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Canadian Women's Health Network's

Submission to

The Commission on the

Future of Health Care in Canada

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Executive Summary

Women are concerned with health care services in Canada. We represent the majority of paid health providers, and also provide the bulk of the unpaid caregiving in communities and homes. As well, we are frequent users of health care services, primarily due to our reproductive roles.

Therefore, it is essential that that a gendered analysis is considered in the « work toward making recommendations to ensure the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.» (www.healthcarecommission.ca)

Despite media reports to the contrary, we do not believe that our health care system is in crisis. Canadians have much to be proud of. However, there are challenges, for example: the de-listing of services covered, increasing drug and technology costs, increased private spending and declining public funding, and the erosion of federal coordination. New service models are needed to address these challenges.

In this light, a renewed vision of Medicare must include as a minimum:

- *Publicly funded and non-profit administered health care system*: It has been well documented that publicly administered health care is more efficient, cost-effective and equitable than a privately run system. Medicare is perceived as a pillar of Canada's health care system and as such should be maintained.

- *Canada Health Act respected and expanded to include*:
  a. A national Pharmacare Program and mechanisms to manage equitable access to medical technologies and new techniques:

  b. *A national Homecare Program*: Women are on the front lines of caregiving and receiving care, and home and community care policies and practices affect them in different ways than men. Caregiving has a greater impact on women's lives, and has been a significant contributing factor to economic inequality between men and women. As such, a national Homecare program would improve the living conditions for both the caregiver and recipient.

  c. *A National program on health promotion and disease prevention*: Our current health care system is focused on treatment and intervention. This is very costly and inefficient. A National program would enhance research, capacity development and information dissemination on health promotion and disease prevention policies and programs in Canada.

  d. *Protection of our Health Systems in international trade agreements*: The Federal Government should exclude health services from all international trade agreements.

  e. *A strong federal role in coordinating equitable access to health services*

This renewed vision must reflect and support the principles of equity, social justice and the precautionary principle. This means a commitment to access based on need not the ability to pay and

that when there is uncertainty about a procedure, policy or activity the onus should be on those who wish to carry it out to demonstrate in advance its lack of harm.

This renewed vision should include in its framework*:*

- *New models of engaging the Canadian public in health services and increasing their capacity to make informed decisions about their health and health care.* Canadians have continued to articulate a desire for increased access to credible information, i.e. the full spectrum of information on health conditions, treatment options, health outcomes, and healthy public policy; support for self care activities; and mechanisms to participate in health service planning. Although there are some exciting examples, there have not yet been systemic changes that would make this goal reachable.

- *Gender-based analysis and women-centred models of care*: Experience has shown that gender is rarely considered as a variable in assessing local health needs and that, the health needs of women are rarely considered separately from those of men. Consequently, gender based analysis should be mandated by all those involved in health service research, planning, implementation and evaluation.

- *Openness to innovative and alternative methods of care*: The health care system should reflect the diverse health practices of Canadians. As more people are discovering complementary approaches to traditional methods, including traditional Chinese medicine, naturopathy, chiropractics and midwifery, the renewed system must consider these approaches.

- *Population health: Role of health determinants*: Research has clearly demonstrated the impact of the "structural" determinants of health on the well-being of populations. The links between health inequities and economic and social inequities are clear. Thus, governmental programs and policies should require health impact assessments and programs that address structural inequities should be reinforced and expanded.

Introduction

Who We Are

The Canadian Women's Health Network (CWHN) is a national, voluntary bilingual organization of individuals and groups concerned with women's health. We work within an equity and population health framework.

After over fifteen years of informal networking, the CWHN was officially launched in May 1993 by women representing over 70 organizations from every province and territory. The CWHN emerged from the generous dedication of health care workers, educators, advocates, consumers and other Canadians committed to sharing information, resources and strategies to better women's health. Our roots are in the women's health movement- a social movement that challenged the basic assumptions, service models and priorities for women and their health.

Our goal is to improve the health of Canadian girls and women by providing easier access to current and accurate health information, building links, as well as providing and contributing to the involvement of women of all ages and varied backgrounds in their own health and the health of

others. Our core programs include a bilingual information center; maintaining an extensive web site and online databases; responding to health information requests from "patients/consumers/clients[1]", health care providers, researchers and policy makers; production of a quarterly newsletter and monthly e-bulletin; supporting the communications activities of a variety of informal networks and research groups; and responding to governmental and organizational requests for consultation and advice. Our distribution programs go to over 5000 individuals and groups, our web site receives on average 2 million individual visitors per year, and we respond to over 1000 information requests per year.

The CWHN is governed by a voluntary Board of Directors whose members include academic researchers, health practioners, health educators, communication experts and community advocates. We do not have branches or affiliates in our organizational structure.

The CWHN is a partner in the national Centres of Excellence for Women's Health policy research program and a member of the program's National Steering Committee and a variety of the working groups and research networks. CWHN is also the Women's Health Affiliate of the Canadian Health Network where we provide information related to health promotion and prevention for use by the Canadian public and providers.

Responding to the Commission

The CWHN is grateful for the opportunity to provide input into the Commissions' work. Our comments are drawn from the work of the Centers of Excellence, particularly the work of the National Coordinating Committee on Women and Health Reform and the Working Group on Women and Health Protection, other research and synthesis reports, submissions and statements from our broader membership as well as our board of directors and staff.

We also have drawn on the work of Commissions and reports that have occurred recently, including the excellent work of the National Forum on Health.

Why women are concerned about health reform

1. Our use of the health care system

Women tend to be the most frequent users of the health care system. In part, this is due to our reproductive role in society, as well as our responsibility as primary caregiver in our families. Women make use of health care services for different reasons than men. However we do not necessarily cost the system more. A recent analysis of health care utilization in Manitoba found that expenditures for health care are similar for male and female subjects after differences in reproductive biology and higher age-specific mortality rates among men have been accounted for[2].

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[1] The CWHN uses the terms 'patients/consumers/clients/public' interchangeably for those who use health care services and who pay for them through taxes and dues. However we have some discomfort as none adequately reflect this unique and complex role. Too often this group is ignored in health care planning, research or evaluation except as research subjects.

[2] *Cameron A. Mustard, Sc.D., Patricia Kaufert, Ph.D., Anita Kozyrskyj, M.Sc., and Teresa Mayer,* Sex Differences in the Use of Health Care Services, New England Journal of Medicine, vol 338:1678-1683 Number 23, June 4, 1998

2. Women as workers in the health care system

Women represent the majority (80%) of health care providers. Although this figure would suggest that our opinions are well represented in health service provision, the somewhat rigid hierarchies of health care institutions and the reliance on medical accreditation for organizational decision making tend to reduce the influence of women's opinions in these settings. The report of the Inquest into the Pediatric Cardiac Surgery Unit at the Health Sciences Center in Manitoba demonstrates the systemic discriminations against senior nursing managers, even when concerns regarding the quality of health care were raised.

More importantly, women provide the bulk of unpaid care giving, in communities and homes. Women, primarily as a result of social roles, are the health 'conveners' and advocates for their families and communities. This work includes managing appointments, organizing and providing direct care for family members. This work is often unrecognized and can have a profound impact on women's lives.

The voices and concerns of these women are frequently not included in the design and provision of health care services. There are no mandated mechanisms for including unpaid caregivers in service planning. This omission must be addressed, and policies that require the participation of unpaid caregivers in health planning established.

This is critical, since at present, the most frequent response to cost containment in health care services has been 'early discharge' and care in the home, which then puts responsibility for the management of care and the associated financial burden costs on the individual and their families. Research has shown the majority of this care to be undertaken by women-- with little outside recognition, support or training and with health and financial costs for the individual. For example, women reduce employment, thereby reducing their access to extended medical and pension benefits as well as increasing the likelihood they will face poverty or low income as seniors.

3. Health needs are different for women than they are for men

Traditionally, men's health needs have been the basis for health research and service delivery. This has led to medical research being conducted on men and then generalized to women, with insufficient evidence. For example, until recently, heart disease was considered a man's disease, and research focused primarily on men. Researchers thought that women had the same symptoms as men. However, studies now show that the symptoms of heart attack in women are very different from those in men, and appear at different ages. Also, the effects of a heart attack and after care needs are often different.

To date "women's health" has been defined by our reproductive and maternal role with the result in the medicalization of natural processes (i.e. menses, pregnancy, and menopause) with at time harmful consequences. This approach has been unbalanced and the consequence has been the over-medicalization in some areas of women's health and neglect in others.

Health Reform: Values and principles

The CWHN believes we should have confidence in the principles that are enshrined in the Canada Health Act; universality, accessibility, comprehensiveness, portability and public administration. Canada's health care system was given by far the highest rate of satisfaction among a broad range of public policy areas; support for the five principles of the *Canada Health Act* also remains strong across the country (Canada Health Monitor, 1995); and, Medicare consistently fares well in international comparisons of citizens' satisfaction with their health care system (OECD, 1995).[3]

Indeed these principles should be enshrined, as standards and each province should be encouraged to develop a provincial equivalent.

We recommend that a *commitment to access based on need not the ability to pay* and *compassion* could be included with support of the majority of Canadians. As well, principles that would require gender based analysis and the engagement of 'patients/consumers/clients' in health care planning and evaluation should be developed.

II. Health reform: Sustainability and the scope of services

1. The CWHN recommends that the Commission's Report articulate a clear commitment to a publicly funded and a non-profit administered health care system. It has been well documented that such a system would be more efficient, cost-effective and equitable. Therefore, based on evidence, the suggestions about the implementation of user fees and expanding private for-profit systems are absolutely inappropriate.

The CWHN recognizes that our current health care system is a complex balance between private and public funding. However, in the last few years, the media and others have created an image of out-of-control spending by the public system in health care. This is a false image.

During the early 1990s, governments severely slashed health care spending in order to bring down the deficient. Since 1997, spending has picked up, as has our economy. We have only now reached the 1992 levels of per capita funding and in reality, Canada now only spend 9.2% of its GDP on health, compared to 10.2% in 1992. In the meanwhile, private spending has increased.

<u>The Impact of Increasing Reliance on private and for-profit solutions</u>

Individuals are increasingly paying more or having the costs partially picked up by their workplace extended health plans for services that used to be covered by Medicare. While this has an impact on both genders, women and men do not have the same financial resources to cope with this change.

This shift in payment responsibility is a distinct disadvantage for women for several reasons.

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[3] National Forum on Health - Maintaining a National Health Care System: a Question of Principle(s) ... and Money, February 1996

a. Women face a higher probability of living in poverty. This is especially true for sole support mothers, single or widowed older women, women with disabilities, Aboriginal and women from visible minority groups.[4]

b. Women generally have part-time employment compared to men (26% versus 9%)[5]. As a result, fewer women have access to a benefits package from their employer.

Some individuals and groups maintain that private clinics are a cost-effective method as well as a way to retain highly specialized professionals; that user fees will prevent abuse: and that these are a solution to the current "health care crisis".

However, private clinics have a tendency to exploit services most likely to maximize profits and the public system has to pay for complications arising from procedures carried out in private clinics. "Despite the rhetoric, user fees don't lead to a more affordable health system. Research has shown time after time that user fees inevitably create advantages for the rich and healthy while making matters worse for the sick and poor."[6]

A natural experiment in the province of Saskatchewan demonstrated exactly this effect when Saskatchewan introduced a user charge for physician visits. The charge, the equivalent of about 10$ in today's prices, led to a reduction in doctors' appointments by the poor of 18%. The total decrease in physician use was, however, only 6-7%. The explanation for this difference is that the physician, rather than the patient, initiates many visits to the doctor. Saskatchewan's physicians, paid on a fee-for-service, saw a potential income drop when poor people sought care less often. As a result, they increased the number of visits from those who could afford to pay. They also used a more expensive mix of services. The results were, despite a substantial drop in use by the poor, almost no savings at all.[7]

The National Coordinating Committee on Women and Health Reform has documented the impact that privatization has on women. This work, and the companion book, "Exposing Privatization: Women and Health Care in Canada", has been submitted to the Commission under separate cover. The burden of current health service restructuring has been born by women.

As well private, for profit agencies reduce transparency and accountability to the Canadian public. Any extra savings should be returned for reinvestment in health and social service—not the dividends for investors.

Privatization strategies serve to increase health inequities, do not address the fundamental challenges in health service provision and reduces access for women and others. As such, privatization in all its forms is a problem, rather than a solution, for most women.

2. CWHN recommends the following solutions to sustainable funding:

- Maintain health care expenditure as a proportion of the GDP, ensuring growth of the health sector at least in relation to the economy. An agreement would fix the relative contributions

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[4] Women's Health Clinic, Women, Poverty and Health in Manitoba: An Overview and Ideas for Action, July, 2000, http://www.cwhn.ca/resources/women_poverty/summary.html

[5] Statistics Canada 1995

[6] Mythbusters -CHSRF

[7] Women's Health Clinic's Brief to The Standing Committee on Social Affairs, Science and Technology, Senate of Canada - quoting information from the Medical Reform Group of Ontario, http://www.hwcn.org/link/mrg/

of the federal and provincial government to the increases in health care expenditures that would be mandated as the economy grew.

- Affirm a strong Federal role in establishing a national mechanism for the coordination and control of health care to ensure the maintenance, and extension, of access to high quality care irrespective of ability to pay. Historically, it is the federal government that has implemented policies (most notably the five original conditions of Medicare, and subsequently the Canada Health Act, and it sporadic enforcement) to ensure equitable access to health care. The current national scene suggests this will continue to be the case. Thus, a high level of federal leadership is critical.[8]

- The institution of transparent mechanisms for evaluation of medical technologies and drugs – see below.

III. Canada Health Act: respected and expanded

The CWHN resolutely supports the principles of the Canada Health Act and its expansion. Not only should the current act be maintained, it also needs to be extended to include home and community care and Pharmacare.

Therefore we urge the Commission's report include recommendations for:

1. A national Pharmacare Program and mechanisms to equitably manage access to medical technologies and new techniques. The CWHN believes there is strong evidence that a national Pharmacare program would reduce drug expenditures and increase health outcomes. This program should include:

- **A national program to develop and maintain an accessible Consumer Drug and Device Information Centre**. Lay people need up-to-date, accurate, comprehensive and unbiased information on the pros and cons of all treatment options, drug and non-drug, as well as the option not to treat, for the health conditions and illnesses they face. A variety of organizations and groups including the Cochrane Collaboration, provincial Medical Technology Assessment units, and voluntary organizations working in health, such as the Canadian Women's Health Network, are addressing this issue.

- **Continued and enforced prohibition of Direct-to-consumer advertisements of prescription drugs**-- given the lack of evidence of health benefits and the potential for harm and improper use of the health care system. See the report on *Direct to Consumer Prescription Drug Advertising* prepared by the Working Group on Women and Health Protection[9]

- **The introduction of disincentives to reduce the impact of pharmaceutical advertising and "educational" activities on physician practice. This should include the introduction of a tax** for pharmaceutical and device manufacturerers, which would in turn support the programs described here. These programs are expensive [includes free lunches, travel, salaries of promotional staff, sampling as well as advertising] and generally

[8] Women's Health Clinic's Brief to The Standing Committee on Social Affairs, Science and Technology
[9] Working http://www.web.net/~desact/anglais/anglais.html

would fall into a category that is not taxable. In the United States, for example, pharmaceutical companies spend over $10 billion each year on drug promotion. Physicians are equally concerned about this. See for example the "NO FREE LUNCH" program -- www.nofreelunch.org/.

- **The development of an Adverse Drug Reaction reporting system that actively involves consumers. This should be a component of the surveillance and health protection systems of Health Canada -not one managed by the industry.** [Experiences with Depo Provera, breast implants, electronic fetal monitoring lead us to have no confidence in private industry's capacity for leadership in this area].

- **The development a national mass purchasing system to reduce costs.**

- **Establishment of a transparent management process for deciding whether drugs, medical technologies and techniques are to be part of Medicare services.**

Canadians are concerned that the current processes are not transparent, understandable and possibly inequitable. Recent challenges to provincial decisions by use of the human rights complaints attest to this. The burgeoning number of expensive new drugs and costly genetic tests should alert us to the need for this.

Too often institution competitiveness, duplication of efforts and lack good outcome data hampers effective decision making. This will also require a credible process for communicating these decisions to the public and consumers. As well, compassion, a corner stone of health care, needs to be recognized and supported within the decision-making processes, as does the precautionary principle

2. National Home and Community Care program

Early discharge, de-institutionalization and increasing numbers of Canadians living with chronic conditions have shifted more and more caregiving to community and to families—particularly to women -- as discussed earlier. The lack of a home care program unfairly discriminates against women.

Throughout their adult lives, women are more likely than men to experience stress and overwork as a result of their multiple care and work responsibilities. The extent and nature of women's unpaid care-giving work and its stress and health impacts are only beginning to be understood. Saskatchewan research has shown that after only 18 months of continuous care giving, the health of 60% of unpaid caregivers begins to deteriorate[10]. Caregivers often sacrifice their own health due to their commitment to maintaining or improving another's quality of life.

A national homecare program would have the advantages of a transparent and accountable delivery of service, quality standards for care, provisions of consistent levels of support and services. More importantly, this process would ensure that the recipients will have a place at the table and will be able to make their voices heard so that they may express their needs, concerns and complaints.

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[10] National Film Board of Canada, *Until the Day Comes*, 1990

3. Development of financial compensation mechanisms for unpaid caregivers

This should include the establishment of pension benefits and other financial supports for informal caregivers, as well as better family leave programs. These are important components of healthy social policy. Better family leave programs would address some of the negative affects on the caregivers' own health and well-being. In addition, the vast majority of these informal caregivers are women who should receive some form of income loss compensation.

Janice M. Keefe, Ph.D. and Pamela J. Fancey, M.A., of Mount Saint Vincent University, in their 1998 report, *Financial Compensation Versus Community Supports: An Analysis of the Effects on Caregivers and Care Receivers*, stated that, "Direct payment to caregivers serve to reinforce social values of helping and caring, values which have become increasing more difficult to realize as a result of changing family demographics." We recommend that:

- Financial compensation in the form of a direct payment be considered as a way to recognize and support family caregivers.

- Direct compensation in the form of a caregiver allowance be further investigated through a pilot program to measure its effectiveness on sustaining the care-giving relationship.

- Financial compensation and services availability should be viewed as complementary. Compensation should not be viewed as an alternative to services but one of a range of supports in the development of a comprehensive and flexible approach to meeting the needs of caregiver. [11]

4. A National program on health promotion and disease prevention

It has been well documented that strong health promotion and disease prevention programs make for a healthier population. A healthier population relies less on expensive medical treatments and interventions. Currently these programs are fragmented and temporary in nature. This program should provide:

- **Support for citizen self help, mutual support and action groups on health.** It has been hard for community groups to maintain themselves since federal cutbacks in this area. A side effect of the federal cutbacks to citizen organizations has been increasing linkages and funding which comes from the pharmaceutical industry. Whether intended or not, these relationships influence the advocacy and policy advice components of these groups activities. Conflict of interest issues arise. This also encourages disease-focused groups to dominate the landscape, as there are few "partners" for healthy public policy and meaningful prevention programs.

- **Support broad public, community and targeted health promotion and education programs.** Strategies must address the links between risk factors and the non-medical health determinants. This should include education and other programs regarding critical

[11] Women's Health Clinic's Brief to The Standing Committee on Social Affairs, Science and Technology

structural determinants of health. This will ultimately strengthen public acceptance and implementation of important healthy public policy.

Note: The promotion of "wellness" should not mean that we shift all responsibility for health to the individual. We cannot ignore the fact that poverty, social and working conditions are the strongest determinants of a person's health status. We need social and economic policies that reduce poverty and otherwise address healthy public policy.

5. The Federal Government negotiate a general exclusion of health services from all trade agreements and that patent protection only be granted after a careful review of the impacts on health status and health services.

It is clear that despite initial assurances, global agreements such as NAFTA and legislation such as the Patent Act can have a real effect on health services and knowledge.

- For example with NAFTA, it will be difficult to undertake national programs such as Pharmacare and Home Care, without an exclusion, since for-profit companies with international ownership operate within Canada.

- A review of Patent protection is needed as existing policy has had, and will continue to have significant impact on Canadians. To date this has been most apparent in the escalating cost of new pharmaceutical products. We only need to look to at the recent example of genetic testing for breast cancer, (i.e. BRCA1 and 2), to reliance that the impact of patenting will affect more than drug prices. For example with BRCA1, Myriad Genetics introduced what can be only described as extreme costs and procedural requirements that led to the de-listing of the procedure in British Columbia and Ontario. This issue has yet to be resolved. [12]

6. New models of engaging the Canadian public in health services and increasing their capacity to make informed decisions about their health and health care.

The CWHN strongly encourages the Commission to enshrine in its values a commitment to empowering citizens and to the development of new models of service delivery. This would ensure that policies and services are responsive and accessible to the needs of the population**.**

There are successful models that exist, especially in the women's community, and they include the following approaches:

- Processes that encourage a partnership between the woman/client and her caregiver. Staff and volunteers de-emphasize differences between consumer and care provider, and seek to develop a partnership with her/him in addressing her/his health issues.
- Consumer centred services: The consumer, in the context of her/his community is the centre of service and planning. For example Community health centers with boards of directors drawn from the clients the clinic serves are excellent models of this form of service delivery.
- Access to better health information. Canadians have continued to articulate a desire for increased access to credible information, i.e. the full spectrum of information on health conditions, treatment options, health outcomes, and healthy public policy; support for self

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[12] Women's Health Clinic's Brief to The Standing Committee on Social Affairs, Science and Technology

care activities; and mechanisms to participate in health service planning. Although there are some exciting local examples, there have not yet been systemic changes that would make this goal reachable. Support for voluntary sector organizations working in health and expansion of models such as Info Sante and expansion of the mandate of the Canadian Health Network to provide Drug and treatment information would support this work.

- Team approaches: Interdisciplinary teams of health care providers working collaboratively, including professional, paraprofessional and volunteer staff are most effective in meeting women's needs.
- Use of peer volunteers: Peer volunteers play a key role in promoting the empowerment of clients through modeling self-help skills, demystifying medical information, and bringing community perspective to the design and delivery of services.
- Community involvement: Working in partnership with various communities concerned about health, building on the strengths and interests of partners, including volunteers, clients, service provider or other members of the community are important approaches.
- Innovative program development: Continuous development and re-focusing of services approach based on new understandings of consumer's needs and issues includes collaborating with community women and researchers, and integrating newly gained knowledge. [13]

7. Requirement of gender-based analysis (GBA) to service delivery and planning.

GBA is described as an analytical tool that uses sex and gender as an organizing principle or a way of conceptualizing information. It provides a framework that recognizes that women and men are not the same and that policies and practices impact them differently. It also allows for a diversity analysis that considers such factors as race, ethnicity, level of ability and sexual orientation.

GBA makes for healthy public policy as it recognizes the need for participation of women and men in decision-making and gives equal weight to the knowledge and experiences of both genders. Further, gendered statistics requires that all official data include a breakdown by sex including differences in health status, outcomes, success, utilization, etc. and be analyzed carefully to reflect the influence of gender issues. Qualitative methods of data collection also provide a particularly valuable perspective, as women's voices are an important part of evidence.

As a result of International Agreements, Health Canada has recently committed to the implementation of GBA throughout the department[14]. This approach will ensure that all policies, programs and legislation that reviewed or developed will be in the best interest of ALL Canadians. It is unclear what impact this process will have on direct service delivery at the provincial level. Research produced by the Prairie Center of Excellence in Women's Health has demonstrated that without gender analysis, women's issues and perspectives can be missed in regional planning processes despite the belief that these processes are more community based. [15] . Recently the Province of British Columbia has released a new document "Gender-Inclusive Health Planning: A

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[13] Women's Health Clinic's Brief to The Standing Committee on Social Affairs, Science and Technology

[14] Women's Health Bureau, Health Canada, Guide to Gender-based Analysis http://www.cwhn.ca/resources/gba/gender.pdf

[15] Invisible Women: Gender & Health Planning in Manitoba & Saskatchewan and Models for Progress T. Horne, L. Donner and W.E. Thurston (1999) http://www.pwhce.ca/pdf/iv.pdf

guide for Health Authorities in British Columbia that could be used as a model.[16] Quebec has also undertaken a similar project but it is as yet not complete.
There are many models of successful women centred care throughout the country for which GBA is a central component of their functioning. Essentially, these models recognize the importance of empowering of women and encourage their involvement health service and program planning, implementation, evaluation, policy and research. They also acknowledge that women face additional barriers in accessing health services and as such strive to ensure that programs are respectful, safe and meet consumers' needs. Some provinces or regional health boards have developed their own models e.g. Vancouver Richmond Regional Health Board's Framework for Women Centered Care[17] or the Women's Health Clinic in Winnipeg [18]but this is inconsistent.

Therefore, it is important that gender based analysis become a mandated activity.

8. Recognizing complementary and alternative methods of care

More and more Canadians are turning to alternative and innovative therapies in order to care for various chronic conditions and maintain their health. Our multicultural society has a variety of traditions and experiences to draw on and to which Canadians will seek access. These include for example, traditional Chinese medicine, traditional Aboriginal healers, ayurvedic medicine, and naturopathy.

As well, access to dentistry and counseling services remain on fringe of health services. We will need flexible mechanisms to allow for individual choices and access to culturally sensitive care within the context of population health and health needs, and assurance that these will be high quality services and treatments.

Those who use alternative therapies state that they fit better with their values and beliefs about life and health. As well, these methods assess the whole person and use natural means to help the body heal itself. While there are many alternative and complementary therapies that have been used safely for generations and have proven their efficiency, there are many that exist outside public accountability and lack evidence of their effectiveness.

As such, **the Commission's report should recognize these phenomena and develop recommendations for addressing these needs. This should include:**

- Establishment of transparent processes for the evaluation and accreditation of complementary and alternative care providers and their treatment modalities where they do not already exist.
- Support for research and demonstration project funding for alternative health care providers as part of an integrated health care team.
- Medical, midwifery and nursing schools offer courses in alternative and complementary methods of care.

[16] Ministry of Health Services www.healthservices.gov.bc.ca/whb
[17] http://www.vcn.bc.ca/vrhb/Down_Loads/Womens_PHAC/WomenCentredHealth-Jun-2001.pdf
[18] See www.womenshealthclinic.org for ordering information

9. Establishment of mechanisms for addressing the Determinants of Health and Health Inequities. These mechanisms should include:

- Requiring that Health Impact Assessments as part of the **government operations and policies**.
- **Establishing a Health Commissioner to monitor and report on the impact of government policy on health.** This is an area where knowledge uptake and evidence based decision making is needed, particularly involving senior staff in all departments. At times we do not have a knowledge gap so much as we have an "action gap".

There is now a well-established positive connection between income and health. Newer research has shown a connection not only between income and health, but also between societal income inequalities and health. That is, those societies with greater economic inequalities have higher death rates than more egalitarian societies. This is important because it points to our interdependencies as members of a community.[19] The costs of social exclusion and health inequities are experienced by everyone.

However, women form the majority of the poor in Canada. One in five Canadian women live in poverty – that's 2.8 million women."[20] Further, sole support, widowed and single older women, aboriginal women, women with disabilities and women from visible minority groups are especially vulnerable to living in poverty.

Understanding women's socioeconomic status is more complicated than for men because women earn significantly less than men, they have lower labour market participation rates, are more likely to work part time and may temporarily leave the labour force while raising young children.

Recent analysis of Canadian data by Margaret Denton and Vivienne Walters has shown that the connection between income and health is stronger for women than for men, both for measures of self-perceived health and of functional health. This contrasts with earlier work which typically found that smaller socioeconomic inequalities for women than for men. Denton and Walters also found that the structural determinants of health, including socioeconomic status, had a greater impact on women's health than the behavioural determinants of health - lifestyle factors such as smoking, alcohol consumption, physical activity and weight. Again this points to the importance of addressing income inequalities in order to improve the health of women.

Currently governmental policy and programs are not evaluated for their impact on health status of the population despite what is known about the links between socio-economic status and health. This is not well understood by the general public or policy makers. It is unclear why we require environmental impact studies but not ones related to health impacts.

10. Precautionary principle

The CWHN recommends that the Commission include the precautionary principle as a fundamental value in a renewed health care system. The "precautionary principle" is an approach which states that when there is uncertainty about an activity, policy or procedure, the onus should be on those who wish to carry it out to demonstrate in advance its lack of harm. (This contrasts with the more common approach of endorsing an activity until such time as one finds

[19] Women's Health Clinic, Women, Poverty and Health in Manitoba: An Overview and Ideas for Action, July, 2000, http://www.cwhn.ca/resources/women_poverty/summary.html

[20] CRIAW

harm.) This is especially important in the regulation of drugs, tests and devices. This principle should be part of the renewed values and vision of health care.

11. Improved education, recording, reporting and monitoring be at the heart of health care reform. This should include:

Consumers/Public/Patients/Clients

- Patients have access to best-quality, easy-to-assimilate information on their health status and treatment choices that are appropriate to their gender and other personal characteristics. Risks and benefits for each treatment are fully explained to the patient by the health care team as well as the benefits and risks of doing nothing.

- Information about the quality and outcomes of the health care institutions and providers and possible models of service delivery

- Population health information about their community and the impact of governmental policy on health.

Policy makers

- Policy makers have access to patient care and cost benefit information in aggregate form to protect patient privacy, and information on the priorities, interests and values of their constituents. Longitudinal studies and projections are readily available, and an effective forum for stakeholder debate and involvement exists.

- Once a year, governments should issue a Report card on women's health. This report would document the state of women's health at the national and provincial levels and would explore the policies that impact either positively or negatively on women's ability to enjoy good health. This process would allow for accountability and would put a focus on women's health issues. An example of such a Report card can be found on the Oregon Health and Science University Women's Health Center web page http://www.ohsu.edu/women/ReportCard.htm.

Service providers

- Administrators of health care services and institutions including home care, mental health and community health have access to longitudinal and comparative data on service variations. Short- and long-term performance indicators exist. Integrated, linked information on socioeconomic indicators, medical and non-medical determinants of health, utilization costs and health care capacity are available. Information systems provide comparative analyses across planning areas, leading to the understanding of the relative contributions of non-medical and medical inputs to health; the linkage of information to current funding and delivery perspectives; and the flexibility to provide focused responses to well-articulated policy questions.

- Providers have access to high-quality patient care evidence at the point of care. The evidence is as specific to the situation as possible taking all relevant differences, including gender and culture, into consideration. Information on standards of practice and cost evaluations are readily available. High-quality evidence, with appropriate incentives and tools, enables adoption of new approved standards of practice. Health and medical records distributed over a

number of institutions and organizations are accessible as needed through information technology, which guarantees privacy and confidentiality of patient records. [21]

In conclusion, we would like to thank you for the opportunity to share our thoughts and to present our position to the Commission on the Future of Health Care in Canada. The Commission is in a unique position to ensure that our health system remains founded on equity, need and accessibility for generations to come.

[21] Report from the National Forum on Health