

# “Multiple margins” (being older, a woman, or a visible minority) constrained older women’s access to Canadian health care

Kinch JL, Jakubec S. Out of the multiple margins: older women managing their health care. *Can J Nurs Res* 2004;**36**:90–108.

**Q** What are older women’s experiences with the Canadian healthcare system? How do they manage their health and access health care?

## DESIGN

A feminist phenomenological study.

## SETTING

Calgary, Alberta, Canada.

## PARTICIPANTS

32 Canadian women who were 65–83 years of age. 14 were Caucasian, 11 Ismaili, 3 Aboriginal, and 4 Japanese.

## METHODS

Participants were interviewed (for 1.5 to 2.5 h) in 5 small groups of 3–11 women. A follow up interview was held with 5 members of 1 group. Interviews were audiotaped, transcribed, and analysed for emergent themes.

## MAIN FINDINGS

4 themes were identified within and across the interviews. *Femininity, relationships, and means of support.* The women were intrigued by the concept of sharing their stories in an organised discussion (eg, “We always get together and we sit around and talk, but never discussing the ...the personal things”). Examples of “personal” matters included the loneliness they had endured after spending years in various relationships in their working and personal lives. They made a connection between extreme loneliness and widespread depression.

*Health information and the politics of access to care.* 2 areas stood out under this theme. (1) Technologies of support and isolation. Some participants used computers (and the internet) and technology such as television to mediate support in the face of their isolation. For other women, friends were central to the management of their health. One woman described community support given to a friend who had recently died at home: “She didn’t go into hospital, everybody was there... We looked after one another, and we decided we would be each other’s advocates.” (2) Access to health care. Many women seemed to lack knowledge about how to access services (eg, where to go, who to ask, how to navigate the system, and how to avoid long waits in the emergency department), as well as specific health information. This lack of access was compounded by poverty and environmental factors. For many participants, family and cultural groups were their means of accessing health services.

*The supportive role of faith, religion, and tradition.* Women consistently reported faith and religious affiliation as central to their health. Some reported that in times of need, “prayer letters come from all over,” or “it’s the traditions, the incense I turn to.” Those from the First Nations community relied on traditional remedies, and some consulted with elders about their health.

*Abuse and power.* 3 subthemes of abuse and power were identified. (1) Historical tensions. First Nations and Japanese Canadian women spoke about historical abuses, explaining that traditional knowledge and practices had helped them to persevere and overcome injustices of the last century. (2) Unspeakable stories. Women reported feeling guilty and full of shame for many years over secrets about verbal and emotional abuse during long term marriages to men considered good

husbands and good neighbours. The topic arose during a discussion about the deaths of their husbands and having to adjust to a new lifestyle, which some found to be fulfilling. (3) Lack of understanding, poverty, and the politics of poverty. The issue of being treated differently was addressed in all groups. Ismaili women struggled the most in their pursuit of healthcare services. They were hesitant to criticise what they perceived as a flawed system. Many managed to obtain the information they needed by consulting their pharmacists who also served as translators. When their needs were still not being met, many women waited until their condition worsened. One woman’s comment suggested ageist, cultural, and gendered marginalisation: “We are women; we are not allowed to complain.”

## CONCLUSIONS

Older Canadian women managed their health care privately, with the support of family, friends, and voluntary organisations. However, being older, a woman, and a visible minority constrained and challenged their access to equitable health care.

## Commentary

It has repeatedly been acknowledged in research studies that healthcare systems should strive to extend and improve the nature and scope of services to better meet the needs of older women. These needs and associated healthcare priorities often differ from those of older men.<sup>1 2</sup>

The findings of the study by Kinch and Jakubec support the view that older women have complex needs and that they often have problems negotiating the healthcare system.<sup>1 2</sup> Ironically, Kinch and Jakubec further identified that when support was provided by family, friends, and cultural groups, healthcare providers may have assumed that the recipient had both the opportunities and abilities to access all relevant forms of care with the aid of such support.

The researchers suggested that opportunities to reflect on their experiences in negotiating the healthcare system helped these women to identify factors that led to their marginalisation in society: old age, female gender, and membership in a visible minority.

Several marginalised groups were included in this study. It was unclear which findings were found across all groups. The study could have been strengthened by including more participants in the smaller groups and recurrent data gathering sessions. The relatively small number and size of groups and the brevity of the contact limited the depth of understanding and transferability of the findings.

The findings of Kinch and Jakubec highlight the importance of carrying out active, detailed assessments with older women in order to more comprehensively determine their healthcare needs and expectations. The study also highlights the importance of considering the effects of marginalisation (age, gender, and culture) on access to healthcare services.

Diane Pirner, RN, MN  
School of Nursing, Ryerson University  
Toronto, Ontario, Canada

1 Tannenbaum C, Mayo N. Women’s health priorities and perceptions of care: a survey to identify opportunities for improving preventative health care delivery for older women. *Age Ageing* 2003;**32**:626–35.

2 Tannenbaum CB, Nasmith L, Mayo N. Understanding older women’s health care concerns: a qualitative study. *J Women Aging* 2003;**15**:103–16.

For correspondence: Dr J L Kinch, Faculty of Nursing, University of Calgary, Alberta, Canada. [jkinch@ucalgary.ca](mailto:jkinch@ucalgary.ca)

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