New Brunswick Women's Council | Conseil des femmes du Nouveau-Brunswick

Submission to the 2021 Health Care Review

About the New Brunswick Women's Council

The New Brunswick Women's Council is an independent advisory body for study and consultation on matters of importance, interest, and concern to women and their substantive equality. Its objectives are:

a) to be an independent body that provides advice to the Minister on matters of importance to women and their substantive equality;

b) to bring to the attention of government and the public issues of interest and concern to women and their substantive equality;

c) to include and engage women of diverse identities, experiences and communities, women's groups and society in general;

d) to be strategic and provide advice on emerging and future issues; and

e) to represent New Brunswick women.

In delivering on these objectives, the council may conduct or commission research and publish reports, studies, and recommendations. The council is directed by an appointed volunteer membership that includes both organizations and individual women. The work is executed by a small staff team.

COVID-19 digital library

The New Brunswick Women's Council has created a library of online content on the COVID-19 pandemic that considers marginalized populations, the not-for profit sector, or uses a social justice lens. Visit the library at bibliothequecovidlibrary.ca

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New Brunswick's next health plan: Effectiveness requires equity

If New Brunswick's next health plan is going to be effective, it must be equitable for women. The plan must take women's distinct needs and experiences into account and respond to them—if it doesn't, we're setting it up to fail our province, plain and simple.

We're providing this submission to support the government in preparing an equitable health plan. The first section grounds us in a number of critical concepts for this work. Section two explores how women experience health care in New Brunswick, what support women need as workers, and how caring labour (paid and unpaid) is gendered. The third section shares tools, processes, and approaches that the government must use to develop a health plan that is equitable and effective. Finally, we include an appendix that summarizes the recommendations provided throughout this submission.

Section 1: Critical concepts

Sex and gender

Sex and gender are often treated as if they are the same thing. The terms female and women are often used interchangeably in English; in French, "femme" is used in both sex and gender. But sex and gender are different things—and the distinction is important.

The Institute of Gender and Health (IGH) of the Canadian Institutes of Health Research explains:

> Sex refers to a set of biological attributes in humans and animals. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and reproductive/sexual anatomy. Sex is usually categorized as female or male but there is variation in the biological attributes that comprise sex and how those attributes are expressed.
>
> Gender refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender- and sexually-diverse people. It influences how people perceive themselves and others, how they act and interact and the distribution of power and resources in society.

Sex is typically assigned at birth as male, female, or intersex[1] based on externally observable physical characteristics but the language of gender is often used (e.g. "It's a girl!").

Most people who are assigned female at birth are women (more specifically, they are cisgender women) and most people who are assigned male at birth are men (cisgender men), but not all. Some people who are assigned female at birth are men (transgender men) and some people who are assigned male are women (transgender women). People of any sex can be non-binary (e.g. agender, Two Spirit, gender-fluid, and many other non-binary gender identities). Basically, we cannot assume someone's gender based on their sex and vice versa.

In health care, both sex and gender matter. The IGH explains that "Sex and gender influence our risk of developing certain diseases, our symptoms and severity of illness, how well we respond to interventions,

[1] Many intersex people are assigned male or female at birth, rather than intersex.

and how often we seek care." The IGH also explains that "Given that every cell is sexed and every person gendered, it stands to reason that gender and sex should be key considerations in examining the basic mechanisms of disease development, social determinants of health, health policy and services, and clinical interventions."

Despite this, health data collection often focuses on sex only or mixes the language of sex and gender (e.g. forms or surveys will ask for gender, but then provide male or female as the possible answers). Until data collection consistently includes both sex and gender, we have to work with existing data to draw reasonable conclusions and make recommendations about women's health. We also need to do this without contributing to the conflation of sex and gender or the erasure of gender minorities (people who are not cisgender).

Our approach at this time—and we recognize it is imperfect and will evolve—is this: as most women are also female, we treat disaggregated data from outside sources on female persons as data we can interpret to also apply to women. Our own data collection is gender-based and will be used to provide context and nuance.

The Women's Council recently recommended a review of the use of sex and gender in legislation and that a plan be developed to update legislation in response to the findings. This would include identifying when sex and gender are erroneously used interchangeably, when is sex used when gender is likely the appropriate term, and when non-binary sexes and genders are erased or referenced in non-affirming ways (e.g. as "other").The government would benefit from a similar review of its policies, forms, data collection practices, etc.

We also want to be clear that some women and non-binary persons require health care that is traditionally framed as "men's health care" (e.g. a transgender woman may require care related to prostate health) and some men and non-binary persons require health care that is traditionally framed as "women's health care" (e.g. an agender person may require cervical health care).

Efforts like these to be accurate and inclusive are sometimes derided as erasing women. Our perspective is that explicitly including transgender women and taking care not to erase other gender minorities is our obligation under the *New Brunswick Human Rights Act.* It also aligns with our agency-level commitment to anti-oppression and inclusion. These efforts are critical because trans women *are* women and because all people who belong to gender minorities face gender-based discrimination and oppression.

Intersectionality

Considering women in the development of our next health care plan—or in any policy and program development—isn't only about sex and gender. Women's experiences and needs are also shaped by race, language, disability, sexual orientation, etc. The IGH explains:

> While it is important to clearly distinguish between sex and gender, we also need to understand the dynamic relationship between these and other factors that influence health and well-being. Intersectional factors—like income, social status and supports, Indigeneity, sexual orientation, education, employment, ability, ethnicity, social and physical environments, geographical location, genetics and personal health practices—contribute to varied experiences and outcomes for men, women, girls, boys and gender-diverse people.

It is critical to emphasize that these factors are *intersecting*, not simply co-existing. This means that there is a dynamic interplay between them. For example, we cannot understand a Mi'gmaw woman's experience of health care in New Brunswick by attempting to separate her experiences as a woman from her experiences as an Indigenous person; being a woman impacts her experience of being Mi'gmaw and being Mi'gmaw impacts her experience of being a woman. There is a specificity to the experience of being an Indigenous woman that is not accounted for except through an intersectional lens that does not try to parse her identity into separate categories.

This is intersectionality, a concept that emerged out of Black feminist political analysis. Dr. Kimberlé Crenshaw coined the term, which has also been profoundly shaped by the Combahee River Collective's work on identity politics and the work of Audre Lorde.

Unfortunately, most of the quantitative data we have access to for this submission does not allow us to cross-reference gender with other factors like race or disability. Given this, we focus on sharing data that compares women and men as respondents and where possible we also reference data that is based on other factors but is not sex or gender disaggregated (e.g. disabled respondents/respondents with disabilities vs. non-disabled respondents/respondents without disabilities of all reported sexes and genders). This is not intersectionality, but it is the best we can do at this moment.

We balance this with qualitative data from our own public engagement initiative, Resonate. Through Resonate, the Women's Council heard from more than 1 400 individuals in New Brunswick in 2017 and 2018. Data was gathered through two streams, one for women and one for individuals belonging to gender minorities of any gender (transgender women could complete either version of the survey as they are both women and individuals who belong to gender minorities). All questions were open ended and participants were invited to speak to the specificity of their lives. The directions and examples provided were designed to make it clear that we were striving to use an intersectional approach. The full findings of Resonate are available at resonatenbresonances.ca. They include stories, ideas, and priorities from participants in their own words as well as detailed information on the initiative's methodology.

Section 2: Women and health care in New Brunswick

Experiences with health care

In Resonate, health emerged as a priority in the data streams for both women and for individuals belonging to gender minorities of any gender.

Through the women-focused data collection stream, three specific sub issues emerged:

- accessing mental health supports and services;
- accessing reproductive health care; and
- meeting basic health care needs.

For individuals belonging to gender minorities, there were two main sub issues: accessing health supports and services (including mental health services) and coverage for medical transition.

In both data collection streams, issues related to health care were also the most common answers to questions on what one thing could make the lives of New Brunswick women and gender minorities, as respective groups, easier as well as what one thing could make participants' own lives easier.

Women's stories from Resonate[2]

"As a young woman I had been receiving annual Pap test with my female doctor while out of the province for University. When I came back to New Brunswick and asked for my male family doctor for my regular Pap I was told to find a clinic / go elsewhere. That was two years ago. I have yet to have a follow up. There was no support nor guidance provided."

"Health care is the primary area for improvement - for example, wait times for ultrasounds are unacceptably long. The number of women without family physicians is unacceptably wrong."

"Many people don't have access to a family doctor and rely on the ER or walk-in clinics. This is a poor way to service health care and makes access to simple things, like birth control or chronic health meds, more difficult than it should be and Im sure costs the system more in the long run."*

"The health system doesn't consider the menstrual pain I live with. The doctors that I've met minimize this pain and say they're "normal." The gynecologists that I've seen were worse, they didn't ask for my consent before touching me, didn't tell me what they were doing which caused me immense pain and trauma."*

[2] Quotations are stories women shared about how they, or a woman they know, have experienced the priority issues. They appear exactly as they were submitted unless translated (indicated by an *) or edited for length.

The issues with access to and quality of health care for women that emerged through Resonate have only been amplified by a number of recent developments, including:

- media coverage of women not receiving the gynecological care they require;
- the closure of Clinic 554 in Fredericton, which was not only the only non-hospital provider of surgical abortion care in the province but also a provider of specialized LGBTQIA2S+ care and a family practice; and
- the diversion of ambulances from the Dr. Georges-L.-Dumont University Hospital Centre (Vitalité Regional Health Network) to the Moncton Hospital (Horizon Regional Health Network) and the temporary closure of the Emergency Department of the Sackville Memorial Hospital (Horizon Health Network) due to a shortage of nurses.

These issues are further supported by data from surveys conducted by the New Brunswick Health Council (NBHC). In a 2017 survey on primary care, the NBHC found that women were more likely than men to have:

- "experienced difficulties in getting the health care they needed in the last 12 months because they were unable to leave the house due to a health problem" (11.4 vs 7.8 per cent);
- "needed health care services in the last 12 months, but it was not available in their area at the time they needed it" (15 vs. 11.4 per cent);
- "reported that the cost for treatments or procedures was too high in getting the health care they needed in the last 12 months" (17 vs 14.2 per cent); and
- "reported that the cost for medication was too high in getting the health care they needed in the last 12 months" (34.9 vs 31.4 per cent).

For each of the above scenarios, Indigenous respondents and disabled respondents/respondents with disabilities were more likely to have faced the issues described than non-Indigenous and non-disabled respondents, respectively. On the final three, individuals who preferred French as their language of service were more likely to have faced the issues described than individuals who preferred English.

A 2018 NBHC survey on home care included data on care provided through the Extra-Mural Program (i.e. care provided in the home by health care professionals and allied health professionals and paid for by the Department of Health). It showed that women were less likely than men to report positive experiences and more likely than men to report negative experiences or room for improvement.[3] On 33 out of 37 questions about positive experiences, a greater number of men than women said yes or scored high; on seven out of 12 questions on negative experiences, a greater number of women than men said yes or scored high. Indigenous respondents also reported positive experiences in lower numbers and negative experiences in higher numbers than non-Indigenous respondents.

[3] Positive experience refers to questions where a "yes" or a high score from a respondent is desirable as the question describes accessible or quality care; negative experience refers to questions where a "yes" or a high score from a respondent is not desirable as the question describes an issue with access or quality of care or room for improvement.

A 2019 NHC survey on acute care showed a similar pattern. On 47 out of 53 questions about positive experiences, a greater number of men than women said yes or scored high; on 2 out of 3 questions on negative experiences, a greater number of women than men said yes or scored high. Similar patterns emerged for Indigenous, racialized, and immigrant respondents when compared to non-Indigenous, white, and non-immigrant respondents, respectively.

Effectively, this means that on the Extra-Mural Program and acute health care men reported experiences that were positive or did not need improvement in higher numbers than women did 82 per cent and 88 per cent of the time, respectively.

The 2018 survey on home care also collected data on home support services that are not provided by health care or allied health professionals (e.g. support with personal care, housekeeping, grocery shopping, etc.) and are funded by the Department of Social Development. This kind of care impacts the health care system by supporting individuals to remain in their homes and increasing their wellness. On 11 questions out of 23 on positive experiences, a greater number of men than women said yes or scored high; on 8 questions out of 10 on negative experiences, a greater number of women than men said yes or scored high. In other words, men reported experiences that were positive or did not need improvement in higher numbers than women did 58 per cent of the time.

There are clearly inequities in access and quality of care for women in New Brunswick. Addressing this requires rethinking and reorienting health care services—recommendations on this are included in the second section of this submission. There are, however, a number of recommendations on specific health care issues that the Women's Council has made in the past that are still relevant and that we want to reiterate:

- **Midwifery**
  In New Brunswick, midwifery is only available in the Fredericton region. Midwifery care saves money and reduces stress on hospitals and specialists by moving low-risk pregnancies into a community health care setting. Based on information shared by New Brunswick Families for Midwives, the Women's Council is concerned that the demonstration site in Fredericton is under-resourced. Since the practice started there has been a waitlist of over 100 families. The site continues to face issues related to inadequate staffing; this is, in part, because the wages offered are not competitive with those in other jurisdictions. The site must be properly resourced not only to serve the local community, but also to generate data required for evaluating the site and planning for an expansion of midwifery services to more regions of the province.

- **Pharmacists' scope of practice**
  The Women's Council recommends that government explore expanding pharmacists' regulated scope of practice to allow them to prescribe hormonal birth control. It should be eligible for billing to Medicare to ensure equitable access (rather than having patients pay out of pocket or having pharmacists absorb the cost of the service).

- **Abortion access**
  Government must expand access to abortion services regionally. We also advise government to review Regulation 84-20 Schedule 2 (a.1) to allow for surgical abortions outside of hospitals to be billed to Medicare (this would also require enabling community-based surgical abortion providers to bill ultrasounds to Medicare).

- **Mental health**
  Increase the availability of mental health services. This will relieve pressure on family practices, community health centres, walk-in clinics and hospitals. Given the current social deficit and debt in mental health services, early-intervention, ongoing maintenance, and crisis services must all be available.

Women as health care workers

Women make up the majority of health care workers in New Brunswick by a large margin. In 2019, women accounted for:

- 94 per cent of all regulated nursing professions (registered nurses,** licensed practical nurses,** and nurse practitioners**), which is the largest group of health care workers;
- 88 per cent of health care sector social workers**;
- 77 per cent of respiratory therapists**;
- 76 per cent of physiotherapists**;
- 71 per cent of psychologists**;
- 100 per cent of midwives;
- 92 per cent of occupational therapists**;
- 98 per cent of audiologists**;
- 68 per cent of pharmacists**;
- 75 per cent of medical radiation technologists**; and
- 85 per cent of medical laboratory technologists.**[4]

Given this, supporting women as workers is critical to health care in New Brunswick.

In recent years, we've seen promising updates that will support women as workers, such as the addition of violence and harassment under regulations of the *Occupational Health and Safety Act* as well as the creation of a paid leave under the *Employment Standards Act* for individuals who have experienced intimate partner, domestic, and sexual violence. While these changes are not going to eliminate workplace violence or provide survivors of violence with all the material support they require, they are positive starts.

How else can women be supported as workers? By naming and addressing the gendered nature of care work—and treating that work as the critical infrastructure that it is.

[4] Canadian Institute for Health Information. Canada's Health Care Providers, 2015 to 2019 — Data Tables. Ottawa, ON: CIHI; 2020.
**Individuals in these professional roles within Regional Health Authorities are currently working under expired collective agreements (note that not all individuals in these roles work for the Regional Health Authorities).

We're speaking specifically about care work that is not provided by health care and allied professionals, such as early learning and child care (ELCC—which is both care and educational work) and home support services outside of the Extra-Mural Program. Home support service workers and ELCC workers are disproportionately women. We're also including the unpaid care work that women disproportionately provide in homes and communities—this includes care for friends and family members, as well as the physical and cognitive work of maintaining and managing households.

The path forward on health care cannot rely on more unpaid caring labour that will fall disproportionately to women. This would be inequitable and antithetical to the goals of the health care plan as women—including but not limited to health care workers—will increasingly burn out and/or withdraw from the work force. This will, in turn, affect their economic security and their career trajectories—and, therefore, their lifetime earnings and health outcomes.

Canada's Women's Health Strategy explains that health reform can impacts women through an increase in demand for unpaid care labour:

> Reform and modernization of the health system will be positive if it means that fewer women will be subjected to unnecessary or ineffective interventions or drugs, that they will have access to better preventive medicine, to midwives and to quality care in their own home. But, if women find that access to important services is limited, or that the net effect of an increased reliance on home care simply means that women assume the greater burden of family caregiving for long-term rehabilitation or chronically ill family members, then the impact of health reform will be less positive.

Resonate further supports this. Access to and provision of care emerged as a priority from Resonate's data stream for women (with child care and care for family and friends as specific sub issues). Women providing unpaid caring labour, or watching the women around them do so, were concerned about burnout, having to withdraw from the workforce, and consequences to their health.

Women's stories from Resonate

"I'm expected to be caring and nurturing, which is not a problem, but it gets very draining when working full time, taking care of the house and helping a sick parent."

"My mother is showing signs of dementia and the worries have increased, soon she will not be able to be alone and I cannot quit my job to take care of her so everything is up in the air."

"My disabled husband on the reserve doesn't qualify for a lot of help since provincial programs don't apply on the reserve and therefore I, As his wife, have to do the majority of the unpaid care work. We live below poverty line. I can't leave reserve cos then we lose our housing."

Women's stories from Resonate

"Authorities seem to ignore the huge responsibilities that adult women face by having to take care of their aging parents. This requires time, having to travel on a regular basis. I feel caught between my children and the increasing needs of my parents…it doesn't make sense to not have a geriatric multi-disciplinary team in rural regions where there is a higher aging population. Adding to this that, generally, women live longer than men. They need those services otherwise they are at the mercy of a health system that doesn't understand them."

"I have watched my grandmother, mother and friends struggle through exhaustion and frustration because they are the primary caregiver for a ill or disabled family member - in fact, my mother is going through this experience right now."

In addition to avoiding increasing the burden of unpaid care work on women, the new health plan will also need to reckon with how to better support those providing paid care work. Wages for ELCC and home care workers must be raised so that workers are properly compensated for their labour—which will, in turn, ensure that day care and home care services are available in New Brunswick. The availability and accessibility of these services directly affect women's ability to participate in the labour force.

In Resonate, many women noted that paid caring labour is usually provided by women earning low wages. They worried about the low wages of those providing care for their family members. Women providing care work themselves noted that low wages left them economically insecure or made their participation in the workforce untenable.

Women's stories from Resonate

"I feel the government (all, not just this one) does not fully appreciate that most community services function on the backs of under-paid women… as government off-loads more and more work onto non- profit services, women are increasingly feeling the effects, including physical and mental health, issues around poverty and childcare, and more."

"Government does not recognize the value of care-giving. Child care workers, women's shelter workers, in-home support providers, personal care workers etc. are not paid consistent with the work they do."

In this, the issue of caring labour intersected with another priority that emerged from the data stream for women: economic security and employment, including pay equity as a specific sub-issue.

Pay equity ensures that people are paid equally for performing work which is not the same but is of comparable value. Comparable value is determined through a rigorous methodology that accounts for skills, responsibility, efforts, and working conditions. Pay equity addresses the fact that due to gender-based discrimination jobs that are predominantly held by women are underpaid in relation to jobs of comparable value that are predominantly held by men. For example, two graduates from a college, one with a trade and one with a diploma in child care, will incur the similar levels of debt and both will provide vital services to society. Their income, however, will be very different.

Currently, New Brunswick has a pay equity law for the public sector and maintains pay equity adjustment payments to home care workers who are employed by agencies that are contracted by the Department of Social Development as well as to ELCC workers. The New Brunswick Coalition for Pay Equity, however, has longstanding concerns that the methodology used to determine the adjustments is flawed, resulting in wages that are too low. For example, the Coalition estimates that the entry level hourly wage for personal support workers providing home care (with the current pay equity adjustment) is $15.30 an hour but evaluates equitable pay to be $21.97. Legislating pay equity in the private sector would provide an opportunity to address the methodology (and would also ensure pay equity for those home care workers not employed via contracts with the Department of Social Development).

Investing in care work has health care benefits beyond supporting women's participation in the workforce and reducing the likelihood of burnout for women. Home care labour provided outside of health system plays a tremendous role in the health and wellbeing of New Brunswickers and reducing strain on the health care system, as mentioned previously in this submission. Equitable pay for care workers will improve their economic security over their lifetimes, helping to ensure they do not age into poverty and improving their health outcomes. Pay equity would also contribute to addressing the systemic undervaluing of women's labour (and labour that is perceived to be women's labour) which, in turn, would contribute to broader work to address gender-based discrimination. ELCC evens the playing field for vulnerable and marginalized children, which impacts their long-term outcomes, including but not limited to health outcomes.

Section 3: Tools, processes, and approaches

To develop an equitable and effective plan, the government must:

- conduct gender-based analysis;
- address issues of systemic inequity and oppression; and
- use co-creation.

All of these tools, processes, and approaches are complimentary and mutually reinforcing.

Gender-based analysis

Gender-based analysis (GBA) is a tool used to assess how specific populations may experience policies, programs, and initiatives differently than others. GBA goes beyond sex and gender to consider intersecting factors that shape individuals' experiences, including age, location, race, culture, disability, and language. It is an essential part of effective and evidence-based public policy.

In 2016, government announced that GBA was required in decision-making and policy development—but that requirement was not universal, as it eventually became apparent that it did not apply to the budget. The Women's Council has consistently reiterated the importance of rigorous GBA to government and recommended that as a matter of transparency and accountability government should publicly share more information on its use of GBA as well as information generated by GBA processes. Earlier this year, government made strides in this area by publishing a Gender Impact Statement as part of the budget; we recommend that government build on that progress and provide a robust public account of how GBA shaped the health plan.

To support GBA, the government should resume the production of a statistical profile on women in New Brunswick similar to the Equality Profile that it has produced in the past.

An example of why GBA is important:

In 2017, New Brunswick was the first jurisdiction to announce that Mifegymiso (the two-drug combination used in medical abortions) would be free to anyone with a valid provincial health card.

Once this free coverage was in place, a settlement service agency informed the Women's Council that refugees in the province had been required to pay out of pocket for Mifegymiso.

The refugees were using the Interim Federal Health Program (IFHP). The IFHP's drug coverage is based on the drug plan formulary of the province or territory that the beneficiary is living in. Formularies list the drugs that a given jurisdiction will cover for residents on social assistance or other benefit programs. This approach ensures that IFHP beneficiaries in a given province or territory are provided with drug coverage that is similar to the coverage that the jurisdiction's vulnerable residents receive.

An example of why GBA is important (continued)

Given the criteria of IFHP drug coverage, how was it that refugees using IFHP in New Brunswick weren't covered for a drug that the provincial government intended to be available *all* residents of the province, including but not limited to the most vulnerable?

The issue was that Mifegymiso was covered through a standalone medical abortion program and therefore wasn't initially added to the formulary.[5] This didn't impact individuals with Medicare coverage as the medical abortion program was built for them—but it did mean that refugees using the IFHP weren't able to access Mifegymiso for free.

The medical abortion program was created outside of the box to order to ensure Mifegymiso was as accessible as possible—but despite the focus on broad accessibility, the unique program design inadvertently caused a particularly vulnerable group to be excluded from a federal program. Rigorous GBA should help identify and address gaps like this.

Address issues of systemic inequity and oppression in New Brunswick

We are concerned that the discussion paper supporting the health care review only briefly mentions "improving the economic and social conditions of New Brunswickers" but elaborates on individual lifestyle changes.

Health is shaped by various determinants, many of which are outside of people's control. A 2016 report from the Office of the Chief Medical Officer of Health on health inequities in New Brunswick explains the social determinants of health specifically:

> These determinants of health are the social conditions in which people are born, grow up, live, learn, work, play and age, and the systems put in place to deal with illness, shaped by political, social and economic forces. The consequences of an unfair distribution of the social determinants of health are avoidable death, disease, disability, distress and discomfort.

This unfair distribution affects women. In *Social Determinants of Health: The Canadian Facts*, Juha Mikkonen and Dennis Raphael explain that:

> Women in Canada experience more adverse social determinants of health than men. The main reason for this is that women carry more responsibilities for raising children and taking care of housework. Women are also less likely to be working full-time and are less likely to be eligible for unemployment benefits. In addition, women are employed in lower paying occupations and experience more discrimination in the workplace than men.

[5] Mifegymiso is now listed on New Brunswick's formulary.

Mikkonen and Raphael also explain that "Racialized Canadians experience a whole range of adverse living circumstances that threaten not only their health but also the overall health and well-being of Canadian society,"

These conditions hold true for New Brunswick. For example, women are overrepresented among minimum wage, low wage, and part-time workers. One of the consequences of this is that women are less likely than men to have extended health care benefits through an employer, which creates additional barriers for them in meeting their health care needs and in exercising control over and choice within their health care. Women have a greater likelihood of experiencing poverty, which puts them at greater risk for poor health outcomes because poverty limits access to safe housing, healthy food, and leisure time necessary to attend to their health and well-being. Women, across Canada and in New Brunswick are more likely than men to experience intimate partner violence and sexual violence, which directly impacts their physical and mental health and may also impact their workforce participation, and in turn their long-term health outcomes.

Given this, individual health and wellness strategies may prove to be inequitable as they will be inadequate for or even irrelevant to the wellness needs of specific groups of women, including disabled women/women with disabilities and senior women with chronic health conditions or women who may have different wellness needs relating to their cultures and communities.

These strategies may have additional inequitable impacts as women are disproportionately responsible for tasks such as meal planning, grocery shopping, and food preparation. Increased expectations tied to personal wellness initiatives may contribute to further stress and a lack of leisure time for women to tend to their own wellness. This may also take a psychological and emotional toll on women, as they are more often blamed or shamed for failures to maintain the health of their families or to achieve a particular ideal of health and wellness themselves.[6]

Strategies that are focused on systemic rather than individual changes are more likely to lessen the inequalities that women experience and to improve women's wellness. To improve the health of New Brusnwickers, the government needs to address oppressions that negatively impact people's health, including gender-based inequality, racism, poverty, and ableism.

Co-creation

One of the best ways to increase the odds of a service's success is by involving the people and communities who are impacted in the process of identifying the problem, designing the services that will address it, and establishing how the services will be evaluated. This is co-creation. Our existing recommendations to government on using this approach can be found here and apply to the development of a health care plan.

[6] Clow B. The meaning of healthy living discourse. In: Clow B, Pederson A, Haworth-Brockman M, Bernier J, editors. Rethinking women and healthy living in Canada. Vancouver: British Columbia Centre of Excellence for Women's Health; 2013. p. 33-50.

Clow B, Pederson A, Haworth-Brockman M, Bernier, J, editors. Rising to the challenge: Sex- and gender-based analysis for health planning, policy and research in Canada. Halifax, NS: Atlantic Centre of Excellence for Women's Health; 2009, 180 p.

We must note that government recently used the language of co-creation in relation to First Nation communities in New Brunswick while approaching the proposed work in ways that do not align with co-creation. Co-creation is not simply new language to apply to existing dominant ways of working to make them sound more inclusive and equitable. It is a specific approach that is rooted in sharing power and requires those in decision-making positions to adopt a stance of cultural humility.

Appendix – Summary of recommendations to government

- Ensure that the health plan is equitable for women.
- Develop the plan using gender-based analysis and co-creation.
- Provide a robust public account of how gender-based analysis shaped the plan.
- Do not rely primarily on strategies that are focused on individual lifestyle changes to improve the health and wellness of New Brunswickers; address oppressions that negatively impact people's health, including gender-based inequality, racism, poverty, and ableism.
- Review of the use of sex and gender in policies, forms, data collection practices, etc. to identify when these terms are erroneously used interchangeably, when is sex used when gender is likely the appropriate term, when are non-binary sexes and genders erased or referenced in non-affirming ways, etc. A plan should be developed to make updates in response to the findings.
- Resume publishing a statistical profile on women in New Brunswick.
- Properly resource the midwifery demonstration site in Fredericton not only to serve the local community but to generate data required for evaluating the site and planning for an expansion of midwifery services to more regions of the province.
- Expand pharmacists' regulated scope of practice in New Brunswick to allow them to prescribe hormonal birth control. This service should be eligible for billing to Medicare.
- Expand access to abortion services regionally and review Regulation 84-20 Schedule 2 (a.1) to allow for surgical abortions outside of hospitals to be billed to Medicare (this would also require enabling community-based surgical abortion providers to bill ultrasounds to Medicare).
- Increase the availability of mental health services. Given the current social deficit and debt in mental health services, early-intervention, ongoing maintenance, and crisis services must all be available.
- Treat care work as the critical infrastructure that it is:
    - Do not rely on unpaid caregiving as a path forward on health care.
    - Support early learning and child care and home support services workers by legislating pay equity in the private sector. Review the pay equity methodology that was used to establish pay equity adjustment payments for home care workers who are employed by agencies that are contracted by the Department of Social Development as well as early learning and child care workers.