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Chair

Ms. Anita Neville

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● (1115)

[*English*]

The Chair (Ms. Anita Neville (Winnipeg South Centre, Lib.)): Good morning, everybody, and thank you all for being here.

I just want to begin by reminding members that this is the first time we have been in this room and that the proceedings here today will be televised, so the cameras are on.

I'd like to welcome our presenters here. Before you begin, I'd like to apologize to you for the short notice you had for these meetings. We've been putting these discussions together on very short notice because we didn't know we had the budget, and timing has been somewhat of an issue. But we're pleased you're here and pleased to have the opportunity to hear from you today.

I again want to apologize, but there are going to be some comings and goings by colleagues. I know that some of our members are not well; some who aren't well are here, and may have to leave. It's just that time of the year, so we will do our best.

We'll begin, because we're behind already.

Jane MacDonald from the Canadian Nurses Association, would you like to begin your presentation.

Ms. Jane MacDonald (Primary Health Care Consultant, Canadian Nurses Association): Thank you very much to the committee.

My name is Jane MacDonald. I am pleased to be here today to represent the Canadian Nurses Association.

In Canada there are more than 230,000 registered nurses. They make up the largest professional group working in the Canadian health care system, and the nursing workforce is predominantly over 95% female. Nursing is inextricably linked to the impact of its gender history. Despite a century of progress, nursing has suffered historically from the impression that little education is required to be a nurse, that nursing is an innate skill of all women, and that nurses are little more than the silent handmaids of physicians.

As a result, nurses have often been easily dismissed by policy-makers, sidelined when the health system decisions are being made, underpaid, and undervalued. The reality is that men have not in any numbers been beating down the door to enter nursing. That finding stands in stark contrast to the gender mix we now see emerging in all other health professions. Nurses know from all the public opinion surveys that they are the most trusted of any professional group, but they perceive a lack of respect in their profession. They are dissatisfied with working conditions, their lack of control over workplace and practice decisions, and the level of workplace violence. Many nurses feel they are treated as budget line items to be increased or eliminated based on the prevailing economic breeze.

Within the workplace, the problems of balancing child and elder care can conflict with inflexible or unpredictable work schedules. To keep the system going, aging nurses, mostly women, work more overtime than any other profession. Perhaps it is no surprise then that for 15 years they have also had the highest absenteeism rates of any occupational group in Canada.

Compounding pace and workload challenges, emotional and physical violence, bullying, and sexual harassment are still daily workplace realities for many nurses. In health care patients and staff typically continue to turn their abusive behaviour toward female workers, and nurses are the most highly visible female caregivers in most health settings. In Alberta, for example, 40% of nurses surveyed said that they had experienced at least one incidence of emotional abuse during the previous five shifts they worked.

The role of nursing leaders is important to nurses at different phases in their careers but is fundamental to novice nurses. Due to budgetary cuts, many first line management positions have been eliminated or managers have been forced to take on a wide span of control, handicapping their ability to effectively supervise staff. In Canada some 5,500 nursing management positions were eliminated between 1994 and 2000. Beyond eliminating the early coaching and supportive presence that seems integral to launching successful nursing careers, nurses believe that the erosion of the head nurse role has reduced their input in policy and allocation decisions.

Budget restrictions and cuts in the last decade have also led to the growth in part-time and casual positions. In many cases, part-time work and casual or temporary work are the only entry points into the workforce, thereby reducing the attractiveness of nursing as a career. Nurses graduating with a significant debt load feel they must seek out full-time employment, often in other countries, in order to pay back their debt. Important to understand in the employment status equation is the reality that many part-time nurses in fact work full-time hours, or more. They do so by working across multiple units within an employment setting and/or working for multiple employers in order to make up the equivalent of a full-time wage. In some cases, they provide those services at a premium cost to the system. The fact is that the work exists and is being paid. The nurses exist who are willing to meet the need, but the mismatch of available nurses and available work leaves both sides scrambling to meet their needs.

To conclude, the Canadian Nurses Association believes that significant work remains to be done to improve work environments and workplace practices that penalize a largely female workforce by promoting casualization, the need for multiple employment, and long-standing inequities in power and decision-making authority. The Canadian Nurses Association has called on the federal government to address these concerns by leading and participating in a roster of activities to strengthen the nursing workforce and broader health human resources.

Thank you very much.

● (1120)

The Chair: Thank you very much.

I'm just going in order of the agenda.

Margaret, I'll ask you if you would....

Ms. Margaret Haworth-Brockman (Executive Director, Prairie Women's Health Centre of Excellence): Good morning. I'm delighted to be here. I am the executive director of the Prairie Women's Health Centre of Excellence located in Manitoba and Saskatchewan and it is my pleasure to make this presentation to the standing committee. I will provide a written submission as well at a later date.

I am here today in my professional capacity but also as a Canadian woman. My comments are thus both professional and personally based. My goal in talking to you today is to highlight the areas in which Prairie Women's Health Centre of Excellence has been working and to make some key recommendations to address the social determinants of health and improve the health of women and their families and communities.

Prairie Women's Health Centre of Excellence receives core funding from the Women's Health Bureau, and as part of the women's health contribution program we have a comprehensive research, policy advice, and communications program. We have an extensive network of colleagues and associates in women's communities among academic researchers with government and regional health authorities and with our counterparts across the country.

With a focus that remains in Manitoba and Saskatchewan, Prairie Women's is respected for credible, applicable research relevant to the women who live here and who wish to provide appropriate supports and care. We have a mandate to redress the gaps in our understanding of the influences of social factors on women's health, particularly women who have not been well represented so far in research and policy discussions. We have tiny offices in both Manitoba and Saskatchewan that provide a vital link for the women in these oft-ignored provinces.

Our main focus in the more recent years has been to look at the gaps in our understanding of health concerns for women living in poverty, aboriginal women, women who live in rural remote and northern communities, including of course the interaction of these three, and consideration of gender and health planning and health services. So I would like to speak very briefly about each of these four areas and draw your attention to a few recommendations.

Health is not just about acute care management or about providing the most up-to-date technology, although these are of course very important to good health care. Rather, good health is achieved by addressing fundamental needs—basic income, housing, clean water, adequate nutritious foods, and genuine involvement in decisions affecting one's own life. There is overwhelming evidence that the health of all people is profoundly affected by social and economic determinants, and there is also good evidence that health will be profoundly improved when there is a substantial investment in these social factors.

Despite some real gains in women's overall equity in Canada, women still bear the greater burden of poverty in this country. They are more likely to be among the poor, and women are particularly vulnerable to being poor if they are elderly, a member of a visible minority, aboriginal, or have a disability. Many women, of course, are more than one of these. Women are the majority of those on social assistance, and women are overrepresented among the working poor because they are frequently employed in insecure and poorly paid jobs.

Much of the discourse across this country has drawn our attention to the plight of children who live in poverty, and the statistics are horrendous. But we must recognize that if children are deprived, then they are likely living with parents, mostly mothers, who are struggling with poverty. The work done by the Prairie Women's Health Centre of Excellence has highlighted the poor women's own assessment of the effects that poverty has on their health and that of their families and the benefits of adequate services, especially good housing.

Preventing disease in the first place by promoting social and living conditions that support healthy lifestyles has been neglected. In the elimination of the Canada assistance plan and the institution of the Canada health and social transfer, the underlying principles of CAP that guaranteed the right of citizens to basic income and other necessities were removed. Reduced federal spending and greater flexibility on how the moneys are spent has meant that much of the block funding has been directed to health care, but this leaves social assistance and other programs to stagnate. This is despite a wealth of research that demonstrates the importance of adequate income and social services to maintain the population's health. We hope that the work of the new Public Health Agency of Canada, including population health promotion, will provide a strong contribution.

I do not presume to speak for Métis, first nation, and other aboriginal women, but we have had the privilege of working with many aboriginal women at Prairie Women's Health, including members of our board and staff. By supporting and enabling community women, there is a growing, though still small, body of work developed in the community of aboriginal women using methods that are owned by themselves.

We recommend that the federal government continue to support indigenized research and research processes and recognize that the community of aboriginal women struggles to achieve adequate representation at federal and national forums and that the issues and concerns from Métis, first nation, Inuit, and other aboriginal women differ according to jurisdictions, legal entitlements, and communities. Continued support for the Aboriginal Women's Health and Healing Research Group, as it becomes a centre of excellence, can make a profound change in how aboriginal women's health has been conceptualized and carried out.

● (1125)

I had the good fortune to be part of a comprehensive national project on the health concerns of women who live in rural, remote, and northern Canada. There were a number of key findings that came from this study, but a prime one was that women feel uninvolved in health and health care decision-making, despite the fact that many health care reforms have been made in the name of being more accessible and responsive to local communities.

In fact, women tell us they feel the decisions are being made without them and that citified solutions are imposed without consideration of the implications for their smaller communities. Rural women appreciate that there is a shortage of doctors and nurses, but they remind us that good health care can be shared with other providers—dentists, midwives, therapists, and mental health workers, for instance. Consideration of accessible care for rural women and their families can be based on collaborative community models.

The health needs of women and men are different and therefore gender is identified as a determinant of health. In addition, while family relations are changing, the women continue to serve as the primary care providers for themselves and their families. Furthermore, the majority of employees in the health system are women, as my colleague has noted. Their intensive involvement with the health system provides women with a unique perspective on what is working and on the changes that would lead to greater effectiveness. Accurate gender-based analysis of policies is needed to understand the differential impacts on women and men and to forge policy alternatives that will improve women's health.

What we find at the Prairie Women's Health Centre of Excellence is that while there is a great deal of emphasis on indicators and outcomes, the data that should be available in sex-disaggregated form is not available widely and thus these analyses are very difficult to conduct.

I would like to conclude with a few recommendations.

We suggest that you follow through on federal commitments to gender equality and implement gender-based analysis at all levels of policy and program development. This would include having all proposals demonstrate gender and diversity analyses and ensure that moneys flowing out relate to policies that demonstrate gender-based analysis.

We ask that you recognize the complicated ways that income and gender affect health and recognize that health is also a cultural and social construct.

We recommend that you support and strengthen aboriginal women in their communities and understand the important concepts of health and how they vary in communities among first nations, Métis, Inuit, and other aboriginal women.

We ask that you treat women's poverty seriously. We ask that you redress women's poverty because of the inherent right women have to a decent standard of living, not only because of their place in a family.

We suggest that you reinstate federal policies and guidelines that require that the right to income security be upheld despite how the transfer of funds and responsibilities is governed.

We ask that you create affordable housing for women with low incomes and ensure that the federal government upholds a commitment to provide new money and strategies for social housing for low-income citizens based on local solutions and involving local consultation with the women involved.

We also recommend that base funding be reinstated for community resources and organizations. A dependence on volunteers is not able to withstand the ongoing and sustained momentum needed. By providing a basic infrastructure, then the work can continue with a momentum that is built on and worked on with the people locally.

Thank you.

● (1130)

The Chair: Abby Lippman.

[*Translation*]

Professor Abby Lippman (McGill University; Co-Chair, Canadian Women's Health Network): Thank you and good morning. I'm very pleased to be with you today. I'll speak in English

[*English*]

in order to not upset too many ears, since my accent both in French and in English comes from my New York background.

I'm delighted to be here. I represent today the Canadian Women's Health Network. I am co-chair of the board of the Canadian Women's Health Network. So I'm wearing that hat, but you will probably hear a few other personal things come through.

I would like to fill you in on the network. The Canadian Women's Health Network is a national bilingual network of individuals, organizations, and institutions concerned with women's health. It's a clearing house for women's health information and communicates this information as well as policy advice to health care providers, policy-makers, the media, and the general public. As is the Prairie Women's Health Centre of Excellence in women's health research, we are a member of the centres of excellence for women's health programs supported by the Women's Health Bureau. And the CWHN sits on the steering committee.

We also play a large role in two national working groups that have been supported by Health Canada: one is called National Coordinating Group on Health Care Reform and Women, and the other is Women and Health Protection. One of my other hats is being on the Women and Health Protection steering committee.

The CWHN is governed by a voluntary board of directors. The members include academic researchers, health practitioners, educators, and so on.

I'm going to very quickly jump over a few points today. We were given short time notices and short papers to present. Much of what I say will be an echo of what Margaret has said, although we did not collude in presenting this to you. One comes from Quebec, the other comes from Manitoba, so what can I say?

My major message is basically that although the topic today is health, I hope you will continue to keep in mind how all the other topics that are on your agenda for discussion, whether it be economic issues, social justice issues, or international problems, are related to health. Women's health must be seen in a holistic perspective, and as the saying goes, all the dots connect: economic, rural, social assistance policies—you heard that from Margaret—to name but a few. There's also working conditions, and you heard that from Jane MacDonald. Everything intercepts with respect to the health of women and girls.

This does not mean that health should be taking over everybody's agenda and running the world. That would be far from what we're encouraging. We want to emphasize that the health impact be seen in policies that would seem to have no relationship to health. What makes these dots connect perhaps is the framing of women's health as a human rights and social justice issue. It is not one that is only disease treatment based. It connects the dots also by thinking of women in terms of their equity and their equality rights.

The five points I want to make will be fleshed out in the document we hope to present.

The first one is this. In 1999 the then Minister of Health announced a women's health strategy. This comprised an ambitious set of promises and it was supposed to set a basis for future actions. In order to make sure that it works properly, the CWHN strongly urges this committee to invite the current minister to provide you with a report card that notes in specific and concrete terms the accomplishments and progress that have been made with regard to the women's health strategy in 1999.

Everybody likes five-year reviews. If you invite him now, you're making the five-year limit even though he might not show up until the sixth year.

We also urge this committee to ask the minister to renew this strategy, if not to develop a new women's health strategy that will take us into the next decade. Critical here will be policies that reflect women's strategic interests, not just our immediate needs, although those are important if we want to ensure sustained change. Strategies are important. We don't usually go for this cotton-candy type of approach, but the strategy does engage the public and its imagination and gives you a score card to be used, and it will allow for the development of multi-sector approaches.

Second, in developing this renewed or new strategy, the Canadian Women's Health Network would urge you to have the minister build on the fledgling attempts to include gender-based analysis, GBA, in all government policies in ways that will ensure that women and their issues are truly integrated. Again, Margaret spoke about this, and I will only underline this.

● (1135)

We've seen in the recent past a number of reports, and I would mention just the Romanow report, particularly its home care and pharmacare chapters, the mental health strategy, and the healthy living strategy, which to our view just do not seem to have fully integrated how these endeavours will affect women differently from men. The dots between gender and health policy haven't been connected appropriately in the past, and pre-existing government commitments lead us to urge adequate GBA, or

[*Translation*]

if you want to use the method used in Quebec, integrated feminist analysis.

[*English*]

Gender always needs to be a crosscutting theme, and this does not mean merely presenting sex-disaggregated data, as welcome as they are. The disaggregated data are merely a start to show if there is a difference between men and women according to something, but the real issue is why there are these differences. When you don't see sex-disaggregated data, the question is, why don't you see them? The absence of a difference is as critical as the presence of a difference.

Number three, keeping to the connect-the-dots theme, I would now apply it to a specific area. We would point out that other kinds of connections are missed when, in discussions on primary health care reform, particular attention is not given to the decreasing access for women to safe, supportive childbirth facilities, nor is attention given to their actively increasing rates of infertility and sexually transmitted infections. True, we need women-centred services, but we also need structural changes that will allow women to actually make these choices.

We strongly support strengthening the primary care services and policies, broadening the kinds of health care providers who are included therein, and also treating those who are considered the more standard providers with the respect that is due them in meeting their needs.

But too often primary care is still framed as a need for some medicine. The CWHN is very concerned about the undue influences from pharmaceutical and biotech industries that are clouding the health agenda. Making pills seems to be the highest priority for primary care. Medicalization continues apace and we need to invest in prevention and promotion in real ways. I can give examples later if anybody wants.

Next, among other dots needing connection to women's health issues are those that centre on policies and practices that lead to the continuing increase in the feminization of poverty in Canada.

I promise you we didn't get together.

Again, as with GBA, there seems to be more lip service than action with regard to the structural determinants of health. These were neatly listed in the 1999 “Women's Health Strategy”, but they seem to have been largely forgotten in the subsequent construction of policies, policies we see as leading to further inequities among women and between women and men.

When you ask the Minister of Health—which we hope you will do—about a renewed women's health strategy, be sure to learn specifically how the determinants will be taken into account and why, as we think is the case, there has been so little uptake of all that is known about the risk conditions in which women live and how these are damaging health. Why is the focus still inappropriately on individual behaviours and not on the societal conditions that can either limit or enhance what women can do to stay healthy?

My final comment for today is this. One response to this absence of uptake is that we need—this is touching on what Margaret said again—a healthy, thriving, active civil society to ensure the various dots between social, economic, and other policies are connected to health. Alas, there has been a serious and problematic deterioration in the ability of these groups to function because of the decreasing core funding for women's and equity-seeking groups. Constant attention to public-private “partnerships” has distracted government from the pillar that perhaps they can do more to promote and protect women's health. There needs to be reinvestment in community groups, the civil sector, so they can work with women on their own health concerns.

In conclusion, the CWHN is very pleased that this community has put health on its agenda, and we hope you will not fail to connect the dots that will truly lead to the promotion and improvement of the health of girls and women in Canada. The CWHN is committed to working with you and with all others to achieve these goals.

Thank you.

The Chair: Thank you very much.

Let me just explain. I don't know whether you've been before a committee before or not, but we have rules governing the committee. We have a speaking order. The first round is seven minutes for each questioner, and that seven minutes includes the answer from the respondent. I'm a fairly lax chair but I do try to keep some order to it.

Who from the Conservatives is leading off? Our vice-chair, Ms. Grewal.

Thank you.

● (1140)

Mrs. Nina Grewal (Fleetwood—Port Kells, CPC): Thank you, Madam Chair.

I would like to thank Jane, Abby, and Margaret for taking the time and giving us their presentations. Certainly, they were very useful to us. Thank you.

British Columbia announced a women's health strategy for British Columbia in October 2004, pointing out significant health issues for women in B.C. such as mental health, problematic substance use and addictions, cardiovascular disease, diabetes, HIV/AIDS, lung cancer, breast cancer, and falls.

Is enough being done for women on these health issues across the country? What are some of the health promotion and disease prevention approaches being used to address these issues? What has been the role of the federal government in issues such as addictions, mental health, and disease prevention for women?

Ms. Margaret Haworth-Brockman: That health strategy was developed in collaboration with my colleague Lorraine Greaves at the B.C. Centre of Excellence for Women's Health, so I'm fairly familiar with the background to that.

Is enough being done in the areas you mentioned? I think we can always say not enough is ever being done. There's a history of not thinking about women separately from men, but we are getting better at that. Clinical trials are more specific and consideration is given about different management and treatment for women. That is certainly changing.

However, in the area of HIV/AIDS, for instance, I think we are going to find, as my colleague Barbara Clow at the other end of the country would say, that women are in particular danger of acquisition of HIV/AIDS because of the socio-economic conditions they live in.

We can look at countries like South Africa and see an example of a country that thought it was doing okay compared with other ones on its continent, yet suddenly they find themselves in the terrible state they're in. We worry that the same kind of thing could happen in Canada unless appropriate measures are taken in consideration of women's particular needs.

Women's mental health issues continually come up. I think this is largely because of the many pressures women are under, the different workloads, roles, and responsibilities they have and their feelings of lack of power involved in their own decision making, whether it be in a particular household or in their place of work.

I will leave it at that and turn it over to my colleague.

The Chair: Jane MacDonald, and then I'll come back to you, Ms. Lippman.

Ms. Jane MacDonald: I think there are two issues. You asked what the federal government has been doing. The primary health care transition fund has been funding innovative projects across Canada, looking at different ways of supporting communities to work in primary health care. One of those ways is through community health centres, which get at some of the issues you and colleagues were talking about around more involvement of local communities, more involvement of people who actually live in the communities, in their own health care. So there are innovative ways that are being looked at. It's not perfect, but at least there are people out there who are trying to look at different partnerships in the community and involving women and other community members.

The other issue is around mental health and the issue around the sandwich generation, informal caregiving, which for nurses and other people, particularly women, is a huge issue. This committee could take a lead, and hopefully the federal government will take a lead in the issue around supporting caregivers.

Prof. Abby Lippman: To answer that question, I would just add that it's important to know not just what's being done but how it's being done. There is a lot of research and there are a lot of data that have addressed some of these issues, and the concern many of us have is that those data are sitting here, the policies are being made there, and the connections aren't being made. It's important to know not only where the problems are but how we're addressing them and to pull on the wealth of knowledge from the women's groups themselves, from the women's researchers, in order to keep moving things ahead.

That is why I said it's nice to see all these strategies, but one of my concerns with the mental health strategy is that it does not seem to take gender into account in some aspects. The other is that it does seem to give a lot more weight to pharmaceutical treatment of the mental health problems of women and much less to what the real reasons are for why women may be feeling blue at some point. That's where the "what" and the "how" need to be thought through.

● (1145)

The Chair: Thank you.

Ms. Yelich.

Mrs. Lynne Yelich (Blackstrap, CPC): My question is going to be really short. I'm not feeling too well today.

You mentioned roles and responsibilities in the workplace and said you should acquire more power. How would you ever expect to do that? Ms. MacDonald, I really enjoyed your comments about nurses, because I really do believe that nurses take the hit whenever there are funding cuts, and of course there's the employment equity. I think that happened in eastern Canada; they weren't compensated properly. But how can you get that power? We can change roles and responsibilities from within, perhaps, or we can guide, but when it comes to power, how do you do it?

Ms. Jane MacDonald: I think there are various ways you can address it. One is through the educational system. There's the whole issue around mixing different faculties together so nurses aren't educated separately from physicians, dentists, and social workers. Everyone is educated at the same time and together, so you get used to being colleagues. They each have their special skill set, but they're basically colleagues.

The other way is through putting in place structures that ensure there's representation of not only nursing but other unrepresented or poorly represented professionals and other groups in those management structures to ensure it's not just one group of people who have a voice. During the nineties some of those structures were basically cut down completely, so those structures need to be put back into place by people consciously thinking of the power issues involved.

Mrs. Lynne Yelich: Because unfortunately, for nurses, it always seems to be about labour, it doesn't seem to be about all the other roles and responsibilities. For example, take just the documentation that nurses are responsible for now; there's so much burden and, I think, responsibility put on the nurses that it makes your job very difficult.

But I'd ask you this specifically. I had mentioned the roles and responsibilities, so do you want to address how would you ever do that? Give me an example of where you could apply it.

Ms. Margaret Haworth-Brockman: I don't know if I could come up with an example quickly, but to echo what Ms. MacDonald said, I think we need to set an example by setting standards and guidelines that make sure community consultation is truly happening and truly representative. And the community might be those people who are employed in the particular occupation that we're talking about or that the roles and responsibilities are considered. So if a woman is living in a rural community, is she adequately compensated not only for her travel time and perhaps her child care, but for her personal time away from whatever else she's doing? Because we have to acknowledge that she has made time to come to a consultation, it's something she believes in likely, and that means something else is doing without.

I find right now that, to my horror, women are describing more of a backlash both in their communities and in their workplaces. So what I'm describing is an anti-feminist attitude and arena that they find themselves in, and I really find that quite disturbing. They worry about their jobs, they worry about who is going to look after their families, they worry about their personal safety, and so all of these things are under that umbrella of roles and responsibilities.

The Chair: Thank you.

Ms. Brunelle.

[*Translation*]

Ms. Paule Brunelle (Trois-Rivières, BQ): Good morning, mesdames. I'm pleased to meet you today.

You've all referred to women's health. The social determinants are obviously quite significant for women's health. We know that, when we talk about health, we're also talking about income, social status, work and a set of problems. In addition, there is the problem of jurisdictions. We know that health is a provincial jurisdiction; so that's another problem in addition to the others.

How do you work with the provinces, since health is a provincial jurisdiction, and how do you make sure you don't cause dual-jurisdictional problems, which would complicate the many problems already in existence?

● (1150)

Prof. Abby Lippman: I imagine you're asking me the question.

I'm very much aware of federal and provincial jurisdictions. Most of the time I answer in English because I think better in that language. The interpreters find me difficult since I switch from one language to the other.

I work with the Réseau québécois d'action pour la santé des femmes, and we're very much aware of the differences.

[*English*]

But I think that fundamentally the issues we are trying to address in a federal organization such as the CWHN or any of the centres of excellence, as well as the provincial ones, with respect to the determinants are the same. I'm not a jurist and I'm not a parliamentarian, but it would seem to me that once the principles are there, there can be buy-in by the provinces to do it their ways and how they're going to do it. Quebec has that option to do it in its own way and Quebec usually does it its own way. So I'm not concerned about the stepping on toes so long as there is, within the province itself—and now I speak as a Quebecker—a way to make sure we are following the same kinds of principles and processes that we would encourage when I'm wearing my CWHN hat on the federal level.

I don't know if that addresses it. I think there's always that balance to be done, and for most of these, for the structural determinants, there are some provinces that have been much better in setting up some conditions than others and I think that the provinces should really learn from each other in terms of what's working. The day care in Quebec has been set up as standard for every place else. The CLSC system used to be a model for the rest of the country in terms of rethinking primary care. I think Quebec has destroyed the CLSC system by withdrawing money from it in bad ways, and I would like to see Quebec buying into a primary care model that brings us back to where we were.

I hope that helps address some of your questions.

Ms. Jane MacDonald: On the jurisdictional issue as well, I suppose the CNA would always like to make the point that the federal government, with Health Canada, has I think the fourth largest health system in Canada and it's responsible for the health of aboriginal and first nations people. As far as being a leader is concerned, Health Canada and the federal government can do tremendous amounts around looking at primary health care initiatives and working with communities and aboriginal communities to improve their health status, and hopefully then providing a basis and providing a sharing for other jurisdictions across Canada. But the jurisdictional issue is difficult, not only in provincial and federal governments but also within the nursing profession. It's also an issue there. It's a problem. It's an issue we need to look at.

Ms. Margaret Haworth-Brockman: I would like to add to what the other two have said. When I mentioned jurisdiction issues, I was thinking in particular of the Métis women, who don't fall under Health Canada's jurisdiction and often are ignored in other ways. As well, we at the Prairie Centre and our colleagues are fortunate that we have a mandate to provide policy advice as it's applicable at any level. So we actually have a very good relationship with our two provincial governments and are able to provide some advice. I don't know that we necessarily don't want overlap of jurisdictions. I think there's a place for the federal government to provide the leadership and guidelines that are required across the country so that the provinces follow suit and make sure that women's issues are included in their thinking.

The Chair: You have more time.

[*Translation*]

Ms. Paule Brunelle: We can agree that the government that's closest to women and people in general is in the best position to know what care must be given and what priorities should be established.

I would like to ask you a supplementary question. We're observing the aging population phenomenon. Older women are generally the poorest women, and they have health problems. Furthermore, younger poor women and their children are no doubt preparing for a very difficult future: they will have health problems. What priorities should this committee set at the federal level for the next 10 years? What should we work toward at the federal level?

● (1155)

[*English*]

Ms. Margaret Haworth-Brockman: I want to say that I completely agree, and I think I did mention that elderly women are often not considered when we think about who is poor in this country. The priority I think is to maintain and make sure that there is a basic income and income security for all our citizens and consideration given especially to women, because we need to think about personal income. Household income may not reach all the members of the household and may not be equitably shared in a household. We have good examples in our history of making sure the money gets to the right members of the family, and we need to remember that the power dynamics exist at all levels.

The Chair: Thank you.

Does anybody else a quick answer? If not, I'm going to move to the next.

Ms. Jane MacDonald: In addition to the income issue, the focus of the health system needs to be on health promotion and prevention. There needs to be a complete flip around.... The focus on acute care just isn't going to get us where we need to be.

A voice: Or more on lifestyle.

Ms. Jane MacDonald: Yes, on lifestyle.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Madam Chair. I'll try to ask this quickly because we don't have a lot of time allotment.

Welcome, everyone.

What would you identify as the biggest impediment to women's health, if you can capsulize that as one question? As well, to what would you attribute the apparent lack of proper respect and support for the nursing field, and has that resulted in a reduction of people, women and men, going into this particular field?

The Chair: Who wants to take the first question? Jane.

Ms. Jane MacDonald: The biggest impediment right now in people not going into the nursing field?

Mrs. Susan Kadis: No, just to women's health.

Ms. Jane MacDonald: To women's health? I'd probably go back to the issue around income and lack of community supports. We'll do the first one, right?

The Chair: You can do both.

Ms. Jane MacDonald: You want me to do both? Okay.

For people not going into nursing, actually we have had.... People are still applying for nursing, which is good. But there are the working conditions, the stress levels, the health levels that nurses are living under, and the problems with that. So people are still going into nursing and want to go into nursing, but the job is becoming unmanageable, and this is nothing new. This has been identified for the last 15 to 20 years. The reports are out there. The stats are out there. So whatever is happening, we haven't reached what Linda Duxbury called the burning platform. We still have nurses sometimes, unfortunately, who are doing the work. But they're still interested in being in nursing; it's just that the working conditions are very difficult.

Mrs. Lynne Yelich: … [*Inaudible—Editor*]... education systems, they have to take five years instead of two. There's not a two-year program for nursing anymore, I understand, so that would definitely be a disadvantage.

Prof. Abby Lippman: Yes, I want to address this situation of the nurses. I can't speak for that, but in terms of the biggest challenges or impediments, I think poverty is definitely there, and I think there would be a consensus on that. I can start every talk by saying that the biggest threats to women's health are violence and poverty—but poverty usually comes before violence.

The other concern I would just like to throw in is one I alluded to, which is that I think we're perceiving a re-medicalization of women's concerns under the guise of the lifestyle approach to doing things and the guise of saying there's a pill to prevent everything. I think this is an encroaching concern because it's deflecting attention from what makes women have these problems in the first place.

My concern is, why are all of the things happening to women these days being seen as medical problems, from post-partum blues —everybody now has a serious post-partum depression, and you have to be treated for it—to the plain, ordinary stresses of life being treated with pills? I think we should all use the wake-up call given by the recent scandals with Vioxx and, even more so, Depo-Provera, and recognize that women's health issues are not only being medicalized but also are not being seen outside of the current exact context. So we need to look at the life force of what's happening to women. When we intervene in a young woman's life, what's going to happen when she's older? The real scandal with Depo-Provera shows that, as well as the translation of knowledge that women's groups have had for 30 years into the working field of policies.

Ms. Margaret Haworth-Brockman: Just to add to what my two colleagues have said, I also object to being treated for being female all the time.

But another area where this committee can perhaps provide some influence is in housing. We've already gone on and on about basic income, but housing is another area that's coming up for discussion. There are various round tables and policy think-tanks going on... Appropriate housing in various models—it doesn't have to be one-size-fits-all, but it has be a locally driven solution, based on what the needs of the people are. Providing the means to develop that housing —and not just building it, but operating and maintaining it, so that it has some sustainability—will go a long way to alleviating the pressures of the roles and responsibilities women feel when they are living in poverty.

● (1200)

The Chair: You still have a little bit of time left.

Mrs. Susan Kadis: Regarding the recent funding the federal government is affording the provinces and the recent agreements, of which the details are still being worked out, I'm getting the impression that you feel it's not necessarily enough if it does not reach the right people. Could you elaborate on that? Have you had discussions, for example, with the minister, or those associated with that, and what is your biggest concern with how that money is used?

Ms. Jane MacDonald: I guess for the CNA, our biggest concern is that the money allocated is actually going to be implemented; that's probably our biggest concern.

Prof. Abby Lippman: I think a general concern of the CWHN is where the money is going. Now, I'm only wearing my hat for the CWHN and am speaking only on federal issues, but the CWHN has consistently and forcefully called for accountability to know where the money is actually going and how it's being spent, and whether there can be reporting back so that we can have not only reports back, but reports on the right thing as well.

One of the issues I always like to use is the creation of jobs per se, to get a woman out of poverty, let's say. It's a marker. You can say we've created *x*number of jobs. That's really not a gender analysis of that number, because we don't know what it takes that woman to have that job. Can that woman have the child care she needs so she can go off to work? Is working at a minimum wage job actually going to put her into a lower income level than if she were getting social assistance? What means is she's going to have for taking care of an aged parent who's in the house?

So merely creating a job is good; I'm not saying don't create jobs, but that's only a start of something. Unless it's put into the picture... That's where I talked about the kind of accountability that's done with a gender analysis, to know if it is actually going to directly change situations of inequality and inequity. Those, to me, would be the measures that have to be used, as well as any kind of change in the unemployment rate per se.

The Chair: Thank you.

Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you to the panel for their informative presentation. The downside is that much of what we've heard today is something we're hearing consistently from many presenters.

I actually have two questions. One is that the gendered analysis has come up fairly consistently as well. Part of what I have also heard from presenters is that they're concerned that there actually has been a policy in place since 1995 that has not been implemented in any kind of government-wide way. The other issue is that people are concerned that gendered analysis is actually done in a meaningful way, and I wonder if you could comment on that.

My second question is around the social and economic determinants of health. Health Canada's website, for a number of years, has listed the social and economic determinants of health. One of you referenced—they may be my own words—to the silos that we operate in. Although Health Canada acknowledges the social and economic determinants of health, many of the policies that are actually in place for them are actually the responsibility of other departments. I wonder if you could talk a bit about any recommendations around how there could be a more integrated approach to this. I know those are two big questions, but....

Prof. Abby Lippman: I can only say that I ask the same questions you've been asking, so thank you for asking them.

In terms of making gender-based analysis meaningful, we've been crying about this for a long time. There is work going on right now, and the question is going to be how to get the various government departments and agencies to buy into it, to get the World Health Organization, the United Kingdom, the United States, Canadians in the Women's Health Bureau, all putting together resource kits and trying to do the training to get people to understand what it takes. I don't really know, but maybe it means this committee, which is looking at the status of women, holding people's feet to the fire and saying, “You've committed to doing this. Where have you done it? Show me how it works”. That comes back to the report card we asked for originally, about the minister's strategy for the health of women.

In terms of the determinants, yes, the silos are there. It's sad to see not only that the silos are there, but that they're being misused when they're there, insofar as everything then becomes, “If it's a social determinant and it's education, why haven't you gone to school?” That's done without realizing why a young girl may actually be dropping out of school. If it's a matter of getting activity, it's a matter of not just assuming that everybody can put on their clothes and go to the gym at the end of the day, because that's not an accessible thing. Why aren't the streets safe so women can go on the streets?

My sense is to get rid of those silos. Maybe I'm being a little bit idealistic and romantic, but I guess at my age I'm allowed to revert to that. I think this committee may have that kind of overseeing function that can be called your status of women. We don't live in pieces here. I'm not in the economic pile here, then in the housing pile there, or in the health pile here. I'm me, and what are you going to do about it? I don't mean to be aggressive in saying it, but I'm saying that in terms of the status of women, we should be able to weave those together.

There are resources that have been created out there. We will be very happy to provide any that you want that are available, and we encourage you to develop others.

● (1205)

Ms. Jane MacDonald: I'm going to share my views on the silos. For those of us who have worked in this field for many years, the silos exist, as you know and as I'm sure you've been told. They're very difficult to manage as equally at the community level as they are in the bureaucracy level.

I just want to give a short example. A few weeks ago in Ottawa, there was a conference of the Chronic Disease Prevention Alliance of Canada, It was interesting, and CNA was involved in the planning of that committee. Traditionally, the chronic disease people, the disease groups—that's what they call themselves; you know, heart and stroke, lung, or whatever—I think have been much more disease oriented. It was an interesting process, because in the planning committee there was a tremendous enthusiasm for realizing that chronic disease is not just a physical problem, it's a whole other group of factors that influence how you're going to live with a chronic disease, influence what your life expectancy is going to be, how you deal with it.

The conference was very exciting. We had over 600 people in various groups, including schooling. We had educational people, we had community people, and then we had what I would call your health people. People were talking, people were excited, and they were realizing and putting into practice some of the stuff around social determinants. It wasn't perfect, but at least they were talking over the silos, and the amount of enthusiasm at the conference was very exciting. I'm not sure where it's all going to go, but David Butler-Jones was there, and Carolyn Bennett was as well. It was forcing people into a room where we all had to talk and we had to listen about the different ways that chronic disease is played out across Canada and in different communities.

So that's one example, and I do think we have to break down these silos in very conscious, strategic ways, because there's wisdom in all of the silos that often is just not communicated.

Ms. Margaret Haworth-Brockman: I appreciate your question about gender-based analysis and why it isn't proceeding.

At the Prairie Centre we've done a couple of exciting pieces of work. It's taken a long time to get them done because we also had to work in government timeframes. What we discovered is that practical examples of applying gender-based analysis seem to speak to people in a way that all the theoretical and written training in manuals doesn't seem to provide. Developing practical applications that have to do with people's daily jobs seems to work.

I do think you have some excellent examples coming through CEDAW of just making sure that gender keeps coming up all the time and isn't ignored. I like to remind people that women are not a special interest group, and that this isn't an add-on to their work but should be integrated into their work.

Both my colleagues have spoken well about integrating the silos. The Public Health Agency I think could be an exciting place to start. It's new. It has leadership that understands the issues.

But I think we all can be reminded that throwing money at health care isn't sufficient. We already know that. We have all the evidence. I can provide you with lots and lots of examples. When this comes up at various tables, to be able to say “and that will help health” might be the way to counter some of these arguments.

The Chair: Thank you.

I think that brings you to the end of that.

Ms. Guergis.

Ms. Helena Guergis (Simcoe—Grey, CPC): Thanks very much for being here. I have a tickle in my throat. Hopefully I won't lose my voice.

The subcommittee on the status of women prepared a report on unanswered questions on breast cancer. I'm told it was tabled in 1992. The Canadian Breast Cancer Network notes, however, that many of these recommendations from the report remain outstanding, and that while some regional cancer facilities have been created, rural areas remain isolated from effective cancer treatments.

There are a number of questions here, but I'm just going to read out three: Are there regional differences in access to screening programs for breast cancer and cervical cancer? Do first nations and Inuit women benefit from prevention and treatment services in the same way as other Canadian women? How effectively is information on breast cancer risk and prevention being communicated between researchers and the general public? What efforts are being made to communicate with populations that are hard to reach?

Here is one last question. My mother is a breast cancer survivor, and two of her sisters are. Its been suggested that I try the genetic testing. Do you have any comments on that for me that would be helpful?

● (1210)

Ms. Margaret Haworth-Brockman: I'm going to defer to Abby for your last question, because she's the expert.

There are regional differences in screening for breast and cervical cancer, because of course it falls under provincial jurisdiction largely. Fortunately, groups like the CBCN help to illustrate what the difficulties are.

First nations and Inuit women, to my knowledge, appear to benefit from appropriately provided screening that comes to women, and this really actually is the same for women in any rural or remote or northern community.

Any travel time is extremely difficult for women. They may not have a car. They may have to travel for a day. They may have to make arrangements for children and other dependants.

Risk and prevention communication doesn't necessarily meet people if they don't have the means to pick it up. Not everybody has a computer, or they may not have access to the computer. There might be one in a community centre at ridiculous hours of availability. And who has control over who gets to use it?

What we've heard in the course of our rural project, which was nationwide, is that the basic education means are not getting to women, that they're not in the plain language and local language that are needed.

There are some really very basic things that can be provided. Mobile screening units are one way of meeting an immediate need, particularly for cervical screening for women in the north, and aboriginal and Inuit.

Remember as well that Métis women aren't necessarily being thought of in anybody's jurisdiction. They are particularly marginalized.

Prof. Abby Lippman: I'm going to step in and create some rough waters. First of all, I think I'm going to separate out screening from cervical cancer and breast cancer. Cervical cancer screening is something that should be accessible and available to every woman in this country for whom it is appropriate. I'm going to put cervical cancer aside and speak mostly about breast cancer.

I was at that breast cancer forum. It was an exciting, exciting event. In the 1990s when the whole agenda was put together for breast cancer action, I in fact chaired the subcommittee on research for the breast cancer forum that brought women with breast cancer, survivors, researchers, whatever, together. I want to make about three or four points.

One is that I think we have to be very careful and not talk about screening and prevention as the same thing. They are not. Screening does not prevent anything. Screening may detect something early. I work with a group in Montreal called Breast Cancer Action Montreal, and I work with some other groups that are not really very pro mammography screening for women—certainly not for all women; for selected women, yes. But when you do screening, you pick up an early diagnosis. We do not now know what it means to pick up some of the cancers that are being identified on the mammography, because we don't know if they would, like with prostate cancer, just have been there your whole life and not happened into anything, so we're putting women into a really difficult position. We are not pushing mammography on everybody. Mammography is a detection tool, not a prevention tool.

We unfortunately do not know very much about how to prevent breast cancer, and it's a crying shame, because there's been a huge amount of money put into the basic research about breast cancer development, about medications, about pharmaceutical interventions, but there has been practically no money or very little money put into a really in-depth look at environmental causes of cancer, breast cancer in particular. With other cancers there have been occupational links, but not with breast cancer.

I think we're pretty happy that there is now going to be, starting next year, I believe, if not now, forced labelling of what the chemicals are in all cosmetics, because there is concern about various chemicals, whose names I can't pronounce because my mouth is a bit dry and they all start with “phth”. Phthalates is one of them. We don't know what they do. We need to find this out, but the research has not been going into that kind of environmental research. There are groups that are trying to prepare materials so women know how to ask questions. We just need that epidemiological information.

In terms of the breast cancer genetics, I'm not going to answer that without knowing a lot more, because I'm not a physician. I have been trained in genetics, among other things, but I don't think it would be appropriate for me to answer from what you quickly threw out. Breast cancer genetic screening is a tool that is being used sometimes. I'll leave it at that. But the prevention one is really where things have fallen short.

● (1215)

The Chair: Thank you.

Ms. Torsney and then Ms. Guay.

Hon. Paddy Torsney (Burlington, Lib.): I'm reminded of the anecdote about dealing with the older doctor. The woman goes in with a stomach problem, and rather than ordering up a whole series of tests, he says, “So how are the kids getting along? What's happening with your husband?”

Those are the issues. There needs to be some kind of mix. I'm from the generation that grew up with OHIP in Ontario, and, frankly, there has to be a cure for everything I'm suffering from and I must get it now. So we are losing some of that holistic approach.

I found it fascinating that you're so involved, Ms. Lippman, in the breast cancer area. As you were all presenting such a commonality about the key determinants of health and your approach being so holistic, I wondered if, had we had a breast and cervical cancer group or women's mental health group here, they would not be advocating for a different set of things. I do think everybody is starting to understand that it is much more, that we need to look at these issues of empowerment, poverty reduction, and what have you.

In terms of how we core-fund—because all of you talked a bit about the need for core funding particularly—if we were to try to move back to some kind of core funding, how would we do that? Would we be funding the groups that are already in place and therefore prevent some of the rural women's groups from starting up? Would we have an ever-expanding list? Is there some kind of percentage, like a cap, for instance? Even for provinces, we supported the same dollar figure in each province, but it was a different percentage of welfare, depending on what province you were from. If you were from New Brunswick, it may have been 50%, but the welfare rates were so low compared to Ontario's that I don't know how people survived three days out of the month rather than the whole month.

So how would you go about re-establishing some core funding? What would be the priorities?

To you specifically, Ms. Haworth-Brockman, where is your group involved in the SCPI consultations? I know that in my community, the broad base of individuals who came together on the housing and homelessness need was totally impressive, and they really got to some of these underlying factors. In our community, while there is obviously homelessness, it's the risk of homelessness, and that often means just too great a percentage of limited income on housing needs, and inadequate housing for a lot of people.

If you weren't involved, I'd be very disappointed, but I hope you were involved or that we can get you hooked up. My bigger question is, how do we deal with this issue of core funding?

Ms. Margaret Haworth-Brockman: I'm not sure I can answer right away, but I'd love to work on the problem of reinstating core funding. There are some very fine organizations that are currently struggling, project to project, with enormous energy gone into every single application and all the reporting required. I think the accountability is a fine thing, but it takes a lot of energy and doesn't provide that infrastructure, so I think we need to undo some of those ties that bind. Examples like Status of Women Canada, where there are project funds to particular areas of priority, may be a way to begin that.

I can only think of Manitoba and Saskatchewan, where right now I'm working with civil servants from Status of Women Canada in the regional offices. They hear about a project, are in the community, know what the issues are, and could help develop what would then become reinstatement of core funding. Other than that, I wouldn't want to get too specific.

With regard to SCPI consultations, I personally have not yet been involved, but we have recently supported a couple of projects that are specific to women's housing needs where we work. We're just getting at the table and exhorting people to provide the gendered analysis. Our work was placed elsewhere, and now we are joining the people who are involved in the discussions. Fortunately, we have met some of the key people we need to be talking with. This is largely in Manitoba at this point, and not in Saskatchewan.

● (1220)

Hon. Paddy Torsney: Were any members of your network involved in their local SCPI consultations?

Ms. Margaret Haworth-Brockman: Yes, actually a previous employee went, and her principles for gender-based analysis in allocation of funds were adopted by some of the local community groups. But it wasn't me. I delegated that responsibility.

Hon. Paddy Torsney: But there was some involvement.

Ms. Margaret Haworth-Brockman: Yes.

Hon. Paddy Torsney: Do either of you others have ideas on how we can do something on core funding?

Prof. Abby Lippman: It seems to me there are two parts to the core funding. One is the money that's going back to the individuals, but my concern is with regard to the groups that get funded. Is that what you mean?

Hon. Paddy Torsney: Yes, that's what I mean.

Prof. Abby Lippman: Okay.

I think part of it—and now I'll be a heretical researcher, in some ways—is that the best solutions come out of small groups that work together and know what their problems are. We use the term “one size fits all”, but there is no one size that fits all. They have to be valid.

I think there is a lot of strength and a lot of organization among women's groups already out there that we just have not built on. It's time to recognize what's going on out there, and who's doing what, and to then try to help them get together with what they need to do.

These are not big projects. They don't need a lot of money to get some of these things done. The money is really needed not for projects but for core funding. I think there are too many hours spent writing a grant application for these priorities this week, because when we get the application in, and the priorities change next week, the group has lost all its personnel. It just can't go on that way.

Hon. Paddy Torsney: But do we spend 50¢ per every member of your organization? Do we cover phone lines, say, and half of the rent? I'm really talking about the mechanics here. How do we choose? Do we fund you because you've been in existence for five years, or two years... How do we start new groups?

Prof. Abby Lippman: I don't have the answer to that. I wish I did; I like to think I'm smart, but I'm not. What I would suggest is that a think-tank be set up with those community groups, with those who would not otherwise be identified, and ask them, how would you survive best? What do you need? It may be that somebody needs one paid full-time person, or somebody else needs the rent paid.

So as much as there are consultations about everything, it would be inexpensive and very productive to find out what it could be. And Status of Women should be taking the lead on this.

The Chair: Do you have a very brief answer, Ms. MacDonald?

Ms. Jane MacDonald: The consultation would be very useful, and so would thinking long term. Across Canada there's a duplication of groups, as well, and bringing them together to talk would probably be something very positive that this committee could do. But I would think long term—five years, minimum.

The Chair: Thank you.

Ms. Guay.

[*Translation*]

Ms. Monique Guay (Rivière-du-Nord, BQ): Thank you, Madam Chair. It's a pleasure to see one another again in this new Parliament.

Mesdames, thank you very much for your presentations.

I'd like to comment on the federal government's withdrawal from certain issues. That's why there are a number of problems among women today. We know your concerns about the jurisdictions of the levels of government. Earlier you referred to Aboriginal women. If there is one issue on which the government has not done its job, it's Aboriginal women's health. There is a serious problem in that regard. The government definitely has to move because this is its jurisdiction and its responsibility.

As for social housing, for nearly 10 years now, CMHC has totally withdrawn from financial assistance, even in the case of buildings that belong to it in all the provinces. This has become virtually obsolete. Today the provinces are being asked to take this back, but that's not what we need. We need new housing subsidies so that we can renovate housing units and build new ones. There's been a withdrawal not only in health, but also in housing. Women, families and seniors are being impoverished as a result. Older women suffer greatly from this. There are people with housing problems in each of our ridings. Since they can't afford normal housing, they're waiting for social housing.

We have to examine the situation not only from a health perspective, since health is a provincial jurisdiction, but the situation as a whole. My concern is that there are still overlaps. You said earlier that nurses were being mistreated and not respected. They have the highest rate of absenteeism. There is a Canadian nurses association. Do you do business with the associations? There's one in Quebec. Do you work together? Are you setting up things that can really work, or is each doing its own business without communicating with the others? If you manage to conduct certain studies that could benefit other levels, you should share them. We have to help each other.

You didn't say much about this aspect of the matter, and I would like to hear your comments.

● (1225)

[*English*]

Ms. Jane MacDonald: In terms of nursing, the Canadian Nurses Association—and actually, the federal government has provided quite a few studies over the last two years—in its nursing sector study brought together the various levels of nursing, so registered nurses, licensed practical nurses, and other nurses from across Canada, to try to deal with the issue. This was done in concordance as well with the jurisdictions and with the federal government.

The issue has been studied. It's been worked on. There's been a lot of collaboration across Canada. And that's good, because that hasn't always been there.

So yes, we have been trying to work together.

Prof. Abby Lippman: With respect to the transfer payments and so on, I don't think any of us would disagree with you that we want the money to be transferred back. It has to cut across the various domains, not just across the various jurisdictions.

I think it's interesting as well that in just the health area itself, even though the CWHN works on the federal level, we are also working with the francophonie *hors Québec*, with the Franco-Manitobans and other groups. We do have very close links with groups, as they do in all the provinces. We're not provincially based in that sense. We're all trying to get the same things done, and at the end of the day, doing it in a coherent way is best.

Ms. Margaret Haworth-Brockman: I would just add that I completely agree with your comments on federal spending and the serious problems there. The CMHC's withdrawal of funds is particularly problematic. The programs they do have tend to focus on private home ownership and not on public funding, not on landlords providing decent, adequate housing for their tenants.

I think we at the Prairie Centre are very privileged, with our colleagues at CWHN, among other professional associations, that we have access to computers. We do communicate and share knowledge on new studies that come forward. We are part of listservs. That information is really important. Each of these associations can work on its own part, with the detail that's needed, and then feed that into the greater community of knowledge.

So the information is there. Any way we can provide that, we would be most glad to do so.

[*Translation*]

Ms. Monique Guay: Allow me to make one final comment, Madam Chair. This will be very brief.

You say you're cooperating. I hope that cooperation will increase. When you have nowhere suitable to live, everything else follows: health deteriorates and children live in poverty. If you can't feed yourself properly because all your money goes into rent, everything else follows. I think this is a priority. The federal government withdrew from this field 10 years ago. I know you're very concerned about health, but you may want to include housing in this. This is extremely important at all levels. This is a flagrant problem among Aboriginal people right now, and the government has to get involved again. With a surplus of $45 billion, it could very easily invest in this area.

[*English*]

Prof. Abby Lippman: All three of us have been saying, really, that when we speak about health, we're looking at it almost as the outcome, not as the input. In other words, we're not saying put all this money into medical services, or health services, in the strict definition of health. I think all of us have said that housing, jobs, security of the person, non-violence—these all lead to a woman being healthy or not healthy. In that sense, one has to determine where the energy should go.

I would support what you're saying. If I suggested that all the money should go to health, it's not really what I meant. As I thought I said at the beginning, I don't want to see all the money going to health, because when it goes to health, it usually means going to medical services that I don't think need the money in the same way that we need it in the preventive promotion way. The cures are going to be there, because there's enough private investment and enough private profits to be made in finding cures. There isn't as much profit to be made in the private sector by investing in the housing, the food, the security, the non-violence. And that's where the government has a responsibility to act.

● (1230)

The Chair: Ms. Crowder.

Ms. Jean Crowder: Thank you.

I'm burdened by the weight of evidence out there, by the number of reports and studies and research. We're so well informed about what the problems are, and yet we can't seem to make the movements. Just two weeks ago, Campaign 2000 issued their report on the state of poverty among women and children in this country. I come from a community with a significant population of aboriginal people. My colleague from the Bloc talked about housing, and with regard to aboriginal housing, there are appalling conditions on reserves around water and sewer.

One of you had earlier talked about the disconnect between policy and strategy. I would suspect that many of the committee members here have not really heard new evidence from the witnesses who are talking to us. As I asked the last group of witnesses who came before us, is there anything you can suggest to us to break this impasse around the amount of evidence that's available and the lack of forward movement? I mean, women and children in this country are sliding backwards.

I don't know if you have a couple of specific recommendations that can help us break the logjam so that we can actually move forward on so many of these issues.

Ms. Margaret Haworth-Brockman: I'll leave most of that to my other two colleagues. From our own experience, I would say that the personal relationships we have with the people working in government have gone a long way. As well, making the research directly applicable and meaningful to the job that has to be done seems to be key.

The research is out there. People really want to make good policy, and are doing their very best in their jobs. They're overwhelmed in their own positions. What we need, and what we've so far been able to do in some respects, is to translate that—without getting into the jargon of knowledge translation—and actually demonstrate where the applicability is of the research, and provide the evidence that's always needed in the background material.

Ms. Jean Crowder: Can you send the committee some samples of that?

Ms. Margaret Haworth-Brockman: Sure, I would be delighted to.

Ms. Jean Crowder: That would be wonderful, thank you.

Prof. Abby Lippman: I think one other approach, and it's sort of a generic one, is that those who will be making the policy have to get their hands dirty. They have to work with those who are creating the evidence. Unless they start working together at a higher level, not just saying, “Here's my report, what are you going to do with it?”, it will just sit in a desk drawer someplace.

So one thing would be just to say, if you're going to be moving on this, you're going to start together. We want to change social housing in this country, for example. Who are the people in the government who are going to work on social housing? Who are the people who've been creating the evidence, having the testimony? Sit them down, hold their feet to the fire, and say, move on it; in five years from now we want to see a change. In other words, there's enough data to show that unless you start to engage the policy-makers early on, they'll just sit and ignore it.

Another approach might be—I'm making this up as I go along—at the level of the Canadian Institutes of Health Research, where a lot of this evidence is being generated about what is and is not good for people's health. Hold their feet to the fire as well. Ask them, what knowledge has gone back into the communities, and what are you supporting to make the communities change? They have to have partnerships with the pharmaceutical industries. Well, make non-paying partnerships with community groups, and make them have to live up to those standards as well.

● (1235)

Ms. Jane MacDonald: This is a good question. I think it would be very interesting to have another discussion about this at a strategy session.

There are a couple of things I'd probably say here. One thing is getting people at board tables. The kind of discussion that's occurring here, I'm not convinced it happens at a lot of board tables. People may intellectually say that they agree around, or they understand around, the determinants of health, but I'm not sure they do. At the board table we should try to get not necessarily people like us but people who are community members, who are living in difficult circumstances or experiencing whatever it is.

This goes to another point, that you may want to look at ways of training and educating those community members so that they can participate in these meetings. These aren't easy meetings to participate in. You need a certain set of skills. So that's something very practical one could do with community members and people working at different levels.

I always like to talk about field trips to communities, and I have a feeling that a lot of people who work at the policy level have.... They have their own private lives, and many of those people are parents. Many of those people are women. I would probably try to tap into some of those things.

That takes me back to the caregiver, to the sandwich generation. Look at some of the issues that women themselves are experiencing in the bureaucracy, and try to deal with those in a positive way. Involve them in trying to deal with some of the solutions. Field trips to communities are always good, if you can find the right communities and the right kinds of people to talk about the issues.

Those are just some ideas.

The Chair: Thank you.

Are there any more questions? Ms. Kadis or Ms. Torsney.

Hon. Paddy Torsney: It seems to me that a lot of what you're talking about is fundamental human rights and women's rights. I just came back from Kenya, where we visited some pretty horrifying slums and the only rape crisis centre in Kenya in total. The things they've developed there, we have come to take for granted. Unfortunately, with the issues that they're dealing with because of frustration and lack of equality and everything else, their incidence of rape is frightening. It's the worst example, but it gives you a lot of pause to think about how much we have achieved in this country and how much we have to protect.

I wonder about the role of education and how we encourage the education of boys and girls to understand that it's about rights and equality. How do we get that generational change, so that we don't continue to have these frustrations and so that we don't slide backwards in some of the areas where we are making gains?

Ms. MacDonald, you talked about who is at the boardroom tables. I would like to hope there are a lot more of us at the boardroom tables. In my community, we have a very vibrant social planning council, and they bring together lots of business leaders, as well as others working in social services. They talk about why this is important to everyone in the community. Their head is actually on our economic development board, because it's part of what our community is, and I think it's a great example of integrating the issues.

I once had a real estate agent ask me if it was really true that there were people in our community, because they hadn't ever noticed. Who else but a real estate agent is driving around, all over a community? I wanted to point out the neighbourhoods, as they had seemed to have missed where there are people who are a bit challenged.

No one has mentioned the role of special planning councils. I think they exist in many communities across the country. How do we integrate what they're doing and operationalize the research they are developing and make sure it is integrated across services in our communities? I think they're at the base of dealing with the determinants of health, talking about the impact of lack of food, identifying where we need breakfast programs and things, pushing the business community in particular to play its part, as well as the social services agencies that exist in some form across all of our communities.

You can tackle either one of those if you like.

Ms. Margaret Haworth-Brockman: To answer your question about the role of education, to me it ties directly into health promotion and health prevention, and it absolutely has a role that is always given lip service but never really gets the attention that I think it deserves.

We at the Prairie Women's Health Centre, and probably many of our colleagues, do work with the social planning councils locally because they also have enormous expertise and resources.

I wanted to also mention that community economic development models and community development models do seem to be a way of bringing women into meaningful discussions, making them feel welcome to participate, and providing the means for their meaningful participation. We at the Prairie Women's Health Centre are just beginning to delve into some of that work. We're about to release a study that is very specific to very young women who are at risk of continued poverty and how to address them.

● (1240)

Prof. Abby Lippman: Just to tweak my memory, there was a study completed just recently that was sponsored. I forget who sponsored it, but I was part of the one that was done in Montreal. It was done in four or five locales across the country, based out of the women's Y at Montreal. It was a project on how to engage women from the communities in municipal politics. They have some very interesting material that they've now come out with in terms of the timing issue, when a woman can go and speak up at city hall.

I think it's using those local groups and those local structures as they exist. That's where they will have to tie together the pieces and come out of the silos, because they see them in the place, unlike your real estate agent friend or a colleague or whatever, because they know they're living it.

Ms. Jane MacDonald: I was just going to second what you said around the role of the schools, how important it is, and how often. We don't forget about them, but having two children in the school system, I think it's very easy to see it as a monolith over there that's hard to interact with. I would really encourage the committee to hear from educators who are doing some really innovative and critical things around working with our young people, around caring environments, looking at what needs to be done in the world. There's some really neat stuff going on.

Too often, we forget that it's hard to find the intersect, particularly between health and education sometimes, although it should be very obvious. Public health nurses were very active in schools. They aren't doing as much anymore, but the intersect is critical.

Prof. Abby Lippman: May I make some comments about the school issue? And it may be local, only in Quebec.

One of the concerns we have in a group I'm working with is that the only material available for sexual health education of girls in the province right now is provided by the pharmaceutical companies. There is no allowance being made for community-based material. There is no school nursing program. Health is now considered a transversal in Quebec. I hope it's not the same thing in every other province. But in Quebec right now it's going to be taught by the geography teacher, the history teacher. There is no focus. So it may be useful to bring this in, but these are not teachers who know how to integrate health in a determinants way in the lessons they're doing. So I think there's been a fallback on the pharmaceutical industry for health education. I just had to put that on the table.

The Chair: Thank you.

Does anybody from the Conservatives have any further questions?

Ms. Helena Guergis: I have two questions. On nurses and the safety issues they have, being on the front lines with SARS and other things we've seen, do you feel that has been addressed—safety concerns for nurses?

Ms. Jane MacDonald: Some of it's been addressed. It's certainly not addressed fully because we still don't have enough nurses working in full-time positions, which was one of the issues in SARS. There were nurses working in casual positions so they were going into different areas, and that was a danger to them and to the community as well.

It's being worked on, but we still have the issue that we don't have enough nurses. So there are things that have been done within work environments to make the workplace safer for issues such as SARS, but it's not perfect.

Ms. Helena Guergis: Would you be able to forward something to the committee in further detail on that?

Ms. Jane MacDonald: Sure.

Ms. Helena Guergis: Okay, thanks.

Another question is on the morning-after pill that I hear now is easily accessible over the counter. I have concerns about young women in high school who are perhaps not being educated and protecting themselves. Do you see some concerns with that at all with the access for young women?

I mean, I'm okay with it. Don't get me wrong. I'm just concerned about whether they're going to use it too often and so on.

Prof. Abby Lippman: I am part of a coalition that is working both to ensure the government does put the morning-after pill onto what's called schedule II status, which means it will no longer require a physician's prescription. We would like to go even further and have it completely available over the counter, as you mentioned, which it won't be at that point.

We've done a very deep review of the data. There is no health risk associated with taking the pill. The data from young girls in particular show that they tend to use condoms more after they've taken the pill once than they were before using it. In other words, it's almost like a wake-up call to them.

There is no reason why a young girl or any other woman should have to be counselled by a druggist in order to get a medication. Our only concern is, once it becomes available without a prescription notice, whether the prices will go overboard and young girls will be able to afford it. So it's going to be important in the provinces to keep track of what the pricing is.

I work with a group that hates every drug, practically, or that's what we're seen as—the anti-druggers—but on this one we're pushing very hard to get emergency contraception approved and available over the counter so that you just walk in and buy it. It does not lead to promiscuity. It does not lead to any health dangers. You can take it—actually the two pills—at one time. You don't even have to wait the 12 hours. It's really pretty innocuous, and there is almost less risk associated with it than taking aspirin over the counter, if I can be that brave.

● (1245)

Ms. Helena Guergis: Okay. My concerns were of course more focused around youth not using protection because they think they can take this. You're telling me there's data—

Prof. Abby Lippman: The data in the countries where there have been studies show they actually start using condoms and other contraception better. You don't want to take it twice. People really are not recidivists. They're not repeat users. It really is when there's been an accident—I made a mistake, I wasn't prepared, and now I am.

Ms. Helena Guergis: That data would be very helpful.

Prof. Abby Lippman: We will get it to you very happily.

The Chair: Thank you.

I'm going to go to Ms. Kadis and then Ms. Brunelle and then come to the conclusion.

Mrs. Susan Kadis: Yes, it's been very insightful today, I must say. It's been extremely enlightening. We've had several sessions of this and it's very cumulative—a lot of the same themes are coming up—so it's been quite helpful to me as a new MP.

I'd just like to know how you see this committee's role in improving women's health.

Ms. Margaret Haworth-Brockman: I would encourage this committee and all its members to not step away from the issues of women and to just make everyone realize—your colleagues and other women you work with—that women are not a special interest group. We're not here to bring to your attention minority concerns. I encourage you, and I compliment you on your involvement in this, and I hope you feel strong and able to say this is not about special interests, this is about the greater part of the population.

Prof. Abby Lippman: I would just repeat what I said at the beginning. When you're dealing with a health issue, I would invite the Minister of Health to come and give a report card on what he did since 1999 in terms of the strategy that was there, and I would say we want a new strategy. Work with him to put into those reports the issues you're hearing about—housing, food, security—and all these other issues that you're being informed about by the people you're hearing. Say we want those included in the women's health report. We don't just want to know that *x* number are being screened by mammography. We want a broader picture.

Ms. Jane MacDonald: I would see you as advocates and I would see you as role models for women out there who may not have the voice that you have around this table. If you can bring the issues of women, families, and children to the levels that they need to be at... I'm thrilled that you're doing this work. The CNA is absolutely thrilled and we're supportive and we'll work with you in whatever way we can. That's where I think you have the power. You guys have the power.

The Chair: We're fearful of raising expectations that we can't reach.

Ms. Kadis, you have another couple of minutes...

Thank you very much. We'll talk again. Thank you for your help. I gather you've agreed to send some material to us.

Ms. Torsney.

Hon. Paddy Torsney: You had mentioned that a lot of people needed to have training or to be encouraged to come before committees, and sometimes committees do travel, so it's a little easier. But because we are actually broadcast today, I thought it's not a bad opportunity for a PSA that in fact we do encourage people to approach this committee and every committee in the House of Commons on the issues. They can access it through the Internet at *www.parl.gc.ca* and they can see what work the committees are doing. In fact the House of Commons provides a budget to bring people in for committees like this.

We do actually encourage people. It's much better for a committee to have too many people applying than to have to go out and search. I know, as a former vice-chair of the finance committee at one point, that it's really hard to get women's voices to the table. To all the women who are there watching, if they have a perspective—individually or as part of a group—they can participate. We want more people to know that.

We tried too to send a message when we were at finance that if child care was an issue, we would try to see if there wasn't a way. If people do have child care issues, they should be letting us know so that we can try to find a solution to that, if that prevents people from coming to testify. They can also send in written submissions.

To your earlier point, Ms. MacDonald, I would think that we may want to expand in terms of thinking about the role of education and about making sure more people understand that women's rights are human rights and that it is a crosscutting issue and it would affect many areas. Especially this week, I think that's an important thing to remember.

● (1250)

The Chair: Thank you.

Ms. Brunelle.

[*Translation*]

Ms. Paule Brunelle: Ms. MacDonald, there's one thing that struck me when you began your remarks.

You referred to the erosion of the role of head nurse. As you know, in Quebec and elsewhere, we're having trouble recruiting doctors. In the Quebec regions, among others, they're having trouble attracting doctors. I wonder whether there's a link between this erosion and the fact that nurses can't perform certain medical procedures. If nurses were allowed to perform certain medical procedures, it seems to me that could be a solution to this doctor shortage. Were you suggesting this to us?

[*English*]

Ms. Jane MacDonald: When we were talking about the erosion of the head nurse's role, we were meaning that within the bureaucratic structures of many of the acute care facilities and also in public health, that management level has been taken out. It's now other people.

To speak to your issue about nurses playing other roles in the system and looking at primary health care, certainly with respect to nurse practitioners there is a huge initiative right now, funded by Health Canada through the primary health care transition fund that's looking at the role of nurse practitioners and how nurse practitioners could play a more active role and a more appropriate role in primary health care delivery across Canada, particularly in the rural areas, particularly in under-serviced areas, and in other areas as well. It's a huge issue that looks at interdisciplinary and multidisciplinary tasks in health care. So yes, we're looking at that very closely.

The Chair: Thank you.

Do you have a question?

Mrs. Lynne Yelich: I was wondering if there were any barriers to becoming a nurse practitioner. What are some of the barriers?

I agree, I think there is a real need for nurse practitioners, given the shortage of doctors, but how could we do this? Is it very simple, given the education you have? Would it take much to extend your education to be able to do that?

Ms. Jane MacDonald: We can certainly get the committee more information on nurse practitioners and their preparation, because the project is going on right now in the CNA. What we're looking at is that to be a nurse practitioner you need to have a basic nursing degree. It's on top of a basic nursing degree across Canada. You need more education and more training and practical experience as well. There are barriers because it implies you need training programs and educational programs to do that.

Mrs. Lynne Yelich: I think it was Abby who mentioned, on breast cancer, that the research varied from province to province. I think you said it was research, perhaps just breast cancer, but why is it that some provinces offer more services than others?

Prof. Abby Lippman: As for these decisions that are made in regard to cancer, most—though not all—of the provinces have a cancer care organization that coordinates things. In Ontario it's pretty good compared to the other provinces. So the level of variation depends. In Quebec there's been a mammography screening program for women 50 and over, and we've just finished a study showing where the promises of that program are not working.

The issue of access is for me a double-edged sword. In other words, what would be the right proportion of women who were getting mammography? Personally, I am not a pusher of mammography. It's not something I've ever pushed very hard. I'm much more at the preventive end of things, so I'm probably not the right person to ask what the level of mammography screening should be.

Each group that has set up a program has its own self-determined numbers, and it lives by them. But there are differences in access in terms of timing, when you can go and get it. Some places have mobile X-ray machines that go around, and others you have to go to get them. It varies according to the policy that was made, and these are strictly provincial-level decisions.

● (1255)

The Chair: I'm going to say thank you very much to the two of you for coming here, and particularly for coming here on such short notice. This was very informative. I think I can speak for everybody when I say that. Some of what you presented was quite new to us, but much of it as well repeated themes we've heard in the past, particularly gender-based analysis and core funding. I thank you.

If you have further information, would you please send it to the clerk, and she'll distribute it to us.

To my colleagues on the committee, I look forward to seeing you—as many of you as are healthy—here back across the hall tonight at 5:30. We have a large number of delegations coming.

Thank you.

We're adjourned.

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