MEASURING SUSTAINABLE DEVELOPMENT

THE NOVA SCOTIA GENUINE PROGRESS INDEX

WOMEN'S HEALTH

In

ATLANTIC CANADA

A Statistical Portrait

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WOMEN'S HEALTH IN ATLANTIC CANADA: Abstract

While not a comprehensive overview of women's health in the region, this report to the Atlantic Region Policy Forum on Women's Health and Well Being illustrates the utility of a health determinants approach, both for improving population health and women's health and for reducing long-term health care costs. The report notes the highly interactive nature of the determinants of health, and points both to data limitations and the need for more research in the area.

The report presents statistical evidence to illustrate the need for strategic investments in several key determinants of health to improve women's health in Atlantic Canada:

1) Gender-based analysis reveals different health patterns and outcomes among men and women. Teenage smoking, activity limitations among seniors, and different exercise and physical activity trends among Atlantic men and women are used as examples.

2) Increasing stress levels have negatively impacted mental health and psychological well-being among women, which in turn produces adverse physical health outcomes.

3) Despite increased educational parity, the persistent gender wage gap and high poverty levels among single mothers and unattached elderly women negatively impact health. Social and income supports for single mothers are seen as a key investment priority.

4) Interventions to reduce high smoking and obesity rates in the Atlantic provinces and to increase exercise rates can significantly improve population health and reduce treatment costs.

5) High levels of social support and voluntary work are a key buffer against stress and ill-health in the Atlantic provinces. However, the shift from hospital to home care threatens the well-being of informal caregivers, mostly women, and illustrates the need for adequate supports for these caregivers.

6) The report concludes by demonstrating that the Atlantic region receives far less than its fair share of health research funds, which must be dramatically increased if Atlantic Canadians are to learn about their particular health issues and determinants, and to target health promotion investments effectively in the region.

WOMEN'S HEALTH IN ATLANTIC CANADA

Purpose and Framework

1. Approach

Policy discussions on health issues currently focus almost entirely on disease treatment. Health is generally thought of as the absence of disease, and "health care" expenditures are devoted almost entirely to the treatment of illness. It has been estimated that health *promotion* and disease *prevention* account for only about 2% of health budgets.

By contrast, this analysis follows the World Health Organization definition of health as:

> *…a state of complete physical, mental, spiritual and social well-being, and not merely the absence of disease.*

That view of health has practical policy implications. Disease treatment is far more costly than investments promoting health and well-being. The serious budgetary crisis in the Canadian health care system is provoking a major shift in focus to the *determinants of health* -- the physical, mental and social factors that cause and predict health outcomes.

Health Canada has identified twelve such "determinants" of health -- including education, income, employment status, gender, personal lifestyle, and social supports. Understanding these determinants not only moves us closer to the broader WHO perspective on health, but enables policy makers to target strategic investments in *population health* that can produce significant savings in later health care costs.

2. Limitations

Although this seems obvious, there are currently serious obstacles to this approach, both from a policy and an information point of view:

1) A population health approach requires genuine cooperation among government agencies in order to integrate social, economic and environmental policy with health outcomes. Our current sectoral approach to decision-making, each department with its own budget, hierarchy and mandate, makes it difficult to affect the determinants of health positively.

2) The determinants of health are highly interactive. For example, unhealthy lifestyle habits are highly correlated with low income and poor education. This is basically good news, because a strategic investment in one determinant can produce positive outcomes in several others. But our understanding of the causes and nature of these interactions is still very limited by the paucity of research and analysis in this field.

3) The Advisory Committee on Population Health has made tremendous progress in advancing the determinants of health approach in its 1999 *Second Report on the Health of Canadians* and the accompanying *Statistical Report* based on the 1994-95 and 1996-97 *National Population Health Surveys.* But those reports frankly

acknowledge major data gaps in areas like mental health, *quality* of health care, environmental health impacts, trends over time, and provincial breakdowns according to health determinants..

For example, there are almost no published population health data giving basic gender breakdowns at the provincial level. For this report, the author accessed electronic Statistics Canada data containing raw figures that were then correlated manually with population statistics in corresponding years to assess incidence rates over time. Far more work is needed to assemble and present population health data in forms that are easily accessible to the public and to provincial policy makers responsible for health policy.

4) The Atlantic region currently receives less than one percent of health research funding from the major national research councils, far less than the region's population share merits. Good information on specific Atlantic region health determinants will be difficult to obtain unless research funding to this region is dramatically increased.

Because of these and other limitations, this report does not attempt a *comprehensive* analysis of women's health in the four Atlantic provinces. It focuses instead on selected key issues in women's health to illustrate the utility both of gender-based analyses of health issues and of the population health approach in general. Despite the limitations described, the report also demonstrates that we *already* know enough about what determines health in several key areas to invest strategically in ways that will certainly improve population health and cut long-term health care costs.

3. Why a Gender Perspective?

Instead of blunt across-the-board solutions that often miss the mark, waste money, and even cause harm to particular groups, a gender perspective can allow policy-makers to identify and target health care dollars more effectively and accurately to achieve the best return on investment. The more precisely health dollars are directed to high-risk groups, the greater the long-term cost savings to the health care system.

For example, a gender based analysis reveals that teenage smoking rates have been rising faster among girls than boys. In Nova Scotia, 38% of high school girls smoked in 1998, up dramatically from 26% in 1991. We also know that lung cancer mortality among women today is five times higher than it was in 1970, that women smokers are more than twice as susceptible to lung cancer as male smokers, and that teen smoking predicts adult behaviour. Surveys also tell us that young women have more than twice the stress rates of young men, and that stress relief and weight loss are primary motivations for smoking among teenage girls. Programs, brochures, materials, and counseling that acknowledge these gender-specific motivations and consequences are more likely to be effective than blanket statements about the health effects of smoking.

Similarly, gender-based health analysis reveals that more than twice as many older women suffer activity limitations from arthritis than men, but that older men are far more likely to have heart problems. We also find that exercise rates among Atlantic region men have dropped precipitously since 1985, but increased among Atlantic women. Physical exercise regimens, physiotherapy programs, and health promotion programs geared to these different gender-based needs and trends will also be far more effective than a "one-size-fits-all" approach.

In these simple examples, it is quite clear that attention to gender-based lifestyle determinants of health can reduce high future health care costs. Federal Health Minister Allan Rock announced last year:

> *I have undertaken to fully integrate gender-based analysis in all of my Department's program and policy development work.*

The Minister also spoke of "the need to enhance the sensitivity of the health system to women's health issues," and "the need for more research, particularly on the links between women's health and their social and economic circumstances." That recognition sets the stage for a fundamental re-orientation of health policy at all levels.

WOMEN'S HEALTH IN ATLANTIC CANADA

Executive Summary: Determinants of Women's Health

The following examples indicate that a health determinants approach can assist policy makers in making significant improvements to population health in general and women's health in particular. Again, it should be emphasized that the sample results that follow are by no means a comprehensive overview, but are intended here for illustrative purposes:

1) Mental Health

In 1985 Atlantic Canadian women registered lower stress levels than men. Women now have much higher stress levels than men; and 20% more Atlantic Canadian women than men register *low* levels of psychological well-being. Women still do nearly twice as much unpaid housework as men, with 38% of employed mothers registering "severe time stress" levels as they juggle their double work burden. Time stress and long work hours are implicated in cardiovascular, gastrointestinal, neuroendocrinal and other disorders.

Among the Atlantic provinces, Newfoundlanders have the highest levels of mental health, and Nova Scotians the lowest. Women have a 14% higher rate of psychiatric hospitalization than men, and a 21% higher rate of general hospital admission for mental disorders, with particularly high separation rates for depression. As psychiatric illness accounts for more hospital days than any other illness, women's mental health and stress is clearly a high policy priority.

2. Education

Educational attainment is positively associated with both health status and healthy lifestyles. Women have made major progress in this area: There are now four times as many women university graduates as there were in 1971, and there are less female than male high school dropouts in Atlantic Canada.

3. Income Distribution and Poverty

Poverty and income inequality are the among the most reliable predictors of poor health. Despite relative educational parity, Atlantic Canadian women earn only 81% of the hourly wages of men. Even with identical education, field of study, employment status, work experience, job tenure, age, job duties, industry and occupation, female hourly wages are still 10% lower than equivalent male wages. Full-year full-time working women in the Atlantic provinces earn 71% of male wages, with a quarter of these women earning less than $15,000 a year ($8 an hour or less).

Nearly one in five Atlantic Canadian women live in poverty. Single mothers and unattached elderly women have the highest poverty rates, with more than 70% of Nova Scotian single mothers living below Statistics Canada's low-income cut-off. Nearly half

the province's poor children live in single parent families. Low-income earners have poorer physical and mental health and higher rates of hospitalization and health service usage. Just as concerted public policy has dramatically lowered poverty rates among seniors, improving social supports for single mothers is one of the most cost-effective strategic investments governments can make to reduce long-term health care costs.

4. Personal Lifestyle

The Atlantic provinces and Quebec have the highest smoking rates in the country, and Nova Scotia women register the country's highest lung cancer rates. Although public support for smoking restrictions is higher in Atlantic Canada than in the rest of the country, a smaller proportion of this region's population is protected by restrictive by-laws than in the other provinces. Atlantic region exercise rates are below the national average, and Atlantic Canadians have higher rates of obesity and high blood pressure. The four Atlantic provinces register the highest rates of unhealthy body weight in the country. Obesity is linked to diabetes, heart problems, asthma and many other illnesses.

5. Preventive Health Services

A higher percentage of Atlantic region women have been screened for cervical cancer using Pap smears, but they are less likely to have been tested recently than other Canadian women. Newfoundland and Nova Scotia have the country's lowest rates of mammogram screening, with long waits the norm. As the Maritimes have high breast cancer rates, easier access to screening for older women could reduce breast cancer mortality in the region. All four Atlantic provinces have succeeded in dramatically reducing teen pregnancy rates from among the highest to the lowest in the country.

6. Social Supports

Atlantic Canadians have the highest rate of voluntary work in the country, and one of the strongest networks of community and social support, a proven buffer against stress, social problems, and adverse health effects. Nevertheless, the shift from hospital to home care for many disabled, elderly, and chronically sick patients, has placed an increasing burden on family caregivers, particularly women, with negative effects both on earning capacity and time-stress levels.

7. Conclusion

These and other health determinants are highly interactive, with investments in one yielding improvements in several others. While considerably more research is needed to understand the nature of interactions among the determinants of health, the examples above illustrate that well-placed strategic investments at this time can greatly reduce future health care costs. Alleviation of high poverty rates among single mothers stands out as a highly effective intervention that can improve the health status of both women and children, promote healthy lifestyles, and reduce long-term hospitalization and health service utilization costs.