

You have made no mention of maternal or reproductive health issues. Why not?

Traditionally, women's health has been viewed as "different" simply because women are the ones who carry and bear children. Of course, there are significant and specific issues associated with reproductive health and the Advisory Council plans to look at those issues in a separate policy package. Right now, though, we want to emphasize the fact that women's health is, as one advocate puts it, "more than boobs and tubes."

In the past, health issues besides reproduction were approached as if the male experience was also true for women (One medical historian described the situation as treating women like men with vaginas!). But, the differences are more complex and they require attention. Women's lives depend on it. For example, the Canadian Heart and Stroke Foundation has been doing public education around the fact that women experience a different set of symptoms for heart attacks. And, the way that the heart attack proceeds is also different. If health practitioners and policy makers do not look at women's health as a unique entity aside from reproductive considerations, women will not get the education and treatment that they need.

What is the link between women's health and women's equality?

All definitions of health share one thing in common. They stress fulfilment and control. The World Health Organization puts it this way: "Health is the ability of a person or groups of people to reach their dreams and satisfy their needs and change or cope with the world. Health is a way of everyday life, not the goal of life." For many women, their life circumstances inhibit their ability to take control of their environment and live in a state of health. Because women are still the primary caretakers of children and because the marketplace does not place equal value on work that has traditionally been associated with women, typically, a woman can expect to earn less money. That lessens her power and control. Also, women are more likely to experience abuse and all its health consequences, further inhibiting women's ability to experience that power and control. Overall, from a health perspective, because of their life circumstances and their status in society, women are working from a deficit position. Supporting women in moving towards equal status improves their health and the opposite is also true. Status of Women Canada makes the link this way: "Good health - physical, emotional, social, and spiritual well-being at all stages of life - is key to women's equality. Conversely, gender equality is a necessary condition to achieving good health."

How is women's poverty linked with their health?

In 1999, the Advisory Council on the Status of Women sponsored a project that interviewed women from Queens County who were single mothers living on social assistance. Results showed that 83% of these women were suffering from poor health. Some of the learnings were that, when faced with the severe budget restrictions resulting from living on an income about 30% below an acceptable standard, these women chose to put their children's health first. *The British Medical Journal* states unequivocally, "Wealth is the single most important driver of health worldwide, even more important than smoking. Income is the best predictor of health and life expectancy." Poverty has a direct impact on women's health when women cannot afford nutritious food, prescription drugs, or appropriate dental care. It has an indirect impact when, faced with the stress that comes from living with uncertainty or from working in poorly paying jobs that offer little control, women may develop addictions as unhealthy coping mechanisms. Being stuck in poverty restricts women's ability to develop a healthy life and, in turn, that unhealthy lifestyle may keep women in poverty. The Canadian Research Institute for the Advancement of Women (CRIAOW) puts it this way: "The more income you have, the more likely you are to be healthier and to live longer. There is something about inequality that kills people."

Here on Prince Edward Island, there is wage parity between men and women ... until women marry and/or have children. Then, the wage gap becomes pronounced. And, we must also consider that, in the first place, Island wage levels are lower than those in the rest of the country. We see that the numbers of women receiving social assistance have dropped but we know that former recipients have moved into low-paying, highly stressful jobs.

It appears that Islanders, including women, pay a higher proportion of their own money for health care than other Canadians. While our government pays less per capita than any other province or territory, Islanders pay the second highest proportion of our gross domestic product for health care expenses. Given our economy as a whole and this discrepancy in public and private spending, issues around women's poverty and health have particular significance for women in this province.

How is women's self-esteem linked to their health?

Women face a barrage of societal and media messages about the way they should look and act. Women learn that they should be thin, beautiful, successful at work, and perfect mothers. Living up to those high expectations is quite a burden. Add to that the impact of abuse that a lot of women experience during their lifetime and the result is that women tend not to value themselves as highly as men do. Along with having adequate resources, feeling good about yourself is the cornerstone of taking care of your health. Those with low

self-esteem are more likely to do things that harm their health like smoke, drink too much, or abuse drugs. Over the past twenty years or so, Island women have taken up these unhealthy practices. Even with heavy public education about the dangers of smoking, for example, young women take up smoking at higher rates than young men. Women are accepting society's measure of them and treating themselves accordingly. That in itself is unhealthy and leads to a cycle of further issues and problems.

What kind of approach would best help women become more healthy?

Basically, what women need is an approach to health that sees women as individuals and as a social group whose health is critically and intimately related to the conditions under which they live, work, and play. Women chafe at a system that wants to treat their symptoms separately from their entire life experience. For example, their physician may treat their migraine headaches without considering related issues such as depression, abuse, or environmental illness. Women feel disconnected from a system that treats their body parts as separate, unrelated entities. For example, their physician may treat a localized infection without considering women's stress levels, hormonal balances, or blood counts.

The word "holistic" may be so over-used by now that it is losing its meaning but it is the best description of what women want from the health care system. They want to be treated as a whole person, not as a symptom or a body part.

Why is universality so important to women?

Simply put, women have the most to lose if Canada moves away from publicly funded health care. They use health care services most frequently themselves and they are the guardians and caretakers for other family members. With this consumer position and with less economic power, women will feel any change more deeply than anyone else in Canada. And, it is important to note that women are, of course, not a generic group. Different women - minorities, lesbians, senior women, women with disabilities - will feel the effects differently. For all except the most privileged women in Canada, two-tiered health care would present significant challenges to their health and the health of their families.

What did you hear from Island women about their health concerns?

The Island women who we consulted view themselves as caretakers and guardians for themselves and their families. They take a broad view of health and they want health care providers to serve them accordingly. They identified several specific issues which include: 1) providing appropriate physician care; 2) providing access to complementary health practices; and 3) improving the availability and the quality of mental health services.

By “appropriate physician care,” women are referring to two main issues - the quality of the relationship and the gender of the doctor. Women report feeling rushed through their medical encounters without time to build rapport, to develop trust, and to have full, frank discussions of their health concerns. They also report that it can be very difficult to access the services of women physicians here on PEI. The numbers tell the story. The latest figures show that there are only 13 women general practitioners in the province. For some women, having a female physician is something that they prefer because they find communication easier. For women who have been abused, having a female physician may be essential because their earlier trauma makes it impossible for them to tolerate an encounter with a powerful male figure in such an intimate setting. The Prairie Centre of Excellence for Women's Health has done some interesting research on the interaction between abused women and the health care system and they have found that women may forego essential preventative measures such as breast exams and pap smears when they cannot see a female physician. Thus, they miss out on opportunities for early detection and, accordingly, face increased health risks.

We see that some clinics and health regions are moving away from the fee-for-service system for physician payments and we look forward to seeing what impact that may have on the quality of contact between patient and physician. We also see that the Province is conducting a fairly successful physician recruiting campaign. We wonder why that plan has not included specific measures to actively recruit women physicians when many aspects of our lifestyle would suggest that this is a place conducive to meeting the needs of women physicians. For example, women physicians, as the primary caregivers of their own children, typically work shorter hours. Can our province offer this possibility to women physicians?

The women we consulted were very open to complementary health practices such as seeing an acupuncturist, a naturopath, or an osteopath. They see value in these services as less costly adjuncts to the primary health care system that can help them take control over their own health. However, using such services is not possible for women who are receiving social services or who are in low-paying jobs with no health insurance coverage. The women we consulted want to see such services made available in our own provincial health insurance system.

Again and again, women spoke about the extreme stress that they feel in their lives. And, the numbers back them up. The *Second Report on the Health of Canadians* showed Island women reporting a higher level of time-crunching stress than Island men and that stress level had increased considerably since the previous report. As well, the Atlantic Centre of Excellence for Women's Health reports that 5 - 10% of all women in the Western world experience depression and, over their lifetimes, face twice the risk for depression that men experience. In our consultations, women spoke of the lack of mental health services

here on Prince Edward Island and the difficulties involved in accessing the ones that are available. They reported that they do not want to be drugged and hospitalized (such drastic measures make it impossible for women to continue their busy lives and carry out their responsibilities!). They want appropriate support in their own communities, specific to their experiences as women in this culture. And, for women who have been abused, studies such as the 2001 needs assessment conducted by the PEI Rape / Sexual Assault Crisis Centre shows that Island women, especially women in rural areas and those with special needs, have virtually no access to the specialized mental health services required for them to deal with and overcome their trauma.

Are your conclusions confirmed by any studies in the province?

Yes. The East Prince Health Authority conducted a needs assessment in 2001 that showed similar results. The main health problems extrapolated from the assessment were these: 1) lack of information and awareness regarding the availability of health services for women; 2) lack of services and resources to meet women's health needs; 3) services that are not accessible due to lack of transportation, inflexible hours, expense, and waiting lists; 4) complacent or negative attitudes towards dealing with mental health issues; and 5) health professionals who are judgmental and insensitive when dealing with female clients.

The needs assessment concluded with a recommendation for an East Prince Women's Health Clinic which would offer: 1) direct medical services such as pap tests, breast exams, birth control, PMS treatment, menopause treatment; 2) resource material; 3) education sessions with a prevention focus; and 4) individual counselling sessions and referrals - all within an environment with flexible hours and childcare.

The Advisory Council on the Status of Women is really interested in this idea as a model for service that could be offered in other regions of PEI.

What did you learn about health care spending on Prince Edward Island?

The Canadian Institute of Health Information in its report, *National Health Expenditure Trends*, reports that, at \$1679/person, the Province of PEI has the lowest per capita spending in the country. The government also spends the lowest proportion of its total budget. We understand that we do not have the total budget available to other, more prosperous provincial/territorial governments, but we wonder why the proportions are different than national averages. What is taking priority in this province?

Within the health budget, the Province spends more on hospitals than the national average. As well, we have noted that the Island has the highest rate of psychiatric hospitalization in the country. That makes us think that our health care system must be spending more

money than it should on hospital treatment for mental illness.

What did you learn about the women who work in the Island's health care system?

We learned that they compose about 88% of the workforce, that they are working really hard under stressful conditions, and that they get paid the lowest rates in the country. At the same time, recent efforts by the PEI Nurses Union suggest that health care workers, particularly registered nurses, enjoy fulsome public support. Islanders recognize the tremendous contributions made by women health care workers and are willing to pay them accordingly. The agreement recently ratified by the PEI Nurses Union is an indication of changing attitudes towards the value of the work that they do. However, women health care professionals still struggle with a history of sexism in their workplaces where tradition dictates the doctor (in the past, typically a man) gives the "orders" and the women carry them out. It will take a concentrated effort to shift the culture to a more collaborative, team-oriented model with correspondingly fair pay structures. The Advisory Council on the Status of Women supports all female-dominated health care professions in their struggle for respect and equal status, especially in light of ever-increasing shortages.

What did you learn about the women who provide health care at home?

Back in 1994, the Advisory Council recognized that caregiving was an issue of particular importance for women. We produced the *Sandwich Generation Needs Assessment*, looking at the needs of women who provide care for children and, at the same time, provide care for elderly or disabled family members. That was back when health reform measures were just beginning to take their toll on women as institutions were shifting their responsibilities back to the community and the home with earlier release dates. In that report, caregivers told us that caregiving is highly stressful, often creating health problems in caregivers themselves and creating negative impacts on personal and working lives.

National research on caregiving suggests that not only are women providing more care at home, they are providing a much higher level of care than what used to be expected and that burden creates additional stress as women may not feel qualified to do medical procedures and use sophisticated equipment.

Almost a decade down the road from the first health reform efforts on PEI, it is likely time to assess what is happening with informal caregivers in our province to learn how they are coping and what they may need to support them. It also may be time to re-evaluate related government policies, asking the question of whether the burden that it has placed on one particular group - mostly women in their forties and fifties - is a fair one.

What did you learn about the health of Island women?

We learned that Island women have slightly higher disease incidence and mortality rates than other Canadian women which is interesting in light of the fact that Island women are more likely to take part in disease screening procedures. We wonder if that is an indication that our disease treatment processes are falling short somehow. Island women have a lower mortality rate than men and it looks like that can be explained by the fact that men are more likely to take part in risky behaviours like drunk driving or to commit suicide. We have seen some dramatic increases in certain diseases among Island women - particularly breast, colorectal, and lung cancer. We wonder about the inter-relationship between that trend and environmental issues such as pesticide use.

Island women will typically live longer than Island men but they will have a higher rate of chronic and degenerative diseases in their later years. That reality, combined with a lifetime of lower income, means that senior women are vulnerable to living their final years in ill health and in poverty.

What are some positive actions that government could take in order to promote women-focused health services?

We think that three key steps are: 1) leadership development; 2) well-coordinated women-specific research; and 3) gender analysis of health and social service policy.

Right now, regional health boards carry a lot of responsibility for decision-making around resource allocation. It is important that these boards be truly representative of their communities, including representation along gender lines. Looking at the composition of the current boards, we see that government is taking an equity approach with its appointees but we suspect that there are still barriers that prevent women from standing for election to these boards. There should be an equity approach to that process, too - an effort to equalize things so that women feel welcomed and respected in the process.

Better research on women's health can improve and save lives. Such research happens in pockets right now. It recognizes that women's bodies are different than men's bodies, not just in terms of reproductive functions, but also in size, weight, hormonal patterns, metabolism, biological susceptibility and resistance to a range of diseases and disorders and works to understand those differences. But, there needs to be an effort to coordinate this research in a more systematic and effective matter and to relate the research to women's place in our society. Here in Atlantic Canada, we have community-based, women-specific research emanating from and revolving around the Atlantic Centre of Excellence for Women's Health but it is uncertain how much learning and change is happening in the health care system as a result of this research.

Gender analysis looks at policy positions and asks the question, how will this policy impact on men and on women differently? Such an analysis is important in all policy areas but particularly so in health and social service policy wherein women do most of the work and receive most of the services. Without a doubt, they will be affected differently. For example, shifts from hospital to home care occurred without making an analysis that revealed that women would be absorbing the impact of that budgetary/policy change. At the very least, women want to have that reality explicitly stated so that we do not act as if the caregiving work simply disappears when it is no longer performed in a government-funded setting. In a best case scenario, the policy development process would be incomplete without adding in adequate supports for women who are “picking up the slack.”

A long-term and concentrated effort on all three fronts would eventually produce results. Women would have greater say in health policy development, they would receive appropriate care, and they would receive consideration in policy development processes that look at the realities of health care delivery.

How successful have you been so far in promoting this emphasis on women's health?

The perspective is starting to be heard. In 2001, the Department of Health and Social Services circulated a draft strategic plan outlining the department's direction for the next five years. We were shocked to find no specific mention of women in that document. Instead, the document used the word “people” as if all Islanders had the same health needs and would be affected the same way. The Advisory Council presented a submission in response to the document and this submission was received respectfully by the department and circulated among the regional health boards. And, the final draft contained reference to some specific women's health issues needs, such as those experienced by single women with children. And, it is heartening to see the work being done to support women with addictions and to develop women-specific health services in East Prince.

It was discouraging to take part in the federal Royal Commission on the Future of Health Care. In 1996, Canada signed an international agreement in which they pledged to conduct a gender analysis process on all policy in all departments. Since that time, Health Canada has done considerable work on the issue of gender and health policy. Despite this commitment and preparation, the Royal Commission proceeded with its consultation process with no specific gender process in place. When we asked Commissioner Romanow about including gender considerations in the process and results of the Commission's work, he seemed genuinely puzzled by the question. This is disheartening. It suggests that the Commission will make recommendations for the future of health care in Canada without conducting a proper analysis of how those changes will affect women and men differently.