

A Profile
of Women's Health
in Manitoba



Introduction





A *Profile of Women's Health in Manitoba (Profile)* is a partnership of Prairie Women's Health Centre of Excellence (PWHCE)¹, Manitoba Health and Healthy Living, Health Canada's Bureau of Women's Health and Gender Analysis, and the Health Canada Manitoba-Saskatchewan Regional office. The *Profile* is a first-ever comprehensive review of over 140 indicators of women's health in the province, including an examination of health status, health services use, socio-economic influences, health system performance and lifestyle choices. *Profile* was developed using existing data from provincial health administrative files (aggregate data about physician and hospital use), national surveys, Census of Canada, and municipal and other studies. Using a gender-based analysis (GBA) the data are presented in the context of women's lives, using the most current research literature and community knowledge, to understand better what the data report. Where possible, the analysis includes information by RHA, age, and Aboriginal ancestry, as well as urban-rural comparisons for women in the province, providing a unique report on the status of women's health in Manitoba, and with recommendations for data monitoring and policy change.

The *Profile* is in keeping with epidemiological and health planning research already underway in other jurisdictions. National and international examples demonstrate how the production and publication of this *Profile* increases the breadth of knowledge about women's health by contributing new information on the ways in which gender influences health and how gender interacts with other social and clinical factors [1, 2, 3, 4, 5]. These profiles and surveillance reports have proven very popular and have been requested by a variety of governments, health planners and clinicians because they provide the type of detailed information needed for effective and efficient allocation of scarce resources.

This introductory chapter gives some context about Manitoba for the *Profile*. Following a brief look at the province and its geography, we provide a short description of how health care is delivered, including a description of how health service delivery for Aboriginal women is complicated by jurisdiction and historical entitlements. The chapter concludes with information about the value of looking at women's health indicators and how the *Profile* is presented.

Manitoba

The province of Manitoba is in the east-west centre of Canada, south of the arctic territories, with a southern border with the United States of America (see Map 1). As is the case for most Canadian provinces, Manitoba's land mass is vast (649,950 km²), with a relatively sparse, unevenly distributed population (1.2 million). More than half the population lives in the capital city, Winnipeg (640,000), with two smaller cities of Brandon and Thompson having populations of 39,716 and 13,256, respectively. While Thompson is more northerly, most of the Manitoba population lives south of 53°N.

¹ PWHCE is funded by the Women's Health Contribution Program of Health Canada to improve the health of women and girls through policy advice, new research, information analysis, networking and communications. For more than 10 years PWHCE has developed considerable expertise in applying gender-based analysis to health and health-related issues at all levels; locally, nationally and internationally. For more information about PWHCE see www.pwhce.ca





Map 1: Canada

The original indigenous peoples lived throughout what is now called the province of Manitoba (See Chapter One for a brief description of the women of Manitoba, including an explanation of the term Aboriginal and the women it describes.) During European colonization, Aboriginal people were moved off their traditional lands by force and by law, and many were required to live in reserves set up by the Canadian government.

Although Europeans came to Manitoba for opportunities in farming, forestry and mining, most of the land in the province is not arable. A great deal of the “land” in Manitoba is in fact covered with freshwater rivers and lakes.

The history of the settlement and colonization of Manitoba, and the distribution of the arable and non-arable land, has led to considerable disparities in economic development and economic stability. Systematic and systemic oppression have created large inequities for Aboriginal residents in particular. Other rural residents are largely dependent on single resource-based incomes that can be unstable, subject to the vagaries of weather, market demands and international trade agreements.

Manitoba’s first immigrants came from Scotland, England and France, and later from other European countries. Newcomers and new immigrants continue to settle in Winnipeg and other towns, most recently from Southern and Southeast Asia as well as Northeast Africa.





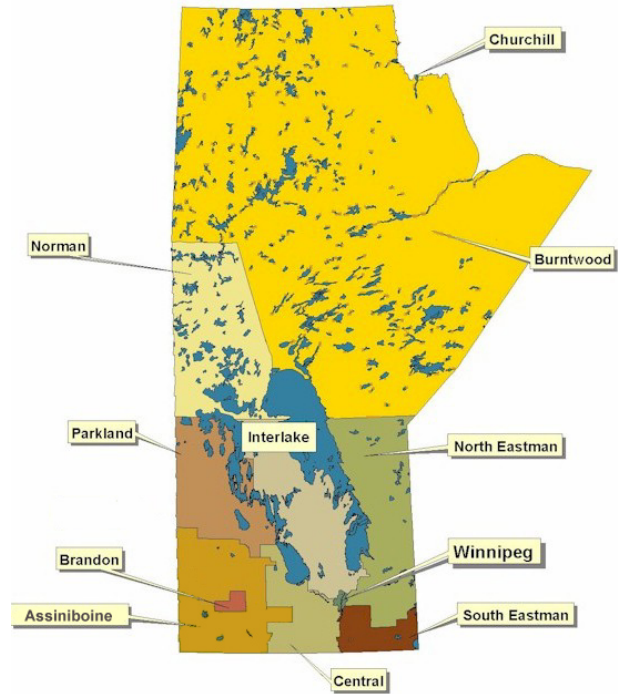
Health Systems in Manitoba

The health care system in Manitoba is multi-layered. Under the federal system of government, health is a matter of provincial jurisdiction; provinces are responsible for health budgets and monies and the provision of health care. Provinces are accountable, however, under the federal *Canada Health Act*, which since 1984 has ensured universal access to health care for all residents.²

In 1997, Manitoba *de-centralized* the direct provision of health care to 11 Regional Health Authorities (RHAs) (see Map 2)³. The province maintains responsibility for ultimate oversight of health care expenditures and Manitoba Health and Healthy Living (MHHL) sets certain policy and provides leadership. RHAs are governed by voluntary Boards of Directors, the members of which are provincially appointed. Because the regionalized system was developed to give the community more local control over health care provision, it has in some ways led to regional *centralization*: community hospital boards were dissolved and some smaller hospitals were closed or reduced their hours and range of service.

The actual delivery of health service then, is almost exclusively the domain of the RHAs. RHAs are responsible for public health, hospital administration, and community health clinics. Complex systems of exchange for services and care come into effect when services are not available in a given region of the province. Policy makers, planners and programmers are employed by the RHAs, as are most nurses, midwives and other providers. Physicians are usually in private practice and they bill directly to MHHL, on a fee-for-service basis. The RHAs are bound to report and be accountable to MHHL.

Manitobans are free to seek care from the physician of their choice. Access is an issue, however, since there is a shortage of both family physicians and specialists, and this is particularly true outside of Winnipeg, where there are very few specialists in practice. Rural and northern Manitobans are often referred to Winnipeg for specialist care, and under some circumstances their travel costs are covered by the medicare system.



Map 2: Regional Health Authorities in Manitoba

² See http://www.hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html.

³ There were originally 13 RHAs under the legislation.





Because fee-for-service physicians bill Manitoba Health directly for all medical services⁴ and because hospitals report patient information directly to Manitoba Health, the department can maintain two comprehensive data bases for information about health care utilization among its residents. Manitoba provides some prescription drug coverage (Pharmacare) and home care services as part of its medicare system, for which related administrative data are also collected.

Jurisdictional Issues and Health Data Collection for Manitoba Aboriginal Women

The term Aboriginal in Canada is commonly used to mean those persons who are First Nations (legally called Indian), Métis and Inuit⁵. The federal *Indian Act*, amended and revised for over one hundred years, legally defines “Indian” (more commonly now First Nations), and among First Nations people there are distinctions made for Treaty Status and Non-Status as well as for band membership [6].⁶

Like all Canadians, Aboriginal people are entitled to physician and hospital services per the *Canada Health Act*. Treaties between First Nations and the Government of Canada, most dating back a hundred years, create additional entitlements for those Canadians with Treaty Status. Health Canada has a fiduciary responsibility to provide health services to treaty (Status) residents of First Nations Reserves and Inuit people. This includes non-insured health benefits.⁷

However, only those persons recognized under the current legislation as having Treaty Status and are Registered are entitled to these additional uninsured health services, including dental care, and non-prescription medication [7]. This is significant to the population of Manitoba because some Aboriginal persons are entitled to some funded health services, while others are not. Distinctions are made between and among Aboriginal women and men residing on reserve, off reserve and in rural and urban settings, and the provision of health care and services may be broken along federal, provincial, regional and band community lines. Free prescription drugs, certain dental procedures and eye care, for example, are not provided for Aboriginal men and women who do not have treaty status [7]. For Manitoba Aboriginal residents there can be confusion about which services are available and where people apply for compensation and reimbursement.

⁴ Information from salaried physicians employed at hospitals and community health centres is obtained through “shadow billing”.

⁵ For example: “The Aboriginal identity population is composed of those persons who reported identifying with at least one Aboriginal group, that is, “North American Indian”, “Métis” or “Inuit (Eskimo)”, and/or who reported being a Treaty Indian or a Registered Indian, as defined by the *Indian Act of Canada*, and/or who were members of an Indian Band or First Nation.” (Statistics Canada. 2001 Aboriginal Population Profile). Note however that definitions of “Aboriginal” vary among surveys.

⁶ These terms are confounded when they are used interchangeably in some policy and research discourse. PWHCE commissioned a paper which elucidates the issues for researchers and policy-makers alike [7].

⁷ “The non-Insured Health Benefit Program is for registered Indians according to the *Indian Act*, Innu members of one or two Innu communities in Labrador, Inuk recognized by one of the Inuit Claim organizations, and any infant less than age one (1), whose parent is an eligible recipient.” Source: <http://www.hc-sc.gc.ca/fnihb/nihb/publications/infobook.htm>.





Though the federal non-Insured Health Benefits system is complicated for First Nations women, there are no additional benefits at all for Métis women. Métis women are entitled to only those health care services available to all provincial residents. Settlement patterns, family ties, changes in the *Indian Act* and geography have thus contributed to having some people in a community receiving health care on one side of a community road (or a lake) and others not [7].

The issues of jurisdiction and entitlement are further complicated in the data available. Manitoba Health collects health utilization data about all Manitobans. Health utilization data can be retrieved about those persons who voluntarily declare their First Nations status to Manitoba Health, however, Manitoba Vital Statistics which is responsible for data about births and deaths in the province, include in their death registry as “First Nations” all those, and only those, whose place of residence at the time of their death was a First Nations reserve. This is a restrictive definition since it excludes all First Nations Manitobans who live off reserve. These two data sets then do not necessarily identify the same persons as First Nations.

Other surveillance reports based on existing administrative, survey, population and other data sets are limited by how populations were included. Statistics Canada, for instance, uses several methods for identifying Aboriginal ancestry. Most often, Statistics Canada uses the broadest definitions, allowing survey and census respondents to self-identify as having Aboriginal ancestry. However some First Nations reserves refused to take part in some national surveys (e.g. Census Canada, for instance), and in other cases survey design did not include residents of the northern territories, most of whom are Aboriginal (e.g. Canadian Community Health Surveys). Smylie and Anderson summarize the numerous limitations in existing data sets [8]. Throughout this *Profile* the authors have clearly defined how populations are identified.

While these definitions and points of jurisdiction are important, the main issue should not be overlooked: However one defines them, Aboriginal people, especially Aboriginal women, have much greater rates of morbidity and mortality when compared to other Manitobans. This theme emerges time and again through our analyses of the indicators presented in this *Profile* (see further discussion in Chapter One).

Women’s Health Indicators in Manitoba

As part of its leadership to the Regional Health Authorities, Manitoba Health provides guidance and sets expectations for certain targeted initiatives. In 2000, for instance, Manitoba Health acknowledged and adopted the concept of gender as a determinant of health. One year later, the department and the provincial Women’s Directorate jointly released a *Women’s Health Strategy* [9]. Among the 12 steps to implement the *Strategy* was the development of “a provincial profile of women’s health”, and PWHCE was commissioned to conduct a feasibility project. *Producing a Profile of Manitoba Women’s Health: Background Report* (published in 2004) outlined a framework for over 100 key indicators in women’s health, based on available data sets collected and administered by the province as well as other data sets held by Statistics Canada [3]. The framework of indicators recommended for the *Profile* covers a broad definition of health, including not only health status and outcomes, but also factors such as unpaid work, income, employment and exposure to violence. Ultimately this final *Profile* covers more than 145 indicators of women’s health.





As the *Profile* began, PWHCE had an opportunity to include work for the World Health Organization, testing an international Core Set of Gender-Sensitive Leading Health Indicators [10]. The Manitoba field test of the Core Set allowed the *Profile* authors to test and refine our methods and analyses for women's health indicators. It also gave us an opportunity to consider new indicators that were not included in the original framework. The WHO Kobe Centre provided technical assistance for the development of the pilot test of the core indicators in the province of Manitoba [11].

Description of the Manitoba Women's Health Profile

The *Profile* is divided into seven chapters. Chapter One describes the women of Manitoba in general and demographic terms. Particular emphasis is given to the health and health indicators for Aboriginal women in the province. It is important to note that while the health and health issues for Aboriginal women may be better understood than they were, there are many other sub-populations (e.g. new immigrants, other ethnic groups, women with disabilities etc) among Manitoba women about whom we are unable to comment.

Chapters Two to Seven are arranged according to the factors that influence health and health conditions and outcomes. For each of the indicators contained in a chapter, the authors of this report retrieved the necessary data; described the primary analysis; and then proceeded with a gender-based analysis of the implications for women's health.

Gender-based analysis (GBA) is a method of analysis which assesses the differences and similarities between and among men and women. It is used to demonstrate the differences and similarities in health status, health care utilization, and health needs of men and women. *"GBA helps to clarify the differences between women and men (and the diversity among them), the nature of their social relationships, and their different daily activities, life expectations and economic circumstances. It identifies how these conditions affect women's and men's health status and the different and similar ways they are vulnerable. Ultimately GBA brings into view the influences, omissions and implications of our work in health policy, programming and planning"* [12].

GBA gives us the framework to provide comments on how the data are collected, what we learn about the women in the province, what other evidence there is in the subject area, followed by discussions of policy implications arising. The discussion and analysis set the survey and administration data in the context of women's daily lives. Differences and similarities based on gender between women and men, and among some groups of women are noted, as are other variations and trends.

"Tailoring the health care system to meet the particular needs of women and men should lead to better use of resources" [13].





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Material in this chapter was previously produced for the World Health Organization in *Manitoba Field Testing of Gender-Sensitive Core Set of Leading Health Indicators*, by Donner, Haworth-Brockman and Isfeld (2006). The authors are grateful to the World Health Organization for technical assistance.

