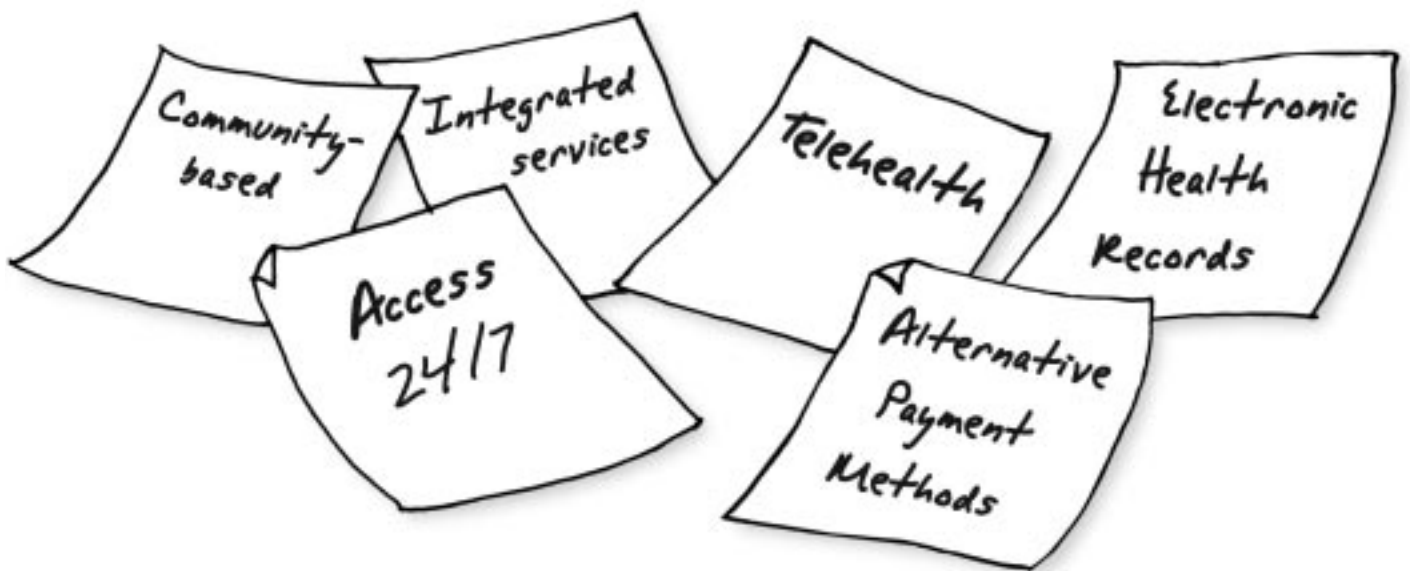


Primary Health Care Reform *and Women*



**Why are these women's issues
and what are the issues
for women?**

This guide is intended to encourage debate about primary health care reform in Canada and why it is important to women. Given that women are both the majority of the users of the health care system and the majority of health care providers, how can reforms be made to work for **all** women — no matter where they live, what their income levels, education, language or health issue, sexual orientation or level of physical disability?

Why Women?



Women use health care services more than men. Much of this difference results from medical care related to reproduction and sexuality. However, women in Canada also tend to live longer than men, with the result that they experience more chronic illness that requires care. Nevertheless, women with chronic diseases are less likely than men with similar conditions to be hospitalized, even though they are more likely to visit physician's offices.

Women also use the health care system differently from men. For instance, until age 15, boys are taken to emergency rooms more often than girls. This pattern is reversed between age 15 and the mid-40s, after which visits by men once again outnumber those by women. These different patterns not only reflect differences in male and female bodies, they also reflect differences in the patterns of men's and women's lives, including our respective involvement in sports, risk taking and alcohol and drug use.

Women are the majority of paid and unpaid care providers. Approximately 80% of health care workers are women and women provide most of the unpaid health care within the home. Women provide unpaid personal care to the elderly and to those of all ages with long-term disability or short-term illness. As unpaid caregivers, women are more likely than men to provide personal care and offer emotional support, while men are more likely to offer care management, household maintenance, shopping or transportation. Women are also the majority of volunteers in the community who do personal care work.

Women have been leaders in change. Women have established health information sources so they are better informed about health and are able to make better decisions about care. Women have challenged the narrow view of women's health as being about reproductive health care, arguing that research needs to better understand how problems such as heart health, addictions, violence, mental health, occupational health, migration and bone health — to name only a few important topics — affect girls and women. Women have been critical of over-prescription of drugs, especially for natural life processes and depression. They have reminded one another and our health care providers that pregnancy and childbirth are natural life events, not diseases, and should be supported by the health care system accordingly. Women have called for recognition of midwives and nurse practitioners as self-regulating health care providers.

Women have challenged accountability mechanisms and resisted limitations on access to abortion and emergency contraception. They have argued for greater access to alternative therapies and for support for the unpaid work of caring for family members. Inside the health care system, they have established some women-focused and women-managed community health centres and have developed programs such as rape crisis programs, food banks, and shelters for women in the community.

Women's Primary Health Care Needs



Women's health needs are different from men's, both as a result of differences in men's and women's bodies and as result of the ways that women live, work, play and study.

Historically, women's health was often thought of in terms of reproduction, in part because female bodies are different from male bodies. Access to comprehensive reproductive care has been critical to improving women's health. It has allowed more women to participate fully in society. The removal of legal barriers to birth control, access to abortion and primary care are therefore priority issues for women both here in Canada and around the world. Without the ability to control if, when and where they have children, women's ability to complete their education and participate equally is compromised. Only women menstruate, become pregnant, give birth, breast-feed or have abortions. Even though women and men may both be concerned with sexual and reproductive health issues, sexually transmitted diseases, birth control and infertility, the differences in our bodies create different options and consequences. For example, women and men are both vulnerable to sexually transmitted infections, but only the woman faces the possibility of an unplanned pregnancy or pelvic inflammatory disease.

However, women's health concerns extend far beyond reproduction.

Women's patterns of illness are often different from those of men. There are conditions or diseases that are not unique to women, but are much more common in women than in men. Women experience higher rates of breast cancer, depression, arthritis, lupus, and self-inflicted injuries than men. As women tend to live longer than men, they experience more chronic illness. While both women and men may try to achieve popular ideals of beauty through too much/extreme dieting and exercise or even surgery, women are much more likely than men to put their health at risk in this way. Hence, disordered eating is a much more significant problem among girls than among boys.

Diseases and illnesses are often not the same in men and women. Until recently, most research focused on men and assumed that the results could be applied to women. For example, women were excluded from research on heart disease for many years. But we know now that the signs and symptoms of many conditions may be quite different for women and men. Men with heart disease are more likely to experience crushing chest pain, sweating, and numbness in the left arm while women are more likely to experience nausea, anxiety and pain radiating from the chest to the neck and jaw. Primary health care providers need to be aware of such differences when making diagnoses and developing strategies to deal with illness and disease.

Women and men may require or receive different treatment or respond differently to the same treatment. Even when women and men have the same health condition or illness, they may receive different treatment. For example, women receive fewer kidney transplants and cardiac bypass surgeries than men, even when living with the same level of disease. On the other hand, women and men may receive identical treatment, whether or not it is appropriate. For example, both women and men may be advised to take aspirin to prevent heart attacks even though research now suggests that aspirin is not as effective for women.

Women face violence and sexual harassment that is different than for men. Much of this violence is hidden in the household, making it invisible to care providers who do not necessarily look for signs of abuse. Women are also much less likely than men to have the resources that would allow them to leave violent households, and are much more likely to be tied to such households by their children.

There are significant differences in health status and the need for health services among diverse groups of women. Women vary enormously in terms of age, culture, language, income and other resources, sexual orientation, where they live, and how much power they have. These differences may produce health inequities among women, create specific health care needs and lead to different patterns of use. This means that 'one size does not fit all' — no single model of care can respond to the needs of all women or even to the needs of one woman over her lifetime. Women need a variety of primary health care options that will meet their needs regardless of circumstances, illnesses, problems or resources. And providers need to be educated to respond to differences among women.

Sometimes, women's problems have been treated as health problems when they are really about other things, such as normal life or body changes, including aging. Some stages of women's lives, such as pregnancy and menopause, may be labelled as health problems that require medical treatment. While some women may benefit from medical treatments, menopause and pregnancy are natural events in women's lives. In the vast majority of cases, these experiences can be managed with little or no medical interference. Sometimes medical treatments are used to help women solve non-medical problems, such as family difficulties, when other forms of care, such as counselling, might be more appropriate.



Women's Lives



Women's lives are different from those of men. Overall, women have *less* financial security and *less* social status than men, but *more* responsibility for caring for others. These differences affect women's health, use of the health care system and ways of responding to the care. If primary health care is going to be effective, it must be provided in ways that recognize that many women have limited resources but significant responsibilities. Primary health care must also recognize differences *among* women.

Women and men do different work, for different rewards. Although there have been many changes in paid and unpaid work patterns over the last century, society still defines men's work as different from women's work. Women are almost as likely as men to work for pay, but are still paid less than men and receive fewer job-related benefits such as pensions. Nevertheless, most women take paid work for the same reason men do — they need the money.

While the majority of women work full-time for pay, women are more likely than men to work part-time, on a casual basis, and at odd hours, due to family caretaking responsibilities and discrimination in the labour force. Paid work, by providing income and sometimes benefits, contributes to women's overall security and health but it also perpetuates inequality between women and men as well as among women.

Women are much more likely than men to have a second job caring for children and doing the housework. As a result, women have more limits on their time and their personal freedom than men. Women also face more stress from handling the demands of paid and unpaid work, and from managing personal relationships. And they face more discrimination in terms of promotion, other rewards and opportunities, even though women now match men in terms of education, training and experience.

Women are the majority of health care providers. Health care work is separated into work done mostly by men and work done mostly by women. Indeed, it is even more sex-segregated than the overall labour force. Health care is women's work. More than 9 out of 10 RNs are women and almost all of the nurse practitioners are women. Women are also most of the nutritionists, the therapists, midwives, counsellors, homecare workers and social workers.

Increasingly women are becoming physicians; they will soon be the majority of family physicians. They are changing the nature of physician practice, in part as a result of their own caretaking and family responsibilities and in part as a result of their ideas about care. Even so, they are not the main decision-makers in primary health care or the main focus in primary health care reform. Power lies mainly with economic policy makers, managers and specialist physicians, most of whom are men.

Meanwhile, women are still the majority of those who provide unpaid personal care in the home and who take others to paid providers for care. They also do most of the paid home support work through homecare services.

Primary health care reform, then, is mainly about women's work even though women are not the ones making most of the decisions about reforms.

Decoding Primary Health Care Reforms

An understanding of the patterns of women's lives, the nature of women's health concerns, and the lessons women have learned from delivering and receiving primary care provide the background for looking at the risks and opportunities in current primary health care reform.

There are many differences in the meaning and forms of primary health care reform across the country. However, when we review the terminology and approaches that are being used, common themes appear. By analyzing these themes, we raise questions about whether proposed and current primary care reforms will meet women's needs.

1. Community-based care

On the one hand...

Community-based care *can* mean that service providers understand and take into account the daily lives of women in their specific communities. It *can* mean that women have services such as mental health counselling, day care, maternity and home care, emergency services and health promotion facilities within a reasonable distance of their homes that are also accessible by public transit.

This kind of community-based care would encourage a wide range of women to participate in deciding about where to put health care resources, what kinds of services to offer, and where to locate those services. It would have service providers who are trained to respond to women's needs, and to the needs of different cultural communities.

This approach to care not only *responds* to communities, it helps *build and sustain* communities.

On the other hand...

Community-based care can be a 'code word' for fewer services because of financial cutbacks. Responsibility for care is shifted to 'the community' while resources are reduced. Too often, a transfer of responsibility has meant



Decoding Primary Health Care Reforms cont'd

a transfer to women who have to take on unpaid care work as volunteers or family members. It has also meant a reduction in care, where women have to purchase more services.

When decisions about community-based care are made 'top-down' by people who aren't invested in the long-term effects for that community, cutbacks can have serious consequences. For example, with less money, some communities may be tempted to provide some or all services in partnerships with for-profit companies. Yet research shows that for-profit health services increase costs and the quality of care and access decline.

Often, with for-profit health services, the working conditions for the mainly female employees get worse. Under the terms of international trade agreements, including the North American Free Trade Agreement (NAFTA), once we adopt this strategy we can't decide to go back to public service delivery even if for-profit care is more expensive, the quality is poor and the working conditions are inferior. We need to be careful about the long-term consequences for short-term decisions.

Despite the glowing evaluations community-governed models like community health centres have received, many new primary care organizations are modeled after physician group practices or after outpatient departments of hospitals. These services are designed and decided by professionals for 'patients,' where the only alternative is to leave if we are not satisfied with the care.

2. 'Integrated services' and primary care teams

On the one hand...

Primary health care services with a wide range of providers who work as a team could address women's needs in the context of their whole lives. A collaborative team can combine skills in ways that are not simply more cost-effective but are also more care-effective. The focus would be on whole women rather than individual parts to be fixed or on isolated illnesses to be treated.

Women could take their children and their parents to the same place for care. Providers, social workers, health educators, midwives, nutritionists and physiotherapists would join nurses, nurse practitioners and doctors as partners in a care team. They would know each other, know the patients, and know the full range of services available in and outside the community. They would recognize that health is determined by many factors, only one of which is medical treatment or tests. Thus, promoting health could be combined with addressing illness.

Primary health care services with a wide range of providers who work as a team could address women's needs in the context of their whole lives.

These care teams could provide supportive work environments for the mainly female providers, where the skills and practices traditionally associated with women's care work are recognized and valued.

On the other hand...

Too often, integrated services mean more doctors in one place sharing space and patients, with perhaps the addition of nurse practitioners who take on some of the doctor's work. These nurse practitioners are hired to reduce doctors' workloads and lower their costs on the assumption that nurse practitioners are less costly than physicians. This approach would do little to challenge the doctor-centred care many women have found problematic or that policy makers and administrators have found so costly. More important, it would do little to shift the focus of care to include the many non-medical factors that influence women's health.

3. Access to health care: '24/7'

One of the most common features of primary health care reform that is being promoted is the concept of access to care 24 hours a day, seven days a week. This is partly a response to providers' needs. Doctors practicing alone cannot easily be on call 24/7. The informal call groups of private physicians have not been effective in providing quality care, because the doctor on call frequently does not know the patients and thus cannot as readily assess a particular patient's needs. Concern about being on call 24/7 is one of the major reason physicians seek urban practices and leave rural communities. At the same time, emergency rooms are responding to primary health care issues such as chronic disease management, the need for reassurance, and gaps in supportive care.

The call for 24/7 is also a response to changes in the lives of women. More women are in paid jobs; combined with the increase in shift work and the distance travelled to work, these changes make 9-5 office visits a challenge.

On the one hand...

Care 24/7 could mean that women do not have to leave their paid work in order to get care for themselves, their children or other adults for whom they are responsible. Equally important, getting care from a 24/7 primary care team could mean that the team would be familiar with the patient/family and could respond to their individual needs in the context of their personal history.

The emergence of nurse-staffed health information phone lines that provide general information on health questions and initial triage, complements on-call systems. Access 24/7 to a member of a familiar primary care team could also save money by improving quality of care and reducing the use of emergency rooms and walk-in clinics.

On the other hand...

Access 24/7 may primarily mean access to a phone service of complete strangers who follow 'canned' scripts for advice. Advice lines are not intended to address our specific needs in the context of our particular lives and histories. Moreover, they may primarily result in advice to seek care at the emergency unit or a walk-in clinic. Naming the service 24/7 does not necessarily mean the same care will be there 24/7.

Decoding Primary Health Care Reforms cont'd

4. 'Telehealth'

On the one hand...

Telehealth is another means of improving care. Electronic communications systems can make it easier to reach women and easier for women to reach providers. Telephone and TV access can be particularly important to those women confined to the house by poverty, frailty or disability. Television screens and computers make it possible to communicate often and at odd hours and enable information such as lab results, consultation reports and new research to be accessed more quickly. Nurse-staffed health information lines provide access to health information as does the World Wide Web.

Telehealth also makes it possible to reach a wide range of experts. Women, who are the majority of those needing home care, could benefit from such services, as could those receiving or providing care in remote communities.

On the other hand...

Much depends, however, on the conditions for getting access to advice or care, and on who answers the phone. Telehealth could mean that electronic communication is substituted for the face-to-face and hands-on contact that can be central to the social support needed for care. It may be a way to justify limiting care rather than an extra mechanism for providing care. It may be a way of treating anonymous patients rather than addressing the primary care needs of individual women. Telehealth could also encourage an emphasis on diagnosis, treatment and cure rather than on health promotion and disease prevention.

5. Electronic patient records

On the one hand...

Electronic patient records can support the blending of services, allowing teams even in remote locations to work together for care. They can reduce the need for duplicating tests and paperwork. A wide range of providers could access records quickly and easily, allowing them to see known risks and failed treatments, and help reduce wait times.

On the other hand...

Electronic patient records are not without risks. They could mean that diagnoses based on traditional assumptions about women are spread and reinforced throughout the system. What comes to mind is how often providers describe women's complaints as "all in their heads." If this assessment of a patient makes it into an electronic record, then she may face unanticipated barriers to good care when she reaches the next provider who has already learned and possibly accepted a colleague's opinion.

Furthermore, the need to communicate quickly and clearly with a wide range of others can mean that complex symptoms and experiences get reduced to simple terms designed to fit the format of a computer program. These terms may be ones used by doctors rather than midwives, therapists and individual women. Many things can be



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Decoding Primary Health Care Reforms cont'd

lost in translation, such as how different parts of a women's life interact to shape her health and different providers' perspectives on care. A woman's specific life situation and relationships are not likely to be captured in electronic shorthand.

Electronic patient records may also lead to a major breach of privacy. Information that women want entirely private, such as an abortion, an HIV diagnosis, or a mental health concern, may be shared among more people than they intend. This information could potentially reach an insurer or an employer. One of the reasons some women have more than one provider is to maintain their privacy and sometimes their anonymity.



6. Alternative Payment Methods

Fee-for-service

The majority of physicians and surgeons in Canada are paid *fee-for-service*. This means there is a price attached to each service they provide, from an assessment of a mole to a Caesarean section. So a doctor who treats a woman complaining of heartburn will be paid the same amount of money, regardless of whether the visit involves five minutes writing out a prescription for heartburn medication or a half-hour discussion about the patient's life, including diet, exercise, stress, etc. More complex surgical interventions and procedures have a higher price tag than primary care services such as cervical cancer screening tests. A doctor is paid more for a Caesarean section than for attending a 'natural birth'.

Some contacts with a doctor, such as advice offered over the telephone or health questions not related to the specific reason for a particular visit may not be paid for at all and so may not bring in any money for the doctor.

Physicians who wish to practice from a health promotion or women-centred model of care or who wish to focus on women with complex health problems will have incomes significantly below those who move patients quickly through the system or who focus on more highly paid procedures.

On the one hand...

The fee-for-service payment model may make doctors more 'efficient' by encouraging them to see more patients and to spend the minimum time required with each. It may also encourage them to focus on quick medical treatments (to save time and see more patients), more complicated procedures (which pay more) and single issues (which take less time) rather than on promoting health and preventing illness.

On the other hand...

Under a fee-for-service system, doctors can increase the number of patients they see and the number of complicated procedures they perform. This makes it difficult for the government to control the total amount paid to doctors, and thus to control the cost of the health care system. Shared care and team approaches can appear as threats to income.

Clients with complex health problems and those needing counselling and support are more expensive for doctors working within a fee-for-service system. Thus all those women with chronic health issues may find it harder to get care.

Alternatives to fee-for-service

For these reasons, most primary health care reforms include ideas about alternatives to fee-for-service payment. One alternative is to pay doctors a *salary and benefits*. This is the practice in many community health centres and community-based services.

Decoding Primary Health Care Reforms cont'd

Global Budgets

On the one hand...

When primary health care organizations are paid through an overall or what is usually called a **global budget**, doctors and other providers are usually paid a salary and benefits. As salaried employees, doctors can take the time to listen to women and to explore their health and social issues without feeling financial pressure to squeeze more patients into a day. Income levels are set through labour/management negotiations and budgeting is made easier for administrators and government. Governments have more control over what doctors are paid and community organizations may as well. When everyone is an employee, expectations about accountability and team participation are easier to put in place.

On the other hand...

Salaried physicians have a different practice approach which typically includes allowing patients to book longer appointment times and deal with multiple issues. In taking the time needed to provide care, physicians are more likely to provide care to those who were excluded from care under the fee-for-service system. In this way, there is a risk that fewer people get access to care.

Thus there can be a conflict between providing quality of care, including the amount of time spent with physicians, and ensuring access to care. Organizations employing doctors may still pressure them to serve a specific number of people per day regardless of the patients' needs and concerns.

In addition, money is not the only driver of health care practice. To achieve some of the elements of primary care that women most want, physicians will need to be educated regarding the work environment, participation in team structures, and about collaborative decision making between providers and with women.

Capitation

One payment method that is becoming more common is called **capitation**. Under this scheme, doctors are paid for looking after a fixed number of patients. This method is usually combined with **rostering**, which requires people to sign up with one doctor or primary health care organization. Payment is provided by a complex fee formula based on patients' age, sex and health status. Capitation funding has been used to fund physician group practices and some community health centres in Canada. In Canada, people on a roster are free to use other health services should they wish to. However, should this happen, the organization they are rostered with could be charged for the service.

On the one hand...

This approach could mean that women and their families would have a sense of engagement when they belong to a primary health care group. It could also mean people will see the same health provider or group of providers over time, thus creating continuity in care.

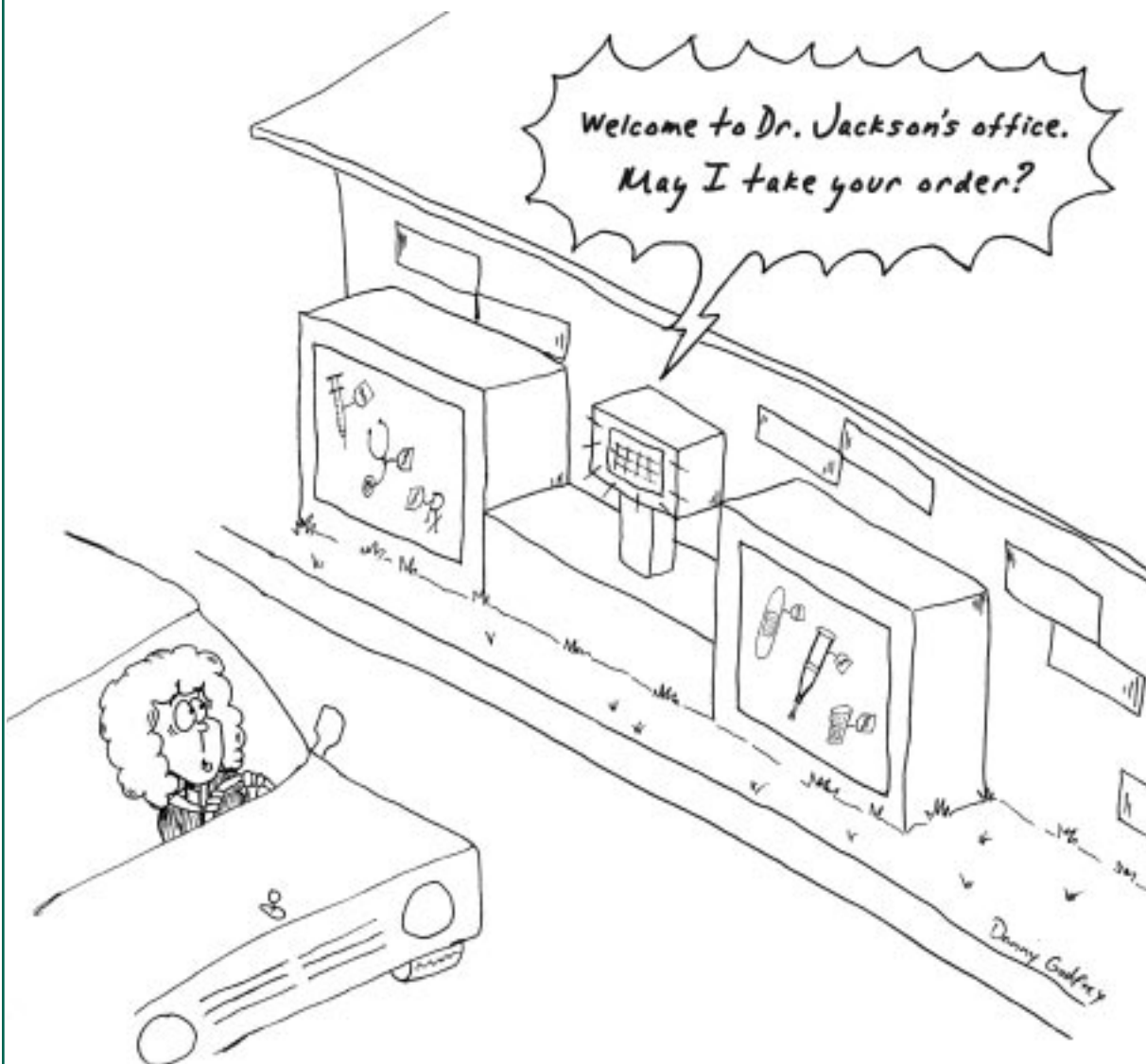
Capitation removes financial incentives to see more patients and creates financial incentives to keep patients coming back for care. It could also increase the likelihood that care will be provided in ways that work for

those who are enrolled and it may increase the emphasis on prevention and support. Organizations which receive capitation funds may have greater flexibility regarding the way they organize their staff. Under this scheme, they can use the funds to hire a variety of care providers, not just physicians. There may be opportunities for developing innovative client-centred programs.

This model also allows costs to be controlled, both because doctors have an incentive to keep people well in order to spend less money on their care and because governments know in advance how much doctors will be paid.

On the other hand...

What capitation and rostering do not do is ensure that care will be there for everyone or even for those who are rostered. Capitation fees are based on averaging costs of care in the community. It generally does not take into consideration needs for care that arise as a result of early discharge and hospital closures. Therefore capitation rates can be too low to provide care. Capitation may encourage doctors to enrol as many young healthy people as possible, that is, those people who will require the least care. Women with children and those who intend to have more children, elderly women with chronic illness, poor women with poor nutrition and women with mental illnesses are among those who may find it harder to locate doctors willing to roster them.



Decoding Primary Health Care Reforms cont'd

Without some say in how care is delivered, a woman rostered to a service or doctor still has no guarantee she will get the care she wants and needs. Being rostered to a large health care practice may mean that she does not get to see the same doctor each visit.

By rostering only healthy clients, physicians or group practices could theoretically make 'profits' and reduce the overall level of care available in a community. And rostering does not create more services, so if the problem is not enough doctors and other providers, then rostering does not solve the shortage, it only helps ensure that the rostered people get care.

In other countries, rostering has been associated with reducing choices regarding health care providers. Once rostered, in these systems a woman may be penalized if she uses another health provider. Yet a woman may want to see another provider in order to ensure confidentiality about her condition, or for particular expertise, while keeping her connection with her main doctor for her other health care issues. A woman whose heart attack symptoms are ignored, dismissed or undiscovered by her doctor may want to get another opinion without giving up her own doctor for other care. Lesbian women may find that they are not comfortable with one doctor but may not feel that they can look elsewhere if they're already rostered.

Currently most women in Canada are signed up to a provincial plan that allows them to use any primary health care service without restriction, if the primary care provider is accepting new patients. It is important that a rostering program not reduce choices for women.

Payment schemes for doctors are central to reforms. These schemes reinforce the central role doctors play as gatekeepers and decision-makers in the health care system. They do little in themselves to challenge this authority or promote other kinds of care that is sensitive to women.

Very little is said about payment for other primary health care providers — the counsellors, physiotherapists, health educators, midwives, dentists, nurses and nurse practitioners, etc., who are important providers of primary care. Other than program-based budgets for the community health centre models, there are no mechanisms in place for the inclusion of these other health care providers. This is particularly important since hospitals have cut back their supports for community care.

Without some say in how care is delivered, a woman rostered to a service or doctor has no guarantee she will get the care she wants and needs.

Women's Voices, Women's Experiences



Women have a great deal of experience in and with primary health care. However, women's voices are hard to hear in current discussions of reforms and there is little indication that women's views will be included in ongoing decisions about the organization and delivery of primary health care. Despite the various reports, innovative examples, frameworks, action plans, consultations and research done over the past decade, women's voices are not necessarily informing primary care reform discussions.

However, a national workshop in the winter of 2004 brought together providers, researchers and policy makers to share the major lessons they had learned from years of experience with care, lessons that need to be learned in the development of primary care. Here are the lessons they shared with one another:

Lesson 1. *The design of primary health care should begin with an understanding of what determines and promotes health.*

Creating health means acting on what are called the determinants of health — the factors, conditions, actions and environments that shape our health, even if they lie outside what we think of as health care. Health depends on creating supportive work, home and community environments, strengthening community action, developing personal skills, and ensuring that health services are geared to illness prevention and health promotion rather than being focused largely on treatment.

Income has a strong influence both on how women define their health and their ability to function as healthy people. For women, income, access to resources and other things like housing and work organization may have more impact on their health than personal practices such as smoking, drinking, exercising and dieting.

In other words, the things women control may be less important for their health than those aspects where their control is very limited. While primary care organizations cannot easily change these influences, they can take them into account in developing means to promote health and address illness or disability. They can also include relevant services, such as access to income support programs and shelters. And they can work with communities to develop programs designed to reduce health disparities, such as housing and pollution.

Lesson 2. *Community involvement is essential to health and health care.*

Effective primary health care depends on community involvement and must be both responsive and responsible to those it serves. An investment in community development and community participation in decision making is also an investment in primary health care. Indeed, active participation promotes health.

Many community-based health services, like community health centres, support volunteer-led programs such as community gardens, cooperative kitchens and community peer educators to keep strong community links and to increase the capacity of their community members.

Women's Voices, Women's Experiences cont'd

Planners and policy makers should work closely with women to design services that meet their needs, taking seriously women's knowledge about health issues and how care should be provided.

Involving women in designing care also means a different type of relationship between women and their health care providers. It means more emphasis on health information, explanations of options in care and consent. It also means different relationships between and among health care providers — ones in which various types of expertise are valued equally.

Lesson 3. *Models of women-centred care should be adopted.*

In keeping with women's involvement in planning services, women have repeatedly told health care planners and providers that the current health care system does not respond well to their needs. They want the system to consider their specific needs and develop appropriate responses, with women at the centre of services and activities.

Organizations such as Women's Health in Women's Hands in Toronto and the Women's Health Clinic in Winnipeg have developed models based on their experiences of women working with women. Vancouver Coastal Health, a regional health authority, facilitated the development of a Framework for Women-Centred Health which has 12 elements:

- The need for respect and safety
- The importance of empowering women
- Involvement and participation of women
- Collaborative and inclusive work environments
- Women's patterns or preferences in obtaining health care
- Women's forms of communication and interaction
- The need for information
- Women's decision-making processes
- A gender-inclusive approach to data
- Gendered research and evaluation
- Gender-sensitive training
- Social justice concerns

These elements are useful for planners to consider in developing services and priorities.

Lesson 4. *Develop skills in gender-based analysis and gender-sensitive service planning.*

Gender-based analysis is a tool which assists making health services more effective and appropriate for women. It illuminates the differences in health status, health care utilization and health needs of men and women. Gender-based analysis, which wrestles with issues of women's social location, gender-related power and access to resources, is needed in addition to sex-disaggregated health information to fully understand women's lives. Such analyses must always consider issues of diversity as well as sex, because there are important and meaningful differences among women as well as between women and men.

Lesson 5. There must be multiple responses across multiple systems, rather than an attempt to create one universal solution for primary health care reform.

Primary health care reform should draw on different models of ensuring that services and providers are available to respond to the particular needs of particular communities. For example, women living with HIV may require care in a place that protects their privacy if they so choose. Similarly, women raising children on their own need primary health care that respects their parenting responsibilities and their needs for child care. Women with substance use problems may require specialized services and innovative models to support them as mothers and ensure that their children are safe.

Some communities are experimenting with innovative health services to serve themselves. Such services can serve as models for innovation for the rest of the health care system.

Lesson 6. Home care must be seen as an essential part of primary care.

As a result of hospital bed closures, insufficient long term care facilities, an increase in ‘self-managed care’ and early discharge programs, more and more frequently women and their family members are being sent home for care. Yet resources have not been sent home with them. Instead, it is too often assumed that any women in



Women's Voices, Women's Experiences cont'd

the home can and should fill the care gap. Women should not be conscripted into providing care without choices, training, pay or other supports. Home care services must be directly connected to other primary care services, and connected in ways that allow women patients and providers choices about care.

Lesson 7. *The need for privacy and need for accountability must be balanced.*

There are conflicting needs in primary health care reform that cannot be easily resolved. The push for improved accountability by governments, the need for better research on primary health care and the increasing use of electronic medical records reduce individual privacy and confidentiality. But we need to remember that women and men often use different care providers purposely to maintain privacy.

We need to work toward ensuring that only necessary information is collected about people, and that people understand what information is collected and why as well as how it may be used. A woman should be able to decide, for example, if information such as whether she has had an abortion, mental health counselling or genetic testing is recorded or remains part of her medical record. She should also have the power to remove information from her file. The different interests of patients and providers, and the different perspectives of national and local policy makers cannot be made to disappear by choosing privacy over accountability, or vice versa. We need to acknowledge such tensions and develop strategies and mechanisms to balance them.

At the same time, increasing access to information about the effectiveness of care and the quality of care in facilities and by providers is important to women. Too often, concerns remain secret about health interventions or the quality of care provided by specific professionals, particularly doctors, and institutions. Increasing transparency and access to this information is about accountability to women.

Lesson 8. *Primary health care must be understood as being about providing and receiving health care, not just about organizing or managing health care, or finding ways to save money.*

Primary health care reform should be guided by the same principles that guide care in hospitals: equity, compassion and access based on need rather than on ability to pay. Women's experiences of receiving and giving care are central to the quality of health care. Quality, rather than the bottom line, should be the main concern in primary health care reform. Primary health care should recognize women's skills and abilities, and should provide support and guidance through the emotional, social, physical, medical and financial aspects of care. This means fostering relationships between patients and care providers, rather than simply focusing on records and services, as many policy makers and health care professionals do in discussions of primary health care reform. Among decision-makers and health care providers, there must be a duty to care, not just a duty to be fiscally responsible.

These lessons growing out of women's experiences with primary care tell us that primary care is about much more than how and where you enter the system. It is also about what kind of care will be there and what say we will have over that care.

What Would Good Primary Health Care Look Like?



OMEN's experiences tell us that to work for women, primary health care should:

- Begin with an understanding of health in the context of their lives, taking the global, national, regional, local and individual contexts into account.
- Have sufficient, continuous funding to provide services.
- Be publicly financed and be delivered by not-for-profit organizations.
- Enable women's participation in deciding how care is organized and delivered.
- Respect women, their skills and their knowledges.
- Pay attention to how women are different from men and how women are different from each other.
- Offer 24-hour access to coordinated services.
- Have transparent quality assurance and planning processes.

Primary health care for women includes:

- Mental health and counselling
- Occupational health services
- Maternity care, including home birth and birth centres
- The full range of sexual and reproductive health care services, including birth control and abortions and screening for reproductive cancers
- Managing of chronic conditions, such as diabetes, arthritis, pelvic pain
- Access to hospitals
- Home care
- Coordination of care between primary care and hospitals, specialists and the home
- Strong links with social services, legal aid and economic development programs
- Health education, promotion and disease prevention beyond immunization
- Community outreach
- Programs that seek to address health disparities and develop healthy communities

Primary health care providers include a wide range of people including:

- Physicians
- Nurses
- Midwives
- Nurse practitioners
- Social workers
- Health educators

No single model of primary health care will provide all these things or respond to all the needs talked about here. However, by building on the contributions made by community health centres and the women's community, we will increase the chances that primary health care reform will provide a range of models that meet the needs of women within their particular communities to the benefit of everyone.

Where to Find More Information

PUBLICATIONS ON PRIMARY CARE

NATIONAL COORDINATING GROUP ON HEALTH CARE REFORM AND WOMEN

- **Madeline Boscoe.** *Advancing primary care: models of women-centred care in Canada*, 2004.
Available online at:
www.cewh-cesf.ca/healthreform/primary_care/Model%20of%20Care%20PPT%2020042_files/frame.htm
- **Ann Pederson and Beth E. Jackson,** *Dare to dream: reflections on a national workshop on women and primary health care*, 2004.
Available online at www.cewh-cesf.ca/healthreform/publications/summary/dare.html
- **Carolyn Schellenberg.** *Primary [health] care and women: an annotated bibliography*, 2001.
Available online at www.cewh-cesf.ca/PDF/health_reform/phc-biblioEN.pdf

For more publications by the National Coordinating Group on Health Care Reform and Women, visit our web site at www.cewh-cesf.ca/healthreform

WOMEN'S HEALTH CONTRIBUTION PROGRAM

For more publications on primary care and women by other organizations supported by the Women's Health Contribution Program, visit their web sites at:

- **Aboriginal Women's Health and Healing Research Group** www.cewh-cesf.ca/en/publications/awhhrg/index.shtml
- **Atlantic Centre of Excellence for Women's Health** www.acewh.dal.ca
- **British Columbia Centre of Excellence for Women's Health** www.bccewh.bc.ca
- **Canadian Women's Health Network** www.cwhn.ca
- **National Network on Environments and Women's Health** www.yorku.ca/nnewh
- **Prairie Women's Health Centre of Excellence** www.pwhce.ca
- **Women and Health Protection** www.whp-apsf.ca

ORGANIZATIONS CONCERNED WITH PRIMARY CARE AND WOMEN

- **Association of Ontario Health Centres** www.aohc.org
- **Canadian Alliance of Community Health Centre Associations** www.swchc.on.ca/web/links.htm
- **Canadian Association for Health Services and Policy Research** www.cahspr.ca
- **Canadian Health Coalition** www.healthcoalition.ca
- **Canadian Health Services Research Foundation** www.chsrf.ca
- **Canadian Home Care Association** www.cdnhomecare.ca
- **Centre for Health Services and Policy Research** www.chspr.ubc.ca
- **Coalition of Community Health and Resource Centres of Ottawa** www.coalitionottawa.ca
- **Medical Reform Group** www.hwcn.org/link/mrg
- **Women's Health Clinic** www.womenshealthclinic.org

Who We Are and What We Do

The National Coordinating Group on Health Care Reform and Women consists of Pat Armstrong (Chair), Karen Grant, Madeline Boscoe, Kay Willson, Barbara Clow, Ann Pederson, and Beth Jackson (Research Coordinator). We came together in 1998 as a collaborative group of the Centres of Excellence for Women's Health (CEWH), the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, all funded by the Bureau of Women's Health and Gender Analysis. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at www.cewh-cesf.ca/healthreform/index.html

The Centres of Excellence for Women's Health were initiated by the Bureau of Women's Health and Gender Analysis of Health Canada in 1996. The Centres are multi-disciplinary and operate as partnerships among academics, community-based organizations and policy makers. Their major aim is to inform the policy process and narrow the knowledge gap on gender and health determinants. Both a brochure providing an overview of the CEWH program and a *Research Bulletin* are available on the CEWH website (www.cewh-cesf.ca/).

We wish to thank the participants of the **National Workshop on Women and Primary Health Care Reform** for their contributions to our thinking and analysis of primary health care reform in Canada and its implications for women. The views expressed herein, however, are our own and do not necessarily reflect a consensus of opinion from the participants of the workshop. Responsibility for interpreting the discussion rests with the National Coordinating Group.

ordering information

Copies of this booklet can be downloaded from www.cwhn.ca/health-reform/index.html
or ordered free from:

Canadian Women's Health Network

203-419 Graham Ave.

Winnipeg, MB R3C 0M3

Email: cwhn@cwhn.ca

www.cwhn.ca

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Également disponible en français.

written and published by

The **National Coordinating Group on Health Care Reform and Women**, with financial support from the **Women's Health Contribution Program, Bureau of Women's Health and Gender Analysis, Health Canada**.

The views expressed herein do not necessarily represent the views of the Bureau of Women's Health and Gender Analysis, Health Canada.

Cartoons: **Danny Godfrey**

Design: **Folio Design**

Production: **Canadian Women's Health Network**

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ISBN: 0-9733117-4-6

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