

Women's Health Clinic Brief
To the
Standing Senate Committee on Social Affairs, Science and Technology
November 2001

WHY WOMEN ARE CONCERNED ABOUT HEALTH CARE REFORM

Women's Health Clinic* submits this brief as we strongly believe that health care reform is a women's issue. Women account for the majority of care recipients and of those who take care of others. Women provide more than 80% of the paid and unpaid health care in this country. This is especially the case among the elderly. In many ways examining the experiences of women with health care is illustrative of what is happening to all Canadians.

Women's use of the health care services is higher primarily because of our reproductive role. As with men, the burden of ill health is connected to income levels. This is of a significant concern to women as the poverty becomes increasingly 'feminized'. For example:

- Almost half, 49%, of all unattached (single, divorced, widowed, separated) Manitoba women over the age of 65 live in poverty.
- More than two thirds of poor Manitoba women work and are not on social assistance.
- Almost 70% of Aboriginal women in Manitoba live below the poverty line.
- Most poor women feed and take care of their children before they care for themselves.
- There are 40% more poor women in Manitoba than poor men.
- Most single parent families are headed by poor women.
- Without their spouses income 50% of married women in Manitoba would be poor.
- Poor women are found in all areas and among all groups of Manitobans.
- 25% of Manitoba kids grow up in poverty. Obviously a lot of long-term problems are ahead, unless specific, practical ways are found to help their mothers.
- Research shows that overall everyone in a community, rich and poor, is less healthy when there are big gaps between the people living in that community.
- Most poor women report that they feed and take care of their children before they care for themselves. 25% of Manitoba kids grow up in poverty.

Recent work by Denton and Walters, show that the connection between income and health is stronger for women than for men. Due to unequal labour force participation, such as part time work and low wages, women generally have lower lifetime earnings and accumulation of pension credits, thereby adding to women's risk of poverty and reducing access to extended medical insurance which covers drugs, dental services etc. As well poor women are less likely to access prevention and screening programs unless targeted client friendly models are used. Women's Health Clinic paper, *Women, Poverty and Health in Manitoba* (see attached) explores these issues in more depth.

* see APPENDIX for background information on the Women's Health Clinic

Women are profoundly interested in what consequences reforms have for women as patients and as caregivers, either paid or unpaid. It is important to acknowledge that there are significant differences among women related to their physical, social, economic, cultural/racial background, locations and their age and sexual orientation. These, too, must be considered in assessing the consequences of reforms.

“It appears that privatization has been the primary strategy in health care reform, and this was the case even before Alberta and now Ontario made this strategy a public issue.

Privatization of health care refers to several different policy directions, which limit the role of the public sector and define health care as a private responsibility or even a market commodity. Privatization in the health care system can occur in the payment for health care services or the provision of health care services. The multiple forms of privatization often confuse the public debate and we found it useful to sort out its various strands.

The privatization of health care includes:

- privatizing the costs of health care by shifting the burden of payment to individuals;
- privatizing the delivery of health services by expanding opportunities for private for-profit health service providers;
- privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- privatizing care-work from public sector health care workers to unpaid caregivers; and,
- privatizing management practices within the health system, by adopting the management strategies of private sector businesses, by applying market rules to health service delivery and by treating health care as a market good.”¹

All provinces have moved to shift health care costs to individuals, to shift care delivery to for-profit concerns, to shift managerial practices to for-profit approaches, to shift care responsibility to households and care work to unpaid caregivers.

Although there are similarities among provinces, there are also significant differences. The process is uneven across the country. Indeed, some provinces have reversed privatization in some areas while others explicitly rejected certain forms of privatization. In Ontario, for example, midwifery has become a public service and Manitoba has reverted to public home care services after experimenting with some for-profit delivery.

Research that does take women into account suggests many health care reforms are having a negative impact on women. Those doing paid health care work are facing increasing workloads and increasing stress. More women are being “conscripted” into unpaid health care work, without training and with few supports. Those sent home quicker and sicker are finding it more difficult to get care, and important questions need to be asked about the quality of care they are receiving not only at home but also in institutions.

A Quebec study, for example, found that women often “had to give their spouses more complex types

¹ Armstrong et al. *Brief to the Senate*, April, 2001

of nursing care, such as changing dressings, irrigating wounds and administering and monitoring medications, hygiene and diet: 75% of these women were themselves receiving services from health care professionals every week...The main problem that these women reported were as follows: the lack of any choice about the way they handled the situation, having their own health become more fragile because of the burden they were carrying as caregivers; feeling insecure because they had to provide such complex care; the lack of planning surrounding the patient's discharge from hospital and the home care to be provided subsequently; and the transfer of costs from the health care system to the people receiving care"²

The research on differences among women, although even harder to find, suggests that those who have traditionally been most vulnerable are facing deteriorating conditions for care. User fees, for example, can mean elderly women who are more likely than men to be poor, cannot get their prescriptions filled.¹

NEW MODELS OF PRIMARY CARE

Women's Health Clinic strongly supports actions that reform how primary care and health promotion/education activities are delivered. Women's Health Clinic wants to emphasize that new roles for clients in the development and evaluation of programs and services need to be clearly articulated in the restructuring—something that has not occurred to date.

The language used in section 5 of your report, which uses the language of business, for example, "service industry" was initially alienating. However on reflection, in many ways it envisioned the kind of practice and vision we have at the Women's Health Clinic – one of the community health centers alluded to in your report. Reform of primary care delivery is a critical component but one we are confident can be done within the principles of medicare and broadening of public programs. Introducing the profit motive and business models merely muddies the waters and interferes with the provision of care and innovation of service delivery. **Women's Health Clinic and other similar agencies, demonstrate primary care reform can be done when community, "clients", administrators and providers work together.**

Patients/clients/public want more input into the kind and quality of care they receive [eg Teen clinic, evening hours, more information and education to manage their health care and give consent] Women's Health Clinic experiences show that the public is very interested in receiving service from a variety of health care providers—not just doctors or clinical nurse specialists and when educated about their condition and treatment options, they tend to be conservative about treatments and new drugs and devices. For example controls on the use of electronic fetal monitoring technology or use of lumpectomy arose out of well informed consumers demanding evidence based practice guidelines.

² Ducharme et al. quoted in Jocelyne Bernier and Marlene Dallaire, *The Price of Health Care Reform for Women, The Case of Quebec*. Quebec Le Centre d'excellence pour la sante des femmes

¹ Armstrong et al. *Brief to the Senate*, April ,2001

Women's Health Clinic strongly supports restructuring the system with a framework for women-centred health care services, that would be more responsive and accessible to the needs of women. Such a framework would recognize the impact of income on the health of women.

Two successful models of Women Centred Care, specifically Vancouver/Richmond Health Board, and our Winnipeg Women's Health Clinic model are described in detail in the *Women, Poverty and Health in Manitoba: An Overview and Ideas for Action*, prepared by Women's Health Clinic, and attached for information. The key elements of the Vancouver/Richmond Health Board model³ are summarized as **essential components that must be included in the framework.**

- **The need for respect and safety:** Women want to be listened to and they want providers to accept the validity of their opinions, taking the diversity and complexity of their lives into account. Respect and safety also needs to be reflected in services accessible to those with different needs, such as disabilities, language barriers, child care, past experiences of violence of abuse, etc.
- **The importance of empowering women:** When people have a sense of control over their life situation, health status improves. Women who have a core sense of self, the ability to take action based on that sense of self, a sense of control over one's life, and being connected with others, reflect empowerment. When these components of empowerment exist, women are more likely to participate and take action in their communities.
- **Involvement and participation of women:** Women's participation in health service and program planning, implementation, evaluation, policy and research, can be limited by social roles and limited financial resources. Only by encouraging full and equal participation by diverse women in these activities, will women's perspectives and needs be incorporated.
- **Women's patterns/preferences in obtaining health care:** Women's multiple roles as homemakers, paid workers, caregivers and family caregivers often mean that they will minimize their own needs because there are others to take care of. Other factors limiting women's access to services include poverty, lack of independence because of disabilities, abuse, isolation, language, physically unable, etc., and many women's preference to see women practitioners,
- **Women's forms of communication and interaction:** Gender socialization encourages women to be gentle, compassionate and nurturing, thus influencing their patterns of communication and interaction. Cultural differences can also have an impact on communication and interaction.
- **The need for information:** Women's learning styles are influenced in part by their forms of communication and interaction. They ask for information more than men, obtain information from other women, and often pass on information to others. Nevertheless, literacy rates and immigrant/refugee women's unequal participation in English as a Second Language training, often affect women's access to information.
- **Women's decision-making processes:** Women make health decisions not so much from an individual perspective, but in consideration of their families, their caregiving and interpersonal relationships, and the social and economic environments in which they live and work. All options need to be presented and support provided to women in making informed decisions within the context of their lives.

³ Women's Health Clinic, *Women, Poverty and Health in Manitoba: An Overview and Ideas for Action*

- **A gender-inclusive approach to data:** 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.
- **Gendered research and evaluation:** Major health research gaps exist for populations of women such as lesbians, bisexual and transgendered, Aboriginal women, immigrant/refugee women, women of color, and women with disabilities, particularly research that reflects their priorities and needs. We need to improve our existing knowledge of health problems specific to women and gain a better understanding of sex and gender differences in those illnesses that affect both women and men.
- **Social justice concerns:** Many women are affected by levels of poverty and injustice and hence providing advocacy around socio-economic issues and access to service are necessary. Assisting and supporting efforts that address the broader determinants of health such as income assistance, disability benefits, safe housing, are critical.
- **Gender sensitive training:** Provide a comprehensive gender-sensitive training program that can be adapted and integrated into all levels of services and program delivery. Models of training need to include consumers as full partners in developing and implementing the programs.

The Women's Health Clinic strongly supports a women-sensitive approach to service planning and delivery that utilizes a population health approach, including the following approaches from our model of care:

- **Women centred services:** The woman, in the context of her community is the center of service and planning. Sufficient time is taken with each woman to gain an understanding of how her unique background and life situation impacts upon her health. Interventions and educational strategies are flexible and varied and may involve linkages beyond the formal health care system.
- **Develop a partnership between the woman and care giver:** Programs and services are based on the assumption that the woman brings a valuable perspective of her life situation and her body and that in order to make informed decisions about her health and health care she must feel empowered. Staff and volunteers de-emphasize differences between woman and care provider, and seek to develop a partnership with her in addressing her health issues.
- **Most appropriate care giver and services:** Efforts are made to ensure that women receive the most appropriate service, provided by the most appropriate service provider, in the most appropriate location. Services and approach offered may include information, education, support through groups or individual counseling, medical treatments, health screening, advocacy, community action as well as linkages with the secondary, tertiary, rehabilitation and long term care or other sectors.
- **Team approach:** Interdisciplinary teams of health care providers working collaboratively, including professional, paraprofessional and volunteer staff are most effective in meeting women's needs.
- **Empowerment:** Programs and services are designed to enhance the understanding, self-care, self-help and self-advocacy abilities of women. This is achieved by: providing a wide range of

accessible information and educational services, as well as support and training services based on adult education principles; facilitating the development of understanding and skills through social action groups around issues of concern to women and a system of participatory management and involvement of community members in agency decision making and evaluation processes.

- **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 perspectives to the design and delivery of services. Training to women of various backgrounds in order to enable them to develop informal and formal helping and leadership skills in the provision of health information.
- **Community involvement:** Working in partnership with various communities concerned about the health of women, building on the strengths and interests of partners, including volunteers, clients, service providers or other members of the community are important approaches.
- **Evaluation and cost effectiveness:** Women's Health Clinic recognizes the importance of ongoing review and evaluation of the approaches and service strategies used including sound information and evidence about how programs, services and approaches meet the health needs of diverse women.
- **Innovative program development:** Continuous development and re-focusing of services approach based on new understandings of women's needs and issues includes collaborating with community women and researchers, and integrating newly gained knowledge
- **Advocacy for system change:** Identifying critical emerging issues for women's health and bringing together key stakeholders to develop innovative policy recommendations which are responsive to women's needs and concerns is another approach of the Winnipeg Women's Health Clinic model.

PAYMENT MODELS

“The public has an abiding sense of the values of fairness and equity and do not want to see a health system in which the rich are treated differently from the poor. The Forum supports this view and supports necessary changes to our system only if we preserve the essence of medicare - universal coverage based on need, without financial barrier, portable across the country, to a comprehensive array of publically administered health care services”.

- National Forum on Health, 1997

Women's Health Clinic strongly supports your committee's recommendation that decisions regarding health care reform be evidence based. Therefore, based on evidence, the suggestions about the implementation of user fees, expanding private, for profit systems are inappropriate.

In our view it has been well demonstrated that these processes do not help address the problems being experienced at present. But rather these processes create more costs, create other variables in the system making evaluation more difficult, draw off our care providers from the public system and, as important, they normalize line jumping – a social ill if ever there was one.

The media, and others have however created a flawed picture of out-of-control health care spending which influences debate in this area. The media has, by and large, presented a picture of rapidly

escalating health care costs. This presentation has, for many Canadians, created the impression that ensuring high quality care without financial penalties for illness is becoming unfeasible. This is not true. Until recently we have been containing costs. Since 1997, spending has picked up again. The increases have been gradual, and we have only just returned to 1992 levels of per capita spending on health care.

In the meanwhile, the economy has grown. The result is that Canada now spends only 9.6% of its GDP on health, still less than the 10.2% in 1992.

Canadian spending on health, as a proportion of GDP, has also dropped in relation to other countries. In 1992, we were second in the world on health care spending as a proportion of GDP. Now, both Germany and France spend more than Canada. The United States, spends almost 14% of its GDP on health, and its per capita health care expenditures is almost twice that of Canada.

Current funding arrangements result in neither federal or provincial governments being accountable for ensuring adequate resources for health care. For instance, in 1995, the federal government was able to unilaterally make massive cuts in health care funding available to the provinces. Furthermore, even in the face of huge budget surpluses, the federal government was able to delay returning funding to 1995 levels for 6 years. Finally, when they have returned funding to 1995 levels, they are able to characterize their actions as huge new funding commitments for health care.

At the same time, the provinces are able to avoid committing increased resources of their own to health care, and effectively use the federal money to fund tax cuts. For instance, the Harris Ontario government has increased health care spending by little more than the federal increase in transfer payments, and only after considerable public pressure, while instituting huge tax cuts.

This situation allows both levels of government to accuse the other of being responsible for health care delivery problems, and for inadequacies in funding. The current funding structure compromises both sustainability and co-operation.

Women's Health Clinic recommends the following solutions to sustainable funding:

1) Maintain health care expenditure at a proportion of the GDP, ensuring growth of the public health sector at least in relation to the economy. An agreement would fix the relative contributions of the federal and provincial government to the increases in health care expenditures that would be mandated as the economy grew.

2) A strong Federal role in 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 original five conditions of Medicare, and subsequently the Canada Health Act, and its 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 control is critical.

We need to take a lesson from experiences with rationing and use containment to assure Canadians that the system is and will continue to provide for their needs. We need better systems to communicate

with “clients” – through mechanisms that are real and trustworthy—not messages that come from spin doctors. This is tied to our recommendation of enhancing the capacity of community groups to engage in discussions and participate in the debate.⁴

FUNDING OF HEALTH CARE

Women’s Health Clinic strongly supports equitable access to health care as a key Canadian value. The principles of the Canada Health Act should be strongly maintained, and extended to other areas of currently inequitable access, including home care and prescription drugs.

Advocates of user fees argue that fees may save the system money by decreasing health care use. That might be a good thing, but only if the health care visits patients avoid are for unnecessary care. If patients stay away when they need care, they will undergo unnecessary suffering in the short term.

Their long term health may suffer as well. Women’s Health Clinic questions whether patients can always distinguish between necessary and unnecessary doctors visits and avoid only the unnecessary ones? We advocate an education program to assist in this, not user fees. In the end, patients may actually need more care, and more expensive services, when they avoid seeking needed care. For instance, if user fees keep patients from visiting the doctor to have their blood pressure checked, the result over the long term may be a disabling stroke.

Both Canadian and American studies of the impact of user fees for prescription drugs have repeatedly shown exactly this effect. Short-term gain of savings for reduced drug use leads to long term pain because of serious illness when patients don’t take needed medication. The result is greater use of doctors and hospitals, and increased rather than decreased total costs.

This argument is particularly compelling when we consider that poor people are sicker, and need more health care. Thus, with user fees, the additional burden of payment falls disproportional on those least able to bear it. Those most likely to reduce health care utilization because of user fees are the people who need that health care the most.

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’ visits 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 basis, 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 the user fee. 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.

⁴ Medical Reform Group web page

User fees place a disproportionate burden on the sickest segment of the population, the poor, who are least able to bear the burden. They do little or nothing to reduce unnecessary health care utilization and give rise to wasteful administrative costs.

We should continue, to the greatest extent possible, to ration by need and not by ability to pay.

A NATIONAL PHARMACARE PROGRAM – one which is part of Medicare

Women’s Health Clinic strongly supports a national pharmacare program, as a part of Medicare. Women’s Health Clinic believes there is strong evidence that a national pharmacare program would reduce drug expenditures and increase health outcomes. Programs such as a national formulary, a system of reference-based pricing, and prohibition of direct to consumer advertising are critical components. Since the National Forum on Health there has been little action on this issue, which is of concern.

Women’s Health Clinic further supports that these additional components also be included:

- **Support a national program to develop and maintain an accessible Consumer Drug and Device Information.** Several centres are working on components of this including the Cochrane Collaboration, several provincial Medical Technology Assessment centres, consumer groups such as ours and the Canadian Women’s Health Network. Indeed applications have been made for this to be developed – and they have yet to be successful.
- **Introduce disincentives to reduce the impact of pharmaceutical advertising and “educational” activities on physician practice.** Although control of Direct To Consumer Prescription Drug Advertisement exists, there remains a great amount of misinformation distributed to physicians. These programs are expensive [includes free lunches, travel, salaries of promotional staff, sampling as well as advertising] and generally would fall into a category that is not taxable. **This should be investigated.** 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 -- <http://www.nofreelunch.org/>
- **The development of an Adverse Drug Reaction reporting system that actively recruits and 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].
- **Develop a national mass purchasing system producing considerable bargaining power to reduce costs.**

The report on *Direct To Consumer Prescription Drug Advertising* prepared by the Working Group on Women and Health Protection provides clear evidence on how problematic this is. We are heartened

to see this alluded to in the report. **Women's Health Clinic endorses the recommendations in the report including:**

- Direct-to-consumer advertisements of prescription drugs should not be allowed, given the lack of evidence of health benefits and the serious potential for harm.
- The 1978 amendment allowing pharmacists to post comparative prices should be accompanied by explicit, rigorous criteria to ensure that it is used for this purpose, and not as a loophole to allow reminder advertisements.
- Regulation of drug promotion to Doctors in Canada is a public responsibility and should not be left up to the industry. It should be carried out directly by Health Canada or by an independent body, at arm's length from both the pharmaceutical and advertising industries.
- The principle on drug promotion included in section 9(1) of the Food and Drug Act is sound, and needs to be enforced.
- Lay people need up-to-date, accurate, comprehensive and unbiased information on the pros and cons of all treatment options, both drug and non-drug, as well as the option not to treat, for the health conditions and illnesses they face.
- Canada should implement legislation based on the World Health Organization Ethical Criteria, including provisions stating that promotion should be in keeping with national health policies and should not be designed so as to disguise its real nature, for example, as educational or scientific activities.

HOME CARE

Women's Health Clinic supports the establishment of a national home care program as an essential improvement to Medicare and primary health care reform.

The measures discussed in the senate paper are critically important. The program should be established with the same principles as enshrined in the Canada Health Act and with a clear role for the client in providing direction and leadership regarding the management of care. The range of home care services required are broad [everything from services once provided in hospital as a result of early discharge, not for admission, to long term support due to disability] and therefore a system that is flexible and client centered is critically important.

During the establishment of a national home care program restructuring must ensure that a shift of costs from the institution to home care does not result in patients bearing the cost of medication and supplies which are covered when in hospital.

A comprehensive home care program remains the most cost effective and socially strengthening answer to the delivery of health care services. Evidence has shown that unless essential home care services are provided, that more expensive procedures in hospital facilities are the long term result.

FINANCIAL COMPENSATION FOR INFORMAL CAREGIVERS

Women's Health Clinic supports 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 and should be implemented.

It is well known that 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 caregiving, the health of 60% of unpaid caregivers begins to deteriorate.⁵ Caregivers often sacrifice their own health due to their commitment to maintaining or improving another's quality of life.⁶ 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." **The Women's Health Clinic supports their recommendations including:**

- 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.
- The focus of consumer-directed care be adopted in order to recognize the centrality of the client and family caregivers.
- 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.

DETERMINANTS OF HEALTH AND POPULATION HEALTH ROLE

Women's Health Clinic strongly supports the proposed activities in the Kirby Report and recommends some expansion of the Federal role in:

- **supporting healthy public policy to ensure that policy developed by all sectors contributes to health-promoting conditions.** Since health is overwhelmingly affected by income, we need

⁵ National Film Board of Canada, *Until the Day Comes*, 1990

⁶ Canadian Women's Health Network

to change the way health policies are considered. Anti-poverty programs are also a health policy. Affordable housing policies are health policies. Better access to education, pay equity, adequate food, and any policy that seeks to eliminate inequality is a health policy too.

- **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”. It would strengthen the role of the commissioner to require health impact assessments as part of government policy, planning and reporting.
- **supporting broad public, community and targeted health promotion and education programs.** Comprehensive health promoting/education programs are essential components of improving population health. We agree with your report, “that strategies must address the linkages between risk factors, as well as between health status and socio-economic, demographic, and environmental factors.”
- **social marketing activities** designed to influence public opinion regarding critical areas influencing health determinants will ultimately strengthen acceptance and implementation of important healthy public policy.
- **increasing consumer access to health information about diseases and treatments** that is evidence based and not prepared by product producers.
- **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.

OTHER

Women’s Health Clinic strongly recommends that 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 like Pharmacare and Home Care, without an exclusion, as for-profit companies with international ownership operate within Canada.

- Patent protection has had, and will continue to have significant impact on Canadians, both in terms of access to legitimate tests but also the assessment of the tests. We only need to look to the recent example of genetic testing for breast cancer, (ie. BRCA1 and 2). Myriad Genetics patented this and 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.

CONCLUSION

Women's Health Clinic again urges that evidence based decision making be the basis for health care reform. The evidence strongly shows that public funding is more efficient, less expensive, provides better access and produces superior health outcomes.

The Senate has the opportunity through this Report to provide Canadians with a vision of health care, that will ensure a health service system for the next century founded on equity, need and accessibility, irrespective of the ability to pay.

Thank you for the opportunity to present our position to the Commission and to provide this brief for further consideration.

Attachments:

1. Women's Health Clinic Annual Report 2001,
2. Women's Health Clinic's last newsletter- Fall 2001,
3. Women's Health Clinic's Model of Care
4. Women's Health Clinic general brochure
5. Women, Poverty and Health in Manitoba: An Overview and Ideas for Action, Women's Health Clinic, July 2000
6. Women and Health Care Reform, National Coordinating Group on Health Care Reform and Women, c/o Canadian Women's Health Network. Available on line
7. Direct to Consumer Prescription Drug Advertising: When Public Health is No Longer a Priority, DES ACTION in collaboration with Working Group on Women and Health Protection
8. Research Bulletins 1 and 2, Centers of Excellence in Women's Health
9. Recent newsletters 2 and 3 of the Canadian Women's Health Network

APPENDIX

The Women's Health Clinic (WHC), located in Winnipeg, MB, serves as a 20 year old community resource to a broad range of individual women - from teens to elders, as well as to service providers and agencies in Manitoba. The Women's Health Clinic is governed by a volunteer board consisting of clients, community members and representatives of our volunteer and paid staff .

The Women's Health Clinic provides a unique form of primary health care that emphasizes health promotion, education and client empowerment. In addition, the Clinic monitors emerging issues of importance to women's health, brings together coalitions and networks for debate and discussion, encourages and sponsors research and develops policy options and innovative service approaches within a population health framework. While most Clinic services are offered in Winnipeg, clients and providers from other parts of Manitoba and Canada also seek Women's Health Clinic services and resources. The scope of Clinic policy, advocacy and networking initiatives is both provincial and national.

Women's Health Clinic staff are made up of an interdisciplinary team of health care providers who work collaboratively and include professional, paraprofessional and volunteer staff. Women's Health Clinic has current staff complement of 18.5 EFTs, which include: physicians, nurse practitioners, health educators, dietitian, midwives, counsellors, outreach volunteer coordinators, client service workers, medical assistant and administration personnel. A half time position coordinates the Advocacy and Community Outreach program.

Our program areas include reproductive and sexual health including contraception, unplanned pregnancy, free and low cost contraceptive supplies, consultation services, endometriosis, weight preoccupation and tobacco use reduction support groups, free and low cost counseling, health education programs in the community and schools, regular menopause sessions and other emerging areas of importance to women.

Some of our key programs use volunteers – including sexuality, contraceptive and unplanned pregnancy counseling and speakers in schools and the community. We believe in capacity building and support the understanding of health information and put it back into the community.

Women's Health Clinic recognizes that women's health issues have not always received the attention they deserve and require in health policies and practices, nor has the recognition of gender as a determinant of health always been acknowledged. The Clinic has been a strong advocate for this perspective and has worked with others across Canada and internationally to remedy this including efforts on Reproductive and Genetic Technologies, Health Protection Branch restructuring, Midwifery and Health Reform.

Programs and services are designed to enhance the understanding, self-care, self-help and self-advocacy abilities of the woman. This is achieved by:

- providing a wide range of accessible information and education services with a key role being played by the Clinic's Resource Centre, as well as support and training services based on adult education principles;

- facilitating the development of understanding and skills through social action groups around issues of concern to women such as breast implants, new reproductive and genetic technologies or birthing options; and
- structuring the Clinic to include involvement of community members in agency decision-making and evaluation processes.

Women's Health Clinic works to identify critical emerging health issues for women and brings together key stakeholders, such as women affected by the issue and related service providers to develop innovative policy recommendations which are responsive to women's needs and concerns. We are celebrating our 20th anniversary this year