



Contradictions:

Health Equity and Women's Health Services in Toronto



WELLESLEY INSTITUTE
a decade of advancing urban health



Commissioned Research

Commissioned research at the Wellesley Institute targets important new and emerging health issues within the Institute's priority research areas. The projects commissioned may speak to current policy issues, or they may seek to inform and help shape deliberation on policy issues just over the horizon. Wellesley's Commissioned research reflects community voices, interests, and understandings, and includes the community fully in the research wherever possible.

About the Authors

Tamara Daly, Ph.D.

York University, School of Health Policy and Management, Faculty of Health

Pat Armstrong, Ph.D.

York University, Department of Sociology, Faculty of Arts

York University, Graduate Programme in Women's Studies, Faculty of Graduate Studies

CHSRF/CIHR Chair in Health Services and Nursing Research

Hugh Armstrong, Ph.D.

Carleton University, School of Social Work

Susan Braedley, M.S.W., Doctoral Candidate

York University, Department of Sociology, Faculty of Arts

Vanessa Oliver, M.A., Doctoral Candidate

York University, Graduate Programme in Women's Studies, Faculty of Graduate Studies

[With research assistance from](#)

Monnah Green, M.A. Doctoral Candidate

York University, Department of Sociology, Faculty of Arts

Sabiha Merali Merchant MES

York University, Graduate Programme in the Faculty of Environmental Studies

Kate Rexe, M.A.

Carleton University, Institute of Political Economy

Table of Contents

| | |
|--|----|
| Acknowledgements | 4 |
| I. Executive Summary | 5 |
| i. Equity Planning for Women's Health Services | 7 |
| ii. Responding to Diversity | 8 |
| iii. Matching System Level Priorities to Organizational Level Innovations | 9 |
| iv. Measuring Different Outcomes and Adopting Different Funding Approaches | 9 |
| v. Supporting Women's Health Research | 11 |
| II. Introduction | 12 |
| a. Women's Health Services in Toronto | 12 |
| b. Method | 13 |
| i. Data Collection Sites | 14 |
| ii. Community Advisory Group | 14 |
| iii. Data Sources | 14 |
| c. What are Women's Health Services? | 15 |
| d. Why Do We Need Different Strategies for Women's Health Services? | 16 |
| i. Reproductive and Sexual Health | 17 |
| ii. Cardiovascular Disease | 17 |
| iii. Mental Health | 18 |
| iv. HIV/AIDS | 19 |
| III. Health Reform and Women's Health Services | 20 |
| a. Women's Health Services in Toronto | 20 |
| IV. Discourses, Constraints and Practices | 23 |
| a. Women's Health Philosophy and Culture | 24 |
| b. Patient Equity: Less Access and More Inequity with Increased Private Payment .. | 28 |
| c. Maintaining a Healthy Workplace | 30 |
| V. Strengths, Distortions and Gaps in Women's Health Services | 32 |
| a. Reproductive and Sexual Health | 34 |
| b. Mental Health | 36 |
| c. HIV/AIDS | 37 |

| | | |
|-------|---|----|
| d. | Cardiac Care | 37 |
| e. | Innovative Services | 37 |
| VI. | Communities' Voices..... | 38 |
| a. | Constrained Voices | 38 |
| b. | Communities' Needs | 39 |
| i. | Gaps in Women's Health Services..... | 40 |
| c. | Responding to Diversity..... | 47 |
| VII. | Accountability and Action | 49 |
| a. | Accountability and Measurement | 49 |
| VIII. | Health Equity for Women's Health: Conclusions and Recommendations | 54 |
| a. | Policy Development..... | 55 |
| i. | Equity for Women's Health Services..... | 55 |
| ii. | Responding to Diversity | 56 |
| iii. | Matching System Level Priorities to Organizational Level Innovations..... | 57 |
| iv. | Different Outcomes With Different Funding Approaches | 58 |
| b. | Women's Health Research: Beyond Structural and Service Barriers..... | 59 |
| IX. | References..... | 61 |

Acknowledgements

The authors gratefully acknowledge the Wellesley Institute for research funding for the project: Women's Health Services in Toronto: Assessing Economic, Social and Philosophical Costs of Changes (1990 –2007). The authors also gratefully acknowledge funding from Dr. Pat Armstrong's CHSRF/CIHR Chair in Health Services and Policy Research.

We also are grateful to all of the people who agreed to act as liaison, key informant or focus group member.

The views expressed in this report are those of the authors. Any limitations, errors or omissions are solely our responsibility.



I. Executive Summary

Health equity is, as Lesley Doyal (2000) argues, about women's, and men's access to the health care resources needed to achieve their health potential. It is about reducing, if not eliminating, structural and health system barriers that contribute to health disparities. Structural barriers include macro-level social, political, cultural, and economic circumstances that privilege some people and disenfranchise others. This report draws on the growing body of research that demonstrates health disparities for and amongst women as a result of structural barriers.

Health services barriers, the focus of this report, are the meso-level constraints imposed by current ways of financing, delivering, and organizing services, and of supporting programs of research. These barriers result from existing ways of doing things, such as funding processes, rules of accountability, and engaging with the community. This report contributes to the literature on health system barriers by investigating how they add to women's inequality of access to health services, arguing that current health system barriers prevent us from adequately addressing women's health disparities in Toronto.

All health services are women's health services. There is a tendency for policy-makers, managers and even clinicians to assume that women's health is only about the distinct body parts that women have or about giving birth because it is something unique to women. But this view of women's health ignores two things. First, by concentrating on biology, it ignores the complex gendered experiences of everyday life that contribute to health; and second it ignores the reality that women's equal access to health and health services are not being fully addressed by existing ways of doing things.

While women have many things in common, different women have different gendered life experiences that depend, among other social locations, on her class, race /ethnicity, and sexual orientation, and/or whether she experiences a disabling impairment or illness. As a consequence, in this report, when we look at women's health services, our starting points are the health needs of diversely-situated women, and, in terms of services, included the entire spectrum of health services that women need based on their unique gendered and biological requirements.

Our findings are based on a qualitative study, which investigates changes to women's health services in Toronto between 1990 and 2007. We triangulate data from key informant interviews, focus groups, and archival document analysis. We assess the practices, policies and services of two hospital-based sites in the city to understand issues affecting women's health services funding, delivery, organization, and research but it is not a case study of two hospitals. Rather, it is a case of changes to women's health service delivery in Toronto using two data collection sites: an Ambulatory Care Centre and a Community Hospital. We chose to concentrate on hospital-based services because they are the formal sites of insured publicly funded health services provision. But, we also looked outside of hospitals to understand the ways that

hospital services are linked to services provided in the community. While keeping an eye on all women's services, we further narrowed our focus to concentrate on four broad areas of women's health services for which a growing body of literature provides the rationale for a tailored health services approach: reproductive and sexual health; mental health; cardiovascular health; and HIV/AIDS. We chose the first area because it is traditionally associated with women's health. Mental health services are one area in which there is increasing evidence in favour of using a gendered approach. In the case of cardiovascular health, ample evidence points to sex- and gender- based disparities for women accessing services. Finally, more research and attention is being focused on HIV/AIDS as growing numbers of women, many from marginalized groups, are increasingly vulnerable to HIV transmission and are now living with what has become a chronic and manageable condition.

The report is organized to reflect issues at each of the sites, but we refer to the sites as an Ambulatory Care Centre and a Community Hospital, rather than by name, reflecting the fact that our case is women's health services in Toronto, and not a case study of each of the sites. It is organized into the following sections.

- Section I discusses the study's method, our definitions of health equity and women's health services, and the evidence supporting the use of different strategies when caring for women's health.
- Section II documents the history of women's health services reforms in Toronto since 1990, and reviews what happened at each of the two sites during the period of health reform.
- Section III presents findings from the interviews, focus groups and archival document analysis. It explores the gaps between the discourses of women's health and factors that mediate these gaps. It explores how the sites articulate and operationalize their women's health services philosophy and culture; equity of access for patients including areas of increased privatization for women's health services; and how the sites maintain healthy workplaces.
- Section IV further identifies the strengths, distortions and gaps emblematic of the contradictions inherent in women's health services funding and delivery in Toronto. We provide specific examples from the areas of reproductive and sexual health; mental health; HIV/AIDS and cardiac care.
- Section V identifies programs that have been closed, transferred or off-loaded to the community; what has happened to the communities' voices following the changes made at each of the sites; and the accountability regimes that govern each site's actions.
- Section VI discusses how each site manages issues of accountability.

- Section VII provides our conclusions and recommendations about future policy action and further research.

The study's focus was finding out how, where, why and by whom existing services are funded and delivered, and what elements we need to consider in designing health services to meet diverse women's needs. Our findings fall into 4 areas all arguing that responding to women's health equity and health diversity must be Ministry and LHIN priority areas.

i. Equity Planning for Women's Health Services

Despite the increasing volume of good research documenting disparities in women's access to health services in many clinical areas, most services are neither funded nor delivered using gender- and sex- based lenses. If organizations continue to operate as though women's health is primarily about reproductive and sexual health, and not about all health services, then there will continue to be serious inequities and poorer outcomes for women's health across the province.

In some instances, positive change may be hampered by administrators' and policy-makers' inadequate approaches to addressing equity. Treating everyone the same is not equitable. To be equitable, women's health requires different approaches than men's health. It requires that resources be shifted to target the needs of diversely situated women, acknowledging that women do not currently access services in the same ways as men, present with the same symptoms, have the same supports available to care for them when they are sick, nor require the same clinical interventions.

Even when organizations have taken the initiative to develop women's health programs, and a vision for women's health, our research shows that there may be problems with sustaining or implementing programs which address women's health needs, highlighting how internal discursive logics are hampered by political pressures and priorities that pull attention or resources away from fully implementing women's health visions about training, research and practice. There must be a system level response to this serious inadequacy. Key recommendations include:

- The Ministry and all LHINs should require hospitals to adopt a health equity plan. Hospitals' health equity plans must acknowledge that:
 - Health equity is not about treating everyone the same; it is about how men and women can access health care resources to achieve their health potential.
 - Gender and biology contribute to health.
 - All services must be considered women's health services.
 - Women's health services, delivered in a way that acknowledges the needs of diversely-situated women, need to be targeted as current ways of delivering services are not meeting women's health needs.

- Hospitals must implement a culture that questions whether and how well women are able to access services.
 - Hospitals must adopt performance measures related to women's access to service, and women's health outcomes.
- The Ministry and the LHINs must adopt broader definitions of women's health services including, but more expansive than, reproductive and sexual health. The Ministry must support women's health by targeting more funding for gender-based and sex-based women's health research.
- In its stewardship role, the Ministry must demonstrate a commitment to supporting equity for all women's health services (not just some reproductive and sexual health services). Strategies to accommodate equity need to take both sex and gender into account. In other words, biological and social, economic and political experiences contribute to ill health and must be incorporated into health models.
- The Ministry must ensure that women's equitable access to targeted care services is given priority attention by being treated as a critical issue across the province.
- The LHINs must direct hospitals to incorporate a broad definition of women's health into their clinical areas, and to adopt performance indicators and standards to measure progress in terms of equitable access.
- The LHINs must ensure that funding flows to individual hospitals to properly implement plans to address local health needs of diversely situated women.

ii. Responding to Diversity

Diversity issues are not sufficiently addressed at hospital, regional, or ministerial levels. Programs that target specific cultural groups are lacking. Language translation services and staff training in cultural competency need attention and improvement. Programs that address diversity must not only consider race / ethnicity and culture, but also ability, sexual orientation and identification, as well as the needs of the poor, homeless, socially isolated, and disadvantaged.

Hospitals need to reach out to their immigrant populations and people who are marginalized, socially disadvantaged and/or isolated. To do this, hospital staff should work with community organizations to create programs located in the community close to the places where people who require these services reside. Relationships with the community may improve if the hospitals could make efforts to have staff and physicians create substantive connections with community organizations, which would help to improve patient referral in both directions.

- The Ministry and the LHINs need to incorporate a vision of health that addresses the complexity of diversity and that funds hospitals to do more than worry about who comes through the door.

- Hospitals need to be empowered (funded) to be community leaders and to help to engage with and lead innovative change. Addressing immigrant women's health and that of the socially disadvantaged is crucial.
- The Ministry and all LHINs should require hospitals to implement a diversity policy, grounded in an analysis of the demographics and needs of their patient populations. Everything from translation, to food choice (e.g. Kosher, Halal, Asian etc.), and availability of take-home information should be considered and should appropriately reflect the cultural composition and literacy of their local patient populations.

iii. Matching System Level Priorities to Organizational Level Innovations

Current methods of *counting* accountability, which emphasize financial and quantitative measures, but do not consider other measures of quality, do not adequately support alternate practices that represent improved equity for diversely situated women. Policy makers must consider accountability more broadly than as a process of counting service units and budgets. Accountability should reflect rigorous qualitative and quantitative measurement and analysis. Important outcomes are lost, and programs are discontinued, when outcomes measurement and accountability rules are too narrowly focused on financial or short-term outcomes data, but ignore the spectrum of experience that come with details and contexts.

- How the Ministry and LHINs "count" accountability and measure outcomes require re-evaluation, as narrowly defined measurement and accountability regimes are inadequate and miss important qualitative measures of quality.

The Ministry needs to prioritize women's health across the province by emphasizing women's health outcomes, performance indicators and standards in accountability reporting frameworks. Teaching, research and clinical practice for all health conditions must be gender- and sex-based, as a major part of attaining equitable health care.

- The Ministry and LHINs must be evaluated on the extent to which they implement gender- and sex-based- outcome criteria, performance indicators and standards into accountability reporting frameworks.

iv. Measuring Different Outcomes and Adopting Different Funding Approaches

The Ministry and LHINs need to amend the incentive structures in the priority areas of women's health equity and health diversity. The acute care disease model is not completely attuned to the ways in which the majority of women experience ill health. But, the current hospital-funding model does not adequately reward an integrated, chronic approach to health care, or a careful reflection of managing diversely situated patients and providers.

The Ministry and LHINs should:

- Fund hospitals and community organizations to jointly address chronic health problems and diseases. Hospitals are increasingly focusing on problems that are acute and episodic and are downloading chronic health problems to the community. The community lacks resources to properly address the gaps in service.
- Identify how to best facilitate these relationships by implementing sustainable project- and program- based operational funding and partnering on coordination.

Innovative programs that are interdisciplinary in nature and address a wide gap in service are lost when stable operational funding is not secured. In order to create program continuity and to allow for innovation that develops over time, the Ministry and LHINs must address the ways in which innovative programs are assessed and funded.

- The Ministry and LHINs must support innovative programs that cross professional practice areas, service areas (e.g. health, social welfare, education) and are multi-institutional (involving more than one hospital or community organization) with stable operational funding, moving away from the current emphasis on short-term program-funding.
- It is important to create funding agreements that maintain sufficient staff resources and create interdisciplinary teams;
- Put in place access to long-term funding for innovative programs that can demonstrate research and clinical importance;
- Long-term funding for innovative cross-disciplinary programs should draw on the hospital's global budget;
- Provide funding for hospital-community linkages.

The Ministry and the LHINs need to evaluate the current funding model and consider implementing different funding models, especially in academic settings, so that innovative programs that can demonstrate leading edge research and a financial need are able to access additional operational funding, which may improve the dissemination of best practices to other community hospitals. In order to achieve this goal, the Ministry should consider the following:

- Implementing salaries for doctors working in areas of research and clinical significance where there is a good possibility for amending knowledge and practice;
- Financially supporting innovative approaches that seek to promote wellness and address "chronic" health problems with outcomes that are longer term and more qualitative in nature.
- Funding the development and on-going creation of interdisciplinary teams that adequately address the ways in which women need, and want, to use health services.

v. Supporting Women's Health Research

The Ministry and LHINs must support excellence in Women's Health Services research and service delivery by:

- Protecting the links between clinical work, research and innovation;
- Championing women's health equity and diversity planning across the province;
- Strongly supporting and funding leading edge sex- and gender-based health research, research infrastructure and research chairs across the province;
- Providing operational funding to organizations that maintain avenues for virtual women's health networks; and
- Cultivating open arenas of exchange for knowledge mobilization between research, program design and delivery, and clinical practice by implementing performance measures and standards.

Researchers' development and assessment of women's health indicators and outcomes must continue to be supported, but with an important caveat. Use of indicators, and the measurement of outcomes, must not be confined to readily available data, financial indicators, or standard clinical metrics, which tell us little about the people receiving care.

- Policy-makers and researchers must identify and develop indicators based on what we need to know, and then build measurement and data collection systems around this. Our current emphasis on using readily available data is not meaningful in terms of outcomes or accountability.

Far from arguing that greater equity can be achieved by providing the same services for everyone, this report argues that funding priorities and rules must better accommodate and target the needs of diversely situated women.

II. Introduction

a. Women's Health Services in Toronto

Since the restructuring and reorganization of Ontario's health care sector in the late 1990s, many different "baskets" of health services have been retrenched, restructured or cut because, though formerly part of the province's publicly funded system, these services were not mandated by the Canada Health Act (1984) and protected with federal financial transfers. Urban women's health services, which are provided with a women-centred, community-focused philosophy, constitute a unique basket of these health services.

This study used qualitative methods to investigate changes to the organization, delivery and funding of women's health services in Toronto for the period from 1990 to 2007. We gauge the extent to which services have been privatized (i.e. requiring out-of pocket payment); retrenched (e.g., less service due to long wait lists); internally re-organized; improved; shifted to the community; ignored; or have disappeared altogether. We also assess changes to the location, accessibility, and availability of care for women, and the women-centred philosophy guiding care delivery despite provincial legislative protections for women's health services.

While the study defines women's health care broadly to include all services provided to women across the continuum of care, it focuses on four health services areas: reproductive and sexual health; mental health; HIV/AIDS; and cardiac care. In addition to focusing on four health service areas, we also focused on two organizations to better understand some of the trends and issues affecting women's health services. The first organization is an academic **Ambulatory Care Centre** focused on providing health services for women and research in the area of women's health; the second is an acute care **Community Hospital** serving a particular geographic catchment area.

The report is organized into the following sections:

- Section I discusses the study's method, our definition of women's health services, and the evidence supporting the use of different strategies when caring for women's health.
- Section II documents the history of women's health services reforms in Toronto since 1990, and reviews what happened at each of the two sites during the period of health reform.
- Section III presents findings from the interviews, focus groups and archival document analysis. It explores the gaps between the discourses of women's health and factors that mediate these gaps. It explores how the sites articulate and operationalize their women's health services philosophy and culture; equity of access for patients including areas of increased privatization for women's health services; and how the sites maintain healthy workplaces.

- Section IV further identifies the strengths, distortions and gaps emblematic of the contradictions inherent in women's health services funding and delivery in Toronto. We provide specific examples from reproductive and sexual health; mental health; HIV/AIDS and cardiac care.
- Section V identifies programs that have been closed, transferred or off-loaded to the community; what has happened to the communities' voices following the changes made at each of the sites; and the accountability regimes that govern each site's actions.
- Section VI discusses how each site manages issues of accountability.
- Section VII provides our conclusions and recommendations about future policy action and further research.

Competing philosophical, political, research, and resource allocation agendas govern the delivery of health services for women in Toronto. On one side are those who continue to define women's health largely in terms of reproduction, and operationalize health services for the whole population without specifically addressing women's unique biological and social needs. On the other side are the proponents of unique health approaches and practices following feminist organizational theory and practice, and acknowledging the relevance of a woman's experiences for her health, a consultative patient-provider relationship, and a multi-disciplinary team-based approach to medicine.

Among the report's findings, we explore how philosophies of women's health are operationalized within each site by interrogating discourses and organizational practices of caring for women – both as patients and providers of care – in these two care settings. In particular, taking note of the spaces between discourse and practice, we analyse who is and is not cared for; who provides the care; and how the organizations are challenged in the practice of their caring. Our research shows examples of both exemplary service delivery and areas that require further investment or re-organization. There are many contradictions in the funding and delivery of women's health services in Toronto, which raise questions about the equity of women's health services funding and delivery.

b. Method

This qualitative study investigates changes to women's health services in Toronto between 1990 and 2007. Although the study uses the services provided at two sites to understand issues affecting women's health services funding, delivery and organization, it is not a case study of two hospitals. Rather, it is a case of changes to women's health service delivery in Toronto using two data collection sites. We chose to look at services in hospitals because they are the formal sites of public health services provision. We have situated our analysis of the health services provision at the two sites, based on what community-based women's health services providers indicate is required. We further narrowed our focus to concentrate on four areas of women's health services: reproductive and sexual health; mental health; HIV/AIDS;

and cardiovascular health. Our reasons for choosing these particular areas are provided in more detail below.

The report is organized to reflect issues at each of the sites, but we refer to the sites as an **Ambulatory Care Centre** and a **Community Hospital**, rather than by name, reflecting the fact that our case is women's health services in Toronto, and not an individual case study of each of the sites.

i. Data Collection Sites

The **Ambulatory Care Centre** has provided more than a century of woman-centred approaches to health care. The hospital started as a training ground for women health practitioners who were, at that time, barred from studying at medical school. Over time, the hospital also became known as a place where women could exercise reproductive choice.

The **Community Hospital** was established in the 1920s. The hospital currently identifies itself as an acute care community teaching hospital, which provides inpatient acute care, day medicine, day surgery, ambulatory care, emergency services and community programs and services. Its origin is as a general hospital providing health services that stretch beyond the traditional definition of a non-teaching community hospital, and includes services such as a high-risk nursery unit. The hospital's community is geographically bound, and it is the only acute care hospital within its boundaries; however, it also provides some patient services extending beyond its catchment area. As a point of reference, females comprised 56% of the hospital's patients in the year 2005.

ii. Community Advisory Group

We formed a community advisory group comprised of four people who are very knowledgeable about women's health in the city. The advisory group members were helpful in identifying key informants and documents, and in helping to refine our questions.

iii. Data Sources

We looked at the clinical, research, education, support and outreach services available at the two sites. The data used to prepare this report were triangulated among historical and archival documents, administrative and policy documents including health services restructuring reports, verbatim transcripts from 16 key informant interviews with mid- and senior- level managers, and 5 focus groups with up to 8 community-based providers of women's health services.

Literature Reviews: We completed annotated literature reviews of Ontario health reform and women; women's reproductive and sexual health services; women's mental health services; women's HIV/AIDS services and women's cardiovascular health services.

Key Informant Group Sample: Our initial key informant list was generated with the Community Advisory Group's assistance. We recruited subsequent participants

employing a snowball technique. Each of the interviews took between 1 and 1 ½ hours. Interviews were tape-recorded and verbatim transcribed. Key themes were identified during a series of group meetings. We discuss these themes in this report.

Focus Group Sample: Our focus group sample was generated with the aid of the Ontario Women's Health Network (OWHN). Participants were grouped according to their role providing community services in 1) reproductive and sexual health; 2) mental health; 3) HIV/AIDS; 4) cardiovascular health; and 5) broad support for community-based women's health issues. A trained OWHN staff member facilitated the focus groups. Verbatim transcripts were content analysed for themes. Each hospital's relationship with the community is discussed as a key theme in this report.

Document Analysis: We spoke with many people at each hospital who helped us to navigate its history and archival documents. In addition to archival documents held by the institutions, we received numerous documents from people's private collections. We also downloaded current documents from each hospital's website. Each institution's annual reports, budgets, strategic planning documents; and provincial and city health system policy and planning documents were analysed for key themes related to the provision of health care to women.

We ran into several challenges with respect to people agreeing to be interviewed, or keeping scheduled interviews, and as a result we requested many interviews with people who did not participate. In the first instance, our sense is that recent reforms to women's health have meant that Ministry-sponsored reviews, concurrent with the study's timeframe, diverted people's attention and capacity to engage in research requests. In the case of both hospitals, province-led scrutiny in the past five or so years may have made people more sensitive to being interviewed, or more guarded in their interviews. A number of our potential interviewees are physicians, and their busy schedules often meant that scheduled interviews were cancelled at the last minute, or that they agreed to participate, but we were not able to get a firm booking commitment from them. Finally, in the case of the community hospital, the fact that this is a study about "women's health services" may have led them to think that they had nothing to contribute, given the hospital's more narrow reading of what is included as women's health.

c. What are Women's Health Services?

Our study is grounded in a broad definition of women's health services, which include the spectrum of health services that women need, and acknowledges the importance of gearing women's services to their unique gendered and biological needs. The study focused on finding out how, where, why and by whom existing services are being delivered, and on what elements we need to consider in designing health services to meet diverse women's needs. In this section we focus on where we started: the "what" of women's health services and the literature in four clinical areas that documents why we need different strategies for women.

Women's health is influenced by both biology and gender relations. Biological differences result from different physiologies, hormones, and reproductive organs. Gender relations influence women's health due to women's unequal power and control over material resources, and their greater exposure to violence. The inherent complexity of understanding women's health more fully is highlighted by Reid (2002: 3) who points out that "[w]omen's health involves the interplay of social, individual and biological factors and is experienced within physical, emotional, intellectual, social and spiritual dimensions."

A singular focus on biomedical sources of "women's diseases" ignores the insights offered by gender approaches by missing underlying social, cultural and economic causes of ill-health (Reid, 2002). Gendered analyses of women's health address the context of individuals' lives, since, as Reid (2002) asserts, there are differences in health between men and women regardless of income, occupation and lifestyle. Women, for instance, have more chronic conditions and higher levels of depression. Gender is also about relationships. In other words, "women" and "men" are neither static nor homogeneous categories. Not only are there differences depending on which women and men we are talking about, but also, as Armstrong (2003) asserts, all other social locations (e.g., class, age, culture, disability and race / ethnicity) are gendered as well. In other words, examining how sex and gender identities intersect with other social differences such as race, ethnicity, socio-economic status, sexual orientation and ability is important.

While biological sex is about the complexity of the body, gender places bodies in their social, political, economic and cultural contexts. Thus, a full account of women's health needs to take account of bodies, and of bodies' multiple and shifting contexts.

d. Why Do We Need Different Strategies for Women's Health Services?

There is an increasing volume of research on sex and gender aspects of health. Interesting new studies are being conducted that show disparities in women's access to health services, and question whether the ways that health services are delivered meet diverse women's needs. For instance, recent research conducted over two years in thirteen Ontario hospitals that are part of the Canadian Critical Care Research Network suggest that access to care for women and men in Intensive Care Units (ICU) is unequal, with women older than 50 less likely than men to be admitted, less likely to receive life-supporting treatments and more likely than men to die after a critical illness (Fowler, Sabur *et al.*, 2007).

In our study, we focused our attention on four areas of women's health: reproductive and sexual health; cardiovascular health; mental health and HIV/AIDS. We chose the first area because it is an area traditionally associated with women's health. In the case of cardiovascular health, ample evidence points to sex- and gender- based disparities for women accessing services. Mental health is an area in which there is increasing evidence in favour of using a gendered approach. Finally, more research and attention is being focused on HIV/AIDS as growing

numbers of women, many from marginalized groups, are increasingly vulnerable to HIV transmission and are now living with what has become a chronic and manageable condition. A growing body of literature provides the rationale for a tailored health services approach in each of these areas.

i. Reproductive and Sexual Health

Reproductive health is an integral component of women's health, though in some places they are considered one and the same. Much of the reproductive health debate focuses on what factors contribute to higher Caesarean Deliveries rates, and the extent to which a planned Caesarean is a safe alternative.

Some researchers explore the socio-economic disparities that affect pregnancy outcomes (Kramer *et al.* 2000). Kramer (1998) argues that researchers should be looking at the causes and prevention of adverse pregnancies rather than just offering nutritional resources to poor pregnant women. Cubbin *et al.* (2002) also look at the socio-economic disparities as well as racial/ethnic disparities when exploring the issue of unintended pregnancies, suggesting that policies and programs could be developed to reduce these social disparities.

Abuse and violence can increase the risk of adverse birth outcomes and some argue that health care professionals/providers should be screening women during pregnancy and during the postpartum period as part of a crisis intervention strategy (Lipsky *et al.* 2003; Martin *et al.* 2003; Walsh and Weeks 2004; Jasinski 2004). The literature suggests that violence and abuse against pregnant women (pregnancy related violence) is a serious public health issue (Martin *et al.* 2003) that can cause adverse effects on the infant's birth outcomes (Campbell 2001; Jasinski 2004). Murphy *et al.* (2001) also draws our attention to the link between abuse and low birth weight (adverse outcomes).

ii. Cardiovascular Disease

Cardiovascular disease manifests differently for women and men (Pilote, Dasgupta *et al.*, 2007). Recent studies have demonstrated that women have different risk factors, present with different symptoms, and experience different access to follow-up treatments in their care for cardiovascular disease (Grace, Fry *et al.*, 2004; Murdaugh, 1990). Cardiovascular disease is a solid example of a condition for which we have good research data to support women-targeted health strategies, but where few programs are actually geared to recognizing the combination of women's unique biology, as well as their social, economic and political situations.

In terms of gender-based risks, a growing body of evidence focusing on low-income women examines socio-economic barriers as risk factors for women's cardiovascular disease (Gettleman and Winkleby, 2000; Johnson and Fulp, 2002; King, Thomlinson *et al.*, 2006; Lawlor, Davey *et al.*, 2005; Lawlor, Smith *et al.*, 2004). Other studies point to the importance of considering race / ethnicity, class, gender, and geographic location (Graham-Garcia, Raines *et*

al., 2001; Mensah and Dunbar, 2006). Wong and Wong (2002) address gender and cultural lifestyle factors for women's cardiovascular health. Yet another study indicates that women tend to have a lower quality of life and more impairment than men, noting that women with few social resources are at particularly high risk for poor adjustments to cardiovascular disease (Rueda and Perez-Garcia, 2006). Overall, the findings suggest that researchers recognize that the social determinants of health framework need to be incorporated when looking at women and cardiovascular disease.

In terms of biological risks, studies investigate the interaction of hormone replacement therapy and menopause with cardiovascular disease. For example, MacPherson (1992) discusses the biomedical and hormone debate. Grover (1999) explores the benefits of HRT on cardiovascular and Batt (2003) looks at the harmful effects of HRT on cardiovascular disease for women. Fugh-Berman (2006) also argues that it is a myth that HRT has cardiovascular benefits for women. Abramson (2002) points out that not only is estrogen not beneficial to cardiovascular health, it is also a big business for pharmaceutical companies.

Given that there are strong biological and gender dimensions to cardiovascular disease (Rieker and Bird, 2005), policy makers, hospital administrators, boards and providers must think about funding and delivering services in ways that better accommodate women. They need to carefully consider how different social locations, including class, and race / ethnicity, ability and geography play a role in equitable access to prevention and treatment options for women (Van Wijk, Ta et al., 1996).

iii. Mental Health

There is also clear evidence that mental health issues are different for women than they are for men. For instance, more women than men experience depression, uni-polar depression, anxiety, and somatic disorders (World Health Organization, no date). A review paper addressing gender disparities and their relationships to mental health by the World Health Organization (no date) identifies sex- and gender-based differences in women's vulnerability and experience of mental disease. Age of symptom onset; how often someone experiences psychosis; the disease course; access to social supports and social adjustment; and long-term outcomes are all thought to be influenced by both sex and gender experiences. While both sexes experience equal rates of serious mental disease such as schizophrenia and bipolar disorder, perinatal and antenatal depression remain serious women's health concerns. Women with mental illnesses like schizophrenia find it difficult to cultivate and maintain social support networks (Chernomas and Clark, 2006). Some evidence suggests that depression is more persistent in women (World Health Organization, no date). Women exposed to high physical exertion were found to be at more risk for major depression (Wang and Patten, 2001).

Hall (1998) argues that the health care system is "insensitive" to women's health needs, and that women's mental health issues need to reflect women's different life contexts. What this

means in a practical sense is that mental health services need to be more responsive to the realities of all women's lives, as women are more likely to live in poverty, have family care work responsibilities and be exposed to violence in relationships. Mental health services also need to reflect the diversity of women's lives. For instance, housed women's needs differ from those of homeless women who frequently experience high rates of abuse throughout their lives, and are often prone to depression (Sternac and Paradis, 2001). For Aboriginal women, mental health programming needs to address higher rates of suicide, sexual abuse, and substance abuse compared with non-Aboriginal women (Grace, 2003).

How services are designed matters. Morrow and Chappell (2000) indicate that there are few mental health programs in place that treat women as a specialized population. A review of four demonstration projects in B.C. showed that women-only support groups helped women to better navigate the mental health system (Morrow, 2003). Rhodes, Goering et al (2002) found that women are more likely than men to use outpatient mental health services, regardless of the type of mental disorder. Mental health and addictions services for women and men should be accessible, comprehensive, gender-specific and should integrate mental health and addictions care (Salmon, Pole et al., 2006). Merging mental health and addictions will improve continuity of care and better incorporate gender issues such as trauma and violence into mental health programming and planning. Health care professionals in the mental health services need to listen to the views and experiences of women, particularly when designing specialized services such as those for low-income mothers (Anderson, Robins et al., 2006).

iv. HIV/AIDS

HIV/AIDS is a health issue of growing importance for Ontario women (Public Health Agency of Canada, 2005). The social, political and economic context of women's lives makes some women more vulnerable to HIV/AIDS than others (Maggi and Daly, 2006). For example, in Canada, women in prison, Aboriginal women, and black women are disproportionately infected. Hough, Magnon, et. al (2005) remind us that women living with the disease are also often coping with single parenthood, poverty and racism as well as HIV/AIDS. Hospitals and community-based agencies have not adequately transitioned to fully meet women's unique needs, particularly the integration of services dealing with violence, and vulnerability to HIV, women's multiple care-giving roles, and women's needs for emotional and social support (Maggi and Daly, 2006).

A considerable amount of research has documented behavioural interventions for men who have sex with men (Johnson, Hedges et al., 2003), but the social and political contexts of women's lives makes it difficult to easily translate strategies that may work for men who have sex with men to a heterogeneous female population. In other words, we need to understand that "choice" may look different for women than it does for men (Sherwin, 1998). Doyal (1995:80) notes that "women's sexual behaviour is the outcome of a complex set of internal calculations and interpersonal negotiations that cannot be understood outside the context of

their cultural, social and economic environment.” What this means is that prevention strategies available to women are more limited because women sometimes lack control over whether or not a condom is worn, a partner's fidelity, or over sexual negotiation, even in consenting sexual relationships (Petchesky, 2000). This is particularly the case for women who have lived in areas of war or social instability (O'Manique, 2004).

By focusing on some of the structural and contextual realities of women's lives means that we may be able to identify areas of women's increased vulnerability. Recent research from other parts of the world points us in the direction of the link between violence and the inability to negotiate sex as a key risk factor for women (Arriaga, 2002; Chege, 2005; Durr, 2005; Garcia-Moreno, 2000; Go et al, 2003; Hirschmann, 2005; Johnson, 2001; Klot et al., 2007). Violence associated with living in urban environments creates unique sets of vulnerabilities for women and young girls (Mabala, 2006). The trauma of previous abuse also plays a major role in the experiences of women living with HIV/AIDS (Leenerts, 1999).

Violence and its relation to HIV transmission have received more attention in the international literature, and there has recently been a call to include violence as an indicator of women's vulnerability to HIV (Türmen, 2003; Arriaga, 2003; Doyal, 2002, Petchesky, 2003). Studies have begun to document women's exposure to violence and HIV in places in Africa (Bentley, 2004; Kalichman, 2003; Kathewera-Banda et al, 2005; Mantell et al, 2006; O'Manique, 2004; Onyejekwe, 2004; Outwater, 2005; Seeley, 2004; Strebel, 2006; Win, 2006; Wojcicki, 2001); Papua New Guinea (Seeley et al, 2006); Thailand (Leiter, 2006); and India (Go et al, 2003), but little research has attempted to specifically understand the complexities of sexual and domestic violence in increasing women's vulnerability to HIV in the Canadian context. Very few North American studies have looked at the relationship between violence against women and the transmission of HIV, or violence prevention linked with HIV prevention (Lichtenstein, 2005; Teti, 2006). Moreover, given that Canada is country of immigrants, it is important to pay attention to research that highlights the complexities of women's exposure to violence in different cultural contexts.

III. Health Reform and Women's Health Services

a. Women's Health Services in Toronto

The period from 1990 to the spring of 2007 was a tumultuous time for targeted women's health services in Toronto. In 1996, Ontario's health reforms began in earnest with the Mike Harris Conservative government's creation of the arms-length Health Services Restructuring Commission (HSRC), though many different initiatives including bed closures under the former Premier Bob Rae's New Democratic Party had led to considerable problems in the system. The HSRC had a four-year mandate to restructure Ontario hospitals, and to make recommendations about reinvestments and restructuring for other parts of the health care system. With the release of each region's report, all hospitals in the province felt the sting of reforms, and many hospitals

were merged. The province went from having 119 Public Hospital Corporations operating at 144 sites to just 76 on 117 sites post-HSRC, representing more than a one-third reduction in Ontario's number of hospital corporations (Jordon and Stuart, 1999/2000).

Many of the recommendations that the HSRC followed for the Toronto district were found in the pages of the controversial 1995 Metro Toronto District Health Council's Hospital Restructuring Committee Report (Feldberg and Miller, 1996; University of Toronto Faculty of Medicine, 1995). The report called for the closure of Women's College Hospital, and the transfer of its women's health programs and merger of its governance with Sunnybrook Health Sciences Centre. This recommendation was criticized by the University of Toronto's Faculty of Medicine because it would de-emphasize women's health programs and jeopardize the "educational value of a distinct approach to women's health".

The final HSRC report for Metropolitan Toronto was released in July 1997. Among its other recommendations, the Commission called on Women's College Hospital to amalgamate with Sunnybrook Health Science Centre and the Orthopaedic and Arthritic Hospital; thus, becoming a single corporation that would govern all services except the Sexual Assault Treatment Centre, which was to be transferred to the Western Division of the Toronto Hospital. The Commission identified that Maternal-newborn and musculoskeletal service be designated as the new hospital's priority programs (HSRC, 1997). In response to all of its recommendations for Toronto, the Commission received 650 representations from hospitals, health agencies and organizations, labour, individuals and other groups, plus fifteen letter-writing campaigns, which contained thousands of signatures opposing the report.

The 1997 decision to amalgamate two hospitals created an additional need to ensure that women's health was recognized as a priority in the province. As a result, the Health Services Restructuring Commission (HSRC) recommended the establishment of the Ontario Women's Health Council (OWHC) to advance leadership in women's health and to advise the minister on health issues affecting women. The Ontario Women's Health Bureau (1987) in the Ministry of Health was folded into the OWHC to create a single provincial women's health entity. In 2003, in order to mainstream gender perspectives, the Ontario Women's Health Council (OWHC) introduced "Women's Health Champions" into hospitals throughout the province. These champions are intended to serve as communication facilitators and advocates of women's health within their organizations, and to influence an unchanging mainstream by integrating gender and health services delivery.

The Friends of Women's College maintained political pressure by lobbying against the merger, and the earlier HSRC decision was reversed when, in August 2005, the Honourable George Smitherman, Minister of Health and Long-term Care, announced two things of considerable political importance for women's health practice and research. First, Women's College would regain its independence from Sunnybrook Health Sciences Centre with the Honorable Elinor Caplan overseeing the dissolution of the formerly merged corporation. On April 1, 2006, the

New Women's College Hospital gained its independence, with a plan to create "a state-of-the-art academic ambulatory care hospital to meet the special needs of women and their families" (Strategic Plan, 2006).

Post-merger, Women's College organizes its services around five women's health themes: primary care, surgical services, management of chronic disease; reproductive and sexual health; women and cancer; and women and violence. Services are cross-disciplinary. It also established the Women's College Research Institute; an ambulatory surgical services day-program including same-day breast and urological surgeries; expanded cancer care services particularly focused around rapid screening and diagnostics for under-served immigrant and marginalized women; an urgent care pilot project; and a task force to aid in the site's capital re-development (Strategic Plan, 2006).

Secondly, a new provincial Women's Health Institute (WHI) was also announced. Dr. Diana Majury of Carleton University was appointed Vision Lead, and set out to consult broadly with stakeholders about what the Institute should look like (Women's Health Institute Project, no date). Its initial mandate was to promote women's health throughout Ontario and to become a national leader in addressing women's health issues. The Institute would be a separate entity from Women's College, with its own Board of Governors, but would incorporate the OWHC. One year later, with consultations and a name change completed, Echo was officially announced and given an operating budget of \$7.6 million per year. Not initially intended to be an acronym, but following some controversy over the choice of name, it has since come to stand for Effecting Change in women's Health in Ontario, with the "w" notably missing. The new institute will open under the direction of Dr. Caroline Andrew of the University of Ottawa, with a commitment to:

- Conduct, fund and partner on research initiatives in women's health;
- Provide input to government policy, in collaboration with stakeholders, to improve the health status of women, and promote the provision of accessible, effective and equitable care for women;
- Collect and distribute information on women's health through a variety of communication tools and services; and
- Advise the minister on health issues affecting women.

Some organizational fuzziness remains regarding the lack of perceived or real integration between ECHO and the Women's College Research Institute, what one respondent called "an integral part of the three-legged stool"; this lack of clarity is potentially problematic in terms of academic goals to focus on researching and teaching best practices for women's ambulatory care (Manager_061707). But the legacy of the OWHC's broad knowledge base, research and research capacity, and a strong will to influence policy decisions will likely continue with its being folded into Echo / ECHO. For instance, it recently funded the *Ontario Women's Health*

Evidence-Based Report Card (POWER) project (Bierman, 2005), which continues on even though OWHC is now officially closed. The project will provide a comprehensive set of evidence-informed indicators for planning and evaluating women's health status. While several other jurisdictions have indicators for planning (Donner, 2003; Horne et al, 1999) and evaluating women's health status (Health Canada, 2003; Ontario Women's Health Network, 2006; Stewart et al. 2002; World Health Organization, 2004), and have undertaken performance measurement projects (Colman, 2003; Lin et al, 2003; Misra, 2003), the POWER projectⁱ is unique in its incorporation of health determinants; its ability to track changes over time; and its provision of an important web-based tool for women's health stakeholders. During this period of reform, the **Ambulatory Care Centre** faced substantive and successive organizational challenges despite its own organizational successes in launching a new vision for the delivery of women's health services. Starting in the 1990s the ACC was restructured, reorganized, merged, and now has been recently de-merged. The most significant challenge to the ACC's autonomy occurred in 1998 when it was merged with another hospital that espoused a very different organizational culture. At the time of the merger, its site became an ambulatory care centre. Through negotiation with the province's Health Services Restructuring Commissionⁱⁱ, the organization retained a quasi-independent governance structureⁱⁱⁱ, and also a legislated provincial government commitment to women's health (Bill 51) and to a sexual assault centre. The ACC remained regulated under the *Public Hospitals Act*, but lost its inpatient hospital beds (Ontario Legislature, 1998), but it did "not go gentle", and rallied a formidable opposition to the forced merger. A highly effective public relations and media campaign fuelled attempts to get the HSRC's directions nullified in court, which was backed up with multiple proposals and continual demands to meet with the Metropolitan Toronto restructuring team (Sinclair, Rochon and Leatt, 2005). Despite these efforts, the forced amalgamation proceeded.

This section briefly described the political and organizational reconfiguration of targeted women's health services in Toronto during the period from the mid-1990s to the present. This history provides the backdrop for the discussions to follow about women's health culture (Section IV), service delivery (Section V), communities' voices (Section VI), and accountability and action (VII). It also provides a context for our concluding discussion and recommendations about Women's Health Services' Equity (Section VIII).

IV. Discourses, Constraints and Practices

This section discusses the ways in which women's health services at the two sites have changed over time, but these changes are not unidirectional. For instance, at the same time within the same site, services may be lost in one area, while more attention is paid in another; access may improve for some patients, while impeding the access of others; the work environment may open opportunities to women providers in some ways, but hinder them in others. Our findings show that contradictions are inherent in the funding and delivery of women's health services in Toronto.

In this section, we document how the philosophy and culture of women's health articulated by each of the sites reveals conflicts between their discourse and their practice. We also note structural constraints, at both the system-level and the organizational-level, that limit the extent to which aspects of their women's health philosophy are practiced for patients *and* for providers.

a. Women's Health Philosophy and Culture

The **Ambulatory Care Centre's** definition of women's health, dating from 1997—the time of the impending forced merger—is both a source of organizational strength and practical difficulty. Their broad definition of women's health includes the following elements:

- Empowerment of women;
- Patients as partners and equals;
- Accessibility of the programs;
- Advocacy for women;
- Collaborative decision-making and planning;
- Programs adaptable to the context of women's lives;
- High quality of care acknowledging patient choice and autonomy;
- Innovative and creative approaches to women's health research;
- The provision of quality academic, career and leadership opportunities for women and working together with the community (Academic article, 1997).^{iv}

Their definition is relational: it links Sevenhuijsen's (1998) notion of solidarity to caring for women at individual and political levels; it situates women in their life context; and it envisions equality of status between health providers and patients by empowering and engaging women in making health decisions and engaging in health planning. This definition is also wed to a need to differ both in philosophy and structure from other health organizations (Academic article, 1997).

One manager noted that the ACC's philosophy is one of collaboration and cooperation (Manager_051806). It uses large multidisciplinary practice teams, which include only a few doctors, and, in many instances, teams are self-managed. In the case of mental health, teams include counsellors, psychologists, nurses, social workers, art therapists, and sex therapists, among others (Manager_051806).

The ACC was started as a place to train and mentor women clinicians, practitioners and managers; however, some respondents argue that the failed merger has shifted the **Ambulatory Care Centre's** foci.

...we were a beacon in terms of leadership for academics for women for a long time. We aren't any more. ... we used to be able to say ... half of our department chiefs are women or more, or more than half,

*and our leadership is women. We can't say that any more.
(Manager_061707)*

One respondent, who had earlier in the interview argued that the ACC is a collaborative organization, indicated that it is a closed culture that can be difficult for people to break into because of many unwritten norms that are not typically discussed (Manager_051806). Others also revealed this sense of division between the philosophy and practice of women's health.

I don't think we live in what I would consider a truly collaborative endeavour. There's still a hierarchical aspect. We haven't embraced our women's health values and lived them. Some of us have... when you do it you're not necessarily very popular. (Manager_061707)

The way services are talked about in the **Ambulatory Care Centre**, compared with the way that they are managed and delivered, represents an important contradiction. While some managers noted how flexibly and non-hierarchically the Centre is, emphasizing distributed control and empowerment of individuals at the point of service to react to the needs of clients, other managers contradicted this belief. One manager notes:

[T]he difficulty is the administration here, the decisions are made right now at a very senior level and they don't involve front line staff in brainstorming or being part of committees and they don't use resources they have here ...because ... many of the administrators here have the same issues that I talked about before. They don't understand women's health. They're very, they're women who have been successful in life, have money ... don't want to deal with tough issues like abortion, like sexual assault, like women who are poor and consequently stay above the fray and are making decisions that I don't think they understand the implications. (Manager_030906)

Despite advocating a model empowering women, involving collaborative decision making, and creating a work environment conducive to women practitioners, the ACC does not necessarily accomplish the task of fully caring for its practitioners in a way that is consistent with its values around collaborative decision making.

The ACC has partnered with other hospitals / organizations numerous times in the past, with plans to continue to do so in the future.

...we're doing everything we can in our power to be collaborative, cooperative, looking for gaps, we're not trying to compete with

*anybody, we're trying to be a partner for what an ambulatory care
centre can do, focused on women's health (Manager_051806)*

However, words such as “fight”, and “survive”, “competition” and “big boys down the street” peppered throughout the transcripts, suggesting that the organization's emphasis on survival may have affected its ability to fulfill its potential for collaboration, to fully develop some innovative programs, and to retain providers. Indeed, many innovative programs, including the pelvic pain program, were lost when the ACC was merged with another hospital. Other services, such as the sexual assault centre, have been watered down and are now a shadow of what they were. Still other services, such as the maternal and newborn program, have been taken. In many cases, the clinical practitioners moved to work at other sites when the political turmoil raged, and the ACC is now in a process of re-building. Finally, there is a sense that the ACC is left to build its women's program by “filling gaps” around other hospitals' lack of services, or engaging in turf wars to get some important women's health services back under the rubric of the ACC. So far the ACC has engaged in a strategy of gap filling, but this strategy may have serious long-term detrimental side effects if it prevents the Centre from creating a cohesive program of women's ambulatory care. Moreover, like other parts of the health sector, the ACC is subject to constraints of operating funds whilst its physical plant (now undergoing renovations), withers under the weight of years of neglect.

There is no doubt that the ACC operates within a complex environment, filled with players with competing interests. It is also limited in its ability to provide certain types of services by virtue of the way the province funds health services, and by virtue of its ambulatory status. The limits imposed by a political system that remunerates acute medical care and counts hospital services that are brief, biological, and episodic, not chronic and contextualized in the realities of people's lives, is a key challenge to fully operationalizing ACC values. The ACC is also limited in developing its vision of holistic women's health services within the confines of the organizational rules of operating as an Ambulatory Care Centre, which has no inpatient beds, and allows only day surgeries, as no one is to be treated for a period of more than 18 hours. Furthermore, its Ambulatory status contributed to the loss of its perinatology and gynaecology programs after the Ministry commissioned a review (Review article, 2005), which concluded that retaining birthing at the ACC would require “repatriation” of inpatient medical and surgical services in order to ensure patient safety and for the program to remain sustainable. The report advised against this course of action and indicated that the program should be transferred to the partner site. One interviewee described it as a program that had been “well protected, well loved and well nurtured” (Manager_051806). The cultural and philosophical loss of maternity care is thus very difficult to calculate.

Evidence indicates that the ACC's women-centred organizational culture and philosophical approach to health care deteriorated with its forced amalgamation. A decade later, the marriage failed following years of sustained and vocal opposition, and the merged organization's failure to

retain a legislated focus on women's health (Bill 51) and to maintain the viability of the sexual assault centre. The newly independent **Ambulatory Care Centre** retains its woman-centred vision, but with organizational changes that present challenges for the articulation of its philosophy of caring for women.

Women's health is operationally very different at the **Community Hospital**. In 2004, the hospital nominated a "women's health champion." The 2004 appointment was made following an Ontario-wide Hospital Report Card (2003) that gathered the first set of provincial indicators to evaluate women's acute health care services in the province. A cross-organizational committee was struck to link survey data to practical activities in order to "enhance accountability and quality improvement" (internal document). The committee developed a broad and inclusive definition of women's health, and identified their philosophy. Borrowing on that already developed by the Ambulatory Care Centre, it includes the following elements:

- Commitment to excellence in services for women in all lifespan phases;
- Empowerment of women through informed and participative decision-making, community input and consumer program evaluation;
- Collaborative planning involving consumers, the community and the hospital;
- Integrated health care delivery by interdisciplinary teams and in collaboration with partners;
- Innovative and creative approaches to women's health;
- Knowledge of sex-sensitive and sex-specific indicators;
- Acknowledgement of women's distinct role as users of health care systems both for themselves, their families and within their communities;
- Advocates for equity in health care services provision; and
- Providing care at or above benchmarks for women's health (Women's Health Committee, 2004).

Their definition links women's health to social and biological determinants, recognizes the "validity" of women's life experiences, beliefs and experiences of health, and the opportunity to sustain and maintain health as defined by the woman "to her full potential" (Women's Health Committee, 2004).

The hospital's philosophy links caring for women to women's empowerment—it acknowledges that women often take a lead role in negotiating health care for their families. Although it acknowledges support for interdisciplinary team approaches to health, it is more firmly grounded in a medical model, linked to the use of health indicators and benchmarks. The hospital's definition speaks to the need for social justice and equity of access to care, but does not directly acknowledge diversely situated women's needs. Nor does the philosophy address the training and mentoring of women practitioners who are the majority of the health care workforce.

The **Community Hospital's** understanding of women's health reflects the province's organizational culture focused on quantitative measurement, aiming to understand sex-sensitive and sex-based indicators of care and to provide care at or above benchmarks for women's health. How this type of benchmarking is incorporated into everyday practices is not explored in depth. It is virtually silent on gender.

In the years since 2004, when the "Champion" was appointed, the Women's Health Committee initiative has stalled, marking a key difficulty for the hospital to advance its women's health philosophy. Three factors are related to the failure: no budget or specific outcomes were assigned to the committee, reflecting the low priority status the issue holds for the hospital; the committee was initiated as a response to the release of an external Hospital Report Card measuring the hospital's performance against a number of others; the chair had expressed interest in undertaking the task of reviewing women's health at the hospital, but also holds a heavy workload as the director of two large clinical areas and therefore lacks the time to take on a new initiative.

The failure of the Women's Health Committee to catalyze substantive change must be placed in the context of the organization's overall philosophy. Rather than having individual managers demonstrate what they are doing to provide outstanding care that targets women's and men's specific needs, the task of getting the hospital to address women's health is charged to a single person (with a committee lacking a budget, and a large portfolio lacking full human resources complements). The task of the Committee is to "...demonstrate that women's health as a concept is imbedded in operations and planning" (email exchange, Sept 13, 2005). The ability of a small team to significantly challenge the organizational culture, when lacking a budget or clear senior management support, is not surprising.

As a result of the failure to move the women's health agenda forward, the hospital retains a traditional approach to women's health. It offers outpatient programs in postpartum adjustment; colonoscopy and osteoporosis clinics; breastfeeding; family learning for birth preparation; and choice of practitioner for birthing. For children it has a special care nursery and a neonatal follow-up clinic. It participates in a public health program to ensure home care follow-up for new families, and support women in achieving a 75% rate of breast-feeding. It has many programs for families with children including a child development centre, healthy lifestyles clinic, and is in partnership with a regional children's hospital for paediatric emergencies. The philosophy of women's health that they discussed, however, has not been realized.

b. Patient Equity: Less Access and More Inequity with Increased Private Payment

As part of its strategy to differentiate itself from what other institutions were doing, the **Ambulatory Care Centre** began to focus on "unique" programs that attracted well-heeled, educated and philosophically supportive women. In a country where hospital care services are still predominantly publicly funded, many of its programs and services have been restructured to

"focus on specific patients/clients with customized services," services that are "unique in the eyes of the clients" and that provide the organization with "competitive advantage" and "customer loyalty." The ACC is focused on providing services that competitors cannot easily duplicate (Academic article, 1997). From this reading, it is clear that the organization wants to position itself as *the* centre for women's health service delivery, not as a centre reproducing its model at other organizations. In framing women's health as a commodity, it must carefully avoid the co-optation of feminist ideals of empowerment and alternative modes of health delivery by turning women into "objects of treatment and revenue production," as Thomas and Zimmerman (2000: 27) argue has happened in the United States.

A structural constraint the organization faces is its insufficient public funding for preventive and wellness based programs, which are either run on a shoe-string and have incredibly long waiting times, or charge user fees. In the case of the latter approach, the ACC created a cardiovascular primary prevention program focused on early assessment and lifestyle interventions. Its Osteoporosis Program served in part as the cardiac program's model. There is a \$150 per six-month fee associated with attendance at the cardiovascular program, which covers non-OHIP services. Another one is a preventive care program for women from 40 to 70 who have experienced early menopause, charges fees for some services.

There is a sense that ambulatory care is "seen as less", because of the resource-intensive needs of acute-care (Manager_090807SB). In many ways, the overarching health system focus on acute care intervention creates inequities for women unable to afford the out-of-pocket fees associated with these preventive or rehabilitative programs. The fees for these programs create potential barriers for those unable to pay. Although there are provisions to cover costs for people unable to pay, the cardiac program did not have anyone unable to pay in the program at the time of the interview. One interviewee noted that "we waive the fee for anything, but it's not who has traditionally been attracted to it," (Manager_051806) raising questions about the extent to which these programs are able to cater to women lacking resources.

While payment may prevent some women from accessing programs with associated out-of-pocket payments, accessibility may be greatly enhanced for many women, as a doctor's referral is not required. This means that many of the programs are quite open to a woman who has met with roadblocks in terms of the traditional medical referral structure, or for whom seemingly unconnected health complaints are taken more seriously using a holistic, multi-disciplinary approach.

In a priority setting exercise, the **community hospital** has actively engaged in a process of shifting ambulatory services outside of the hospital. Examples include hearing tests for younger children, and minor surgeries (e.g., biopsies). Services such as physiotherapy have been very circumscribed and terminating chiropody services has been discussed. The shift is related to

values about the public hospital's role and to cost-containment initiatives designed to focus on the provision of acute care services. One manager argued that:

...the private sector can just do it better in the community. It doesn't have to be in the hospital. And it's difficult to recruit those staff and so many hospitals have [it] (Manager_082007TD).

The same manager went on to explain the rationale for the hospital's decisions:

...there are limited dollars and so if the services are available in the community, is it something that we should be having here? So I mean it sort of relates to dollars but then we can use those to provide the acute care services that no one else provides (Manager_082007TD).

Clearly, the two organizations are moving in radically different directions when it comes to deciding which services are appropriately provided within the scope of their organizations.

c. Maintaining a Healthy Workplace

There is ample evidence indicating that low levels of support in the workplace, lack of control or autonomy, and high levels of job strain increase sickness and stress (Karasek and Theorell, 1990). One Quebec study of nurses found a positive association among short-term sick leaves, job strain and low social support in the workplace (Bourbonnais and Mondor, 2001). Minor ailments and fatigue related to work overload were the major causes of absenteeism among a sample of randomly selected Saskatchewan nurses (Zboril-Benson, 2002). In a study of Quebec nurses, researchers found that workplace psychological demands were the result of an increase in job demands, a decrease in social support at work, and a change of workstation (Bourbonnais, Brisson et al., 2005). Yet another health care sector study found that system and organizational restructuring increased levels of psychological distress (Woodward, Shannon et al., 1999). A cross-sectional analysis of the *National Population Health Survey* demonstrates that regardless of gender, when individuals perceive that their jobs are not secure, they experience poorer self-rated health, more distress, and more medication usage (McDonough, 2000).

Good working conditions are negatively affected by cost containment and staff shortages. At the **Ambulatory Care Centre**, one respondent noted that:

If you don't have the money you can't do it. We need retention things to deal with retention issues. I do procedures in the OR. It's incredibly short staffed. And the morale gets bad when you're short staffed

because the people are doing more work. And you get this downward spiral, right? And only money will fix that. (Manager_061707)

Another interviewee laments what has happened to nurses in terms of staffing shortages and the ability to attract highly skilled people to the profession:

...we're pared down to the absolute minimum levels of nursing that we can do. We don't understand the cost that that takes in terms of job satisfaction, in terms of personal health, and the fact that these nurses are skilled, creative, caring people and if they're not able to do a job that is satisfying to them they'll do something else. We've watched a huge exodus of highly competent, skilled, well-educated nurses to go to something else. We're trying hard to backfill but we're not backfilling is my overall impression. We're not attracting the same people to nursing that we did in the past. If we want to have skilled nurses we have to be prepared to pay for them and we have to be prepared to give them careers that are rewarding, you know, that they feel that they've made a difference. (Manager_072307SB)

The link between good working conditions and being able to provide good women's health services was clear to one interviewee: "[i]f you really do care about women's health you have to care about the health of your staff as much as you do about the health of the patients coming to you because you can't have one without the other." (Manager_072307SB)

One of the ways that the **Community Hospital** is dealing with constrained resources, combined with their need to cover certain time periods, is to provide nurses with a pager on their time off, paying them for the hours that they cover the pager, and requiring them to come into work if called (Manager_061907TD). This creates many challenges in terms of employee work life balance (e.g., issues of child care and time with friends and family, the types of activities one can engage in while on call, the distance from home, etc.), and has the potential to create a very challenging workplace.

Safety is an issue that was raised by the **Community Hospital**, where there are a number of initiatives to control and monitor what goes on in the hospital in terms of the prevention or management of violence. For instance, the hospital tries to create an environment where workers feel safe, both inside the hospital and while traveling to vehicles. They have wellness programming focused on the "mind-body-spirit" connection, offering programming that includes a 24-hour gym, acupuncture, spinning, pilates and yoga, singling, volleyball, poetry and photography classes. There is now a 24-hour food cart that circulates the building, as there was once no access to food in the past. The hospital tries to create a stable work environment in

which people are not constantly being laid-off and then re-hired. They also offer flexibility in returning to work following illness.

Despite these programs, the pressures to operate in a cost constrained environment have resulted in asking staff to do more with less. This is often in direct contravention of maintaining a healthy work environment. Directors, one level below hospital vice-presidents, who retire or leave are not replaced (Manager_061907TD). Nurses are asked to be on-call on days off, and staff levels do not flexibly respond to demands for services, as directors are “managing to a budget” and “must sign off on the budget” to meet new Ministerial accountability requirements (Manager_061907TD).

V. Strengths, Distortions and Gaps in Women's Health Services

Organizational challenges have forced the **Ambulatory Care Centre** to consistently justify its uniqueness. We use the word justify quite intentionally. For the last quarter century, the organization has struggled to maintain organizational autonomy. In so doing the ACC has employed a number of strategies. Starting in the early 1990s, it adopted an explicit focus on delivering “unique” health services for women, compared with a more medically oriented model practiced at other teaching hospitals. The ACC positioned itself as unique by adopting a holistic definition of women's health, emphasizing teamwork across disciplinary boundaries, and the empowerment of women as patients; it became a World Health Organization Collaborating Centre; and it established several leading edge programs grounded in medical and social approaches to health. Several factors, including the political instability of the past decade discussed above, a less robust than expected base budget for the newly independent organization, combined with a crumbling physical infrastructure, have contributed to the closure, transfer or offloading to the community of several of the **Ambulatory Care Centre's** programs and personnel.

Lack of funding combined with constraints on services funded and public funding are reasons frequently identified as critical challenges to the success of the ACC's programs^v. In total, Ministry funding accounts for only 64.3% of the ACC's revenues. Other revenue is derived from other agencies and patients (\$6.6 million), ancillary services and other sources (\$12.2 million), service level agreements (\$6.6 million), and investment and amortization (amounting to just over \$0.5 million). The ACC recorded a \$200,000 shortfall during its first year. Although it is difficult to tease out the budgets pre- and post-amalgamation, one program indicated that they have experienced a 15% cutback to their base since amalgamation (Manager_010806SB). In another area, one respondent calculated that 50 per cent of the pre-amalgamation budget has been lost (Manager_061707S).

In the past, infrastructure development was neither well supported nor well equipped, this holds true given that the ACC has had minimal capital development over the past several decades. With the exception of the flood, which necessitated the repair of several floors of the building, the main physical plant is dilapidated and badly in need of renovation. One interviewee matter-of-factly states: "I mean this place is effectively a dump; in fact I think they're going to end up knocking it down" (Manager_070506S). Regeneration of the physical plant is a part of the on-going redevelopment plans, although ignoring the physical space directly contributed to both the HSRC's initial merger decision (HSRC, 1997) and the loss of its perinatal and gynaecological program (Review article, 2005).

The ACC's most marked – and negative – program shifts have occurred in areas related to reproductive and sexual health. Other programs have survived on a shoestring, reflecting the fact that Ministry funding is grounded more firmly in episodic acute care services and physician-led models, not chronic or interdisciplinary practitioner models. For programs that have survived, there is a major emphasis on "trimming," with a secondary emphasis on "efficiency" (Manager_051806S).

Women's health services at the **Community Hospital** are primarily defined as women's reproductive health and family based health services. The hospital does not have a specific women's health focus in its cardiac, rehab, surgical or other areas of care. As a result, there is not a cross-program approach to women's health at the **Community Hospital**. One interviewee noted that "...it's been a real struggle to try and put anything beyond reproductive health on the map as far as women's health is concerned" (Manager_071106SA), and women's health is perceived as "soft" (Manager_071106SB). One email exchange noted that, "apart from the provision of surgical services to women in the areas of gynaecology and plastics, surgery is not directly responsible for women's health" (Sept 13, 2005).

The **Community Hospital's** own surveys of patients identify women's lower satisfaction with care, but the extent to which this has been picked up to better respond to women's needs in departments other than maternal and newborn care is unclear.

One interviewee indicated that program areas and directors are 'siloed' from one another, physically and in terms of focus areas, which may contribute to the hospital's lack of initiative to deploy women focused strategies between hospital units. Cross-unit initiatives are difficult to implement because "everybody is sort of guarding boundaries," worried about how changing services may result in negative consequences for their program or patient population.

We recognize that each of the four service categories discussed below – reproductive and sexual health, mental health, HIV/AIDS and cardiovascular health—have multiple points of intersection with, and are integrally linked to, the others. For instance, the services we have included under the rubric of sexual and reproductive health cannot be viewed as the sole

domain of reproductive and sexual health as they also encompass areas such as mental health. We have categorized services separately here for ease of analysis.

a. Reproductive and Sexual Health

As a condition of the de-amalgamation, the perinatal and gynaecological program (PGP) was transferred to the other hospital involved in the merger. Although these programs remain situated at the ACC, they are no longer ACC programs. As of 2008/09, all birthing services will be conducted at the other hospital (Strategic Plan, 2007). These services include high-risk obstetrics and the NICU (neonatal intensive care unit). When the **Ambulatory Care Centre** first merged with the other hospital, the PGP infrastructure stayed at the ACC, but "...all the intellectual resources went over to (the other hospital)" (Researcher_060607S). The physical capacity of the ACC was the issue. While many other hospitals have moved to labour-birthing-recovery-postpartum (LBRP) rooms, home-like rooms designed so that mothers can remain in one room for the entire birthing experience when possible, the ACC was forced to retain its older birthing rooms due to lack of physical space. Obstetricians at the hospital are over-booked and under-staffed, and, despite the Centre's financial constraints, often have to turn pregnant women away (Manager_072307S). While several interviewees believed that low-risk birthing services could still be provided at the ACC, this idea is seen by some as implausible because of safety and security concerns, especially in light of the fact that the ACC does not operate 24 hours a day (Manager_072307S). One bright light for the ACC is the effort to bring in gynaecological services that meet the community's needs that will endure beyond the transition of the PGP program to the other hospital (Manager_072307SB).

A model of care option being explored is the extent to which nurse practitioners, and extended family practice services can be incorporated into the ACC with obstetricians and gynaecologists serving in more of a resource role; however, the funding model limits the extent to which new models such as this are palatable for an organization to implement. One interviewee notes:

...[w]e still have to work on funding models because that ends up being a huge limiter on what you can do so hospitals pay the salaries of the nurse practitioners. Hospitals don't pay the salaries of the physicians so if you're trying to restrict costs it's cheaper to have a doctor provide the services than a nurse (Manager_ 072307SB).

The defunct pelvic pain program was considered revolutionary when it was created. It was established in 1998 with a one-time \$700,000 award (Manager_01806Sa). The Centre espoused an integrated approach to care delivery and operated on a team-based model, which included a range of health practitioners from sex therapists to naturopaths:

It had a multitude of medical and paramedical specialties so everything from urology, sexual medicine, gastroenterology, sexual medicine, psychiatry. ... we had a social work therapist... we were working with naturopaths and a ... dietician ... so we really tried to put a complementary really full service together and we really are quaternary service for women, that is, women who had seen doctor after doctor after doctor (Manager_01806SA).

The program was so innovative and successful that its waiting list included women from all over the province, out of province, and across Canada. Remarkably, while it was in operation ER visits decreased substantially (Manager_072307SB). Because the Centre was developed as the result of a one-time award, and was without operational funding, the money to sustain it ran out. Although donors offered the operating funds necessary to sustain it, hospital policy forbids donations for operational funding, as it is not considered self-generating (Manager_010806 SA). The ACC wanted to continue to fund the program, but the other hospital refused and the program was closed two weeks after the merger announcement was made. Since the centre has closed, other hospitals have implemented pelvic pain programs; however, some people argue that these programs are more pharmacologically-oriented in their approach, especially when compared with the former ACC program (Manager_072307SB).

Other programs that have been negatively affected by restructuring include a sexual assault centre. Under the terms of amalgamation, the Centre was supposed to be protected in a downtown Toronto location, but since the amalgamation it has suffered a loss of profile, and lost its permanent and full-time director (Manager_030906S). Likewise, a program for menopause education has been cut back substantially, and, due to a lack of funding for outreach seminars, a fee is now levied for attendance (*ibid.*). Finally, a women's health centre underwent substantial restructuring. Originally the Centre served as an umbrella for its three components: reproductive health, education, and a basket of non-medical specialized client services (such as body image support groups). As a result of restructuring, it was dissolved, although an alternate site for women's reproductive choice and counselling remains intact and the resource center has been relocated to the ACC site (Manager_010806SB).

The **Community Hospital** is a level II regional care centre, with co-located neonatal and paediatric subspecialty care. The Centre is capable of dealing with situations of moderate risk in the ongoing care of mothers and infants. Women are provided with choice between a midwife, obstetrician or family physician. The hospital participates in a regional Child Health Network and the Perinatal Partnership Program of Eastern and Southern Ontario.

Additional reproductive health services include a breastfeeding centre open seven days per week. Lactation consultants are available on a drop-in basis. There is also a family education centre that provides childbirth education, teaches relaxation methods, provides nutritional

information and healthy lifestyle guidance, and helps to prepare mothers for birth. The hospital is also working toward meeting World Health Organization / UNICEF "Baby Friendly Status" in not accepting free or low-cost baby formula, feeding bottles or teats, and in implementing 10 steps to support breastfeeding.

b. Mental Health

In the late 1980s and early 1990s the **Ambulatory Care Centre** housed a 30-bed inpatient psychiatric unit. By 1996/97 those beds had been reduced to 14 (Health Services Restructuring Commission, 1997), and by the late-1990s all of those beds were transferred to another hospital (Manager_051806S). As a result of this partnership, a dedicated women's mental health unit was created, while the ACC developed a day program for day-to-day care. With the amalgamation, the ACC had two different institutions to answer to, and neither could agree on the direction that women's mental health should take. Ultimately, the decision was made to separate from the one hospital, and to fully merge the ACC's mental health programs with the other hospital. The ACC got money back from the first hospital, but not beds. The money was redirected to enhance the day program by adding a trauma therapy program, a one-on-one, short-term intensive program for the treatment of men and women's trauma (Manager_010806Sa).

Some see the creation of a life stages program as the only positive thing the ACC achieved from the merger (Researcher_060607S). The program also espouses a team-based approach and includes a range of researchers and complementary practitioners; however, as is the case with most of the ACC's innovative initiatives, the program has a long waitlist. Several interviewees have indicated that general women's psychiatry is still missing, despite the fact that many specialized programs have appeared in its place (Manager_061707S). Without a psychiatry component and in light of long wait lists, it is argued, marginalized populations are not being well-served by the mental health programs (Manager_051806S).

At the **Community Hospital**, prior to 2000, the hospital ran a family education centre, which provided a forum for families to privately discuss pregnancy and non-pregnancy issues including mental health issues directly with a nurse. The program has since been eliminated (Manager_071106SA). Recently, a postpartum depression initiative was started, but these initiatives are not within the maternal and newborn or mental health areas. The program involves a community health centre, public health, the hospital and a community-based mental health agency. The program targets women experiencing episodes of postpartum adjustment, and includes free group support, as well as short-term individual counselling and referrals. In some respects, although these approaches are important, this program still lies squarely within what is traditionally associated as being women's health.

c. HIV/AIDS

HIV programs have not previously been at the forefront of the **Ambulatory Care Centre's** initiatives. Anonymous testing services and counselling are offered, but beyond these services the ACC is just beginning to develop HIV programs (Manager_051806S). In 1997, when the hospital became aware that restructuring was going to force a merger, some people were against merging with another proposed hospital because its HIV focus was not seen as "socially appropriate" or "compatible with pregnant women" (Manager_070506S). In 2007, and with the Ministry supporting the hospital to increase its HIV/AIDS focus, screening and research services started being discussed. A partnership with a women's HIV clinic around research on HIV and women seems to be the best developed of the ACC's preliminary initiatives (ibid.). When the issue of HIV/AIDS care for women was raised with one manager, she indicated "...we've gone to each of them and asked what they are missing or what would be helpful to them. So from all that we will figure out how... we'll need to partner and work with them" (Manager_051806S).

There is a small HIV/AIDS clinic at the **Community Hospital**. Created in 1999, it was driven by the needs of patients who did not want to attend the downtown hospital clinics. The clinic is family oriented and sees a high number of immigrant patients. Since 1999, 4 babies have been born under the clinic's guidance. The clinic also has a partnership with a community organization, which provides milk and diapers for babies of HIV-infected mothers.

d. Cardiac Care

Cardiovascular services at the ACC currently consist of the *Women's Cardiovascular Health Initiative* that was launched in 1996 with a private donation of \$400,000, allowing for the development of a gym dedicated to women's cardiovascular rehabilitation and prevention. The program is run out of the global budget, but, since there is no OHIP funding for cardiovascular rehabilitation, this program never receives more than \$250,000 of the budget. As a result, revenue is generated by user-fees and gym upgrades have been the result of private donations.

At the **Community Hospital**, data on clinical indicators and cardiac care outcomes is available. Data are reported back to physicians, but they are not disaggregated by sex. The hospital does not have a cardiac rehabilitation program or an ambulatory program for those with congestive heart failure.

e. Innovative Services

The **Ambulatory Care Centre** has developed innovative programming. In the case of women's mental health, for instance, it runs a women recovering from abuse program, a trauma therapy program, and a program catering to those with chronic disease. One respondent argues that the fight for survival has prevented the organization from engaging in any truly "new stuff" since development of the cardiac and osteoporosis programs were established (Manager_061707S). Lack of sufficient funding was a persistent theme that was felt to impede the organization from moving forward its model of women focused ambulatory care.

I think that (the Ambulatory Care Centre) has a unique role to play in the way we deliver that care and deliver models of care and develop them within an ambulatory environment. But you can't do it if you don't have the money to actually provide the service 'cause you can't get a model of care if you're not providing the service (Manager_061707).

The same interviewee noted that support services at the **Ambulatory Care Centre**, things like personnel and equipment for state of the art imaging and diagnostics, substantially declined under the amalgamation. The ability to handle late-night emergencies is also gone, since the doors are only open until about 9 p.m. and ambulances can no longer arrive with patients. Surgery is also circumscribed (Manager_061707S). A bright spot is the organization's desire to be at the forefront of innovating women's health ambulatory medicine. The test will be the extent to which it receives funding.

VI. Communities' Voices

This section draws on data from the five community-based focus groups as well as the interviews at the sites, addressing topics such as diversity and board/hospital relations. We asked community organizations about their women's health services, how they currently link or interact with hospitals, and their ideas about gaps in services. In interviews with people located at each of the sites, we asked about the diversity of their patient population, board / hospital relations, and community relationships.

a. Constrained Voices

In 2006 the ACC amended its by-laws to "incorporate a new model of community participation", replacing annual and corporate memberships with community ones, and creating new community advisory panels. Some initiatives currently underway involve consultations about what the **Ambulatory Care Centre's** community advisory panels should look like, how the ACC should address the needs of "undocumented" people (those lacking health insurance), and working with other organizations to address the needs of women living with HIV/AIDS (Manager_090807SB). Despite these initiatives, realizing equity is at best an ephemeral organizational goal that, while talked about, is not really put into practice. Lack of resources and competing issues, such as losing staff positions or closing programs, appear to take priority.

The **Community Hospital's** catchment area includes a diverse population that speaks in excess of 70 languages, and its population is poorer than the average for Toronto.

In relation to the **Community Hospital's** ability to work closely with community, community partner organizations have noted that the hospital is "accessible and responsive to its community partners" (Strategic Plan, 2006). Consultations it held with its community partner

organizations revealed that the hospital must increase its clinical and research foci on community health issues such as determinants of health, wellness and prevention—something highlighted as a broad goal in the women's health philosophy discussed above (Strategic Plan, 2006). The hospital is connected with community organizations, and maintains membership on 20 formalized clinical partnerships, 8 planning committees, 8 education / teaching committees, and 21 networks.

It does currently have a community advisory panel comprised of about 24 members. This panel was formerly a board committee, but it now reports directly to the CEO. They have quarterly meetings to comment on new program initiatives and on program planning and development. In the past, each of the hospital's program areas also had their own community advisory groups, but they were dispensed with in 2001. The hospital is also involved with about 15 other community organizations in a formal structure to provide integrated services in the catchment area.

Several statements from one interviewee point to the community's voice being purposely contained.

...hospitals are probably the most complex organizations to manage and I think when you have significant community interference or anyone interfering with them, that's just exasperated further (Manager_082007TD)

The hospital seems reticent about grassroots, community needs because directors are too overworked to nurture effective outreach (Manager_061907TD) and senior management certainly does not encourage it, owing to constrained resources and the experiences of politicized or incompetent Boards in the past (Manager_082007TD).

...if we see a need in our community that needs to be addressed and we have the resources and expertise and abilities to be able to do that we would do that unless of course the Ministry is saying 'We don't want you to do that.' But I mean that has to be that we have funds available because often there aren't any funds available. (Manager_082007TD)

b. Communities' Needs

The focus groups were largely comprised of community based service organizations helping diverse groups of women across the city. Five groups were held over the course of a two month period: reproductive and sexual health; mental health; cardiovascular health; HIV/AIDS; and general relations between the specific hospital sites and their community based organizations. During the focus groups, participants were asked to reflect on the types of services their

organizations provide; what has changed about women's health services over the course of the past 15 years; the needs of their constituent populations; what gaps persist in women's health services; their organizations' interactions with hospitals; and their dreams about what excellent women's health services would look like in the City of Toronto.

i. Gaps in Women's Health Services

In each of the focus groups we asked about gaps in women's health services. According to one participant,

...women tend to be very directive of [organization name] and say that these are the things that they want. Health services are always at the top of their list because they're not served well. (Service Organization – General Focus)

At each of the groups, group members highlighted health service gaps for women. Figure 1 provides a synopsis of the major gaps noted by participants.

Figure 1. Gaps in Women's Health Services

- Improved case management capacity;
- Psychotherapy and other therapeutic approaches particularly for low income and immigrant women;
- Services for women with eating disorders;
- Proper language translation services;
- Better funding for staff and volunteer accompaniment to appointments to provide for language and cultural translation, and to provide patient advocacy, particularly for low-income women;
- Access to dental care;
- Access to immigrant women's health services;
- Access to lesbian, transsexual, and bi-sexual women's health services;
- Services that address women's healthy sexuality as distinct from treatment of sexual risk and pregnancy planning;
- Community based non-medical women's mental health offered by women's centres, as many have now closed.
- OHIP coverage for home-visiting and hospital-practicing doulas and lactation consultants who make home visits;
- Accessible foot care, particularly for HIV positive or street-involved people;
- If a woman is street-involved, she needs a safe place to store and take medications (like what is already being done for pieces of identification)
- Women need information and education in order to make choices;
- Accessible services where women are located. Some spoke of needing programs focused in the east, and west of the city in addition to the centre;
- Flexibility of scheduling -- recognizing women's requirements around child care and other forms of care

work; this may include some appointments scheduled after 5 p.m.

- There are insufficient numbers of social workers in hospitals;
- Deferral of hospital charges for services not accessible to people on reduced or low-incomes. (e.g. a cast; crutches; or special services offered by the hospital)

In addition to the gaps identified above, several other issues emerged from the groups. One participant noted that hospitals tend to take a symptom-based approach to health, which addresses one problem at a time and is therefore ineffective in dealing with overlapping health concerns (Service Organization – General Focus).

For community agencies, many talked about systemic issues such as Ministerial funding and shortages of staff that affect their ability to fully service their clients' needs.

There's a really strong disconnect in many cases between how the funding is framed through the request for proposals and how you actually need to deliver it because the government seems to have its own agenda regarding ... the optics of the program. And that can often be very... disconnected to the reality of what you need to really service. (Service Organization_General Focus Group)

...we are not able to serve clients who can in fact benefit from our services [because] we don't have enough people to be able to serve them (Service Organization_General Focus Group)

...it's hard to work with people who have really big problems when you have that degree of stress in a workplace where you're just hanging on sometimes by your knuckles. So there needs to be some more care for the caregivers. (Service Organization_General Focus Group)

Patient advocacy was viewed as a universal and time-consuming task performed by many of the community organizations irrespective of the area of health being discussed. Organizations talked about having to accompany women to appointments to provide help or translation. Many organizations, largely comprised of volunteer labour, spoke about their limited capacity to meet women's needs for accompaniment to medical appointments, whether for language or advocacy purposes.

...we found that lots of these immigrant women especially on the [community hospital] mental units ... still have a lot of stigma and that is a big issue and we've been doing lots of education. Most ... have language barrier(s). That's why they cannot access ... the mainstream services. And for the women they are of course quite isolated because of the language barrier and also they are homebound because of the young children at home or the stigma. So it's very hard to get them out. (Service Organization_General Focus Group)

Being a client advocate. That's part of our job at [community organization] as community nurses. That's like our number one job is to advocate for the client and to coordinate their care. (Service Organization_HIV/AIDS Focus Group)

They also discussed how they would follow up with the hospital to make sure that people would arrive at appointments in order to get treatment. They discussed contacting doctors' offices to discuss pain medications or booking appointments. They frequently discussed trying to assist women who are discharged from hospitals without the proper supports in place.

While patient advocacy is a large part of how community agencies liaise with the health system on behalf of patients, the role is now absent in most hospitals, and participants identified this as a service gap.

...a number of hospitals had patient advocates who were great and then they suddenly all disappeared. (Service Organization_HIV/AIDS Focus Group)

[A former hospital] very specifically had an HIV patient advocate because at that time the services were horrific and people were put in isolated units and kept separate from others and there was an incredible stigma to having HIV. (Service Organization_HIV/AIDS Focus Group)

Less frequently, hospitals directly link patients to programs by calling the organizations, though, in some instances, they may indirectly refer a patient to a particular community based program by giving them contact and other information about available services. It is unclear whether

hospitals and physicians do not refer directly simply for reasons of patient privacy or whether they do not see this type of follow-up as part of their job. Improved communication between the hospitals and community organizations is an area that requires attention.

Hospital services that exist outside of the hospital building were identified by one of the focus groups as important for improving diverse women's health needs.

...if the hospital administration could really see the value in their time not being so focused inward in terms of within that structure, that building, but to actually send them out on community buses so that they're taking their experience, their medical information and experience and they're actually engaging with so-called difficult clients. (Service Organization_Mental Health Focus Group)

Communicating more directly with community agencies, whether through lunch and learn sessions or active partnerships may help to reduce the disconnectedness.

Forming partnerships between hospitals and community organizations was a frequently cited topic of discussion. Community organizations do indicate their willingness to partner with hospitals. One participant put it this way:

A hospital can only do so much ... it's about actually having partnerships between the two both so that people who are in hospitals have a savvy and a sense of how to provide care that isn't in such disconnect from the way it's provided in the community so that when a woman goes from one to the other there isn't this big shock... (Service Organization_Reproductive and Sexual Health Focus Group)

For another participant, the following questions were very important: "who does what," "how," and "where"?

I think community can provide some of the health services. But I think it's time for the health sector now to come into the community and to work with the community.(Service Organization_Mental Health Focus Group)

Improved communication between organizations mutually focused on improving outcomes for women's health should certainly be a goal, and, where possible, partnerships to accomplish goals should be encouraged. Hospitals should play a facilitative role in creating partnerships because, although they face cash crunches, they are better resourced in terms of staff and funding.

Hospital aesthetics also emerged as a persistent theme. Participants talked about the way that physical space is configured and how it impacts women's feelings about using its services. For instance, they discussed how the atrium in Toronto Western is more welcoming and familiar, precisely because it does not look like a clinical space. Physical space was often code for "comfort" and "sense of welcoming".

the actual physical space of the Bay Centre is really, really clinical. The look of it, the feel of it, the set up, the way the staff works, the security, all that stuff. And it's not very conducive to making women comfortable about certain things. It sets up a kind of environment which is very hospital like which again kind of goes against some of the things that we're trying to do. The actual physical space is hard.(Service Organization – Reproductive and Sexual Health Focus Group)

The creation of aesthetically pleasing environments that are non-hospital like in appearance, and that provide a sense of warmth were recurrent themes, illustrated by the following two quotes:

...[women] used to be [able to] walk in off the street. It used to be couches and like arm chairs and stuff and it used to be outside a hospital and outside an office building and I think that's a big difference... (Service Organization – Reproductive and Sexual Health Focus Group)

...I realize hospitals might be more limited but having some spaces there where there are things like couches or nice colours on the walls, an actual beautiful space and a pretty space...not all chi-chi but just nice and comfortable and inviting for women. (Service Organization_ Reproductive and Sexual Health Focus Group)

Location also emerged as an important discussion point. Providing accessible services may include providing services where women can easily access them. One participant indicated:

...there has to be outreach ... setting up a service where women have to come to you ... it's not always realistic or feasible for them to do that, so going to where women are, where women already gather. (Service Organization_ Reproductive and Sexual Health Focus Group)

In some cases, hospitals partner with community agencies by providing the clinical staff resources for jointly developed programs (Service Organization – Cardiovascular Health Focus Group; Service Organization – Reproductive and Sexual Health Focus Group). This may be a very effective way for hospitals and community organizations to develop innovative programs for hard-to-reach populations.

In addition to more general comments about women's health services listed above, participants also offered specific comments about some of the four areas our study focused on. With respect to reproductive and sexual health, many cultural and religious issues must be addressed to properly deliver women's reproductive and sexual health services.

Immigrant Women's Health Centre has a mobile van and they go around and they do PAP smears ... the women at [this organization] were readily going there because they feel comfortable ... it's women specific whereas the other health bus isn't. That's when you get into difficulties. Particularly with women who are in the sex trade because if they want to go on and there's men lurking at it ... they're not going to be as honest as they need to be about what their needs are. So that's why they love the Immigrant Health Centre bus. It's a safe environment. (Service Organization_Mental Health Focus Group)

Participants discussed the need for programs to be flexible. One participant indicated that she frequently refers women to the community hospital's breastfeeding clinic because of its flexibility, particularly because it operates on a drop-in basis.

...you don't have to call and make an appointment and then wait for your appointment time to come. They're open 7 days a week and if you know the hours that they're open you can just show up. It's the breastfeeding clinic in the city that I think women who I've worked with have felt the most welcome to just show up, hang out, talk, even talk to other women, wait till the baby needs to feed and then have the experience of getting help with that feed when it's happening instead of being like, in the door, sit down, show me how your baby feeds. 'Well my baby just fed half an hour ago...(Service Organization_Sexual and Reproductive Health Focus Group)

Participants discussed the difficulties some pregnant women experience, particularly those who are under-housed or for whom home is not a safe place, or who do not feel comfortable in the hospital environment. In the mid-1990s, the provincial government under the Harris Conservatives shelved plans to build the Toronto Birth Centre. There may be a need for birthing

centres for women to attain better access. Prenatal Public Health visits are available for women who are at-risk of homelessness or violence, but not for women not so identified.

Service models need to reflect the realities of women's lives. This emerged in discussions about HIV and women's desires to have children.

The face of HIV has changed. A lot of women who are HIV positive want to have families. And so they really need a hospital that's very sensitive to women's issues and their pregnancies and the complications of being HIV and pregnant. These people need to be looked after in a really humane fashion where people are educated and they're not so stigmatized. (Service Organization_HIV/AIDS Focus Group)

When discussing mental health issues, participants noted that an integrated model of care is required—one which deals with a number of issues including harm reduction; safe affordable housing; access to therapists and access to mental health professionals.

...we need to have an integrated care response to people living with mental health. And it's about our government understanding and the various Ministries involved. But where I see hospitals as having so much power and so much leverage is them understanding and being a little bit more political in taking risk and saying: we want to serve these people but we can't do everything. Community agencies can't do everything. These women need supportive housing models that are progressive and responsive to their illness. They need other types of supports in the community. (Service Organization_Mental Health Focus Group)

There was a general consensus that women's psychotherapy services are less accessible than in the past.

I think if we looked at the numbers we would come up with some very discouraging details about how women's services and psychotherapy services have become even less accessible recently. (Service Organization_General Focus)

...in the good old days in the early '80s ... female psychotherapists would have ... a sliding scale where they would allocate a certain number of slots ... to women who were poor or low income that

*couldn't afford the \$85 an hour. And that's a thing of the past now.
(Service Organization_Mental Health Focus Group)*

*...what women are saying is what we really want is therapy, ... in terms
of mental health. ...the community mental health centres don't do it for
us. Most of us have been abused if we've been around long enough by
the psychiatric system or we've been institutionalized before when we
were youth and young women. So that system, they haven't fared well
with that. (Service Organization_Mental Health Focus Group)*

There was also a keen sense that access to mental health services poses unique challenges. For instance, using formal mental health services may pose problems for women who do not want the stigma of a mental health diagnosis. One participant discussed this issue in light of women's access to a service without being formally assessed.

*...people who come to us can be self referred and there is no formal
assessment required. And so they can just self disclose and say well
I'm having trouble and they don't need to be formally assessed in order
to access services. (Service Organization_General Focus)*

When it comes to cardiovascular health, participants note that there is a lack of coordination between hospitals and community agencies when people are discharged from hospital.

c. Responding to Diversity

A key contradiction at the **Ambulatory Care Centre** relates to its goal of diversity. In many ways, the ACC fails to adequately care for the needs of diversely situated women, for example, women of colour, poor women and less educated women. As one interviewee noted:

*Diversity is a huge issue and we're not addressing it. And I think the
difficulty is ... we've depended on very...wonderful women who had
some money, who had a little bit of power ... fighting to keep [the
hospital] as an entity. The difficulty is that you need people with
money and power to get where you're going to get. But I think what's
happened is that you forget, you don't think about the social
determinants of health. You don't think about poverty.
(Manager_030906)*

In an effort to prevent the closure of the hospital in 1997, the senior management submitted a position paper arguing that its “priorities, values, systemic structures and foundational philosophy of [the] Hospital, reflect the priorities, ethical thinking, habits of mind and preferred methods of reasoning, communicating and interacting common to women” (Academic article, 1997: 3). In situating the care that they provide for women, they note that “patients emphasize the kind of empathy, compassion and understanding they receive from the ACC’s staff is only possible because as women themselves, the health practitioners ‘have been there’. This is at the core of the organizations problems inherent in engaging with diversely situated women. It has become a hospital for “women just like us”.

As Sevenhuijsen (1998) argues, it is difficult to care for diversely situated women if they are not represented. Many note that some programs are more attentive to diversity issues than are others, with a clearer link to the organizational discourse of women’s health, including engagement with diversely situated women. The off-site centre for reproductive health is one example of a program that caters to a diverse population of women. The original sexual assault program also epitomized the broad approach to women’s health, but, as one manager noted, “you’re not trying to be all things to all people” (Manager_051806SB).

The organization’s own research of its patient population—which differs from a typical hospital’s geographic catchment in that their patients come from all parts of the city and some from outside of the city as well—showed a “largely English-speaking, Canadian born, probably middle-class white population of women” (Manager_090807SB). Following this research showing that the ACC did not reflect Toronto’s diversity, the ACC Board identified diversity as an issue, and encouraged the work of a diversity committee supported by a coordinator. The ACC has put in place an equity vision for the organization, passed by its Board in March 2007. A work plan was developed over the course of a year, encompassing values and principles of human rights, anti-racism and anti-oppression. It uses inclusive language, espousing barrier-free and responsive services. It tries to address the reality of diversely situated women’s needs, and speaks to the requirement that volunteers, staff, and managers be culturally-competent and sensitive in their practices. The only problem is that the initiative has not been resourced, with the exception of the above mentioned staff position. This a very different situation compared to the work being done at another hospital, where they are championing diversity by dedicating resources to initiatives such as a network for health practitioners to address diversity issues. In fact, diversity seems to be an issue that is being addressed more seriously by other organizations and networks than it is within the ACC (Manager_090807SB).

Addressing the needs of diversely situated women and men is not among the **Community Hospital’s** current priorities (Strategic Plan, 2006), though the hospital’s community is a diverse one. Nearly half of the residents in its catchment area are immigrants who speak languages other than English at home. A higher proportion of low-income households are in the hospital’s catchment area compared with the city overall.

In 2004 the hospital engaged in a strategic planning process, which is renewed and evaluated each year. Among the strategic foci^{vi}, there is an overt concentration on meeting benchmarks. In reviewing key themes that emerged from its 2004 Stakeholder consultations, responsiveness to diversity was identified as a priority by staff, directors, volunteers, the foundation, and local agencies; however, it was not identified as a priority by medical staff. Interestingly, despite the diversity of the population within the hospital's catchment area, managing diversity does not appear in the hospital's strategic success factors documentation (Strategic Plan, 2006). In consultation with local health and social service agencies, the plan indicates that the hospital must "respond better to diversity" and "work harder to meet the needs of "non-connected" patients" (Strategic Plan, 2006). The hospital does use a language translation and interpretation service, but it is not clear whether this service is adequate.

Unlike the case of the **ambulatory care centre**, which cares for "women just like us," that is women who are just like the women providing the services, the **community hospital** attends to diversely situated patients and its workforce is more diverse. Still, addressing diversity issues does not appear to be among its stated priorities.

VII. Accountability and Action

a. Accountability and Measurement

Accountability is a responsibility to report on an action. In the last decade, accountability has been equated with numerical measurement of outcomes, typically financial, though health care clinical outcomes (e.g. morbidity, mortality, lengths of stay) are also widely used. Indicators that are used to measure outcomes are typically scales that measure appropriate performance based on the best available numerical data. Qualitative outcomes –or deep description–have become passé or ignored in a report card, chart, and graph based world. Frequently, accountability is about the available metrics. In other words counting what can be counted, as opposed to what should be counted, described, or explained, despite the fact that this accounting may have little or even no relationship to responsibilities or to true outcomes. An overt focus on numbers and units of service, and specific types of outcomes, are two criticisms of the way in which accountability is operationalized. As one interviewee argues:

...we spend far more time bean counting on every nickel spent than we do on patient outcomes and I can't get timely patient outcome data but the financial data has to be absolutely [perfect] (Manager_072307SB).

The respondent also indicates "... accountability is almost on the dollar instead of the patient care."

Both sites are governed by, and indicate that they adhere to, the Ministry's accountability arrangements, but these are not the only accountabilities. Interviewees at the sites discussed their accountabilities to the Ministry, to their Boards, to their foundations, to community members, to patients and their families, and to physicians and staff members.

While standard reporting procedures are adhered to, each hospital operationalizes its multiple accountabilities in different ways. For the **Community Hospital**, accountability to the Ministry supercedes all others. Conflicting accountabilities were more readily apparent in interviews with the **Ambulatory Care Centre's** staff and physicians. The Ambulatory Care Centre's patient demographic is primarily white, upper and middle-income, urban, women, while the **Community Hospital's** is chiefly multi-cultural and lower income people needing acute care or chronic continuing care. The community hospital does not have programs that sufficiently cater to segments of its population (e.g., women in their diversity).

While the **Ambulatory Care Centre** remains accountable to the Ministry using the prescribed metrics, it also tries to remain accountable to its staff's working conditions, and many interviewees talk about trying to understand and respond to patients' current and emerging needs. Flexibility is a recurrent theme when interviewees were asked about organizational processes, the work environment, and service delivery funding models. Many interviewees remarked on the capacity of the hospital to operate in a very non-hierarchical, flexible way. In terms of organizational processes, the ACC lacks process manuals, and many spoke with pride about the "unwritten guidelines" governing their practices. They also remarked that the hospital is a flexible work environment that attempts to accommodate different people's work-life balance issues. Finally, many spoke about how innovative program delivery, using multi-disciplinary teams, was a critical component of the hospital's operations. They also discussed the relative intransigence of provincial funding for health services, which does not provide adequate base funding to deliver services in a way that truly reflects the culture of women's health espoused by the organization and referred to above.

Many interviewees remarked that many women's health conditions are long-term and chronic, not brief and episodic in nature, but that health services are funded and measured according to the latter model. Recent evidence about women's health at Ontario ICUs shows inequity of services for women over 50 (Fowler et al., 2007). Cardiovascular disease research shows that women have different risk factors, present with a different set of symptoms, and experience unequal access to follow-up treatments in their care for cardiovascular disease (Grace et al., 2004). These findings underline the **importance of having gender and sex specific health services measures**. In other words, services need to accommodate women's specific needs. In not providing services in a way that better reflects women's needs, the health system is inherently unequal, is biased in favour of men's health, and is not accountable to women.

What data we use and how we measure outcomes are important and debated questions. Consensus about how, why, and what should be measured – and valued – to provide a fuller

picture of accountability is lacking. Furthermore, the way that indicator and outcome data are used in decision-making needs to be re-evaluated.

These outcomes are very difficult to establish because sometimes problems take a very long time to get better and some will never improve. One clinician described the issue succinctly:

...if you have chronic pelvic pain and you show up in one of the clinic[s]....for example, that is focusing on this area, you will probably be told in terms of expectations two or three years before you'll start maybe getting [results]... these are problems that don't come quickly and aren't going to go quickly (Manager_072307SB).

The respondent also elegantly articulated how counting something is not the same as achieving outcomes:

Well you're talking about what is the outcome, what is the functional outcome that you're trying to achieve for a patient. And I can say yes, they're getting into doctors' offices but are they achieving their place back in society. That's what we should be measuring. And so I had one of my patients in the pelvic pain centre who came to see me so ecstatic because she had driven herself down to the hospital for this visit and managed to come by herself. It was a huge step for her of independence, of function, of living with joy on her face because she had gotten herself into hospital on her own. I still see her. She is now back living at home with her sister. I'm not going to say this is because of the pelvic pain clinic, but she isn't living a life as a dependent. We have been able to continue to build on that and build on her independence, at least we put value on it. (Manager_072307SB)

In terms of the Board's accountability, some interviewees complained that since the de-merger the Board is being increasingly secretive, undemocratic and "responsible only to themselves and to the Ministry" (Manager_061707S). The previous discussion regarding diversity also underscores an area that needs considerably more attention: the hospital's capacity to be accountable to its community by responding to the needs of diversely situated women.

Accountability at the **community hospital** is discussed using managerial language, and is primarily defined as accountability to the Ministry, especially following a tumultuous period in the hospital's history (Manager_082007TD). Around 1999 the hospital hired a consulting firm to help develop an accountability framework. The following five success factors were identified: patient focus, ensuring value, collaborative spirit, innovation, and encouraging people. These factors are linked to individual accountabilities for each job in the hospital. Following a

Supervisor's appointment, its bylaws were re-written. Part of those changes included forbidding the hospital to run a deficit.

The hospital is highly influenced by previous difficulties at the Board level. A manager notes that "...we are accountable primarily to the Ministry of Health, not the community" (Manager_082007TD). The interviewee also notes that "...we wouldn't undertake a program or a service or stop a program or service without Ministry dialogue and we all see ourselves as not advocating against the Ministry but really working in partnership with them as our primary funder" (Manager_082007TD).

Given the hospital's previous experience with Ministerial supervision, the **community hospital** firmly identifies its line of accountability, which is, according to one Manager, directly to the Ministry, to the patients and their families, and to its foundation that provides funds. Priority setting is top-down, attached to Ministerial priorities and funding dollars. One interviewee noted that part of the hospital's philosophy is to work closely with government:

...we make sure that we are seen as team players but periodically we have requests. And being a team player, I mean you never want to embarrass the Minister or the Ministry of Health. That's sort of our philosophy. We want to work with the government to provide the best service for our community and I think it's worked well.
(Manager_082007TD)

Accountability to the community is circumscribed. Accountability does not translate into advocacy by the hospital, and the hospital's management sees a clear demarcation point guiding its actions:

...we have been in the past (been) approached by some groups that might have an advocacy position, that they want to take, which we always shy away from participating in because then we become at loggerheads with our primary accountability to the Minister of Health.
(Manager_082007TD)

Within the hospital, clinical directors have the ability to move their own budgets around and to shift program priorities. New program funding only moves forward with a business case, which requires a template be filled in to address how the project / program relates back to the strategic plan and the hospital's priorities. New hospital initiatives in an area like women's health, which are not articulated anywhere in the strategic planning process, likely would not receive sufficient support simply within a business case. A cross-hospital initiative such as this would likely have to be integrated into the strategic planning process before proposed projects / programs would be taken seriously.

Initiatives like the electronic patient record, the wait-time strategy, and a new documentation system leave women's health "out of the main stream" (Manager_071106SA). There is a real sense of competition between the different areas, and promoting something like "women's health" means something else has to go to the back of the line. There is also a sense that initiatives focused on certain disease areas carry more weight and receive more support.

Restructuring using a strategic planning and benchmarking exercise in 2005 has focused on cutting \$6 million in administrative costs over one year with a major emphasis on streamlining management. As a result, program directors are not replaced when they retire or quit, and remaining directors are taking on more and more areas of responsibility (Manager_071106SA). Since the hospital's restructuring efforts began, many different program areas were consolidated under a single director: respirology, cardiology and adult and elder care have become medicine; musculoskeletal, ORS and general surgery have become surgery; emergency and pharma have become one; and maternal and newborn, and mental health have become one (Manager_082007TD). The budgets for some of these areas are larger than the entire global budgets of most of the hospitals in Ontario. Each of these areas reports to one of three vice presidents. The consolidation has both negative and positive implications. While it reduces program silos, and may create opportunities because one can move around large budgets that include more than human resources, on the downside it also increases workloads, and, with cost-cutting, other managerial positions are not quickly replaced, in part because of the need to recruit people with cross-functional skills.

Furthermore, the hospital's operating budget does not keep pace with the costs of running the hospital. For instance, union negotiated salaries increased just over 3 per cent in 2006, but the budget only increased by 2 per cent. Over time, the gap between revenue and expenses keeps increasing. It is not an abrupt change, as the hospital knows what their Ministry funding will be year over year, and can calculate its commitments. This explains in part why the hospital is constrained in terms of filling positions and meeting community needs. As one interviewee noted:

We know what our funding is going to be and we plan for that. And that's why we don't take on new programs and services without having a business case in place because that's how hospitals get into difficult situations and hospitals also get in difficult situations if they try to meet all of the needs in their community. That's not our mandate. It's the government's mandate to meet all the needs within the community. It's not our mandate 'cause we don't have the resources (Manager_082007TD).

In order to manage to their budget, the hospital undertakes several different initiatives. Firstly, it does not launch new programs without a business case. It tries to automate as many

processes as possible, and uses workflow tools to map individual work processes in identifying areas that can be streamlined. It attempts to transfer care to the community because "if it's not acute care...it's not something that must be done in the hospital" (Manager_082007TD). The hospital retains some ambulatory care services so that it can have physicians covering the emergency department, but it has found that they spend more on ambulatory care than other hospitals. As a result, it is reviewing which services, including diagnostics (e.g., hearing tests, ultrasounds, heart stress tests) and education services (e.g., diabetes counselling), are necessary. It also refers out minor operations such as biopsies, which it can transfer out of the hospital to physician offices or to the community, including private clinics and practices.

Despite its difficulties, one interviewee indicated that the hospital is viewed as an industry leader and recognized for having good leadership, strong community relationships, and excellent relations with physicians. The hospital does not see itself catering to particular groups overall. Its aim is to be a general community teaching hospital meeting the acute care needs of local residents. One interviewee noted that:

As soon as you start saying 'We're going to focus in on women's health' internally you're going to have a big divide. Oh. So I'm going to lose my resources and they're going to be going for (that)?".... When we've done our consultation internally and externally we're not hearing 'I've got to have a women's health program that's the best in all of Toronto.' (Manager_082007TD)

When asked if the hospital is even asking whether or not it should have a greater focus on women's health issues, the response was as follows: "We're not asking 'Should we have the best men's health program in all of Toronto.' We're asking more general questions. It's a challenge because all of our resources are dedicated right now" (Manager_082007TD). Dedicated resources aside, however, the hospital has run a surplus budget for the past six years.

VIII. Health Equity for Women's Health: Conclusions and Recommendations

This report documents changes to women's health services in Toronto since 1990. Drawing on key informant interviews, focus groups, archival and current documents and the research literature, our study reveals that there are both excellent examples of innovation in women's health and areas that require more investment. In other words, the provision of women's health services is fraught with contradictions.

Using the experiences of people working at two sites as a means to better understand trends and issues, the research gauges the extent to which services have been privatized; retrenched;

internally re-organized; improved; shifted to the community; ignored; or made obsolete. We explored changes to the location, accessibility, and availability of care for women, and the women-centred philosophy guiding care delivery. The report discusses how the Ambulatory Care Centre and the Community Hospital operationalize their women's health philosophies. In each of the care settings we explored discourses and organizational practices of caring for women as both patients and providers of care. We noted who is and who is not cared for, who provides the care, and how the organizations are challenged in the practice of their caring. In this final section, we identify areas for a) further policy development by the Ministry, the LHINs and individual hospitals, and b) future research that should be conducted in order to create a fuller account of women's health in the city.

a. Policy Development

i. Equity for Women's Health Services

Despite the increasing volume of good research documenting disparities in women's access to health services in many clinical areas, most services are neither funded nor delivered using a gender and sex based lens. If organizations continue to operate as though women's health is primarily about reproductive and sexual health, then there will continue to be serious inequities and poorer outcomes for women's health in the province.

In some instances, positive change may be hampered by administrators' and policy-makers' inadequate approaches to addressing equity. Treating everyone the same is not equitable. To be equitable, women's health requires different approaches than men's health. It requires that resources be shifted to target the needs of diversely situated women, acknowledging that women do not currently access services in the same ways as men, present with the same symptoms, have supports available to care for them when they are sick, nor require the same clinical interventions.

Even when organizations have taken the initiative to develop women's health programs and a unique vision for the future of women's health, our research shows that there may be problems with implementation as a result of health system barriers. Both institutions articulated problems with moving women's health values forward, highlighting how internal discursive logics were hampered by political pressures and priorities that pulled attention or resources away from women's health services training, research and practice.

There must be a system level response to this serious inadequacy. We recommend the following:

- The Ministry and all LHINs should require hospitals to adopt a health equity plan. Hospitals' health equity plans must acknowledge that:

- Health equity is not about treating everyone the same; it is about how men and women can access health care resources to achieve their health potential.
- Gender and biology contribute to health.
- All services must be considered women's health services.
- Women's health services, delivered in a way that acknowledges the needs of diversely-situated women, need to be targeted as current ways of delivering services are not meeting women's health needs.
- Hospitals must implement a culture that questions whether, and how well women are able to access services.
- Hospitals must adopt performance measures related to women's access to service, and women's health outcomes.
- The Ministry and the LHINs must adopt broader definitions of women's health services including, but more expansive than, reproductive and sexual health. The Ministry must support women's health by targeting more funding for gender-based and sex-based women's health research.
- In its stewardship role, the Ministry must demonstrate a commitment to supporting equity for all women's health services (not just some reproductive and sexual health services). Strategies to accommodate equity need to take both sex and gender into account. In other words, biological and social, economic and political experiences contribute to ill health and must be incorporated into health models.
- The Ministry must ensure that women's equitable access to targeted care services is given priority attention by being treated as a critical issue across the province.
- The LHINs must direct hospitals to incorporate a broad definition of women's health into their clinical areas, and to adopt performance indicators and standards to measure progress in terms of equitable access.
- The LHINs must ensure that funding flows to individual hospitals to properly implement plans to address local health needs of diversely situated women.

ii. Responding to Diversity

Diversity issues are not sufficiently addressed at hospital, regional, or ministerial levels. Programs that target specific cultural groups are lacking. Language translation and cultural competency training of staff need improvement. Programs that address diversity must not only consider race / ethnicity and culture, but also ability, sexual orientation and identification, as well as the needs of the poor, homeless, socially isolated, and disadvantaged.

Hospitals need to reach out to their immigrant populations and people who are marginalized, socially disadvantaged and/or isolated. To do this, hospital staff should work with community organizations to create programs located in the community close to the places where people who require these services reside. Relationships with the community may improve if the

hospitals could make efforts to have staff and physicians create substantive connections with community organizations, which would help to improve patient referral in both directions.

- The Ministry and the LHINs need to incorporate a vision of health that addresses the complexity of diversity and that funds hospitals to do more than worry about who comes through the door.
- Hospitals need to be empowered (funded) to be community leaders and to help to engage with and lead innovative change. Addressing immigrant women's health and that of the socially disadvantaged is crucial.
- The Ministry and all LHINs should require hospitals to implement a diversity policy, grounded in an analysis of the demographics and needs of their patient populations. Everything from translation, to food choice (e.g. Kosher, Halal, Asian etc.), and availability of take-home information should be considered and should appropriately reflect the cultural composition and literacy of their local patient populations.

iii. Matching System Level Priorities to Organizational Level Innovations

There is a wide and growing gap between the two organization's women's health "talk," (their discourse) and their women's health "action" (the actual practice of caring for women). This disconnect occurs at both the organization strategically focused on women as clients and providers, and at the community hospital which is committed to serving its geographic catchment area. While these organizations demonstrate a willingness and some capacity to care for women in ways that differ from past approaches, and their discourse about women's health services is broad and inclusive, system level issues including current funding streams, and Ministerial priorities aligned with political issues such as waiting times, do not adequately support alternate visions which represent improved equity for diversely situated women.

Current methods of counting accountability, which emphasize financial and quantitative measures, but fail to consider other measures of quality, do not adequately support alternate practices that represent improved equity for diversely situated women. Policy makers must consider accountability more broadly than as a process of counting service units and budgets. Accountability should reflect rigorous qualitative and quantitative measurement and analysis. Important outcomes are lost, and programs are discontinued, when outcomes measurement and accountability rules are too narrowly focused on financial or short-term outcomes data, but ignore the spectrum of experience that come with details and contexts.

- How the Ministry and LHINs "count" accountability and measure outcomes require re-evaluation, as narrowly defined measurement and accountability regimes are inadequate and miss important qualitative measures of quality.

The Ministry needs to prioritize women's health across the province by emphasizing women's health outcomes, performance indicators and standards in accountability reporting frameworks.

As part of this, gender- and sex-based teaching, research and clinical practice for all health conditions must be implemented as part of equitable health care.

- The Ministry and LHINs must be measured on the extent to which they implement gender- and sex-based outcomes, performance indicators and standards in accountability reporting frameworks.

iv. Different Outcomes With Different Funding Approaches

The Ministry and LHINs need to amend the incentive structures in the priority areas of women's health equity and health diversity. The acute care disease model is not completely attuned to the ways in which the majority of women experience ill health. But, the current hospital-funding model does not adequately reward an integrated, chronic approach to health care, or a careful reflection of managing diversely situated patients and providers.

The Ministry and LHINs should:

- Fund hospitals and community organizations to jointly address chronic health problems and diseases. Hospitals are increasingly focusing on problems that are acute and episodic and are downloading chronic health problems to the community. The community lacks resources to properly address the gaps in service.
- Identify how to best facilitate these relationships by implementing sustainable project- and program- based operational funding and partnering on coordination.

Innovative programs that are interdisciplinary in nature and address a wide gap in service are lost when stable operational funding is not secured. In order to create program continuity and to allow for innovation that develops over time, the Ministry and LHINs must address the ways in which innovative programs are funded.

- The Ministry and LHINs must support innovative programs that cross professional practice areas, service areas (e.g. health, social welfare, education) and are multi-institutional (involving more than one hospital or community organization) with stable operational funding, moving away from the current emphasis on short-term program-funding.
- It is important to create funding agreements that maintain sufficient staff resources and create interdisciplinary teams;
- Put in place access to long-term funding for innovative programs that can demonstrate research and clinical importance;
- Long-term funding for innovative cross-disciplinary programs should draw on the hospital's global budget;
- Provide funding for hospital-community linkages.

The Ministry and the LHINs need to evaluate the current funding model and consider implementing different delivery models, especially in an academic setting, so that innovative programs that can demonstrate a financial need are able to access additional operational funding. In this way, proper evaluation can occur, and dissemination of best practices to other community hospitals is possible. In order to achieve this goal, the Ministry should consider the following:

- Implementing salaries for doctors working in areas of research and clinical significance where there is a good possibility for amending knowledge and practice;
- Financially supporting innovative approaches that seek to promote wellness and address “chronic” health problems with outcomes that are longer term and more qualitative in nature.
- Funding the development and on-going creation of interdisciplinary teams that adequately address the ways in which women need, and want, to use health services.

b. Women's Health Research: Beyond Structural and Service Barriers

Far from arguing that greater equity can be achieved by providing the same services for everyone, this report argues that funding priorities and rules must better accommodate and target the needs of diversely situated women.

Research linking women's needs -- in terms of their bodies and life experiences -- to their (lack of) access to service is crucial because hospital administrators, policy-makers and even clinicians frequently assume that men's and women's health require the same services and supports. Research in the clinical areas discussed in Section I shows that this is not the case. Despite substantive research evidence pointing to the need for services tailored to meet different women's needs, and addressing both biological and gendered health determinants, much remains to be done.

Macro-level structural and meso-level system barriers need addressing if we are to realize gains in women's health equity and diversity. A growing body of literature documents macro level structural barriers to health, for instance, how the social determinants of health, things like poverty, homelessness, recent immigration, and lower levels of education, are also implicated in putting one at greater risk for poorer health. We are only starting to understand the ways that cultural practices are implicated in health and wellness.

Research on health system barriers documents women's inequality of access when services are designed to suit *everyone*. Research showing how funding practices, accountability practices, and even clinical assessments that do not support women is critical to improving women's health equity.

Policy-makers need to look at qualitative and quantitative research that addresses sex and gender in terms of identifying needs and service delivery gaps. The Ministry and LHINs must support excellence in Women's Health Services research and service delivery by:

- Protecting the links between clinical work, research and innovation;
- Championing women's health equity and diversity planning across the province;
- Strongly supporting and funding leading edge sex- and gender-based health research, research infrastructure and research chairs across the province;
- Providing operational funding to organizations that create and maintain virtual women's health networks; and
- Cultivating open arenas of exchange for knowledge mobilization between research, program design and delivery, and clinical practice by implementing performance measures and standards.

Current research that develops and assesses women's health indicators and outcomes must continue to be supported by the Ministry and granting agencies, but with an important caveat. Use of indicators, and the measurement of outcomes, must not be confined to readily available data, financial indicators, or standard clinical metrics, which tell us little about the people receiving care.

- Policy-makers and researchers must identify and develop indicators based on what we need to know, and then build measurement and data collection systems around this. Our current emphasis on using readily available data is not meaningful in terms of outcomes or accountability. In addition, it says little about the populations receiving the care.

We need to stop making women's health secondary to "mainstream" research and service delivery agendas that homogenize populations by not successfully accommodating women's different needs and experiences.

IX. References

- Abramson, Zelda. (2002). "Losing Heart: The Estrogen Dilemma - Rethinking Health Research for Midlife Women". *Women's Health and Urban Life*, 1(1): 1-13.
- Academic article (1997). Toronto: [organization].
- Anderson, C. M., Robins, C. S., Greeno, C. G., Cahalane, H., Carr Copeland, V., and Andrews, R. M. (2006). "Why Lower Income Mothers Do Not Engage With the Formal Mental Health Care System: Perceived Barriers to Care". *Qualitative Health Research*, 16 (7), 926-943.
- Annual Report. (2007). *Annual Report*. Toronto: [organization].
- Armstrong, P. (2003). *Promoting Equality for Men and Women*. Paper presented at the Gender and Health Summit.
- Arriaga, Alexandra (2002). "HIV/AIDS and violence against women." *Human Rights*. 29(3): 18-20.
- Batt, Sharon. (2003). "Hormone Therapy: Health Protection Lessons from the Women's Health Initiative". *Centres of Excellence for Women's Health research Bulletin*, 3(2): 4-6.
- Bentley, Kristina. (2004) "Women's Human Rights and the Feminisation of Poverty in South Africa." *Review of African Political Economy* 31(100): 247-61.
- Bierman, A. (2005). *Ontario Women's Health Report Card: Improving Health and Promoting Equity for the Women of Ontario (Proposal)*. Toronto: POWER.
- Bourbonnais, R., Brisson, C., Malenfant, R., and Michel, V. (2005). "Health Care Restructuring, Work Environment, and Health of Nurses". *American Journal of Industrial Medicine*, 47, 54-64.
- Bourbonnais, R., and Mondor, M. (2001). "Job Strain and Sickness Absence among Nurses in the Province of Quebec". *American Journal of Industrial medicine*, 39, 194-202.
- Campbell, Jacqueline C. (2001). "Abuse During Pregnancy: A Quintessential Threat to Maternal and Child Health - so when do we start to act?" *Canadian Medical Association. Journal*. 164(11): 1578-1580.
- Chege, Jane. (2005) "Interventions Linking Gender Relations and Violence with Reproductive Health and HIV: Rationale, Effectiveness and Gaps." *Agenda* Special focus: 114-23.

- Chernomas, W. M., and Clark, D. E. (2006). "Fostering Social Support for Women Living With Serious Mental Illness." *Centres of Excellence for Women's Health, Research Bulletin*, 5(1), 14-15.
- Colman, R. (2003). *A Profile of Women's Health Indicators in Canada*. Prepared for the Women's Health Bureau, Health Canada. Halifax: GPI Atlantic.
- Cubbin, Catherine; Paul A. Braverman; Marchi, Kristen S.; Chavez, Gilberto F.; Santelli, John S and Brenda J. Colley Gilbert. (2002). "Socio-economic and racial/ethnic disparities unintended pregnancies among postpartum women in California". *Maternal and Child Health Journal*, 6(4): 237-246.
- Donner, L. (2003). *Including Gender in Health Planning: A Guide for Regional Health Authorities*. Winnipeg: Prairie Women's Health Centre of Excellence.
- Doyal, Lesley (1995). *What makes women sick: gender and the political economy of health*. New Jersey: Rutgers University Press.
- Doyal, Lesley (2000). "Gender Equity in Health: debates and dilemmas". *Journal of Social Science and Medicine*, 51: 931-939.
- Doyal, Lesley (2002). "Putting gender into health and globalization debates: new perspectives and old challenges." *Third World Quarterly*. 23(2): 233-250.
- Feldberg, Georgina and Miller, Fiona. (1996) "*Who's Counting? The Faulty Calculations of the Metropolitan Toronto District Health Council's Hospital Restructuring Committee*", Centre for Health Studies, York University, November 14, 1996.
- Fowler, R. A., Sabur, N., Li, P., Juurlink, D. N., Pinto, R., Hladunewich, M. A., et al. (2007). "Sex- and Age-based differences in the delivery and outcomes of critical care". *CMAJ*, 177(12), 1513-1520.
- Fugh-Berman, Adriane. (2006). "Menopause and Heart Disease: Another Myth Dashed". *Women's Health Activist*.
- Garcia-Moreno, Claudia, and Charlotte Watts. (2000) "Violence against Women: Its Importance for HIV/AIDS". *AIDS* 14: S253-65.
- Gatali, M. and C. Archibald (2003). "Women and HIV". *Women's Health Surveillance*. H. Issue: available at: http://www.phac-aspc.gc.ca/publicat/whsr-rssf/chap_26_e.html.
- Gettleman, L., and Winkleby, M. A. (2000). "Using focus groups to develop a heart disease prevention program for ethnically diverse, low-income women". *Journal of Community Health*, 25(6), 439-454.

- Go, Vivian F., et al. (2003) "When HIV-Prevention Messages and Gender Norms Clash: The Impact of Domestic Violence on Women's HIV Risk in Slums of Chennai, India." *AIDS and Behavior* 7.3 (2003): 263-72.
- Grace, S. L. (2003). "A Review of Aboriginal Women's Physical and Mental Health Status in Ontario". *Canadian Journal of Public Health*, 94(3), 173-175.
- Grace, S. L., Fry, R., Cheung, A., and Stewart, D. E. (2004). "Cardiovascular Disease". *BMC Women's Health*, 4(Suppl 1: S15.).
- Graham-Garcia, J., Raines, T. L., Andrews, J. O., and Mensah, G. A. (2001). "Race, ethnicity and geography: Disparities in heart disease in women of color". *Journal of Transcultural Nursing*, 12(1), 56-67.
- Grover, Steven A. (1999). "Estrogen replacement for women with cardiovascular disease. Why don't physicians and patients follow the guidelines?" *Canadian Medical Association Journal*, 161(1): 42-43.
- Hall, N. (1998). "Context of Women's Lives Informs How We Understand and Treat Mental Health Issues". *Visions: BC's Mental Health Journal*, 3, 2-3.
- Health Canada. (2003). *Women's Health Surveillance in Canada*. Ottawa: Minister of Public Works and Government Services Canada.
- Health Services Restructuring Commission. (1997). *Metropolitan Toronto Health Services Restructuring Report*. Toronto: Health Services Restructuring Commission.
- Hirschmann, Olaf. (2005) " 'Culture of Rape': Men, Sexual Violence and HIV/AIDS in South Africa." *curare* 28.2-3: 289-308.
- Horne, T., L. Donner, and W. Thurston. (1999). *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*. Winnipeg: Prairie Women's Health Centre of Excellence.
- Hough, E. S., Magnan, M. A., and et al. (2005). "Social Network Structure and Social Support in HIV-Positive Inner City Mothers". *Journal of the Association of Nurse in AIDS Care*, 16(4), 14-24.
- Jasinski, Jana L. (2004). "Pregnancy and Domestic Violence: A Review of the Literature". *Trauma, Violence and Abuse*, 5(1): 47-64.
- Johnson, P. A., and Fulp, R. S. (2002). "Racial and Ethnic Disparities in Coronary Heart Disease in Women: Prevention, Treatment and Needed Interventions". *Women's Health Issues*, 12(5), 252-271.

- Johnson WD, Hedges LV, Diaz RM. (2003) "Interventions to modify sexual risk behaviors for preventing HIV infection in men who have sex with men". *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD001230. DOI: 10.1002/14651858.CD001230
- Johnson, F. Catherine. (2001) "Strategies to End Gender Based Violence: The USAID Approach." *Development* 44.3: 125-8.
- Jordon, M. and Stuart, N. (1999/2000) "Hospital Mergers: Why some fail and others succeed". *Healthcare Quarterly* (Winter), 41-46.
- Kalichman, Seth C., and Leickness Simbayi. (2003) "Perceived Social Context of AIDS in a Black Township in Cape Town." *African Journal of AIDS Research* 2.1: 33-8.
- Karasek, R. and Theorell, T. (1990) *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books.
- Kathewera-Banda, Maggie, et al. (2005) "Sexual Violence and Women's Vulnerability to HIV Transmission in Malawi: A Rights Issue." *International Social Science Journal* 57.4: 649-60.
- King, K. M., Thomlinson, E., Sanguins, J., and LeBlanc, P. (2006). "Men and women managing coronary artery disease risk: Urban-rural contrasts". *Social Science and Medicine*, 32(5), 1091-1102.
- Klot, Jennifer, and Pam DeLargy. (2007) "Sexual Violence and HIV/AIDS Transmission." *FMR* 27.Jan: 23-4.
- Kramer, Michael S. (1998). "Maternal nutrition, pregnancy outcome and public health policy". *Canadian Medical Association Journal*, 159 (6): 663-665.
- Kramer, MS; Seguin, L.; Lydon, J. and L. Goulet. (July 2000). "Socio-economic disparities in pregnancy outcome: Why do the poor fare so poorly?" *Paediatric Perinatal Epidemiology*, 14(3): 194-210.
- Krippendorff, K. (1980). *Content Analysis: An Introduction to its Methodology*. Beverley Hills, CA: Sage Publications.
- Lin, V., S. Gruszyn, C. Ellickson, J. Glover, K. Silburn, G. Wilson, and C. Poljski. (2003). *Comparative Evaluation of Indicators for Gender Equity and Health*. Kobe: Women and Health Program, World Health Organization, Centre for Health Development.
- Lawlor, D., Davey, S., G. , Patel, R., and Ebrahim, S. (2005). "Life-course socioeconomic position, area deprivation, and coronary heart disease: findings from the British women's Heart and health Study". *American Journal of Public Health*, (1), 91-97.

- Lawlor, D., Smith, G., and Ebrahim, S. (2004). "Socioeconomic position and hormone replacement therapy use: explaining the discrepancy in evidence from observational and randomized controlled trials". *American Journal of Public Health*, 94(12), 2149-2154.
- Leenerts, Mary Hobbs. (1999) "The Disconnected Self: Consequences of Abuse in a Cohort of Low-Income White Women Living with HIV/AIDS." *Health Care for Women International* 20(4): 381-400.
- Leiter, Karen, et al. (2006) "Human Rights Abuses and Vulnerability to HIV/Aids: The Experiences of Burmese Women in Thailand." *Health and Human Rights* 9.2: 88-111.
- Lichtenstein, Bronwen. "Domestic Violence, Sexual Ownership, and HIV Risk in Women in the American Deep South." (2005) *Social Science and Medicine* 60(4): 701-14.
- Lipsky, Sherry; Holt, Victoria L.; Easterling, Thomas R. and Cathy W. Critchlow. (September 2003). "Impact of police-reported intimate partner violence during pregnancy on birth outcomes". *The American College of Obstetricians and Gynaecologists*, 102(3): 557-564.
- Mabala, Richard. (2006) "From HIV Prevention to HIV Protection: Addressing the Vulnerability of Girls and Young Women in Urban Areas." *Environment and Urbanization* 18(2): 407-32.
- MacPherson, KI. (1992). "Cardiovascular disease in women and noncontraceptive use of hormones: a feminist analysis". *Advances in Nursing Science*, 14(4): 34-49.
- Maggi, J., and Daly, T. (2006). "Gender matters: understanding the emotional and social support needs of women with HIV/AIDS". *Centres of Excellence for Women's Health Research Bulletin*, 5(2), 16-17.
- Mantell, Joanne E., et al. (2006) "The Mpondombili Project: Preventing HIV/AIDS and Unintended Pregnancy among Rural South African School-Going Adolescents." *Reproductive health matters* 14(28): 113-22.
- Martin, S.L.; Beaumont, J.L. and L.L. Kupper. (2003). "Substance Use Before and During Pregnancy: Links to Intimate partner Violence". *American Journal of Drug and Alcohol Abuse*, 29(3): 599-617.
- McDonough, P. (2000). "Job Insecurity and Health". *International Journal of Health Services*, 30(3), 453-476.
- Mensah, G., and Dunbar, S. (2006). "A framework for addressing disparities in cardiovascular health". *Journal of Cardiovascular Nursing*, 21(6), 451-456.
- Misra, D. (2001). *The Women's Health Data Book: A Profile of Women's Health in the United States*, 3rd Edition. Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation.

- Morrow, M. (2003). *Demonstrating Progress: Innovations in Women's Mental Health*. Vancouver: BC Centre of Excellence for Women's Health.
- Morrow, M., and Chappell, M. (2000). "Hearing Voices": Mental Health Care for Women. *Centre of Excellence for Women's Health Research Bulletin*, 1(1), 18-19.
- Murdaugh, C. (1990). "Coronary artery disease in women". *Journal of Cardiovascular Nursing*, 4(4), 35-50.
- Murphy, Claire C.; Schei, Berit; Myhr, Terri L. and Janice Du Mont. (2001). "Abuse: A Risk Factor for Low Birth Weight? A Systematic Review and Meta-Analysis". *Canadian Medical Association Journal*, 164 (11): 1567-1572.
- O'Manique, Colleen (2004). *Neoliberalism and the AIDS crisis in Sub-Saharan Africa: globalization's epidemic*. New York: Palgrave-Macmillan.
- Ontario Women's Health Network. (2006). *Review of Health Canada's Women's Health Strategy*. Toronto: Wellesley Central Health Corporation.
- Onyejekwe, Chineze J. (2004) "The Interrelationship between Gender-Based Violence and HIV/AIDS in South Africa." *Journal of International Women's Studies* 6(1): 34-40.
- [Organization], (2006), *Media Release*, accessed on February 22, 2008.
- [Organization]. (2000). *Strategic Plan, Draft # 1* Toronto: [organization].
- Outwater, Anne, Naeema Abrahams, and Jacquelyn C. Campbell. (2005) "Women in South Africa: Intentional Violence and HIV/AIDS Intersections and Preventions." *Journal of Black Studies* 35.4: 135-54.
- Petchesky, Rosalind Pollack (2000). "Human rights, reproductive health and economic justice: why they are indivisible." *Reproductive Health Matters*. 8(15): 12-17.
- Pilote, L., Dasgupta, K., Guru, V., Humphries, K. H., and McGrath, J. (2007). "A Comprehensive View of Sex-Specific Issues Related to Cardiovascular Disease". *Canadian Medical Association Journal*, 176(6) (SUPPL), S1-44.
- Public Health Agency of Canada, (2005), *HIV/AIDS EPI Updates*, Her Majesty the Queen in Right of Canada, represented by the Minister of Health, May, pp. 25-29.
- Public Health Agency of Canada. (2005). *HIV in Canada Among Persons from Counties where HIV is endemic*. Ottawa: PHAC.
- Reid, C. (2002). *A Full Measure: Towards a Comprehensive Model for the Measurement of Women's Health*. Vancouver: British Columbia Centre of Excellence for Women's Health.

Review article. (2005). [organization].

Rhodes, A. E., Goering, P. N., To, T., and Williams, J. I. (2002). "Gender and Outpatient Mental Health Service Use". *Social Science and Medicine*, 54(1), 1-10.

Rieker, P. P., and Bird, C. E. (2005). "Rethinking gender differences in health: why we need to integrate social and biological perspectives". *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 60B (2).

Rueda, B., and Perez-Garcia, A. M. (2006). "Gender and the social support in the context of cardiovascular disease". *Women and Health*, 43(1), 59-73.

Salmon, A., Pole, N., Morrow, M., Greaves, L., Richard, I., and Pederson, A. (2006). *Improving Conditions: Integrating Sex and Gender into Federal Mental Health and Addictions Policy*. Vancouver: British Columbia Centre of Excellence for Women's Health.

Seeley, Janet, and Kate Butcher. (2006) " 'Mainstreaming' HIV in Papua New Guinea: Putting Gender Equity First". *Gender and Development* 14(1): 105-14.

Seeley, Janet, Rachel Grellier, and Tony Barnett. (2004) "Gender and HIV/AIDS Impact Mitigation in Sub-Saharan Africa -- Recognising the Constraints." *Sahara J: Journal of Social Aspects of HIV/AIDS/Journal de Aspects Sociaux du VIH/SIDA* 1(2): 87-98.

Sherwin, Susan et al. (1998). *The politics of women's health: exploring agency and autonomy*. Philadelphia: Temple University Press.

Strebel, A., et al. (2006) "Social Constructions of Gender Roles, Gender-Based Violence and HIV/AIDS in Two Communities of the Western Cape, South Africa." *Sahara J: Journal of Social Aspects of HIV/AIDS/Journal de Aspects Sociaux du VIH/SIDA* 3(3): 516-28.

Sevenhuijsen, S. (1998). *Citizenship and the Ethics of Care. Feminist Considerations on Justice, Morality and Politics*. London: Routledge.

Sinclair, D., Rochon, M., and Leatt, P. (2005). *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996 - 2000*. Montreal: Institute for Research on Public Policy.

Sternac, L., and Paradis, E. K. (2001). "Homeless Women and Victimization: Abuse and Mental Health History Among Homeless Rape Survivors". *Resources for Feminist Research*, 28(3/4), 65.

Stewart, D. E., A.M. Cheung, L. E. Ferris, I. Hyman, M.M. Cohen, and J. I Williams. (2002). *Ontario Women's Health Status Report*. Toronto: Ontario Women's Health Council.

Strategic Plan (2006). *Strategic Plan* Toronto: [organization].

- Strategic Plan (2007). *Strategic Plan*. Toronto: [organization].
- Sunnybrook and Women's College Health Sciences Centre Act, (1998) Bill 51, 2nd Session, 36th Legislature, Royal Assent June 26th, Ontario, 2nd Session
- Thomas, J. E., & Zimmerman, M. K. (2007). "Feminism and Profit in American Hospitals: The Corporate Construction". *Gender & Society*, 21(3), 359 - 384.
- Teti, Michelle, et al. (2006) "Identifying the Links between Violence Against Women and HIV/AIDS: Ecosocial and Human Rights Frameworks Offer Insight into US Prevention Policies". *Health and human rights* 9(2): 40-61.
- Türmen, T. (2003). "Gender and HIV/AIDS". *International Journal of Gynaecology and Obstetrics*. 82: 411-418.
- University of Toronto, Faculty of Medicine (1995), *Med.E.Mail*, Nov 6, 1996. Volume 4, No. 10, accessed on September 28th, 2007, on, <http://www.library.utoronto.ca/medicine/medemail/vol4/4number10.html>
- Van Wijk, G., Ta, C. M., Van Vliet, K. P., and Kolk, A. M. (1996). "Gender perspectives and quality of care: towards appropriate and adequate health care for women". *Social Science and Medicine*, 43(5), 707-720.
- Walsh, Deborah and Wendy Weeks. (2004). *The Support and Safety Survey: The Social, Economic and Safety Needs of Women During Pregnancy*. Women's Social Support Services and the Royal Women's Hospital. www.rwh.org.au/emplibrary/socialsupport.WhatASmileCanHide.pdf accessed November 2007.
- Wang, J., and Patten, S. B. (2001). "Perceived Work Stress and Major Depression in the Canadian Employed Population, 20-49 Years Old." *Journal of Occupational Health Psychology*, 6(4), 283-289.
- Win, Everjoice J. (2004) "Not very Poor, Powerless Or Pregnant: The African Woman Forgotten by Development." *IDS Bulletin* 35(4): 61-4.
- Wojcicki, Janet Maia, and Josephine Malala. (2001) "Condom use, Power and HIV/AIDS Risk: Sex-Workers Bargain for Survival in Hillbrow/Joubert Park/Berea, Johannesburg." *Social Science and Medicine* 53(1): 99-121.
- Women's Health Committee. (2004). *Women's Health*. Toronto: [organization].
- Women's Health Institute Project. Women's Health Institute Project FAQ. Retrieved April, 2007, from <http://www.womenshealthcouncil.on.ca/English/Women-s-Health-Institute-Questions--Answers.html>

- Wong, J., and Wong, S. (2002). "Trends in lifestyle cardiovascular risk factors in women: analysis from the Canadian National Population Health Survey". *International Journal of Nursing Studies*, 39(2), 229-242.
- Woodward, C., Shannon, H., Cunningham, C., McIntosh, J., Lendrum, B., Rosenbloom, D., et al. (1999). "The impact of re-engineering and other cost reduction strategies on the staff of a large teaching hospital: A longitudinal study". *Medical Care*, 37(6), 556–569.
- World Health Organization. (2004). *Expert Group Meeting on Gender-Sensitive Leading Health Indicators*. Kobe: Women and Health Program, World Health Organization, Centre for Health Development.
- World Health Organization. (no date). *Gender Disparities in Mental Health*. Geneva: World Health Organization, Department of Mental Health and Substance Dependence.
- Zboril-Benson, L. (2002). "Why nurses are calling in sick: the impact of health-care restructuring". *Canadian Journal of Nursing Research*, 33(4), 89-107.

ⁱ More information about the POWER study is available at: <http://www.powerstudy.ca/en/about>

ⁱⁱ Starting in 1996, this arms-length body was charged with implemented reforms to Ontario's health care system.

ⁱⁱⁱ The Hospital's Board retained independence by signing of a management agreement with the merged Hospital Corporation to operate the Ambulatory Care Centre, though all of the assets of the Hospital were transferred to the new Corporation.

^{iv} Academic article from 1997.

^v In 1995/96 the ACC had net expenses of \$76,891,983 (HSRC, 1997). Over a decade later, for the year ending March 31, 2007, the ACC had expenditures of \$73,263,918. Its 2007 Ministry of Health and Long-term Care base budget funding was \$39,316,075 plus one-time funding of \$6,096,268 and other amounts of \$1,622,871 (Annual Report, 2007).

^{vi} Its current strategic foci are to increase patient satisfaction particularly around the provincial wait time measures initiative; increase patient safety; increase its market share in its catchment area; increase staff safety; demonstrate business acumen and accountability; improve patient care through service integration; increase its teaching activities; improve care and productivity through an integrated information system; and increase research activity (Strategic Plan, 2006)

Stay in touch

Register with the wellesleyinstitute.com to participate in our blog discussions and receive the latest news and analysis.



45 Charles St. E. Suite 101
Toronto, ON, M4Y 1S2
416-972-1010
contact@wellesleyinstitute.com
www.wellesleyinstitute.com

The Wellesley Institute advances the social determinants of health through community-based research, community engagement, and the informing of public policy.



Contradictions: Health Equity and Women's Health Services in Toronto by Tamara Daly et al., October 2008, is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 2.5 Canada License.

Media and Publications inquiries, please contact us by phone at 416-972-1010 or by e-mail at contact@wellesleyinstitute.com.