Bringing Women and Gender into "Healthy Canadians: A Federal Report on Comparable Health Indicators 2004"

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Executive Summary

In March 2005, the National Coordinating Group on Health Care Reform and Women and the British Columbia Centre of Excellence for Women's Health hosted a workshop where twenty-five women's health researchers and policy advisors analyzed *Healthy Canadians: A Federal Report on Comparable Health Indicators 2004*. Participants considered the following questions:

- How well does this report incorporate the latest work on gender-sensitive health indicators?
- Given the federal government's commitment to gender-based analysis, does this document fulfill that requirement?
- Do the selected indicators provide meaningful reflections of women's health?
- Will these indicators alert us to actions that need to be taken to improve women's health?

This paper outlines our analysis of *Healthy Canadians*. In Part I, we discuss seven cross-cutting issues and offer recommendations to improve the future selection of health indicators. In Part II, we examine a few indicators to illustrate our concerns in more detail. In Part III, we give examples of additional indicators to address important women's health concerns.

Part I

We begin with the assumption that health indicators should be clearly linked to the goals of promoting and improving health and reducing health inequities among Canadians. We also maintain that mainstream health indicators should be gender-sensitive and contribute to the improvement of women's health. We assert that indicators should point to actions (strategies) that can be taken to improve the health system, including actions to make it more responsive to women's needs . In our review of *Healthy Canadians: A Federal Report on Comparable Health Indicators 2004*, we identified seven major concerns:

1) Lack of gender analysis.

In spite of federal commitments to gender equity and gender-based, diversity-sensitive analysis, and despite the availability of international and Canadian resources to support this analysis, the *Healthy Canadians* report fails to: (1) report sex-disaggregated data wherever possible, (2) select indicators that examine important gender-related determinants of health, and (3) monitor for gender inequities in health or in the health system.

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* Prepared for the National Coordinating Group on Health Care Reform and Women by Kay Willson, PhD, Research Manager, Prairie Women's Health Centre of Excellence and Beth E. Jackson, PhD, Post-doctoral Fellow with the CHSRF/ CIHR Chair in Health Services, York University. January 2006. The members of the National Coordinating Group on Health Care Reform and Women are Pat Armstrong (Chair), Madeline Boscoe, Barbara Clow, Karen Grant, Beth Jackson, Ann Pederson and Kay Willson.

The Report and proposed set of indicators thus repeat the gaps and shortcomings of conventional indicator frameworks which have been soundly critiqued in the international literature.

The growing body of research on women's health and on sex and gender as important determinants of health highlights the importance of taking sex and gender into account as we develop health indicators. Women's health and health needs are different from men's because of differences in their bodies and because of differences in how women and men live, work, and play. Women interact with the health care system more frequently than men, in part because of their roles in reproduction and overseeing the care of other family members. Overall, women have less financial security and less social status than men, but more responsibility for caring for others – women are the overwhelming majority of paid and unpaid care providers. Moreover, there are many differences *among* women, based on their socioeconomic status, race and ethnicity, age, sexual orientation, (dis)ability, and other important social locations. These differences affect women's health, their use of the health care system, and their ways of responding to care.

2) Lack of an explicit and comprehensive conceptual framework.

The development of indicators must be guided by a coherent analytical framework. While some of the indicators in *Healthy Canadians* have merit, there is no explicit conceptual framework which explains why these indicators were given priority or how they will 'do the job' that indicators are meant to do. The selection of the 70 comparable health indicators and the 18 indicators included in the 2004 federal report should have been informed by a gender and diversity analysis.

The Canadian health system should: provide high quality, cost-effective care for all; treat illness, prevent disease, promote health, address health determinants and reduce health inequities. Well-chosen indicators informed by a comprehensive and explicit conceptual framework can help us assess how well the health system is meeting these goals and where it falls short.

3) Narrow biomedical definition of health and health care.

The selection of indicators in *Healthy Canadians* reflects a narrow, biomedical definition of health and a very limited range of health determinants. Of the 70 indicators listed in the report, 22 deal with specific diseases and 35 deal primarily with health care services. Little or no attention has been given to well-known social determinants of health, e.g. income, socio-economic status, gender, culture, working conditions, housing, social support or environmental factors. By focusing primarily on the performance of the health care system, the report diverts attention away from these important determinants of health. Reporting on indicators of such determinants would enable us to identify a broader range of interventions for health promotion and healthy public policy, within and beyond the health care system.

4) The report overlooks health inequities.

The *Healthy Canadians* report does not adequately address health inequities. The way that indicators are produced and reported may mask the different experiences or health status of various groups within Canadian society. Through its federal laws and international conventions, Canada has long recognized the universal right to health, in addition to the right to health care. It therefore follows that health indicators need to monitor progress toward reducing the health

inequities that undermine the health of low income Canadians, Aboriginal Canadians, and other marginalized groups. This requires indicators that measure differences in access to the resources that maintain and restore health and to differences in power and control over the conditions that influence health.

5) Indicators do not reflect the health of diverse communities and populations.
The report contains many indicators which are based on data that exclude significant portions of the Canadian population. Moreover, global reporting masks diversity. That is, even when diverse groups are included in the data collection, the data are not disaggregated to examine how health status and health determinants are affected by the intersections of class, race, ethnicity, gender, age, ability, sexual orientation, region and other social locations.

Indicators need to be developed using a gender and diversity lens, in order to ensure that the indicators offer valid reflections of the health of women and men from diverse communities and social locations. This includes not only inclusive data collection and reporting of disaggregated data, but engaging diverse communities in the selection of indicators relevant to their own needs and values.

6) Some indicators are weak, invalid or misleading; indicators must draw upon the full range of evidence available.
The indicators we select to measure our progress toward health/health care goals must be valid and reliable – they must measure what they purport to measure, and those measures must be reliable across time and space. However, some indicators persist even when they are shown to be weak, invalid or misleading.

Moreover, the indicators in *Healthy Canadians* are based solely on quantitative data from large-scale surveys – as such, they are not linked to other important sources of evidence and relevant knowledge. While quantitative measures may provide useful data about health and well-being, a thorough understanding of the contexts, issues and meanings that surround health issues requires the critical synthesis of quantitative *and* qualitative research findings.

7) Indicators are not linked to action.
The *Healthy Canadians* report does not clearly link the indicators to calls to action. With any indicators, there is a danger that people take action to simply improve indicator scores, rather than improving the health care system, the quality of care, or the health of Canadians. Reports on indicators should discuss meaningful action strategies to address the underlying problems that the indicators presumably reveal.

Part II

In this section, we have selected an example indicator for each of the themes of Timely Access (wait times), Quality (patient satisfaction), and Health Status and Wellness (prevalence of diabetes) to illustrate in greater detail some of the issues we raised in Part I of this report.

Part III

Work has already begun, in Canada and internationally, to develop indicators that are sex-specific or that are of particular importance to women (e.g., indicators for sexual and reproductive health, or the impact of caregiving on the health of care providers; and indicators related to social determinants of health such as income inequality). It is appropriate that the federal government's major reports on health indicators include some of these indicators in order to provide adequate reflections of women's health.

It is important to improve the indicators which governments use to measure health and health system performance, because such indicators are used to influence government decisions about where to allocate public resources. We assume that indicators are meant to lead to action, and that useful action to improve women's health will depend upon correctly identifying the problems that need to be addressed.

RECOMMENDED PRINCIPLES
FOR THE DEVELOPMENT OF COMPARABLE HEALTH INDICATORS

Recommendation 1: Take direction from existing Canadian and international work to develop indicators that are gender-sensitive, in order to promote interventions that are responsive to the health needs of women, girls, men and boys.

Recommendation 2: Indicators should be based on an explicit and comprehensive conceptual framework that includes a gender and diversity analysis of health status, health determinants, and the performance of the health system.

Recommendation 3: Select indicators which reflect a more expansive understanding of health and monitor important determinants of health.

Recommendation 4: Indicators should be clearly linked to explicit goals to improve health and reduce health inequities. Promote social justice by selecting indicators to monitor progress on reducing health inequities.

Recommendation 5: Develop indicators that reflect the health concerns of diverse communities and populations.

Recommendation 6: Develop indicators that are based on solid evidence from multiple research methods and that provide valid, useful tools for monitoring and identifying significant health issues and emerging health problems.

Recommendation 7: Select indicators and report on indicators in ways that will clearly identify when action is required. Link indicators to clear targets to improve health and reduce health inequities.

Bringing Women and Gender into "Healthy Canadians: A Federal Report on Comparable Health Indicators 2004"

Introduction

In November 2004, the federal government released a report entitled ***Healthy Canadians: A Federal Report on Comparable Health Indicators 2004.*** This report identified 70 health indicators agreed upon by federal, provincial and territorial governments, but focused on 18 indicators dealing with health status, timely access to health services, and quality of care.

In March 2005, the National Coordinating Group on Health Care Reform and Women and the British Columbia Centre of Excellence for Women's Health hosted a workshop where twenty-five women's health researchers and policy advisors spent two days analyzing the recent federal report on comparable health indicators.[1] As we reviewed the ***Healthy Canadians*** document, we asked ourselves:

- How well does this report incorporate the latest work on gender-sensitive health indicators?
- Given the federal government's commitment to gender-based analysis, does this document fulfill that requirement?
- Do the selected indicators provide meaningful reflections of women's health?
- Will these indicators alert us to actions that need to be taken to improve women's health?

The workshop discussions were very fruitful and provided an opportunity for interdisciplinary dialogue that enriched our understanding of the need for a solid conceptual framework to underpin the conceptualization, content and selection of health indicators. The development and selection of indicators requires more than technical expertise. Drawing upon our own research and policy work in women's health, gender-based analysis, and health care reform, we aim to fill a gap in the current conceptual framework underlying the development and selection of indicators.

This paper outlines our analysis of ***Healthy Canadians***. In Part I, we discuss seven cross-cutting issues and offer recommendations to improve the future selection of health indicators. In Part II, we examine a few indicators to illustrate
our concerns in more detail. In Part III, we give examples of additional indicators to address important women's health concerns.

[1] We sincerely thank all the participants in the Vancouver workshop for their contributions to these discussions. This paper represents the views of the authors and makes no claim to have captured the views of all participants or the full proceedings of that event.

Part I

What are indicators for and what do they do? How are they related to goals and interventions? What are the principles for developing good indicators?

In the lexicon of public health policy and information systems, 'goals,' 'objectives,' 'targets,' 'indicators,' and 'strategies' have particular meanings. Specifically:

- 'Goals' refer to "broad statements of desired states or directions in which a society wishes to move" (e.g. 'To promote healthy weights and reduce obesity') – these are generally not quantitative;
- 'Objectives' are "more specific and measurable statements of intent" (e.g. 'Increase the proportion of Canadians who are at healthy weight'). Ideally objectives are specific, measurable, achievable, relevant to the goals, and timed – they may include 'targets';
- 'Targets' specify the amount of progress to be made and the time by which it is to be accomplished (e.g. '10% increase in proportion of the population at healthy weight by 2010);
- 'Indicators' are specific measures by which progress toward goals will be gauged (e.g. 'Prevalence of healthy body weight as measured by Body Mass Index (BMI) based on physical measures of height and weight, or self-reported height and weight');
- 'Strategies' coordinate various interventions that are designed to achieve a goal and its objectives and targets (e.g. several strategies may be required to achieve the goal of healthy body weight for Canadians: a healthy eating strategy may have components addressing particular sectors [e.g. food industry]; a physical activity strategy may have components dealing with particular settings [e.g. schools]).[2]

We begin with the assumption that health indicators should be clearly linked to the goals of promoting and improving health and reducing health inequities among Canadians. We also maintain that mainstream health indicators should be gender-sensitive and contribute to the improvement of women's health. We assert that indicators should point to actions (strategies) that can be taken to improve the health system, including actions to make it more responsive to women's needs. In our review of ***Healthy Canadians: A Federal Report on Comparable Health Indicators 2004***, we identified seven major concerns. In this section of the paper, we provide a brief explanation of these concerns and offer recommendations to improve the selection of health indicators in order to advance women's health.

Issue 1: Lack of gender analysis

Sex (biological characteristics) and gender (the socially normative behaviours and roles assigned to males and females) have both separate and interactive effects upon health and illness. The Report pays little attention to sex and gender influences on health. While some indicators have reported data separately for men and women, the influence of sex and gender is largely ignored. While the sex-disaggregation of data is necessary for gender-based analysis, it is not in itself sufficient. The indicators do not reveal or clarify the ways in which systemic group processes

[2] Canadian Public Health Association, n.d. Public Health Goals for Canada: Background for a Discussion. p. 3.

like gender norms and sexism are generated and maintained, nor how gender relations produce health inequities – yet these are important determinants of health.

The federal government has made several commitments to gender equity and gender-based, diversity-sensitive analysis.[3] Gender equality is guaranteed under Sections 15(1) and 28 of the Canadian Charter of Rights and Freedoms and by many international human rights instruments to which Canada is signatory. Canada's international commitments to gender equity also include ratification in 1981 of the UN Convention on Elimination of All Forms of Discrimination and adoption in 1995 of the UN Platform for Action (the concluding document of the UN World Conference on Women in Beijing). At the Beijing Conference, the Government of Canada presented its Federal Plan for Gender Equity (1995-2000), which states that all subsequent legislation and policies will include, where appropriate, an analysis of the potential for differential effects on men and women.

The Plan also made a commitment to government-wide implementation of gender-based analysis in the development of policies, programs and legislation. In 2000, the federal government approved the Agenda for Gender Equality, an initiative which included engendering current and new policies and programs and accelerating implementation of gender-based analysis commitments. Several federal government departments have issued formal gender-based analysis guidelines, including the Canadian International Development Agency, Human Resources Development Canada, the Department of Justice Canada, Status of Women Canada, and Health Canada. Health Canada's commitment is expressed in the Women's Health Strategy (1999) and Gender-Based Analysis Policy (2000).

There also exist international and Canadian resources that provide a rationale and guidance for developing and implementing gender-sensitive indicators. But in spite of these commitments and available resources, the Report on Comparable Health Indicators fails to: (1) report sex-disaggregated data wherever possible, (2) select indicators that examine important gender-related determinants of health, and (3) monitor for gender inequities in health or in the health system.

The Report and proposed set of indicators thus repeat the gaps and shortcomings of conventional indicator frameworks which have been soundly critiqued in the international literature. This literature suggests that the key problems with conventional health indicator frameworks are:

- the dominant 'illness/disease-focused' concept of health fails to address broad determinants of health;
- gender analysis of health tends to be undertaken when it is in the interests of individuals or organizations, rather than as a result of broad and ongoing concern;
- health status indicators are overwhelmingly focused on health outcomes, rather than process and output variables;
- many health outcome measures are not sensitive enough to detect gender differences in health experiences;

[3] Health Canada. Women's Health Bureau. Exploring Concepts of Gender and Health. Ottawa. June 2003.

- health system performance measures assume equal needs and focus on technical aspects of care, rather than on relational aspects of care.[4]

We hope to see future reports on health indicators reflect a gender-based analysis of health status, health determinants and health system performance.

The growing body of research on women's health and on sex and gender as important determinants of health highlights the importance of taking sex and gender into account as we develop health indicators. Recent Canadian and international work on women's health surveillance and gender-sensitive health indicators provides the groundwork for moving gender-based analysis into the mainstream of reporting on health indicators.[5] Lin et al (2004) have assessed over one thousand indicators of gender equity and health, drawing upon major international reports that monitor health and social development as well as special reports from agencies like UNIFEM (United Nations Development Programme for Women).

Their literature review has revealed an "absence of gender consideration in health indicators" as well as recommendations from women's health advocates for "greater focus on gender relations" and more "participatory processes for indicator development."[6]

Why is a gender-based analysis important? Women's health and health needs are different from men's because of differences in their bodies and because of differences in how women and men live, work, and play. Women interact with the health care system more frequently than men, in part because of their roles in reproduction and overseeing the care of other family members. Overall, women have less financial security and less social status than men, but more responsibility for caring for others – women are the overwhelming majority of paid and unpaid care providers. Moreover, there are many differences *among* women, based on their socioeconomic status, race and ethnicity, age, sexual orientation, (dis)ability, and other important social locations. These differences affect women's health, their use of the health care system, and their ways of responding to care.

Yet as Lin et al point out, "the paucity of gender-sensitive indicators for health system performance points to a glaring absence of engagement between those working on gender equity and those working on health sector reform."[7] Many indicators do not disaggregate data by sex, and very few, if any, measure the effects of gender. To begin to address this gap, Lin et al

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[4] Women and Health Programme, World Health Organization Centre for Health Development, Comparative Evaluation of Indicators for Gender Equity and Health, December 2003, Kobe, Japan.

[5] See for example: Health Canada. Women's Health Surveillance: A Plan of Action for Health Canada: A Report from the Advisory Committee on Women's Health Surveillance. Ottawa. 1999; Canadian Institute for Health Information. Women's Health Surveillance Report. Ottawa. 2003; Ontario Women's Health Council. Improving Women's Health Reporting: Federal-Provincial-Territorial Performance Indicators. July 2003; World Health Organization Centre for Health Development. Expert Group Meeting on Gender-Sensitive Leading Health Indicators. Kobe, Japan. 2004.

[5] Vivian Lin et al. Comparative Evaluation of Indicators for Gender Equity and Health: From adequacy to usefulness. Prepared for Forum 8, Global Forum for Health Research: Health research to achieve the Millennium Development Goals, Mexico City, November 2004, pp. 2-3.

[6] Lin et al., pp. 2-3

[7] Lin et al., p. 7.

suggest developing gender-sensitive indicators which monitor issues of accessibility, responsiveness, effectiveness, resource distribution and affordability. They call for a gender-based analysis of health expenditures. They also propose monitoring the privatization of health care costs through indicators of affordability, such as percent of men and women with private health insurance coverage and percent of men and women not accessing care because of costs.

In 2004, the World Health Organization (WHO) convened an Expert Group Meeting on Gender-Sensitive Leading Health Indicators, the aim of which was: "To influence and modify the mainstream health indicators system by integrating gender perspectives into a core set of leading health indicators in order to improve women's health and quality of life."[8] Participants at the WHO Expert Group Meeting established seven criteria for the selection of gender-sensitive health indicators.

In their view, indicators should:

- act as an early alert for emerging health issues and have a predictive capability;
- highlight current and significant health issues that require and will respond to priority action;
- cover issues that underlie a range of health problems and would be further elucidated by gender-based analysis;
- be based on sound empirical evidence in relation to health effects;
- be useful for monitoring performance and for evaluation of interventions;
- be feasible to measure;
- be valid and reliable for the general population and for diverse population groups.[9]

Participants in the WHO Expert Group Meeting agreed on several other key points, including the need to:

- improve gender-sensitivity of current data…
- build on indicators proposed through key international consensus and reporting frameworks, including: World Health Report, Human Development Report, State of the World's Children, Millennium Development Goals (MDGs), Beijing Platform for Action, International Conference on Population and Development (ICPD), the Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW)…
- incorporate a life cycle approach and extend beyond reproductive health issues…
- ensure reported indicators include an expanded concept of health and the full continuum of care…

[8] World Health Organization Centre for Health Development. Expert Group Meeting on Gender-Sensitive Leading Health Indicators. Kobe, Japan. 2004, p. 5.
[9] World Health Organization Centre for Health Development, Report of the Consultative Meeting to Finalize a Gender-Sensitive Core Set of Leading Health Indicators, 1-3 August 2004, Kobe, Japan. WHO Kobe Centre, 2005, p. 5.

- ensure conceptual clarity and soundness, particularly in relation to 'gender' and 'sex'…
- report on both quantitative and qualitative indicators…
- set benchmarks for performance monitoring where possible.[10]

In August 2004, the WHO Centre for Health Development convened a Consultative Meeting to Finalize a Gender-Sensitive Core Set of Leading Health Indicators. One third of the chosen indicators address determinants of health. The remaining indicators address either health status or health system performance. The entire indicators framework is informed by a gender analysis and an overarching concern with equity. The WHO core set of 36 gender-sensitive indicators includes several which are notably absent from the Canadian list of 70 indicators, including rates of poverty and measures of the feminization of poverty, rates of literacy, sexual violence, domestic violence, condom use, access to safe abortions, and the proportion of health facilities offering gender-sensitive care, among others. These indicators (the data for which must be disaggregated by sex, age, ethnicity, socioeconomic group, and other important social locators) take into account the contexts of women's lives and attend to intersecting structural determinants of health (e.g. sexism, poverty, racism, heterosexism).

Recommendation 1: Take direction from existing Canadian and international work to develop indicators that are gender-sensitive, in order to promote interventions that are responsive to the health needs of women, girls, men and boys.

Issue 2: Lack of an explicit and comprehensive conceptual framework

The ***Healthy Canadians*** document reports that the selection of indicators was based on invitational workshops with 'stakeholders' and focus groups with members of the public; these consultations were held to determine whether the indicators reflected important concerns of Canadians. It is crucial that indicator-development processes are participatory. However, indicators must also be guided by a coherent analytical framework. While some of the indicators have merit, there is no explicit conceptual framework which explains why these indicators were given priority or how they will 'do the job' that indicators are meant to do. Given the aforementioned federal commitments to gender-based, diversity-sensitive analysis, the selection of the 70 comparable health indicators and the 18 indicators included in the 2004 federal report should have been informed by a gender and diversity analysis.

The World Health Organization Expert Group Meeting on Gender-Sensitive Leading Health Indicators agreed to adopt the Health Information Framework developed by the OECD and the International Standards Organization (ISO), and adapted by the LaTrobe Consortium (it draws on models that include the one used by the Canadian Institute for Health Information). Debates in 'indicators literature' have raised "the question of whether frameworks for examining indicators for gender equity and health should be based on conceptual frameworks for understanding determinants of health; on conceptual frameworks for understanding gender

[10] World Health Organization Centre for Health Development. Expert Group Meeting on Gender-Sensitive Leading Health Indicators. Kobe, Japan. 2004, p. 6.

relations (or at least women's position in society); or, from mainstream frameworks for the production of statistics."[11] The Consortium "determined that a comprehensive Health Information Framework that could allow for both *analysis of gender equity within mainstream health systems as well as recognize sex-specific issues* was appropriate."[12]

The Framework was chosen for its comparability with existing mainstream health frameworks – that is, it is an attempt to 'engender the mainstream.'

It includes four tiers of information:

- Health Status (overall health of the population);
- Determinants of Health (proximal factors that affect health at the individual, household, and/or community levels);
- Health System Performance (design and delivery of health services and how well the system is performing in relation to major goals of access, effectiveness, and cost); and
- Community and Health and Welfare System Characteristics (contextual factors which affect the population as a whole).

The tiers and dimensions that they contain are informed by notions of health as being 'caused' or affected (to some extent) by a variety of proximal/direct factors (e.g. injury) or distal/indirect factors (e.g. health literacy). At each of the four tiers, gender analysis is applied and key equity issues are identified. This is an important addition to conventional health information frameworks.[13] For example, at the Health Status tier, equity in health outcomes may be addressed by indicator topics such as 'capability to achieve good health' and 'health status of poorest compared to wealthiest quintile of population.' At the Determinants of Health Tier, equity may be measured by the distribution of educational resources and suitable 'living conditions.' In the Health System Performance tier, a gender-based analysis of accessibility, acceptability and effectiveness of the health system could be addressed by indicator topics such as 'fairness of processes' (e.g. non-discriminatory health care delivery) and participation in the conceptualization and design of projects. At the tier of Community and Health and Welfare System Characteristics, equity may be addressed by topics such as the distribution/sharing of income or resources (e.g. GINI index of income/resources inequality).

It should be noted that this kind of framework (which has informed Canadian health information systems) "is *not* well suited to making links between elements (or tiers), or showing explicit relationships (such as cause and effect, pathways, or causal chains), and 'although many of the underlying causal relationships between the dimensions are understood or implied, they are not

[11] Women and Health Programme, World Health Organization Centre for Health Development, Comparative Evaluation of Indicators for Gender Equity and Health, December 2003, Kobe, Japan, p. 7.
[12] Ibid., p. 9 (emphasis added).
[13] "Monitoring or tracking inequities is central to tackling inequity. Effective monitoring of equity/inequity trends can support policy development and reform through answering such questions as: 'Is the gap in health status or determinants of health improving or worsening over time?' and 'How effective are the policies and interventions working to narrow the gap?', regardless of whether the focus is on gender, health, socioeconomic status, or other forms of equity/inequity." (Women and Health Programme, World Health Organization Centre for Health Development, Comparative Evaluation of Indicators for Gender Equity and Health, December 2003, Kobe, Japan, p. 23.)

specifically borne out by this model' (ISO, 2001:11)."[14] The need for a conceptual model that makes such links and accounts for gender and other dimensions of inequality remains.

Like most Canadians, we want a health system that provides high quality, cost-effective care for all; a system that treats illness, prevents disease, promotes health, addresses health determinants and reduces health inequities. Well-chosen indicators informed by a comprehensive and explicit conceptual framework can help us assess how well the health system is meeting these goals and where it falls short.

Recommendation 2: Indicators should be based on an explicit and comprehensive conceptual framework that includes a gender and diversity analysis of health status, health determinants, and the performance of the health system.

Issue 3: Narrow biomedical definition of health and health care

The selection of indicators in ***Healthy Canadians*** reflects a narrow, biomedical definition of health and a very limited range of health determinants. Of the 70 indicators listed in Appendix 3 of the report, 22 deal with specific diseases and 35 deal primarily with health care services. The list of 70 includes few 'non-medical' determinants of health; those that are included focus on individual behaviours, e.g. smoking, physical activity and immunization against influenza.

Aboriginal peoples, the Canadian health promotion movement, and the women's health movement have been instrumental in broadening understandings of health to include the social, economic, spiritual, and environmental determinants of health. For over thirty years, the Government of Canada has recognized the importance of addressing a wide range of determinants of health.[15] International statements have also sought to broaden conceptions of health and health care. For example, the Ottawa Charter for Health Promotion (WHO, 1986) states "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity" and further that "Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept responsibility for health." In 1995, the Platform for Action which emerged from the Fourth World Conference on Women clearly stated "Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology."[16] Comparable health indicators should be developed to reflect this comprehensive understanding of health.

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[14] Women and Health Programme, World Health Organization Centre for Health Development, Comparative Evaluation of Indicators for Gender Equity and Health, December 2003, Kobe, Japan, p. 63 (emphasis added).
[15] For example, see: Marc Lalond. *A New Perspective on the Health of Canadians.* Department of Health and Welfare. Ottawa, 1974; Jake Epp. *Achieving Health for All: A Framework for Health Promotion.* Department of Health and Welfare. Ottawa, 1986; F/P/T Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians*. Ottawa, 1994.
[16] United Nations Platform for Action, Fourth World Conference on Women, Beijing, 1995.

Yet, in the ***Healthy Canadians*** report, little or no attention has been given to well-known social determinants of health, e.g. income, socio-economic status, gender, culture, working conditions, housing, social support or environmental factors. By focusing primarily on the performance of the health care system, the recent federal report on comparable indicators diverts attention away from these important determinants of health. Reporting on indicators of such determinants would enable us to identify a broader range of interventions for health promotion and healthy public policy, within and beyond the health care system.

Recommendation 3: Select indicators which reflect a more expansive understanding of health and monitor important determinants of health.

Issue 4: The Report overlooks health inequities

The ***Healthy Canadians*** report does not adequately address health inequities. The way that indicators are produced and reported may mask the different experiences or health status of various groups within Canadian society.

There are major health disparities within Canada, with low-income, Aboriginal and socially marginalized Canadians experiencing much higher rates of disease and morbidity, and earlier death. Government reports on health indicators need to prioritize the problem of inequities in health and in the distribution of resources needed to maintain health. Health indicators should be useful not only for improving the health of the Canadian population as a whole, but should help us to focus on reducing health inequities and promoting conditions that contribute to health inside and outside the health care system.

Canadians have been at the forefront of health promotion research which demonstrates the linkages between social justice, equity and health. Through its federal laws and international conventions, Canada has long recognized the universal right to health, in addition to the right to health care. It therefore follows that health indicators need to monitor progress toward reducing the health inequities that undermine the health of low income Canadians, Aboriginal Canadians, and other marginalized groups. This requires indicators that measure differences in access to the resources that maintain and restore health and to differences in power and control over the conditions that influence health.

Recommendation 4: The federal government should follow through on its commitment to promote gender equity and undertake gender-based analysis. Indicators should be clearly linked to explicit goals to improve health and reduce health inequities. Federal, provincial and territorial governments should promote social justice by developing and selecting indicators to monitor progress on reducing health inequities.

Issue 5: Indicators do not reflect the health of diverse communities and populations.

The report contains many indicators which are based on data that exclude significant portions of the Canadian population. Moreover, global reporting masks diversity. That is, even when diverse groups are included in the data collection, the data are not disaggregated to examine how health status and health determinants are affected by the intersections of class, race, ethnicity, gender, age, ability, sexual orientation, region and other social locations.

In addition, culturally diverse communities have different understandings of health and health care, different health goals and different ways of measuring progress toward health. The indicators in ***Healthy Canadians*** reflect mainstream biomedical approaches to health that may not be the most appropriate measures of the health of diverse communities, whose own experiences and understandings of health are not reflected in the measures chosen.

Indicators need to be developed using a gender and diversity lens, in order to ensure that the indicators offer valid reflections of the health of women and men from diverse communities and social locations. This includes not only inclusive data collection and reporting of disaggregated data, but engaging diverse communities in the selection of indicators relevant to their own needs and values.

Recommendation 5: Develop indicators that reflect the health concerns of diverse communities and populations.

Issue 6: Some indicators are weak, invalid or misleading; indicators must draw upon the full range of evidence available

The indicators we select to measure our progress toward health/health care goals must be valid and reliable – they must measure what they purport to measure, and those measures must be reliable across time and space. However, some indicators persist even when they are shown to be weak, invalid or misleading. For example, Body Mass Index (BMI) (calculated as weight divided by height squared) continues to be used as an indicator of health status and wellness, even though it has been shown to be invalid for individuals under 18, pregnant women, disabled individuals, aged individuals, and athletes. It is also race/ethnicity-insensitive. The concept of 'healthy weight' and its links to socio-economic status, food availability, culture, and other factors, are not captured by BMI. While some indicators, like smoking and physical activity, are based on strong evidence of their relation to health, the evidence for others, like BMI, remains questionable.

Moreover, the indicators in ***Healthy Canadians*** are based solely on quantitative data from large-scale surveys – as such, they are not linked to other important sources of evidence and relevant knowledge. While quantitative measures may provide useful data about health and well-being, a thorough understanding of the contexts, issues and meanings that surround health issues requires the critical synthesis of quantitative ***and*** qualitative research findings. This assertion is frequently repeated, but rarely acted upon.

Recommendation 6: Develop indicators that are based on solid evidence from multiple research methods and that provide valid, useful tools for monitoring and identifying significant health issues and emerging health problems.

Issue 7: Indicators are not linked to action

Good indicators are not simply measures of specific data; they need to tell us something about the larger picture. Good indicators should reveal where things are working well, where health status is improving or where health inequities are declining. Likewise they should serve as an early warning system to alert us to the need for action to improve health care services, address emerging or persistent health problems, and reduce health inequities.

The need to identify important health problems and take timely action is one of the fundamental reasons for developing and monitoring health indicators. But the ***Healthy Canadians*** report does not clearly link the indicators to calls to action. How should policymakers respond to the indicators as they are presented? If indicator reporting is to be more than a public relations exercise, then indicators need to clearly specify the problems that require action.

With any indicators, there is a danger that people take action to simply improve indicator scores, rather than improving the health care system, the quality of care, or the health of Canadians. Reports on indicators should discuss meaningful action strategies to address the underlying problems that the indicators presumably reveal.

According to Lin et al, "The value of good quality and conceptually sound indicators, however, is limited if there is not an appropriate monitoring system. Such a system requires not only adequate infrastructure for collection and collation of valid and reliable data but also a social process through which the meaning/s of indicators are reviewed, implications for action are distilled, and decisions are taken to effect greater equity."[17]

Recommendation 7: Select indicators and report on indicators in ways that will clearly identify when action is required. Link indicators to clear targets to improve health and reduce health inequities.

[17] Vivian Lin et al. Comparative Evaluation of Indicators for Gender Equity and Health: From adequacy to usefulness. Prepared for Forum 8, Global Forum for Health Research: Health research to achieve the Millennium Development Goals, Mexico City, November 2004, p. 9.

Part II

In this section, we have selected an example indicator for each of the themes of Timely Access (wait times), Quality (patient satisfaction), and Health Status and Wellness (prevalence of diabetes) to illustrate in greater detail some of the issues we raised in Part I of this report.

Taking a Closer Look at Wait Times

While timely access to health services is important to patients' well-being and health outcomes, the construction and measurement of wait times can only be understood within the context of a political struggle over how the health system should be organized. Wait times have become significant both for defenders of public funding and not-for-profit delivery of health care and for proponents of privatization who argue that privatized health care services would increase efficiency and reduce wait times (despite evidence to the contrary). Wait times are also a matter of concern for those whose health is jeopardized or whose discomfort or pain is exacerbated by having to wait for care. This complicated mix of interests should induce us to view evidence on wait times with caution. We need to examine what wait times mean in different circumstances, in different regions, to patients, providers, and government decision-makers.

In ***Healthy Canadians: A Federal Report on Comparable Health Indicators 2004***, one of the indicators of timely access to health care is a measure of self-reported wait times for diagnostic services. These figures measure wait times only for access to non-emergency MRIs, CT scans and angiographies. The figures are based on a survey that does not include people living in the Territories, on First Nations reserves, in other remote regions, or in institutions; it also excludes full-time members of the Armed Forces and persons under the age of 15 – consequently, it tells us nothing about their timely access to these services. The report itself suggests the need to use such data with caution because of high sampling variability. Moreover, the reported data are not sex-disaggregated, so we do not know whether there are differences between men's and women's wait times. We can reasonably suspect that gender is an important factor in wait times – because women constitute most paid and unpaid caregivers, women bear most of the burden of assisting others who are waiting for health services; and women who are waiting for care frequently continue to shoulder caregiving responsibilities.

In the case of this indicator, self-reports may not be as accurate as administrative data, which some provincial jurisdictions use for reporting wait times.[18] If the government uses wait times for these specific services as an indicator of timely access to the health system, will that lead to focusing resources on those specific services? If so, what makes those diagnostic services a priority in relation to other investments such as primary care or health promotion?

Furthermore, the indicator 'self-reported wait time for diagnostic services' does not address whether the service is in fact appropriate. This is a case where the links between the health of the population, determinants of health, and the performance of the health care system are poorly articulated. Waiting for health services is not necessarily or always a bad thing. Sometimes

[18] See, for e.g., the Manitoba Centre for Health Policy and Evaluation, "Waiting times for surgery in Manitoba: A second look" (Winnipeg, 2000) and the 2005 [Ontario] Institute for Clinical Evaluative Sciences report discussed by Tanya Talaga and Rob Ferguson in "Need surgery? Get in line," (Toronto Star, April 7, 2005).

problems are resolved without health care interventions, and sometimes access to diagnostic services may lead to false positive test results and unnecessary interventions. Some waiting periods can be very stressful and detrimental to patient health, while others may cause little disruption in daily life. It may be misleading to compare Canadian wait times with those of countries with more diagnostic technologies (e.g. the United States, Japan, or South Korea) because these countries may be over-utilizing those services.

Taking a Closer Look at Patient Satisfaction

Just as the assessment of 'timely access' with wait time indicators must be put in a political context, the measurement of health care quality through indicators of patient satisfaction must be understood in the context in which patients' assessments and satisfaction levels have gained prominence in the last three decades.[19] As rising health care budgets have come under increased scrutiny, there has been greater public demand for system accountability. There has also been a shift toward consumerism in public service, including public policy. Managers of health services have been encouraged to cultivate a culture of 'customer service,' and to implement quality management systems and patient consultation. While some proponents of this move to consumerism claim that it will increase people's involvement in health service planning, empower service users, and make services more democratic, an economic model of the health service consumer may be an inappropriate framework of empowerment in a system where patients have little genuine choice and are dependent on others' expert knowledge.

This concern leads us to several conceptual and methodological weaknesses of 'patient satisfaction' measures. First, to reiterate, satisfaction surveys may function dangerously as a kind of ersatz accountability in the absence of genuine, democratic accountability mechanisms in health care systems. Second, satisfaction, frequently conceptualized as the fulfillment of a patient's expectations, is a weak and unreliable indicator of quality because patients' expectations are highly idiosyncratic (they depend on unique frames of reference, including attitudes to receiving care, knowledge of services available, their previous experience, reports from others, etc.). Third, the generally high levels of satisfaction (typically 75-90%) recorded in most studies and the lack of variation in responses suggests that 'satisfaction' is poorly conceptualized and operationalized, and fails to capture nuances of meaning.

Among other limitations, satisfaction measures tend not to address structural aspects of care, such as cost, access and bureaucracy, the social-political context in which care is delivered, or patients' expectations regarding power, control and autonomy in the patient-provider relationship. There is also evidence that patients' expectations have only an indirect effect on satisfaction and that patients may report being satisfied even when their expectations are *not* met. Some researchers have found that many patients reviewed their current experiences of care in light of previous episodes of bad care, in which case, "failure to realize their worst fears may paradoxically be a cause for satisfaction".[20]

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[19] See: Avis, M., Bond, M. and Arthur, A. Satisfying solutions? A review of some unresolved issues in the measurement of patient satisfaction. *Journal of Advanced Nursing*. 22:316-322, 1995. Also see Sitzia, J. and Wood, N. Patient satisfaction: a review of issues and concepts. *Social Science and Medicine.* 45(12):1829-1843, 1997.

[20] Avis, Bond, and Arthur. 1995, p. 319.

Consequently, "a positive response in a satisfaction survey should not be interpreted as indicating that care was 'good' but simply that nothing 'extremely bad' occurred."[21] The discrepancy between patients' reports of satisfaction and their unmet expectations may be illuminated in qualitative interviews which permit patients to offer detailed descriptions of their experiences. Patients may be reluctant to criticize health services in situations where they have little control over what happens to them; they may feel obliged to report satisfaction when resources and effort have been expended on their behalf (better indicating 'gratitude' than 'satisfaction'); or they may feel that positive reports of satisfaction are more desirable to researchers and administrators.[22]

The patient satisfaction indicators in the ***Healthy Canadians*** report are also not able to adequately address gender (and other) differences, nor inequities among subpopulations. For example, while the patient satisfaction measures in the ***Healthy Canadians*** report are disaggregated by sex, they are nevertheless gender insensitive. Apart from the validity issues already raised, several studies have shown that different *aspects* of the content of primary care are important to women and men – something that is not revealed in a survey question that universalizes the experience of 'satisfaction.'[23] Because women and men experience basic health care differently, it is quite probable that they evaluate it based on different factors, or weight factors differently. For example, the fragmentation of women's primary care, in which routine reproductive services and other elements of care are often provided by different providers at different visits, may contribute to women's more frequent experiences of access problems, lack of coordination across visits, or gaps in service.

In turn, access issues may be evaluated differently by women and men because women make more primary care visits than men and confront specific barriers (such as less discretionary time, and more caregiving responsibilities). So, although generic satisfaction surveys often reveal very few statistically significant differences between women and men, more detailed analyses that attend to various patient characteristics reveal gender differences: for example, women appear more concerned than men about the informational content of primary care visits, continuity of care across visits, and multidisciplinary aspects of care; men appear more concerned than women about the personal interest shown in them by physicians.[24]

Moreover, qualitative focus groups provide evidence that some aspects of primary care that are important to women are not included in standard patient satisfaction measures. These include: providers who are familiar with their medical histories and prior visits; providers who initiate discussions of sensitive topics (e.g. sexual issues, domestic violence); providers who respect women's opinions and their decision-making abilities; and comprehensive services at one visit and location.[25]

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[21] Sitzia and Wood. 1997, p. 1840.
[22] Avis, M., Bond, M. and Arthur, A. 1995; Sitzia, J. and Wood, N. 1997.
[23] Weisman, C.S., Rich, D.E., Rogers, J., Crawford, K.G., Grayson, C.E. and Henderson, J.T. Gender and patient satisfaction with primary care: tuning into women in quality measurement. *Journal of Women's Health and Gender-Based Medicine.* 9(6):657-665, 2000. Also see: Wilde Larsson, B., Larsson, G. and Starrin, B. Patients' views on quality of care: a comparison of men and women. *Journal of Nursing Management.* 7:133-139, 1999.
[24] Weisman et al. 2000.
[25] Weisman et al. 2000.

Satisfaction instruments not developed with gender issues in mind and not analyzed for gender or other differences do not advance quality improvement efforts and limit opportunities for systemic change. Moreover, such instruments may give a misleading impression about health system performance and quality of care.

Taking a Closer Look at the Prevalence of Diabetes

One of the indicators reported in ***Healthy Canadians*** focuses on the prevalence of diabetes within the population. This is a useful indicator and it is reported in ways that help to reveal some of the gendered dimensions of the disease and health disparities between Aboriginal people and the Canadian population as a whole. However, the data used to construct the indicator are limited. It is important to note that Canadian data exclude New Brunswick, Newfoundland and Labrador, and the figures for Aboriginal people are based on a survey that included only First Nations people living on selected reserves. Moreover, Canadian figures are drawn from diagnostic (administrative) data whereas "North American Indian" data are self-reported. It cannot therefore be assumed that these figures accurately reflect the prevalence of diabetes among all Canadians, nor among Metis, Inuit or off-reserve First Nations people, nor can it be assumed that the data accurately reflect the difference among these groups. Finally, rates of diabetes are high in some immigrant populations, but the reported data shed no light on this concern.

It is interesting to note that diabetes, excluding gestational diabetes, is more common among men than women in the population as a whole. However, Aboriginal women have higher rates of diabetes than Aboriginal men in all age groups. This raises important questions about what causes this discrepancy, what are the protective factors for men in this group, and what factors account for the higher incidence/prevalence in women?

While this indicator reveals an important health issue and health inequities that call for action, there is a need to unpack this indicator and the complex factors which would help us understand the prevalence of diabetes and design more effective prevention and intervention strategies. One barrier to this progress is that the data presented in ***Healthy Canadians*** consolidate all types of diabetes (Type I, Type II, and gestational diabetes), making it difficult to separate conditions for which non-medical interventions (e.g. diet and exercise) can be successful. In order for the indicator to serve its function as a call to action, it needs to be presented in ways that help us identify the upstream and downstream opportunities for action. This includes attention to the impacts of changing diets, sedentary lifestyles, reduced physical activity *and how they came about in social and historical context*. It also includes the examination of effective programs to control diabetes, minimize complications, and reduce risk factors. Individual behaviours need to be understood within the context of social and economic barriers which make it difficult for people to make healthier 'choices.'[26]

[26] For a gender-based analysis case study of diabetes, see: Donner, Lissa. Including Gender in Health Planning: A Guide for Regional Health Authorities. Project #62, Prairie Women's Health Centre of Excellence. Winnipeg, May 2003.

Part III

Additional Indicators to Reflect Women's Health

There are some health indicators that are sex-specific or that are of particular importance to women. Work has already begun, in Canada and internationally, to develop these indicators. It is appropriate that the federal government's major reports on health indicators include some of these indicators in order to provide adequate reflections of women's health.

While it is important to recognize that women's health encompasses all aspects of health across the lifespan, sexual and reproductive health remains an area of major concern to women. Many women consider access to sexual and reproductive health services an important measure of health system performance. Specific indicators might include monitoring the geographical distance to childbirth facilities, the waiting times for access to abortion services or the availability and accessibility of midwifery services.

It is well documented that the majority of unpaid family care providers are women and that care providers' health is often affected by the physical and emotional demands of caregiving, the conditions of caregiving and the availability of appropriate community supports including home care and institutional care. Therefore, it makes sense for the government to monitor the health status of those who are providing care to family members and juggling the demands of work and family responsibilities. Given our knowledge of the impact of caregiving on the health of caregivers, it would be worthwhile to monitor state-family balance in terms of money invested in home-care and services to caregivers versus unpaid contribution and out of pocket expenditures of caregivers.

There is a need to include indicators that give a more complete picture of important determinants of health beyond the health care system. In particular, the government should report on social structural determinants of health, as well as individual behaviours. Given the important correspondence between income inequalities and health inequalities, indicators on poverty levels and levels of income inequality belong in a health indicators report. Likewise, given the fact that violence and sexual abuse underlie a host of health problems for a large number of women, and men, indicators of the prevalence of violence and sexual abuse also belong in a health indicators report.

Conclusion

In this discussion paper, we have explored some of the weaknesses in the recent federal report on comparable health indicators. We have identified several basic principles to guide the development of indicators. We have examined a few specific indicators to illustrate some of their limitations and we have suggested new areas for indicator development. While much work has been done on the development of women's health and gender-sensitive health indicators, many challenges remain.

- How can future government reports on health indicators be founded on a more rigorous conceptual framework that establishes the basic criteria for indicator selection and development?

- How can we participate in more inclusive processes for the identification and development of important health indicators?

- How can we go beyond the measurement of quantitative indicators and deepen our analysis by including qualitative data?

- How can we develop more complex indicators that better capture the contexts of women's lives?

- How can a gender and diversity analysis lead to the development of new indicators or to the rethinking of commonly used indicators?

- Moving beyond the sex-disaggregation of data, how do we strengthen our conceptualization of variations in gender relations and their impact on health?

It is important to improve the indicators which governments use to measure health and health system performance, because such indicators are used to influence government decisions about where to allocate public resources. We assume that indicators are meant to lead to action, and that useful action to improve women's health will depend upon correctly identifying the problems that need to be addressed.

We offer our critique and recommendations because we believe that women have a right to participate in the decisions of a democratic society and that women have something important to say about how their health and the performance of the health system should be assessed. We also recognize that women come from many diverse communities and life circumstances which influence our understandings of health and our health needs. For the health system to become more responsive to women's health needs, both gender and diversity need to be taken into account.

APPENDIX A

RECOMMENDED PRINCIPLES FOR THE DEVELOPMENT OF COMPARABLE HEALTH INDICATORS:

Recommendation 1: Take direction from existing Canadian and international work to develop indicators that are gender-sensitive, in order to promote interventions that are responsive to the health needs of women, girls, men and boys.

Recommendation 2: Indicators should be based on an explicit and comprehensive conceptual framework that includes a gender and diversity analysis of health status, health determinants, and the performance of the health system.

Recommendation 3: Select indicators which reflect a more expansive understanding of health and monitor important determinants of health.

Recommendation 4: Indicators should be clearly linked to explicit goals to improve health and reduce health inequities. Promote social justice by selecting indicators to monitor progress on reducing health inequities.

Recommendation 5: Develop indicators that reflect the health concerns of diverse communities and populations.

Recommendation 6: Develop indicators that are based on solid evidence from multiple research methods and that provide valid, useful tools for monitoring and identifying significant health issues and emerging health problems.

Recommendation 7: Select indicators and report on indicators in ways that will clearly identify when action is required. Link indicators to clear targets to improve health and reduce health inequities.