Women and Primary Health Care Reform: A Discussion Paper

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1. What is Primary Health Care?

In the 1978 *Alma Ata Declaration*, the World Health Organization stated the following about primary health care:

> *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.*
>
> *Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.*
>
> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.* (World Health Organization 1978, 1-2)

The *Declaration* goes on to define primary health care to include prevention, health promotion, curative and rehabilitation services.

The work of the women's health movement was important in setting this direction for health policy. It was the women's movement that pioneered the political approaches to health and health care, taking them from the domain of the personal to the domain of the political, understanding that “control over our own bodies” would be impossible without social and economic changes.

As Barbara Ehrenreich and Deirdre English wrote in *Complaints and Disorders*, five years *before* the Alma Ata Declaration:

> *This, to us, is the most profoundly liberating feminist insight – the understanding that our oppression is socially, and not biologically, ordained. To act on this understanding is to ask for more than "control over our own bodies." It is to ask for, and struggle for, control over the social options available to us, and control over all the institutions of society that now define those options.* (Ehrenreich and English 1973, 89)

In contrast to the Alma Ata Declaration, Health Canada has defined primary health care as "*the first point of contact for Canadians with the health system, often through a family physician*." (Health Canada 2001)

This definition, refreshing in its brevity and simplicity, leaves unanswered important questions, including what constitutes the essential components of primary health care.

Elsewhere, Health Canada has made a strong commitment to understanding the importance of the non-medical determinants of health, such as income and social status; employment; education; social environments; physical environments; healthy child development; personal health practices and coping skills; health services; social support networks; gender; and culture.[1] This commitment dates back to the 1974 report by then Federal Minister of Health, Marc Lalonde, *A New Perspective on the Health of Canadians.* (Lalonde 1974) Health Canada also has an expressed commitment to both gender based analysis and women's health, as evidenced by Health Canada's *Women's Health Strategy*, its *Gender-based Analysis Policy* and *Exploring Concepts in Gender and Health*. Yet these do not appear to be reflected in its work to date on primary health care reform. The Canadian Health Services Research Foundation's recently published report, *Choices for Change: The Path for Re structuring Primary Healthcare Services in Canada* (Lamarche 2003) proposes a definition which is slightly broader than that offered by Health Canada:

> *The term "primary healthcare" has been interpreted in different ways. At its core, however, primary healthcare is defined as a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services.* (Lamarche 2003, 2)

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[1] See Health Canada's *Women's Health Strategy* at http://www.hc-c.gc.ca/english/women/womenstrat.htm

The authors then list six broad effects which should be produced by primary health care: effectiveness, productivity, accessibility, continuity, quality and responsiveness. Equity – including gender equity but also equity more broadly conceptualized – is notably absent as a criterion. In fact, the authors made an explicit decision to exclude the equity indicator from their analysis due to the "ambiguity of its wording." (Lamarche 2003 Appendix 2, 50)

The definitions used by Health Canada and the CHSRF are both problematic. They are de-politicized definitions that exclude both any mention of the health determining systems outside of the health care system itself, as well as any statement about individual and collective rights to participate in the planning and implementation of health care. They lead to a focus on systems management rather than on attention to prevention. Like the approach of the Romanow Report, with its emphasis on individual behaviours and its silence on the structural determinants of health, this approach strips primary healthcare, and primary health care reform, of their radical roots.[2]

All of these definitions, including that used in Alma Ata Declaration, are written in language which ignores the differing primary health care needs of men and women.

Is primary health care thus defined healthy for Canadian women?

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[2] See Armstrong, P. et al. (2003).

2. Primary Health Care Reform in Canada

Primary health care reform in Canada is not a new idea. Nor is primary health care reform limited to Canada. Indeed, primary health care reform as we will discuss it reflects larger, global trends toward the commodification of health and health services.[3]

In Canada, primary health care reform has been underway for decades. Long before the Lalonde Report and Alma Ata, Saskatchewan pioneered community health centres with the formation of the Community Health Services (Saskatoon) Association in 1962 by pro-medicare doctors and citizens. The Sault Ste. Marie and District Group Health Association opened in 1963. Beginning shortly after the introduction of medicare in 1971, Québec introduced local community service centres (CLSCs). By 1972, Manitoba had joined this movement, issuing a *White Paper on Health Policy*, which called for the establishment of more community health centres and the introduction of district health boards.

In 1969, the Hon. John Munro, Federal Minister of National Health and Welfare stated:

> *The key is contact, the place is the community, the concept is preventative…group practice, community health centres, mobile out-patient clinics, increased case-findings through home visitation, greater availability of local alternate-care institutions, better home care, increased team work with community social agencies.* (Government of Manitoba 1972, Appendix 1, page 16)

Later that same year, the Mr. Munro said the following about community health centres:

> *…I think that there are some advantages which are immediately foreseeable. The very fact that the consumer has a real role in the planning, development and operation of these centres on a community basis represents a substantial step forward.* (Government of Manitoba 1972, Appendix 1, page 17)

All of the initiatives in primary health care reform from the 1960s and 1970s have several things in common. First, all are closer to the language and approach of the Alma Ata Declaration than current Canadian primary health care reform policy. Second, none led to major changes in the provision of primary health care, which is still for the most part delivered by physicians who are remunerated on a fee-for-service basis. And none of them acknowledge the importance of gender in primary health care, nor of the contribution of the women's health movement to primary health care reform.

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[3] See Armstrong, P. (2001).

Current initiatives for primary health care reform in Canada are being led by the Federal/Provincial/Territorial First Ministers and Ministers of Health. In 2003, in response to the Romanow Report, the First Ministers' *Accord on Health Care* identified primary health care reform as one of three areas which required additional investments. (The others were home care and catastrophic drug coverage.)

In this Accord, the First Ministers stated:

> *The key to efficient, timely, quality care is primary health care reform. First Ministers agree that the core building blocks of an effective primary health care system are improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to ensure that new approaches to care are swiftly adopted and here to stay.*
> *First Ministers agree that the ultimate goal of primary health care reform is to provide all Canadians, wherever they live, with access to an appropriate health care provider, 24 hours a day, 7 days a week.*
> (Government of Canada 2003)

The First Ministers' statement of their "ultimate goal" as "access to an appropriate health care provider" is telling. Gone is any sense that primary health care reform is a tool to improve the health of the most vulnerable, or a means to a more just and equitable society. In this model, access is seen as an end in itself, rather than locating access to health services within the web of health determinants. Moreover, this approach to primary care is clinical, despite the aside to prevention, suggesting that prevention is a particular form of clinical intervention as well. Equity is not identified as a goal but efficiency is.

While the First Ministers' Accord did not include any statement of priorities, the federal, provincial and territorial governments have agreed on common objectives for the Primary Health Care Transition Fund (PHCTF), the purpose of which is:

> *to support the transitional costs of implementing sustainable, large-scale, primary health care renewal initiatives. As a result of such initiatives, it is expected that fundamental and sustainable change to the organization, funding and delivery of primary health care services will result in improved access, accountability and integration of services.*

The objectives of the PHCTF are to:

- *increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population;*
- *increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;*
- *expand 24/7 access to essential services;*

- *establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider; and,*
- *facilitate coordination and integration with other health services, i.e. in institutions and in communities.* (Health Canada 2002)

The problems of primary health care have therefore come to be represented in official policy documents as primarily lack of access to services and inadequate service integration. Framing the issues this way has clearly influenced the solutions proposed. Primary health care reform is now seen as a problem which can be solved through better management (to mandate co-ordination and integration) and the use of appropriate economic incentives and disincentives (to establish teams of service providers and expand the hours of service). Furthermore, accountability, in this rubric, seems to be primarily about financial accountability, rather than accountability for quality care and about accountability to the managers of the system rather than to communities and users of health services.

One can imagine how different the solutions and priorities would be if the problem had been framed as one of health inequalities (including for example, inequalities based on sex, socio-economic status, migration experience, Aboriginal status and disability), with an improved primary health system care as part of the solution.

This approach to primary health care is built, in part, on notions of population health. Population health, built upon epidemiological models, involves predictions about groups rather than individuals. This raises questions about how services are "planned" for individuals who do not fit the models, including standards for diagnostic procedures and treatment. This in turn has implications for rostering of users of the health services.

The spirit of social justice evident in the Alma Ata Declaration has disappeared from the dialogue about primary health care reform. This is not good for the health of women.

It is also important to remember that primary health care reform is taking place in the context of a broader health reform, which in Canada has been characterized by cost containment, reductions in services particularly through early discharge (and the assumption that families, particularly women, will take on increased unpaid caregiving roles), the introduction of corporate management systems and recently the incursion, in some provinces, of for-profit health services in areas that have been primarily in the public sector. These reforms are themselves occurring in the context of larger social and economic forces, notably trends to reduce trade barriers between countries, globalization, particularly international trade agreements, which may have the impact of limiting the ability of governments to mange social programs and may increase pressures on governments to privatize the delivery of health care services. The quality of care provided in for-profit hospitals has been shown to be associated with a higher risk of death to patients. (Devreaux 2002, 1399)

Pressures for privatization and the demands of international trade agreements are also linked, as noted in a report by the Canadian Centre for Policy Alternatives prepared for

the Romanow Commission. (Canadian Centres for Policy Alternatives 2002) The authors state:

> *If the underlying conflicts between Canadians' health care priorities and the commercial interests promoted in the most recent trade treaties are not addressed, the nation's health care system will come under increasing strain and the options for reform will be seriously diminished. Fortunately... there are many practical ways in which greater coherence between health and trade policy can be achieved. Governments should begin by acknowledging, rather than denying, that health care reform entails some risk of trade challenges. They should then fashion health reforms so as to derive maximum benefit from those limited safeguards that exist in trade treaties; this generally means minimizing the role of private financing and for-profit health care delivery.* (CCPA, 59)

Who would benefit from such changes? As the health economist Robert Evans has noted, market mechanisms are popular because they operate to the advantage of influential groups (Armstrong 2001, 42). As Pat Armstrong has noted:

Most *of those who benefit are men, albeit a small minority of men; most of those who bear the burden and express dissatisfaction with market solutions are women*. (Armstrong 2001, 42)

3. Where are Women in Canadian Literature About Primary Health Care Reform?

Literature on the impact on women of the proposed changes in primary health care services is scarce.[4]

Most research in primary care ignores the existing evidence about the impact of gender on health care needs, preferences and utilization. Two recent synthesis reports, the Canadian Institute for Health Information's *Health Care in Canada 2003* (CIHI 2003) and the Canadian Health Services Research Foundation's *Choices for Change: The Path for Restructuring Primary Healthcare in Canada* (Lamarche et al. 2003) are examples of this.

The CIHI Report illustrates one of the problems created by ignoring the existing evidence on gender differences in health – not knowing that the information is even missing. CIHI's list of "What We Don't Know" about primary health care reform does not include missing evidence about gender as an "information gap." (CIHI 2003, 25)

Even newly published data designed to inform the primary health care reform process often publishes only data aggregated by sex, or only sex-adjusted data.[5] For example, Statistics Canada's *Access to Health Care Services in Canada* (Statistics Canada 2001) which contains information about access and barriers to access to health services, including the reasons for self-reported unmet health needs, contains only sex-aggregated data. This is in sharp contrast to the stated commitment to gender-based analysis of Health Canada, one of the funders of *Access to Health Care*. The production and analysis of sex-disaggregated data is an important step, but not sufficient to understand these issues. 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 data to fully understand to women's lives.

Research supported by the Centres of Excellence for Women's Health has described the health issues of specific groups of women, for example, women with addictions (Poole and Isaacs 2002 and Tait 2000), immigrant women (MacKinnon and Howard 2000 and Weerasinghe 2000), lesbian women (Anderson et al. 2001), visible minority women (Sharif et al. 2000), Aboriginal women (Browne et al. 2000, Benoit et al. 2001, Dieter and Otway 2001) or rural women (Roberts and Falk 2001, Donner 2001). These reports approach the issues from the perspective of the women concerned, and draw conclusions about policy and services from their point of view.

Interesting work has also been done to develop women-centred models of care, notably the Winnipeg Women's Health Clinic *Model of Care* (Women's Health

[4] See for example, Schellenberg, 2001 and Armstrong, P. and Armstrong, H. (2001).
[5] In this process, the rate is adjusted to allow comparisons among different groups, by standardizing the sex distribution among the populations. While allowing inter-group comparisons it masks sex differences.

Clinic) and the Vancouver/ Richmond Health Authority *Framework for Women-Centred Care.*

While this literature, and other work by women's health scholars and activists, provides valuable information about particular programs and models of care for specific subgroups of women, it does not typically address the potentially different impacts of primary health care reform on women and men.

To summarize – women are largely absent from research about Canadian proposals for primary health care reform.

4. Why Focus on Women's Primary Health Care Needs?

Outside of the women's health movement, discussions to date about primary health care reform have excluded women's primary health care needs and how these might be different from the primary health care needs of men. This absence is based on the assumption that gender is not an issue in primary health care, that is, that the primary health care needs of women and men are the same. Are they?

At the most superficial level, if one examines the First Ministers' five objectives for the Primary Health Care Transition Fund, these changes will benefit women. After all, don't women need better access to services and better health promotion, prevention and disease management services? Won't women benefit from access to essential services "24/7"? Won't better co-ordination and interdisciplinary teams of service providers benefit women as well as men?

Of course they do and they will. But once one moves beyond these general statements, the differences between women and men (and boys and girls) become apparent.[6]

We suggest that these are manifested in six ways, all of which affect the organization and delivery of primary health care:

First, there are sex-specific conditions, including the full spectrum of reproductive care, which should be included in a reformed primary health care system. These include birth control for women, pregnancy, childbirth, menstruation, menopause and female infertility, all of which are part of women's primary health care. Other sex-specific conditions which are part of women's primary health care include screening for cervical cancer. Any reformed primary health care system must include the full range of reproductive health care services and their delivery must be organized in ways which recognize women's diversity and which promote women's autonomy, control and health.

Second, there are conditions more prevalent among women, such as breast cancer, eating disorders, depression and self-inflicted injuries.[7] For example, screening programs for breast cancer are part of women's primary health care. And as more women live longer with breast cancer, more of their care will become the responsibility of the primary health care system. In the case of conditions such as eating disorders, depression and self-inflicted injuries, good primary health care for women must include prevention and treatment programs which recognize the gendered nature of these conditions, including women's distinct risk factors and the need for gender-specific interventions.

[6] As our task with this paper is to discuss the impacts of primary health care reform on women, we have not addressed the sex- and gender-specific primary health care needs of men, nor the ways in which these may differ from women's needs.
[7] For descriptions of some of the conditions that are more prevalent in women, see Donner (2003), Greaves et al. (1999) and Health Canada (2003).

Third, there are conditions which appear to be sex-neutral, such as heart disease, but where the signs, symptoms and optimum treatment of the disease may be different in women and men (Grace 2003a). Good primary health care for women incorporates this knowledge into all processes of care, including health promotion, disease prevention and treatment.

Fourth, there are the ways in which women's gendered roles in our society influence their health. Examples of this have been documented extensively by women's health researchers and activists, including:

- women's caregiving responsibilities often cause them to give higher priority to the health of others than to their own health;
- the sex-segregation of the labour force, both in general and within health care in particular;
- the demands of women's caregiving responsibilities contribute to their own ill health;
- women have lower average incomes than men and lower incomes are associated with poorer health;
- women's paid work and their working conditions influence their health.

Good primary health care for women must both incorporate this knowledge and be a catalyst for change, helping to reduce the contribution of gender differences to health inequalities.

Fifth, there are the ways in which the gender stereotypes within the health care system negatively affect women's health. These include both stereotypes about women's use of care and stereotypes about women's caregiving roles.

Women are often assumed to use health care services more than men. But there is good evidence that this is related to sex-specific care and not to male stoicism or to women's predisposition to seek help. For example, in Manitoba in 1994-95, the per capita cost of providing females with health care services funded by the medicare system was approximately 30% higher than for men. However, after the costs of sex-specific conditions were removed,[8] and considering costs for both physicians' services and acute hospital care, the costs of insured health care services for women were about the same as for men. That is, the female: male ratio went from 1.3 to 1.0. (Mustard et al. 1998)

There is also good evidence that negative stereotypes about women lead to women receiving negatively differential treatment in everything from the use of life-saving drugs during heart attacks (Grace 2003b) and the secondary prevention of ischemic heart disease (Hippisley-Cox 2001), to physicians being more likely to assume women's physical symptoms are psychological in origin (McKie 2000). The result of the application of these stereotypes includes increased costs for the system as well as

[8] These included for women, normal and abnormal reproduction, and for women and men, diseases of the genitourinary system and of the breast.

individuals. If advocates of primary health care reform are truly interested in costs, they may want to eliminate sex- and gender-stereotyped practices.

Despite all of this evidence, and in the era of "evidence-based medicine" and "evidence-based decision-making", those designing changes in primary health care persist in choosing to ignore the overwhelming evidence about sex and gender.

Sixth, there is the over-medicalization of normal aspects of women's lives including pregnancy, childbirth and menopause. This has been challenged by the women's health movement for over thirty years, with some successes (notably the reintroduction of midwifery into Canada and its organization as a licensed profession.)

But women are not ignored in the plans for primary health care reform. We have been assigned two important roles – as vessels (for future human beings) and as vectors for the transmission of things both good (e.g., breast milk, nurturing, health information, nutritious food, caregiving, a physically active life style) and bad (e.g., second hand smoke, alcohol during pregnancy, junk food, a sedentary life style) to our families. Every plan for primary health care reform includes women as the unnamed and unpaid delivery agents of health promotion without a critical examination of how this perpetuates unhealthy gender stereotypes.

Daykin and Naidoo (1995, 59) have argued, for example, that health promotion has neglected women's experiences of morbidity such that campaigns are based on "male-centred epidemiology." Further, they suggest health promotion strategies may put responsibility on women "despite their relative lack of power to effect change." They also suggest that the individualized, victim-blaming nature of much health promotion affects women in their caring roles by ignoring the social context that marginalizes that role. Finally, women are often the targets of health promotion campaigns not for their own sake, but for others', notably their children; the emphasis, for example, on pre-conception health, while well intended in its support for healthy child development, runs the risk of reducing women yet again to the state of being perpetually and always "pre-pregnant," thus emphasizing a woman's reproductive role over other aspects of her own health and well-being.[9]

[9] For a discussion of the discourse around pre-conception health and mothering, see Greaves et al. (2002).

5. Considering Women's Health in Primary Health Care Reform

Even with the absence of literature about how various schemes for primary health care reform might differentially affect women and men, it is possible to use the lessons learned from other work in women's health and apply them to these proposals. These are discussed below using the five objectives of the Primary Health Care Transition Fund as a framework.

Objective #1- *Increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population.*

This objective includes many different types of organizations, from physician group practices, to managed primary health services based on rostering and capitation, to community health centres. It raises a number of issues of concern to women:

- *Who defines the "set of comprehensive services"?* In the physician-managed alternatives (such as Ontario's Family Health Networks), this is determined by negotiation between physicians and their representatives and government and/or regional health authorities. The sex- and gender-specific primary health needs of women are unlikely to be considered in these schemes. In community health centres, community based boards set their own service priorities, based on their perceptions of community needs (which may or may not be sensitive to women's health issues) and in negotiations with their funders (either the provincial government directly or a regional health authority). While some of the most innovative, gender sensitive primary health care programs have been developed by community health centres, others have focused on "family health", in which women are valued for their work as vectors to transmit health information, but in which women's distinct health needs receive little attention.

- *What will be included in a "defined set of services"?* These are crucial issues for women's health for a number of reasons. For example, will women's reproductive health care be included in ways which treat pregnancy, menstruation, childbirth and menopause as normal elements of women's lives? Will existing knowledge about sex and gender differences be used to design, implement and evaluate services? Will the service needs of all women be assumed to be the same, or will knowledge about differences among women (for reasons such as disability, migration, Aboriginal ancestry, ethnic and visible minority status and sexual orientation) be used? Will existing knowledge about the ways in which gender interacts with the other determinants of health (such as income, education and social and physical environments) be used? We have not yet seen evidence of the use of knowledge about sex, gender and diversity in the development of the defined set of services.

- *Who will constitute the "defined population"?* Unfortunately, women still encounter discriminatory treatment from physicians and other health care providers who are not sensitive to their needs. Examples of this include, lack of detailed knowledge of sex-specific conditions (endometriosis for example) and biased attitudes (for example that women complain and seek help more readily). Therefore, systems such as rostering, which limit women's abilities to seek a second opinion without the consent of their designated family physician are not good for women's health.[10]

- *How will the views of women who use the health care system be included in designing, implementing and evaluating these organizations*? Given that no "consumers" were consulted, for example, in the recent *Choices for Change* project, the views of women as users of the health care system and as informal, unpaid care providers, are not reflected in their research, analysis or conclusions.[11]

- *How will these organizational models recognize the feminization of health care, particularly family practice?* According to Statistics Canada, in 1998/99 there were approximately 38,000 students enrolled in full-time and part-time undergraduate health professional programs, over three-quarters (76%) of whom were women. This mix has been changing over time: in medicine, for instance, women graduates have outnumbered male graduates since 1996. (CIHI 2001, ix) We know that part-time work is more common within the health care sector than other sectors of the labour market and physicians are among those working part-time. (CIHI 2001, 41) Women also practice differently than men; a recent self-report survey indicated, for example, that women family physicians see a higher proportion of patients with chronic mental illness, provide a higher proportion of preventive services, particularly Pap smears, do more counselling and obstetrics, and are more likely to practice in an urban or suburban setting. (College of Family Physicians) Since most primary care reform models rest upon family or general practitioners (Armstrong and Armstrong 2001) and women account for an increasing proportion of family physicians, the organization of primary care needs to reflect not only this demographic change but also, as Woodward et al. (1996, 50-51) argue, the differences between female and male family practitioners "in the organization of physicians' practices, in the doctor-patient relationship, and in the profession's response to government health policy."[12]

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[10] In Ontario, patients enrolled in Family Health Networks must be referred by their participating family doctor to a second family physician, should they wish a second opinion. This system may limit patient autonomy and privacy (see Family Health Network patient brochure, available from http://www.ontariofamilyhealthnetwork.gov.on.ca/english/index.html)

[11] See the appendixes to Lamarche 2003 for a full description of the methods used to obtain expert opinions.

[12] See also discussions on women in medicine in three papers from the 1996 Canada – U.S. Women's Health Forum by Phillips, S., Tudiver, S. and Zimmerman, M.

Objective #2- *Increase emphasis on health promotion, disease and injury prevention and management of chronic diseases.*

The explicit inclusion of health promotion and prevention in primary health care is of course welcomed. One of the major criticisms of fee-for-service payment systems as we know them has been that they do not reward those family physicians who take the time to work with their patients on promotion and prevention. But the conceptualization of health promotion and injury and disease prevention will be critical to their success and to women's health. For example:

- Will health promotion focus on the behavioural determinants of health (such as diet, smoking and exercise) or will adequate resources be attached to challenging and changing the structural determinants of health (such as income, working conditions and education)? Given the current definitions of primary health care reform, this does not appear to be the case.

- Will gender as a determinant of health, and the ways in which gender interacts with other determinants, be considered in the design, implementation and evaluation of these programs? Given the absence of gender analysis from current plans for primary health care reform, this does not appear likely.

- Will health promotion and prevention programs promote gender stereotypes by uncritically treating women as vectors and vessels? For example, if women remain the target of health promotion campaigns because of their role as the "health guardian" (Heller 1986) of the family, to the extent that these campaigns individualize problems and blame women for their ill health and the health problems of family members, they compound women's sense of personal responsibility for health problems that are, in fact, largely beyond their control (Daykin and Naidoo 1995). There is little evidence to suggest that this practice will change.

Objective #3- E*xpand 24/7 access to essential services.*

Expanded access to services is a good idea. However, "access" for women means more than an open door, or someone answering the telephone. For example:

- What services will be provided over the phone?

- What does access to primary health care 24/7 really mean? The expectation is that additional services will be provided outside of "normal" office hours. Working women will benefit from the expansion of "normal" office hours so that they can seek primary health care for themselves in the evening, for example. However, what effect will establishing such hours have on the health of care providers, the majority of whom are women. How do we therefore balance the conflicting desires and needs of women from both of these perspectives?

- Will childcare services be available to women who need to seek care for themselves?

- What measures are needed to make services accessible to women with physical disabilities?

- How can services be culturally and linguistically accessible to women from minority communities?

- Will service providers recognize that women's work and family commitments limit their ability to seek care?

Objective #4- E*stablish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider.*

While a comprehensive approach to health, including health promotion and disease prevention, is important for women's health and well-being, and the greater use of multi-disciplinary and interdisciplinary teams has the potential to increase the quality of care available, there remain concerns for women.

- How will the appropriate mix of team members be established? CIHI acknowledges that even within the same profession, roles and skills may vary. Moreover, the mix of providers needed – and available – in a rural setting is not likely to be the same as in an urban setting. For example, rural physicians provide more emergency services than urban family practitioners; this difference has implications for the composition of the team needed to provide appropriate care to rural residents. (CIHI 2001) What will this mean for women, who are the vast majority of health care workers? Some proposals, for example, suggest that nurse practitioners will fill in during off-hours, an approach that implies that care will differ depending on the time of day. [13]

- How will adequate training for sex- and gender-sensitive health care be ensured? In British Columbia, gender-inclusive health training is being piloted with front-line workers, and in Manitoba training has been undertaken to teach gender-inclusive health planning to health authorities. Such training is a first step toward a more gender-sensitive health care system but must be supported by entrenching this kind of training within formal health care training programs.

- How do we ensure that the patient/client is involved as an active member of this "team" and that continuity of care is maintained?

[13] See Armstrong, P. and Armstrong, H. (2001), *Primary Health Care Reform: A Discussion Paper* prepared for the Canadian Health Coalition, available at http://www.healthcoalition.ca/health-index.html

Objective #5 - Facilitate coordination and integration with other health services, i.e., in institutions and communities.

Increased facilitation and coordination are also to be welcomed. However, this is frequently reduced to a discussion of an electronic medical record to address the desire of the system for a seamless flow of health information. This raises two concerns. First, it fails to recognize women's desires to protect the private nature of their discussions with their primary health care providers or with specialized service providers. Women may not discuss reproductive health issues, such as the decision to terminate a pregnancy or to give a child up for adoption if this information will be available to others. Similarly, women may not wish to discuss their experiences of violence by their partners if this information will be included in a chart which is available to other community agencies and institutions. These issues are especially acute for women in rural and remote communities. Second, an electronic medical record is the solution to a very narrow definition of "co-ordination and integration." The original promise of primary health care reform as an opportunity to improve continuity of care and flexibility of care appears to have been lost.

6. A Feminist Alternative: Gender-Sensitive Primary Health Care Reform

We have lots of questions, and some ideas. We don't have all the answers – yet. But, there are some things that "we know for sure":

1. The radical spirit of Alma Ata has been removed from current primary health care reform. If primary health care reform is limited to changing management, governance and payment schemes, the potential for primary health care reform to contribute to reducing health inequalities will be lost. Women's health will suffer as a result.

2. To truly promote women's health, a reformed primary health care system should incorporate how both sex and gender influence women's health.

3. To improve women's health, a reformed primary health care system should recognize the diversity of women's lives.

4. Rostering is intended to limit costs by limiting patient choices. Capitation proposals shift financial risks from provincial governments to individual practitioners and/or community boards. Both are potentially harmful to women's health.

5. A reformed primary health care system has the potential to reinforce gender stereotypes, by uncritically treating them as vessels and vectors. This is damaging to women's health.

6. If women in local communities are involved in the processes of designing and governing reformed primary health care organizations, then primary health care reform has the potential to improve women's health, by increasing women's social engagement and social control. If the design and governance of the system is left to "the experts," the system will lack this important information and this valuable opportunity will be lost.

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