EXECUTIVE SUMMARY

THE LINK between poverty and poor health is well established and makes common sense. There are many ways in which poverty can lead to ill health, including lack of access to affordable housing, transportation, food and non-insured health benefits, such as medications.

Poverty also discriminates in more subtle ways. For example, women and their children who are poor are more likely to be socially isolated, which also contributes to ill health. We do not yet completely understand all of the ways in which low income and income inequality in our society lead to poor health. But we do not need to completely understand these mechanisms in order to act now to improve health.

The link between income and health has a special importance for women. In Manitoba (as in the rest of Canada), poverty discriminates, striking women substantially more frequently and more severely than men. This study looks at that disparity and how income inequality affects the health not only of women living in poverty but of everyone in our society.

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Income and Inequality

Poverty is a serious issue in Manitoba. This province has the country's third highest rate of poverty (18.5%) among Canadian provinces, compared to 16.2% for all of Canada. For women, the picture worsens: 19.9% of Manitoba women aged 18 and over were poor in 1999.[1] This also has an impact on the lives of children and Manitoba also has the second highest child poverty rate in Canada, 23.7%.[2] The disparity between women and men is remarkable. In 1999, there were 29,000 more poor women in Manitoba than poor men – a difference of 54%.[3]

Marriage does not protect women from poverty. In 1996, one in ten married couples were poor. And married women's earnings are vital to their families' well-being; without them, that proportion would have risen to one in four.[4]

Minimum wage earners, even those working full-time, live in poverty. A single mother with one child working full-time and earning minimum wage in Manitoba lives 43.4% below the poverty line. If she is married with two children, even when both spouses work full-time at minimum wage, their family will live 25% below the poverty line.

Some groups of women are especially vulnerable to poverty:

- More than half (51.3%) of senior women who live alone are poor.[5] This has remained virtually unchanged in the last thirty years.
- Women with disabilities also face a higher risk of poverty. In 1997, 27% of women with disabilities, aged 16 to 64, lived in poverty. Almost two-thirds of those lived more than 25% below the Low Income Cut Off.[6]
- Aboriginal women are more likely to live in poverty than non-Aboriginal women or Aboriginal men. In 1995, 42.7% of Aboriginal women (excluding those who lived on Reserves and those living in the Territories) lived in poverty, compared to 35.1% of Aboriginal men, 20.3% of non-Aboriginal women and 16.4% of non-Aboriginal men.[7]
- In 1996, 31.8% of visible minority women in Manitoba lived in poverty.[8] Yet, they are more likely than other Canadian women to be employed full-time.[9]
- Recent immigrant women have particularly low incomes. In 1995, their average income for all of Canada was only $12,000, about 62% of the amount earned by Canadian-born women that year.[10]

These disparities are becoming worse, not better. A recent report for the Centre for Social Justice noted that:

> *Not only are there more families in the lowest income category but they have also become poorer over time: to belong to the poorest 10 per cent of the population meant earning less than $11,567 in 1989. By 1997, it meant earning less than $6,591.* [11]

Income and Health

There are many studies showing the connection between income and health. As the Manitoba researcher Patricia Kaufert, Ph.D has observed:

> *locating health in the social conditions of people's lives is an idea which can be dated back to the origins of the public health movement.*[12]

Research shows that medical care is less important in ensuring the well-being of the entire population than economic security, social support and a more equitable distribution of income. The connection between poverty and poor health has continued to exist even as medicine has progressed, persisting despite the reduction in mortality and improvements in other measures of health.

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Inequalities in health are not only a problem for poor Canadians. Data from Manitoba is consistent with data from other countries. Health status worsens at every step down the socio-economic ladder. Poor people may be more at risk, but everybody is affected.

Economic inequality itself is a health risk.

> *Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole.*[13]

What the Research Tells Us

There is a substantial body of research linking women's household incomes and their health. While past research has found the connection to be weaker for women than for men, recent Canadian research shows the reverse.[14] This research also suggests that socio-economic status and other factors beyond individual control (such as family structure, age and social support) are more important to women's health status than lifestyle factors such as smoking, alcohol consumption and physical activity. Women's health services that focus only on lifestyle will, therefore, not be as effective as a broader approach that addresses poverty and the economic inequality faced by women.

One consistent theme in the research is the additional burden of ill health borne by Aboriginal women. They are at much greater risk of violent death and suicide than other Canadian women. They have poorer health than Aboriginal men or other Canadian women; they develop chronic conditions earlier and suffer more frequently from heart problems, hypertension, diabetes, arthritis and rheumatism. This is compounded by the fact that Aboriginal women face formidable barriers in obtaining appropriate health services, including discrimination, distance and cultural barriers.

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[1] Statistics Canada, *Income in Canada*, Table 8.5

[2] Social Planning Council of Winnipeg, *Promises Not Kept: 2001 Report on Child Poverty in Manitoba*

[3] Statistics Canada, op. cit, Table 8.5

[4] National Council of Welfare, *Poverty Profile 1996*, p 87

[5] Statistics Canada, op. cit., Table 5

[6] *Federal, Provincial and Territorial Ministers Responsible for Social Services, In Unison 2000: Persons with Disabilities in Canada*, page 79

[7] Statistics Canada, *Women in Canada 2000*, page 268

[8] Statistics Canada, *1996 Census*, Dimension Series, #94F009XDB96003

[9] Statistics Canada, *Women in Canada 2000*, page 227

[10] ibid, page 204

[11] Yalnizyan, A., *Canada's Great Divide: The politics of the growing gap between rich and poor in the 1990s*, Toronto: Centre for Social Justice, 2000, page ii

[12] Kaufert, Patricia "The Vanishing Woman: Gender and Population Health", from *Sex, Gender and Health*, forthcoming, Cambridge University Press, 1999, page 121

[13] Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians*, 1999, page ix

[14] Denton, Margaret and Walters, Vivienne "Gender differences in structural and behavioral determinants of health: an analysis of the social production of health", *Social Science and Medicine*, 48 (1999), page 1232

Poverty is also an important factor in the health of older women. Many factors compound this, including poor housing, higher heating costs, increased isolation, fear for personal safety and functional impairments that may make day-to-day life difficult and painful. The link between inequalities in income and health is strong even for those over the age of 85.

Income & Health in Manitoba

We examined the experience of all Manitoba women in 1994-95, the most current year for which data were available. As in other jurisdictions, there was a connection between income and health services utilization for Manitoba women for most health conditions. That is, women in low-income neighbourhoods were more likely to see physicians both in hospital and in physician offices than were women in high-income neighbourhoods. The experience of women in middle-income neighbourhoods fell in between.

Importantly, the reverse was true for two preventive screening services. Women in the highest income neighbourhoods were most likely to use Pap smears to screen for cervical cancer and mammograms to screen for breast cancer.

This is not intended to suggest that low and middle-income women, whose health care costs are higher than those with high incomes, use the health care system inappropriately.

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The solution lies not in restricting access to the health care system with user fees or other mechanisms but, rather, in improving the health of the population.

The health effects of income inequalities increase the burden of illness in all body systems. Discussions of women's health and socio-economic inequalities must be broad enough to incorporate and build on this information. Strategies which focus only on reproductive and sex-specific conditions will not be successful in reducing inequalities in women's health.

Making Public Policy Healthier for Women

Healthy public policy for low-income women will require changes both inside and outside the health care system. The health care system has two important roles to play:

1. changing the way in which health care services are planned, delivered and evaluated to better meet the needs of low-income women;
2. working with other sectors outside of the health care system to help them understand the health impacts of their policies.

Manitoba health care organizations interested in developing health services which take issues of income, gender and health into account have several models to consider. Three in particular – developed by the Winnipeg Women's Health Clinic, the Vancouver/ Richmond District Health Board and the Commonwealth Secretariat – offer ideas for improving health services to better meet the needs of low-income women.[15]

Perhaps most importantly, health care organizations must change by specifically considering the needs of low-income women. **The best way to do this is by including low-income women in the planning and evaluation of health services.**

In order to improve the health status of low-income women, we will also need policy changes outside of the health care system. While these issues have not traditionally been part of the work of the health care system, it has an important role to play in encouraging organizations outside of health to consider the health consequences of their decisions. In *Toward a Healthy Future*, the

[15] Vancouver Richmond Health Board, Framework for Woman Centred Care, available at: http://www.vcn.bc.ca/vrhb/, Women's Health Clinic, *Model of Care*, The Commonwealth Secretariat, *Models of good practice relevant to women and health, including research, policy, implementation, strategies, testing and evaluation* (For full texts see the complete version of this Report.)

Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) identified **"renewing and reorienting the health sector"** as the first of three priorities and called on health care organizations to **"initiate dialogue with other health-determining sectors about the health impacts of policies in sectors outside health and about collective actions that can be taken."** [16]

The ACPH also identified *"improving health by reducing inequities in income distribution and in literacy and education"* as another of its priorities for action.[17]

It is important to take actions both to increase the incomes of low-income women and to limit the costs of essential services. Some ideas for action include:

- increasing the minimum wage
- increasing social assistance rates
- broadening eligibility for Employment Insurance
- reducing the costs of public transportation
- increasing the number of subsidized child care spaces
- making child care fully subsidized for women living in poverty
- reducing the cost of basic telephone service
- making recreation programs freely available for those living in poverty
- providing non-insured health benefits, such as dental care and prescription drugs to all those living in poverty

These are some of the many opportunities which exist for decision-makers, health service providers and the public to use our existing knowledge about the connections between income and health to make our community healthier for all.

While we may not have a detailed understanding of the mechanisms by which income and social status affect health, we know that the connection is there. Now is the time to use the knowledge which we do have to make changes to improve women's health.

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[16] *Toward a Healthy Future: Second Report on the Health of Canadians*, pages 175 to 177

[17] *Toward a Healthy Future*, page 175

B. INTRODUCTION

Much work has been done to date on the connection between poverty and ill health, and, more generally, on income and various measures of health and illness. The purpose of this paper is to explore the relationship between the health of Manitoba women and their socio-economic status. This paper will therefore:

1. briefly describe income distribution and poverty in Canada and Manitoba today;
2. provide a summary of the literature on the relationship between income and health;
3. expand that work with new information about the connections between women's income and their health, including an analysis of data about the utilization of health services by Manitoba women;
4. describe some of the key health services issues for low-income women and present models of service which addresses those issues;
5. present ideas for interventions in public policy that will improve the health of Manitoba women living in poverty.

Because of the significance of income and poverty issues for Aboriginal women, information specific to their situation and needs has been included wherever possible.

This paper has been commissioned as part of a project by the Women's Health Clinic of Winnipeg and has been funded by the Health Promotion and Programs Branch of Health Canada.

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C. INCOME DISTRIBUTION IN CANADA

1. Measurements of Poverty

Canada does not have an official measure of poverty. Most researchers use the Statistics Canada "Low Income Cut-offs" (LICOs) as its measure of poverty. The Canadian Council on Social Development (CCSD) and others have criticized this measure. Some, such as the Fraser Institute, have criticized it for defining poverty too generously; that is, for including too many people.[1] Others, including the CCSD have developed alternative measures which are more generous.[2] There is an active debate among those involved with social policy in Canada about the best way to measure poverty.

The National Council on Welfare has described this controversy as follows:

> *Statistics Canada itself has consistently maintained that it does not regard the LICOs as poverty lines, presumably because the federal government does not want to give official recognition to poverty. Most social policy groups in Canada have consistently disagreed with the position of the federal government and continue to use the LICOs as poverty lines. Despite the long-running dispute over terminology, the low income cut-offs are by far the most widely used measure of poverty in Canada. The survey data and methodology used to generate the cut-offs are done by a federal government agency with an international reputation for high-quality work. Statistics produced using the LICO methodology are readily available to researchers inside and outside government year after year at modest cost. Coincidentally or not, the income levels of the LICOs are in the mid-range of the alternative poverty lines that have appeared from time to time.*[3]

Consistent with the majority of social policy experts in Canada, we have used the Statistics Canada Low Income Cut Offs to define "poverty" for the purposes of this paper.

In 1999, Manitoba had the third highest rate of poverty of all Canadian provinces, at 18.5%, compared to 16.2% for all of Canada. Only Newfoundland (at 20.7%) and Québec (at 19.5%) were higher. Manitoba had the second highest poverty rate for senior women at 28.3% and the fourth highest rate for women aged 18 to 64 years.

Women's poverty has a significant impact on the income of children. Manitoba has the second highest child poverty rate in Canada, 23.7% . The rate of poverty for Manitoba children living with single-parent mothers was also the second highest in Canada at 70.7%.

2. Income Distribution in Canada

2.1 POVERTY IN CANADA

The following chart summarizes some 1999 Statistics Canada data about who is poor in Canada and Manitoba.

TABLE 1

A SNAPSHOT OF WHO IS POOR IN CANADA AND MANITOBA - 1999

	CANADA		MANITOBA	
	Number	Percent	Number	Percent
ALL PERSONS	4,886,000	16.20%	202,000	18.50%
All Females	2,699,000	17.70%	113,000	20.40%
All Males	2,187,000	14.60%	89,000	16.50%
SENIORS	646,000	17.70%	32,000	22.00%
Senior Women	487,000	23.50%	24,000	28.30%
Senior Men	159,000	10.00%	9,000	13.60%
UNATTACHED SENIORS	519,000	44.00%	25,000	44.20%
Unattached Senior Women	417,000	48.50%	21,000	51.30%
Unattached Senior Men	101,000	31.90%	4,000	25.60%
ALL CHILDREN UNDER 18 YRS.	1,298,000	18.50%	64,000	23.70%
Children in 2-parent families	697,000	12.10%	34,000	15.50%
Children with single mothers	521,000	55.80%	28,000	70.70%

SOURCE: Statistics Canada, *Income in Canada, 1999*, Table 8.5

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2.2 CANADIAN WOMEN AND POVERTY

As the above data show, there were 29,000 more poor women in Manitoba than there were poor men. To put this another way, 40% of all poor adults in Manitoba were men; 60% of them were women.

As Monica Townson has stated:

> *It's not something we have heard much about recently. Yet women remain among the poorest of the poor in Canada. Over the past two decades, the percentage of women living in poverty has been climbing steadily. As Canada enters the 21st century, almost 19% of adult women are poor – the highest rate of women's poverty in two decades. About 2.2 million adult women are now counted as low-income, compared with 1.8 million who had low incomes in 1980.*[4]

From 1976 to 1999, the percentage of women 15 years of age and older who were employed in the paid labour force increased from 42% to 54%. During the same period of time, Manitoba women increased their employment rates from 46% to 56.5%[5]. Were it not for the increased earnings resulting from the massive increase in women's labour market participation, many more families would have slipped into poverty.

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The National Council of Welfare has calculated the poverty rates for husband-wife families in 1996 and the percentage of families who would have been poor without the earnings of the women in them. In Manitoba, in 1996, 10.5% of husband-wife families were poor. Without the earnings of the wives, 25.5% would have been poor.[6] This illustrates several points. Firstly, marriage itself does not protect women from poverty. Secondly, married women's earnings are crucial to the economic well-being of their families.

The gender gap in poverty in Canada has been the subject of international discussion. Canada was recently criticized internationally for the extra burden of poverty borne by Canadian women. The United Nations Committee on Human Rights, in its *Concluding Observations on Canada's Compliance with the International Covenant on Civil and Political Rights*, stated in part:

> *The Committee is concerned that many women have been disproportionately affected by poverty. In particular, the very high poverty rate among single mothers leaves their children without the protection to which they are entitled under the Covenant. While the delegations expressed a strong commitment to address these inequalities in Canadian society, the Committee is concerned that many of the programme cuts in recent years have exacerbated these inequalities and harmed women and other disadvantaged groups. The Committee recommends a thorough assessment of the impact of recent changes in social programmes on women and that action be undertaken to redress any discriminatory effects of these changes.*[7]

Much attention has been paid to the extremely high rates of poverty among children of single-parent mothers. Child poverty has become a topic of much public discourse, including a 1989 resolution by the House of Commons to eliminate child poverty by 2000. Since 1990, the number of poor children in Canada has actually increased by 103,000.[8] **As the National Action Committee on the Status of Women has consistently pointed out, the children of single-parent mothers are poor because their mothers are poor.**

Health Canada has established Centres of Excellence for Children's Well-being. A February 1999 discussion paper entitled *Fostering Knowledge Development on the Health and Well-Being of Children in Canada* recognized that "while not all children who are poor experience negative health outcomes, there is a great deal of evidence showing a major link between family income and many measures of health and well-being."[9]

Less attention has been paid to the plight of **unattached senior women** – that is, those women 65 years of age or older who are either single, separated, divorced or widowed. In 1999, over 51% of these senior unattached women in Manitoba were poor. This number has not changed in the thirty years since the publication of the *Report of the Royal Commission on the Status of Women*.[10]

Women with disabilities are also at higher risk of poverty than either women without disabilities or men with disabilities. In 1996, 27% of women with disabilities aged 16 to 64 lived in poverty. Almost two-thirds of those lived more than 25% below the poverty line.[11]

As Gail Fawcett has noted, *"men with disabilities face many of the same barriers as women; however, for women, the barriers are often more pronounced and the negative outcomes more severe."*[12]

Other groups of women at higher risk for poverty include Aboriginal women (see below 2.3), visible minority women (see below 2.4), and women who are separated and divorced.

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2.3 ABORIGINAL WOMEN AND POVERTY

In 1996, Manitoba, with approximately 5% of the total population of Canada, was home to 16.1% of the country's total Aboriginal population, 64,665 women and 62,900 men. [13] Looking at this another way, in 1996, 11.7% of Manitoba's population were Aboriginal people.

The term "Aboriginal" includes First Nations, Métis and Inuit people. This terminology, while useful, does not allow exploration and analysis of the very real differences within and among these groups. The lives of First Nations peoples, for example, are affected by their status under the *Indian Act*. First Nations people may be classified as "Status" or "Non-Status" Indians, "Registered Indians On Reserve" or "Registered Indians Off Reserve", "Treaty" or "Non-Treaty" or "Bill C-31 Members". For the purposes of this paper, the term "Aboriginal" will be used to refer to all of the original people of Canada.

It should also be noted that while 1996 Census of Canada data is used below, some First Nations communities chose not to participate in the 1996 Census of Canada. What impact, if any, their participation might have had on this data is not known.

TABLE 3

ABORIGINAL AND NON-ABORIGINAL POVERTY RATES, 1995

	POVERTY RATES PERSONS 15 YEARS AND OVER		
	Male	Female	Gender Gap
Aboriginal People	35.1%	42.7%	21.60%
Non-Aboriginal People	16.4%	20.3%	23.8%

SOURCE: *Women in Canada 2000*, Table 11.14

TABLE 4

AVERAGE INCOMES – ABORIGINAL AND ALL CANADIANS

	AVERAGE INCOME, 1995		
	Male	Female	Gender Gap
Aboriginal People	$18,221.00	$13,305.00	26.90%
All Canadians	$31,117.00	$19,208.00	38.3%

SOURCE: *1996 Census* – Statistics Canada 94F0009XDB96001

These data clearly show that Aboriginal women have higher poverty rates than either Aboriginal men or Non-Aboriginal women or men. Their average incomes are lower than those of Aboriginal men, or all Canadians. The average income of Aboriginal women in Canada in 1995 was $17,812 lower than the average income of Canadian men. Put another way, for every dollar earned by Aboriginal women, Canadian men earned $2.34.

These data are important to keep in mind when considering issues of income and health. Firstly, poverty among Aboriginal people is gendered, as it is among the Canadian population as a whole. Secondly, these lower income levels are a contributing factor the poor health status of Aboriginal women in Canada (see 5.3 below).

The combined effects of racism and sexism are clearly evident in the income levels of Aboriginal women. **Examining these issues considering only Aboriginal status (and not gender), or gender (and not Aboriginal status), will mask the true situation of Aboriginal women. The combined effects of racism and sexism are clearly evident in the income levels of Aboriginal women.**

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Aboriginal people face additional barriers in the labour market. As Michael Mendelson and Ken Battle have noted:

> *The labour market prospects facing Aboriginal Canadians are much worse than for other Canadians. Many Aboriginal people are unlikely to find consistent employment in their lifetime. The potential costs of high unemployment extend beyond the social sphere. The economic future of a region is greatly diminished when a growing percentage of its workforce is unemployed. The threat to economic well-being is especially grave for the Prairies.* ***There is probably no single more important issue for the economic future of the Prairies, particularly Manitoba and Saskatchewan, than the advancement of its Aboriginal human resources.***[14] *(emphasis added)*

2.4 ABORIGINAL WOMEN - KEY INFORMANT INTERVIEWS

As part of the data collection process for this paper, interviews were held with key informants to discuss the connections between income and health for Aboriginal women.

Seven Aboriginal women participated in these interviews. They were selected because of their experience working in the health care system, health research experience, and/or knowledge of Aboriginal women's health. The interviews were conducted by Angela Busch, an Aboriginal woman with experience in the field. Ms Busch also designed the questions which were asked of each of the interviewees, which are included as Appendix 4.

The Aboriginal women who participated in the health interviews had much to say on the subject of Aboriginal women and poverty. They recognized that poverty is endemic in Aboriginal communities, both on reserves and in urban centres, and identified that this as more so for Aboriginal women than men. Comments about poverty as it relates to the health of Aboriginal women were discussed holistically, in terms of its mental, physical, emotional and spiritual consequences.

One of the recurring themes that arose during these interviews was that Aboriginal women tend to think in terms of their children's and families' health, more often than that of their own health. One of the major problems identified for Aboriginal women was poor access to medical care.

The interviewees identified the following reasons why Aboriginal women have poor access to health care:

- for those who live in rural areas, health care facilities are limited or non-existent;
- for those in urban areas, women do not always have transportation (e.g. bus fare) or childcare readily available;
- racism and discrimination in the health care system were identified as major problems;
- Aboriginal women who do not have treaty Indian status can not always afford to pay for the prescriptions that they need.

For those interviewed, poverty meant that Aboriginal women were unable to afford to meet their basic needs. They saw poverty as largely responsible for poor nutrition or improper diet, which they recognized could lead to a multitude of health problems. Poor women cannot always afford to buy fresh foods and tend to consume food that is processed and very high in fat, sugar, salt and nitrates. Diseases such as diabetes and heart disease were identified as largely attributable to poor nutrition. Improper diet was noted as being an even greater health issue for pregnant or nursing women.

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Poor housing and lack of housing were also identified as key health issues for Aboriginal women who live in poverty. Inactivity and lack of exercise were noted as health issues for Aboriginal women, specifically as contributing factors to diabetes.

Low educational levels were also seen as a factor contributing to poverty among Aboriginal women, since women who are not well educated have a much lower chance of securing well paid employment. The interviewees saw lack of education as a contributor to poor health, since women with low levels of education may not understand their own bodies and physiology. This creates problems for them in understanding preventative health measures and knowledge of basic healthy living (e.g. four food groups).

Interviewees discussed the problems faced by Aboriginal women during childbirth, and saw these as a result of double discrimination faced by being both Aboriginal and poor. For example, one woman who was interviewed described situations where Aboriginal women had been left alone while in hospital, during the actual birth of their babies. This is an unacceptable standard of care, placing both the woman and her baby at risk.

Aboriginal women also identified difficulty in receiving help or instruction on breastfeeding when their child is first born. One woman commented that health care professionals have a tendency to assume that Aboriginal women will not breastfeed their children.

The interviewees noted that this type of discrimination and mistreatment of Aboriginal women in the health care system greatly affects their overall health. They identified poverty, as well as poor treatment and discrimination, as factors which can have negative effects on the mental, emotional and spiritual well-being of Aboriginal women.

The majority of women interviewed saw depression, low self-esteem and feelings of low self-worth to be attributed to poverty among Aboriginal women. One woman explained that, if a woman is unable to provide basic nutrition and housing for herself and her children, this can have a devastating effect on her mental, emotional and spiritual health. Another woman felt that, although a woman's mental and emotional side would be negatively affected in such a situation, her spirituality would remain strong.

Stress was identified as being a major health issue for Aboriginal women who are poor, because of the mental and emotional effects of poverty. It was noted that many Aboriginal women smoke as a result of stress, which the interviewees understood to be harmful to their health.

Finally, many interviewees emphasized that Aboriginal women who are poor will ignore their own health needs in order to fulfil the health needs of their children or other family members. As an Aboriginal Medical Interpreter (who requested anonymity) told us:

> *Aboriginal women do not make as much money as their male counterparts. Especially if they are single women, there is so much more that are going to do without. So, they have more worries, mentally and spiritually, they would be more stressed. Aboriginal women just ignore their own health to look after others.*

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2.5 VISIBLE MINORITY WOMEN

Data from the *1996 Census of Canada* shows high rates of poverty for visible minority Canadians as follows:

TABLE 7

POVERTY AMONG VISIBLE MINORITY CANADIANS AND MANITOBANS

	CANADA	MANITOBA
Males	35.00%	30.80%
Females	36.80%	31.80%

SOURCE: Statistics Canada, *1996 Census*, Dimension Series, Ethnocultural and Social Characteristics of the Canadian Population - 94F0009XDB96003

Based on data published in 1998 by Statistics Canada, Armine Yalnizyan has noted that:

> *...Canadian-born members of visible minority groups have only a slightly better earnings profile than people who have just arrived in the country. Their average employment income of $18,565 was almost 39% below all other Canadian-born earners. Only one-third of this group of earners have full-time full-year work, compared to half of the rest of Canadian-born earners.* ***More than one in three of the visible minority population live in poverty compared to 20% of the general population.***[15] (emphasis added)

However, this remains for Canada a relatively new area of research. The research of Derek Hum and Wayne Simpson, using data from the Statistics Canada *Survey of Labour and Income Dynamics*, has yielded somewhat different results. They found that:

> *with the exception of Black men, there is no statistically significant wage gap between visible minority and non-visible minority group membership for native born workers. It is only among immigrants that the question of wage differentials for minorities arises, and consequently, the differential wage gap among members of different visible minority groups.* ***Furthermore, we would note that there are differences between men and women. Among immigrants, we find a wage disadvantage for visible minority men relative to other men, but not for visible minority women relative to other women.*** [16] (emphasis added)

They note that **foreign-born women in Canada "face a disadvantage in the Canadian labour market whether they are members of a visible minority or not**." [17] (emphasis added)

Further research will likely clarify our understanding of these apparent differences. In the interim, **it is clear that visible minority Canadians, both men and women, face a much greater likelihood of living in poverty than do other Canadians. Their greater risk of poverty places upon them a greater burden of ill health. Additionally, they face the burdens resulting from racism, which further contribute to stress and ill health.**

D. THE CONNECTION BETWEEN INCOME AND HEALTH

1. What Is Known about the Connection between Income and Health?

There now exists a considerable literature on the relationship between income and health. Robert Evans' book *Why Are Some People Healthy and Others Not?*[18] has become the Canadian classic text. Evans' main thesis is that the major determinants of health are social and economic and that health care makes only a small contribution to the health of populations. Manitoba researcher Patricia Kaufert has summarized Evans' model as one in which:

> *the well-being of the population depends not on medical care, but on a relatively equitable distribution of income, on a social environment which provides people with a sense of security and control, on stable and satisfying employment, and on the availability of social support.*

She goes on to note that:

> *locating health in the social conditions of people's lives is an idea which can be dated back to the origins of the public health movement...Within the last 25 years, the Lalonde Report (1974) in Canada and the Black Report (1980) in the UK put forward many of the same arguments.* [19]

Vivienne Walters and Margaret Denton have examined the Canadian as well as the international data and have concluded that:

> *Research in Canada and other countries has revealed relationships between level of health and structures of inequality such as social economic condition, sex, race and age. With respect to social economic condition (measured by income, occupational status, home ownership, access to a car), health differences can be observed throughout the socio-economic spectrum...*
>
> ***Poor health is not simply concentrated among those who are most deprived. Health status declines with each decline in socio-economic status and thus it is important to focus on the broader structure of social economic condition rather than on material deprivation alone**, though the determinants of health may vary at different levels of socio-economic status.*[20] (emphasis added)

The November, 1998 report of the British Independent Inquiry into Inequalities in Health contains a wealth of useful, current information. The report summarizes the current state of knowledge as follows:

> *Socioeconomic inequalities in health and expectation of life have been found in many contemporary and past societies. In England, although information based on an occupational definition of social class has only been available since 1921, other data identifying differences in longevity by position in society have been available for at least two hundred years. These differences have persisted despite the dramatic fall in mortality rates over the last century.*
>
> *Inequalities in health exist, whether measured in terms of mortality, life expectancy or health status; whether categorised by socio-economic measures or by ethnic group or gender. Recent efforts to compare the level and nature of health inequalities in international terms indicate that Britain is generally around the middle of comparable western countries, depending on the socioeconomic and inequality indicators used.*
>
> *Although in general disadvantage is associated with worse health, the patterns of inequalities vary by place, gender, age, year of birth and other factors, and differ according to which measure of health is used.*[21]

The similarities between Canada and Britain (a shared Commonwealth heritage, both industrialized western countries, both with a universal, public medicare system, both with major reductions in social spending and both with multi-cultural populations) make the British literature particularly applicable to the Canadian context. The American literature, which was also examined for this paper, was of limited applicability to the Canadian context because, for many Americans, their lack of health insurance severely limits their access to health care services.

The link between income and health exists in other industrialized countries as well. Sally Macintyre summarized her findings in an international overview of social inequalities and health as follows:

1. *Socio-economic inequalities in health have been observed since statistics have been available.*
2. *They are observable in all industrialized countries.*
3. *They are observable in most measures of health and longevity, and using most measures of socio-economic status.*
4. *Their magnitude varies between countries.*
5. *Main causes contributing to inequalities vary between countries.*
6. *Health and longevity tend to have a stepwise, not threshold relationship with socio-economic status.*
7. *Socio-economic differentials in health are less strong and consistent for women and minority populations.*[22] *(Some recent Canadian work shows a stronger connection for women than for men.* *See page 28 below.)*

The issue, therefore, is broader than just poverty. It is the inequality of distribution of wealth in a society, which affects the health of the whole population, since differences in health and illness exist across all socioeconomic levels and not just between the poor and the non-poor.

women's health clinic

Dennis Raphael has stated:

> *These findings suggest that the factors that make poor people more at risk also affect just about everybody but in somewhat lesser degrees. And consistent with the view that we are all affected by these social forces, it is now accepted that societies with greater economic inequality have higher death rates than more egalitarian societies. This had been seen as reflecting the poverty and illness relationship already described. But recent analyses have suggested that these socioeconomic differences in health actually reflect basic structures and functions of a society – and how the populations responds to these structures and functions – not simply that this group or that group are lacking resources that can be remedied by directing programs to assist the poor.* [23]

2. Income Disparities in Canada

Given what is known about the positive connection between income inequalities and the health of all members a society, it is worrisome to note that income disparities in Canada are increasing. In a 1999 report for the Centre for Social Justice, Armine Yalnizyan has noted that:

> *In 1973, the top 10% of families with children under 18 earned an average income 21 times higher than those at the bottom ($107,000 compared to $5,200 in 1996 dollars). That ratio goes up and down over the course of each business cycle. But the last two decades have ushered in creeping unemployment, the increasing casualization of work, and real declines in wages paid to young men (under 35).*
>
> *These changes meant the ratio of market incomes for the upper and lower strata ballooned over the 1990s. By 1996 – still near the peak of the business cycle in this decade, and so presumably a 'good' time for reducing income disparities – the top 10% made 314 times as much as the families in the bottom 10% (an average $137,000 compared to an average annual market income of less than $500).* [24]

These figures are for market income, which includes earnings from wages, salaries, self-employment and return on investments. When transfers from government income support programs are included, the poorest 10% earned $13,522 (the lowest amount, in 1996 constant dollars, since 1973), while the richest 10% earned $138,177 (higher than in previous years and including an average of $1,177 per person in government transfers). When total income is used, the top 10% received 10 times as much as the lowest 10%.[25]

Yalnizyan has also documented the parallel reduction in Canada's middle class. While the richest and poorest groups in Canada got bigger, the number of middle-income earners declined. She compared the number of families earning in a "comfort zone" of $31,666 to $55,992 (in 1996 dollars) in 1973 and one generation later, in 1996. While 40% of Canadian families earned in this range in 1976, the number had decreased to 27% in 1996.[26]

For Canadians, who have undergone a massive reduction in social benefits (including social assistance rate reductions, reductions in the number of Canadians eligible for Employment Insurance benefits, reductions by the federal government in health and other transfers to the provinces) as well as the increased income inequalities described by Yalnizyan, these data should be of concern.

Economic inequalities are increasing in Canada and the international research shows that increased economic inequalities lead to decreased health for all members of a society. For example, **Dennis Raphael has noted that after decades of rapidly increasing economic inequality, the most well-off adult men and infants in Britain now have higher death rates than their least well-off counterparts in Sweden.**[27] Future researchers may find increasing disparities in the health of Canadians and a deterioration of the health and/or longevity of Canadians if we allow income inequalities to continue to grow.

women's health clinic

3. How has the connection between income and health been explained?

Dating back to the publication of the *Black Report* in England in 1980, there have been four main explanations for the connection between income and health. These are as follows:

1. class differences in health are explained as an **artefact of measurement** with no causal meaning. This theses is not widely accepted.
2. class differences in health are the result of a **process of natural and social selection**. That is, ill health leads to reduced income and socioeconomic status. A case can be made for this when examining serious mental illnesses, intellectual disabilities and those physical disabilities which, because of social and physical barriers, impede one's capacity to earn. However, this does not explain the connection between income and health which is present across societies.
3. class differences in health are the result of **material or structural factors**. That is, individuals' choices are constrained by their life material resources. This explanation has had the broadest support among researchers, including the authors of the Black Report and the recent British Independent Inquiry into Inequalities in Health and, in Canada, by the National Forum on Health.
4. class differences in health are the result of **cultural and behavioural factors**. That is, lifestyles are associated with social class and lower class people smoke and drink too much, make poor dietary choices and do not exercise enough. This is not well supported by research. Recent Canadian data by Vivienne Walters and Margaret Denton[28], described below on pages 31-32, demonstrate that in a recent large Canadian sample, structural determinants of health accounted for significantly more variation in health status than did behavioural factors.

Sally MacIntyre has provided a further elaboration of "hard" and "soft" versions of each of the above explanations in the following chart.[29]

EXPLANATION	"HARD VERSION"	"SOFT VERSION"
Artefact	No relation between class and mortality; purely an artefact of measurement	Magnitude of observed class gradients will depend on the measurement of both class and health.
Natural/social selection	Health determines class position, therefore class gradients are morally neutral and explained "away".	Health can contribute to achieved class position and help to explain observed gradients.
Materialist/ structural	Material, physical conditions of life associated with the class structure are the complete explanation for class gradients in health.	Physical and psychosocial features associated with the class structure influence health and contribute to observed gradients.
Cultural/ behavioural	Health damaging behaviours freely chosen by individuals in different social classes explain away social class gradients.	Health damaging behaviours are differently distributed across social classes and contribute to observed gradients.

She notes that the authors of the *Black Report* accepted both the "hard" and "soft" materialist explanations and rejected only the "hard" versions of the other explanations. She then describes a long-term, negative consequence of the focus on this debate:

> *The 'big question' addressed in much of the research literature following the Black Report was: 'how much can artefact, selection or behaviours contribute to observed social class gradients in mortality?', to which the usual answer given was 'not much'. This can be seen as having diverted attention from two other 'big' questions; namely, 'what are the precise mechanisms or pathways by which social inequalities in health are generated and maintained in particular contexts?' and 'what effective actions, if any, can be taken to reduce, or ameliorate the effects of, social inequalities in health?*[30]

It is to this last question that we will return in Section G of this paper, documenting best practices for health services for poor women.

While Health Canada recognizes gender as one of twelve determinants of health, much of the research in population health makes no reference, or limited reference, to the health of women, and the few references that are included deal mostly with women as mothers.[31] The consequences of this are well illustrated in the case of the Whitehall I study of British civil servants

and coronary heart disease. The Whitehall I study was widely seen as the standard reference on coronary heart disease risks in humans. It contained no data about women and so the risk factors for coronary heart disease in women were completely excluded, at the same time as the study was accepted as the gold standard reference.

As Patricia Kaufert has noted:

> *being invisible within the determinants of health model may prove deleterious for women and limit our understanding of the ways in which the determinants of health may function differently for women.*[32]

The next section of this paper, will review and summarize a body of literature which has begun to address the connections between the health of women and their socio-economic status.

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E. INCOME AND THE HEALTH OF WOMEN – WHAT WE KNOW FROM THE LITERATURE

1. Measuring Women's Socioeconomic Status

The ways in which women's socioeconomic status and their health are connected is determined in part by how one measures socio-economic status. The most common methods are:

1. **using the woman's own occupation (individualistic approach)**. This is problematic because it may underestimate women's actual socioeconomic status, since many women with partners may work part-time or may re-enter the labour force after an absence to care for young children at a lower occupational grade than that which they previously occupied. In a prospective study of all of the children born in England, Scotland and Wales during one week in 1958, Matthews et al concluded that they may have underestimated socioeconomic inequalities in women's health by using this approach.[33]

2. **using the "head of household's" occupation (conventional approach)**. This is problematic because it may underestimate the effect of women's own occupations on their health. It is also complex because, since men and women tend to work in different jobs, it combines two different occupational structures. In this approach, a woman's marital status is the sole criterion for deciding which gender-segregated occupational class structure to use.[34] However, research using this method tends to show larger inequalities than research using women's own occupation.[35]

3. **using the highest occupation, income or education level in the household (dominance model)**. Since most women earn less than most men, this method has the same limitations as the conventional model.

4. **using measures of material circumstances**. Some researchers have included housing tenure (in England, comparing those who own their own with those in private rental housing and those in public housing) and car ownership.

5. **using education as a measure of socioeconomic status**. Because of the difficulties in using occupation as a measure of women's socioeconomic status, some researchers have suggested using education. Sara Arber, in the study noted above, found that education was strongly linked to self-assessed health for both English women and men and recommended using it as an alternative indicator of social disadvantage for women, rather than own occupational class.[36] Margaret Denton and Vivienne Walters found that education was an important predictor, for both men and women, of both self-perceived health and functional health in a recently published study using data from the Canadian National Population Health Survey.[37]
6. **using neighbourhood as a measure of socioeconomic status**. This is the method currently used in analyses of Manitoba Health Services Insurance Plan data by Patricia Kaufert of the University of Manitoba and by the Manitoba Centre for Health Policy and Evaluation. By linking Manitoba Health data with Census Canada data for census subdivisions, they have grouped neighbourhoods into income quintiles and compared the patterns of health services utilization among those quintiles for women and men. This method has the advantage of avoiding all of the problems associated with defining women's socioeconomic status by occupation. It includes a measure of material circumstance, noted by other authors to be important in understanding health inequalities. The weaknesses of this method are that it works best in urban areas and that it uses a measure of socioeconomic status which is generalized to the level of the neighbourhood, rather than a specific individual or household measure of socio-economic status.

Each of the measures above which use some measure of household income (2, 3, 4 and 6) are further limited by the assumption that income is equitably distributed within a household. Work done for the 1992 Report of the Women and Taxation Working Group of the Ontario Fair Tax Commission, suggested that it is misleading to assume that income within a family is pooled so that all family members have equal access to it. They found that this was particularly true in families where wife abuse occurs.[38]

2. How Health Is Measured

In the studies which are reviewed below "health" is measured in two ways:

"**Self-perceived health**" is how survey respondents describe their own health. A scale from "very poor" to "very good" is usually used.

"**Functional health**" is a more objective measure because respondents answer one or more questions about their ability to perform the tasks of daily living, or they are asked about "limiting, long-standing illnesses"; that is, conditions which in some way limit their ability to function in the world.

Both measures provide valuable, but different, information about health.

3. Current Knowledge – Women's Health & Socioeconomic Status

Understanding women's socioeconomic status is more complicated than doing so for men because women earn significantly less than men throughout Canadian society, 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. So,

whereas for men, occupation is a good measure of socioeconomic status, for women, the situation is more complex. If they are married, then their own occupation and/or income may not be a good predictor of the material resources available to the household. It is, however, important not to ignore women's own occupations in analyzing socioeconomic status and health. To do so risks missing important data on women's occupational health.

Given the above complexities, most researchers have found that the connection between health and socioeconomic status for women is less consistent for women than for men. In reviewing the literature in a recent article, Sharon Matthews, Orly Manor and Chris Power stated:

> *...there is some evidence that the magnitude of SES inequalities differs, with women having shallower gradients than men across a broad spectrum of morbidity measures and mortality. Although smaller SES inequalities for women are cited frequently, there are studies in which men and women have similar SES gradients (using both occupational and non-occupational measures of social position).*[39]

One very recent and notable exception to the previous pattern of a weaker connection between socioeconomic status and health for women than for men is the recent article by Margaret Denton and Vivienne Walters. They examined a group of 15,144 Canadians who participated in the 1994 *National Population Health Survey* and found that:

> *self-perceived health and functional health were associated with education and income for both men and women, but the* ***effects appear stronger for women than men****.*[40] (emphasis added)

Sara Arber has noted that socioeconomic status is used to measure two things which may be quite different for women – the influence of the material circumstances of her household on her health and the influence of her own paid employment on her health.

For men,

> *these two aspects of material position work in concert to increase inequalities in health, since a man's occupation is assumed to be both a primary determinant of his material circumstances and has a direct bearing on his health.* [41]

Denton and Walters used a combination of measures of income adequacy, level of education and occupation to measure socio-economic status. Interestingly, they found that when they controlled for education and income, occupational status was not a predictor of health status, with a few notable exceptions.

One interesting exception was that the functional health status (a combined measure of vision, hearing, speech, ambulation, dexterity, cognition, emotions and pain and discomfort) of women was the reverse of what might be expected, with women in higher status occupations reporting poorer health. The authors state:

> *It may be that these jobs are more tolerant of disability than are blue collar and service jobs which will be more physically demanding. This possibility alone points to the complex explanations that may underlie associations; we cannot always assume the direction of relationships, even when interpretations are grounded in theories of the social production of illness.* [42]

Arber found similar results in her examination of the health of women and men in the British General Household Survey. She found that women in Class 2 (lower professionals, technical workers, managers and employers in small establishments) reported higher levels of chronic illness than women in semi-skilled and unskilled jobs.[43]

In order to accurately measure women's socioeconomic status it is therefore necessary to use more complex measures than women's own occupations and to recognize and understand societal differences which influence women's socioeconomic status; for example, women's patterns of labour market participation, parenting leave entitlements and the extent of wage discrimination against women.

As Arber noted,

> *(w)hich approach explains the most variance in women's health may differ between societies and within the same society over time, because of differences in the structure of women's employment. For example, in Finland, 90% of women work full-time throughout their working life, and their own occupation has a strong influence on their health.*[44]

In Canada, where labour market participation rates among women are lower, and where systemic discrimination means that for married women, their own occupation or earnings may not be reflective of the socioeconomic status of the family, this is an important consideration and one which is demonstrated in

Denton and Walters' finding that occupation was not a strong predictor of women's health status.

More recently, in her background paper for the British Independent Inquiry into Inequalities in Health, Sara Arber has argued for:

> *the importance of using a clear conceptual model of the linkage between socio-economic measures such as educational qualifications, occupational class, employment status and material resources (such as housing, car ownership and income) in order to fully understand inequalities in health. It is necessary to simultaneously analyse all these factors using multi-variate models, and for women with partners to take into account both their own characteristics and the socio-economic characteristics of their partner.* [45]

Researchers in Manitoba may have the opportunity to do this using the results of the 1996 National Population Health Survey (NPHS). In Manitoba, the provincial government paid for the cost of increasing the sample size, so that conclusions which are stronger statistically may be drawn from the data. It may be possible to build on the work of Denton and Walters, specifically for Manitoba, by combining the Manitoba NPHS data with Manitoba Health's existing health services utilization data. This would provide a unique opportunity to pursue these questions, and their answers, locally.

Like Denton and Walters, Arber looked at both an objective measure of health (limiting long-standing illness) and a subjective measure of health (self-assessed health). She found an interesting difference between the two measures. In her study, both car ownership and housing tenure were significantly associated with self-assessed health, but not with limiting long-standing illness. For both women and men, those living in public housing and those with no car in the household reported poorer health. She noted that car ownership was a particularly salient issue for women's self-assessed health.[46] She further noted that "adverse material conditions have a particularly negative effect on self-assessed health if women are not in paid employment." [47]

In a smaller, in-depth study of women in Liverpool, Ruth Young conducted a "time-space analysis" of women's health-related behaviours,[48] which included factors such as car ownership and housing status, as well as income, access to telephone service, task sharing within the household, location of employment and access to public transport. She developed a framework, with four scales of "time-space constraint" which work in concert to influence the ability

of women to care for their own health. These four scales are:

1. economic and social resources;
2. domestic labour and caring constraint;
3. paid employment constraint and
4. individual health status.[49]

The first three are the result of socioeconomic status and the fourth, the health of the individual woman is correlated with socio-economic status. **She noted that women are the health managers in a majority of British households, regardless of class or ethnic group. For women in lower socioeconomic groups, this may have negative consequences.**

> *In circumstances of scarce available time and few resources, therefore, women may 'choose' to neglect their own health needs in order to achieve the best possible overall outcome for the family. Consequently...behaviours which can look 'irrational' or 'unreasonable' to health professionals often have readily understandable origins in the complex and socio-spatial structures which constitute women's everyday lives.* [50]

The image of the self-sacrificing mother who, when faced with inadequate resources, gives greater importance to the needs (and sometimes wants) of her family, rather than to her own needs, is one which is well entrenched in Canadian society. This has been compounded by cutbacks in health services, which increase the burden on family members, mostly women, to care for their ill relatives. The extent to which women's altruism, which is socially valued and publicly lauded, is actually detrimental to women's health, is not known.

Denton and Walters, in their analysis of the National Population Health Survey data, looked at behavioural as well as structural determinants of health. The behavioural determinants they included in their analysis were smoking, alcohol consumption, physical activity and over/underweight. The structural determinants which they included were age, family structure, social economic condition, main activity and social support.

It is noteworthy that they found that for self-perceived health, structural variables explained 19% of the variation for both men and women, while behavioural determinants accounted for 15% of the variation for men and 11% for women. For functional health status, structural determinants accounted for 21% of the variation for men and 24% for women, while behavioural determinants accounted for 9% of the variation for both women and men.[51] **This means that for the women in this study, lifestyle factors accounted for less than 40% of the variance explained by structural factors.**

This is noteworthy and should be considered in planning projects aimed at improving women's health status. It suggests that a focus on access to health services or on lifestyle factors (diet, exercise, smoking and alcohol consumption), rather than on structural factors which influence health, will be less successful than those which include an understanding of the impacts of the structural determinants of on the health of women.

4. The Connections with Employment Status

We know from the work described above, that household income and women's own education are strongly linked to their health and that women's own occupation is less strongly associated with inequalities in health.

Bonnie Janzen, in her recent literature review published by the Prairie Women's Health Centre of Excellence, described the complexities in understanding the connection between women's employment status and inequalities in health:

> *The relationship between health and employment among women is complex. Available evidence suggests that paid work may certainly have a positive influence on women's well-being as a result of increased income, social support, and self-esteem. On the other hand, the potential negative consequence of employment on health also exist, such as the stresses associated with the 'double day,' or the psychological, physical, and/or chemical hazards of a particular work environment. Furthermore, much of the evidence on women, work and health is based on cross-sectional studies, making it difficult to differentiate between 'healthy worker effects' and/or employment as contributing to better health.*[52]

In their work analyzing the *National Population Health Survey* (1994) data on this question, Denton and Walters concluded that their findings supported the literature on the health benefit to women of working outside the home. **Contrary to the idea that caring for children would add to the stress and workload of women and possibly diminish their health, they found an association between better** functional health and women working a "double day" of paid employment and caring for children. In trying to understand why this occurs, they hypothesized that:

> *It may be that the 'double day', through role enhancement, promotes health, at least for some women. Or there may be a selection effect such that only physically healthier women are able to take on such demanding roles. Indeed, both explanations may be relevant.*[53]

5. Inequalities and the Health of Aboriginal Women

5.1 JURISDICTIONAL ISSUES

Jurisdictional issues, and their implications for the provision of health care services, are a major issue in any discussion of the health of Aboriginal people.

In 1867, the *British North American Act* placed "Indians and lands reserved for Indians under full legislative authority of the federal government, while at the same time placing health and social services under provincial jurisdiction"[4] Yet of all of the treaties signed between the Crown and First Nations, only Treaty Number 6 made specific reference to health care:

> *In the event hereafter of the Indians...being overtaken by any pestilence, or by general famine, the Queen... will grant to the Indians assistance...sufficient to relieve them from the calamity that shall befallen them... A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians.*[55]

The *Indian Act of 1876* obligated the federal government to take responsibility for the provision of health care services on reserves. It stated that the federal government had the responsibility to:

prevent, mitigate and control the spread of diseases on reserves...to provide medical treatment and health service for Indians, to provide compulsory hospitalization and treatment for infectious diseases...and to provide for sanitary conditions... on reserves. [56]

The Government of Canada currently provides health care services only to Aboriginal people living on reserves. It has argued that because "all Native people are included in the calculation of transfer payments to the provinces, Natives should be afforded the same health services available to other provincial residents." [57] Health services on reserves are provided by the Medical Services Branch of Health Canada. Other government services on reserve are provided by Indian and Northern Affairs Canada.

5.2 DATA ISSUES

The National Forum on Health noted that Aboriginal women face a heightened risk of a wide range of health problems including both increased morbidity and mortality.[58] Yet, data about the health of Aboriginal people is scarce. This was noted in the 1999 Statistical Report on the Health of Canadians, which stated in part:

> *One issue that cuts across almost all sections, however, is the relative paucity of data on Canada's Aboriginal population and on marginalized groups such as street people. While most of the topics in this Report describe at least 97% of the Canadian population, it is important to remember that the missing 3% often have a disproportionate share of health problems.*[59]

Aboriginal people, including Aboriginal health professionals have strong views on the collection of health data. In March 1999, the Health Canada's Advisory Committee on Women's Health Surveillance held a workshop to discuss the development of its plan of action.

Dr. Judith Bartlett, of the Aboriginal Health and Wellness Centre of Winnipeg stated the following during the closing plenary session:

> *There needs to be a separate or enhanced surveillance system for Aboriginal peoples, particularly Métis, non-status and off-reserve First Nation people. There are no data available except for those that are extrapolated from on-reserve First Nations. The approach to issues and concerns as expressed by the mixed group of women participating in this Workshop is not relevant or contextual to Aboriginal women (for example, the discussion of fatigue or stress). The approach to the disease entities must be holistic; data needs to be collected within an Aboriginal framework and owned by Aboriginal people. Several years ago, a National Aboriginal Women's Conference held in Winnipeg clearly reported that they did not want to discuss specific diseases (need to be holistic and look at root causes), nor did they wish to discuss women's health in the absence of a discussion of men's health. Analysis of Aboriginal data must not be undertaken without Aboriginal participation – at all levels – from initial determination of research questions to data*

analysis, dissemination and resultant policy and program development. Additional rationale for specific focus and control of Aboriginal data lies with the constitution. [60]

Given these reservations, the following information is presented on the health status of Aboriginal women.

5.3 HEALTH STATUS

Aboriginal women have shorter life expectancies than Canadian women as a whole. Data from Indian and Northern Affairs Canada (which includes only those First Nations people whose names appear on the Indian Register maintained by Indian and Northern Affairs Canada) indicate that the life expectancy of Registered Indian women has increased over time, from 65.9 years in 1975 to 75.7 years in 1995. While the gap in life expectancy between Registered Indian women and all Canadian women has decreased over time, it is still significant. In 1995, all Canadian women had an average life expectancy at birth of 81.4 years. That is, they could be expected to live almost six years more than Registered Indian women. This gap has decreased steadily over time.[61]

Aboriginal girls and women are more likely than other Canadian women and girls to die as the result of violence. In the period from 1989 to 1993, Registered Indian women were 2.4 times more likely than the total Canadian female population to die as the result of violence. The age-standardized mortality rate resulting from violence was 84.0 per 100,000 for Registered Indian women and 30 per 100,000 for all Canadian women.[62]

Aboriginal women are also more likely to take their own lives. **In the period from 1989 to 1993, Registered Indian girls and women committed suicide at over three times the rate of all Canadian girls and women** (17.4 per 100,000 compared to 5.5 per 100,000).

The 1999 Report of the *First Nations and Inuit Regional Health Survey* contains some useful information about the health status of Aboriginal women and men. The Survey was conducted in 1997 in nine regions of Canada, including Manitoba. It is not representative of all Aboriginal people, since only people living on reserve and Labrador Inuit were included.[63]

The survey included information about health status by age and gender, as summarized in the following chart, which shows the percentage of male and female respondents in each category:

TABLE 8

FIRST NATIONS AND LABRADOR INUIT PEOPLE SELF-PERCEIVED HEALTH STATUS BY SEX AND AGE

	15 to 29Years		30 to 54 Years		55 & Over	
Health Status	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Very Good - Excellent	67%	57%	51%	49%	31%	24%
Poor - Fair	33%	43%	49%	51%	69%	76%
No Chronic Conditions	77%	66%	56%	44%	20%	13%
At Least One Chronic Condition	24%	34%	44%	56%	80%	87%

SOURCE: "Activity Limitations and the Need for Continuing Care", page 161 in *First Nations and Inuit Regional Health Survey*

This survey found that in every age group, Aboriginal and Inuit women reported poorer health than their male counterparts. These women also developed chronic conditions earlier in life than the men surveyed. In the youngest age group (15 to 29 years of age), over one-third of the Aboriginal and Inuit women surveyed reported at least one chronic condition, compared to one-quarter of their male counterparts. By age 55, the gap between women and men has narrowed, but the absolute numbers remain staggering. Only 13% of women aged 55 years and over reported no chronic health conditions and only about one-quarter defined their health as "very good to excellent".[64]

In analyzing which chronic conditions contributed to these findings, the authors noted that "younger women reported higher rates of respiratory, cardio-vascular and arthritis problems, whereas younger men reported higher rates of diabetes." [65]

The following chart, based on a chart from the *Second Diagnostic on the Health of First Nations and Inuit People*, compares data from the *First Nations and Inuit Health Survey*, with information about the general Canadian population from the 1994/95 National Population Health Survey. Note that "FN&I" refers to "First Nations and Inuit" and "Gen. Can." refers to the general Canadian population.

TABLE 9

CHRONIC DISEASES BY SEX FOR FIRST NATIONS AND LABRADOR INUIT PEOPLE COMPARED TO THE GENERAL CANADIAN POPULATION

Condition	FEMALE		Ratio FN&I/ Gen. Can	MALE		Ratio FN&I/ Gen. Can.
	FN&I	Gen.Can.		FN&I	Gen.Can.	
Heart Problems	10%	4%	2.5	13%	4%	3.3
Hypertension	25%	10%	2.5	22%	8%	2.8
Diabetes	16%	3%	5.3	11%	3%	3.7
Arthritis/ Rheumatism	27%	18%	1.5	18%	10%	1.8

SOURCE: Second Diagnostic on the Health of First Nations and Inuit People, page 7, based on data from *First Nations and Inuit Regional Health Survey* (1999) and *National Population Health Survey* 1994/95

For each of these four conditions, Aboriginal women and Aboriginal men bear a greater burden of illness than the total Canadian population. Of the four conditions, Aboriginal women are the group most likely to suffer from three of these (hypertension, diabetes and arthritis/ rheumatism), while Aboriginal men are the group most likely to suffer from heart problems.

5.4 ACCESS TO HEALTH SERVICES

Aboriginal women face additional barriers in gaining access to health services. For example, they are less likely than other Canadian women to have regular Pap tests to screen for cervical cancer. A study by H. F. Clarke et al, looked at the

Cervical Cytology Screening Program in British Columbia. The authors found that "First Nations women's participation is "less regular and less frequent than other women B.C." [66] They found three main reasons for this:

1. **Knowledge** – Most of the women surveyed had no or little information about Pap testing. Most women found out about the Pap test during their first test or during their pregnancy. Some of the women reported that Pap tests were conducted without their knowledge and/or consent, and that they only found out when the results were reported back to the women. Most of the women also indicated that the procedure was embarrassing and intimidating, and most "objected to getting fully undressed and being exposed on the examining table." Some of the women attributed this discomforting feeling to past sexual and physical abuse.

2. **Inhibiting and facilitating factors** – Several elements inhibited the women surveyed from having Pap tests. These included: travel away from their home communities, lack of knowledge of doctors who were receptive to the Aboriginal people, and the feeling that doctors' offices and clinics were cold and uninviting or located in unsafe neighbourhoods. Most women reported that health care workers (male doctors, nurses) were insensitive and that "sometimes a negative or even discriminatory attitude [was shown] to a person of First Nations ancestry".

3. **Health practices and supports** – Most of the women surveyed indicated that they obtained most of their health-related information from friends and family, rather than from health care professionals. Some of the women also reported that health prevention was an "abstract concept and has a negative health focus…[while] health-promoting knowledge and practices focus on staying healthy and are a positive approach that provides potential for greater personal control in making choices." [67]

women's health clinic

First Nations and Inuit people surveyed for the *First Nations and Inuit Regional Health Survey* also provided information about access to health services. The authors found that:

> *A vast majority of First Nations and Labrador Inuit people had stated that they do not have the same level of health services as the rest of Canadians... Only 29% of people with activity limitations, compared to 35% of people with no limitations, agreed that they have the same level of health services.* [68]

5.5 KEY INFORMANT INTERVIEWS

The Aboriginal women who were interviewed for this paper also provided information and insights about these issues.

Unemployment and the lack of employment equity were identified as factors contributing to poverty among Aboriginal women. It was noted that single mothers in particular face unemployment as an obstacle.

High rates of domestic violence and abuse of all kinds were seen as serious forms of inequality faced by Aboriginal women. Women who were interviewed explained that often abused women have nowhere to go and no one to protect them. They noted that people will often deny or ignore the issue of domestic violence and choose to pretend that the problem does not exist.

The lack of treatment centres specifically designed for Aboriginal women was identified as another health care inequality. One example given was that of a woman who was in need of alcohol addiction treatment but could not receive the help she needed as her former abusive partner was situated at the only treatment centre in her area.

Susceptibility to gambling addictions as a result of poverty was identified as an inequality. Several women cited bingo as being a source for serious gambling addiction among Aboriginal women. Gambling addictions further aggravate the impoverished situations of these women who are already unable to purchase basic necessities. They described these women as not able to afford bingo, but addicted to it.

The rapid growth of cases of HIV among heterosexual Aboriginal women was also identified as a very urgent health issue.

Environmental degradation was also identified as a form of inequality faced by Aboriginal women. One woman explained how environmental damage due to flooding caused by hydro-electric dams has contributed to increased morbidity and mortality among Aboriginal women. Traditional foods eaten by Aboriginal people were nutritious

and not refined or processed, e.g. wild meat, fish, wild rice, marsh potatoes, berries, etc. As a result of environmental degradation, many of these foods are no longer readily available to Aboriginal peoples. Subsequently, the changes in diet from traditional to processed foods has contributed to disease and death. Further, they stated that many women in First Nations communities do not have access to clean, safe drinking water as a result of pollution, flooding and inadequate water treatment facilities.

One woman stated that the biggest inequality is that "nobody wants to listen to what an Aboriginal women has to say about her own health. If an Aboriginal woman points to her left arm and says, 'it hurts', they will say 'no, it hurts right here – and point to her right arm." Finally, another woman made the following comment, "I don't even have the words to describe the inequalities that exist in the health care system for Aboriginal women..."

6. Stress and Socio-economic Status

While a detailed examination of the literature on stress and socio-economic status is beyond the scope of this paper, it is interesting that one of the apparent discrepancies in the literature on gender and inequalities in health is the question of stress. In a 1994 report to the Health Promotion Directorate of Health Canada, using data from the *1990 Health Promotion Survey*, Vivienne Walters, Rhonda Lenton and Marie McKeary found that women in higher income groups were more likely to perceive their lives as stressful than women in lower income groups.[69] This was consistent with earlier work done by Walters and Denton in the Hamilton area.[70]

In the 1994 report, they also found that women with lower levels of education had less stress than women with a university education.[71] Understanding these findings will require in-depth interviews with women to understand how the term "stress" is understood, and how those understandings differ culturally and in women with different levels of education and income.

7. Health and the Socioeconomic Status of Older Women

Most studies of socioeconomic inequalities and health have only examined working age populations. In her background paper

prepared for the British Independent Inquiry into Inequalities in Health, Sara Arber commented on the relative lack of attention paid by researchers to inequalities in both women's health and the health of older people, as follows:

> *The relative neglect of inequalities among these two major population groups may be seen as reflecting both sexism and ageism. One reason for this relative neglect is that the conventional measures of class are often seen as being not applicable for sections of the population who are not currently in paid employment.* ***However, our research shows stark inequalities in health based on the last main occupation of women and men for each age group, including age 85 and over.*** [72] (emphasis added)

The Final Report of the Independent Inquiry contains a summary of the factors which contribute to poor health among older women, including:

1. Older women have a higher low income rate than older men.
2. Low income decreases their chances of maintaining autonomy and independence because of the costs of transport, social care and aids or adaptations to compensate for functional disability.
3. Homes in poor condition are occupied disproportionately by single, older people, the majority of whom are women. These homes have higher heating costs, which again reduces their disposable income.
4. Women of all ages are more likely than men to be reliant on public transport. Fewer women than men own or have access to a car. This gender difference is more pronounced for older women.
5. Fear for personal safety is greater in older women than women of younger ages. This limits their ability to go out alone, yet older women are more likely to live alone than older men and therefore need to go out in order to join social networks.
6. Older women are more likely than older men to suffer from functional impairments sufficient to require help on a daily basis to remain living in the community. [73]

These are also issues for Canadian women. **It is important when making the connections between income and health to include all age groups, not only children and those of working age. The particular needs of older women should be considered in interventions to promote healthy public policies. The development of "best practices" for health care services for low-income women should include attention to the needs of older women.**

8. Gender Inequalities and the Health of Women and Men

What about gender inequalities in a society? Another interesting and relatively new observation in the literature is that, when the fifty states of the United States were studied, gender inequality is strongly associated with both male and female mortality. States where the status of women and men varied the most (measured by rates of political participation, employment, earnings and women's economic autonomy) had higher mortality rates for both women and men but, interestingly, it was men who suffered the most. [74]

In analyzing their findings, the authors state:

> *Higher political participation by women was correlated with lower female mortality rates, as well as lower activity limitations. A smaller wage gap between women and men was associated with lower female mortality rates and lower activity limitations. Indices of women's status were also strongly correlated with male mortality rates, suggesting that*

women's status may reflect more general underlying structural processes associated with material deprivation and income inequality. However, the indices of women's status persisted in predicting female mortality and morbidity rates after adjusting for income inequality, poverty rates and household income. Associations were observed for specific causes of death, including stroke, cervical cancer and homicide. ***We conclude that women experience higher mortality and morbidity in states where they have lower levels of political participation and economic autonomy. Living in such states has detrimental consequences for the health of men as well. Gender inequality and truncated opportunities for women may be one of the pathways by which the maldistribution of income adversely affects the health of women.***[75] (emphasis added)

This very interesting work has begun to address the question of the mechanisms by which income inequalities act on women's health, understanding both the dynamics of economic inequalities in a particular society and gender inequalities in particular. Devising a method by which to apply this research to the Canadian situation may help to increase our understanding of the connections between socioeconomic inequalities and women's health.

F. INCOME AND THE HEALTH OF WOMEN - THE MANITOBA EXPERIENCE

1. Introduction

We are fortunate to have in Manitoba a database about the use of health services by the entire population of the province. The Manitoba Centre for Health Policy and Evaluation has published a series of articles using these data and examining the connections between health status and socioeconomic status in Manitoba.[76] They have found that there exists a strong connection between socioeconomic status and the health of Manitobans, as measured by health service utilization.

Dr. Patricia Kaufert of the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba and Teresa Mayer (a graduate student in the Department) collaborated with us by preparing the following charts which illustrate the connections between income and health services utilization for Manitoba women. The methodology for data collection and analysis is described in Appendix 3.

The charts which follow use per woman health care expenditure as a measure of health care utilization and, therefore, as an indirect measure of ill health. This is not a perfect measure of ill health for a number of reasons:

1. It measures only the costs of those conditions for which women sought medical attention, either in-hospital care or physician services. This may understate the burden of illness encountered by women who manage chronic diseases with infrequent medical intervention.

2. It uses the costs of services provided to women in the same income quintile as an indirect measure of the relative burden of ill health faced by women in that income quintile. That is, it assumes the higher the expenditure, the poorer the health.

3. It measures the cost, rather than the frequency, of health services utilization. Again, this may not accurately reflect the true burden of ill health. A one-time intervention, such as surgery, may be more expensive than the management of a chronic disease, yet the surgical patient may recover completely, while the woman living with a chronic disease may live with reduced functioning on a daily basis.

4. It uses neighbourhood income as a measure of socio-economic status, rather than the socioeconomic status of a particular household.

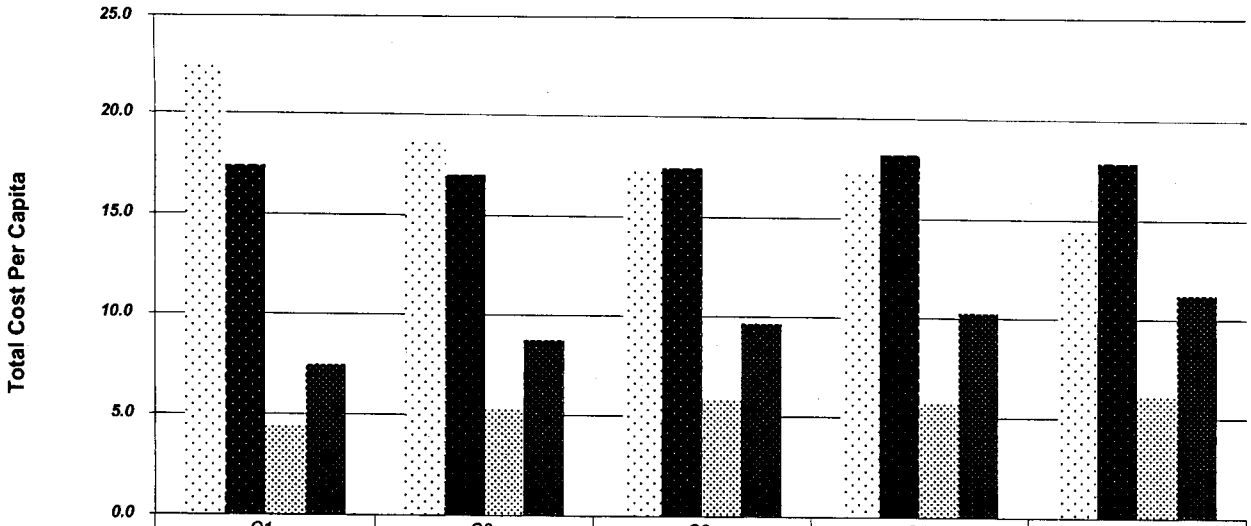
However, given these reservations, it is a reasonable measure to use and allows deeper examination of the connections between income and health specifically for Manitoba women.

These data are presented here in order to contribute to our understanding of these questions and to further debate and discussion. **They are not intended to suggest that low and middle-income women, whose health care costs are higher than those with high incomes, use the health care system inappropriately. The solution lies not with restricting access to the health care system, but rather, in improving the health of the population**.

2. Manitoba Data – Income and Health Services Utilization among Manitoba Women

CHART 1

HEALTH CARE EXPENDITURES ON PREGNANCY, LABOUR AND DELIVERY, CONDITIONS OF THE GENITOURINARY SYSTEM AND BREAST CONDITIONS, 1994-95 PER CAPITA COSTS FOR ACUTE HOSPITAL CARE BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Preg, L&D	22.6	18.8	17.5	17.5	14.6
GU	17.4	17.0	17.4	18.2	17.8
Breast	4.4	5.2	5.8	5.7	6.1
Screening	7.5	8.7	9.7	10.2	11.2

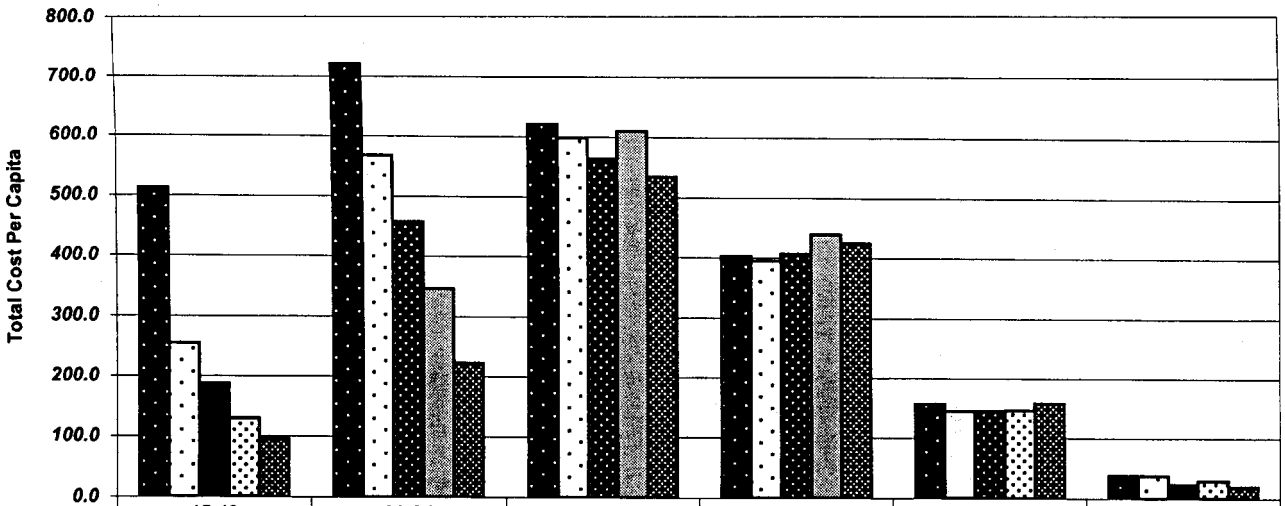
The first chart in this series illustrates the differences in hospital utilization by women in the five income quintiles for three types of sex specific care: pregnancy, labour and delivery[77]; conditions of the genitourinary system such as acute infections, tumours and other diseases; and conditions of the breast.

The data show two trends. Firstly, there is a relationship between income quintile and health service utilization for pregnancy, labour and delivery. Per capita costs (that is the total cost of services divided by the number of women in that quintile) are higher for women in the lowest income quintile than in the highest income quintile and there is a stepwise progression with the costs of hospital care decreasing with each increase in income. However, caution should be exercised in this interpretation, since the extent to which these findings may be the result of higher pregnancy rates among women in lower income quintiles cannot be determined from these data alone.

Secondly, this relationship does not hold true for either conditions of the genitourinary system or of the breast. That is, there is no connection between household income and either of these two groups of diseases. This raises some interesting questions, which cannot be answered by these data alone.

CHART 2

HEALTH CARE EXPENDITURES ON PREGNANCY, LABOUR AND DELIVERY, 1994-95
PER CAPITA COSTS FOR ACUTE HOSPITAL CARE
BY INCOME QUINTILE AND AGE



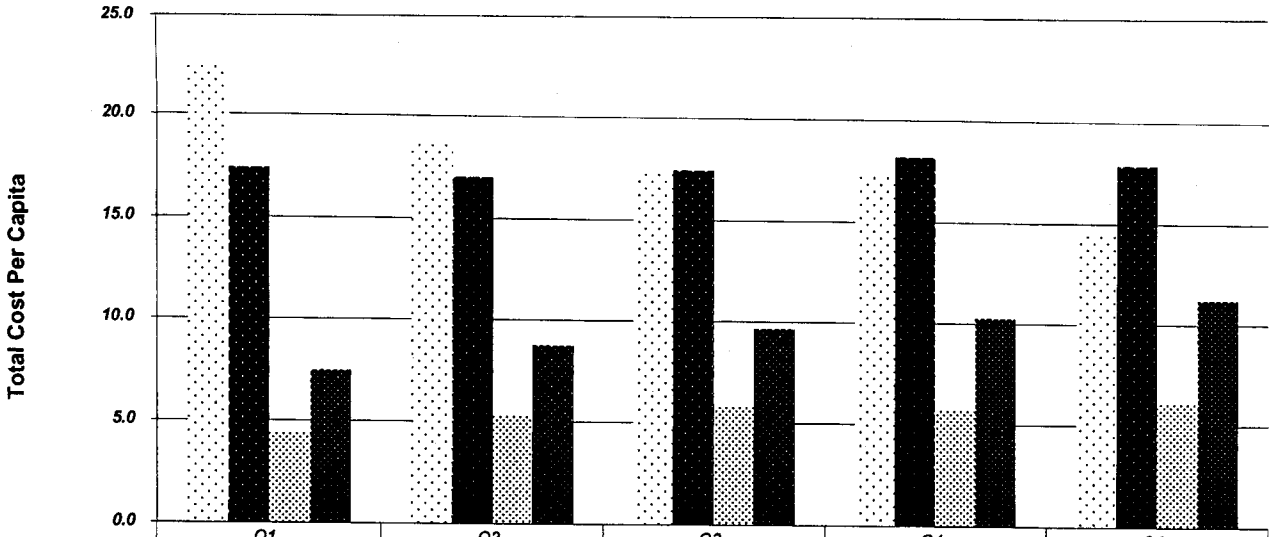
	15-19	20-24	25-29	30-34	35-39	40-44
Q1	512.7	721.7	621.5	402.8	157.3	38.2
Q2	254.7	568.1	598.8	395.0	145.4	37.1
Q3	187.6	457.4	565.4	406.9	144.4	23.3
Q4	129.7	345.7	610.9	439.7	146.0	29.0
Q5	94.2	222.8	534.1	425.3	158.8	19.6

This chart gives a more detailed breakdown of the costs for hospital care associated with pregnancy, labour and delivery by including age as well as income quintile. The connection between neighbourhood income and health services utilization is strongest among younger women. There is no apparent connection between income and health services utilization among women aged 30 to 44.

As with Chart 1 above, the extent to which this may or may not be the result of higher pregnancy rates among lower income women cannot be determined from these data.

CHART 3

HEALTH CARE EXPENDITURES ON PREGNANCY, LABOUR AND DELIVERY, CONDITIONS OF THE GENITOURINARY SYSTEM, BREAST CONDITIONS AND SCREENING, 1994-95
PER CAPITA COSTS FOR PHYSICIAN SERVICES
BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Preg, L&D	22.6	18.8	17.5	17.5	14.6
GU	17.4	17.0	17.4	18.2	17.8
Breast	4.4	5.2	5.8	5.7	6.1
Screening	7.5	8.7	9.7	10.2	11.2

Chart 3 provides data about the three sets of conditions included in Charts 1 and 2, but for the cost of physician services rather than in-hospital care. In addition, information is provided about screening for breast and cervical cancer. Since the costs associated with hospital care are much higher than those for physician services, the per capita costs are much lower.

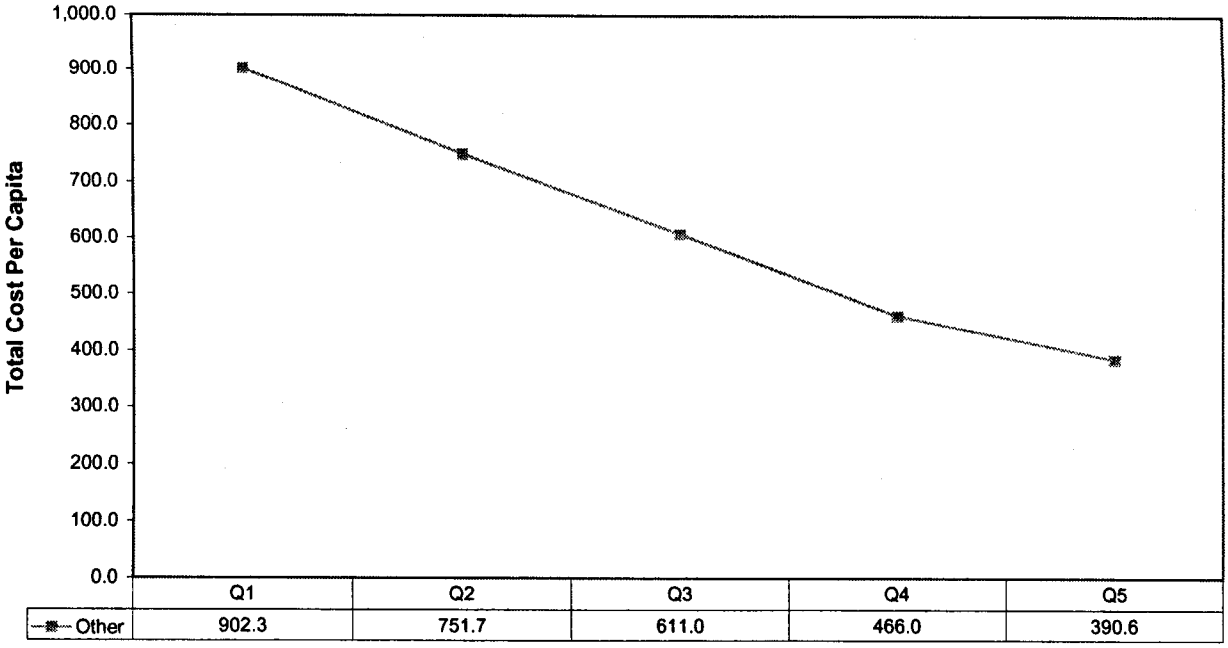
For pregnancy, labour and delivery, the costs of physician care provided to women in the lowest income quintile are higher than for women living in neighbourhoods with higher incomes. The extent to which this is the result of higher pregnancy rates cannot be answered on the basis of these data.

For genitourinary conditions, consistent with the data above describing the use of hospital services, there is no association between income and health care expenditures.

For screening procedures (mammography for breast cancer and Pap smears for cervical cancer) the trend is reversed. This reverse trend is also present for breast conditions.

CHART 4

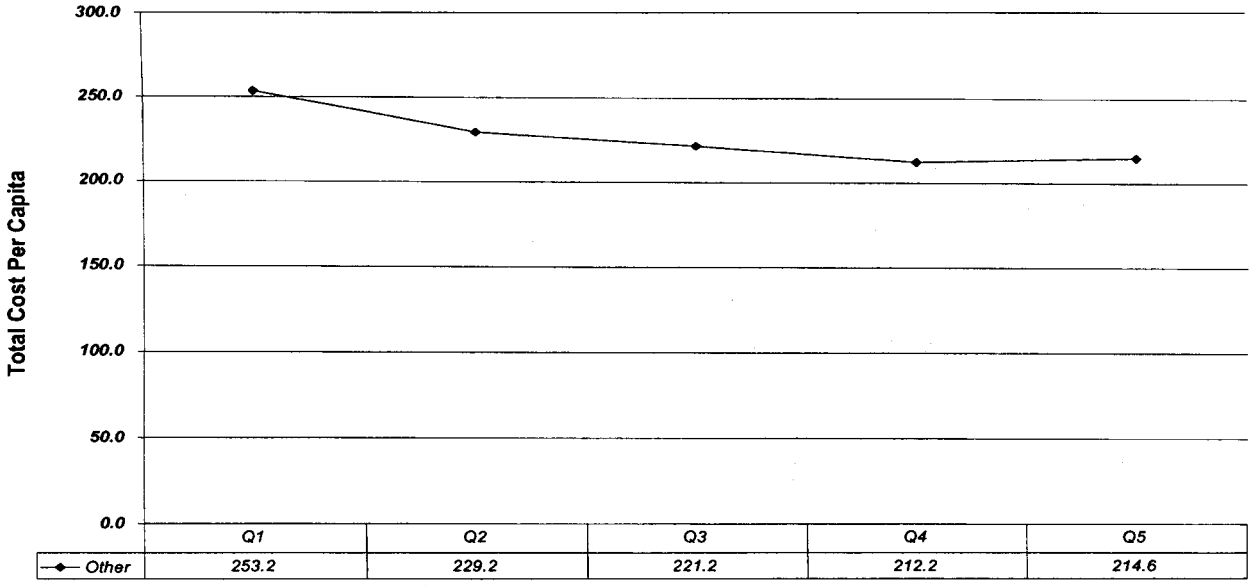
HEALTH CARE EXPENDITURES FOR ALL OTHER CONDITIONS, 1994-95, PER CAPITA COSTS FOR ACUTE HOSPITAL CARE BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Other	902.3	751.7	611.0	466.0	390.6

CHART 5

HEALTH CARE EXPENDITURES FOR ALL OTHER CONDITIONS, 1994-95, PER CAPITA COSTS FOR PHYSICIAN SERVICES BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Other	253.2	229.2	221.2	212.2	214.6

Both Charts 4 and 5 illustrate the connection between income and health services utilization for non sex-specific conditions. Women in lower income quintiles have higher costs than women in higher income quintiles. The connection is stronger for hospital based care than for physician services.

women's health clinic

3. What Does This Mean?

As in other jurisdictions, we have found a connection between income and health services utilization for Manitoba women for most conditions. A strong connection was found in the case of pregnancy, labour and delivery, especially among younger women. Further research would be necessary to determine whether, and to what extent, this is due to higher pregnancy and birth rates among lower income women and/or drift to lower income neighbourhoods as a result of pregnancy and childbirth.

Carole Beaudoin of the Epidemiology Unit, Public Health Branch, Manitoba Health provided some additional data on the subject of pregnancy and income for the City of Winnipeg alone. These data are not directly comparable to that presented in Charts 1 through 5 above. However, it does show that pregnancy rates are highest among Winnipeg women living in the lowest income neighbourhoods, with a stepwise progression downward, so that young women living in Winnipeg's wealthiest neighbourhoods have the lowest pregnancy rates (see Chart 6). These data also show that birth rates were highest, and abortion rates lowest, among young women in the lowest income quintiles. Birth rates decreased, and abortion rates increased, with each income quintile. Pregnant young women in Winnipeg's wealthiest neighbourhoods were least likely to give birth and most likely to terminate their pregnancies. (see Charts 7 and 8)

CHART 6

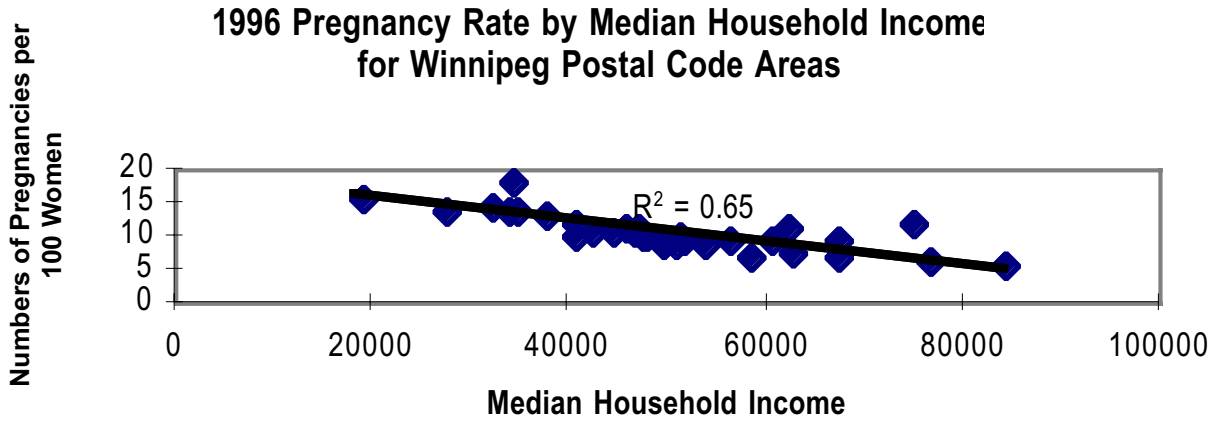


CHART 7

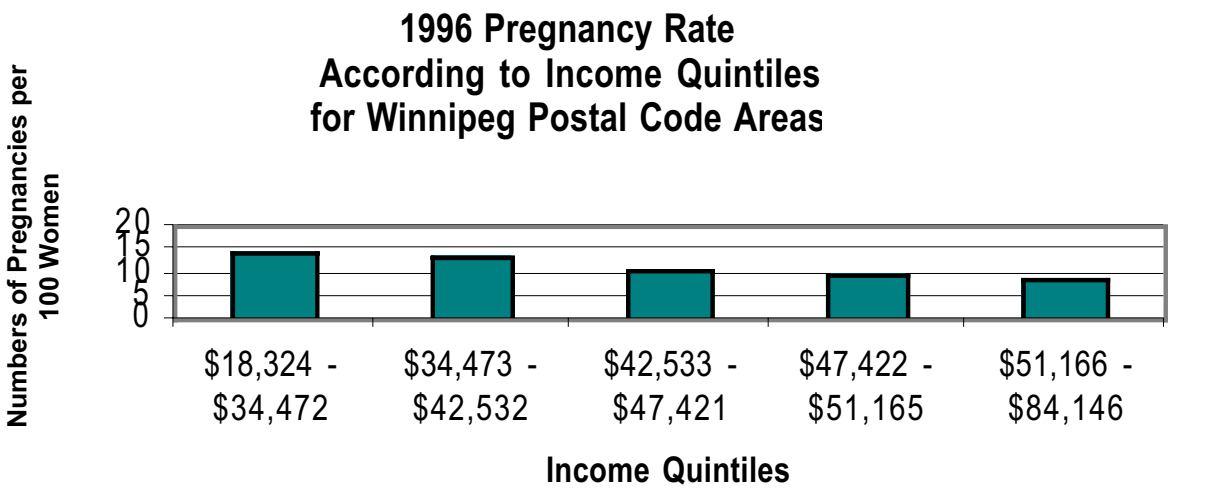
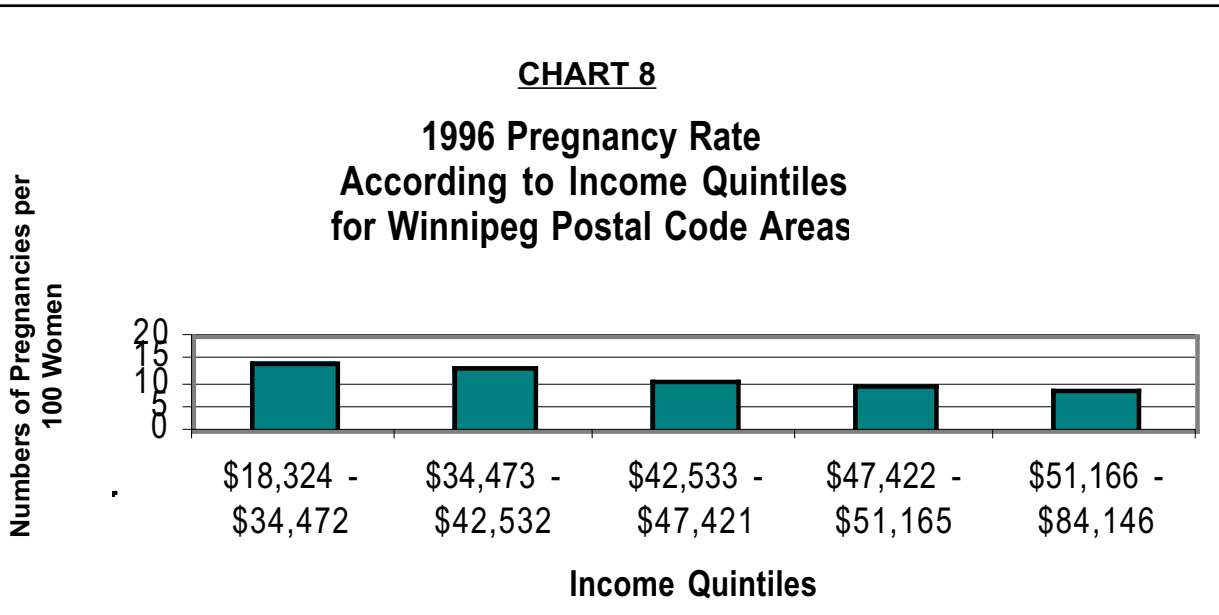


CHART 8



It is interesting to note that there were exceptions to the association of lower income with higher health services utilization costs.

Firstly, there was no connection found between income and health services utilization for conditions of the breast and genitourinary conditions for either hospital based care or physician services.

Secondly, a reverse trend was found for screening procedures – mammography for breast cancer and Pap smears for cervical cancer. This is consistent with the results of other studies, which have found that women in higher income groups are more likely to make use of screening procedures. It is noteworthy that this is true for Manitoba women at each income level. That is, there is a stepwise progression from the lowest to the highest income group.

This may be because women in higher income groups have easier access to care or give more importance to the value of screening procedures for breast and cervical cancer and are therefore more likely to do breast self-examinations, to consult a physician regarding a suspicious breast lump and to be referred to a specialist for further examination and tests.

These data also demonstrate a relationship between income and health services utilization for non-sex specific conditions, the "other conditions" illustrated by Charts 4 and 5.

The health effects of income inequalities increase the burden of illness in all body systems. Discussions of women's health and socioeconomic inequalities must be broad enough to incorporate and build on this information. **Strategies which focus only on reproductive and sex-specific conditions will not be successful in reducing inequalities in women's health.**

G. DESIGNING HEALTH SERVICES TO MEET THE NEEDS OF LOW-INCOME WOMEN

This paper has shown the connections among the issues of income, gender and health. Many health service providers may feel that these issues are beyond their mandate or their expertise. Yet there are practical steps that health services organizations can take to address these issues.

Three models for meeting the health services needs of women living in poverty are presented below. These are:

1. Vancouver/Richmond Vancouver-Richmond Health Board's *Women's Health Planning Project Final Report*.
2. The Commonwealth Secretariat's *Model of Good Practice in Women's Health*
3. The Winnipeg Women's Health Clinic's *Model of Care*

Each of these frameworks include measures which can be taken by health service providers to better meet the needs of low-income women, within their own organizations, with other health services organizations and with other agencies.

1. Vancouver/Richmond Health Board – *A Framework for Women-Centred Health*

In January 2000, the Vancouver-Richmond Health Board (V/RHB) released its *Women's Health Planning Project Final Report*.[78] Following a review of the relevant literature and an extensive consultation process, V/RHB has developed a framework for

women-centred health care services delivery. The adoption of this framework would make the health services delivery system more responsive to, and accessible to, the needs of low-income women. The framework explicitly recognizes the impact of income on the health of women. Excerpts from the framework are included in Appendix 5.

The 11 elements of the framework are:

ELEMENT #1
The Need for Respect and Safety

ELEMENT #2
The Importance of Empowering Women

ELEMENT #3
Involvement and Participation of Women

ELEMENT #4
Women's Patterns or Preferences in Obtaining Health Care

ELEMENT #5
Women's Forms of Communication and Interaction

ELEMENT #6
The Need for Information

ELEMENT #7
Women's Decision-Making Processes

ELEMENT #8
Gender-Inclusive Approach to Data

ELEMENT #9
Gendered Research and Evaluation

ELEMENT #10
Social Justice Concerns

ELEMENT #11
Gender-Sensitive Training

women's health clinic

2. The Commonwealth Secretariat – *Models of Good Practice in Women's Health*

In 1996, the Commonwealth Secretariat published its *Models of Good Practice relevant to women and health, including research, policy, implementation, strategies, testing and evaluation*.[79] The 13 principles included are reproduced below:

SCOPE

(1) Women's health concerns extend over the life cycle and are not limited to reproductive problems.

(2) Women's health problems include, but are not limited to, conditions, diseases or disorders which are specific to women, occur more commonly in women, or have differing risk factors or course in women than in men.

(3) Health must be considered in broad terms and both positively as well as negatively. Dimensions of health include the physical, mental social and spiritual.

DETERMINANTS

(4) Women's health is directly affected by a range of socio-cultural, physical and psychological factors.

(5) Women have gender roles and responsibilities which directly affect their level of access to and control of resources necessary to protect their health. These resources are external (economic, political, information/education, a safe environment free of violence and time) as well as internal (self-esteem, initiative)

(6) Women are diverse in their age, class, race or ethnicity, religion, functional capacity, sexual orientation and social circumstances. These factors may lead to inequalities which adversely affect their health.

COMMUNITY PARTICIPATION

(7) Priority should be given to projects in which the issues have been identified as important by women themselves. Particular attention should be paid to those issues raised by women who are subject to inequities in their society.

(8) Women from the target community should be involved in the planning, implementation, and evaluation or projects involving their health.

(9) Knowledge arising from projects must be accessible to all women but particularly women in the target community. This also means that information must be provided in forms appropriate to different levels of education and literacy.

METHODS

(10) To address the complex issues affecting women's health a broad-based, interdisciplinary gendered approach is needed, involving and bringing together knowledge and methods of social and health scientists and other disciplines where appropriate.

(11) Intersectoral approaches are need to address the social factors affecting women's health and life chances. These may involve the working together of various governmental departments with each other and with nongovernmental and community-based groups and the private sector.

(12) Knowledge from projects should also inform and influence government policies and plans, legislation, research and health care workers.

(13) Where possible, there should be resource sharing of skills within regions.

women's health clinic

3. Women's Health Clinic, Winnipeg, *Model of Care*

The Winnipeg Women's Health Clinic published its revised *Model of Care* in November, 1998.[80] The complete text of the *Model of Care* is reproduced in Appendix 5.

The Women's Health Clinic won the Commonwealth Award for Excellence in Women's Health Practice in 1997. Its *Model of Care* is based on four principles:

1. All women deserve respect and have the right to make informed decisions about their health care. The WHC recognizes the valuable and diverse experiences which women bring to the health care system. In particular, the unique experiences and insights of marginalized women is recognized. Their involvement and participation is seen as essential for the development of quality, culturally appropriate services.
2. WHC is committed to facilitating the empowerment of women, individually and collectively.
3. WHC is committed to a holistic understanding of health, with an appreciation for the interrelationship of physical, social, emotional and spiritual aspects of women's lives.
4. Health promotion, primary prevention and healthy public policies are all recognized as essential strategies for improving women's health.

The WHC's has identified the following as key elements of "woman-sensitive best practices" in the delivery of health care services:

- identifying as priority populations women who are most vulnerable to poor health due to factors such as poverty and women who are more likely to experience barriers in accessing appropriate health services due to their ethnic origin, race, social class, language, sexual orientation or disability;
- providing women-centred services;
- developing a partnership between the women and the care provider;
- using the most appropriate caregiver and services;
- using a team approach;

- designing programs and services to enhance the understanding, self-care, self-help and self-advocacy abilities of women;
- using peer volunteers;
- working in partnership with others in the community;
- reviewing and evaluating its own work;
- developing innovative programs;
- advocating for system change.

4. Aboriginal Women's Experiences

The following information obtained from the seven Aboriginal women key informants interviewed for this project identifies some issues which are specific to the situation of Aboriginal women. However, it is also noteworthy that many of the concerns raised by these women are similar to those raised by other women, both in Canada and internationally.

Most of the women who were interviewed expressed dissatisfaction with the current situation of health care service delivery for Aboriginal women. Health Canada, and more particularly, its Medical Services Branch were the main topic of dissatisfaction for Aboriginal women. Hospitals and hospital care were also the subject of scrutiny by those working in health professions.

Much resentment was expressed over the interviewees' experience of the testing of drugs such as Depo Provera on Aboriginal women, and young Aboriginal women in particular. Many of the women expressed anger at what they described as Aboriginal women being used as 'guinea pigs' for drug and other medical testing and that drugs are prescribed to Aboriginal women without obtaining their informed consent. The example of a young Aboriginal woman who had been the subject of a case study for some time was raised. She was described as one of the youngest people to ever be diagnosed with diabetes. Unfortunately, this young woman died at the age of twenty-four. The women wanted to know why she died of renal failure, when so much testing and research was done on her. One woman angrily suggested that Aboriginal people are treated like guinea pigs because the government feels that they are expendable.

Shortages of nurses in hospitals was also identified as a serious problem in the health care system.

In terms of existing programs, the interviewees noted that there are little or no health programs geared specifically towards Aboriginal women.

The interviewees described significant dissatisfaction with Medical Services Branch and a general sense that the Medical Services Branch has eroded rights guaranteed in treaties. Concerns were expressed about the many cut-backs that have been made to non-insured health benefits. It was noted however, that there is a special needs program for non-status people who can not afford to pay for their prescriptions. It requires that an exemption form be

filled out and unfortunately most people are not aware of this and other existing programs. It was suggested that poor women are faced with the impossible choice of deciding whether to buy medication or food.

The strict guidelines of the Medical Services Branch were also seen as problematic. For example, if an Aboriginal person from a rural community or First Nation is terminally ill in hospital, family members would not be able to come and support that person, since the Medical Services Branch will only allow one escort, and that only in extreme situations. One woman said that sometimes a patient is left to die alone and that it is "really inhumane".

Many women had complaints about the racist and discriminatory treatment that Aboriginal women receive in Winnipeg hospitals, particularly during child birth. Of the three Winnipeg hospitals where women give birth, the St. Boniface Hospital was identified as the best overall. At the other facilities, the interviewees felt that staff racism was an issue.

Several complaints were made about the way in which Aboriginal women were treated. Aboriginal midwives, were not yet licensed to practice in Manitoba at the time of these interviews.

(Midwifery legislation was proclaimed in Manitoba in May, 2000.) The interviewees felt that Aboriginal women are not respected by hospital staff. An interviewee described an incident where hospital staff wanted to immediately perform a D&C (dilation and curettage) on a pregnant Aboriginal woman, who was bleeding early in her pregnancy. The interviewee felt that Caucasian women would have been offered an ultrasound to determine the status of her pregnancy, rather than immediately terminating it.

Other incidents were also described where Aboriginal women were given large doses of analgesics during labour. One case that was described involved a young Aboriginal woman who was heavily medicated with Demerol. The interviewee reported that medical staff were trying to give her an epidural anaesthetic, despite the fact that she was too confused by the medication to give her informed consent.

The interviewees identified pre-natal clinics as examples of successful existing programs. It was suggested that if the opportunities were available, Aboriginal women would be able to take better care of themselves. For example, a concern was expressed that few Aboriginal women have regular Pap smears to screen for cervical cancer. Other important health issues in need of improved programs and services were identified as the following; early intervention, childbearing for young Aboriginal women, Elders' health, breast cancer and menopause.

Aboriginal services in hospitals and medical interpreters were also identified as successful and much-needed programs. Many women who come in from outside of Winnipeg have language barriers that prevent them from understanding what medical professionals are telling them about their health.

One woman concluded that "poverty seems to be overall the greatest detriment to Aboriginal women."

H. MAKING PUBLIC POLICY HEALTHIER FOR WOMEN – SUGGESTIONS FOR ACTION

1. The Current Context

We know that health and income are linked. We know that this is true for women and men and that this holds across all income levels. As well, we know that increasing income inequalities in our society make all of us less healthy. **Therefore the connection between income and health is not only a problem for those living in poverty, but for all of us.**

While this may not be new knowledge among those working in health policy or engaged in research, these facts are not well known or well understood by most Manitobans. Those not living in poverty tend to believe that they can isolate themselves and their families from its effects. They believe that poverty is a problem which affects other people, but not themselves.

In addition, decision-makers in areas other than health, in the health determining systems, may not understand the implications which their decisions have on the health of the community.

Most in our society accept poverty as something which is inevitable. Popular culture emphasizes individual action for self-improvement, rather than on community action to reduce inequalities.

One of the challenges faced by health services providers and equity seeking groups interested in promoting a broader view of health promotion, is to find a way to change these opinions.

Activities to increase the awareness of both the public and key decision-makers about the connections between income and health and to promote the development of healthy public policy, sensitive to the needs of low income women, would be one way in which such groups could use this knowledge to make public policy healthier for women.

Such a focus would be consistent with two of the Priorities for Action identified by the Federal, Provincial, Territorial Advisory Committee on Population Health (ACPH) in their 1999 Report, *Toward a Healthy Future.*

The ACPH identified "**improving health by reducing inequities in income distribution and in literacy and education**" as one of its three priorities for action.[81]

The Report suggested the following six key strategies for achieving a more equitable distribution of income in Canada:

- *Increase earning capacities and employment opportunities among individuals and groups that have been left behind. This includes women...*
- *Continue to use tax and transfer/social policies to reduce inequalities among different levels of wage earners...*
- *Review the effectiveness of current programs that provide a safety net for Canadians who require assistance at different times in their lives. The trends described in this report suggest that this may be especially important for older women who live alone...*
- *Recognize the importance of recreation and social services to health and find ways to provide equitable access to these services, regardless of an individual's or family's ability to pay...*
- *Find ways to ensure that all Canadian individuals and families have their essential needs for shelter, privacy and security met.*
- *Develop long-term strategies to prevent hunger in Canada...*[82]

The ACPH identified "*Renewing and Reorienting the Health Sector*" as another of its priorities for action and called upon the health services system to:

> ***Initiate dialogue with other health-determining sectors about the health impacts of policies in sectors outside health and about collective actions that can be taken.***

The Report stated:

> ***Addressing the root causes of poor health will mean working with other sectors to ensure that the general conditions within society support health.*** *This report suggests that there is a need to initiate dialogue with other health-determining sectors, particularly those in the socio-economic domain, about the health impacts of policies in sectors outside health and collective strategies that can be adopted.*
>
> ***The ideal outcome of these collaborations will be healthy public policies in a variety of health-determining sectors, particularly those in the socioeconomic domain. The health sector cannot do it all, nor can it impose its agenda on other sectors. It can, however, initiate dialogue and act as a catalyst for change.*** [83] (emphasis added)

2. Interventions to Promote Healthier Public Policy

There are three broad types of issues about which equity-seeking groups could intervene to promote healthier public policy for women. These are:

1. **Income Issues**, for example, the minimum wage, social assistance rates and Employment Insurance issues.
2. **Expenditure Issues**, for example, telephone and utility rates, child care costs, pharmacare deductibles and the increasing costs to consumers of purchasing health care services no longer provided through the public system;

3. **Health Services Issues**, including working with Manitoba's Regional Health Authorities (RHAs) to help them become advocates for healthier public policy, working with the RHAs in developing and delivering services which are sensitive both to gender and to socio-economic status, delivering their own exemplary programs and providing training to health services professionals.

Additionally, on any and all of these issues, groups could work with women living in poverty, to help them develop the skills in needs assessment, planning, negotiation and self-advocacy, to positively influence the development of public policies which meet their needs and to provide them with the necessary resources to help them to reach these goals.

It is important to acknowledge that the points for potential involvement are vast and range from the wage gap between women and men, to issues of women's labour market attachment, including pension issues for older women, to federal and provincial income tax issues, violence against women and its consequences for victims of abuse and for all girls and women, issues related to women's expected and encouraged role as caregivers for their families and communities, etc.

What follows, then, is not a comprehensive list of such potential interventions. Rather, it includes a few strategic issues, selected on the basis of the following criteria:

1. the desired policy change would clearly improve the health status of low income Manitoba women;
2 health services organizations and other community groups could work in partnership;
3. the desired legislative, policy or regulatory change could reasonably occur within a three year time frame.

3. Income-Related Issues

3.1 MANITOBA MINIMUM WAGE

The connection between the level of the minimum wage and the depth of poverty in a community is straightforward. The minimum wage in Manitoba is currently $6.25 per hour. This is equivalent to a full time, annual salary of $13,000. The chart below shows the Statistics Canada Low Income Cut-Offs for Winnipeg and the **amount by which someone working full-time, earning minimum wage, would fall below the poverty line.**

MANITOBA MINIMUM WAGE

Hourly $6.25
Annual $13,000.00

		MINIMUM WAGE FAMILY - ONE EARNER	
Winnipeg LICOs		**$ Below Poverty Line**	**% Below Poverty Line**
Family of 1	$18,371.00	$ 5,371.00	29.20%
Family of 2	$22,964.00	$ 9,964.00	43.40%
Family of 3	$28,560.00	$15,560.00	54.50%
Family of 4	$34,572.00	$21,572.00	62.40%

SOURCE: Stats Canada, *Low Income Cut-Offs and Low-Income Measures* 75F002M-01007

Having two full time minimum wage incomes reduces, but does not eliminate, the risk of living in poverty. A family of two adults earning minimum wage and one child, would still be $2,560, or 9% below the poverty line. The same family with two children would be $8,572 or 24.8% below the poverty line.

MANITOBA MINIMUM WAGE			
Hourly	$6.25		
Annual	$13,000.00 (one earner)	$26,000.00 (2 earners)	
		MINIMUM WAGE FAMILY - TWO EARNERS	
Winnipeg LICOs		$ Below/ (Above) Poverty Line	% Below/ (Above) Poverty Line
Family of 2	$22,964.00	($3,036.00)	-13.20%
Family of 3	$28,560.00	$2,560.00	9.00%
Family of 4	$34,572.00	$8,572.00	24.80%

SOURCE: Stats Canada, *Low Income Cut-Offs and Low-Income Measures* 75F002M-01007

Manitoba's minimum wage is set by the legislature, following receipt of a report by a Minimum Wage Review Board established by the provincial government. The Review Board normally conducts hearings across the province, which would be an ideal opportunity for intervention.

There is no fixed schedule for review of the minimum wage. Following the last review in December, 2001, the Minister of Labour announced an increase of 25 cents per hour, effective April 1, 2002. This will not have a significant impact on the poverty of low-income earners. More interestingly, the Labour Representatives on the Review called for linking the minimum wage to the Low-Income Cutoffs. Such a proposal would reduce the depth of poverty faced by low-income Manitobans who earn the minimum wage.

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3.2 SOCIAL ASSISTANCE RATES

Manitoba's social assistance rates have not increased since 1993. The current rates, compared to the Statistics Canada Low Income Cut Offs for Winnipeg, are shown below.

Winnipeg LICOs		SOCIAL ASSISTANCE FAMILIES		
		Social Assistance Rate	$ Below Poverty Line	% Below Poverty Line
FAMILY OF 1	$18,371.00	$5,352.00	$13,019.00	70.9%
FAMILY OF 2 (1 adult, 1 child)	$22,964.00	$9,636.00	$13,328.00	58.0%
FAMILY OF 3 (1 adult, 2 children)	$28,560.00	$10,994.28	$17,565.72	61.5%
FAMILY OF 4 (2 adults, 2 children)	$34,572.00	$12,407.88	$22,164.12	64.1%
FAMILY OF 4 (1 adult, 3 children)	$34,572.00	$12,852.48	$21,719.52	62.8%

SOURCE: Stats Canada Low Income Cut Offs 13-551-XPB January 1998 and Manitoba Family Services

Under the previous provincial government, Manitoba moved to a single tiered provincially administered social assistance system in Winnipeg, with plans to expand this into rural and northern areas. **Health service providers could act as a bridge between their low-income clients and the Government of Manitoba to raise awareness of the health consequences of low social assistance rates.**

3.3 CHILD TAX BENEFIT

The Government of Canada provides a Child Tax Benefit to low and middle-income families, payable monthly, and based on the previous year's taxable income. Provinces were given discretion where these funds were payable to families on social assistance. The previous Manitoba government chose to "claw back" the Child Tax Benefit from families living on social assistance. That is, the full amount received from the Government of Canada is deducted from social assistance payments, and these funds are used to finance other programs which the province considers to be beneficial for children living on social assistance. Underlying this decision

is the belief that women on social assistance would not use these funds in a manner which would best benefit their children and that provincially designed, targeted programs are more efficient.

The Government of Manitoba has announced that parents in receipt of social assistance benefits will be allowed to keep any increases in the Child Tax Benefit implemented from 2000 on.

Interested organizations could, based on their experience working with mothers on social assistance, educate decision-makers about the strengths and competences of women on social assistance and the need to return the Child Tax Benefit to them, so that they may use it to act as independent adults, capable of making the best financial decisions for themselves and their children.

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4. Expenditure Issues

4.1 TELEPHONE RATES

In 1998, the Manitoba Telephone System appeared before the Canadian Radio, Television and Telecommunications Commission to make the case for an $8 monthly increase in basic phone rates. MTS argued that, as a newly privatized company, they would be required to pay income taxes and that this cost should be borne by telephone system users through an increase in the basic rate. The CRTC ruled that the increase would not be allowed for 1999, but hinted that they would respond favourably for 2000.

Groups including the Public Interest Law Centre of Manitoba Legal Aid opposed the rate increase, arguing the cost of the taxes should be paid by the company's shareholders and not by consumers. They further argued that it was unfair for MTS to pass on all of the expected income tax costs to residential customers, with business customers not expected to pay any of the increased costs.

Higher telephone costs will mean that some low-income Manitobans will be forced to give up telephone service. In Manitoba, telephone service is not considered a necessity for those living on social assistance. That is, unless one is disabled, the monthly social assistance payment does not include an amount for telephone service. Social assistance recipients, like other Manitobans, would have to absorb the additional cost of any rate increase allowed by the CRTC.

Telephone service is important to health because:

1. it allows for contact in case of emergencies;
2. it allows for routine contacts with health care providers, schools, social service agencies, etc.;
3. it reduces social isolation by allowing for ongoing contact with family and friends. This is especially important for seniors, parents at home with young children and people with physical disabilities.

Manitoba's cold winter temperatures exacerbate these problems. Those living in rural areas also face additional challenges. In First Nations communities, only 70% of residents have telephones. In some communities, this is as low as 40%.

Some American telephone companies offer a "Lifeline" program providing lower rates or a basic telephone service to low-income people. Canadian telephone companies offer no such service. This is another area where health service providers could work with community and consumer groups to promote change.

4.2 UTILITY RATES

Increases in gas and electrical rates disproportionately affect those living on low incomes, since they already spend a greater portion of their income on essential needs. Additionally, low-income people tend to live in less well insulated housing, which is more expensive to heat. In Manitoba's harsh climate, these are basic health issues.

Gas and electrical rates are set in Manitoba by the Public Utilities Board (PUB), following applications by Centra Gas and Manitoba Hydro. They follow no set schedule.

Manitoba Hydro has not applied for any rate increases since 1996. The PUB does not at this point expect an application for a hydro rate increase.

In the last year, gas prices increased and Centra Gas obtained a rate increase.

Although gas prices are now beginning to decline from the high levels of 2001, **interested health service providers could work with consumers groups and others to help make the connection between utility rates and health.**

4.3 HOUSING

Housing costs are a major portion of the budget of most households and housing itself is a factor which influences health. In recent years, the federal government and the past Manitoba provincial government both withdrew support for non-profit and co-operative housing programs, thus leaving those on limited incomes with few alternatives to the private marketplace.

Housing conditions are a major issue for Aboriginal people, both on and off reserves. The Assembly of Manitoba Chiefs has reported that:

> *Canada has a First Nations population of approximately 800,000 people, yet has only produced 76,000 homes from which this population must raise a family and build a community.* [84]

In Manitoba, rents are regulated by the Residential Tenancies Branch (RTB) of the Department of Consumer and Corporate Affairs. The RTB annually sets a guideline, the maximum amount by which a landlord may increase rent without approval from the RTB. For both 1999 and 2000, the maximum allowable rent increase has been set at 1%. Landlords may apply to have rents increased above 1% if they have incurred additional costs, for example, through repairs or renovations.

For families living on social assistance, the maximum allowable rates for rent, as set by Manitoba Family Services (included in the total social assistance rates shown above), are as follows:

Household	Basic Rent	Rent Including Utilities
Single person with disability Single pregnant woman	$243	$285
2 people	$285	$387
3 people	$310	$430
4 people	$351	$471

Prior to 1993, these rates were linked to the maximum rental increase guidelines set by the RTB. They were then de-linked and there has been no increase in the amount paid to social assistance recipients since that time.

These very low rates lead to increased mobility, as families are forced to move to find cheaper accommodation. As families move, children may change schools in mid-year, and children and adults both may lose their connections with neighbourhood supports. The new, less expensive housing may also be more crowded and/or less safe, which may further contribute to a deterioration in health status.

There are a number of ways in which interested organizations could intervene to heighten public awareness of the impact of housing conditions on health.

In urban areas such as Winnipeg, community organizations may be able to work with school divisions, and organizations representing people with disabilities, to raise awareness of the issue of shelter allowances for people living on social assistance with provincial decision-makers.

It is also important to stress the larger issue of the need for affordable housing for all, and of the connection between good housing and good health.

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4.4 CHILD CARE

High quality, affordable, accessible child care programs are essential to the health and well-being of children, their mothers and fathers. Much recent research has focussed on the benefits of early childhood education to children and to society as a whole. (For example, the recent Early Years Report of the Canadian Institute for Advanced Research [85]).

Less has been written about the impact of the gaps in the child care system on the health of women. Yet these are an obvious source of stress for working mothers and for those wishing to find employment outside of the home.

According to the Manitoba Child Care Association (MCCA), child care in Manitoba is underfunded. This underfunding has led to a shortage of qualified staff, as the mostly women employed in child care leave for better paying jobs.[86] As a result, approximately 25% of licensed Manitoba child care centres have received exemptions from the licensing requirement which stipulates the ratios of trained staff to children in centres. In response to these concerns, the Province of Manitoba increased child day care funding by 18%, or $9.1 million, for the 2000-01 fiscal year. This additional funding is important to the child care system, but several key issues affecting low-income women remain. These are:

1. Cost of Child Care

Child care costs in Manitoba, while lower than those in other provinces, are significant. For parents of infants, the annual cost is $7,124 per year. For the parents of pre-school children, the annual cost is $4,794 per year. While the issue of the affordability of university tuition has had some public profile, the issue of the affordability of child care has not. Yet child care fees are much higher per year than undergraduate university tuition fees. At the University of Manitoba, the annual cost of full-time undergraduate study in the Faculty of Arts is $3,100.

2. Subsidies

The Province of Manitoba provides subsidies for parents of children whose annual income is below a threshold amount. For a single mother with one child, the full subsidy is payable only to those whose net earnings are less than $13,787. Although the

difference between net and gross earnings will vary, the Child Care Office of Manitoba Family Services uses an average figure of 25%. In that case, **a single mother with one child in full-time child care whose net earnings were $13,787 would have gross earnings of $17,233. She would, therefore, receive less than the full subsidy, even while living $5,731 below the Winnipeg poverty line.**

For two parents, with two children in care, the situation is even worse. They would lose some of their subsidy with combined net incomes of $18,895. Using the Child Care Office's figure of 25% to estimate the difference between net and gross earnings, **this family would receive less than full subsidy with combined gross incomes of $23,619, a remarkable $10,953 below the Winnipeg poverty line for a family of four.**

3. Parent Co-Payments

Until 1991 parents in receipt of child care subsidies could be charged an additional $1 per child per day for child care. **In 1991, that amount was increased to $2.40 per day, or $624 per year per child. This presents a real burden for many parents, especially for those living in poverty**. Manitoba Family Services will not cover this cost for mothers in receipt of social assistance, whose children are in child care while they take training or look for work.

women's health clinic

5. Health Services Issues

5.1 Health Planning

Manitoba Regional Health Authorities (RHAs) are required to conduct periodic assessments of the health needs of their population and to submit annual health plans to the Manitoba Health. A review of these documents by the author[87] has shown that **RHAs include little analysis of the health needs of low-income women in these documents.**

Interested organizations could work together to assist Manitoba Health in the development and/or selection of health indicators which are sensitive to both gender and socioeconomic status, for use by RHAs. They could also work with the RHAs, to deepen their understanding of the issues of income inequality, gender and health as they develop their next community health assessments.

5.2 Allies in Developing Healthier Public Policy

As the bodies responsible for needs assessment, health planning and service delivery at the local level, RHAs are well positioned to become allies for the development of healthier public policies, rather than only service delivery agents. But to date, they have taken few initiatives to influence the structural determinants of health, such as poverty.

If RHAs are open to such collaboration, interested organizations have the potential opportunity to work with them to help them fulfill their mandate as locally responsive and responsible health agencies, by helping them to make the connections between income, gender and health in their local areas. **The RHAs, because of their unique position, are particularly well positioned to place these issues on the public agenda. However, without some additional resources, such as research, professional development and networking, they are unlikely to do so. These resources might be provided by other community groups with greater expertise in these areas.**

5.3 Delivering Programs that Meet Women's Needs

In Winnipeg, the Women's Health Clinic (WHC) has twenty years of experience in delivering community-based programs to meet the health needs of women. This has allowed the Clinic to develop its own Model of Care and to be recognized

as a leader in the field of women's health. The WHC's practice has been recognized by its receipt of the Commonwealth Prize for Excellence in Women's Health. WHC also has experience working with women from many different cultural groups and women of low income. **The WHC has used this experience to develop exemplary projects, which could be adapted for use by other health service providers.**

WHC and other organizations, especially the Prairie Women's Health Centre of Excellence, could also use their expertise to offer training to staff of other health service agencies, including the RHAs.

women's health clinic

6. Working with Women Living in Poverty to Promote Healthier Policies and Appropriate Services

Some of those who best understand the impact of poverty on health are the women who live that experience. Their voices can be powerful agents for change.

In order to assist women living in poverty to become actively and meaningfully involved in the health planning and community health assessment processes, interested organizations could offer technical support and skills development to interested women, to enable them to take on these roles for themselves. At the same time, work could be done with the RHAs to help them to understand the importance of listening to the voices of these women and to structure their health assessment and planning processes in such a way as to include them.

These organizations could also work with low-income women to find the most appropriate ways to have their voices heard in the broader public policy arena, and to recommend positive changes to existing services.

The above are provided as examples only. They are meant to illustrate some of the steps that health service providers and other community organizations can take to addressing issues of income inequality and, therefore, to improve the health status of low-income women and the community as a whole.

I. FUTURE DIRECTIONS

There are opportunities for decision-makers, health service providers and the public to use the knowledge about the connections between income and health. In order to do this, they must:

1. recognize the many complex and interwoven ways in which income and gender affect health;
2. consider the implications on health of decisions made outside of the health care system;
3. design and re-design health services systems in ways which recognize the needs of low-income women;
4. recognize that the impact of socio-economic inequalities affects all aspects of women's health. **This will require a major shift in the perspective of health planners and health care service providers, to incorporate gender analysis in design, implementation and evaluation throughout the health care system, and not only in those programs with a specific "women's health" mandate.**

While we may not have a detailed understanding of the mechanisms by which income and social status affect health, we know that the connection is there. Now is the time to use the knowledge which we do have to make changes to improve women's health.

APPENDIX 1: SUGGESTIONS FOR FUTURE RESEARCH

The limited availability of data about income and poverty among Manitoba women limited the work completed in this paper. Statistics Canada does provide special data sets upon request; however, the cost (minimum $1200) was beyond the budget of this project.

WHC should consider working with the Winnipeg-based consortium of fifteen organizations, led by the Social Planning Council, which jointly purchases special data from Statistics Canada each year. WHC would then both have the opportunity to infuse a gender analysis into their data selection and to make use of the data obtained. Of particular use would be data on topics such as trends in income levels and poverty rates for Manitoba women, especially for young women, seniors, single mothers, Aboriginal and visible minority women.

The Manitoba Health data provided for this paper was a very useful beginning point. For pregnancy, labour and delivery, the results indicated a correlation between income and health services utilization. Future research which includes birth rates by income quintile would provide a more thorough understanding of the issue.

APPENDIX 2:
ARE WOMEN SICKER THAN MEN?

Women's reported greater use of health care services has led to a general acceptance of the idea that women are sicker than men ("women get sick, men die") and that women are more likely to seek medical attention than men. These ideas are based on a combination of fact (pregnancy, labour and delivery are experiences unique to women) and assumption (women are believed to be more likely to seek help from experts than men). Some recent research has begun to challenge these ideas.

For example, in Manitoba in 1994-95, the per capita cost of providing females with health care services funded by the medicare system was approximately 30% higher than for men. In an article in the *New England Journal of Medicine*, Cameron Mustard and others demonstrated that **after removing the costs of sex-specific conditions** (including, for women, normal and abnormal reproduction, and for women and men, diseases of the genitourinary system and of the breast) **and considering costs for both physicians' services and acute hospital care, that the costs of insured health care services for women were about the same as for men**. That is, the female:male ratio went from 1.3 to 1.0. [88]

The authors did find two important age-specific sex differences in health care expenditures even after adjusting for sex-specific conditions and care in the last year of life. Per capita health care expenditures for elderly men were significantly higher than for elderly women and expenditures for physicians' services were higher for women during their childbearing years. They hypothesized that these differences might be an artefact of measurement, or, alternatively, related to sex differences in the occurrence of illness or in care-seeking behaviour or social roles. Particularly, women in childbearing years, who continue to have the main responsibility for organizing health care for their children, may have increased opportunities for the use of health care services.[89]

While costs of health services are one measure of illness, there is also some research how women and men differently describe their own health and how that is perceived by health service providers.

Macintyre and Pritchard reported on British study of volunteers attending a research unit investigating the common cold. In a double-blind process, the volunteers were inoculated with either a virus or an inert substance. Their symptoms were then assessed, evaluating the presence and severity of their colds by both a trained, medically qualified observer and by the participants

themselves. In this study,

> *women were no more likely than men to assess themselves as having a cold, although the clinical observer was more likely to rate women than men as having a cold. Men were significantly more likely than women to 'over-rate' their cold symptoms compared with the observer's ratings.* [90]

In another study, Sally Macintyre and colleagues studied a group of 1710 women and men in the West of Scotland, about half of whom were in their late thirties and half of whom were in their late fifties. Participants were first asked the standard question used in the annual *British General Household Survey*.

> *Do you have any long-standing illness, disability or infirmity? By long standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?*

They found no significant gender differences in response to this question.[91] In this study then, women were not more likely than men to report illness. But what happened when respondents were probed about the meaning of their responses was interesting.

The researchers prompted the participants with three more questions about their self-perceived health – about other health conditions which seriously affected their health, about their mental health and finally by showing cards with lists of conditions on them. The number of conditions reported increased for both men and women, but the increases were greater for women than for men, **suggesting that women were more stoic than men, reporting fewer of their illnesses in response to a standard question**.[92]

In Denton and Walters' paper analyzing data from the 1994 *National Population Health Survey*, they found that more women (12.7%) than men (10.0%) described their own health as "fair" or "poor". Men also had higher scores of functional health than women.[93] However, these data were presented in a way which did not control for age and socio-economic status. Whether controlling for these variables would make a difference in this particular study is not known.

In Sara Arber and Helen Cooper's analysis of three years of *British General Household Survey* data for older people, they initially found a similar pattern. However, they concluded that:

> *...the original gender difference in self-assessed health in which older women are more likely to report poor self-assessed health is mainly because of their older age on average than men, and because they occupied lower positions than men in the class structure during their working life. When older women's greater likelihood of experiencing functional disabilities is included in the model, this results in a reversal of the gender difference, so that older women are shown to be less likely to report poor health than older men.* [94]

Arber and Cooper found that older women were less likely than older men to describe their own health as poor, suggesting, on the surface, that they were in better health than the men in the survey. However, when information about functional impairment was measured (using six tasks of daily living), women's health status was significantly worse than that of men. They concluded that:

> *This research supports the finding of others studies that there is little gender difference in self-assessed health among older people in the mid-1990s. However, the 'new paradox' that older women have a more positive self-assessment of their health status than men, once age, class, income and their greater level of functional disability are taken into account, requires further explanation.* [95]

What conclusions can be drawn from this research? **Assumptions based on stereotypes about the health of women, about their behaviour when faced with ill health and about their attitudes towards their own health and illness, may be wrong. When policies and programs are based on these stereotypes, problems may result.**

The dangers of such stereotyping in the diagnosis and treatment of women was reported recently in the British popular press. The *British Observer* published an article in May, 2000, entitled *Moaning men push women to the back of the health queue.* The article stated in part:

> *…it is still commonly assumed by doctors, surgeons, nurses and health workers that women complain more often about illness than men.*
>
> *This 'tendency' is blamed on the fact that women are supposed to have greater concerns about their bodies because they undergo menstruation, childbirth and the menopause, while men are conditioned by society to be strong and stoical. 'It is an attitude that permeates the health service though there is no evidence to support it,' added Macintyre. 'Indeed, it points the other way.'*

women's health clinic

The assumption that men are stoical can also have serious consequences as researchers on both sides of the Atlantic have revealed. In one recent US study, male and female actors performed realistic scripts in which they played the parts of patients suffering from chest pains and shortness of breath. They were then examined by a group of 192 doctors who were asked to describe what they would do for their patients in similar circumstances. The results were striking. The doctors plumped for two main diagnoses: either the patient had a severe cardiac problem or a psychosomatic condition in which emotional disturbance, not physical illness, was the cause. Their choice had a great deal to do with the gender of the actors. ***'When confronted with the same presenting symptoms, vital signs, and test results depicted in a professionally acted way, physicians were much less likely to arrive at a cardiac diagnosis in women, treat women medically, believe treatments were necessary or to make health education and lifestyle change recommendations such as quitting smoking,' state the researchers from the New England Research Institute in Boston. By contrast, the doctors were more likely to rate women 'patients' as suffering from emotional problems and to suggest psychiatric treatment. In other words, if you complain of chest pains, you get intense cardiac care – if you are a man. If you are a woman, you could end up undergoing psychiatric treatment.***

'Women aren't supposed to complain of heart disease and so doctors are less prepared to accept that they have it,' said Macintyre. ***'We make all sorts of assumptions, based on unsupported stereotypes – for instance, that men are silent stoics while women are whingers – but do not test them out before we act on them. We have got to change that kind of thinking.'*** [96] (emphasis added)

APPENDIX 3: HEALTH SERVICE UTILIZATION BY MANITOBA WOMEN – EXPENDITURE BY INCOME QUINTILE

(The following description was prepared by Dr. Patricia Kaufert, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba)

The Manitoba Health Services Insurance Plan (MHSIP) provides insurance coverage to all Canadian citizens and landed immigrants who qualify as residents of the Province. Coverage includes entitlement to a comprehensive range of health care services including acute hospital care and physician services without fees, premiums or co-payment charges. The administrative system developed to run this insurance system has created a computerized record of health service utilization by a complete population of over a million people. Extensively used in research, the reliability, concurrent validity and predictive validity of these data are now well established (Roos et al. 1987; Roos et al. 1988; Muhajarine et al. 1997).

This analysis is based on three of the files created as part of this system; they are the Registry file, the Physician Claims file and the Hospital-Separation Abstract file. The Registry file includes information on the age and sex of every individual entitled to coverage (virtually the entire population of Manitoba), their address and a unique identifier number assigned to them by MHSIP as their Manitoba Health (MH) number. The date when an individual first registered with MHSIP is also entered into the file and, if they leave the province or die, the date when their coverage was cancelled.

A second file, the Physician Claims file, is the product of the system of payment to physicians. The majority of physicians in Manitoba are paid on a fee-for-service system with MHSIP as the unique payer. To be eligible for payment, physicians must submit detailed claims cards which include their own code and specialty, the patient's MH insurance number, the type of service provided (tariff), the reason for the visit (diagnosis) and the date of the service. Regardless of the number of other reasons involved, only the diagnosis identified by the physician as most responsible for the visit is entered into the file. Diagnoses are coded using the first 3 digits of the International Classification of Disease, 9th revision, Clinical Modification (ICD-9-CM) diagnostic codes. The Physician Claims file includes all claims for ambulatory care and for care provided by physicians in hospital on either an in-patient or outpatient basis. The few physicians who are on salary submit 'dummy' claims cards. Claims submitted for diagnostic imagining and laboratory tests carried out in privately owned facilities are assigned a tariff code and entered into the Physicians Claims file.

Manitoba Health documents all hospital utilization through detailed separation abstracts submitted by the province's hospitals for every patient they discharge. These abstracts include the patient's MH number, the identification numbers of the attending physician(s), and up to 16 fields of diagnostic and procedure codes. These are coded using the 5-digit ICD-9-CM diagnostic and 4-digit procedure codes.

GENDER-SPECIFIC CONDITIONS

We selected all the diagnoses and procedures specific to either women (such as obstetric care) or men (such as testicular cancer) from the Physician Claim File and the Hospital Separation Abstract File and constructed the following categories: pregnancy and childbirth; 'well woman care'; diseases of the reproductive system; and diseases of the breast.

The second category, 'well woman care' combines the tariff codes for bilateral mammograms, the Papanicolaou (Pap smear) test for

cervical cancer and the ICD-9-CM code for "Encounter for Contraceptive Management". (Tariffs for unilateral mammograms were assigned to the breast disease category on the assumption that their purpose was diagnostic rather than screening.) Use of the PSA test to screen asymptomatic men for prostate cancer is not recommended in Manitoba; therefore, could not serve as an indicator of preventive care, equivalent in men to the Pap smear or the mammogram in women (Lipskie 1998). Separate categories were created for diseases and conditions of the breast and those of the reproductive (or genitourinary) system.

COSTS

The fee paid to the physician is recorded on each claims card, as also are the tariffs paid for any laboratory service or other procedure. Hence, it is possible to calculate the costs of services by summing the amount reimbursed by MHSIP for every claim submitted by physicians or laboratories for the same individual over a given period of time (individuals are identified by their MH number). This analysis uses claims submitted from April 1, 1994 to March 31, 1995. The total fees are combined and tabulated by sex and by 5-year age group.

Hospital care in Manitoba is funded based on a global facility budget rather than a per case basis; therefore, the costs of hospital care cannot be calculated using the same direct method. As an alternative, the Manitoba Centre for Health Policy and Analysis has developed a system for calculating hospital costs based on an adaptation of the refined diagnosis-related-group-method (Shanahan et al., 1994; Mustard et al. 1998). Using this system, we have estimated the costs of acute hospital care on an individual-by-individual basis, tabulating these costs by sex and 5-year age group (Mustard et al. 1998). Per capita costs for physician fees and hospital care costs are tabulated using the 1994 Manitoba population as at the December 1994 registry file.

INCOME QUINTILES

The population was divided into five groups or quintiles based on average neighbourhood household income data derived from the 1986 Canadian Census public use data base. Based on mean household income, the enumeration areas were ranked from poorest to wealthiest and grouped into five population quintiles. Each woman was linked to an enumeration area by residential postal code and a quintile rank assigned with Q1 being the poorest and Q5 the highest.

RESULTS

This analysis is based on the 1,140,200 individuals registered with MHSIP from April 1, 1994 to March 31, 1995. The combined cost of physician services and acute hospital care during this period totalled $1,189,000,000 (Mustard et al 1998). Women made up 51% of the total population of 1,140,200 individuals registered with MHSIP, but their service use accounted for 57% of the total costs. The crude per capita costs of physician services from April 1 to March 31 are $277 for women compared with $198 for men; the costs for hospital services are $887 for women compared with $720 for men (Mustard et al. 1998).Gender specific diseases and conditions account for approximately 23% of the total dollar value of medical and hospital care used by women, but only 3% of the services used by men.

APPENDIX 4: INTERVIEWS WITH ABORIGINAL WOMEN KEY INFORMANTS

As noted in the body of this paper, the data collection for this project was enriched by the inclusion of information from seven Aboriginal women who agreed to be interviewed.

The interviews were conducted by Angela Busch.

The following questions were asked of each participant:

1. Aboriginal Women and Poverty

   a) In your opinion, how does poverty affect the health of Aboriginal women?

   b) How does poverty affect Aboriginal women's health in a holistic sense, in terms of not only physical, but mental and spiritual health, etc.?

2. Inequalities and the Health of Aboriginal Women

   a) In your opinion, what do Aboriginal women face in terms of inequalities in regards to their health?

   b) According to the National Forum on Health, Aboriginal women face a heightened risk of a wide range of health problems including both increased morbidity and mortality. In what way do you see inequalities in health for Aboriginal women playing a role in these findings?

3. Meeting the Health Needs of Poor Women-Best Practises

   a) In terms of pre-existing health services and programs, what has worked and why?

   b) In terms of pre-existing health services and programs, what has NOT worked and why?

Each interviewee answered these open-ended questions in her own way. Some responses were direct, others used stories and personal experiences to illustrate their points or to give the interviewer additional information. There was, therefore, significant variation in the type of responses, all of which were recorded by the interviewer, synthesized, and included in the body of this report.

The seven women interviewed were:

1. **Audrey Leader** - Director of Health (Assembly of Manitoba Chiefs)
2. **Doreen Sanderson** - Assistant to the Director of Health (Assembly of Manitoba Chiefs)
3. **Darlene Birch** - Aboriginal Midwife
4. **Randi Gage** - Aboriginal Elder/Diabetes and HIV specialist
5. **Dee Milberg** - Aboriginal Psych-Health Nurse (HSC)
6. Anonymous Community Health Representative
7. Anonymous Medical Interpreter

We wish to graciously thank each of the above women for their contributions, Ekosi-Meegwetch.

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APPENDIX 5: MODELS OF WOMEN-CENTRED CARE

1. VANCOUVER/RICHMOND HEALTH BOARD

In January 2000, the Vancouver/ Richmond Health Board (V/RHB) released its *Women's Health Planning Project Final Report*. Following a review of the relevant literature and an extensive consultation process, V/RHB developed a framework for women-centred health care services delivery. The adoption of this framework would make the health services delivery system more responsive to, and accessible to, the needs of low-income women. The framework explicitly recognizes the impact of income on the health of women.

The framework includes 11 elements. Excerpts from the framework appear below.

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ELEMENT #1
THE NEED FOR RESPECT AND SAFETY

Understanding this Element

"Addressing women's health in the context of women's lives begins with respect and safety...women want to be listened to; they want providers to accept the validity of their opinions; taking the complexities and diversity of women's lives into consideration...

Many women avoid the health care system because of past encounters where they have experienced discrimination, or felt unsafe or unwelcome. Many women feel their voices are not heard within the health care system. Others find their concerns or contributions are not treated with respect or that the system's response further compounds their problems.

The health care system replicates the values and structures of a society where women have a lower status than men, and face negatives stereotypes on a daily basis...Providers may be unaware of how their language and behaviours discount women's realities...

Respect and safety are also reflected in whether services are accessible to those with different needs, e.g. disabilities, language barriers, child care, past experiences of violence of abuse, etc. Some women feel safer when staff and providers reflect the demographics of their region...

It is important for health care providers to be aware of the effects of violence and abuse to avoid retraumatizing women...

The level of documentation required by the health system may operate as a systemic barrier to safety for some women, particularly those who have experienced violence. Women fear child apprehension or loss of custody and may be reluctant to share health information. In some cases, chart information has been used against them, or charts have been subpoenaed by the courts; yet women may be viewed with suspicion when they ask not to have something charted."

Some Ways to Apply this Element

- "Ensure an accessible physical environment and physical safety...
- Provide an environment that welcomes diversity, with warm and welcoming staff.

- Listen to women, take their concerns, opinions and feelings seriously...To equalize power, let women know their rights.
- Acknowledge the likelihood of any woman having experienced violence and abuse. Recognize the consequences of violence on women's physical and mental health.
- Provide women-only space.
- Facilitate referrals to community agencies that address violence and other women's issues...
- Address safety of workers within the health system, both in the workplace and at home. Implement employment equity for diversity.
- Ensure privacy and confidentiality regarding sensitive information like dependence on social assistance, requests for subsidies, answers to questions about sexual health.
- Workers should take the time to explain their role (not immediately start writing notes/reports), identify and provide for interpretation needs, explain the system and process, including child apprehension issues."

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ELEMENT #2
THE IMPORTANCE OF EMPOWERING WOMEN

Understanding this Element

"Health status improves when a person has a greater sense of control over their life situation.

Four themes of women's empowerment are:

1. a core sense of self;
2. the ability to take action based on that sense of self;
3. a sense of control over one's life; and
4. being connected with others....

Women who feel individually empowered are more likely to participate and take action in their communities. And community participation builds community capacity – the ability of individuals and groups to identify common problems or concerns, take action to effect change within the community, and to improve the quality of life for all community members..."

Some Ways to Apply this Element

- "Encourage women to focus on themselves as a priority.
- Give women space and support to change their lives to improve their well-being.
- Facilitate the development of self-help and support groups to provide opportunities to overcome isolation.
- Equalize power by letting women know their rights, and ensure their rights by giving women access to their own health files and information.
- Use health "coaches", or a system of health advocates, and mechanisms for complaints to assist women to build knowledge and skills and have a voice. Cut down on the use of technical and mystifying language.
- Initiate community development projects that facilitate women to take action and learn skills as motivators and health educators so they can contribute to building community capacity.
- Incorporate health promotion, literacy, skill-development, and income-generating activities into health projects which address broader development issues, e.g. community kitchens."

ELEMENT #3
INVOLVEMENT AND PARTICIPATION OF WOMEN

Understanding this Element

"Social roles and limited financial resources can limit women's participation in health service and program planning, implementation, evaluation, policy and research. It is important to encourage full and equal participation by diverse women in these activities, to ensure that women's perspectives and needs are incorporated."

Some Ways to Apply this Element

- "Achieve equitable representation of women on advisory committees, steering committees and boards and, in particular, facilitate women's input into decision-making about resource allocation.
- Make a commitment to involve community groups and/or obtain their input. Work in partnership with community-based women's organizations.
- Involve women from diverse communities in all phases of designing, developing and implementing services and programs in collaboration with service providers.
- Support women to participate by providing childcare, transportation, honorariums, accessible physical environments, as well as mentoring for skill-building and orientation to the health system.
- Inform women and communities about new knowledge, relevant data, service delivery and new initiatives, using friendly and accessible communication strategies.
- Integrate ongoing feedback processes such as key informant surveys, exit interviews and follow-up evaluation three months after service. Use the information from these processes to enhance or change programs or services.
- Employ consumers to work with consumers."

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ELEMENT #4
WOMEN'S PATTERNS OR PREFERENCES IN OBTAINING HEALTH CARE

Understanding this Element

"Women seek health care in the context and circumstances of their lives. This determines when and how they seek services, and whether they are able to access services at all. 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. They may also feel that they can or should take care of themselves.

Some women lack independence of have difficulty leaving their homes for various reasons, e.g. women with disabilities, isolated immigrant and refugee women, women being abused by their spouse, or senior women who are afraid or physically unable to leave their homes.

Poverty is a factor limiting women's access to services. Women use public transit more than men, and travel with dependent children. Shift work and night work create barriers to access and are associated with ill-health for women.

Poverty particularly affects women who have been abused, who may face health issues that limit their ability to work.

Mental health problems associated with violence also affect the ways women obtain health care.

Lack of understanding of how the health system works or what services are available may also limit women's access to services. Many women prefer to see women practitioners

or a variety of reasons, including religious and cultural beliefs, past sexual abuse experiences or the belief that women practitioners are easier to communicate with and take more time during appointments.

Women request and use alternative, traditional and complementary therapies more often than men. Many women cannot afford these therapies, while others want information about these therapies from health care providers but do not feel safe discussing them."

Some Ways to Apply this Element

- "...we have come to learn that all women must be treated as individuals and we cannot make assumptions about values, attitudes or practices. Therefore, now, if we want to know how a women will approach her care experience and recovery, we ask her."
- Change various aspects of the way care is organized to allow for more flexible services.
- Extend hours of operation.
- Provide evening programs when women and girls have free time; schedule programs for women at the same time as those for children.
- Provide childcare if possible; ensure space for children to play safely; provide adequate space for breast-feeding mothers.
- Locate services together so that women are not sent from person to person to tell their story over and over ('one stop' services).
- Provide for transportation, e.g. bus tickets.
- Make home services available for women who cannot leave home easily and for women who need them after discharge from hospital – or allow some women to stay in hospital longer to recover when they have no support at home.
- Provide financially accessible preventive/ complementary/alternative services.
- Offer good communication about services, in simple and straightforward language and formats that are inclusive of and appropriate for diverse populations of women, e.g. lesbians.
- Have access to translation and interpretation services.
- Plan and provide specific services to meet the unique needs of women."

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ELEMENT #5
WOMEN'S FORMS OF COMMUNICATION AND INTERACTION

Understanding this Element

"Gender socialization encourages women to be gentle, compassionate and nurturing. Consequently, certain patterns of communication and interaction are more characteristic of women than of men. For example, women allow themselves to be vulnerable with other women, and are more comfortable asking for help and relying on others for support when needed. Women consider it important to have a network of many friends, and they often use stories to describe their situations in context.

However, women who have experienced violence may not want to talk to others, and often prefer to have something to take away and read. Abused women are not likely to share information easily, and may have dissociative behaviours or become numb to pain. If they do not recognize pain, they may not seek medical help early or at all.

Cultural differences can also have an impact on communication and interaction. The V/RHB's *Aboriginal Health Planning Report* points out how this can affect Aboriginal women: 'Physical actions can...be intimidating. For example, standing over someone with arms folded, asking questions too quickly, and not waiting for an answer discourages communication. Aboriginal people tend to have a more reflective and deliberate speech pattern than non-Aboriginal people.' "

Some Ways to Apply this Element

- "Enhance communication by encouraging discussion and allocating appropriate amounts of time or setting up successive appointments.
- Provide venues where women can share experiences and knowledge, or refer women to peer support programs...
- Encourage women and girls to bring their friends/support persons to programs.
- Provide or refer to professional counselling/ peer counselling."

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ELEMENT #6
THE NEED FOR INFORMATION

"Women ask for information more than men, and often obtain information from other women. As well, they often pass on information to others...

Women's learning styles are influenced in part, by their forms of communication and interaction. Women remember testimonials from other women and learn from them. Exchanging stories between women may be an important educational method.

Constraints on women's lives limit time for learning. Literacy rates and language training affect women's access to information. For instance, immigrant and refugee women in some communities do not have access to English as a Second Language (ESL) training on an equal level to men.

Women may require an advocate or intermediary to get information.

Education materials need to be tied directly to women's needs and interests and be directed to their developmental stage and period of life..."

Some Ways to Apply this Element

- "Have health information resource centres that included trained nurses/librarians/volunteers to answer phone calls...
- Provide information in advance of care when possible.
- Develop innovative ways to get information to women who are harder to reach, e.g. outreach to immigrant women's workplaces.
- Use interpreters and community workers or advocates who can help women use resources and gather information.
- Provide information on issues specific to women in accessible formats, e.g., plain language, inclusive language, translations, alternate formats.
- Sponsor public education/awareness campaigns, e.g., promote women's wellness, address caregiving roles and stress.
- Use principles of peer education."

ELEMENT #7
WOMEN'S DECISION-MAKING PROCESSES

Understanding this Element

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 (their economic status).

Women who have experienced violence and coercion may have had few opportunities to make their own decisions.

Women and providers both bring important knowledge and perspectives to decision-making."

Some Ways to Apply this Element

- "Encourage women to discuss the context of decisions, rather to make 'choices.'
- Encourage women to access information services.
- Present all options as clearly as possible and support women in making informed decisions within the context of their lives. Ensure that they feel supported with whatever decision they make.
- One local agency has a peer support and self- management framework for facilitating informed consent."

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ELEMENT #8
A GENDER-INCLUSIVE APPROACH TO DATA

Understanding this Element

"Data provide a basis for formulating policies, monitoring change and evaluating outcomes. Data that reflect gender issues help to promote change, eliminate stereotypes, promote understanding of the health status of women and men, as well as identify access issues and/or gaps in service delivery.

The production of gendered statistics requires not only that all official data include a breakdown by sex, but also that concepts and methods used in data collection and presentation adequately reflect gender issues in society and take into consideration all factors that can produce gender-based bias.

Data may reveal sex differences, but differences in health status, outcomes, success, utilization, etc. must be analyzed carefully to reflect the influence of gender issues.

Women's voices are an important part of evidence. Qualitative methods of data collection provide a particularly valuable perspective, and the information gathered through qualitative methodology can inform the development of relevant quantitative data elements as we work to better reflect the context of women's lives in our traditional databases.

Data should be presented in user-friendly ways."

Some Ways to Apply this Element

- "Collect all data disaggregated by sex, socioeconomic status, age, disability, language and culture.
- All variables and characteristics should be analyzed and presented with sex as a primary and overall classification. This, in turn, enables all analyses and presentations to be sex specific.
- All statistics should reflect gender issues.
- Develop inclusive strategies for consulting with different communities of women.
- Use innovative and inexpensive methods to create 'snap-shots' of women's health status. Snapshot health profiles can use both quantitative and qualitative methodology and are a resource-efficient, methodologically sound and effective way to gather information.

- Time series data collection (gathering data on the same questions/issues for women at different points in time) is another methodology to consider for some program initiatives. This method samples different groups of women at each time, but allows us to see trends emerging and to monitor program outcomes. It is less costly than either continuous data-gathering or longitudinal periodic studies that require that the same group of women be tracked over a period of time."

ELEMENT #9
GENDERED RESEARCH AND EVALUATION

Understanding this Element

"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. We need to ask the appropriate questions to capture the different experiences of women and men. This will require sustained research with adequate infrastructures for continuity...

Major health research gaps exist for populations of women such as: lesbians, bisexual and transgendered; First Nations, Inuit and Metis women; immigrant and refugee women; women of colour; and women with disabilities, particularly research that reflects their priorities and needs.

Evaluations of women's services should include a gender perspective.

The findings of women's health research is not being adequately communicated to women, particularly those who are low-income."

Some Ways to Apply this Element

- "Research and develop more appropriate, gender-sensitive indicators of women's health and well-being.
- Involve women in setting research agendas.
- Use inclusive methodologies that respect and empower women's voices, e.g. participatory action research.
- Include gender analysis in outcome evaluations.
- Disseminate research findings to women's communities in appropriate formats."

ELEMENT #10
SOCIAL JUSTICE CONCERNS

Understanding this Element

"People who work with women see many women who are affected by social determinants like poverty and discrimination. Workers may be overwhelmed by how to help individual women or by how to have an impact on societal levels of poverty and injustice.

The V/RHB addresses social justice issues within Statement #3 of their mission, vision and principles:

> 'The framework for the delivery of health care will be based on the ideals of integrity, excellence, social justice and access to service; respecting the rights of every individual regardless of socio-economic status or personal belief or disability; supporting the efforts of our diverse communities to work cooperatively to address the issues of health and safety in their neighbourhoods as they apply to the broader determinants of health.' "

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Some Ways to Apply this Element

- "Support the involvement of service providers and all women in advocating for women's achievement of political, cultural, social and economic equality.
- Use institutional positions and power to advocate for change.
- Embed gender equity in policy development.
- Provide advocacy around income assistance and disability benefits.
- Provide court support for women in custody processes.
- Advocate for people who cannot go home from rehabilitation programs or hospital unless they have an appropriate level of care or structural changes are made to their homes to accommodate disabilities.
- Assist women in recovery who need housing to link up with other women who can offer short-term accommodation.
- Provide clothing exchanges for women searching for or starting jobs."

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ELEMENT #11
GENDER SENSITIVE TRAINING

Understanding this Element

"Providers of services and programs need resources and support in order to recognize the need for and provide women-centred care on an ongoing basis. Where gender-sensitive training exists now, it is often dependent upon individual workers who bring forward this perspective.

There is a clear need for gender-sensitive training in the area of violence against women, so that service providers can recognize and respond appropriately to women who may have been abused.

Models of training need to include consumers as full partners in developing and implementing training projects.

Training needs to address underlying societal assumptions about women."

Some Ways to Apply this Element

- "Provide a comprehensive gender-sensitivity training program that can be adapted and integrated into all levels of services and program delivery. Include issues related to diversity and marginalized women, e.g. street workers, Aboriginal, lesbian.
- Have the training facilitated by experienced consultants with a combination of professionals, community agencies and community women.
- Provide periodic updates, current information, and awareness workshops for board, staff and volunteers.
- Appoint a staff and advisory committee to oversee implementation and monitoring of gender-inclusive programs.
- Provide relevant and current women's health research and information resources.
- Assign staff to look at other services with gender-sensitive programming and report back." [98]

2. WINNIPEG WOMEN'S HEALTH CLINIC *MODEL OF CARE*

PHILOSOPHY

The Women's Health Clinic Model of Care is based on the following philosophy and principles.

1. All women deserve fundamental respect and have the right to make informed decisions about their health care. In particular, it is recognized that:
   a) all women bring valuable and diverse experiences as care providers of family and friends, as workers, and as consumers of health services. Their ideas and insights should be encouraged and valued in developing health services appropriate to their needs; and
   b) women from equity communities, including Aboriginal women, immigrant women, visible and language minority women, women with disabilities, and lesbians, bring unique experiences and insights to an understanding of health and illness. Often marginalized in the planning of health service delivery, their involvement and participation is essential for the development of quality, culturally appropriate services.
2. Health status improves when a person has a greater sense of control over their life situation. Women's Health Clinic is committed to facilitating the empowerment of women, individually and collectively, in all its programs and services.
3. A person's health must be understood holistically, with an appreciation for the interrelationship of physical, social, emotional and spiritual aspects.

APPROACH

The Women's Health Clinic approach to delivery of services is based on the principles and philosophy outlined above. Key elements of **woman-sensitive, "best practices**" include:

Priority Populations

In keeping with its population health approach, Women's Health Clinic programs and services strive to serve the needs of:

(a) women who are **most vulnerable** to poor health due to factors such as poverty; and

(b) women who are **more likely to experience barriers** in accessing appropriate health services due to their ethnic origin, race, social class, language, sexual orientation or disability.

Women-Centred Services

The **woman**, in the context of her community, is the **centre of Women's Health Clinic service planning and delivery**. 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. These services may be offered by the Clinic directly or through referral to other service providers or agencies, such as justice, education, housing or employment.

Develop a Partnership Between the Woman and Care Provider

Programs and services are based on the assumption that the woman brings a valuable perspective of her life situation and her body. She must feel empowered to make informed decisions about her health and health care. Accordingly, 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 Caregiver and Services

Every effort is made to ensure that women receive the most appropriate service, provided by the most appropriate service provider, in the most appropriate location. Women may access services through **a variety of avenues and routes of entry** as appropriate to their particular situation and needs. Services and approach offered may include information, education, support through groups or individual counselling, medical treatments, health screening, advocacy, community action, as well as linkages with the secondary, tertiary, rehabilitation and long term care or other sectors. Services sensitively address a **wide range of issues** (such as sexuality, childhood sexual abuse, violence) which have not been adequately addressed by health care providers in the past and try to ensure that appropriate care is provided.

Team Approach

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.**

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Empowerment

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

1. 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;
2. 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
3. structuring the Clinic to include 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 **modelling self-help skills, demystifying medical information, and bringing community perspectives to the design and delivery of services**. Therefore, Women's Health Clinic provides 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

Women's Health Clinic works in **partnership with various communities concerned about the health of women**, building on the strengths and interests of its partners, including volunteers, clients, service providers or other members of the community.

Evaluation and Cost-Effectiveness

Women's Health Clinic recognizes the **importance of ongoing review and evaluation** of the approaches and service strategies it uses, taking into account sound information and evidence about how programs, services and approaches are meeting the health needs of diverse women. This requires the development of effective methods for feedback and evaluation, both qualitative and quantitative, and attention to the cost-effectiveness of various strategies.

Innovative Program Development

Women's Health Clinic is committed to continuous development and re-focussing of its service approach based on **new understandings of women's needs and issues**. The Clinic collaborates with community women and researchers and works at integrating newly gained knowledge.

Advocacy for System Change

Women's Health Clinic works to identify critical emerging issues for women's health and brings together key stakeholders to **develop innovative policy recommendations which are responsive to women's needs and concerns**.

The design and delivery of all Women's Health Clinic programs and services reflect the understanding that:

1. Gender is a key determinant of health. For example, women within all socio-economic and cultural backgrounds are at a higher risk than men of experiencing poverty, abuse and violence, all of which serve to seriously undermine health status.
2. Women's health status is influenced by a variety of social and structural factors, including social status, income and employment, education, and social supports; and
3. Gender-sensitive health care services help women reclaim and re-define normal life transitions (such as childbirth or menopause) which have been overly medicalized or pathologized.
4. Health promotion, primary prevention and healthy public policy are essential strategies for improving women's health. In addition to individual work with clients, Women's Health Clinic also emphasizes community and group based approaches as a means to effect positive change in women's health status.

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ACKNOWLEDGEMENTS

The author would like to express her gratitude to the many people who assisted in the development of this project.

Firstly, to **Madeline Boscoe** and **Barbara Wiktorowicz** of the Women's Health Clinic, Winnipeg, and **Pat Hope** of the Health Promotion and Programs Branch, Manitoba/ Saskatchewan Region, Health Canada, for the opportunity to engage in this project.

Secondly, to **Dr. Patricia Kaufert** of the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, for her generosity in reviewing drafts of this paper.

Teresa Mayer of the Department of Community Health Sciences, working under Dr. Kaufert's supervision, produced the data necessary for the analysis of the health status of Manitoba women.

Jackie Pantel of the Department prepared the charts included in this report.

Dr. Cam Mustard also provided advice and assistance prior to his departure from Manitoba.

Thank you also to the **Access and Confidentiality Committee of Manitoba Health** (Susan Rodgers, Secretary) for releasing the data to us which appear as Charts 1 - 5.

Carole Beaudoin of the Epidemiology Unit of Manitoba Health was generous with both her time and her data. She prepared Charts 6 - 8.

Ken Battle and **Michael Mendelson** of the Caledon Institute, **Kevin Lee** of the Canadian Council on Social Development and **Darren Lezubski** of the Social Planning Council of Winnipeg were generous in sharing information.

Christiane Gour, Senior Statistical Officer, Indian and Northern Affairs Canada, answered methodological questions about *Aboriginal Women: A Demographic, Social and Economic Profile*, and provided additional data.

Staff of the Winnipeg office of Statistics Canada answered many questions and were always helpful.

Finally, thank you to **Dr. Sara Arber** of the University of Surrey, who sent valuable, unpublished work to a complete stranger in response to a request.

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WOMEN, INCOME AND HEALTH IN MANITOBA:
An Overview and Ideas for Action

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Prepared for
WOMEN'S HEALTH CLINIC
Winnipeg

Funded by
HEALTH CANADA:
Health Promotion
and Programs Branch
Manitoba/Saskatchewan Region

July, 2000

Revised January, 2002

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TABLE OF CONTENTS

women's health clinic