

PRIMARY [HEALTH] CARE AND WOMEN

AN ANNOTATED BIBLIOGRAPHY

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I. Introduction

This bibliography has been developed on behalf of the National Coordinating Group on Health Care Reform and Women. Its purpose is to address the following question: Do policy and research related to primary [health] care consider gender, ethnicity, socio-economic status, and other differences, and in what ways are these differences considered? With this question as the dominant concern, the citations are listed under six categories:

- definitions of primary health care and primary care
- gender and other differences in policy and research
- care recipients and their access to care
- services and providers
- payment schemes for patients and providers
- decision-making structures related to how, when, where, and what care is delivered.

The second category, gender and other differences in policy and research, while implicit to the entire work, is also made explicit through the use of a separate category.

The term “primary health care” was initially framed in this work as an over-arching term inclusive of “primary care”. This is an important consideration since the terms are often used interchangeably in literature. In addition, primary care is often conflated with medical care, based no doubt on the fact that for many people throughout the developed world the physician is their point of entry to the health care system. This bibliography is not limited in its scope to primary health care, primary care, or medical-based care.

As work on the bibliography progressed, it became increasingly evident that primary health care is not an over-arching concept for primary care. Primary care is physician-oriented and physician-directed care. To a high degree, the focus of research in primary care is on individuals and their access to diagnostic and treatment services. Primary health care emerges infrequently in surprising places welcomed mainly by vulnerable and underserved groups. The providers, often nurses and a growing number of other health care professionals, offer a range of services: treatment, prevention, support, and health promotion. Their interests are directed toward individuals and groups and at times toward populations. Their interest also at times extends beyond service provision to the economic, social, cultural, and political experiences that shape peoples lives. But let the bibliography make its own contribution so that the reader can attach the meanings she/he perceives.

II. The citations

The citations included have been selected because of their relevance to the topics and broad areas of interest, their ability to expand knowledge of the field by providing scope or depth, their historical significance, and/or their critical perspectives and analyses. Many of the citations are relevant to both policy and research. Therefore, in organising

the material, I have placed the citations alphabetically under the six categories of interest rather than separating them in categories for policy and research. I have attempted to place each citation under the topic to which it is most relevant, but the distinction is somewhat arbitrary since many of the citations address more than one specific area. Each citation consists of a summary that describes the purpose, the point of view, the main points, themes, or arguments made, and a brief discussion of the reference's relevance or strengths or limitations. The length of the citations averages 300 words. Each citation is referenced according to the *Publication manual of the American Psychological Association 4th edition* (1994). The two exceptions are: (1) the use of asterisks to note a reference made within the text and indicate its citation at the end of the annotation, (2) the use of square brackets when I inject a point of clarification or comment, and (3) the letter (A) after the citation to indicate that the paper has been appended. Appendices include copies or portions of the most relevant or useful documents, some abstracts of particular interest, and a list of available websites.

III. The search

The citations have been collected from an on-line search of academic, professional, and government sources for North America, Europe, Australia, and New Zealand since the 1970s. Search sites include CINAHL, Health Star, Humanities and Social Science index, Women's Studies, Medline, Microlog, and CSA Political Science and Government Abstracts. The following search terms were used to qualify primary health care (PHC) or primary care: policy or research; policy and women or gender; research and women or gender; women or gender. I used additional search terms and/or qualifiers, e.g. general practice or health professionals for certain databases with lower yields.

I also accessed a number of websites of interest including those for the World Health Organisation, Canadian Nurses Association, National USA-Canada forum on women's health, UK/US/New Zealand/Australian and Canadian government documents, and Canadian Council on Social Development. Many of the citations and websites have pointed me to additional relevant references and/or websites leading to an abundance of research literature in particular. I have also hand-searched some journals, which enabled me to locate literature that did not emerge using the keywords. Government policy documents themselves, particularly for countries outside North America, have been difficult to access, although abstracts are more readily available.

IV. Limitations

Due to the scope of this project and the extent of available literature on the topics of primary health care and primary care, it is not possible to fully survey all the literature in order to select only citations that may best represent the field. The field is enormous, for example, the terms *primary care* and/or *primary health care* generate over 40,000 citations in the Healthstar index alone, and that is only one of a number of databases. Even with the addition of limiting keywords such as *women or gender*, *policy or research*, the field of possible selections remains huge. For example, *primary health care or primary care and women or gender* produces 39,000 plus citations in Healthstar. By

adding additional keywords, policy or research (subject headings and abstracts) the field drops to 1118. I used some key words, such as *general practice* and *community care*, which are also relevant to primary care and/or primary health care teams and services to a limited extent, again because of the scope of material. The literature selected must, therefore, be seen as a sample of the literature available, although I have attempted to provide scope, depth, and diversity in my selections.

I was unable to locate relevant literature, apart from WHO documents, that dated back to the 1970s. Most of the databases begin in the 80s, and the bulk of literature is concentrated in the 1990s. There is also limited literature available in the databases that pertain to Australia, New Zealand, or European countries other than the U.K. I was able to search in five libraries: at the Registered Nurses Association of B.C. and the University of B.C. in Vancouver, the University of Victoria, and the libraries at the University of Northern B.C. and the Prince George Regional Hospital in Prince George. Of the journals available at UNBC, my primary search site, most were available only from 1994 when the university officially opened. It required two to three weeks to obtain many of my requests through inter-library loan and some were returned as “unavailable” within the time frame specified.

Finally, the bibliography does not include literature from OECD, EC, and UN sites and the WHO literature included is limited. This follows an agreement that enabled some division in focus between the two consultants searching the French and English literature respectively. Despite the limitations, the search yielded a great deal of fascinating, relevant, and rich material. It was difficult to eliminate one paper in favour of another at times because each provided scope or depth or another point of view.

V. Annotated bibliography

A. Definitions of primary health care and primary care

1. Advisory Committee on Health Services. (1996, September). *What we heard: A national consultation on primary health care*. Ottawa: Health Canada Publications Unit.

In September 1995 Federal, Provincial, and Territorial Ministers of Health asked the Advisory Committee on Health Services to consult with Canadians on primary health care (PHC). This process was one of a series of consultations that took place between 1994 and 1997 in Canada under the mandate of the National Forum on Health. The task of the Committee was to seek broad formal and informal input in what is valuable in the present PHC system and how the system can be improved. This document represents the findings obtained from questionnaires completed and round table discussions organised in each province and territory in 1996. Participants included staff and members from professional and provincial associations representing physicians, nurses, chiropractors, as well as labour and union groups.

One of the messages conveyed by participants, who expressed many different and often contradictory views, was the need for a common definition of PHC. This definition should distinguish between health, health care, and medical care, and also articulate the nature of insured core primary health services. One group suggested that there is a need to distinguish between PHC and primary medical care (PMC), where the latter excludes broader determinants of health and emphasizes boundaries. The document does not conclude with any definition of PHC. National and provincial groups in roundtable discussions did identify the Canada Health Act and access to medical services as a fairly consistent strength of the current system. They also identified the need for improvements in coordination and collaboration between providers as a weakness.

This document is interesting for several reasons: (1) it demonstrates a high degree of confusion about the way people understand health, health services, and Canada's health system, (2) there is little critical analysis or understanding of issues pertaining to access to services and the barriers that exist for marginalized groups, and (3) it evokes questions about the extent to which the consultation process itself provides opportunities for powerful groups to advance their own interests.

2. Daykin, N. & Naidoo, J. (1997). Poverty and health promotion in primary health care professionals' perspectives. *Health and Social Care in the Community*, 5(5), 309-317.

This paper draws on policy analysis and qualitative research findings to demonstrate different meanings of health promotion and PHC. As the authors indicate, the broader definitions of health promotion, which are informed by the WHO (1978) *Health for All* strategy, emphasize the social causes of ill health. There is also extensive research in the UK linking social class, gender, race or ethnicity to ill health. However, the WHO concern with broader social goals is missing in the UK's tendency to emphasize health promotion within a narrower individualistic model. For example, the *Health of the*

Nation (DOH, 1992) strategy for England plays down the relationships between health and poverty, and offers little to support interagency collaboration as a way of broadening PHC beyond a medical framework. Thus, what is called PHC must be understood as mainly primary, or medical-based care.

Drawing on their own research and that of others, Daykin and Naidoo identify constraints that characterize PHC and express concerns in relation to the health promotion needs of people affected by poverty. Among the constraints identified are: (1) the structure of the GP contract which has led to a narrow medicalized focus in health promotion, e.g. coronary heart disease, (2) the organisational culture of PHC may itself present barriers to the development of effective responses to poverty issues, (3) training of front line workers which leads health professionals to see poverty as a secondary rather than causal factor, and (4) a strong professional ethos of one-to-one intervention. The authors' research, a qualitative study with a range of PHC professionals, suggests that some professionals have a high awareness of the broader models of health promotion. However, their ability to implement strategies in relation to poverty is impeded by organisational and policy barriers within the system itself.

3. DHSS (1986). *Primary health care: An agenda for discussion. Cmd. 9771*. London: HMSO.

This document was prepared as part of a review of and consultation process for PHC services in the UK. Primary health care services are defined as all those services provided outside hospital by two service components: (1) Family practitioner services (FPS), consisting of family doctors, dentists, retail pharmacists, and opticians, and (2) community health services, consisting of community nurses, midwives, health visitors, and other professions allied to medicine. Together these services constitute 9/10 of the contacts the public have with the health service. In the UK as a whole, 30% of the total expenditure on the health service is directed to PHC.

This review, which focused on the FPS, was the first conducted on PHC since the National Health Service (NHS) was established in 1946. The document is of interest for several reasons: (1) the terms primary care and PHC are used interchangeably to describe a range of providers who offer PHC services, (2) it outlines changing trends in the scope and utilization of various services, methods of payment, and issues in access, and (3) it compares PHC arrangements in the UK with those in North America and Europe.

4. Editorial (2000). Primary health care: does it deny definition? *Primary health care research and development*, 1, 1-2.

Primary health care and primary care are often used interchangeably. This editorial offers definitions that distinguish between the two, and places primary care within the context of PHC.

Primary care

the first contact point for the community with the health care system, may be seen as a constituent part of a wider PHC system which embraces wider principles, or a wider philosophical perspective (p. 2)

Primary health care

Essential 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...(World Health Organisation, 1978*, p.2)

The definition of primary health care taken from The Alma Ata Declaration (WHO, 1978) – see Appendix – is used consistently throughout the literature. The definition of primary care varies from country to country and it is in these variations that

*World Health Organisation (1978). *Primary health care*. Geneva: World Health Organisation.

5. Epp, J. (1986). *Achieving health for all: A framework for health promotion*. Ottawa: Health and Welfare Canada. Available: <http://www.hcsc.ca/hppb/hpo/ahfa/htm>

Jake Epp, Minister of Health and Welfare in Canada at the time, convened the First International Conference of Health Promotion in Ottawa in 1986. This document, which was released at the conference, is one in a series of initiatives associated with the World Health Organisation's (WHO) Health for All movement. This international movement was launched in the World Health Assembly's resolution in 1977 and at the WHO's Alma Ata conference in 1978*. The document identifies three major challenges that must be addressed within Canada's health system: (1) reducing inequities - the higher rates of mortality and morbidity among disadvantaged groups, (2) increasing prevention to reduce or eliminate preventable diseases and injuries, and (3) enhancing people's capacity to cope with disease, distress, and disability through adequate community support. "Health promotion" is named as the vehicle for integrating public health, health education, and public policy to strengthen the system of care in Canada (p. 2) and for addressing the identified challenges. The report also identifies three leading strategies for confronting the health challenges: (1) fostering public participation, (2) strengthening community services, and (3) coordinating public policy. Many of the concepts and strategies presented in the report are consistent with principles of primary health care and have been integrated into Canada's primary health care reforms. This is an eloquent and interesting document to read. It is a lead document in Canada in addressing relationships between health and socio-economic conditions but it also places considerable emphasis on the individual's ability to make choices that promote her/his own health. In that

emphasis it overlooks the fact that the social and economic conditions of many people's lives limit their choices and opportunities to achieve health.

*See WHO (1978), *The Declaration of Alma Ata*, appended.

See also: Stewart, M. (2000). *Community nursing: Promoting Canadians' health*. Toronto: W.B. Saunders Canada.

6. Glass, H. (2000). Primary health care: Then and now. *Canadian Journal of Nursing Research*, 32(1), 9-16.

This paper offers an historical perspective of progress toward the achievement of PHC goals. The author reminds readers that the international conference on PHC that produced the Alma-Ata Declaration (WHO, 1978, see Appendix 1) also produced a universally applicable definition of PHC, key concepts and principles, and strategies for achieving universal health care.

The author draws attention to Canada's contributions in the development of PHC. Within Canada, two events signaled Canada's interest in PHC and helped to stimulate reform in other countries. The first event was the release of the report *Achieving Health for All: A framework for health promotion* (Epp, 1986), which was instrumental in initiating health-care reforms that reflected PHC principles (p. 11) and notably health promotion. The second event occurred when representatives from 32 countries came together in Canada to debate intersectoral action for health. Following this event, the WHO released the *Ottawa Charter for Health Promotion* (1986), which has stimulated further PHC initiatives in Canada and abroad. Although this paper lacks analysis of the political context surrounding these reforms, it provides a summary of developments in PHC. The author points to areas of continuing concern throughout the world, notably poverty, non-communicable diseases, tobacco use, reproductive health, and the need for quality care to children, adolescents, and women (p. 14).

7. Muzychka, M. (1993). Nurses become key players in providing primary care to Canadians, CPHA meeting told. *Canadian Medical Association Journal*, 149 (8), 1171-1174.

This paper reports on a presentation delivered by Barbara Mathur, a nurse academic to the Canadian Public Health Association's 84th annual conference who addresses the influence held by physicians on the provision of primary care. Mathur asserts that in contrast to developing countries where nurses have a lead role in PHC practice, nurses' primary care role in developed countries is only beginning to emerge because of the greater availability of physicians. Nurses in primary contact with patients can now be found in a variety of settings in Canada from rural centres to nurse-run primary care clinics. The speaker suggests that unless physicians support nurses in a primary care first-contact role, little additional progress will be made. Physicians who are unsupportive will not collaborate with nurses and will reflect their reluctance to the public. Although the speaker does not explicitly address the issue of power, she

illustrates the power of medical interests in shaping and defining the nature of health care services in Canada.

8. Pathman, D., Steiner, B., Williams, E. & Riggings, T. (1998). The four community dimensions of primary care practice. *The Journal of Family Practice*, 46(4), 293-303.

This study is based on the assumption that the 'community' should play a larger role in the work of physicians in the US. This interest follows changes in the Institute of Medicine's definition of primary care. The Institute's 1978 definition of primary care emphasized the role of the physician in caring for individuals, whereas the revised [politically correct] 1996 definition also considers the role of the family and community in health services.

The goals of the study, which involved a mail survey of physicians, were to test an organising framework that identified four distinct categories of activities whereby physicians can interact with their communities. These categories are: (1) identifying and intervening in the community's health problems, (2) responding to particular health issues of local cultural groups when caring for patients, (3) coordinating local community health resources, and (4) assimilating into the community and its organisation.

One finding of interest was that community participation and assimilation were lower for those physicians who lived and worked in poorer counties, those with more minority patients, those caring for more HMO patients, and those raised in rural areas, in contrast to that of physicians living and working in more affluent counties. The authors suggest that if physicians are motivated by community need, then there must be other factors that impede their community involvement, such as cultural distance between them and their communities, fewer resources for them to rely upon, and greater professional burnout. These factors, as well as the original premise, warrant further research.

9. Scrivens, E. (1994, February). Shifting boundaries: Possible futures for primary care. *Bath Social Policy Papers, No. 19*. University of Bath: Centre for the Analysis of Social Policy.

This study explores the shift in services from secondary (hospital based) care to primary care under the NHS, and examines possible future directions for primary care. The author suggests that some of the directions for change are driven by the following: (1) central government policy, (2) policy from any level of the health service, (3) developments at the local level which are creating a variety of different structures for primary care, and (4) competition among the different institutions of the health service to provide community and primary care services. The study envisions a model of primary care services that may be either dominated by general practice or subsumed under other forms of community service organisation.

This is an interesting document. While, on the one hand, the author explores a range of options for primary care, she also emphasizes the role of GPs in delegating work to nurses (a trend since the 1960s) and in accepting more responsibility for other

professionals and their activities. In addition, the author identifies the argument that not only may community nursing be subsumed by general practice, but also that it could disappear as local authorities [similar to municipal governments in Canada] assume their lead responsibility for community care [In UK policy, community care is considered to be mainly social care]. This view of a diminishing role for nurses contrasts directly with the expanded role that WHO envisions for community nurses.

10. Scully, J., Birchfield, M., & Munro, L. (1999). An international nursing course: The health system, England. *Nursing and Health Care Perspectives*, 19(5), 208-213.

This paper compares and contrasts the health systems of the US and the UK and the degree to which each does or does not incorporate characteristics of PHC. The comparisons arise in the context of a description of a nursing education program in Chicago that enables undergraduate or graduate nurses to gain first-hand experience of the system in England.

Viewed against the WHO definition of PHC, the US and British systems are at opposite ends of a continuum. At one end is the US where PHC is largely absent. The US system is characterized by inequalities, where large numbers of people are not able to access basic care, while others who can afford to do so undergo costly treatments. In contrast, the UK's PHC system is first among those of ten developed countries when rated according to system characteristics. The NHS is characterized by a relatively low cost universal system. PHC is evolving through the roles of community nurses who, as members of a PHC team, provide health promotion and first contact services through clinics such as those for asthma and heart disease. This paper contributes to the definition of PHC through a comparison of delivery systems and it demonstrates the relatively greater progress the UK has made in developing a PHC team. However, the authors do not discuss the inequalities still present within the UK's health system.

11. Shoultz, J. & Hatcher, P. (1997). Looking beyond primary care to primary health care: An approach to community-based action. *Nursing Outlook*, 45(1), 23-26. (A)

In 1994 the US Institute of Medicine* (IOM) defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health services, developing a sustained partnership with patients, and practicing in the context of family and community” (p. 23). The IOM distinguishes primary care from PHC by suggesting that primary care “addresses personal health services and not population-based public health services” (p. 23).

The terms primary care and PHC, while often used interchangeably, are indeed different. Primary care emphasizes the work of clinicians in delivering personal health services. In contrast, PHC emphasizes not only population-based services, but also a multi-sectoral approach of which health services are only a part. Additional sectors are education, politics, economics, agriculture, and the environment. As the authors point out, policies or programs that only attempt to increase access to primary care or personal health

services cannot address many of the complex health issues in the US such as substance abuse, violence, poverty, and homelessness.

*Institute of Medicine (1994). *Defining primary care: an interim report*. Washington: National Academy Press.

12. Starfield, B. (1991). Primary care and health: A cross-national comparison. *Journal of the American Medical Association*, 266(16), 2268-2271. (A)

For the purposes of this study, ten industrialized nations were compared on the basis of three characteristics: (1) the extent of their primary health service, (2) their relative standing with respect to twelve health indicators, and (3) the satisfaction of their populations with the overall costs of the system. Data were gathered from published sources of the 1980s. The countries compared, which included the US, UK, and Canada, are listed in the appended paper.

This paper contributes to a definition of primary care that is focused on the role of the physician as the first point of contact to health services. The criteria used for rating the primary health service fell within two categories: health system and practice. Within both categories, the characteristics are also consistent with a physician-oriented focus. It is unclear how the criteria and their characteristics were actually determined, however, they were drawn from sources such as the WHO, OECD, and National Centres for Disease Control. It is of interest to note the low ratings attained by the US in contrast to those of other industrialized countries. The US was in the top third of distribution for only one health indicator – life expectancy at age 65 for men, and in the bottom third for seven of the twelve indicators. Ratings for the US were high on all three measures, while those for Canada, Sweden, and the Netherlands were generally high. The UK had the highest primary care rating, but was rated low on satisfaction-expense. This may not be surprising given that the UK has the lowest per capita spending on health of all the countries studied (p. 2271).

13. Sullivan, N. (2000). CNMs/CMs as primary care providers: scope of practice issues. *Journal of Midwifery & Women's Health*, 45(6), 450-456. (A)

The concept of primary care providers (PCPs) in the US began in the 1960s when there was an increase in and emphasis on medical specialties, while at the same time there was an acute shortage of general practitioners. The American Academy of Family Practice was founded in 1969 to meet the growing need for PCPs (p. 450) and to attract recruits to family practice in order to relieve the physician shortage. With the introduction of major health care reforms under President Clinton the primary care provider – physicians and to a lesser extent other professionals – became recognized as the access point for consumers.

The writer argues for the recognition of midwives as PCPs. The Institute of Medicine committee on the Future of Primary Care has not, however, included certified nurse midwives (CNMs) or certified midwives (CMs) in discussions regarding the workforce,

education and training of PCPs. Regardless, most midwives deliver primary care services, and there is no legal mandate for their designation as PCPs. Reimbursements vary depending on whether the patient is referred by a PCP, pays out of pocket, or has an insurance plan that will pay. Designation as a PCP may, in fact, have negative implications for midwives. Several implications are cited, among them that: (1) under managed care arrangements, PCPs are required to take assigned patients, (2) PCPs may have no choice in defining their limitations due to patient risk factors, (3) many PCPs are paid a capitated rate per patient, which may be inadequate to cover the time and effort provided, and (4) PCPs are restricted by the health plans that cover their services. This paper contributes to the definition of the primary care concept in the US by describing limitations of the system for nurses, midwives, and other predominantly female providers.

14. Tovey, P. & Adams, J. (2001). Primary care as intersecting social worlds. *Social Science and Medicine*, 52, 695-706.

Primary health care is a political priority in the UK and principles of PHC have been incorporated into a number of lead government policies. This paper offers as definition of primary care as “community based, multidisciplinary health services” (p. 695), which is consistent with the service aspect of PHC. This interchange of terms is confusing, and the terms general practice and primary care are also often conflated. The authors suggest, however, that the boundaries between worlds are fluid. They also suggest that what is problematic about PHC falls under two themes: the character, effectiveness, and legitimacy of the care, and the reorganisation and delivery of services (p. 696). The purpose of this work is to offer a theoretical perspective – that of social worlds theory – to assist in the conceptualization of PHC. In the struggle for clarifying definitions, this approach invites attention to the political dimensions of primary care and PHC and to the “episodic negotiations and conflicts over who and what constitute authentic service provision” (p. 697). Delivery systems are not bounded by definitions but are constructed and reconstructed in the activities and competing interests of patients, providers, and the public.

15. Weel, C., Smith, H., & Beasley, J. (2000). Family practice research networks. *Journal of Family Practice*, 49(10), 938-943.

This citation is included for its clarity around the definition of primary care. The authors state that primary care implies medical care in the context of the individual’s psychosocial and family structure. The medical discipline most directly involved in developing primary care is family practice which, in Europe and the United Kingdom, is referred to as general practice (the work of general practitioners). According to the authors, the terms primary care and general practice are used *interchangeably* [italics added] in international literature.

B. Gender and other differences in policy and research

16. Advisory Committee on Health Services (1996, April). *A dialogue on primary health care: It's your choice*. Ottawa: Publications Unit, Health Canada.

This document constitutes a guide for a policy consultation process conducted on behalf of the Federal government on the strengths and weaknesses of the present publicly funded PHC system in Canada. The findings were gathered for presentation to the Conference of Federal, Provincial, and Territorial Ministers of Health in September 1996.

The document is of particular interest in the way that it structures the process of consultation. For example, it identifies nine principles that “might define the kind of PHC system we want in Canada” (p. 6). The principles suggested are:

- patient involvement – partnership between the individual and the provider
- emphasis on keeping people healthy
- appropriate high quality care
- 24 hour access to care
- individual choice of provider
- ongoing provider-patient relationships
- clinical autonomy
- effective management based on evidence
- affordability

The document then goes on to suggest and explore options for reform in terms of provider arrangements, payment mechanisms, administrative structures, and integration of services. The principles and options articulated thus guide the consultation process toward outcomes that may have been largely pre-determined. Consultation with communities and sub-populations is often mandated as a preliminary stage to the development of health policies. Yet the language and process that guide consultation obscure layers of meaning within an ideology that is seldom made explicit to participants. Whether intended or unintended, the process of consultation may also exclude the opportunity for those from marginalized groups to raise their concerns.

17. Advisory Committee on Women's Health Surveillance (1999). *Women's health surveillance: A plan of action for Health Canada*. Minister of Public Works and Government Services Canada, Cat. No. H49-125/1999. (A)

In 1998 the Laboratory Centre for Disease Control (LCDC) identified gaps in its surveillance activities regarding women's health. As a result it initiated an advisory and planning process to address these deficiencies. An advisory committee composed of volunteer health professionals prepared this action plan for Health Canada in order to identify issues, priorities, and approaches to serve as the basis for a national women's health surveillance system.

Health surveillance was originally set up for the prevention and control of infectious diseases. It involves the systematic collection, monitoring, and reporting of trends that

can be used for policy, program planning, and services evaluation. Surveillance data have traditionally reported on variables such as sex, age, income, and region in Canada. However, this new surveillance initiative marks a profound departure from that model. This document reports on the LCDCs intention to incorporate gender-based analysis into its surveillance activities. Gender is “the culturally specific set of characteristics that identifies the social behaviour of women and men and the relationship between them [as well as]...the way it is socially constructed” (p. 14). Gender-based analysis contrasts with analysis according to sex, which identifies only the biological differences between men and women.

The plan identifies three new priority areas for women’s health surveillance: (1) musculo-skeletal conditions, (2) mental health, and (3) violence. Using gender-based analysis, the LCDC also intends to:

- strengthen existing surveillance activities for such things as cancer, heart disease, tobacco use, and abortion
- include non-conventional data such as qualitative data [i.e. non-conventional in this field]
- initiate new strategies to reach subgroups of the population
- gather data from groups to whom certain issues are most relevant.

This document is included because it draws attention to a major shift in traditional approaches to conducting research concerning women. In addition, the data generated may have significant future implications for policies and primary care services and their relevance to women.

18. British Columbia. Provincial Health Officer (1996). *A report on the health of British Columbians: Provincial Health Officer’s annual report 1995*. Victoria, B.C.: Ministry of Health and Ministry Responsible for Seniors.

The Provincial Health Officer in B.C. has a mandate to report on population health status as measured against population health targets. At the time this report was written, a consultation process was underway to establish these targets. The 1995 report is of particular interest because it features a section on women’s health. Women’s health involves “emotional, social, cultural, spiritual, and physical well-being, and it is determined by the social, political, and economic context of women’s lives as well as by biology” (p. 78). This perspective encompasses a number of influences on women’s health: (1) living and working conditions, (2) the natural environment, (3) biological influences, (4) individual skills and choices, and (5) health services. Sections covered in the report are consistent with issues that are commonly identified by women such as:

- violence
- substance misuse
- mental health
- reproductive health
- chronic diseases, especially cancer

The author of the report recommends actions and objectives to address each of these issues, while affirming the view that income and social status are among the most important determinants of health. The approach to women's health is consistent with principles of PHC, which acknowledge inequities among populations and the need to address issues that arise in the social, cultural, and economic context of women's lives.

19. Byles, J., Feldman, S., and Mishra, G. (1999). For richer, for poorer, in sickness and in health: Older widowed women's health, relationships and financial security. *Women's Health*, (1), 15–30.

The Australian Longitudinal Study on Women's Health was funded by the Australian Department of Health and Family Services to explore a range of social, mental health, and lifestyle factors and their effects on physical health. This research examines the health and social needs of older women, through a comparison of widowed and married women.

To obtain the data, researchers mailed survey questionnaires to a randomly selected sample of women between the ages of 70 and 75. Of the 12,624 women who completed the survey, 4,106 were widowed. In the widowed group, 13.5% (n=540) had lost their partner in the past 12 months. Married women comprised 55.5% (n = 6,640) of the sample.

As expected by the researchers, women in the more recently widowed group had the lowest self-rated health and the lowest health-related quality of life (p.25). Women widowed for longer than 12 months had quality of life scores equivalent to married women. These results correlate with the view that the poor health experienced by widows in the first year resolves with time. The only significant difference in health care utilization between recently widowed and the two other cohorts was a greater use of sedatives. This finding may have relevance to other factors (e.g. physician attitudes and behaviours), however, this variable was not explored in this study. The authors concluded that widowhood is characterized by "extraordinary variability" (p. 28). While this study identified negative implications for the health and social needs of recently widowed women, it also revealed a need for further research to separate negative outcomes associated with widowhood from the effects of women's aging. This study was selected because it is concerned with the needs of a marginalized and under-researched group: older women.

20. Canadian Nurses Association (1990, March). *Submission to The Standing Committee of the House of Commons on Health and Welfare, Social Affairs, Seniors and the Status of Women. Select issues in health care delivery.* Canadian Nurses Association.

This document, prepared by the CNA, a national association for registered nurses in Canada, provides a perspective on three issues significant to the health care of Canadians: (1) the aging population, (2) access to services, and (3) health human resources. The submission affirms the organisation's interest in and support for PHC reform enunciated

in the federal government's document, *Achieving health for all* (Epp, 1986). The CNA document is, however, notable for its omissions.

As a national organisation recognized internationally for its leadership of a predominantly female workforce, the CNA provides no explicit gender-based analysis of the issues. This is concerning since each of the issues discussed – the aging population, access to services, and health human resources – affect predominantly female populations. Each issue relates to the context of the living and working conditions that marginalize older women and women seeking or working in health services. The CNA also demonstrates a lack of gender awareness in discussing the role of volunteer caregivers and their need for respite. For example, the CNA uses gender-neutral terms that obscure the role and contribution of women and the implications of their unpaid work. Similarly, CNA discusses the human resource issues for nurses as a gender-neutral topic, despite the gendered nature of the workloads, the inclusion of many non-nursing duties, the lack of nurse involvement in decision-making structures and processes, and the inflexibility of working environments that fail to take into account women's dual roles as caregivers at home and in the workplace. The CNA has thus failed to integrate current research and critical analyses in addressing policy issues important to both Canadian women and the CNA members.

21. Canadian Public Health Association (1997). *Health impacts of social and economic conditions: Implications for public policy*. Ottawa: CPHA.

The Canadian Public Health Association (CPHA) is a national, voluntary, non-profit association representing public health agencies in Canada. This discussion paper was developed by a CPHA working group to identify the health impacts from socio-economic factors, and their associated implications for policy. The paper provides an excellent summary of relationships between the social and economic environments and health. The authors cite evidence that shows a gradient exists in the rate of disease according to a social hierarchy for almost every disease studied (p. 4). They dispute trends that focus on individual choice and lifestyle, and assert that lifestyle decisions must be understood in the context of the socio-economic environments that influence them. The document also addresses income distribution and poverty and the differential and gendered impacts on women, aboriginal peoples, and other vulnerable groups.

The CPHA also state that improvements in medical care, including better technology and access to services, while important for individuals, have little chance of reducing inequalities in health (p. 5). In other words, in terms of their relative contribution to health, factors outside the medical care system are more significant. This recognition is often overlooked in policies, many of which focus on relationships between health services, access to services, and health.

22. Denton, M. & Walters, V. (1999). Gender differences in structural and behavioural determinants of health: an analysis of the social production of health. *Social Science & Medicine*, 48, 1221-1235.

The focus of this research is on the ways in which health is shaped by social structures and lifestyles or behaviours for men and women in Canada. These determinants were explored using data from the 1994 Canadian National Population Health Survey. Three assumptions central to the research are that: (1) structures of social inequality are the most important determinants of health, (2) the structures act both independently and through their influence on behaviours, and (3) determinants do not operate the same way among men and women. Structural determinants included age, family structure, socio-economic conditions, main activity such as work/hours of work, and social supports. Behavioural determinants included life style factors such as smoking, alcohol consumption, and physical activity. Data was gathered by means of interviews and file analyses; health was measured according to self-report and an established measurement system called the Health Utility Index.

Analyses confirmed that social structures are more important than behavioural factors in shaping health, with structural effects more pronounced for women. This latter finding, the authors suggest, could be related to design and warrants further study. The findings also support previous studies that demonstrate health benefits for women who work outside the home. This study reinforces the need for research that includes “features of people’s material and social circumstances that are patterned by gender” (p. 1233). It was also selected because research into the determinants of health is a growing area of interest in the context of PHC reforms.

23. Department of Health (1995). *Carers (Recognition and Services) Act 1995*. London: HMSO. (A)

This Act of Parliament was passed in the UK following intense lobbying efforts on the part of carers, carer support organizations, and other advocacy groups. The Act lays out the obligation on a local authority to assess the needs of a carer for the provision of services when a carer requests such an assessment. The Act (subsection 1b) defines a carer as: “an individual (‘the carer’) [who] provides or intends to provide a substantial amount of care on a regular basis for the relevant person ...”

There are no additional specifications in the Act regarding the carer [who is described in gender-neutral terms], nor is there an explanation of what constitutes a substantial amount of care, or for whom the care is provided [usually a spouse, child or relative]. There is also a gap between the Act’s recognition of carers and their needs and the government’s provision of funds and services. In research* conducted in Scotland, one participant from a carer support agency stated, “The Act gives carers legal recognition, but there are no resources to match”. This statement is illustrated by the fact that there are no funds dedicated to the provision of respite for families caring for their chronically ill or disabled child. Nevertheless, carers value the symbolic nature of the Carers Act, which acknowledges their contribution and also provides a process through which their

needs can be assessed and documented. This Act is included because it illustrates the role of informal carers in the provision of health services in the community and assumptions that women will be available to provide that care.

*Schellenberg, C. (2000). *“Running to stand still” Nurses’ roles with children and families in the community in Scotland: Relationships between policy and practice*. The University of Northern B.C.: MSc Thesis.

24. Department of Health (1999). *Saving lives: Our healthier nation*. London: HMSO. (A)

This central government document identifies the four priority areas of health concern currently targeted in the United Kingdom (U.K.): cancer, coronary heart disease and stroke, accidents, and mental illness. The document provides objectives for the reduction of morbidity and mortality to be achieved by the year 2010.

Like a number of UK public policies, the document identifies issues relating to women and other groups in broad terms that concern relationships between health and inequalities. Among the inequalities identified are those that exist between social classes, men and women, and different ethnic groups (see 4.2 and 4.3). While addressing specific differences between men and women in relation to certain health conditions, the document is lacking in a gender-based analysis. For example, in discussions pertaining to employment and health (see 4.20), the information conveyed is either specific to men, or is described in gender-neutral terms such as “lone parents” and “disabled people”. Similarly, initiatives to address workplace concerns (see 4.27) fail to acknowledge the social and structural elements that foster unhealthy and discriminatory environments for women.

The language throughout the document emphasizes the importance of partnerships between communities, local organisations, and the public and private sectors, while also acknowledging individual responsibility for health: “People improving their own health supported by communities working through local organisations against a backdrop of action by the Government” (Executive Summary, p.3). Although the document does not specifically refer to PHC, the language is consistent with the language and/or principles of PHC reform, such as partnerships, community action, and health for all.

25. Federal, Provincial, and Territorial Advisory Committee on Population Health (1994). *Strategies for population health: Investing in the health of Canadians*. Ottawa: Publications, Health Canada.

This document was prepared for a meeting of the Ministers of Health in Halifax in order to provide strategic directions for the promotion of population health. A population health strategy focuses on factors that improve the health of the overall population (p. 9). Consistent with the key elements of PHC, population health takes into account people’s living and working environments and the conditions that assist or constrain them in making healthy choices.

The document reflects an interest in research that demonstrates inequalities associated with gender, ethnicity, class, income, and social status and their relationships with health, and it highlights the impacts on certain groups. For example, among Canada's population, Aboriginal peoples are the most disadvantaged and have the poorest health status, and these disadvantages are intensified for Aboriginal women. There is also an acknowledgement that much of our existing research is based on men and that there is a need for gender-specific studies. This is not an in-depth document, but it is included because it incorporates principles of PHC reform (although they are not named as such) and demonstrates intent on the part of governments to begin to address issues affecting the health of populations and marginalized groups.

26. Jones, C., Tulman, L, & Clancy, C. (1999, July/August). Research funding opportunities at the Agency for Health Care Policy and Research. *Nursing Outlook*, 156-161.

The Agency for Health Care Policy and Research (AHCPR), situated in the U.S. Department of Health and Human Services, encourages and supports health services research that links clinical work with the delivery of care. This paper provides a step-by-step guide for nurse researchers who are interested in the application, review, and funding processes. It also summarizes the number of research proposals submitted by and awarded to nurse researchers for the years 1994 – 1997, and offers recommendations to prospective nurse applicants.

This paper has been included because it emphasizes the AHCPR's interest in research pertaining to the health of minority groups, women, and children, as well as the application of research to policy. This interest demonstrates intent on the part of government to consider gender, ethnicity, and other differences in policy formulation and research. The document could be strengthened by providing evidence of the scope of research conducted with marginalized groups.

27. Manderson, L., Kelaher, M., Williams, G., & Shannon, C. (1998). The politics of community: Negotiation and consultation in research on women's health. *Human Organisation*, 57(2), 222-229.

In this paper, the authors explore methodological and ethical issues involved in community-based research. The researchers describe challenges they encountered during the first stage of a national Australian Longitudinal Study of Women's Health in their efforts to consult with and recruit women who would otherwise have been under-represented in the national cohort. Among the issues described are the following: (1) problems in gaining access to marginalized groups when, for example, there is no infrastructure in Aboriginal communities to support community consultation with women, (2) concerns on the part of different sub-populations, for example, Aborigines and Torres Strait Islanders, that the use of labels such as "special cohort" lumped groups together and thereby ignored the differences between them, and (3) the nature of

“community” itself, for example, community boundaries are fluid and the definition of community is often imposed rather than arising from groups themselves (p. 224).

This research offers valuable insights into the issues and politics that can be involved in participatory and community-based research, which are central elements in PHC initiatives. It also illustrates that research intended for women must reflect the diversity and concerns of women in all stages of the research process.

28. Minister of Health (1995). *A statistical report on the health of First Nations in British Columbia*. Canada: Minister of Supply and Services.

This document contains a compilation of demographics and health status information for 1987-1992 on the First Nations people in B.C. Among the information included are:

- morbidity and contributing factors
- socio-economic factors
- the delivery of health programs including primary care and social-financial services

While the document provides detailed information on health and social problems and their indicators, such as suicide rates, it is lacking in gender-based analysis. For example, the sections on family violence and sexual abuse are discussed as generic issues pertaining to families and children. The discussion thus fails to incorporate the risks, circumstances, and impacts that apply to women who, along with children, constitute the majority of victims of violence and abuse. Equally surprising, there is little integration of health hazards such as substance abuse and family violence with the social and economic factors that contribute to these problems.

This report was intended to provide a basis for developing future First Nations health policies and programs. However, it lacks the information and analysis that would assist primary care providers in their delivery of gender/culture sensitive services to women, men, and children in First Nations communities.

29. Mitchell, M. & Salmon, D. (1999). Involving the user in midwifery research. *British Journal of Midwifery*, 7(6), 389-393.

Among UK government policies, some have provided clear statements expressing the need for user participation in the health research process. For example, the Audit Commission (1997)* identified the need for the involvement of marginalized groups in the development of health care initiatives; similarly, the NHS Executive (1998)** require that researchers bidding for government funded contracts demonstrate how they will partner with users. The need is for researchers and participants to work together at each stage involving: (1) identifying the problem, (2) deciding how to study it, (3) finding meaning in the data, and (4) deciding how to use the findings.

Certain barriers, however, must be overcome in the process of involving women users in, for example, the development of maternity care services. Some women may encounter

difficulties in: (1) expressing their views publicly, (2) dealing with skeptical attitudes of professionals about user involvement, (3) managing costs for child-care and transportation. Researchers may have to contribute extra time and expense to facilitate user involvement. The long-term benefit is the development of women-centred services that are sensitive and responsive to the needs of women and families.

*Audit Commission (1997). *First class delivery*. London: Audit Commission.

**NHS Executive (1998). *Research: What's in it for the consumer?* London: NHS Executive.

30. National Forum on Health (1997). *Canada health action: Building on the legacy. Final report of the National Forum on Health, Vol. I*. Ottawa: Author. (A)

This document is more than a report; it was a process. The National Forum on Health was a federal government initiative launched in October 1994 to involve Canadians and to advise the federal government on ways to improve Canada's health system and the health of its citizens. The Forum was established as an advisory body consisting of Prime Minister Chretien as Chair, the Minister of Health as vice-chair, and 24 voluntary members. Public consultation was central to the four-year process. The findings were tabled in this final document.

The findings affirmed the need to preserve the fundamental principles of the Canada Health Act. The Forum recommended that home care should be included as a publicly funded service. The document states: "It makes little sense to guarantee public coverage when services are provided in hospitals, yet provide partial or no coverage at all for the same services out of hospital" (p. 14). The Forum recommended integrating the funding and delivery of health care services through primary care reform and reviewing the activities of all health care providers in order to establish the best use of human resources. It also recommended primary care reform that included a remuneration method not based on the volume of services provided by physicians (i.e. fee-for-service) but on a method that promotes a continuum of preventive and treatment services available through a team of providers.

Among the gaps the Task Force identified are knowledge about women's health, ethnic and cultural influences, non-medical determinants of health, and alternative or complementary practices and therapies. The Task Force also identified the need for more women to conduct research on women's health. This document reflects and builds upon a growing awareness by Canadians of deficiencies in knowledge and research on socio-economics and other health determinants, women's health, and the needs of sub-populations.

31. Research Centre for Gender and Health (2000). *The Australian longitudinal study on women's health. A summary.* (A)

Available: <http://www.fec.newcastle.edu.au/who/study.html>

This research project, also cited elsewhere in the bibliography, is a government-funded effort intended to collect information on relationships between women's health and biological, social, and psychological factors. Five themes are central to the study: (1) life stages and key events such as a birth, divorce, job change, (2) time use, including paid and unpaid work, (3) weight and exercise, (4) violence, including physical, psychological, and social abuse, and (5) use of and satisfaction with health care services.

Data has been and will continue to be collected for up to twenty years from three age groups that include indigenous and immigrant women in Australia. Methods of data collection comprise both mailed questionnaires and, to a lesser extent, face to face interviews with particular groups. The study also links factors identified by women with the Medicare utilization data. A list of issues being researched includes:

- alcohol consumption in young women
- prevalence of body dissatisfaction and factors associated with this in young women
- chronic illness among older women
- the health of widows

The findings of this study will be used for future health policy and service deliveries plans and, therefore, have implications for primary care services in Australia. The scope of the study reveals the state's interest in women's health, but it is unclear from the information provided whether the emphasis is on health services utilization or on the socio-economic and cultural conditions that shape women's lives.

32. Reutter, L., Neufeld, A., & Harrison, M. (2000). A review of the research on the health of low-income Canadian women. *Canadian Journal of Nursing Research*, 32(1), 75-97.

This paper summarizes a review of research published between 1990 and 1997 on the health of low-income Canadian women. The authors describe a recent shift by policy-makers and health sectors in Canada to giving priority to the reduction of health inequities associated with socio-economic factors. This perspective is congruent with the recent discourse on women's health (p. 76). The authors point to the relevance this area of research has for nurses who increasingly are focusing on the social and political determinants of populations.

The research describes gender differences associated with poverty. In Canada, women face a significantly higher risk of poverty than men. The authors cite studies indicating that the circumstances as well as the effects of poverty may be different for women and men. They note that low-income women themselves are not a homogeneous group, but they found limited evidence of the inclusion of women's diverse backgrounds in the studies.

Among observations the authors drew from their review: 1) the importance of involving participants in the research so that their voices are heard, and of producing actions that result in improved conditions, 2) the need to recognize and address diversity among women in the research, and 3) the need for more studies in the areas of health status, health practices, and health-care utilization. This is a valuable study that may reflect the growing interest among nurse-researchers on the social conditions that influence health.

33. Salsberry, P., Nickel, T., Polivka, B., Raymond, K., Slack, C., & Shapiro, N. (1999). Self-reported health status of low-income mothers. *Image: Journal of Nursing Scholarship*, 31(4), 375-380.

Despite the growing body of research that describes a relationship between socio-economic status and health, there is little available research on the health status of low-income women. This study was conducted to determine self-reported health status of low-income mothers in Ohio.

Using structured interviews and questionnaires, graduate nursing students interviewed 502 low-income women within the Ohio Welfare Medicaid system. The low-income designation was based on eligibility for a poverty-related program, although there was variability in income within the sample. Medicaid is the primary insurer of low-income women (p. 379). The study yielded three key findings: (1) a significant level of depression among the women, according to a mental health component score, (2) differences in physical health scores among insurance groups (people insured privately had the highest scores; those enrolled in Medicaid had the lowest), and (3) lack of difference in health status of black and white subgroups. A major limitation of the study was that it did not account for vulnerable groups that could be missed because they were not receiving services.

The authors describe the need for new approaches in conducting research with vulnerable groups, and a key role for nurses in working with women and families who may be suffering ill health associated with poverty. There is also a need for nurses and other professional groups to take strong advocacy and lobbying positions directed toward initiatives to prevent the social conditions that foster ill health in the first place.

34. Secretary of State for Health. (1992). *The health of the nation*. (CM 1986) London: HMSO.

This UK White Paper builds on the WHO's *Health for all* by promoting a shift in focus for the NHS from a sickness-oriented to a wellness-oriented system. The strategy for achieving an improvement in the health of the population in England (Scotland, Wales, and Northern Ireland each have similar strategies) targets five key areas: coronary heart disease and stroke, cancers, mental illness, HIV/AIDS and sexual health, and accidents.

Gabby (1992)* offers a valuable critique by outlining the risks of making targets ends in themselves. He notes that, while *The health of the nation* emphasizes a need for health

promotion and underlines the role of primary care, it plays down the effects of poverty, unemployment, and homelessness on health (p. 129). One might also suggest that because the document underlines the role of primary [medical] care it retains an illness-orientation that is reflected in the targets.

*Gabbay, J. (1992, July). The health of the nation. *British Medical Journal*, 305: 129-130.

35. Shumaker, S. & Smith, T. (1994). The politics of women's health. *Journal of Social Issues*, 50(4), 189-202. (A)

During the past decade, the United State's government has instituted national policies designed to redress the imbalance that exists between research funding and health care for women. For example, in 1990 the government established an Office of Research on Women's Health (ORWH) for the purposes of coordinating, reviewing, and monitoring Public Health Service activities pertaining to women's health. Funding applications to the National Institutes of Health (NIH), the largest health research funding agency in the world, are no longer considered unless they address issues regarding the inclusion of women and ethnic groups. The authors point out, "Becoming a political agenda does not guarantee optimizing health for women or men" (p.189). To illustrate this point they provide a discussion in two parts. The first is a review of the recent political history that has led to women's health achieving its status on the political agenda. The second is a consideration of the question, "In what ways and by whom is the research agenda established" (p. 201)? The question, which is explored through a discussion of two content areas, childbirth and heart disease, provides an historical perspective that differs from mainstream writers on these subjects. This is an insightful paper in which the authors also raise questions about the content and quality of medical research not covered by NIH guidelines, the technological imperative in research agenda, and the measures used to fund and evaluate health research.

36. Standing, H. (1997). Gender and equity in health sector reform programmes: a review. *Health policy and planning*, 12(1), 1-18. (A)

This author reviews the literature on health sector reform and debates implications for gender equity. Although the review is focused on reforms taking place in developing countries, it offers valuable analyses relevant to the developed world. The author identifies six components of reform and explores possible gender implications. These components, cited with examples of gendered implications (*italics*) are:

- Improving the performance of the civil service- *gender balance and human resource policies*
- Decentralization-*how does this affect access for vulnerable groups?*
- Improving the functioning of national ministries of health-*what criteria are used in setting priorities?*
- Broadening health financing options-*gender implications of different payment schemes*
- Introducing managed competition-*effects on equity and access*

- Working within the private sector-*are women more or less likely to benefit?* p. 4-5

This paper provides an excellent guide for a gender-based analysis of policies.

37. U.S Department of Health and Human Services. (2000). *Healthy People 2010*. (pp.1-16). Available: <http://raceandhealth.hhs.gov> (Retrieved April 10, 2001).

This document outlines the US federal government's goals and objectives for health promotion, disease prevention, and improvements in the delivery of health services in the first decade of the 21st century. Among the goals identified are those intended to increase quality and years of healthy life, and to eliminate health disparities. Health disparities are understood to be associated a number of factors including the following:

- gender
- race or ethnicity
- education or income
- disability
- geographic locations
- sexual orientation

Despite these linkages, e.g. between health and income, gender-based analysis is distinctly absent. For example, the section on gender identifies only differences between the sexes in terms of physical indicators and diseases without reference to social, cultural, economic, and political factors within which the differences arise. Similarly the section on race and ethnicity lacks analysis. In describing the inequalities in income and education, the document identifies disparities by race, ethnicity, household composition, and geography. A graph depicting the percentage of persons below the poverty levels reveals a staggering 68% for related children below 18 years of age in female-headed households, followed by 58% for African American. However, there is no analysis regarding the factors that contribute to high levels of poverty and unemployment for women. This document has clear orientation to physical health and health services, and offers perspectives that appear in sharp contrast to the vision and principles of PHC.

38. Villarruel, A. (2001). Eliminating health disparities for racial and ethnic minorities: A nursing agenda for children. *Journal of the Society of Pediatric Nurses*, 6 (1), 32-34.

US federal policy has targeted health issues for minority groups. This paper describes those targets and discusses implications for nursing. The President's Initiative on Race and Health* focuses on the needs of racial and ethnic minorities in six areas: (1) infant mortality, (2) cancer screening and management, (3) cardiovascular disease, (4) diabetes, (5) HIV infection and AIDS, and (6) immunizations. This commitment to the needs of racial minorities is also affirmed in the federal document, *Healthy People 2010* (1990).

There is a growing body of evidence related to health disparities for racial/ethnic groups. Among the increasingly diverse ethnic population in the US, the percentage of non-Hispanic white children has decreased steadily since 1980, while the percentage of Blacks, Hispanics, and Asian Americans continues to increase. Hispanic children

comprise the largest minority group in the country (p. 32). While infant mortality and HIV/AIDS are decreasing for some groups they are increasing for others. The infant death rate for Blacks, for example is twice the average for whites. Similarly, the incidence of HIV/AIDS is increasing rapidly in Black and Hispanic women.

The National Institute for Nursing Research (NINR)** has developed a strategic plan to eliminate health disparities by addressing institutional barriers and environmental concerns that affect children, families, and communities. It is evident, however, that despite the expressed policy intentions to reduce inequities, policy implementation is lacking. The US continues to have the greatest disparities between rich and poor of any industrialized nation.

* US Department of Health and Human Services. (1993). *The initiative to eliminate racial and ethnic disparities in health*. Available: <http://raceandhealth.hhs.gov>

** National Institute for Nursing Research (2000). *Strategic plan for reducing health disparities*. Available: www.nih.gov/ninr/a_mission

39. Weisman, C., Cassard, S. & Plichta, S. (1995). Types of physicians used by women for regular health care: Implications for services received. *Journal of Women's Health*, 4(4), 407-416. (A)

This research examines associations between care for women and the types of physicians seen by women in the US. As the authors note, one of the main objectives of health care reform was to improve access to primary and preventive services. Yet little is known about how women obtain primary care or what types of physicians should be designated as their primary care providers. This paper begins to address this gap in information.

Research data was obtained from a 1993 women's telephone health survey which, in order to ensure their representation, included over-samples of African American and Latina women. The survey examined the following: (1) types of physicians women see for regular care (the major primary-care providers include family and general practitioners, general internists, and to a lesser degree, obstetricians or gynecologists i.e. OBGYNs, (2) characteristics of women with each type of physician use pattern, for example, education, age, socio-economic indicators, and (3) types of preventive services received, for example, Pap test, cholesterol, and mammogram.

The findings revealed that:

- one third of women see both a primary care physician and an OBGYN
- women seeing a primary care physician alone receive fewer preventive services than women seeing both types of physicians, independent of health insurance
- African Americans are half as likely as non-Hispanic white women to have received a mammogram.

The authors conclude that the types of physicians seen are partly a function of socio-economic circumstances, including type of health insurance, and of geographic location,

e.g. physician availability. Women who see both a primary care physician and an OBGYN for regular care (33 % of all women) are relatively affluent and tend to have private health insurance or be enrolled in Health Maintenance Organizations (HMOs).

This study demonstrates that, while research is being conducted on women's health and service utilization, outstanding issues remain. For example, there is an implicit assumption in this research that more visits and screening tests equate with better care, but this assumption has not been validated. The use of mammography remains controversial for some age groups, and the use of screening does not necessarily correlate with appropriate follow-up and care.

40. Writing Group of the 1996 Expert Panel on Women's Health, (1997, Jan/Feb). Women's health and women's health care: Recommendations of the AAN* Expert Panel on Women's Health. *Nursing Outlook*, 7-15.

Women's Health in the western tradition has generally been viewed from a bio-medical perspective. This paper offers a view of excellent women's health care – care that encompasses the context of women's lives across the life span. The panel identifies six features basic to excellent women's health care: (1) grounded in women's lives, (2) reflective of women's diversity, (3) oriented to care across the lifespan, (4) incorporated in a range of services, (5) delivered by a range of providers, and (6) accessible to all women.

Access to health care is a special concern for women and women's health. The ability to obtain services correlates at least partly with the ability to pay. Estimates suggest that twelve million adult women in the US are uninsured, and even when women are employed they earn on average less than men and are more likely to live in poverty. Women's lack of power as workers in organisations also limits their opportunities and access to services and benefits. The panel argues for changes in nursing education, practice, and policy in order to prepare and support nurses in their efforts to provide excellent women's health care.

41. Wyke, S., Bond, C., Morrison, J., Ryan, K., & Sullivan, F. (2000, Sept). Research priorities in primary care. A report from the CSO's primary care implementation committee. *Health Bulletin*, 59(5), 426-433. (A)

This paper describes the process used in Scotland to determine priorities for primary care research and it identifies those priorities. The process was an initiative of the Chief Scientist Office and was intended to guide priorities for funding primary care research in the year 2000. Research questions and topics were developed from recent reviews on primary care research and from the contributions of a range of professional groups in primary care settings in Scotland. In total, 347 research questions were identified. Subsequently, questionnaires were distributed to groups of ten members from a variety of backgrounds in primary care. Each member ranked their support during successive rounds and re-ratings until levels of agreement were achieved within each group. A

postal questionnaire that identified the strongly supported topics was then mailed to a sample of the primary care community.

The 34 highest ranked research questions and topics were placed into six thematic areas: (1) palliative care, (2) mental health, (3) organisation of care, (4) acute illness, (5) promotion and prevention, and (6) quality and standard of care. A list of suggested criteria for judging proposals was also developed. Among the priorities, two questions were specific to women's health.

This study contributes to an understanding of the scope of primary care in Scotland, the nature of research concerns and interests, and the processes for determining research priorities. Similar to a number of UK policy documents, the focus is on inequalities more than it is on specific vulnerable groups.

42. Young, R. (1996). The household context for women's health care decisions: impacts of UK policy. *Social science & medicine*, 42(6), 949-963. (A)

This detailed paper offers three valuable contributions: (1) an overview of significant UK policies in the area of PHC and social care reform, (2) an overview of the literature describing impacts of the reforms on women in their roles as paid and unpaid workers, and (3) a discussion of the author's own research, which explored the complex negotiation processes for paid and unpaid labour within families in Liverpool.

Among the finding and issues discussed, I highlight four: (1) the increased emphasis in PHC policy on healthy lifestyles and preventive care has meant extra responsibility for women, (2) regardless of class or ethnicity, women are the primary health managers in most households, (3) people with physical illness and disabilities who need help with everyday tasks are concentrated in low-income households, and (4) caregiving poses constraints on women's own health, and health care behaviour, especially if social support is limited. This research points to the need for those involved in both policy and practice to take into account the complexities of people's everyday lives and the characteristics of particular places (localities) when addressing local needs.

C. Care recipients and their access to care

43. Barnett, S. Niebuhr, V., & Baldwin, C. (1998). Principles for developing interdisciplinary school-based primary care centers. *Journal of School Health*, 68(3), 99-105.

School-based primary care centres (SBPCC) have been established in the US to promote access to primary care services for children. The expansion of centres from 150 in the late 1980s to over 900 in 1997 reflects an approach to addressing the health and psychosocial problems of children and youth, especially those who are underserved and high risk. Despite this expansion and early indications that the centres reveal some evidence of improved access to care, there are criticisms of the centres. Some of the criticisms are that: (1) published evaluations have shown limited effects on longer term

outcomes such as health status measures and health behaviour, (2) financing may divert dollars from education and, (3) there is a potential for duplication and fragmentation of health services.

In an effort to address the criticisms, the authors outline five principles they believe should be considered in the development of the centres: (1) the need for community participation, (2) the conduct of a needs assessment prior to development, (3) development of a long term financial plan, (4) the need for an interagency and interdisciplinary approach, and (5) the inclusion of comprehensive process and outcome evaluations. It will be of interest to follow the development and evaluation of SBPCCs and the extent to which they can sustain funding for a viable primary care service for underserved children over the long term. This paper was included because it represents an alternative to 'usual sources of care' for high-risk children who may lack a usual source of care.

44. Berk, M. & Schur, C. (1998). Measuring access to care: Improving information for policy-makers. *Health Affairs*, 17(1), 180-86.

This paper discusses methodological problems in measuring access to health care in the United States. Although the authors do not make specific reference to either PHC or women, access is a basic principle of PHC, and is particularly relevant to women and other vulnerable groups whose access may be limited. The authors point out that despite more than 60 years conducting major national surveys, researchers have widely differing estimates on the number of American people who do not receive adequate health care. Two primary factors impede the effort to provide consistent and meaningful information: (1) the lack of agreement about standards for measuring access, and (2) the lack of consensus about the conceptual definitions of access and need.

Methods used in gathering data, such as telephone interviewing, may be biased against vulnerable populations thereby resulting in under-reporting of the problems that they encounter. Similarly, the apparent magnitude of the access problem varies considerably with the conceptual measures used. For example, the focus on surveys is often on medical or surgical services, which presents a narrow view of access to health care. When the definition was broadened in one survey to include failure to obtain dental care, prescription drugs, eyeglasses, and mental health care the numbers of people reporting access barriers almost tripled. The findings have implications for researchers as well as for policy-makers who use research findings to develop political agenda. The authors raise questions about the use of research funds for repeated access surveys when survey methodology and findings are already in question.

45. Franks, P. & Clancy, C. (1992). Gatekeeping revisited – protecting patients from overtreatment. *The New England Journal of Medicine*, 327(6), 424-428. (A)

In over 90% of Health Maintenance Organizations (HMOs) primary care physicians serve as gatekeepers to authorize access to specialty, emergency, and hospital care, and to diagnostics. Gatekeeping occurs when patients need health care and select a doctor

(primary care physician or specialist) to help them move through the system. The authors argue that the traditional concept of the gatekeeper role, which predates the current association with HMOs and managed care, must be reclaimed. The gatekeeping concept emphasizes two *key* contributions: (1) patient advocacy, and (2) a critical decision-making function to protect patients from potentially harmful or unnecessary services. The authors discuss both the hazards of under-treatment and risks associated with over-treatment or “intensity of care”, and they suggest that the increasing intensity of care is driven by the aggressive medical culture in the US (p. 424). Primary care physicians tend to deliver less intense care for specific conditions than specialists, yet specialists provide at least 20% of the primary medical care.

This paper describes issues of access to and appropriateness of care and their implications for specific groups. In particular, the authors note the paradox that the differential in access to services for the poor and not poor may not favour either. In other words, intense medical care may involve both benefits and harm. The poor, through limited access benefit, in effect, from less harm! The overall point of the paper is, however, one that promotes the gatekeeping role of primary care physicians as vital to the health care of patients. The paper is included because it demonstrates the centrality of the physician’s role for people who are knocking at the gate for health services in the US.

46. Gulzar, L. (1999). Access to health care. *Image: Journal of Nursing Scholarship*, 31(1), 13-19.

Access to health care is one of the key principles of PHC (see Appendix 1). Yet the term access is often poorly defined and misunderstood. Using concept analysis, the author describes and analyzes conceptual and operational definitions of access based on an integrative review of nursing and non-nursing literature. The author also provides definitions of “health” and “care”, noting that in the literature, “health care” and “medical care” have been used interchangeably (p. 14). The WHO (1984) suggests that medical care is a component of health care; defining health in terms of medical care seriously limits the scope of the former. However, many researchers limit their studies to access to medical services only rather than access to health care (p. 14).

Based on her review and analyses, the author concludes the following definition of access to health care: “the fit among personal, socio-cultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services “ (p. 17). Access to health care is a key component of health research and this paper explores some of the associated complexities. But the issue of access also begs a question: What processes have generated this emphasis on service acquisition when issues such as income and employment are more central influences on health?

47. Hatton, D., Kleffel, D., Bennet, S., & Gaffrey, E. (2001). Homeless women and children's access to health care: A paradox. *Journal of Community Health Nursing*, 18(1), 25-34. (A)

In the US health care access is “undeniably inequitable” (p. 26). For homeless families, the problems of access are greater than for other poor families. Barriers to access for homeless families include: (1) lack of insurance, (2) lack of a regular care provider, (3) reluctance by care providers to assist them, (4) attitudes to people who are homeless, and (5) lack of transportation.

The purpose of this qualitative study conducted with shelter staff members, was to explore how staff members in shelters for homeless people manage the residents health problems and assist their access to services. The findings revealed that homeless women and children came to the shelters with multiple acute and long-term problems ranging from head lice and scabies to tuberculosis, HIV infection, schizophrenia, and suicidal behaviour. Despite the range of public health concerns present, no community health nurses were involved in any of the shelters studied. Shelter staff reported a frustrating paradox when dealing with health care agencies: “Society has two publicly and privately funded systems that oppose each other. One system tries to gain access for clients. The other tries to keep them out.” (p. 30-31). The authors suggest that this paradox raises questions about “withholding or limiting access to health care as a form of social control – a means to control impoverished women and children” (p. 31). The study concludes with recommendations for assessment, planning, advocacy, and prevention that fall within the scope of public health policies and community nursing practice.

48. Juarbe, T. (1994). Access to health care for Hispanic women: A PHC perspective. *Nursing Outlook*, 43(1), 23-28.

There are 22.4 million Hispanic people in the US (1990 figures) of whom 49% are women. This paper uses the term Hispanic women to refer to those whose country of origin (or parents country) is Puerto Rico, Cuba, Mexico, or Central/South America. Hispanic women are younger, usually marry and have children at younger ages, and have more children than any other women in the US.

Hispanics are less likely than almost any other group to have access to health care, and their most likely source of primary care is the emergency department. This paper provides an analysis of the social and cultural environment of Hispanic women, as a background to understanding barriers in access to care. The author identifies five areas that must be considered in any analysis of health care access issues: poverty, employment, education, language, and culturally competent care. The author challenges nurses to draw upon PHC perspectives in their work with different groups, because they focus attention on the socio-political and cultural factors that influence health and health promoting activities.

49. Kopenen, P., Oksanen, H., Perttola, K. & Aro, S. (1996). Population views on access to community nursing services in Finland. *Journal of Advanced Nursing*, 24, 727-735.

Access to PHC and continuity of care are essential elements in PHC, according to principles outlined by the World Health Organisation. The purpose of this research was to evaluate potential access to personal community nurses who provide PHC, and to determine the desirability of access from the point of view of different population groups. Potential access was defined as having one or several community nurses to contact when needing help and advice regarding health matters (p. 729). Potential access to such personal nurses was considered to be an indicator of good continuity of care. The research method involved a computer-assisted telephone interview with a random sample of the population ages 16 – 79 in ten health center areas of Finland.

The findings revealed that of the total (n=943) that considered personal nursing services desirable, 48% indicated they did not have potential access. Most of these people were elderly and had a chronic disease or disability. People who belonged to the target groups of the traditional preventive health care programs indicated that they had more potential access to personal nursing services than other groups. These target groups consisted of women as users of family planning, maternity, or child health services, employed people, and students.

The findings highlight the need for improved access to services for the elderly and those with disabilities. They also indicate the need for further studies to evaluate access to care for subgroups such as the unemployed. There is a concern that in focusing on nationally defined target populations some groups and their needs may be left out. This study is interesting because it suggests that there are barriers for certain groups in accessing services, even in a health care system that is considered to be accessible to all.

50. Loring, M., and Smith, R. (1994). Health care barriers and interventions for battered women. *Public Health Reports*, 109 (3), 328-338.

According to the American Medical Association nearly 25% of women in the US are abused by a partner during their lives. The medical costs associated with hospitalization, emergency department visits, and physician visits are staggering. Battering may be the major cause of injury to women and greater than the combined total of injuries due to automobile accidents, muggings, and rapes (p. 329). Battering is also a serious and under-research problem in lesbian and gay relationships. Overall, the extent of battering is under-reported. Battered women are often not identified as battered and do not receive appropriate and comprehensive care.

This study identifies service barriers and victim-related barriers to care primary care services in Emergency Departments and clinics. Among the service barriers identified are:

- the need for payment for services: isolation and financial factors associated with control by the batterer often constrain access to resources

- interview questions by primary care providers and hospital personnel that fail to determine the causes of injuries,
- negative attitudes of health care providers that lead to blaming
- denial and other attitudes by emergency response personnel.

The authors describe a need for comprehensive social changes that target health care professionals, the justice system, and the community as a whole. They also suggest that [paradoxically] in the managed care climate with its focus on cost-effectiveness and efficiency, it may actually be easier for HMOs to identify battered women, for example, by tracking injuries and/or the need for an unusual amount of services.

See also: Flitcraft, A., et al. (1992). Diagnostic and treatment guidelines of domestic violence. *Chicago American Medical Association*.

51. Mason, G., Coates, J., & Millette, B. (1997). Immunizations and rural health: Considerations for nurse practitioners. *Clinical excellence for Nurse Practitioners*, 1(7), 428-436.

It has generally been assumed that rural children are at greater risk for inadequate primary care due to provider shortages, poverty, lack of health insurance, transportation, and inadequate public funding. In this paper the authors review the results of a study of immunization levels for two year olds living in a rural setting (defined according to specified criteria in Massachusetts, US). The results are discussed in the context of primary care and what is known about health behaviours of rural populations.

A retrospective study of immunization levels for kindergarten age children in a rural area with no public health clinics revealed that 76.5% of the children were fully immunized compared with 73.5% in the overall state rate. The study challenges the commonly held assumption that low immunization rates are an indicator of low access to primary care services for children. In this and earlier studies, immunization has been shown to be one area of preventive care used more frequently by rural than urban residents. The study is valuable because it points to the need for research that considers rural health behaviours not only from a biomedical perspective but also from a socio-cultural one.

52. Paxton, D. & Taylor, S. (1998, May). Access to primary health care for adults with a learning disability. *Health Bulletin*, 56(3), 686-693.

Primary health care teams in the UK have a lead responsibility for providing care to adults with disabilities. Yet a number of studies have demonstrated that this group of people often have unmet needs and do not necessarily obtain the services they require. Several reasons may account for this: (1) the complexity of their health needs, which are not necessarily well understood, (2) poor communication on the part of patients or providers, and (3) lack of awareness of services by individuals and/or their carers.

This paper reports on a project designed to assist individuals and their carers to access primary health care services by means of first receiving a health assessment, followed by

periodic reviews. Health assessments were completed for 71 people, followed by the provision of additional services including hearing and vision screening, dental care, immunizations, as well as other services as indicated. All of the people assessed had at least one health need identified (p. 691). The study is important because it demonstrates the need for proactive planning and health care for individuals, as well as the need for support and education to their carers. Without appropriate assistance and support, both people with disabilities and their carers are vulnerable.

53. Puffer, F. (1986). Access to primary health care: a comparison of the US and the UK. *Journal of Social Policy*, 15(3), 293-313.

This paper contributes to discussions concerning access to health care for people with low income by comparing the US and the UK. Although the title concerns PHC, the actual content refers to primary medical care. The measure of access to primary medical care is the number of physician visits. For purposes of comparison, the measures are drawn from reasonably comparable survey data from both countries, taking into account differences in the demographics and morbidity of lower income groups. The author devotes considerable discussion to methodological issues. For example, one problem with measuring access by physician contacts is that contact frequency does not account for differences in quality.

Given the methodological challenges in this comparative study, the findings are not conclusive. Overall however the results suggest that there is some bias in access to primary care physicians for lower income women in the UK. The US data show relatively less access for lower income people, but sex (male/female) appears to make no difference. This study confirms the findings of others regarding methodological challenges in measuring access to care for different groups. The difficulties are compounded in cross-national comparisons.

54. Stevens, P. (1993). Marginalized women's access to health care: A feminist narrative analysis. *Advances in Nursing Science*, 16 (2), 39-56. (A)

The author provides compelling evidence of barriers in access to care for marginalized women. Through narrative analysis, the study reports the experiences of 45 low-income lesbians (from several ethnic groups) in three models of care in the US: (1) the private fee-for-service care, (2) health maintenance organizations (HMOs), and (3) the public sector. Of the total, 16 had no health coverage and thus were confined to public sector services. Seventeen had coverage through standard private insurance and 12 had coverage in HMOs.

The presence and type of health care coverage was the strongest indicator of the individual's experience. Participants in all three models of care experience profound access difficulties. Under fee-for-service coverage, women could choose providers but they were required to have cash in order to receive service. Health status stipulations in policies *guaranteed* coverage only if they were free of illness (p. 53)! HMOs promised complete coverage, but the women encountered many obstacles, procedural delays, and

long waits. The stories of the women's encounters with the public system are shocking. The women experienced such dreadful and dangerous conditions that some chose to leave without service. Apparently 61 million Americans deal with this system (p. 53). The author makes a compelling case for a PHC system that offers accessible, affordable, comprehensive care and asserts that nurses are the most appropriate group of PHC providers.

55. Vrabec, N. (1995). Implications of U.S. health care reform for the rural elderly. *Nursing Outlook* 43(6), 260-264.

Twenty-five per cent of people over 65 years live in rural settings in the US, depending on the definition of rural used. The Bureau of Census distinguishes between rural and urban on the basis of settlement size and density. This study identifies elderly people, that is, over age 65, as underserved due to at least four barriers: (1) inadequate financing of rural health centres, (2) lack of awareness of services, (3) fewer available providers, and (4) geographic dispersion (p. 260).

The lack of access to or availability of health services has identified effects on the health of rural elderly. For example, the lack of community-based services has led to earlier rates of institutionalization than in urban settings. Shortages of health care professionals are a long-standing problem in rural areas. The author proposes changes in reimbursement strategies in order to: (1) improve funding for the educational needs of rural providers, (2) offer incentives for rural practice, (3) promote the services of ANPs, and (4) allocate funds to rural health centres.

This paper lacks a gender-based analysis. Rural elders suffer from high rates of poverty estimated at 25% versus 18% for urban dwellers, and many of these elders are women. Research on the needs of rural elders and barriers to services must incorporate recognition of women's needs and the barriers also faced by older women.

56. Weinick, R., Weigers, M., & Cohen, J. (1998, Mar/April). Children's health insurance, access to care, and health status: New findings. *Health Affairs*, 17(2), 127-136.

There is no certainty in the US that children will receive the medical care they require. A substantial number of children are uninsured, and evidence indicates that the numbers of uninsured are increasing. The lack of health insurance is perceived to be a significant barrier to access for primary care services.

This paper reports on a survey designed to identify which children are at greatest risk of having difficulties with health insurance (or lack of), access to care, and health status. The research involved a sub-sample of data obtained in a National Health Survey on 9400 households. Data analyses included relationships between a number of factors including health care use, access, health conditions, insurance, and income. Hispanic children were found to be more likely than children of all other racial/ethnic groups to be uninsured, lack a usual source of care, and be in fair to poor health. In addition, children with no

employed parents are greatly dependent on public insurance and are significantly more likely than others to be in fair to poor health.

This paper is curious in its approach. By focusing on children's health insurance and access, the authors obscure the conditions of and public responsibility for children and their families in the context of their shared lives.

D. The services and providers

57. Deane, K. (1997). CNS and NP: Should the roles be merged? *The Canadian Nurse*, 93(6), 24-28.

In the current climate of cost-cutting in the Canadian health care system, nursing organisations have identified opportunities for advancing the scope and power of the profession. By merging two separate nursing streams – the clinical nurse specialist (CNS) and the nurse practitioner (NP) – nurse leaders would have a basis for lobbying for a more autonomous advanced practice role.

The two roles have separate histories, each with a different focus. The CNS, who is a registered nurse with graduate education in a clinical specialty, works with clients and families and acts as an expert resource for others, usually in hospital settings. The NP is generally baccalaureate prepared with additional training in order to fill an expanded role in PHC. In the US, these roles have merged under the designation Advanced Practice Nurse (APN) and in some states, APNs have primary care provider status. In other words, APNs who have status can be directly reimbursed for their services. In Canada, however, physicians have resisted the development of programs for the education of nurse practitioners. While NPs have been “permitted” to provide primary care services (i.e. first contact for the patient) in remote settings which lack general practitioners, they have had limited success in establishing direct services in other areas of the country. As provincial governments seek alternatives to the high cost of physicians' services, the efforts of nursing leaders to improve the status of nurses in advanced practice may finally be realized.

58. Cabral, R., Galavotti, C., Gargiullo, P., Armstrong, K., Cohen, A., Gielen, A., & Watkinson, L. (1996). Paraprofessional delivery of a theory based HIV prevention counseling intervention for women. *Public Health Reports*, III, Suppl. I, 75-82.

This paper describes the work of para-professionals (lay workers trained to provide designated services) in an HIV/AIDS prevention project for women. The Centre for Disease Control and Prevention (CDC) funded a five year research project in the US aimed at preventing HIV infection and unplanned pregnancies in women at risk for infection and/or transmission. The women were recruited from drug treatment centres, homeless shelters, HIV clinics and other public projects in Baltimore and Philadelphia. The majority of women in both sites were African-American and receiving public assistance. In Baltimore, 92% of the women were also living with HIV.

This report is a mid project evaluation on whether para-professionals (also called advocates) can successfully provide theory-based counseling. The advocates are women; many are living with HIV and have personal/family histories of homelessness or drug abuse. The evaluation concluded that the advocates were able to understand, adapt, and deliver a theory-based intervention. This model offers employment and meets the need for cost-effective services. At this stage of the evaluation, there are no measures of user satisfaction or outcomes. The paper is included because it introduces the community based or lay service provider to the discussion on service providers. In PHC reform, the low cost provider is becoming an integral part of service delivery systems, not only in the US, but also in Canada and the United Kingdom.

59. Anderson, M. and Urban, N. (1997). Physician gender and screening: Do patient differences account for differences in mammography use? *Women & Health*, 21(1), 29-39.

Past research on physician gender and screening for breast cancer has suggested that female physicians offer mammography screening more often than male physicians do. This research investigates whether differences between the patients of male and female physicians, for example, in assertiveness or education might contribute to mammography use.

A randomized telephone survey of women (n = 9,484) ages 50 – 80 was conducted as part of a community trial of promoting regular mammography use in Washington. Using logistic regression analysis, the researchers found that women who had a male physician were at a two fold greater risk for not having received a mammogram in the past two years (p. 35). Adjusting for patient or demographic differences did not eliminate these differences between male and female physicians in their respective screening practices. Regardless of physician gender, assertive women (self-rated) were more likely to get mammograms than less assertive women. There is a need for further studies to examine the nature of interaction between physicians and their patients to determine other possible correlations between physician gender and interventions and outcomes for women's health. This study is disturbing in that it is indicative of the responsibility women must take for not only their own care, but also for the attitudinal approach they must assume in order to obtain care.

60. Gregor, F. (1997). From women to women: nurses, informal caregivers and the gender dimension of health care reform in Canada. *Health and Social Care in the Community*, 5(1), 30-36.

This paper is based on the assumption that the principles of health care reform, and indeed their consequences, are not gender-neutral. The author offers a critical perspective on health care reforms that focuses on two major considerations: 1) their impacts on nurses and families, and 2) the support for reform within nursing itself.

Nursing organisations at the national, provincial, and international levels have embraced the principles of PHC. The author notes that principles of health care reform in Canada

and those of PHC are similar in emphasizing partnerships, health promotion, and community-based care (p. 35). Tracing the policy shifts over the past 20 years or so from treatment to prevention and promotion-oriented models of care, the author describes a resulting decline in hospital beds and an increased use of home care services. She observes that the relocation of care from hospital to the home is adversely affecting women as the major providers of care both within and outside the family (p. 30). Not only are nursing positions in hospitals being lost, but women in their homes are taking an increased responsibility for the care of the sick, disabled, and those experiencing early hospital discharge. This paper offers a thoughtful analysis for nursing organisations and for nurses who view their roles as advocates for patients and the public good. As the author states: “Perhaps unwittingly, nurses are complicit in a restructuring of health care that does not favour women” (p. 35).

61. Harrison, K. (1999). Influence of managed care on professional nursing practice. *Image: Journal of Nursing Scholarship*, 31(2), 161-166.

In this study the author explores the perceptions of California-based nurses in advanced practice regarding managed care and its influence on their work. The method employed – called a Delphi technique – involved mailing three successive rounds of questionnaires (refined according to previous responses and agreements) to expert panelists (n=57 on the final round) with advanced practice certification. The work settings of the panelists included primary and specialty care practices, HMOs, employee health centres, public health, and home health agencies. The panelists identified 36 influences of managed care on nursing practice. Of these 16 were viewed as positive in that they provide opportunities for nurses such as role expansion. Twenty influences posed threats to client care quality or to professional identity and security. The panelists also identified a concern that the managed care environment focused the orientation of APNs toward a medical model of practice (e.g. disease/illness orientation as distinct from wellness/health promotion).

The author suggests that structural barriers such as workload, payment schemes and exclusion from contracts constrain nurses’ work. This view, while accurate to a degree, lacks a gender-based analysis of the business and medical environment surrounding a predominantly female workforce. The author concludes that as nurses describe their clinical and economic value to purchasers and providers they will encounter fewer barriers, thereby suggesting that cost-benefits and evidence will transform hierarchical structures.

62. Kirk, S. & Glendinning, C. (1998). Trends in community care and patient participation: implications for the roles of informal carers and community nurses in the United Kingdom. *Journal of Advanced Nursing*, 28(2), 370-381.

‘Hospital care at home’ is a term used in the UK to describe the relocation of hospital services to the home. This shift is occurring in the context of health and social policies such as the *NHS and Community Care Act 1990*, which emphasize the role of families, neighbours, and the voluntary sector in the provision of care. The changes have arisen out of concerns over rising costs and demographic trends related to a growing number of

elderly people (p. 371). Furthermore, developments in technology are now enabling informal carers to provide more complex care at home.

This paper explores implications of these changes for primary health care nurses and informal carers, particularly for parents of children with special health needs. Although there is extensive documentation on the burden of caring, little is known about the needs of parent carers performing complex procedures for their child. The expectations on carers to provide the care may be compounded for mothers because of the cultural expectations that they [usually mums; author's note] will care for children regardless of the nature of care required. This research lacks a gender-based analysis, for example, by neglecting to make explicit the assumptions about women's availability for care that are embedded in community care policies. The authors do identify the power dynamic that may exist between nurses and families when nurses perceive a challenge to their expertise and skill. The paper is an important inclusion, because it introduces a traditional provider to the health care scene: mums caring for sick and disabled children at home.

63. Lum, J. & Williams, A. P. (2000). Professional fault lines: Nursing in Ontario after the Regulated Health Professions Act. In D. Gustafson, (Ed.), *Care and consequences: the impact of health care reform* (Chapter 3). Halifax: Fernwood Publishing.

This chapter describes the Regulated Health Professions Act (RHPA) of 1993 in Ontario and its direct implications for health care providers and particularly for nurses. Prior to the implementation of the Act, the licensure arrangements for health professions were dominated by medicine. Under the Act, which sets out principles common to all the health profession, nursing, midwifery, and other female-dominated professions have gained new legal recognition and autonomy.

The authors identify two contradictory tendencies that are now impacting on nursing: (1) greater professionalization and status, for example, nurse practitioners can now be recognized as primary care providers in their own right, and (2) deprofessionalization and deskilling (p. 50). The trend toward deskilling refers to the growing number of unregulated care providers (UCP) such as health care aides and personal support workers who increasingly are being employed to perform tasks and procedures previously within the scope and control of the nursing profession. The introduction of UCPs into health care provision has raised concerns on the part of nurses for their jobs, created rifts within the profession, promoted fears regarding public safety, and raised questions concerning accountability for the work.

This chapter, and indeed, the book in its entirety, makes a valuable contribution to the literature concerning the power struggles between professional groups, impacts of the reforms on women in paid, unpaid, and low cost work, and the forces shaping health care reform in Canada today.

64. Muzzin, L., Brown, G., & Hornosty, R. (1994). Consequences of feminization of a profession: The case of Canadian pharmacy. *Women & Health, 21*(2/3), 39-54.

The profession of pharmacy, traditionally male dominated, has undergone a marked transition from an influx of female pharmacy graduates over the past three decades in Canada. Concurrent with this so-called feminization of the profession, there is an orientation away from the business/entrepreneurial focus to one of advising patients and physicians. These and other trends have prompted fears among some in the profession concerning an increase in demands for part-time work and an impact on human resources and shortages.

Based on a small survey conducted with 97 pharmacists who graduated in the 1960s, 1970s, and 1980s, the researchers concluded that: (1) the fears of shortages due to women's propensity for part-time work were unfounded, (2) female pharmacists were more likely than males to work in a corporate chain than in an independent business, and (3) the number of women pharmacists has helped to allay shortages in some jurisdictions.

The authors observed that women are found to a disproportionate extent in professions that involve more extensive patient contact and counseling and less management responsibilities (p. 51). In addition, as the numbers of women increase, there is a decline in status and earnings for those in the profession, a finding that is consistent with working conditions for women particularly in the helping professions.

65. Raikes, A. (1992). Gender and the production of health care services: Issues for women's roles in health development. *International Development Services Bulletin, 23*(1), 19-28.

Women are the principal producers of health-related work in households, the community, and in PHC services. The author explores the production of health care services and implications for women in terms of two developments: the acceptance of PHC as a strategy for development, and the economic crisis (p.19). In the context of cost-cutting reforms taking place in many countries, there has been a tendency to shift the burden for health services onto communities and households. Women in developing countries, where limited resources may necessitate choosing between food and health services, have experienced the greatest impact of the economic crisis. However, even in industrialized countries, women are experiencing the impact as the location of care shifts from hospitals and institutions to homes and communities, where women are assumed to be available for unpaid care.

Although this paper focuses mainly on the role of women involved in health care activities and services in the developing countries, it offers a critical perspective that can contribute to women's health policy and research elsewhere. The author invites further discussion on key issues that arise in the context of the politics of gender. These issues include: the roles of the private and public sectors, pay and career structures, and the role of professionalism and the relevant organisations.

66. Schofield, R.F. & Amodeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective? *Health & Social Work, 24*(3), 210-219.

One of the guiding principles of PHC involves the need for collaboration among providers and between patients and providers. Although the authors do not address this principle in the context of PHC reform, they do discuss the changing nature of team work in the delivery of medical, mental health care, and social services in the managed care environment of the US. With the advent of managed care even widely accepted service delivery methods such as team work are being scrutinized to determine their value in terms of effectiveness and efficiency, or in other words, the market.

The authors assert that it is vital to demonstrate the efficacy of interdisciplinary teams in the managed care context. To this end, they conducted a review of literature on interdisciplinary teams to determine if/how such teams could be shown to aid in cost reduction and improvements to the quality of patient care. Overall, within the literature reviewed they detected weaknesses in terminology and substantive content. For example, the terms multidisciplinary and interdisciplinary were rarely defined and often were used interchangeably in a variety of different ways. The vast majority of writing described the education, training, or job satisfaction of interdisciplinary team members.

This paper is of interest because of the complete lack of a critical perspective. For example, there is no identification in this review of the power imbalances that often exist in teams, nor the gendered nature of work in health and human service settings. The authors do observe a point of historical interest: that papers written in the 1980s tended to stress the value of collaboration and interprofessional contributions to patient care, whereas those written in the 1990s were more likely to emphasize as well the team's potential for efficiency.

67. Tapp, D. (1989, Sept). *Primary health care & the role of the nurse: an information package*. Regina: Saskatchewan Registered Nurses' Association. (A)

This document, prepared on behalf of the professional licensing body for Saskatchewan registered nurses, provides an historical and nursing perspective on PHC in Canada and the world, as well as a snapshot view of Canada's changing health care system. The purpose of the paper is to educate nurses about PHC and about the changes taking place in Canada as a result of efforts to shift the system from an illness and medical-based orientation to one of wellness and health promotion.

The author outlines the potential available to nurses through initiating and incorporating the vision of PHC into their work in hospital and community settings. Primary health care offers the potential for nurses to expand their scope of practice, serve as an entry point to health care services, and offer a lower cost integrated service alternative to the services provided by physicians. Given the potential, one can appreciate the interest in PHC that is currently demonstrated by nursing leaders, associations, educators, and governments in Canada.

68. Van Den Brink-Muinen, A. (1997). Women's health care: For whom and why? *Social Science and Medicine*, 44(10), 1541-1551.

In the Netherlands there is a growing recognition of the need for primary care practitioners to incorporate principles and practices distinctive to women's health in their work. The author articulates five principles that are vital to women's health care: (1) consideration of the patient's gender identity and gender roles, and (2) consideration of personal and social factors, (3) respect for the patient, (4) encouragement of the individual's self-responsibility, and (5) prevention of labeling normal physiological processes as pathological (p. 1541).

Using these principles of women's health care, the research examined differences in the female populations of two groups of general practitioners in "Aletta", a practice setting in the city of Utrecht. The two groups consisted of women GPs providing women's health care and women and men GPs providing regular care. Data were obtained from health interviews with 253 patients who had chosen women's health care, and two additional reference groups of women with GPs providing regular care. The findings determined that patients in the women's health care practices comprised a deviant subgroup, and that they were more "androgynous" (male and female characteristics), eg. more competitive, independent, and individualistic than other women. They also reported poorer mental health, and higher use of mental health and alternative health care. The author concludes that women choosing women's health care constitute a specific group of women (p. 1550).

This paper is included because it demonstrates that women's health research does not equate with sound research. In this study, the author uses gendered assumptions and stereotypes, such as deviant and masculine/competitive in describing the women who sought women's health care. Although the researcher suggests that this group of patients were less attuned (in their self-reporting) to the prevailing cultural definitions of femininity and were more attuned to those of masculinity, the researcher seems to conform to those same cultural views. This paper thus provides evidence that research on gender can itself reinforce or even promote socio-cultural stereotypes regarding women.

69. Whyte, N. & Stone, S. (2000). A nursing association's leadership in primary health care: Policy, projects, and partnerships in the 1990s. *Canadian Journal of Nursing Research*, 32(1), 57-69.

The Registered Nurses Association of British Columbia (RNABC) along with other nursing associations in Canada and around the world, has welcomed PHC as the guiding framework for health reform. Since the early 1990s, the RNABC has worked with the provincial government, health care organisations, and nurse members to promote the principles of PHC. Among the association's efforts, the RNABC has advocated for: (1) a health-oriented as distinct from an illness-oriented system, (2) health promotion as a central element in nursing practice, and (3) expanded access to the system through employing registered nurses as a point of entry. These goals have not yet been realized, due at least in part to crises in B.C.'s health system, competing interests with the medical

profession, and the public demand for technological and acute care services. This paper reveals, along with other similar papers, the interest and commitment on the part of nursing organisations to primary health care reform.

70. Xu, G., Hojat, M., Brigham, T., Robeson, M., & Veloski, J. (1994). Primary care and nonprimary care physicians' concerns in practice and perceptions of medical school curriculum. *Evaluation & the Health Professions*, 17(4), 436-445.

There is a growing concern over the declining number of primary care physicians in the US. According to the authors this decline has contributed to the national health care crisis, resulting in increased costs and inaccessible medical care, especially in underserved areas. The purpose of this study was to identify concerns regarding factors that impact on physicians' work.

A mailed questionnaire was sent to a sample of 663 physicians (all graduates from one medical school during a four year period) regarding concerns in medical practice and their evaluation of the medical school curriculum. Comparisons were made between those in primary care and those in specialties (most of whom are in nonprimary care in the US).

Regardless of their field, the physicians overall were very concerned about their personal time. Primary care physicians were more concerned about time for professional development, whereas nonprimary care physicians were more concerned about supply in their specialties (oversupply is more evident than in primary care), hospital payment, and litigation. Both groups rated interpersonal skills as the most important aspect of the curriculum. Primary care physicians place greater emphasis on the importance of psychological, social, and cultural factors. Women physicians rated each of the three items significantly more important than their male counterparts. It would be valuable to conduct further research to determine what implications the findings might have for patient care, particularly for women, ethnic, and other disadvantaged groups.

E. Payment schemes for patients and providers

71. Adock, G. (1999). Primary care – Where? *Holistic Nursing Practice*, 13(4), 38-41.

In the US the deployment of nurse practitioners in the delivery of primary care is developing in the corporate sector. This paper describes a model of nurse-managed primary care centres established by the SAS Institute, the largest private computer software company in the world. The goal of the Health Care Centre located at the Institute in North Carolina is to provide a “full service” nurse practitioner (FNP) driven family practice for employees who choose this as their primary care provider. The services comprise not only the expected treatment of acute illness and management of chronic illness, but also a host of services aimed at health promotion, disease prevention, and wellness. FNPs deliver an estimated 85% of patient care to about 6500 employees and their families. Also among the staff are two family practice physicians, a nutritionist, a nurse psychotherapist, a physiotherapist, and a variety of health technicians. Managed

care practices such as gatekeeping, drug formularies, and preferred provider networks are not utilized. In other words, employees and dependents covered by the health plan have a full choice of providers, hospitals and services, and receive the services for free.

This model of primary care service differs from the occupational health or physician-directed services that constitute the norm in managed care settings. For six years the center was listed among the top ten companies in a magazine featuring “100 best companies for working mothers”, which suggests that it offers features sought or valued by women. The criteria for the award are not described but it is interesting to speculate on what type of services women do seek and value.

72. Canadian Healthcare Association (1999). *Funding Canada's healthcare system*. Ottawa: Author. (A)

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial organisations that represents, through its membership, approximately one million health care providers in Canada. This policy brief traces the history of public funding for health services from the inception, beginning with hospital and diagnostic services in 1957, to the present day. The brief is a detailed and comprehensive overview of funding arrangements. In the current transition of services from the hospital to the community, the chapter (three) concerning the federal funding mechanisms for home and community care is of particular interest.

72. Danzon, P. & Begg, S. (1991). *Options for health care in New Zealand*. New Zealand: CS First Boston NZ Limited.

The New Zealand health system is made up of public, private, and voluntary sectors that aid in the financing and provision of medical care. The Department of Health provides free health services for all citizens at hospitals, outpatient services, and public health agencies. Government funding is allocated to health authorities which determine priorities for the area within the conditions described by the New Zealand Health Charter that guides the operation of the public system.

Overall, New Zealand has a tradition of private provision for primary care services. Approximately 45% of the population has private health insurance. Primary care includes services such as general practitioners, diagnostics, and physiotherapists. The Department of Health provides subsidies for primary care, for example, for general practitioner visits, although many people contribute to GP services on their own. Some public funding is provided to GPs on a per visit basis. After 1991, the subsidy for the elderly was set at \$12 for a visit, and for children under 4 it was \$25. These subsidies and others are apparently transitional until a new system of targeted public funding to primary care services is implemented. Private insurance and personal responsibility for health care are dominant features of the NZ health care system. It is unclear, however, from this document how these arrangements impact on vulnerable groups within the population.

73. Hurdis, Griffith, Thomas, N. & Griffith, L. (1991, January). MDs bill for these routine nursing tasks. *American Journal of Nursing*, 22-27.

In a period of escalating payment to US physicians – an estimated 17% per year – reforms of the provider payment system must incorporate not only physicians, but also other health care workers. Nurses perform many of the tasks and procedures that physicians’ bill for. In this study, researchers surveyed experienced nurses (n=4482) who worked in a variety of settings (78% were employed in hospitals, the remainder in primary care settings) to determine the extent to which services billed by physicians are done by nurses. The questionnaire was developed on the basis of the current procedural terminology (CPT) codes that government programs such as Medicare and Medicaid use when determining payments for physicians’ services. The findings revealed that RNs often perform CPT coded services with little or no physician supervision.

This research is part of an effort by US nurses to receive recognition for the services they provide in hospitals and primary care settings. In the words of the authors, it is no longer acceptable to allow policy-makers to treat nurses as “invisible worker bees” (p. 27). Nurses in the US apparently view the reforms as an opportunity to advance their roles through revised payment schemes that incorporate their lower-cost services.

74. Klinkman, M. & Okkes, I. (1998). Mental health problems in primary care. *The Journal of Family Practice*, 47(5), 379-383.

The integration of mental and physical health is considered to be at the heart of primary care. Changes in the US health care environment, notably increasing competition that has led to a growing conflict between primary care physicians and specialists, threaten this integration. The conflict is heightened by criteria for payments to providers. Some insurers define mental health problems and treatment strictly in terms of DSM – IV diagnostic criteria and thereby consider mental health specialists as responsible for service provision. Some insurance carriers deny reimbursement for mental health treatment by primary care physicians. These and other arrangements create a separate system of mental health care and marginalize the role of primary care physicians [what about the patients?!] The authors suggest that the fragmentation of care resulting from these arrangements may have profound implications for higher risk populations. One of the impacts not addressed in this study may also be that the payment system leads to a further medicalization and labelling of people with mental health concerns. This paper is one of a number of studies that reveal ways in which payments for physicians can negatively affect patient care.

75. Lindeke, L., & Chesney, M. (1999, Nov/Dec). Reimbursement realities of advanced nursing practice. *Nursing Outlook*, 47(6), 248-251.

Advanced nurse practitioners (APNs) in the US offer a range of primary care services in physicians’ offices, health centres, and MCOs. Despite the increased public acceptance of and satisfaction with ANPs, reimbursement barriers in MCOs continue to restrict their

practice. This paper reports on a survey of APNs conducted to identify barriers to reimbursement.

Through content analysis of 631 responses to mailed questionnaires, the researchers identified three main barriers: (1) lack of APN recognition by MCOs and third party payers such as insurance companies, (2) lack of APN knowledge and education relating to reimbursement rules, regulations, and policies, and (3) rapid pace of change in a complicated system. Many ANPs work with the elderly, chronically ill, low-income families, and women who are often covered by either Medicare or Medicaid. Reimbursements for work with vulnerable populations are inconsistent; rates for Medicaid, for example, vary from state to state. Thus barriers to reimbursements have implications not only for nurses but also for the delivery of care to vulnerable groups.*

*See also: <http://thomas.loc.gov> *Medicare Patient Choice and Access Act of 1997*, HR 66 IH (Introduced in the House) 105th CONGRESS 1st Session

76. McGlynn, E. (1998). The effect of managed care on primary care services for women. *Women's Health Issues*, 8 (1), 1-14; 25-31.

In this paper the author discusses the effect of managed care on the delivery of primary care for women. Primary care as defined by the Institute of Medicine in the US refers to the provision of services by clinicians. Managed care refers to a variety of organisational and financial structures that may differ in the nature of access to services, costs, and plans. An estimated 22% of the population in the US is enrolled in managed care plans. The components of managed care consist of four main players: the purchaser, the insurer, the provider, and the patient. The author discusses each of these four components in detail along with the dimensions of managed care, one of which is the benefits package.

From the patient perspective, the benefits package contains the rules for obtaining care, such as the services that are covered, conditions of access, and the associated prices. For women, for example, some of the key services include clinical preventive services, such as screening mammography, contraception and mental health services. The author discusses the effect of coverage on access to and quality of care, but notes that most of the research that has been done compares persons with no health insurance to those with insurance, with the latter group reporting better access. Similarly, the author points to differences in access for preventive services depending on the specialty of the physician involved, and whether or not the woman has a regular place of care (reported as a place or a person).

The author concludes that our understanding of the implications of managed care for women's access to primary care services is extremely limited. Women do appear, however, to face greater cost-related barriers to access than men. Concerns have been expressed regarding access to and quality of care for older, low income, and minority women who have been found to receive fewer preventive services. This paper demonstrates how complex care arrangements and definitions can obscure opportunities for effective delivery and evaluation of women's health care.

77. Ontario Health Services Restructuring Commission (2000, March). *Looking back, looking forward: Seven points for action*. (A) Available: www.hrsc-crss.org

The Health Services Restructuring Commission (HRSC) was established in 1996 as an independent organisation to aid and advise in health services restructuring in Ontario. This document completes the work of their four-year mandate. The commission identified seven steps aimed at integrating hospital and PHC services. Action Five concerns the implementation of a new model for providing PHC services. Under the definition given, PHC is the first point of contact people in the province have with the health care system, a definition that conflates PHC with primary care.

The document identifies five essential components of PHC:

- access to PHC services
- 24 hour/7 days per week
- group practices consisting of doctors, nurses, and other health professionals
- consumer enrolment with a primary care physician or primary care nurse
- inter-professional primary care providers organized as groups

In addition, population based group funding, similar to that proposed in the Victoria Report (1997) will be directed to a group of primary care providers. An interesting element in this proposal is that it does outline a shift from a medical-centred system to one that appears to provide a more equitable role for nurses and other health workers in what may constitute a PHC team.

78. Schneider, A., Hyer, K., & Luptak, M. (2000). Suggestions to social workers for surviving in managed care. *Health & Social Work, 25*(4), 276-279.

Clinical social workers, like other health care professionals, are experiencing a transition from hospital to primary care services. This paper describes the impacts and implications of managed care for social work practice. Capitation is a payment scheme used by many HMOs to compensate physician services. In managed care schemes, this usually means that a physician is paid a fixed amount monthly per patient in advance of services provided. Thus the system tends to reward efficient care, in contrast to fee-for-service which rewards the physician for more services. Theoretically, managed care encourages and rewards prevention, early intervention, coordination of care, and an avoidance of duplication in tests and services.

This focus on efficiency has implications for social work practice. In order to fill a role in this corporate climate, social workers are being encouraged to translate their work into health care dollars saved by specifying interventions and their outcomes. However, to evaluate savings, the cost of care must be identified and a cost assigned. This focus on cost efficiency in social work raises questions about the implications for vulnerable groups, for example, the elderly, people with English as a second language, and others who may rely on social workers for coordinating care and for offering financial and emotional support. What happens to care that cannot be quantified or that does not meet a perceived standard of efficiency?

79. Secretaries of State for Social Services (1987). *Promoting better health: The government's programme for improving primary health care. Cmd. 249.* London: HMSO.

This White Paper follows the discussion paper of April 1986, *Primary health care, An agenda for discussion*. A significant development in this 1987 document is the UK government's proposal that GPs receive incentives to promote their role in health promotion and prevention. Family doctors (commonly called GPs) are contracted by the NHS to provide a core of health services in return for payments they receive through capitation fees and other allowances. Capitation fees consist of an annual fee paid for each patient registered with a GP. The government's plan is to complement this income with incentive payments to GPs for preventive services such as immunizations and screening for cervical cancer. These incentives are intended to help shift the emphasis in the NHS from an illness to a health-oriented service. Yet by offering incentives to GPs for health promotion/prevention the government appears to be fostering a GP-led PHC system, which could ultimately negate the trend that is intended.

80. Smith, L. (2000). Promoting the health of people with physical disabilities: a discussion of the financing and organisation of public health services in Australia. *Health Promotion International*, 15(1), 79-86.

Consistent with trends throughout the developed countries, the prevalence of persons with disabilities is increasing. In 1993, an estimated 3.2 million Australians had at least some form of specific disability present for six or more months. This paper emphasizes the significant contribution that health promotion services can make to people with a disability by assisting them in maintaining their present level of health.

Systemic barriers in funding impede the provision of health promotion services for this population. Three significant funding barriers identified are: (1) prospective payment systems in the hospital sector, where hospitals are reimbursed a fixed amount per patient according to the condition treated, do not take into consideration the extra resources and time needed by providers, (2) fixed payments for consultations in general practice create financial disincentives for physicians to take the extra time to assess and offer health promotion interventions, and (3) differences in funding sources (for example, in locations and organisations) for health, educational, and social services compound the problems of access to services for people with disabilities.

The author proposes financial and organisational solutions that provide new models of financing and delivering care for people with disabilities. It is unlikely, however, that new payment systems and coordinating functions will over-ride another factor not addressed in this study: the social and cultural barriers often expressed through attitudes that impact on people with disabilities in their efforts to access comprehensive quality care.

81. The Federal/Provincial/Territorial Advisory Committee on Health Services (1995, July). *The Victoria Report on physician remuneration*. Victoria, B.C.: Author. (A)

This discussion paper was prepared following direction by the Federal/Provincial/Territorial Ministers of Health in September 1994. Its purpose is to assist in the development of alternatives to fee-for-service remuneration for physicians in primary care in Canada. The document provides the context of the health system, identifies goals for the organisation of primary care, and proposes a model for population-based funding, also called capitation.

For the purposes of the document, sub-titled, *A model for the reorganisation of primary care...* the writers offer two definitions of PHC, that provided by the WHO (1978) included in this bibliography, and the following:

PHC is that level of care where the health system is entered and basic services received ... (p. 2)

This latter definition focuses on a provider-oriented and provider-driven service and the access point to other specialized services, which is a perspective more consistent with primary (medical) care.

The document proposes that the medical services budget be provided to primary care organisations that have the overall responsibility for care to a defined population [similar to the organisation of primary care groups in England or LHCCs in Scotland]. This primary care structure then pays providers, including physicians, in whatever manner is decided. Funding would be based on the size and characteristics of the population, and on the ability of the organisation to provide quality services. This proposed structure is flat, as opposed to hierarchical, in order to facilitate inter-disciplinary work. The Victoria Report thus offers a comprehensive approach to financial restructuring for medical services and the potential for PHC services that can be delivered by a range of providers.

F. Decision-making structures/processes

82. Allsop, J. (1986, October). Primary health care – the politics of change. *Journal of social policy*, 15, 489-496. (A)

This paper brings an historical perspective from the 1980s to the discussion on PHC and the roles and relationships among providers and decision-makers. The author directs attention to two policy documents, *Primary Care: An agenda for discussion* (DHSS, 1986)* and *Neighbourhood nursing: A focus for care* (DHSS, 1986)** and their views of providers. The former document focuses on the contractor professions: GPs, dentists, pharmacists, and opticians; the latter is concerned with community nurses and their services. The author's main concern is that neither document addresses the need for a coordinated primary care service directed toward improving the health status of populations.

The analysis is of interest because, in comparing and contrasting two policy documents, the author reveals some of the political and structural constraints to effective service

coordination and delivery. These include: (1) differences in the power of various groups, (2) ways in which power is institutionalized by the state, (3) differences in standards among practices and geographical settings, and (4) a lack of targets and strategies for primary care particularly toward reducing inequalities.

* DHSS (1986). *PHC: An agenda for discussion. Cmd. 9771*. London: HMSO.

**DHSS (1986a). *Neighbourhood nursing: A focus for care*. London: HMSO.

83. Australian Medical Association. (2001, Jan). *AMA position papers: PHC*. Available: <http://domino.ama.com.au> Retrieved April 13, 2001. (A)

This position paper from the Australian Medical Association (AMA) provides a clear statement of their view on the provision of PHC: it should be delivered by physicians in general practice. The AMA recommends that its members comprise the discipline central to the PHC team, with allied health disciplines around it. They advocate for state funding that enables GPs to employ nurses in general practice who can take on responsibilities for case management and for the coordination of care for patients with chronic illnesses. The document disputes the use of the term population-health expressed in the PHC documents. The AMA asserts that the concept of population-health is linked to funding mechanisms calculated to a fixed amount [capitation] of funds. This document provides a fascinating glimpse into the medical profession's efforts to shape a health care delivery system in a way that may advance their own status and power.

84. Baum, F., Sanderson, C., & Jolley, G. (1997). Community participation in action: an analysis of the South Australian Health and Social Welfare Councils. *Health Promotion International*, 12(2), 125-134.

In the 1980s South Australia adopted a Social Health Policy (SAHC, 1988*) and a PHC Policy (SAHC, 1989**) intended as a means of implementing the state's commitment to the WHO's, *Health for all by the year 2000*. Each of the policies advocated for strategies intended to involve community people in the process of planning and promoting health services at the local level. One means of achieving this participation in S. Australia was through the development of four pilot Health and Social Welfare Councils (HSWCs) in 1988. This paper reports evaluation data from an external review of the councils conducted three years later.

The analysis suggests three factors were key to the performance (successful or otherwise) of the councils: (1) the existence of favorable conditions prior to the establishment of the councils, (2) issues of representation on the council, and (3) the role of differing levels of power held by different stakeholders. The authors assert that an important criterion for evaluating the mechanisms of participation within the councils should be the extent to which they give voice to the concerns of marginalized people. Councils were criticized for their failure to represent the whole community, thus calling into question the notion of community and its many competing interests.

*South Australian Health Commission (1988). A social health strategy for South Australia. SAHC, Adelaide.

**South Australian Health Commission (1989). Policy on PHC. SAHC, Adelaide.

See also: Putland, C., Baum, F., & Macdougall, C. (1997). How can health bureaucracies consult effectively about their policies and practices? Some lessons from an Australian study. *Health Promotion International*, 12(4), 299-309.

84. Brandi, C. (2000). Relationships between nurse executives and physicians. The gender paradox in healthcare. *Journal of Nursing Administration*, 30 (7/8), 373-378.

Although 85% of health care workers in the US are women, there is an absence of women in senior level management positions. Female nurse managers face not only the male dominated world of administration, but also their experiences in a predominantly female profession where they are also subordinate to physicians. This qualitative study explores the perception of 17 women nurse executives in California regarding the impact of the managed care environment on relationships with physicians.

The research revealed at least two significant findings: (1) the male dominated managed care and physician environments have exacerbated the gender differences for the participants, and (2) physician behaviours in response to managed care adversely affected participants. Physicians themselves experienced frustration and a lack of control over their own environments in the complex world of managed care, and this served to create tensions in the work setting. The author stated that the problem of gender bias is an impediment to collaboration across disciplines. However this paper is suggestive of a vertical or hierarchical relationship between disciplines where differences in power act as a barrier to collaboration.

85. Bunch, E.H. (2000). Commentary from Norway. *Journal of Nursing Scholarship*, 32 (2), 207-208.

This commentary describes the provision of PHC services in Norway where all citizens have access to a public health system financed by taxation and a minimal user fee. The concept of health for all is foundational in Norway where, even prior to the Alma Ata Declaration, there was a strong tradition of public health and prevention. The health system is highly decentralized. The government allocates block funding for health, education and other services to counties where local officials set priorities for the use of resources.

Despite the strengths of the PHC system, the author articulates concerns in relation to the scope of nurses' practice and argues for changes in nursing education to provide nurses in the community with new knowledge and skills. Among the areas of concern identified is the need to: (1) develop their existing level of autonomy more fully, (2) expand their work with organisational structures and community development models, and (3) understand the political dimensions of community planning and empowerment. The author's argument could be strengthened by a discussion of the need for changes not only

in nursing education but also in organisations that constrain women's efforts and women's work.

86. Canadian Nurses Association (1988). *Health for all Canadians: A call for health-care reform*. Ottawa: Canadian Nurses Association.

Since the 1980s the Canadian Nurses Association (CNA) representing over 100,000 registered nurses in the country has demonstrated a keen interest in the WHO vision of PHC. In 1985 the Director General of the WHO challenged nurses around the world to collectively articulate and develop a vision of PHC as a vehicle for global change. Subsequent WHO documents affirmed that nurses and midwives have an essential role in initiating and implementing PHC. By 1987 the CNA leadership was calling for a PHC model of reform focused on community-based health promotion consistent with the *Health for all movement*. CNA has worked closely with governments, nursing organisations, and educators to bring about these changes in the health care system and within nursing itself. Strategies for change are focused on five of the PHC principles: (1) accessibility, (2) prevention and promotion, (3) public participation, (4) intersectoral cooperation, and (5) appropriate technology. This document details extensive activities and initiatives within each of these five areas.

It is fascinating to read how much interest and effort the organisation has focused on the implementation of PHC. In identifying implications for nursing, the document states that PHC elaborates the traditional roles and functions of nurses while reordering priorities. The priorities for nurses roles are encompassed within four components: (1) direct care provider, (2) teacher and educator of health personnel and the public, (3) supervisor and manager of PHC services, and (4) researcher/evaluator (p. 11). These functions underline the scope of nurses' work but they also position nurses at the centre of a PHC system. The CNA affirms nurses' central contribution in stating: "Nurses are health care professionals who are prepared to provide first contact care in all primary health care settings" (p. 21). A bibliography on PHC reform in Canada would not be complete without acknowledging the lead role that nurses have taken in moving forward a process that promotes both PHC and nurses' roles.

87. Department of Health (1989). *Caring for people: Community care in the next decade and beyond*. London: HMSO.

In the UK this White Paper for England, Scotland, and Wales, and the White Paper, *Working for patients* (DOH, 1989) are called the community care reforms of the 1990s. These reforms set out the government's plans and priorities for health and social services for the next decade. *Caring for people* was intended mainly to reduce the institutional costs for the growing population of elderly and people with learning disabilities, and mental illness by promoting a shift in care to the community. The paper states that community care is about the health as well as the social needs of the population. Primary health care services comprise the health component of community care.

A key feature of the document is, therefore, in the way that it distinguishes between health care and social care (p. 49). Health care is defined as services provided under medical and/or nursing supervision, and these services are free under the NHS. Social care is assistance with daily living, home adaptations, budgeting, respite, employment and so on (p. 10). People seeking services that fall under social care are means tested. Local authorities have the lead role for the provision of social and community care. Health authorities, however, remain responsible for “the health care needs of those people who also have a need for social care” (p.33). This way of conceptualizing and dividing health care and social care fails to address the fact that people have needs for both, and that the two are inter-related. The division has implications for PHC teams and social services providers in their respective roles for the provision of health and social care in the community.

The White Paper also has implications for other providers - families and carers in the informal, unpaid sector of the community. The document acknowledges the role of carers, described in gender-neutral terms, and states: “...it is right that they should be able to play their part in looking after those close to them” (p. 4). The assumptions about women’s availability for unpaid care are thus hidden in language that reflect cultural expectations regarding women’s caring role.

88. Department of Health. (1997). *The New NHS*. London: HMSO. (portions of document appended)

In this White Paper the UK government introduced another reorganisation of the NHS in England*. Among the changes, the document shifts the emphasis away from an internal market, competition, and GP fundholding, introduced in the 1990s by the White Paper *Working for Patients*** , to one that focuses on collaboration and partnerships. The government calls for the formation of “primary care groups” (PCGs; called Local Health Care Cooperatives or LHCCs in Scotland) comprised of all GPs in a given area, together with representatives from community nursing. PCGs will be responsible for arranging health care services and establishing service contracts with NHS Trusts. Although some representation from nursing in PCGs is obligatory (in contrast to LHCCS where it is optional), nursing associations in England have raised concerns about the degree to which nurses will actually have a voice. It is also unclear how these new arrangements will play out in the provision of primary care services over the longer term.

Available: <http://www.open.gov.uk/doh/newnhs.htm>

*The comparable White Paper for Scotland is: The Scottish Office (1997). *Designed to care*. Edinburgh: HMSO.

** Department of Health (1989). *Working for patients*. London: HMSO.

89. Editorial. (1993). Accessibility, ethics and equity in health care. *Social Science and Medicine*, 36 (12), iii-vii. (A)

Equity and accessibility are foundational to the WHO’s PHC initiatives. While countries such as Canada and the UK strive to promote equity in access to health care, much

remains to be achieved. This paper explores the concepts of equity and access from an ethical perspective, one that examines the ideologies, health infrastructures, and operational considerations that promote or hinder the achievement of social justice. The author poses critical questions, such as:

How does the role of private enterprise and a market economy relate to considerations of ethics, accessibility, and equity?

Is the use of higher technology for the benefit of a few or for the many, and who decides? (p. vi)

This paper is included because it invites new ways of thinking about the reforms. Primary health care professionals are educated and socialized to think of access and equity in terms of a desired end-point, such as an accessible health services delivery system. This author's approach invites the reader to take a step back and critically evaluate prevailing ideologies. The author, unnamed, asks:

In the final analysis, is it not economic power, combined with an ideology that promotes social responsibility that will determine accessibility with equity? p.vii

90. Haas, B. (1997). The effect of managed care on breast cancer detection, treatment, and research. *Nursing Outlook*, 45(4), 167-172.

Breast cancer is the most frequently occurring cancer in women. Of the estimated 43,900 women in the US who will die of the disease (1997 estimate), the majority are elderly, poor, and non white. Many of these women die because of diagnoses that occur in the later stages of the disease. Between 1983 and 1987, for example, the five-year survival rate for women with localized cancer was 10% greater for whites than for blacks.

This paper explores the impact of insurance plans (or lack of) on patients with breast cancer. More than 90% of the employed population are enrolled in some type of managed care system, of which health maintenance organizations (HMOs) are most prevalent. HMOs have been criticized for their limitations regarding treatment and research. Among the criticisms are the following: (1) the large variance in approaches to treatment – HMOs rely on standardization of care to reduce costs and may refuse to reimburse individual variations, (2) refusal to pay for experimental therapy, for example, when a patient is participating in a clinical trial, and (3) fewer physicians are choosing to participate in clinical trials out of fear they will be discharged from the HMO. While these challenges exist for women seeking treatment for breast cancer in the managed care environment, an even greater concern is the population of women who are uninsured because they fall outside managed care and fee-for-service systems. This paper serves as a reminder that health must be understood as a commodity* and the health of older women, poor women, and women of colour is not a very valuable one.

*commodity: “an economic good; an article of commerce...” Merriam Webster's Collegiate Dictionary, 10th Edition, 1993.

91. Ham, C. Ed. (1997). *Health care reform: Learning from international experience*. Buckingham: Open University Press.

This book should be read in its entirety by anyone interested in comparative health policy. Contributors to the book provide analyses of health care reform in five countries: The US, Germany, Sweden, the Netherlands, and the UK. In the editor's perspective, the pressure to contain costs and to promote efficiency and standards is central to health reform. The contributors illustrate the approaches to reform taken through different methods of financing and delivery.

The final chapter provides interesting observations and conclusions several of which are noted:

- the WHO *Health for all by the year 2000* initiatives, along with growing evidence on relationships between ill health, socio-economic, and environmental factors, have stimulated a number of countries to develop national strategies targeting health improvements for populations
- the reforms overall give greater priority to primary care and community-based services
- all but the US have retained a commitment to principles of universality and comprehensiveness
- the US is the only country that fails to offer some form of universal coverage for its citizens.

The strength of this book is that it offers a comparative perspective on the forces shaping reforms in each of the countries described.

92. Jaglal, S., Slaughter, P., Baigrie, R., Morgan, C., and Naylor, C.D. (1995, March). Good judgment or sex bias in the referral of patients for the diagnosis of coronary artery disease? An exploratory study. *Canadian Medical Association Journal*, 152 (6), 873-992.

Differences in the treatment of women and men with coronary artery disease (CAD) have been documented in previous studies. In this study, the researchers examined whether there is a different referral pattern by sex among primary care physicians or cardiologists for noninvasive testing for CAD, and factors that may affect referral.

Data were collected from a review of charts for 1,212 new outpatients who met the study criteria and were referred to a group cardiology practice in Toronto. Logistic regression analyses were performed on a number of variables, including age, sex, and cardiovascular risk factors. The study found that women referred to cardiologists were significantly less likely than men to have had non-invasive tests done by their primary care physician (p. 878). Several factors may contribute to this finding including: (1) the probability of a cardiac event in women is lower, (2) the physician may be less convinced of the diagnosis, and (3) physicians may perceive that women, especially housewives, can curtail strenuous activities more readily than men. The researcher concluded that more information is needed to understand referral patterns. This study is of interest because it

adds to the body of research on sex differences while also revealing an absence of gender-based analysis. For example, the authors do not explore the evidence in their findings regarding the assumptions that some physicians make concerning women, women's work, and women's health seeking behaviours.

93. Ministry of Health and Ministry Responsible for Seniors (April 1995). *Policy frameworks on designated populations*. Victoria, B.C.: Council and Board Support Branch.

Following the completion of *Closer to home: The report of the British Columbia Royal Commission on health care and costs* (1991), the B.C. Ministry of Health identified groups that have poorer health and experience barriers to achieving health. These designated populations are:

- children and youth
- seniors
- women
- aboriginal people
- members of minority ethnic groups
- people with mental disorders
- people with mental disabilities (p. 1)

The purpose of this document is to provide guidance to health authorities in B.C. to assist them in developing their own policies that guide equitable access to health services for all residents. The framework is based on principles of equity, accessibility, effectiveness, accountability, partnership, consumer focus, integration, e.g. multi-sectoral effort, prevention focus, and sensitive implementation. Each principle is described, along with a guide for the development of goals and strategies to address the issues for each designated population. The document also discusses two significant factors, poverty and geographic location, and their influences on health status.

This is a detailed and comprehensive document that integrates health indicators and principles with the issues pertinent to each group and provides suggested goals and strategies to address the issues. Although it must be seen as a work-in-progress, it challenges health authorities and PHC providers to meet the health needs of diverse and marginalized groups.

94. Morris, M., Robinson, J. Simpson, J., Galey, S., Kirby, S., Martin, L., & Muzychka, M. (1999, Nov). *The changing nature of home care and its impact on women's vulnerability to poverty*. Ottawa: Status of Women. (A)

This research, funded by the Status of Women Canada's Policy Research Fund, explores the gender imbalance in home care policies and practices and impacts on Canadian women in terms of their vulnerability to poverty. The research is based on interviews conducted in three provinces: (1) with home care recipients, agencies, and paid and informal caregivers in Newfoundland and Manitoba, and (2) with experts and representatives from national organisations and the federal government in Ontario.

The document contains important and disturbing findings that demonstrate gender analysis is absent from or underdeveloped in current home care policy and research in Canada. Among the examples provided:

- many studies do not track gender
- assumptions are made that families will assume responsibility, thus relying primarily on women's unpaid labour
- where gendered data exists concerning women's unpaid labour, little or nothing is done to alleviate the burden on women (p. 57).

The document also describes barriers in access to home care services, including language, education/literacy, rural living, the type of condition or illness, and limitations in hours and need for payments for extra services. The authors provide a critical observation on the implications of policy for women in pointing out that many policies are implicitly gender-biased, for example, when income is a factor gender is a factor, since women make up the majority of the poor (p. 74). The study concludes that current home care policies contribute to women's vulnerability to poverty. They outline recommendations intended to reverse the impacts.

Available: email: research@swc-cfc.gc.ca
[on-line] <http://www.swc.cfc.gc.ca/>

95. Murray, S. (2000). Addressing inequalities in health – possible interventions in primary care. *Health Bulletin*, 58(4), 255-257.

This first person paper by a general practitioner in Scotland identifies ways in which practitioners in primary care can help to address inequalities. Initiatives for addressing inequalities can be directed to both the individual level of care, for example, individual consultations that include discussion on the wider issues affecting health, and to the community level of care. This community orientation, termed “community-oriented primary care” (COPC) involves identifying key social and environmental issues affecting health in the community, of which the author provides an example from practice. The author also stresses the opportunity to foster improvements in the health of communities through participation in local decision-making bodies such as the Local Health Care Co-operative or the Primary Care Groups in England.

This paper has been included because its community orientation demonstrates a striking contrast to the individual, clinical-focused orientation common in primary care. Community-oriented primary care incorporates clinical work with an interest in population health and the social and environmental factors that affect the health of individuals and communities. It is a model that appears to build on the strengths of both primary care and PHC.

96. Pringle, M. (1992). The developing primary care partnership. *British Medical Journal*, 305, 624-626.

This paper describes the development of the primary care team in the UK, with historical roots that are quite different from those of primary care in the US (see Sullivan, 2000). The author describes the development in terms of three pressures – political, organizational and clinical. The 1966 Family Doctors Charter* which laid out the contractual arrangements between the NHS and GP enabled the GPs to expand and employ staff, most significantly nurses, because 70% of their cost was reimbursed. In addition to employing practice nurses, who originally relieved GPs of routine clerical work, some GP practices also saw an expansion of their team through the attachment* of health visitors. The inclusion of nurses in the GP practice marked the beginnings of the PHC team. In some practices there has been expansion to include other health professionals employed either directly by GPs or other employers. During the 1990s, the GP contract with the NHS incorporated incentives to stimulate more health promotion activities, many of which are carried out by nurses.

This paper provides a GP-centred perspective on the development and function of the PHC team. However, the concept of ‘team’ must also be examined in terms of the relationships between team members, the distribution of power/authority and implications for patients. Such analysis is lacking in this report.

*Currently in Scotland, for example, many health visitors are employed by Trusts but the GP practice may purchase their services from their employer, an arrangement that has implications for nurses’ autonomy to set their own priorities for client/community work (Schellenberg, 2000).

See also: Haslen, J. (1992). The PHC team: history and contractual forces. *British Medical Journal*, 302:232-234.

97. Smith-Campbell, B. (2000). Access to health care: Effects of public funding on the uninsured. *Journal of Nursing Scholarship*, 32 (3), 295-300.

In the US, people who are uninsured or have low incomes encounter greater barriers to accessing health services than those who are insured. Yet the numbers of uninsured continue to grow – from an estimated 31 million in 1987 to 44.3 million in 1998*. In the state of Kansas, legislators passed a law that provided funding for Health Care Access (HCA), a voluntary, non-profit organisation offering primary care services to medically underserved people (p. 296). A nurse practitioner (NP) was employed as the main primary care provider.

The author reports on a quantitative study that assessed the influence of the HCA clinic on Emergency Department (ED) use, and surveyed client satisfaction with HCA services. People who are poor, uninsured and mostly non-white often use the ED for basic services (p. 296) and the ED is considered to be a provider of primary care. The study revealed that ED visits by the uninsured dropped dramatically (-39%) the year that state funding

was introduced. At the same time, visits to the HCA (previously staffed by volunteers) were increasing. The overall outcome of the patient satisfaction survey (n=158; 77% of whom were women) revealed a high level of overall satisfaction with the service at the HCA clinic. The author concluded that state policy increased the availability of services for the medically underserved. This paper provides evidence of a trend that is evident in the US literature: the provision of lower-cost care by nurses in publicly funded settings to people who are poor and underserved.

*Bureau of Census. Available: <http://www.census.gov/hhes/www/hlthin97.html>

98. Stanton, P. (2001). Competitive health policies and community health. *Social Science and Medicine*, 52, 671-679. (A)

The research described in this paper focused on how health policy affected the management and organisation of community health centres in one Australian state. Community health centres, which offer a range of preventive and health promotion services, are a characteristic feature of the Australian health system. This orientation toward preventive and community-based activities actually preceded WHO's initiatives in launching PHC reform. Despite the acknowledged importance of community-based programs in Australia, the program overall has developed differently in various states, and has not been well integrated into the mainstream health system (p.671). The centres have been managed mainly under the direction of community-based committees who are ultimately responsible to the state.

Through the use of qualitative methodology, the author explores impacts of market models of service delivery such as competitive tendering and output based funding on community health services. Respondents identified output based funding as the overriding government policy affecting change in community programs. They identified concerns that output based funding, which seeks to quantify services and activities in terms of measurable outcomes, is narrow and restrictive. For example, activities such as networking and consultation with communities were seen as essential in order to plan service provision and avoid duplication of services, but these activities are difficult to measure and value (p. 674). Respondents also identified a contradiction associated with the introduction of competition: while governments introduced competitive policies in order to make centres more flexible, agency managers believe that the health centres have maintained flexibility *despite* these policies (p. 679). Managers also reported that the policies have increased rather than decreased the fragmentation of service delivery.

Although it is not stated in the research, output based funding has important implications for women's work and services to women and other marginalized groups, since some of these services also are not readily measurable. This thoughtful research illustrates the differences that can arise between policy intention (i.e. stated intentions) and implementation. The research would also seem to indicate that competition and market styles of management and service provision contradict the principles of PHC, which underline collaboration.

99. Stevens, P. (2000). A nursing critique of the US Welfare System reform. *Advances in Nursing Science*, 23 (2) 1-11. (A)

This paper provides a critique of recent US welfare system reform and identifies implications for the health and safety of women and children. In 1996, the federal welfare program, Aid to Families with Dependent Children (AFDC) was revoked, and replaced by legislation called the *Personal Responsibility and Work Opportunity Reconciliation Act*. Single mothers are no longer entitled to subsistence payments for food, shelter, or clothing unless they work full-time outside the home. Among the new rules are severe restrictions, including those that deny funding to mothers under the age of 18, or to those who remain unemployed after two years (p. 3). The trends demonstrated in this welfare reform reveal an astounding contradiction. Vulnerable women and children are denied basic subsistence support while, at the same time under health reform, there is a voiced concern about social factors, such as poverty and its relationship to health. The author makes a compelling statement about the relationships between poverty and health. She states:

Poverty is a fundamental social cause of illness, injury, and death, because impoverished people do not have resources like knowledge, money, power, prestige, and social connections that strongly influence their ability to avoid risks and minimize the consequences of disease once it occurs. (p. 8)

This critique provides clear evidence of the requirement for an integration of policies and services to meet the needs of people for both health and social care.

World Health Organisation (1993). *Implementation of the global strategy for Health for All by the Year 2000*. Second evaluation. Volume 3 Region of the Americas. Washington: Pan American Health Organisation.

In 1977 the member states of the World Health Organisation unanimously adopted the *Global Strategy for Health for All by the year 2000*, along with an agreement to monitor progress in the implementation of national strategies. This document represents the second evaluation and covers the countries of the Americas. Data available for the evaluation vary between countries and there is no consistent reporting mechanism. The most current and consistent information available is immunization rates. A number of countries lack national health policies and/or effective strategies for implementing them. Only two countries in the region, Canada and the US, have defined their goals and objectives with regard to the lead document.

The report provides a summary of problems that exist in almost all the countries and impede the achievement of the goal. The following are among the barriers that have been identified:

- increasing urban poverty
- lack of accessibility in rural areas
- decreased local availability of food products
- lack of progress in basic sanitation services

- increasing urban violence
- deterioration of public hospitals
- social security problems due to losses or cuts in funding

These are some of the barriers to the achievement of *Health for all* and they exist in almost all the countries. The document provides a compelling account on a country-by-country basis of information concerning demographics, socio-economic factors, health indicators, health care systems, and primary care. The section on primary care provides evidence of the different ways in which primary care services are understood, accessed, and delivered.

VI. Glossary of abbreviations

ANP	Advanced nurse practitioner
CNS	Clinical nurse specialist
GP	General practitioner
HMO	Health maintenance organisation
LHCC	Local health care co-operative
MCO	Managed care organisation
NHS	National Health Service (UK)
PC	Primary care
PCG	Primary care group
PHC	Primary health care
UK	United Kingdom
US	United States
WHO	World health organisation

VII. Appended documents