

Just the facts, ma'am...

A Women's Guide for Understanding

Evidence about Health and Health Care

Questions Women Should Ask about Health Care Evidence:

- ***About truth and values:***
Who carries out, funds and benefits from the research?
- ***About defining the research problem:***
What is the “problem”? How could it be defined differently?
- ***About what counts:***
Do we use numbers or stories? Which numbers? Whose stories? Do we ask why and how? Or simply how much? What information is missing?
- ***About authority and credibility:***
Who are the “experts” in the research?
- ***Does evidence really matter?***
How does evidence inform health care decisions and health policy?
Are there other factors at work?

**Why are these women's issues
and what are the issues for women?**

"It is now proved beyond doubt that smoking is one of the leading causes of statistics."

(U.S. writer Fletcher Knebel, in *The Globe & Mail*, March 5, 2001, p. A14)

Turn on your television, open the newspaper. Every day, women are bombarded with evidence — statistics, graphs, tables and reports. When it comes to health and health care reform, women face a blizzard of evidence that threatens to blind us rather than guide us. There is new evidence on hormone replacement therapy, evidence on waiting lists, evidence on genetically modified foods, and evidence on government spending on health care. All this evidence is supposed to inform us and help us decide what action to take or not take. But the evidence often seems contradictory, or seems to reject what was offered on the same subject last week, or seems to deny our own experience. What counts as evidence? Where does it come from? How can women judge the evidence they see?

This booklet is about understanding evidence. Because women are always faced with new evidence, it is important to be able to question, interpret and challenge the information that women hear in their everyday lives about health and health care. Our aim here is *not* to offer advice on particular pieces of evidence on things like which treatments are better or worse, or whether the closure of a hospital is a good or bad decision.

In this booklet, we want to provide women with tools to assess arguments and evidence about women, health and health care reforms. Our aim is to help women make their own decisions about health care and health care reforms.

Like all research and writing, ours begins with some assumptions. We recognize that gender matters. It matters whether you are a man or a woman, a girl or a boy. So it is always important to ask, *"to whom does the evidence refer?"* — in this booklet, we focus on women. We also assume that there are significant differences *among* women — of different races, cultures, social classes, ages, abilities, sexualities — so it is important to ask who *produces* the evidence and who the evidence is *about*. We assume that values shape evidence and these values should be made plain. We value social justice, and believe that *all* women should be included in deciding what counts as evidence, in producing evidence, and gaining access to evidence.

Our aim is to help women make their own decisions about health care and health care reforms.

About Truth and Values

There is a widespread belief in our society that the truth is “out there.” Our task is to find the truth and use it.

In our quest for the truth, women look for evidence. Evidence consists of ideas and observations that support (or oppose) an argument. Many people, including researchers, believe that if we follow strict rules for doing research, it will produce evidence that is neutral and free from values. And if enough research evidence is collected, “the truth” about something can be discovered.

There are two problems with this view. *First*, there is no place outside of values or beliefs where we can stand in order to produce absolutely neutral evidence, or see “the truth.” And *second*, no one, no thing, can be separated from its complex environment. All of us exist in a culture, a time and a place that affect how we develop, act and understand the world. This is the case for researchers as well as the subjects they study. This is the case whether they are studying human beings or health care practices. This is also the case for the organizations (including governments and pharmaceutical companies) that fund researchers.

What this means is that evidence and truth don’t simply exist “out there” — real people with real interests and investments select problems to focus on, create the questions to ask, make decisions about how to analyze information gathered, and choose how to present their evidence to others. The argument that research and evidence are created by people and affected by values does *not* mean that we can’t know things at all, or be pretty certain about the “truth” of something. But it *does* mean that women must learn how to “read” the evidence out there and ask some tough questions.

On the subject of truth and values, women need to ask:

- *Where and when was the research done?*
- *Who did the research, and what are their interests?*
- *Who paid for the research, and what are their interests?*
- *What mainstream and/or controversial beliefs are supported by the research?*
- *Who benefits?*

About Defining the Research Problem

Defining the “problem” is a very important first step in doing research. It shapes what questions are asked and what evidence is produced. Not surprisingly, where and when research is done matters. The problem that one person or group thinks is important in one time and place may be very different from the problem that another person or group thinks is a priority in another context. Our values, views of the world, and the contexts we live in influence what we define as problems and the ways we choose to address them. Frequently, we take that step for granted and don’t question the choices and assumptions that the definition of the problem hides.

Consider two women’s medical conditions that we read about on an almost daily basis: menopause and heart disease. Women have always experienced menopause. By the mid-1960s, women were being told that menopause was not “normal.” Dr. Robert Wilson, a prominent gynecologist in the US, wrote in his book *Feminine Forever* that menopause robbed women’s youth — that women would become “living decay” in menopause. He argued



that just as a person with diabetes suffers from an insulin deficiency, women in menopause have an “estrogen-deficiency disease” that requires treatment. In the early 1940s, a pharmaceutical company patented and received FDA approval for a synthetic form of the hormone estrogen. The media popularized the message contained in Dr. Wilson’s book, and before too long, more than 30 million prescriptions for estrogens were written by American physicians. In recent years, research has shown that long-term use of hormones may pose serious health risks such as cancer, heart disease and stroke even while some of the symptoms of menopause such as hot flashes and disrupted sleep are relieved. Defining menopause as a disease guided research and shaped the way in which menopause was treated. It influenced doctors’ and researchers’ ideas about women. It also affected how women saw themselves and the choices they made about the experience of menopause.

Heart disease has long been thought of as a man’s disease. When asked what are the leading causes of death among women, most women think that cancer is at the top of the list. Most women think breast cancer is the leading cause of death. This perception may be related to public health messages about breast self-examination and awareness campaigns such as the “Run for the Cure.” The evidence shows that more women are dying today of lung cancer than breast cancer. But even more women die each year of heart disease. And almost as many women as men die from heart disease. Although it is known that women are less likely to survive a heart attack than men, it is not clear why this is so. Similarly, it is known that women’s symptoms associated with heart disease are often different than those experienced by men. To date, most of the research on heart disease has involved studies of men only, and where women have been included, the differences between men and women have often not been examined in detail. In order to understand heart disease in women and to understand which treatments work for women, research must include women. New studies are focussing on women’s heart health. They are designed to identify the best treatment for women’s hearts and healthy ways for women to live so that they can reduce the risks of developing heart disease.

In short, decisions are taken all the time to invest in research on some conditions and not others. Whether or not something is defined as a problem is influenced by things like who gets sick and how many people get sick. And it is influenced by ideas about women, their bodies and their place in our society. Sometimes, what gets researched is influenced by whether there is the potential for a chemical solution that can be developed as well as the potential for money to be made. And sometimes, defining something as a problem fits with certain social and economic goals in society. Should we try to reduce hospital stays? Do we have too many or too few nurses? Is it better to treat people at home or in institutions? Are women “natural” caregivers? Are women’s wrinkles ugly and are hot flashes a joke?

When we come across research evidence, women need to ask:

- ***What is the problem the research is trying to solve?***
- ***Who defined the problem this way and why?***
- ***Who benefits from this definition and who loses?***
- ***Are there other ways to define the problem that would produce different answers?***

About What Counts

numbers count. Why? Numbers often have been viewed as “pure” — separate from emotion and politics. What could be more straightforward than counting something such as the amount that a temperature increases or decreases, the number of operations performed, the number of days someone waits for a test result? These numbers are just numbers. We are made to think that it doesn’t matter who produces and organizes them because the numbers “speak for themselves.” We are told that it does not matter if the numbers are tabulated by politicians or statisticians, women or men. We tend to believe that statistical evidence is fair and even-handed — it doesn’t play favourites. But this belief conceals all the debates and decisions that go into designing and analyzing the experiments and surveys that produce those numbers.

Numbers as Shorthand

Numbers are used to simplify complex matters. For example, in the news we often hear about how much is being spent on health care, and how health care costs are spiralling out of control. Is this true? One way this question is answered involves looking at how much of our Gross Domestic Product (GDP) is devoted to health care spending. In 2004, \$130 billion was spent on health care in Canada. This translates as approximately 10% of the GDP. In 2003, the US spent over 15% of its GDP on health care. Is Canada’s spending “out of control”?

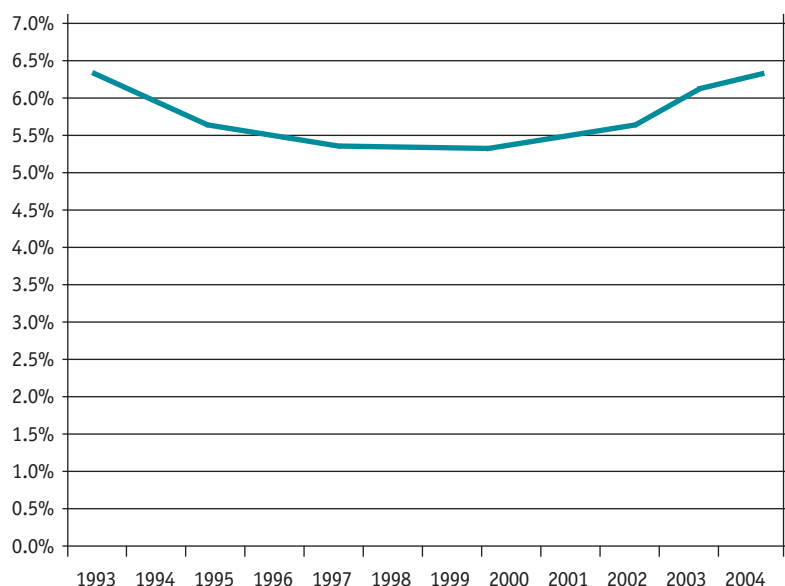
Another way to look at this involves comparing spending over time. In Ontario, for example, from 1993 until 2004, health care spending as a proportion of the provincial GDP has not steadily increased, as is often claimed. When the provincial government introduced tax cuts in the mid-1990s, spending on health care actually began to fall. Only in the early 2000s did spending begin to increase, but even then, it was still lower than it had been in 1993 (see chart 1).

Reporting a single statistic like the proportion of GDP devoted to health care is attractive to politicians, administrators, researchers and the public because it gives us a “snapshot” of a complex issue. But we mustn’t forget that in any snapshot, only some things are brought into focus, and many other things are left out of the frame altogether.

The “Gold Standard”

There are different ways to produce numbers in health research, but one of these is held up as the “gold standard” — the best, most precise method. This is the double-blind, randomized clinical trial or RCT.

Chart 1: Health expenditures and the economy
Health expenditures as a share of GDP 1993 to 2004 (Ontario)



Source: CCPA 2005



Clinical trials are used to test drugs, vaccines and other medical tools and procedures. An RCT usually involves creating two or more groups of people. Researchers randomly assign people to the groups. Because the process is randomized, the groups should be equivalent on things like age and medical conditions. These people then receive a new treatment, an old treatment, or a fake treatment called a placebo. A trial is “double-blind” if neither the researcher nor the people in the study know which group of people will receive the treatment and which group or groups will not. The assumption is that if neither the researcher nor the people being studied know what treatment they’re getting, the researcher won’t behave towards them differently, and the people studied won’t be affected by what they *think* the treatment will do. We assume that if it’s possible to remove these influences, we will be able to see what the impact of the treatment is, without any other factors interfering.

About What Counts cont'd

Such experiments can help show major effects of a treatment and they have helped us save lives. However, there are problems with this approach.

First, it assumes that by randomly assigning people to the groups in the RCT, we can remove the influence of things (other than the treatment) that might affect the results of the experiment. Yet people come in infinite variety and we seldom know what things might be related to these health problems when we begin trials. For example, when trials were done on women with breast cancer to determine if a lumpectomy or a radical mastectomy was better, there was still a lot we *didn't* know about the things that improve or affect survival from breast cancer. So it was difficult to conclude that one procedure was superior to another. Differences in survival rates might have been linked to something that was not measured at all or to a combination of factors that couldn't be measured in an RCT, such as another disease or worries about childcare.

Second, how do we justify offering one group a treatment that we deny to another group, or offering a placebo to people who are ill?

Third, RCTs are usually short-term, so they can't tell us much about long-term effects.

And **fourth**, the trials have, in the past at least, often excluded women. There were many reasons for this. Researchers were concerned that women's menstrual cycles would affect how drugs were processed by the body. They saw women as potentially pregnant and feared the effects of drugs on the fetus. They thought that women didn't get certain diseases in large enough numbers at the "right" ages, so comparisons between women and men were harder to make. For these kinds of reasons, studies showing associations between things like exercise and heart disease, aspirin use and heart disease, coffee and heart disease, etc. were done on samples that included men only. Researchers simply assumed that what holds true for men applies equally well to women, and therefore, there is no need to deal with women separately (or comparatively). For the most part, we simply don't know if this is the case. Take the Aspirin trials, for example, which suggested that women — like men — would benefit from taking a daily dose of Aspirin to prevent heart attacks. More recent research on women suggests that Aspirin may not have the same preventative effect for them that it has for men.

Other Methods

Not all research on health and health care uses RCTs. In fact, for all sorts of public health issues, it would be impossible to conduct an RCT. So, sometimes researchers use research designs that allow them to gather standard kinds of information, but these studies don't allow researchers to determine single causes for particular problems.

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Statistical, quantitative research based on RCTs or administrative studies is often seen as more “scientific” because the numbers seem more precise and more neutral than complicated stories.

Say you wanted to know whether where women live affects their risk of developing breast cancer. It wouldn't be possible to randomly assign women to live in one community or another. So, instead, what researchers would do is look at different communities and then take measurements of water samples and air samples to see if things like pesticide and other chemical residues, naturally occurring and synthetic estrogens, and air and water pollutants are present. They would also collect information on the number and types of cases of breast cancer, and they might map where the cases of breast cancer occur. If the researchers found cancer cases to cluster in communities with high levels of pesticide and chemical residues, this would suggest that it would be safer not to live in these communities. It might lead governments to impose regulations to ensure clean water and air.

Of course, some might not think that this type of research is “good enough” and they might insist that more and better research be done to determine the links between environmental contaminants and breast cancer. More and better evidence in this case might involve using a research design where cause and effect can be determined more clearly, as in an RCT. Or it may mean that it is impossible to determine a single cause, perhaps because there are many causes of breast cancer, including environmental exposures.

Another type of research that is commonly used involves large surveys and the use of “administrative data.” These administrative data are numbers created by health care organizations. In Canada's health care system, the provincial, territorial and federal governments are the major payers of health care. They require organizations receiving funds to keep records of people's visits to various health care providers (doctors, dentists, therapists), hospitals and other long-term care institutions like nursing homes. These types of statistics allow governments to track how often and what types of care are provided to Canadians, as well as how long people wait for services and how long they stay in the system when receiving care. Studies using these types of statistics figure prominently in research on health care (See Home Care: A Help or a Hindrance).

Quantitative or Qualitative?

Research based on statistics is usually called “quantitative.” It focuses on counting things, or quantity. There is another way of finding out about people's experiences of health care, and that focuses on the stories that people tell about their experiences. This type of research is known as “qualitative” because it attends to the quality or meaning of experience.

Statistical, quantitative research based on RCTs or administrative studies is often seen as more “scientific” because the numbers seem more precise and more neutral than complicated stories. It is simpler to compare numbers from experiments that follow the same procedures, or from surveys that ask the same multiple-choice

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Home Care: A Help or a Hindrance?

In 2000, the Health Services Utilization and Research Commission (HSURC) in Saskatchewan conducted a study on the effectiveness of preventive home care services for seniors (defined as including homemaking, personal care and meals) in that province. In the study of 26,490 individuals' records over an eight-year period beginning in 1991, two factors were measured: seniors' ability to live independently and the costs to the system. When the researchers examined the data, they found that for people with similar health status, those receiving preventive home care were at a 50% greater risk of both death and loss of independence, compared to those not receiving the service. What's more, they found that total health service costs for recipients of preventive home care were twice those of non-recipients. This was totally contrary to what one might have expected, but it would make for some interesting newspaper headlines like "Study shows that home care can kill you!" That is what the data showed.

Should we accept this conclusion? What's missing here? What else might we need to know in order to draw any conclusions about whether home care is

good for seniors? Using this guide to health care evidence, we can begin to answer important questions about this research (see the box below).

A study done in 2001 by Hollander Analytical Services, Ltd. drew starkly different conclusions than those reached in the HSURC study. This research was a "natural experiment" in which home care services were cut in one region of British Columbia and retained in another. The researchers were interested in the impact of this policy decision on the costs and outcomes of care. They also decided to do a qualitative study to assess how seniors coped following the elimination of home support services. They found that the elimination of maintenance and prevention aspects of home care led to increased costs for the system, and to suffering, emotional and/or financial costs for a significant proportion of the seniors population. People who were cut from home care were more likely to come back into the continuing care system in worse health than if they had never left. They also found that the quality and length of life may be diminished when home care services are cut. The differences in the cost to the system were not statistically significant in the

The research problems	Does preventive home care help seniors? Does it provide value for money?
The values underlying the study	The assumption is that keeping seniors at home will delay their admission to long-term care institutions. Such a goal is both socially and economically desirable – after all, it's better to keep seniors independent and in their own homes, and it will cost the system less to keep them out of institutions.
What's counted?	Because the HSURC researchers were using administrative data, they were limited by the information that was collected. The researchers were able to report on seniors' risk of loss of independence, or hospitalization, and entrance into long-term care.
What is missing?	The HSURC researchers could not say anything about whether or how meals, homemaking and personal care attendants contributed to seniors' quality of life or their ability to carry out activities of daily living, both key indicators of health and well-being among seniors. The study also could say nothing of the impact of preventive home care on family members (usually women) whose burden might have been alleviated somewhat by the availability of preventive home care for their elderly relatives. Similarly, the study could only speak to the cost to the system. What about the costs to individuals?

first year following the cuts. Cost increases to the system for the group that was cut from service became apparent in the second and third years after the cuts. Personal costs for families and individuals providing care were not recorded or measured, so it is not clear what, if any, additional costs might have been incurred or saved by seniors in the two regions affected by the policy decision.

What these studies tell us is very important. Most of all, we can see that *what you measure matters*. In the HSURC study, the researchers measured what they had available; in the Hollander study, the researchers determined what they needed to measure and then they based their study on those measures. Studies

based on administrative data typically look at what is available in the data warehouse, and then make the best use of it that they can, rather than developing the appropriate measure and going from there. Those doing research using administrative data might be inclined to quote The Rolling Stones, “*You can’t always get what you want...*”

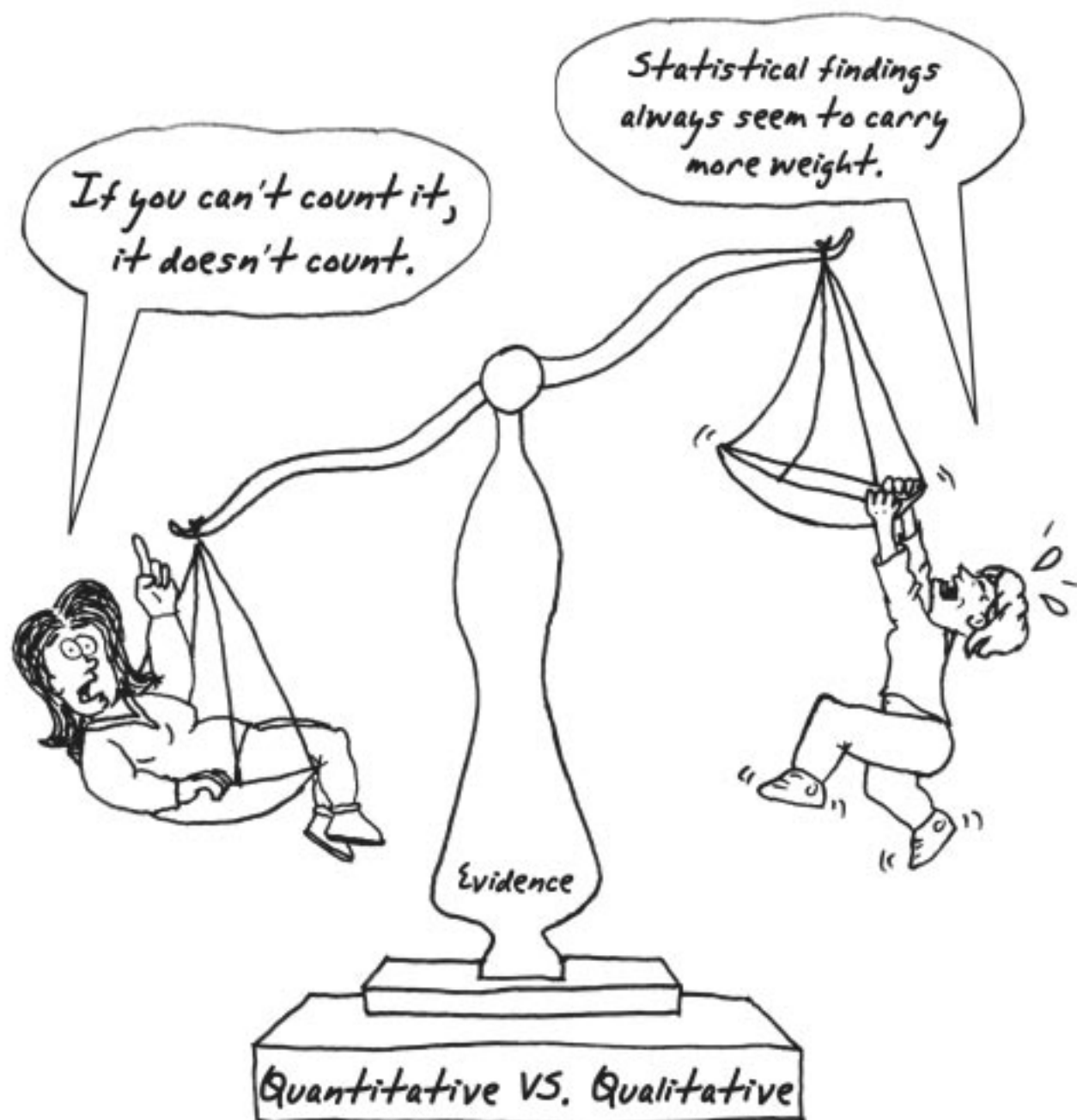
Studies such as the one done by HSURC do have an impact on public policy. That’s because they involve large samples of population-based information. That research might also influence decisions individuals make. So, it is critical that researchers get it right, and that individuals ask of the research about health care reform the tough questions posed in this document.



About What Counts cont'd

questions than it is to compare the stories of individuals. But in order for it to be possible to produce and compare statistics, most of the richness of people's stories must be left out of the "snapshot." This is not always a problem. It is important for us to be able to make comparisons across large groups of people, and to be able to see general patterns.

But we must also pay attention to what the statistics *cannot* tell us. For example, while statistics may be able to tell us that more women than men are diagnosed with depression, or that fewer Aboriginal women



than non-Aboriginal women are screened for cervical cancer, they cannot tell us much about *why*. We may *suspect* that sexism or racism plays a part in these circumstances (one way we might define the “problem”), but collecting information about whether a person is male or female, or Aboriginal or non-Aboriginal, does not tell us about how sexism and racism *work*. Sexism and racism, for example, are not about individuals — they are about social relationships, and they exist *between* people. We need other kinds of evidence to fill in this frame.

Sometimes that evidence is provided by the stories people tell about their experiences, in formal research or informal settings. Qualitative research may produce evidence from individual interviews, focus or group interviews, case studies, and observation where the researcher may be an active participant or remain in the background in a particular site. This type of research tries to provide a picture of the context and complexity of experience. It tries to get at the “how” and the “why,” in addition to “how much.” It makes women’s experiences more visible, and in this way, makes women’s stories matter.

But just as numbers can’t tell the whole story, neither can qualitative research. The picture it paints is limited by whose story is being told. If we interview only male managers, researchers or physicians about health care, we miss the stories and experiences of the women who provide or receive care on a daily basis, that is, the people who make up the majority of providers and recipients of care. And while we should *not* dismiss stories as mere “anecdotes,” we cannot generalize from a few accounts to a large group of people. Stories can fill in the picture and they can challenge the numbers by revealing what is missing and who is missing. They are particularly useful in revealing differences among women, as well as other issues hidden by the numbers.

Ideally, we should be able to access *all* kinds of evidence, weighing their strengths and weaknesses, to help us decide what actions to take. We should think about what evidence we need to help us make informed decisions about our health and health care.

When evidence is offered up, women must ask what counts.

- ***What kinds of evidence (quantitative/numbers or qualitative/stories) are provided?***
- ***What can that evidence tell us: Why and how? Or simply how much?***
- ***Who has provided the information in the research? Whose experiences are represented?***
- ***What information is missing? What do we still need to know to have a fuller picture?***

About Authority and Credibility



We've seen that certain practices of research and certain kinds of evidence such as RCTs and statistics carry more authority and credibility because of how "science" is traditionally defined. The source of that evidence, or who is speaking, also has an impact on how credible it is. We often trust without question the authority of doctors, scientists, management and government leaders because these people are highly educated and are supposed to have our best interests in mind. But multiple interests affect their actions and decisions, and it's important for us to consider the influences that work on them. Doctors are courted by drug companies, scientists think about problems in the contexts where they live or in terms of who will fund the research. It matters where, when and under what conditions research happens. Health care managers may feel compelled to put stockholders' interests ahead of public interests, and government leaders may respond to a wide range of political pressures, from trade agreements to voters. Knowing what these influences are can help us interpret the evidence put before us.

We've also seen that some kinds of evidence carry less authority and credibility. Individuals' stories about their experiences are often dismissed as anecdotal – a single account that doesn't "prove" anything. However, stories are evidence too, and more and more, qualitative studies are being incorporated into the evidence base when it comes to making health care policy decisions. It's worth noting that many stories taken together can offer us an understanding about how people make sense of their experiences and take action in their daily lives. People who provide care often base their practices on a combination of research, their own experiences and the experiences of other providers, and on what they see as possible under present circumstances. Communities, including friends, neighbours, mothers' associations, seniors' groups and women's organizations are also important sources of knowledge about what works and doesn't work in health care. It is crucial that we capture and incorporate these valuable sources of evidence.

No source of evidence should be taken at face value, so women must ask:

- ***Who or what organization has produced this evidence?***
- ***What interests or influences may affect how this evidence is produced and shared?***
- ***Are there other stories to be told, from sources not usually consulted? What's missing?***

Does Evidence Really Matter?

It's clear that we need to pay attention to the research on health care. The reason for doing so is also clear — health care reform is here to stay. Whether governments are seeking ways to control costs or improve care, they will turn to evidence to guide their decisions. While an important element, evidence is not the only thing that influences the decision-making process. Consider the discussions about the privatization of health care in Canada.

Almost every year, The Fraser Institute publishes various reports critical of Canada's single-payer, government-run Medicare program. Its 2004 report *How Good is Canadian Health Care?* concludes that the Canadian system is among the most expensive health care systems in the world, and that it does not yield better health outcomes. The authors of this and other reports of The Fraser Institute have a clear message: the problem with Medicare is that it is a monopolistic, single-insurer, single-provider system, and that Canadians would be better off with the introduction of a private for-profit system.

Privatization of health care is usually understood in terms of *who pays* for health care and *how* that health care is paid for. Advocates of privatization operate on the assumption that publicly-financed and administered health care is inefficient, and robs individuals of choice. Advocates of privatization recommend that health care should be treated like any other consumer good, and publicly owned hospitals and clinics should be sold off to the private sector. Among the strategies proposed by advocates of privatization are increasing private (individual) payment for health care, transferring more responsibility for health care to individual Canadians, the shift to for-profit hospitals, and the introduction of schemes such as medical savings accounts (MSAs). Let's look at some of the research on privatization.

In 2002, researchers at McMaster University reported higher rates of mortality among patients treated for kidney failure in private for-profit health centres in the US. Devereaux and his colleagues found that dialysis patients had a 8% higher chance of dying if they were treated in a for-profit hospital, as compared to those treated in a not-for-profit hospital. Based on their analyses, they estimate that there are annually 2,500 excess deaths in the US. They extrapolated from this meta-analysis that 150 Canadians would die per year if for-profit dialysis were brought to this country. In another study by Devereaux and his colleagues comparing mortality rates of private for-profit and private not-for-profit hospitals, they found that there was a higher risk of death for patients treated in private for-profit hospitals. They found a 2% increased risk of death which would translate into an average of 2,200 extra deaths in Canada each year. The comparable figure for the US is 14,000 extra deaths per year. Why are mortality rates higher? One possibility that might account for this is the need on the part of for-profit institutions to ensure a reasonable rate of return for their shareholders. This factor may also be important in terms of staffing (including turnover) and the quality of care.

Medical Savings Accounts (MSAs) have been praised by some as the way to fix what ails Medicare. In countries with MSAs, a set amount of money is deposited into an account for each individual. As she or he uses the health care system, the funds in the MSA are reduced. If the person doesn't use the health care system, the funds remain in the account to be used at some future date or for activities that will keep

Does Evidence Really Matter? cont'd

people healthier (like fitness club memberships). If, by contrast, a person expends all of the money in the MSA, they are responsible for the added expenses until a “catastrophic threshold” is reached, at which point the insurer would assume additional costs incurred. The logic behind MSAs is that they offer people choice, and where people know the cost (value) of health services, they will be more prudent in their use of the system. Under such a system, costs will be reduced. In a study conducted by researchers at the University of Manitoba, the opposite was found. Forget and her colleagues found that the introduction of MSAs would lead to an increase in health care spending on the healthiest members of the population.

Although these studies on for-profit care and MSAs clearly demonstrate that these measures do not yield savings, and they may lead to poorer health outcomes, some people in government are still singing a chorus in support of these forms of privatization. Who really counts here?

And what about The Fraser Institute’s claims that Canada’s health care system is among the most expensive in the world, and that health outcomes are not better for all of the money spent on health care? The evidence simply does not support such assertions. US spending on health care (approximately 15% of its GDP) far exceeds that of Canada, and even still a substantial number of Americans have no health insurance, or are under-insured. If one looks historically at health care spending over the past four decades, it is clear that costs in both Canada and the US were rising rapidly over time. Once Canada moved to a single-insurer, single-provider system (Medicare) in the early 1970s, health care spending as a proportion of GDP began to moderate in Canada, while US spending has continued to escalate. And as for health outcomes, on most key indicators such as life expectancy and infant mortality, Canada’s health care system performs as well — and more often, better — than the US system. A 2004 study on health care spending and health outcomes by The Commonwealth Fund summarized its findings as follows: “it is difficult to conclude that [the United States] is getting good value for its medical care dollar from these data. The huge difference in the amount the United States spends on health care compared with the other countries could very well be justified if the extra money provided extra benefits. Population surveys have shown that the extra spending is probably not buying better experiences with the health care system, with the exception of shorter waits for nonurgent surgery.”

Decisions may be influenced by evidence; politics may also be at work, or local, national, or international economic considerations may also shape health care policies and decisions about health care.

Whether governments are seeking ways to control costs or improve care, they will turn to evidence to guide their decisions. While an important element, evidence is not the only thing that influences the decision-making process.

Why is Evidence a Women's Issue?

The link between evidence and health care is of great significance for women because the majority of those who give and receive care are women. There are also significant differences among women related to age, income, sexual orientation, immigrant status and racialization. As a result, every change to our health care system has the potential to affect — for better or worse — women's health, work, and financial well-being. So, we need to pay close attention to how decisions are made about health care reforms.

Who counts? That is, whose perspective counts and whose experience is counted? What kinds of information or evidence are trusted? Does that evidence address the needs of women and the circumstances of women's lives? Which women have been taken into account? And which women have been left out?

Nobel laureate Albert Einstein posted a sign on his office door at Princeton University that read: "Not everything that counts can be counted, and not everything that can be counted counts." That's a lesson worth remembering as we contemplate the future of health care in Canada. *What really counts is knowing how to read and understand the evidence.*



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resources on women, health care and evidence

- The *Research Bulletin* of the Centres of Excellence for Women's Health featured an issue devoted to the subject of women, health care and evidence in the Winter of 2002 (volume 2, number 3). This issue is available online at www.cewh-cesf.ca/bulletin/v2n3/bulletin_vol2no3_en.pdf

OTHER USEFUL RESOURCES INCLUDE:

- DesMeules, M. *et al.*, *Women's Health Surveillance Report: A Multi-dimensional Look at the Health of Canadian Women*. Ottawa: Canadian Institute for Health Information, 2003. Available online at: http://secure.cihi.ca/cihiweb/disPage.jsp?cw_page=AR_342_E&cw_topic=342
- Grant, K.R., "GBA: Beyond the Red Queen Syndrome." Keynote address delivered at *GBA: Building Knowledge for Effective Policy, Programs, Research and Laws—A symposium sponsored by Status of Women Canada*. Ottawa Congress Centre, Ottawa, January 31, 2002. Available online at: www.cewh-cesf.ca/PDF/health_reform/gba-red-queen.pdf
- Grant, K.R., *Is There a Method to this Madness? Researching Health Care Reform as if Women Mattered*. Ottawa: National Coordinating Group on Health Care Reform and Women, October, 2000. Available online at: www.cewh-cesf.ca/PDF/health_reform/method-madness.pdf

Who We Are and What We Do

The National Coordinating Group on Health Care Reform and Women consists of Pat Armstrong (Chair), Karen Grant, Madeline Boscoe, Kay Willson, Barbara Clow, Ann Pederson, and Beth Jackson (Research Coordinator). We came together in 1998 as a collaborative group of the Centres of Excellence for Women's Health (CEWH), the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, all funded by the Bureau of Women's Health and Gender Analysis. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at www.cewh-cesf.ca/healthreform/index.html

The Centres of Excellence for Women's Health were initiated by the Bureau of Women's Health and Gender Analysis of Health Canada in 1996. The Centres are multi-disciplinary and operate as partnerships among academics, community-based organizations and policymakers. Their major aim is to inform the policy process and narrow the knowledge gap on gender and health determinants. Both a brochure providing an overview of the CEWH program and our *Research Bulletin* are available on the CEWH website (www.cewh-cesf.ca/).

ordering information

Copies of this booklet can be downloaded from www.cewh-cesf.ca/healthreform/index.html or ordered free from:

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*“There are no impartial ‘facts.’
Data do not have a logic of their own
that results in the same perceptions
and cognitions for all people. Data
are perceived and interpreted in
terms of the individual perceiver’s
own needs, own connotations, own
personality, own previously formed
cognitive patterns.”*

~ David Krech and Richard S. Crutchfield, Theory and Problems
of Social Psychology (New York: McGraw-Hill, 1948)