Submission To

Roy Romanow, Commissioner

The Commission on the Future of Health Care in Canada

From

The Ontario Women’s Health Council

January 15, 2002
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Focus of Submission

Women are the majority of health care receivers and providers in Canada.

In recent years, there has been growing recognition in government and among decision-makers, educators, community organizations and health care providers that when it comes to health, sex and gender do matter. Exciting new research findings are just beginning to tell us how much. Today, there is a growing understanding of the important differences that exist between women and men in relation to their susceptibility, detection, most effective health treatments, and other aspects of health conditions (Advisory Committee on Women's Health Surveillance, 1999). This recognition has raised awareness of the need to better understand the factors that influence the health status of women and address women’s issues including research, education, leadership and health interventions. Also evident has been the need to better understand how gender bias has affected women as users and providers of the health system and as paid and unpaid health care providers (Health Canada, 1999).

The purpose of this submission is to put the issue of women’s health on the Commission’s agenda and to ensure that women’s health issues, needs and concerns are taken into consideration in all deliberations concerning renewal and change in the Canadian health care system.

The Ontario Women’s Health Council (OWHC) believes that the Commission on the Future of Health Care in Canada has an opportunity to –

- **Build on the knowledge that has been gained about sex and gender differences in health and weave this knowledge into strategic and operational frameworks that will set the future directions and priorities of the health care system;**

- **Reinforce and build on the principles, framework and information included in the recent publications – Health Canada’s Women’s Health Strategy (Health Canada, 2001), and the Ontario Women’s Health Status Report (OWHC, 2002)** and use these documents as the tools for identifying and addressing issues that will enhance women’s health and increasing the attention given to women’s health issues; and

- **Ensure that the foundation of all recommendations put forward by the Commission considers the impact of those recommendations on women’s health.**

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1. See Attachment 1 for an overview and background on the Ontario Women’s Health Council.
2. The OWHC has recently completed this project. The report is being published in early 2002.
The OWHC is committed to working with the Commission to ensure that women's health issues are taken into consideration and that future policies affecting changes in the health care system include, where appropriate, an analysis of the impacts of those changes on the health and well being of women.

**Women's health: why is it important to the future of health care in Canada?**

**Defining “women’s health”**

Women’s health involves women’s emotional, social, cultural, spiritual and physical well being, and is determined by the social, political and economic context of women’s lives, as well as by biology. It is defined by, and recognizes the validity of, women’s perceptions and life experiences of health and illness, the values and knowledge of women, and the role of women both as users and as providers of health care.

Did you know?

Women represent 80% of the health care workforce. They also provide most of the unpaid health care within the home.

OWHC working definition of women’s health

Today, in Ontario, 44 per cent of the provincial budget is spent on health care. While women represent 51 per cent of Ontario’s total population, they account for two-thirds of the users of the health care system.

Even factoring out childbirth, women are admitted to hospital more often, have longer lengths of stay when admitted, and are prescribed more drugs.

Compared to their male counterparts, women also experience more chronic illness, more years of disability and more stress in the work place and at home (Statistics Canada, 2001).

Although women live an average of six years longer than men, their longevity is often a mixed blessing. They tend to suffer harder and longer in their older years with their later life often characterized by isolation, disability and health problems (Statistics Canada, 1998).

In recent years, there has been a growing understanding of how the health status of women³ is affected by the political, social, cultural and economic contexts in which they live. Family relationships and roles, language and culture, the work women do (in the labour force and in the home), their ‘unique’ relationship to the health system (based on their reproductive capabilities and as guardians of their families' health), and their vulnerability to violence all impact on and can compromise their health (Centre for Research in Women’s Health, March 17, 2000).

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³ See Attachment 2 for a more detailed overview of women’s health issues.
In addition to differences that exist in illnesses and health status among men and women, there are also great differences in the attitudes and behaviors of women toward health, and in the way women take care of themselves to preserve ‘good’ health. Women, for example, are more likely than men to have health concerns in mind when they select food. They are also more likely to use vitamins regularly, and to be an appropriate weight for their height. Men, on the other hand, are more likely to engage in vigorous physical activity in their leisure time. Improving the level of physical activity among women is an area that could improve their overall health (Statistics Canada/CIHI, 2001).

**Sex and Gender**

There are two factors that influence the different health experiences of men and women – sex and gender.

**Sex (as in “sex differences”)** refers to biological characteristics such as anatomy (e.g., body size and conformation) and physiology (e.g., hormonal activity or functioning of organs). Falling under this broad category are considerations such as the incidence of disease, anatomy of disease and lifecycle relevance.

**Gender (as in “gender differences”)** refers to the array of socially determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. It encompasses those things that make women different from men, including sociology, psychology and the environment.

A recent report released by the Institute of Medicine, a division of the National Academy of Sciences in the United States, confirmed that the differences in health that exist between men and women extend to the cellular level. This means that not only do men and women differ in their patterns of illness and life spans, but they are also --

- Exposed to disease differently,
- Have different methods for energy storage,
- Have different metabolisms, and
- Respond differently to drugs.

The most recent national concerted effort by women in favour of promoting research into their health was seen in pressures to promote the establishment of an **Institute of Women’s Health** as part of the Canadian Institutes for Health Research (CIHR). The existing Institute of Gender and Health is, however, but one of a number of initiatives that need to unfold in the country to promote greater understanding of and knowledge about women’s health and the factors that affect it.

**Did you know?**

Integrating sex and gender into health research is good science.

Working Group on CIHR, Gender and Women’s Health Research, January 2000
Necessity for integrating women’s health into a renewed health system

- The renewed health system must recognize and address the present inequalities that exist both between men and women and among women. For example, currently, there are stark differences in access to health services for women who are under-served because of social, geographical, economic or cultural barriers. Inequalities faced by women include:
  - Unequal access to primary health care;
  - Health policies and programs that perpetuate gender stereotypes;
  - Inadequate and inappropriate health services;
  - Lack of systematically collected, desegregated and analyzed data by age, sex and socio-economic class.

(Advisory Board of the First International Conference of Women, Heart Disease and Stroke, May 2000).

- The changes impacting on the health landscape need to be viewed through a “gender lens”. When viewed through a gender lens, these changes reveal different pictures for women and for men. For example, a study of women’s health in Atlantic Canada revealed that gender based analysis points to significant differences in teenage smoking, activity limitations among seniors, and different exercise and physical activity trends among men and women not otherwise evident in population level data. Some of the broader trends and changes in the health system that need to be looked at through a “gender lens” include –
  - Changing demographics, marked by an aging and increasingly diverse population;
  - The effect of globalization on the health sector;
  - The increasing use of complementary and alternative health practices and therapies; and
  - The implications of the increased reliance on the Internet and other forms of electronic technology for health information.

Did you know?

- Women living in and fleeing from violent an abusive homes face immediate health concerns and are often responding to health crises of their children.
- Women are more vulnerable to developing degenerative diseases and disorders and/or becoming disabled as they age.

OWHC Policy Scan, Prepared by the Centre for Research in Women’s Health, 2000

Looking at health through a gender lens...

This refers to a process whereby policies or programs are assessed to determine their actual or potential differential impact on women and men. Gender-based analysis is an evidence-based approach that will –
- Lead to programs and policies which are not biased on the basis of either sex or gender;
- Help to ensure that the differential economic, political, social and biological circumstances of both girls and boys, and women and men are taken into account;
- Will profile imbalances in areas, such as, addressing women’s (and men’s) health issues, the under-representation of women in decision making, and/or the absence of women in research.

Women’s Health Strategy, Health Canada, 1999

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New knowledge has been acquired about women’s health to further the women’s health agenda, and contribute to improving the overall health of the population in the process. Much has been achieved through federal policy development to further the women’s health agenda (see Attachment 3 for an overview of key milestones). There is now a solid platform of knowledge to move the women’s health agenda forward within a conceptual framework of the broad spectrum of the determinants of health, not just of biology and genetic endowment.

**Embracing the women’s health agenda: leadership opportunities for the federal government**

The Commission has an opportunity to acknowledge and confirm the role and importance of women’s health in developing recommendations and strategies for renewing the Canadian health care system. In finalizing your deliberations, we respectfully ask that the following considerations be kept in mind:

- That while women live longer than men, they suffer greater morbidity and are, in general, less healthy than men. We need to build on what we know, and the new knowledge emerging about sex and gender differences, to identify and develop appropriate policy and program initiatives that will make a real difference in women’s health.

- That cutbacks, reform, and restructuring in the health system impact women disproportionately because they make up the majority of the workers in the system and are the majority of the users of the system.

- That in determining the future directions of the health system and ensuring its sustainability, it will be important to balance not only investments in prevention and health maintenance with investments directed to care and treatment, but also with those targeted at other important areas that impact on the health of women. For example, consideration must be given to the health benefits to be derived from –

  - Working with other sectors to reduce the burden of poverty that affects the health of families and their capacity to develop healthy environments.
  - Enhancing efforts to prevent and support the cessation of smoking by the most effective policy interventions (e.g., higher taxation, reduced exposure to second hand smoke in public places, etc.)
  - Encouraging flexible work hours and on site day care to facilitate working women’s multiple roles.
In accordance with these considerations, the Ontario Women’s Health Council recommends:

- That, in developing its recommendations, the Commission ensure that the sex and gender differences are provided for and that recommendations made consider the impact of these differences.

  - What policies help women stay or become healthy?
  - What policies pose a threat to women’s health?
  - What policies provide all women access to appropriate services and high quality care?
  - What policies foster women’s participation in decision-making?

An example of an application of this recommendation is to ensure that efforts to promote funding and policy strategies that enhance [and support] home and community based care do not negatively impact on the role of women as caregivers (formal and informal).

- That the Commission require the new system to further the development of new knowledge and understanding of women’s health and women’s health needs by –

  - Investing in and facilitating research in women’s health including disseminating findings and translating findings into policy.
  - Promoting research that realizes the balance of both biomedical and social determinants perspectives.
  - Enhancing existing surveillance activity, developing new surveillance systems and creating an infrastructure to support the previous two activities.5
  - Producing an annual report card on the status of women’s health in Canada.

5 Detailed recommendations regarding Women’s Health Surveillance can be found in the report – *Women’s Health Surveillance – A Plan of Action for Health Canada* (1999).
Attachment 1: About the Ontario Women’s Health Council

The Ontario Women’s Health Council (OWHC) was established in 1998 by the Ontario Government to act as a catalyst for bringing about vital and positive changes to improve the health of women at all stages of life.

An independent arms-length agency from government, the work of the Council is focused on creating a legacy of systemic change that will be embedded in the health care system for years to come. To achieve this goal, the Council is working to:

- Establish a solid base of information, evidence and new knowledge that will increase understanding about the factors that contribute to women’s health;
- Advocate and make recommendations for improving women’s health and applying new knowledge acquired to improve the health of women and the decision-making of researchers, educators, government, community organizations and health care providers;
- Contribute to the provincial, national and international body of knowledge and research on women’s health issues; and
- Stimulate the advancement of women’s health by identifying where change is needed and by bringing forward solutions for integrating required changes into the complexities of today’s health care system.

The Council’s work is guided by activities related to three broad strategic directions:

- Research & Innovative Practices
- Education & Outreach
- Advocacy

The Council’s goals are to:
- Improve women’s health in Ontario;
- Promote better access to information and healthcare; and
- Help empower women to make decisions about their own health and health care.

Membership and Funding

Chaired by N. Jane Pepino, the OWHC is comprised of 13 members appointed by the Minister of Health and Long-Term Care. Members bring a broad range of expertise in the areas of treatment, research, public and community health, corporate and consumer issues. The Council receives ten million dollars in annual funding from the Ontario Ministry of Health and Long-Term Care to support its research, partnership and advocacy activities.
Membership

N. Jane Pepino, CM, QC
Partner in the Toronto Law firm Aird & Berlis LLP, Board Member of Sunnybrook & Women’s College Health Sciences Center and Chair of legislated Women’s Health Committee, Board Member and past Chair of Women’s College Hospital and received the Order of Canada, April 2000 (Chair and Member since December 1998)

Nancy Birnbaum, BA, MBA
President and Chief Executive Officer of Invest in Kids Foundation (Member since October 2000)

Ellen Hodnett, BSN, MScN, PhD
Professor and Heather M. Reisman Chair in Perinatal Nursing Research, University of Toronto, Faculty of Nursing (Member since December 1998)

Terumi Izukawa, B.Sc, MD, FRCPC
Deputy Head, Department of Geriatric and Internal Medicine at Baycrest Centre for Geriatric Care, and Assistant Professor, Faculty of Medicine, University of Toronto (Member since December 1998)

Nova Lawson, BA, MBA (In Progress)
Coordinator, Aboriginal Initiatives, Lakehead University and Chair of the Provincial Early Years Steering Committee- Aboriginal (Member since October 2000)

Guylaine Lefebvre, MD, FRCSC, FACOG
Chief of Obstetrics and Gynecology at St. Michael’s Hospital and Chair, Clinical Practice Committee for the Society of Obstetricians and Gynecologists of Canada (Member since February 2001)

Marilyn Linton, BA
Health Editor of the Toronto Sun, Immediate Past Chair of the Canadian Breast Cancer Foundation, Ontario Chapter Toronto, and past President of the Canadian Club (Member since December 1998)

Miriam McDonald, BScPhm, MSc,
Chief Executive Officer of the Northeastern Ontario Medical Education Corporation in Sudbury, member of the Sudbury-Manitoulin Alzheimer Society Capital Campaign Cabinet and the Northern Research Ethics Board (Member since December 1998)

Susan McNair, BA, MD, CCFP, MCISc(FM)
Family physician and Associate Professor, Department of Family Medicine at the University of Western Ontario (Member since December 1998)

Patricia R. Petryshen, BA, BScN, MSN, PhD
Vice President of Patient Care Programs and Chief Nursing Officer at St Michael’s Hospital, Toronto and Associate Professor, Faculty of Nursing, University of Toronto (Member since December 1998)
Nancy Ross, BScN, MSA  
*Former Chief Executive Officer of the Dufferin-Caledon Health Care Corporation and Registered Nurse (Member since October 2000)*

Donna E. Stewart, MD, DPsych, FRCPC  
*Professor and Chair of Women’s Health, Senior Research Scientist, University Health Network and University of Toronto and Chair of the Section of Women’s Mental Health World Psychiatric Association (Member since December 1998)*

Ruth Wilson, MD, CCFP, FCFP  
*Professor of Family Medicine, Queen’s University, and Chair of the Ontario Family Health Network (Member since December 1998)*

**Milestones & Achievements**

**Chairs in Women’s Health**
- Established an annual endowed Chairs in Women’s Health program to ensure a permanent commitment to the mission and mandate of the OWHC. In 2001, issued and awarded Chairs to the University of Ottawa (Institute of Population Health) and University of Toronto (Faculty of Nursing).
- OWHC has recently completed the selection of a new chair that will be announced in February 2002.

**Scholar Awards Program**
- Established an endowed Scholar Awards Program to ensure that Ontario attracts and retains pre-eminent women’s health scholars.

**Education of Health Professionals**
- Assisted in the development of a database of clinical practice guidelines on women’s health to improve health professionals’ access to these guidelines.
- Completed *Evaluation Instruments in Women’s Health for Physicians* – a report that promotes the inclusion of women’s health issues in the testing/licensing of physicians.
- Supported development of MAIN PRO-C on the topic of osteoporosis.

**Health Information/ Informed Women’s Decision-Making**
- Issued a call for proposals and funded 17 demonstration projects (across the province) addressing two core themes: women’s informed decision-making; equitable access to effective health services for women.
- Developed a web-based database of consumer education materials focused on women’s health.
- Supported regional *Resource Directories on Women’s Health* with the Ontario Women’s Health Network to provide on-line and print information on local women’s health resources.
- Commissioned research to identify best approaches to assist women in coping with medical conditions.

**Access to Health Services**
- Advocated for improved access to information and services to promote reproductive choice. Supported development of a pilot project to increase availability of emergency contraception.
- Successful in securing camera equipment and training for 31 sexual assault treatment centres in the province to provide those involved in prosecution of sexual assault, comprehensive and credible forensic documentation in a timely manner.

**Measurement and Evaluation**
- Participated on the Joint Steering Committee and co-funded the Ontario Hospital Association’s *Hospital Report Card 2001/02* project to ensure development and inclusion of meaningful women’s health indicators in the Report.

**Selected Reports / Recommendations to Government**
- In June 2000, the Council released its report on *Attaining and Maintaining Best Practices in the Use of Caesarean Sections*. The report describes several “best practices” that have been integrated successfully into four maternal and newborn programs in the province. The report also sets out recommendations for hospitals and the broader health care system for attaining and maintaining low caesarean section rates.

- In November 2000, the Council presented the Minister of Health and Long-Term Care with its report - *A Framework and Strategy for the Prevention and Treatment of Osteoporosis*. The report outlines recommendations for developing an integrated approach to the prevention, early diagnosis and treatment of osteoporosis from a woman’s health perspective.

- In January 2001, the Council released *Literature Review -- Best Mechanisms to Influence Health Risk Behaviour*. The report compiled the results of a critical appraisal of the published literature in the areas of health promotion and prevention and the area of public policy to identify best mechanisms to influence health risk behaviour among the public, particularly Ontario women. The report describes effective ways to change behaviours that have an impact on health, such as smoking, alcohol and drug use, sexual behaviour, violence against women, nutrition, physical activity and screening for breast and cervical cancer.

- In January 2002, Council released *The Consumer Education Scan on Women’s Health Issues*. This report determined what health information exists in the public domain on women’s health issues with a health promotion focus.

- The OWHC is currently finalizing a document compiling current information on the health, and determinants of health of Ontario women in a single volume included in a report titled – *Ontario Women’s Health Status Report* (pending publication).

Recommendations included in these reports are being disseminated widely to senior staff at the Ministry of Health and Long-Term Care, health care professionals and medical researchers. Efforts are also under way to communicate the key findings from these reports to the public and the media.
Attachment 2: Women’s Health – an overview

Women’s health and the impacts on it are changing in significant ways. Understanding the key trends and drivers of change are integral to determining the role of women’s health in reshaping the underlying infrastructure, processes and relationships that will be part of the renewed health care system in Canada.

**Health Status Indicators**
- Women outlive men by six years. However, because they generally outlive men, women are more vulnerable to developing degenerative diseases and disorders and/or become disabled as they age.
- Life expectancy varies considerably across local regions and sub-populations. Differences in health care behaviors, which have an effect on heart disease, cancer and unintentional injuries are major contributors to these differences.
- While the majority of Canadian women enjoy excellent health, there are specific sub-groups of women who tend to have poorer health (e.g., Aboriginal women, women with disabilities, lone mothers and immigrant women).

**Social and Environmental Determinants of Health**
- Poverty among women ages 65 and over is nearly twice that of men in the same age group.
- Women now make up half the paid workforce, but they spend more time than men attending to family responsibilities.
- Divorce, unemployment/under employment and inadequate pay for work done contribute to the likelihood of poverty, which is directly linked to health status.
- Violence against women (physical and sexual assault) is a key environmental determinant impacting on the health of many women. Individuals at highest risk are urban women, younger women (aged 15 to 24 years), lone mothers, Aboriginal women, and women with disabilities.
- Violence against women is a health and health care issue. Women living in and fleeing from violent and abusive homes face immediate health concerns and are often responding to health crises of their children. Women exposed to violence – whether as a child or an adult – are more likely to have physical and mental health problems and use more health care services.

**Diseases and Disorders**
- One of the areas of greatest difference between women and men is their respective profiles of mental health disorders. Studies report higher levels of depression among women. Young women, in particular, are more apt to have a low self-image.

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6 The majority of information in this section is adopted from the report – *Ontario Women’s Health Status Report* – commissioned by the OWHC as the first comprehensive attempt to compile current information on the health, and determinants of health of Ontario women [2002]. The report will be released in Spring 2002.
The rate of psychiatric hospitalization is consistently higher for women. Psychiatric disorders place women (and men) at risk for suicide and suicidal behavior. While men commit suicide more frequently, women attempt suicide more often but are more likely to fail in their attempts.

Body shape dissatisfaction, social physique anxiety and preoccupation with weight are increasing among girls and young women.

When it comes to cancer deaths in the age group 20-44, women in the prime of life are dying in greater numbers than men. These deaths are primarily due to breast cancer. However, unprecedented numbers of women are now dying from lung cancer.

At Risk Groups
- Aboriginal women have a significantly shorter life expectancy than non-Aboriginal women, and are at higher risk of chronic disease, infectious diseases and mental illness.
- Determinants of Aboriginal health include a history of oppression, loss of autonomy and traditional ways, low socioeconomic status, substance abuse and violence.
- The health of immigrant and visible minority women is largely shaped by environment and living conditions, and may change in response to pressures associated with poverty, marginalization and inequity.
- Most immigrant women arrive in Canada in good health but experience an increased risk of poor health status over time due to financial hardship, work and resettlement related stress, inadequate social support, changing health behaviours, barriers to appropriate health services. These factors also increase the risk of family violence.

Health Concerns/Priorities of Women
- There are a number of health issues unique to women including mental health concerns/issues; violence against women/girls; pregnancy and childbirth; unintended pregnancy; older women; reproductive health; female cancers.
- There are a number of health issues more common in women than men (e.g., breast cancer, depression, auto-immune diseases, violence, poverty, quality of life, active living, occupational health, chronic and degenerative diseases, nutrition; prescribing practices).
- When women are asked what is crucial for their health and quality of life, while the order of themes may differ slightly, the list is always the same. Beside "the classics" - all stages of the cancers prevalent in women; cardiovascular diseases; diabetes; and tobacco use - women identify the following as priorities:
  - Musculo-skeletal disorders with emphasis on osteoporosis, arthritis and auto-immune diseases including chronic pain;
  - Mental health, with emphasis on depression, anxiety and self-harm; and
  - Abortion and reproductive health (basic research and health services research);
  - Violence in its many manifestations and its impact on women's physical and emotional health (Begin, 2001).
Work/Labour Force Participation

- In 2000, approximately 50.5% of women aged 65 or older participated in the labour force, compared to 72.5% of men. Women are more likely to be engaged in part-time employment – 28% of women and 10% of men worked part time in 1999.

- Women make up the majority of the health labour force and provide home care for ill and convalescing family members but are not well represented among health policy decision-makers.

Important policy issues and implications emerge from these trends that can help inform where investments and changes in the future health system should be made to enhance the health and well-being of women.
## Attachment 3: Federal policy development in women's health – an overview

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<th>Year</th>
<th>Event</th>
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<td>1970s-80s</td>
<td>The women's movement in Canada highlighted women's health. The community and government begin to take notice.</td>
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<td>1981</td>
<td>Health Canada funds <em>Healthsharing</em>, a woman's health magazine.</td>
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<tr>
<td>1986</td>
<td>Federal Government conducts a national survey on women's health</td>
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<td>1993</td>
<td>Release of <em>&quot;Working Together for Women's Health: A Framework for the Development of Policies and Programs.&quot;</em> [developed by a working group of federal/provincial/territorial representatives]. The document identified a number of women's health priorities and emphasized the importance of addressing how these priorities affected groups at special risk or the “doubly disadvantaged” (e.g., women with disabilities, immigrant women, women of colour, Aboriginal women, adolescent and elderly women, women who were poor, isolated and lived in rural areas). Health Canada establishes the Women's Health Bureau to promote an understanding of gender as a critical variable in health; analyze and assess the impact of policies, programs and practices in the health system on women and women's health; ensure that women's health concerns receive appropriate attention and emphasis within Health Canada; and Maintain an ongoing relationship with major health and women’s organizations.</td>
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<td>1995</td>
<td>Centres of Excellence for Women's Health Program (CEWHP) created to improve the health of women by fostering collaboration on innovative, multi-disciplinary research and action-oriented approaches to initiatives and woman-centred programs and policies. Canada adopts the <em>Platform for Action</em> – the concluding document of the Fourth United Nations World Conference on Women (Beijing, 1995) affirming its commitment to support the global recognition that the health system should accord women and men equal “treatment,” in every sense of the word, and should strive to attain equitable outcomes for both. In its final report, the National Forum on Health observed that the health system must pay more attention to the factors that influence women's health and be more responsive to the distinct needs of women.</td>
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<tr>
<th>Year</th>
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<td>1996</td>
<td>Health Canada revises its regulatory guidelines to require that drug companies also include women in clinical trials, in the same proportion as are expected to use the drug (to resolve the problem of findings related to drug studies being generalized to women, based on research conducted only on male subjects)</td>
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<tr>
<td>1999</td>
<td><em>Health Canada’s Women’s Health Strategy</em> – released to provide a framework to guide Health Canada in fully integrating gender-based analysis in the Department’s program and policy development work. The Strategy is a reflection of the Federal Government’s resolve to improve the health status of women in Canada (Health Canada, 1999) and focuses on achievement of the following objectives: 1. To ensure that Health Canada’s policies and programs are responsive to sex and gender differences and to women’s health needs. 2. To increase knowledge and understanding of women’s health and women’s health needs. 3. To support the provision of effective health services to women. 4. To promote good health through preventive measures and the reduction of risk factors that most imperil the health of women.</td>
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