may also have been due to the fact that physicians do not see patients who are unable to access care (e.g., patients who noted they are unable to access primary care due to a lack of transportation are not seen by physicians at all and therefore are not factored into the physicians' perspectives of patients with barriers to care). Furthermore, patients may not explain the details of their difficulty accessing care (for several reasons) to their physicians, so the physicians may not be aware that these barriers exist. Indeed, one physician noted "I'm sure there are many people who have difficulty accessing health care due to work schedules - I just think often we don't see them, and they don't complain to us about that" in the final question of the physician survey. This comment highlights the physician's awareness that patients face difficulties accessing care beyond what they (as physicians) are able to see. Alternatively, physicians may have preconceived ideas that women do not actually face increased barriers to care (evidenced by their responses to the question "do you believe women (in particular) face barriers to primary health care") and their responses may have reflected these ideas, rather than actual barriers experienced by their patients.

Impacts of COVID-19 on the Current Research Project

As described above in the methods section (Chapter 5), the initially proposed research plans (which included patient focus groups) were required to be changed as a result of the COVID-19 pandemic. Specifically, in-person data collection was halted by the university as a

result of public health guidelines mandated by the province of Nova Scotia. Accordingly, the online patient survey was implemented to replace patient focus groups.

Using focus groups as a method offers significant and substantial benefits to rich data collection for a study such as this one. Indeed, focus group data is rich, and participants may benefit from discussions about the research topic with other participants. In contrast, online surveys are limited to individuals with internet access, those who are literate and those who are able to see the social media advertisements (e.g., people who use social media platforms or are informed by others who do). Moreover, individually completed surveys lack data that could be produced from interactions between participants, such as in a focus-group setting.

However, there were also significant benefits which resulted from the implementation of the patient survey in the current research study. Particularly, online surveys can access more participants than one or few focus groups can. Indeed, in the current study, over 190 participants were recruited and completed the patient survey. It would not have been possible to collect data from that number of participants in the time and monetary constraints of the current study if a focus group methodology had been used. Moreover, online surveys offer the ability to access a diverse sample of participants in a short period of time. Open-ended survey questions provide participants the opportunity to elaborate on their answers; as such, rich qualitative data was collected.

Because the patient portion of the study was conducted during to the COVID-19 pandemic, it was important to understand if patients' concerns were in response to the temporary changes in health care consequential of COVID-19, or if their responses reflected pre-existing concerns about Nova Scotian health care. Most patient participants noted that the ongoing COVID-19 pandemic did not affect their responses to the survey questions. Though some

participants indicated that their responses may have been affected by their temporary lack of access to health care due to the pandemic, it is evident that most of the concerns patients' shared in the survey are long-standing and have been problematic long before COVID-19 came to Nova Scotia. Indeed, many patients noted their concerns existed before the pandemic (e.g., "no, my problems existed long before now"). Moreover, of the patients who noted that COVID-19 may have impacted their responses, many indicated that the pandemic emphasized problems that already existed in health care in Nova Scotia:

"Yes, in light of the current world circumstances, COVID-19 has brought the holes in our health care system to the surface. I now see the social and cultural importance of supporting our everyday healthcare workers ... these workers need to be paid appropriately for their services and given the support needed to carry out their jobs to the best of their abilities."

And:

"I think that I have felt similarly throughout my adult life, however the COVID-19 pandemic shines a huge light on the current health care models issues. Not enough people are hired, and they are stretched too thin. This leads to many people going without proper care. The system struggles because we need more permanent jobs in this field. We need consistent care from permanent staff and we need to value what alternative practitioners like midwives, nurse practitioners, and mental health specialists provide."

Chapter Eight: Conclusions & Recommendations

Research Insights

Following the data analysis portion of this thesis project, I became aware of a few areas that could be changed to improve the study if a similar research project is conducted in the future. First, several patient survey participants noted that nurse practitioners, in addition to family physicians, are also primary care providers. It would have been useful to include the perspective of nurse practitioners, and to ask patient participants about their experiences with nurse practitioners and family physicians to develop a more comprehensive understanding of primary care delivery in Nova Scotia.

Second, the physician and patient survey questions about participant age were framed in increments of 5- and then 10-years (i.e., 25-30 years, 31-40 years, 41-50 years, etc.). However, Statistics Canada reports age in 5-year increments (i.e., 20-24 years, 25-29 years, 30-34 years, etc.). It would have been useful to align the age increments used in this study to those used by Statistics Canada to allow for a better analysis of representation of the populations for the current study as compared to the general Nova Scotian population.

Furthermore, there was a low response rate from Indigenous persons in the current study. While I did have a collaboration plan in place for the proposed sharing circle, those efforts had to be abandoned as a result of COVID-19 impacts on human research projects. Though some efforts were made to specifically engage with Indigenous participants (i.e., the patient survey was advertised in Facebook groups for Indigenous students, shared via email with Indigenous community leaders, etc. in an effort to avoid low response rates from this group), the efforts were not sufficient. As such, in future research endeavors, more effort must be invested to specifically

recruit and collaborate with Indigenous participants in order to have a more representative population of participants.

Finally, while the online survey was successful in recruiting large numbers of responses, it would have been better to conduct the survey in combination with focus groups as the data would have been richer and a deeper understanding of barriers to care experienced by Nova Scotians would have been obtained. Conducting focus groups following the survey would have allowed us to investigate specific themes that emerged in the survey in more depth. However, due to the COVID-19 pandemic research restrictions, that was not possible for the current project.

Recommendations

Several themes emerged following data analysis of patient and physician perspectives, which informed the following recommendations for primary health care in Nova Scotia. It is evident that further research is required to investigate the specific barriers that Nova Scotians have experienced in attempting to access primary health care. Ultimately, the goal of this research project was to inform future research directions and/or plans of action to improve access to primary health care for all Nova Scotians.

The results from the current study echo results from earlier studies about barriers that Nova Scotians face in accessing primary health care and indicate that these barriers still exist. In particular, recall that Weerasinghe et al. (2012) identified interpersonal barriers that immigrant women in Nova Scotia face in interaction with primary health care providers. Patient participants with various demographic backgrounds from the current study faced similar obstacles (including feeling judged, feeling unheard/not listened to, feeling as though their concerns were not taken seriously) which negatively affected their ability to receive effective care from a family

physician. Accordingly, addressing the interpersonal challenges that patients face in interaction with primary care physicians is necessary. As such, I suggest health care-focused research bodies in Nova Scotia (such as the Nova Scotia Health Authority, Dalhousie School of Medicine, etc.) invest resources to investigate specific interpersonal challenges that may act as barriers to care for Nova Scotians. Further, I suggest the subsequent implementation of training programs/suggested techniques to improve physicians' interactions with their patients in the primary care setting.

Specifically, results from the physician survey suggest that many primary care physicians in Nova Scotia are not persons of colour, and results from the patient survey suggest that some patients of colour in Nova Scotia do not feel they are listened to or taken seriously in the health care setting. Though it is not evident if the two results are linked in a statistically meaningful way, it is concerning that both of these results emerged from the study. Moreover, it is concerning that statistical information about physicians of colour are not available to the public (by Statistics Canada regarding physicians, Doctors Nova Scotia regarding Nova Scotian physicians, nor Dalhousie University regarding medical students). As such, I recommend that race-based data about physicians be examined to determine if patients' experiences (particularly for persons of colour) are impacted by the representation of physicians of colour in Nova Scotia. Moreover, investigations regarding EDI (equity, diversity, and inclusion) practices in medicine in Nova Scotia should be conducted and plans for improvement should be implemented.

Also, concerningly, less than half of physicians in the current study make a moderate to high effort to be culturally inclusive of their patients (of those physicians who do, 100% are women). Similarly, only one-third of physicians in the current study make a moderate to high effort to be inclusive of patients in same sex relationships (87.5% of those physicians are

women). Evidently, there needs to be an increased focus on inclusivity in medicine in Nova Scotia, to improve patients' experiences and ultimately patient health outcomes. Therefore, I recommend that training for physicians (both in medical school, and throughout their careers) should also focus on patient inclusivity, as physicians' efforts to be inclusive of patients with diverse backgrounds ultimately affect patients' experiences and health outcomes in the long term.

Access to primary health care for Nova Scotians is also informed by health care policy at the provincial and federal levels. The current study revealed several themes pertaining to logistical barriers for patients in accessing primary care in Nova Scotia. The particular language (medical jargon) used by primary care physicians was identified as a barrier for one immigrant woman in the current study. Moreover, several patients noted that lack of transportation hinders (and in some cases, inhibits) their ability to access primary health care services. As such, I recommend that the Nova Scotia Department of Health and Wellness invest/increase funds for mediators and/or translators in health care settings for immigrant patients. Further, I recommend that funds (provincial and/or municipal) be allocated to support patients' transportation to service centres, and that access to appropriate funding options be easily available to those in need.

Results and subsequent analyses from the current study have shown that virtual health care delivery options (e.g., telehealth care) are well-liked by Nova Scotians. Indeed, many participants noted that they would like more/improved tele-health services and/or the tele-health services they used during the COVID-19 pandemic were well received. These findings demonstrate that, though there are inevitably difficulties associated with implementation of tele-health services, tele-health delivery is not impossible, and could be a very practical strategy for the future. Moreover, one physician noted that tele-health delivery of primary care services may

help to mitigate some of the current barriers (e.g., transportation, childcare) associated with primary care in Nova Scotia.

It is evident, based on the responses for the patient survey from the current study, that Nova Scotians believe there is a lack of primary care physicians in our province. Though the solution may not be as simple as increasing the number of family care providers (re: Hwang et al., 2017), it is obvious that the allocation of care by family physicians needs to be restructured. Though increasing the number of family physicians in Nova Scotia may mitigate primary care access restrictions that Nova Scotians experience to some degree (and, I fully support efforts to increase the number of family care providers in Nova Scotia), it may be that simply increasing the number of physicians in the area is not sufficient to mitigate barriers to care. Accordingly, I recommend that the Nova Scotia Department of Health and Wellness review and restructure the current plan for the allocation of family physicians in Nova Scotia with the help of researchers who specialize in primary health care provision.

As this thesis project was an exploratory study, and the focus (i.e., physician and patient perspectives of barriers to primary care) has not been explored in the context of Nova Scotia to date, excluding the present study, I recommend that future research projects investigate similar phenomena more deeply. For instance, it would be useful for future research to focus more in-depth on specific barriers (e.g., lack of transportation) that have been highlighted as relevant to Nova Scotians in the current study. I also recommend that future research endeavors continue to focus particularly on the experiences of racialized, Indigenous, and immigrant women in Nova Scotia, as the experiences of these groups in the health care setting are not well researched. Yet, there is ample evidence (peer-reviewed research and anecdotal accounts alike) that these particular populations face unique barriers to health care, which must be addressed in practice.

Research Significance

The goal of this project was to address factors that contribute to the inequities and barriers specific to marginalized populations and their access to care in Nova Scotia.

Investigating the barriers that women with intersecting socially marginalizing characteristics face in accessing primary health care in Nova Scotia is necessary right now. Through developing a greater understanding of the problems that Nova Scotian women face in accessing health care, while considering the perspective of physicians who provide primary care, I was able to collect significant and meaningful data which enabled me to suggest more effective ways to address the health care needs of our population. Patients and physicians alike may benefit from this project as the research findings and subsequent discussion may be used to inform future directions and allocations of primary health care in our province.

Study Limitations

Participant

Online survey participants may have been limited to certain populations of individuals for various reasons. Particularly, factors such as participant availability, interest, concern for health care, among others, may have limited participation. Furthermore, individuals who were able to participate in the online survey were limited to those with internet access and electronic devices that allowed them to complete the survey.

Data collection was limited as a result of the COVID-19 pandemic, as in-person data collection was halted by the university for public health and safety reasons. Accordingly, patient perspectives were collected through online surveys, which unfortunately lack in-person interaction between participants (survey data may have been less rich than the data for which the original planned focus groups may have produced).

Moreover, as data from the patient population were collected during the COVID-19 pandemic, some of the responses may have been skewed unconsciously (e.g., participants' comments about primary care in Nova Scotia may have been informed by the pandemic, even if they were not aware of this consciously). This effect is possible, despite 71.5% of patient survey participants reporting that their responses were not affected by the pandemic.

Personal

As a researcher, I was intimately involved in the production of knowledge from this project, I recognize that I am an outsider from some of the community members who participated in this research (namely, members of the populations of interest: physicians, Indigenous women, women of colour, and immigrant women). I have addressed this limitation through continual support of relationships with participating communities such as the MNFC, and Doctors Nova Scotia who contributed important insights which helped to shape this project.

There were multiple biases (personal and otherwise) that were unavoidably brought into this study which may have affected data analyses. First, my personal biases may have impacted thematic coding/scoring of survey responses for both the patient and physician surveys. Second, my identity as a woman may have influenced data coding, as I may have subconsciously recalled my own experiences while scoring participants' responses. In an ideal situation, more than one researcher would code responses and any discrepancies in coding decisions would be resolved by a third coder.

Moreover, since I was the only researcher directly involved in data analysis, I analyzed one survey with the knowledge of the other survey results in mind. Particularly, the physician survey was analyzed before the patient survey. As such, results from the physician survey may have informed how I interpreted the results from the patient survey. My interpretations of the

results from the patient survey may have also been informed by cultural biases that I may hold as a relatively privileged, white, English-speaking academic female researcher. Importantly, both sets of questions were created prior to any data analysis.

Study Contributions

Feminist Scholarship

This research project has contributed to feminist scholarship through critiquing the androcentric, Eurocentric, and neoliberal nature of the Canadian health care system. Further, the qualitative nature of this project provided rich, in-depth data that cannot be achieved through traditional positivist research in the social sciences. An intersectional analysis strengthened the broader understanding of barriers that women face in accessing health care in the context of Nova Scotia. These findings may be used to inform understandings about barriers to care on a larger scale.

Substantive Benefits

Ideally, this research project will improve substantive knowledge about access to primary care in Nova Scotia for key stakeholders. Following data analysis, I have thought about and subsequently proposed changes for primary care in Nova Scotia at various levels: interpersonal change (i.e., physician-patient relations), regional/local change (i.e., suggesting resources for increasing women's access to care) and provincial policy change. Additionally, participants may have benefited from the study by resolving stresses about access to primary care through detailing the challenges they have had in accessing primary care in Nova Scotia to the research team via the online patient survey.

Research findings will be shared with Doctors Nova Scotia in a brief report. They may use the information detailed in the report to inform future research projects, and/or they may choose to share these results with the community of physicians in Nova Scotia.

Conclusion

The objectives of this research study were to understand physicians' perspectives about barriers that women face in accessing primary health care in Nova Scotia, patients' perspectives about the barriers that they face in accessing primary care in Nova Scotia (with a particular focus on Indigenous women, women of colour, and immigrant women) and to compare the perspectives of physicians and patients.

Data analyses revealed that younger/less experienced physicians were more likely to identify barriers for women in accessing primary health care in Nova Scotia than older/more experienced physicians. Several themes emerged from patients' responses about the barriers they have faced (both physical barriers and barriers to effective care). It is evident that physicians and patients (from various demographic backgrounds) believe that there are barriers for Nova Scotians in accessing primary health care, and that the challenges particularly impact marginalized populations. Subsequently, recommendations for improved primary health care delivery and design were made based on the responses accumulated from both the patient and physician surveys.

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Appendix A

Physician Survey

Section 1: Family Medicine

1. How long have you been practicing family medicine?
 - 1-9 years
 - 10-20 years
 - 21 years or more

2. Do you think that women (in particular) face barriers in accessing primary health care in Nova Scotia?
 - Yes
 - No

3. Do your female patients ever note difficulty attending doctors' appointments due to transportation difficulties?
 1. Very rarely
 2. Rarely
 3. Occasionally
 4. Often
 5. Very often

4. Do your female patients ever note difficulty attending doctors' appointments due to difficulties securing childcare?
 1. Very rarely
 2. Rarely
 3. Occasionally
 4. Often
 5. Very often

5. Do your female patients ever note difficulty attending doctors' appointments due to difficulty missing work?
 1. Very rarely
 2. Rarely
 3. Occasionally
 4. Often
 5. Very often

6. Do your male patients ever note difficulty attending doctors' appointments due to

transportation difficulties?

- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
7. Do your male patients ever note difficulty attending doctors' appointments due to difficulties securing childcare?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
8. Do your male patients ever note difficulty attending doctors' appointments due to difficulty missing work?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
9. a) Are female patients of yours ever accompanied by a male spouse or partner?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
- b) Of your female patients who are accompanied by a male, does the male spouse or partner speak for the female patient?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
 - 6. Not applicable
10. Do your female patients ever bring their children with them to appointments?

- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
11. Do your male patients ever bring their children with them to appointments?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
12. Do your female patients come to your practice complaining of physical symptoms for emotional or psychological stressors (i.e., major life changes)?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
13. Do your male patients come to your practice complaining of physical symptoms for emotional or psychological stressors (i.e., major life changes)?
- 1. Very rarely
 - 2. Rarely
 - 3. Occasionally
 - 4. Often
 - 5. Very often
14. To what extent do your female patients downplay their symptoms?
- 1. Not at all
 - 2. Slightly
 - 3. Moderately
 - 4. Very much
 - 5. Extremely
15. To what extent do your female patients amplify their symptoms?
- 1. Not at all
 - 2. Slightly
 - 3. Moderately

- 4. Very much
 - 5. Extremely
16. To what extent do your male patients downplay their symptoms?
- 1. Not at all
 - 2. Slightly
 - 3. Moderately
 - 4. Very much
 - 5. Extremely
17. To what extent do your male patients amplify their symptoms?
- 1. Not at all
 - 2. Slightly
 - 3. Moderately
 - 4. Very much
 - 5. Extremely
18. On average, how many women of colour (i.e., not white/Caucasian) do you treat per month?
- 0-5
 - 6-10
 - 11-15
 - 16-20
 - 21+
 - I don't know
19. On average, how many Indigenous women do you treat per month?
- 0-5
 - 6-10
 - 11-15
 - 16-20
 - 21+
 - I don't know
20. On average, how many immigrant women do you treat per month?
- 0-5
 - 6-10
 - 11-15
 - 16-20
 - 21+
 - I don't know

21. Do you make an active effort to be inclusive of people of cultures different than your own in your practice?

- Yes
- No

If yes, please explain how: _____.

22. Do you make an active effort to be inclusive of people in same sex partnerships in your practice?

- Yes
- No

If yes, please explain how: _____.

Section 2: Demographic Information

23. Do you self-identify as. . .

- Woman
- Man
- Trans-woman
- Trans-man
- Two-spirit
- Non-binary
- Other: _____

24. What age group do you belong to?

- 25-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71+

25. Do you identify as a person of colour (i.e., not white/Caucasian)?

- Yes
- No
- Prefer not to say

26. Do you identify as an Indigenous person?

- Yes
- No
- Prefer not to say

27. Did you immigrate to Canada?

- Yes
- No

28. Are you a permanent resident or a Canadian citizen?

- Permanent resident
- Canadian citizen
- Other: _____

29. If you immigrated to Canada, how long have you been living here? _____.

30. Do you belong to any other minority group?

- Yes
- No
- Prefer not to say

31. Please name the city/town in which you practice: _____.

32. Is there anything else you would like to mention to the researchers that may be relevant to this study?

Appendix B

Patient Survey

Section 1: Primary (Family) Health Care

Please answer these questions as they relate to your own primary health care.

1. Do you have a family doctor?
 - Yes
 - No, but I am on a waitlist
 - No, and I am **not** on a waitlist

2. In which area do you access primary health care services (i.e., from a family physician or walk-in clinic)?
 - Central Zone (Halifax area, Eastern Shore and West Hants)
 - Eastern Zone (Cape Breton, Guysborough and Antigonish areas)
 - Northern Zone (Colchester-East Hants, Cumberland and Pictou areas)
 - Western Zone (Annapolis Valley, South Shore and South West)

3. If you do not have a family doctor, how do you access health care services?
 - I go to a walk-in clinic
 - I go to the emergency room (in cases when it is not an emergency) because there is no other option available for me
 - I primarily use alternative medicine services (i.e., naturopathic medicine, homeopathy, osteopathy, etc.)
 - Not applicable (I have a family doctor)
 - Other (please elaborate): _____

4. Has there ever been anything (e.g., lack of transportation or money for transport, lack of childcare, inability to leave work, etc.) that has prohibited you from accessing primary health care (i.e., care provided by a family doctor) when you needed it? Please elaborate on your answer.

5. Have you ever felt as though you have been treated unfairly (i.e., spoken down to you, not explained treatments fully to you, etc.) in a health care setting because of your gender? Please elaborate on your answer (e.g., how did this make you feel, what was your response to this way of being treated, did this affect your ability/desire to access further health care?).

6. Have you ever felt that you have been treated unfairly (i.e., spoken down to you, not explained treatments fully to you, etc.) because of your culture and/or socioeconomic status

(i.e., your education, income level, occupation, etc.) in a health care setting? Please elaborate on your answer (e.g., how did this make you feel, what was your response to this way of being treated, did this affect your ability/desire to access further health care?).

7. What changes would you like to see in health care in Nova Scotia?
8. Do you think that your responses to the questions in this survey have been affected by the current COVID-19 (Corona Virus) pandemic? If so, please explain how.

Section 2: Demographic Information

9. Do you self-identify as...
 - Woman
 - Man
 - Trans-woman
 - Trans-man
 - Two-spirit
 - Non-binary
 - Other: _____
10. What age group do you belong to?
 - 18-24
 - 25-30
 - 31-40
 - 41-50
 - 51-60
 - 61-70
 - 71+
11. Do you identify as a person of colour (i.e., not white/Caucasian)?
 - Yes
 - No
 - Prefer not to say
12. Do you identify as an Indigenous person?
 - Yes
 - No
 - Prefer not to say
13. Did you immigrate to Canada?

- Yes
- No

14. Are you a permanent resident or a Canadian citizen?

- Permanent resident
- Canadian citizen
- Other: _____

15. If you immigrated to Canada, how long have you been living here? _____.

16. Do you belong to any other minority group?

- Yes
- No
- Prefer not to say

17. Is there anything else that you would like to mention to the researchers that may be relevant to this study?

Q.7 Male Childcare			r= 0.408* p= 0.031 n= 28		r= 0.559** p= 0.002 n= 28			r= 0.416* p= 0.028 n= 28							
Q.8 Male Work			r= 0.395* p= 0.037 n= 28			r= 0.519** p= 0.005 n= 28									
Q.9 Female Brings Male Partner							r= -0.557** p= 0.002 n= 28								
Q.13 Male Psych Stress								r= 0.648** p= 0.000 n= 27							
Q.15 Female Amplify Symptoms				r= -0.444* p= 0.020 n= 27					r= 0.520** p= 0.005						
Q. 16 Male Downplay Symptoms					r= -0.428* p= 0.029 n= 26								r= 0.496** p= 0.010 n= 26		
Q. 17 Male Amplify Symptoms					r= -0.439* p= 0.022 n= 27								r= 0.496** p= 0.010 n= 26		
Q.18 No. WOC Patients														r= 0.415* p= 0.28 n= 28	
Q.19 No. Indigenous Women Patients														r= 0.424* p= 0.024 n= 28	

Q.20 No. Immigrant Women Patients												r= 0.844** p= 0.000 n= 28	r= 0.455* p= 0.015 n= 28			r= 0.419* p= 0.26 n= 28
Q.22 Inclusive of Same Sex	r= 0.392* p= 0.043 n= 27		r= -0.430* p= 0.025 n= 27	r= -0.393* p= 0.042 n= 27										r=0.500** p=0.008 n=27		
Q.24 Age	r= 0.948** p= 0.000 n= 28	r= 0.487** p= 0.010 n= 27												r= 0.374* p= 0.050 n= 28		