ACCESS Health

On a personal note... By Nancy Barry

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Recently, I have come to realize that life is short, and that time passes so quickly that sometimes we let important opportunities pass us by. I have had the good fortune to come to know many of you over the past several years, and so I feel comfortable sharing my story with all of you.

Ever since I can remember, I have always wanted to be a mother. When I was a little girl, I spent many a day playing with my dolls, pretending to be a mommy, cradling them, loving them, feeding and caring for them. But then I grew up, and with growing up comes many responsibilities. I went to school, graduated from community college and university, moved into my own apartment, got a great job, and then fell in love and married the man of my dreams. One would think that having children would follow in the natural succession of life. Only, for me, that's not what happened.

I thought that I wouldn't be able to handle working full time and being a mom at the same time. My husband and I bought our first home almost nine years ago, and with a mortgage comes even more responsibilities. So it was then that I knew that I had to keep working if I wanted to have my house, and I didn't want to place all of that burden onto my husband's shoulders. It was at that moment that I decided that having kids wasn't going to be part of my future. And I was okay with that, or at least I thought I was.

It's easy to get caught up in the hustle and bustle of everyday life, becoming so wrapped up in your job, meeting deadlines, paying bills, putting food on the table, etc. And then, totally out of the blue, you wake up one day and everything changes. That's what happened to me. I decided, after 13 years of marriage, that I wanted a child and that no matter what, despite my age and my busy life, I was determined to

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make it happen. I talked to my husband about it, and being the loving and supportive man that he is, turned to me said, “if a child is what you really want, then let’s make it happen.”

I was so excited and yet, at the same time, I was concerned about my age. I am 45 years old, so I didn’t know how safe it would be to conceive at my age. I went to my doctor, told her how I felt and what I wanted to do, and she was completely on board, although she did explain that due to my age, the chances of conceiving would be significantly less than if I were younger. I was okay with that, but I knew I had to try, or I would always regret it.

Many women with disabilities have never had an accurate pap smear for many reasons such as: the lack of knowledge of the significance of cancer screening, the inability to have an accurate screening due to disability-related conditions (i.e. spasticity, unable to lie on your back for an extended period of time, mobility issues and the simple inaccessibility of many parts of our health care system). I was one of those women, who at the age of 45 and married, had never had a pap smear.

My doctor felt it was best to refer me to a gynecologist. So I went to one at a well-known hospital, told her about myself, about my disability, and about what I wanted most of all was to try and have a baby.

As my GP had done, the gynecologist went over the chances and risks of having a child at my age just because under the laws of health care system, and as a medical practitioner, she was legally obligated to inform me of all that I needed to know. I understood all that she said, and so we moved forward to the next step.

The gynecologist suggested, that because I was 45 years old and I had never had a thorough internal examination, that I should have a D&C, also known as dilation and curettage, a surgical procedure. Dilation means to open up the cervix; curettage means to remove the contents of the uterus. Curettage may be performed by scraping the uterine wall with a curette instrument or by a suction curettage (also called vacuum aspiration), using a vacuum-type instrument [http://www.americanpregnancy.org/pregnancycomplications/dandc.html].

At the end of November 2011, I went in for a D&C (performed as a day surgical procedure) and went back for a follow-up in early January of this year. I was all excited because I knew I was one step closer to becoming a mom.

When I went back to the gynecologist in early January, I arrived with great enthusiasm. Then the doctor turned to me and said, "Well Nancy, I wish I had better news for you."

As soon as I heard those words, I think my body went into shock. The news wasn't good, and as soon she began to explain what was wrong, it's as if my body was suspending into thin air; I could hear her speaking, but her words were muffled. All I could hear was the word 'cancer'.

I was in shock. I wasn't expecting the worst, as I normally would in a situation like this. I was expecting everything to be alright so that I could move on to the next step in my plan to have a baby.

I was diagnosed with a condition called "Endometrial Hyperplasia with Atypical Cells". This basically means that upon biopsy of my tissue, they discovered that I had 'pre-cancer' cells in my uterus, which basically meant that if I didn't do something to treat this condition, that I had a 10 to 20 percent chance of developing uterine cancer. The problem was that my body was producing too much estrogen and not enough progesterone - "there are times when uterine hyperplasia can get worse, leading to atypical and precancerous cellular changes. This is why any woman with hyperplasia is considered to be at a higher risk for cancer than one without. And even though this sounds scary, especially if you've just been diagnosed with a thickened endometrium, you should know that there are many steps between hyperplasia and full-blown uterine cancer -and early identification and intervention for uterine abnormalities is highly successful" (womentowomen.com).

She provided me with two options:

(a) having a hysterectomy or
(b) taking a progesterone supplement for a period of three months and then having another D & C to determine whether or not the pre-cancerous cells have shrunk, and then I would require close monitoring for at least one year after that.

As the doctor was explaining all this to me, it was as if the earth had dropped from beneath me. Her words became muffled and garbled, and although I knew what she was saying, I couldn't focus mentally or verbalize my thoughts. I was in shock! I wasn't expecting bad news. I was expecting to have a baby.

The days and weeks following my diagnosis were the worst days of my life. I couldn't eat, sleep, go to work or interact with anyone. I was prepared for the thought that I was too old to have kids, but I was totally unprepared for the news that I received. I didn't know what to do. My thoughts suddenly changed from "I want to be a mother" to "I don't want to die" in less than two months. I was totally thrown. My world went from total excitement at the thought of being a mom to the possibility of having cancer. No matter how many people tried to tell me that this was a good thing, that they caught this before it was actually full blown cancer, all I could think of were two things - that I was probably going to die from cancer (even though I knew I probably wasn't), and that my dream of becoming a mom was over.

I did whatever I always do when I find out bad news - worry and research. I was on the Internet constantly, looking for whatever information there was about my 'condition'. Surprisingly, this was a very common condition among thousands of women, and in many cases when the women chose to take progesterone over having a hysterectomy, cancer occurred later on.

So, after a great deal of careful thought, consideration and research, I decided to have a hysterectomy. My husband and my family all supported me in my decision, the most difficult one of my life. My surgery was on February 13th and I had a "total laparoscopic hysterectomy".

A laparoscopic hysterectomy is a surgical procedure that removes the uterus through small abdominal incisions. The doctor may suggest a laparoscopic hysterectomy because it represents the safest and least invasive form of removing the uterus. Women who have scar tissue or endometriosis may have the diseased tissue removed with a laparoscope before having a hysterectomy performed, which will reduce the risk of the bladder being injured during surgery (www.meriter.com/laparoscopichysterectomy).

The surgery took about four hours, and I was in recovery for about two hours. I had to stay in hospital for one night, and I was able to go home the next day.

Three and a half weeks later, I am still recovering at home and doing very well. I hardly have any physical scars, as the incisions were fairly small.

Looking back, while I am still very sad at the thought that I will never be a mother, I am still confident that my decision was the right one for me. While having regrets isn't necessarily a good thing, the situation could have been much worse. If I didn't have the D&C in November, they never would have discovered my condition, and by the time it presented itself, it could have been too far along to be treated.

I believe that everything happens for a reason, whether it be good or bad. While I will never be a mom, I have a great husband, a job that I love, and many wonderful friends. I still have my seven little kitties and they will always be my babies. I am quickly learning that life can go on, even after the most devastating experiences. My future is there for the taking, and I intend to embrace it with open arms.

Gateways to Cancer Screening: Project Update

By Nancy Barry, Peer Program Lead; © Gateways to Cancer Screening Project Working Group, November 2011.

In 2006, the Centre for Independent Living in Toronto (CILT) Inc. recognized the need to explore and understand the cancer screening experiences of women with mobility disabilities. Partnerships were then developed with disability activists, university-based health researchers and health professionals in Toronto:

- Centre for Independent Living in Toronto
- Canadian Cancer Society
- Mount Sinai Hospital
- Ismaili Cancer Support Network
- Springtide Resources
- Faculty of Nursing, University of Toronto

Gateways I Project (2006-2008):

Purpose: To explore the breast, cervical and colorectal cancer screening experiences and care needs of women with mobility disabilities in Toronto.

Methodology:

- Initially conceived as qualitative descriptive research
- Conducted as a community-based, participatory action research project (PAR)

Participatory Action Research (PAR):

- PAR involves all relevant parties examining together current action (which they experience as problematic) in order to change and improve it.
- PAR is not just research which is hoped that will be followed by action. It is action which is researched, changed and re-researched, within the research process by participants.
- PAR aims to be active co-research, by and for those to be helped.
- PAR tries to be a genuinely democratic or non coercive process whereby those to be helped, determine the purposes and outcomes of their own inquiry (much like the Independent Living philosophy). [Wadsworth, 1998]

Gateways I Project Results:

- Focus groups were conducted by peer researchers with 24 women with mobility disabilities from diverse communities in the Greater Toronto Area (GTA)
- Key findings: women with disabilities face architectural, systemic and attitudinal barriers to effective screening.

Recommendation: disability training for healthcare professionals and clinical staff who work in cancer screening on appropriate and clear communication, compassionate behaviour and best practices.

Our Current Initiative: Gateways II Project (2009-2012)

In 2009, the Gateways Team applied for and received a community-based research implementation grant from the Canadian Breast Cancer Foundation for a new project…

Improving the Breast Cancer Experience for Women with Mobility Disabilities: An Educational Intervention with Healthcare Providers (Gateways II)

Gateways II Team:

Mount Sinai - Principal Investigator
Mount Sinai - Project Manager
Mount Sinai - Research Associate
Mount Sinai - Curriculum Developer
Centre for Independent Living in Toronto
Ismaili Cancer Support Network
University of Toronto, Faculty of Nursing
Springtide Resources
Ontario Breast Screening Program

Project Purpose:

- Address barriers to accessing breast cancer screening for women living with disabilities.
- Improving the mammography experience for women living with disabilities.
- Develop, implement, evaluate an innovative, evidence-based education strategy for healthcare professionals to increase their competencies when working with women with mobility disabilities.

Methodology: Principal Investigator-led model of education research and implementation, supported by an Advisory Group.

Project Overview:

Phase 1: Qualitative research study to learn about the experiences, perceptions and learning needs of healthcare providers working in breast cancer screening around providing care for women with mobility disabilities.

Phase 2: Development and delivery of a disability education program for healthcare providers at a cancer screening centre in Toronto.

Phase 3: Evaluation of the education program and production of other educational materials.

Anticipated challenges to maintaining a community-based qualitative action ideology within an institutional setting:

Building team cohesion/trust - introduction of new team members, greater institutional representation on team.

Sharing power and control - Principal investigator (PI)-led decision making, negotiating institutional rules, regulations and requirements.

Maintaining engagement and involvement of all team members.

Representing Disability in Health Provider Education: Overcoming Ethical Challenges

In part one of Gateways, women with mobility disabilities were asked to participate in focus groups to discuss their personal experiences with healthcare providers when accessing cancer screening.

In part two of Gateways, focus groups were held with healthcare providers to hear about their experiences, concerns and feelings when screening women with mobility disabilities. In doing so, the Gateways Team wanted to find out healthcare professionals' learning needs about providing care for women living with mobility disabilities. Focus groups were held with 43 healthcare providers from the Joint Department of Medical Imaging at three different academic teaching hospitals in Toronto: Mount Sinai, Women's College and Princess Margaret. Separate focus groups were held with clerical staff, mammography technologists, and radiologists from each hospital between April and June 2010. Data was then analyzed from each of the focus groups.

Focus Group Questions asked:

- Icebreaker question: When I say the word 'disability', what comes to mind?
- Tell me about any experiences you have had while caring for people with disabilities?
- What have these experiences been like for you as a healthcare professional?
- What do you think these experiences were like for the person with a disability?
- What did you learn from the interaction?
- Based on your experiences, what are some ways to improve the experience for these patients?

Information gathered from all focus group sessions was coded and analyzed in order to come up with some underlying themes. For example:

Internal Barriers: Normative assumptions, healthcare providers' Attitudes and Knowledge, Architectural, Equipment, Human Resources, Systemic Constraints, Communication Constraints

External Barriers: Transportation, Equipment, Support Constraints, Patients Attitudes and Knowledge, Participation and Experience, Anxiety, Communication Constraints, Past Negative Experiences

Facilitators: Providers' Attitudes and Knowledge, Participation and Experience, Patients' Attitudes and Knowledge, Participation and Experience, Notice and Knowledge, Internal Communication, Patient Communication, Volunteer/Caregiver Assistance, Systemic Improvements

Learning Needs: Communication, Disability Education, Clinical Education

Results:

I WANT TO HELP, BUT, WHAT DO YOU DO IN A SITUATION LIKE THAT?

Health Care Providers:

- Care about patients and empathize with the fear and anxiety patients may be feeling when they come for breast cancer screening.
- Recognize the need to treat patients with disabilities as people.
- Recognize that offering help, communicating well, being patient, and being encouraging to patients with disabilities is important for their comfort.
- Recognize that screening is a collaborative activity.
- Understand that patients with disabilities are knowledgeable about their own bodies; staff must ask questions, listen, and follow their lead.

Examples of things Healthcare Providers do to provide appropriate care for women with disabilities:

- Book patients for less busy or longer appointment times.
- Pre-book ultrasound in case it is necessary.
- Expedite appointment (particularly if patient arrives by Wheeltrans).
- Direct patients to larger change rooms, assist with changing, toileting, and completing forms as necessary.
- Communicate more deliberately and talk patients through the mammography procedure.

BUT WHAT DO YOU DO WHEN….

WOMEN WITH DISABILITIES:

- May vent their frustration over systemic issues to HCPs (Healthcare Providers)?
- Respond to assistance from HCPs in a mixed fashion, which is ultimately confusing and paralyzing?

HEALTHCARE PROVIDERS:

- Experience general discomfort and uncertainty about respectful and appropriate communication/interaction strategies for patients with disabilities?
- Find novel care situations challenging?
- Are concerned about suboptimal imaging?

Quotations from health care providers who participated in focus groups:

"I guess maybe sometimes, because a lot of them value their independence, I don't know how to ask certain questions without offending them. So, like, sometimes… you open a door for somebody and sometimes you get, like, 'Thank you', and then other times they'd kind of be like, 'Well, I can open the door myself'. That kind of thing, you know? Them thinking that I feel sorry for them kind of thing."

"So I have my experience, and I know what (person above) was saying in terms of, like, you don't want to cross the line and say, 'oh, do you need help' too much. And you do want to assist them. Sometimes at the desk, like when you're checking them and you see the double doors they have to go through, and you're sitting there. It's like, you want to run and go open the door, but then you don't want to… you know what I mean, you don't want to cross the line by asking, 'can you get the door?'. It's a little bit hard."

Successful mammography screening requires good provider and patient interaction (active engagement and participation during procedure):

- Patients with cognitive impairments may not understand or be able to actively participate in procedure, which is stressful and difficult for health care providers.
- Some patients will not actively participate in the procedure, which is stressful and difficult for health care providers.

Health Care Providers:

- Make a lot of (stereotypical) assumptions about what patients are thinking, feeling, and experiencing: ex. anxiety and frustration is about fear of cancer, being a "burden", the hassle of screening, and transportation issues, rather than other barriers and stressors
- Receive little or no training about how to care for patients with disabilities.

When health care providers were asked how much training they receive on disability issues, some of them said:

"There was no formal training about disability. I think I just learned… There was more, like, regulations and procedures. The rules of what you should do or not do. It doesn't tell you, like, when you do one on one patient care, how can you help the patient the most. Or make them feel more comfortable or how to read their anxiety. That was just more like, 'this is what the government says'. So that wasn't as helpful."

Final Results of Gateways II: The final product of the Gateways Project will be a Disability Education Program which will:

- Bring the voices, needs, and lived experiences of service-users into the walls of an institution in the form of a training video;
- Assist healthcare providers to develop embodied empathy for women with disabilities
- Improve the mammography experience of women with disabilities who get screened for breast cancer; and to
- Promote health equity for women with disabilities accessing cancer screening.

The Gateways Team has recently hired a well-experienced individual who has filmed many teaching videos such as this one. The DVD will be approximately 13-15 minutes in length and will include women with disabilities talking about their cancer screening experiences as well as a health care provider talking about their experiences around screening women with mobility disabilities. It's all very exciting. We will keep you updated as further results enfold.

1000 Women tell Women's College Hospital what they want from Health Care

http://www.womenshealthmatters.ca/health-resources/health-information/resources/feature-article/1,000-women-tell-women's-college-hospital-what-they-want-from-health-care-(womens-health-matters-article)

The best way to find out what women want from health care, and from a health-care facility, is to ask them. And that's just what Women's College Hospital did. The result is *A Thousand Voices for Women's Health*, a report detailing the results of the hospital's survey of women's health-care experiences, fears, needs, criticisms, hopes and desires.

Women's College Hospital reached out to women across Ontario from all kinds of cultures, backgrounds and life situations. In 25 focus groups and 35 online community forums, as well as online and telephone surveys of almost 600 women in Ontario, the researchers heard from new citizens, recent immigrants and women who have lived their whole lives in Ontario. It included women of diverse ages, incomes, religions and orientations, with a wide variety of life experiences and life circumstances, and differing abilities and health issues.

'This is not research about Women's College Hospital,' said Women's College president and CEO Marilyn Emery at an event on Sept. 28 launching both the research report and the next phase of the development of the hospital's new facility. 'It's about what women want from their health-care facility and their health-care experience. And it's based on feedback from nearly 60 distinct communities of women.'

Their responses yielded some important themes: safety, empowerment, respect for and understanding of cultures and lifestyles, and a holistic approach to health care that focuses on wellness.

Some notable results:

- Only 30 per cent of respondents said they felt empowered when dealing with health-care providers. A great many women had less positive feelings: 45 per cent said they felt isolated when visiting a hospital, 57 per cent said they felt afraid, 63 per cent felt frustrated and 76 per cent felt anxious.
- Sixty-five per cent of women felt they were treated like a number rather than a person, and 70 per cent felt the focus was on rushing them through their appointments and treatments rather than discussing their needs and circumstances.
- The vast majority – 88 per cent of respondents – said it was essential to approach health care holistically, treating the whole person rather than isolated body parts. However, less than half that number (43 per cent) felt that hospitals and health-care facilities actually achieved this.
- Most women prefer to remain in the community – and in their lives – while their conditions are treated. Ambulatory care – or outpatient treatment, as opposed to being admitted to hospital – was the preference of 90 per cent of respondents.
- A health-care facility that is knowledgeable about, sensitive to, and actively addresses diverse cultures was important to 80 per cent of respondents.
- More than 85 per cent of women feel women's health issues should be a research priority for a health-care institution. However, only 56 per cent think institutions successfully keep women's health at the forefront of research programs.

Emery told almost 300 people gathered for the launch event at Women's College Hospital that the survey results are being put into action with the hospital's new, state-of-the-art facility, which will be completed on the hospital's current site by 2015.

'It will be a hospital designed unlike any other. It will allow for light to stream in, privacy in all encounters, curved walls and fluid spaces,' Emery said. 'Our new hospital will be built not around in-patient wards and bedrooms, but around specialized clinics, centres and surgical suites.'

This innovative approach is designed to keep women out of hospital. The new facility will be Ontario's only ambulatory hospital focused on women's health.

'We're delivering an entirely new model of care. Ambulatory care is working, and it's giving women what they want: convenient treatment in their communities and in the context of their lives,' Emery said.

The Hon. Deb Matthews, Minister of Health and Long-Term Care, officially unveiled the sign announcing construction of the new hospital, and placed her fingerprint on a mock-up of the facility. Women from diverse community groups joined her in adding their own fingerprints, and guests at the event were invited to do so as well.

The new facility will include the Women's College Research Institute (WCRI), making women's health research a key focus.

'Our research institute is one of the few in the world – and the only one in Canada – devoted to women's health and innovations in ambulatory care,' said Dr. Lorraine Lipscombe, an endocrinologist at Women's College Hospital and a scientist at the WCRI who spoke at the event.

'Our scientists ask questions that are not only unique to women's lives, but that are specific to distinct communities of women.'

Dr. Lipscombe highlighted the work of Women's College researchers who are investigating views of intimate partner violence in Toronto's Tamil community, inherited breast and ovarian cancers in Ashkenazi Jewish women, and the pregnancy-planning needs of HIV-positive women and their families. Dr. Lipscombe's own research recently probed why lower-income women with diabetes are more likely than wealthier women to die from the condition.

'Equally important, we're putting our research into action,' she said. 'I'm proud that Women's College is building a research institute that supports and celebrates the world's best in women's health.'

The new Women's College Hospital is designed to bring the health-care priorities, needs and hopes articulated by Ontario women to life. To find out more about *A Thousand Voices for Women's Health*, and to add your own voice, go to www.womenshealthmatters.ca/1000women

The Anne Johnston Health Station kicks off its Campaign to Encourage Women with Disabilities to get a Pap Test

The Anne Johnston Health Station (AJHS) is pleased to announce that it will be expanding its Pap screening for women with physical disabilities. Women with physical disabilities face numerous barriers to accessing Pap tests, which may account for lower rates of screening than able-bodied women. Echo: Improving Women's Health in Ontario, a provincial agency dedicated to improving women's health, recently selected AJHS as a demonstration site for women with physical disabilities seeking Pap tests in order to support efforts to adapt and adopt the AJHS model of practice across Ontario.

AJHS offers a barrier-free environment including a fully accessible building equipped with ramps, elevators, electronic doors, ceiling lifts and accessible examination tables. The Pap tests are provided safely in a welcoming, non-judgmental way by Nurse Practitioners.

AJHS executive director, Brenda McNeil says, "we are very happy to partner with Echo in its effort to increase access to cancer screening for underserved groups of women around Ontario. AJHS is pleased to have been selected as a 'best practice site' and our staff look forward to sharing our knowledge and expertise in this important area of cervical cancer screening."

Many women with disabilities are under the misconception that they do not need a Pap test while others find physicians' offices are inconvenient and inaccessible. "We provide longer appointment times and an attendant to assist with additional needs due to physical limitations," says Janis Macdonald, Nurse Practitioner at AJHS.

A Pap test is an important screening tool used to prevent the development of cervical cancer. The test detects abnormal cervical changes before they become cancerous. It is a woman's best protection against cervical cancer. For more information or to arrange an interview please contact one of our Nurse Practitioners by email or phone at: Edith Keeler, edithk@ajhs.ca or Janis Macdonald, janism@ajhs.ca 416-486-8666.

NEWS RELEASE: Ontario Budget Leaves More Than 30,000 Ontarians Waiting for Health Care

From the Ontario Health Coalition: www.web.net/ohc/budget/releasemarch272012.pdf

In a provincial budget that notes Ontario is a "low tax" (and low service) province that spends the least on public services of any province in Canada, the government has unapologetically written a provincial budget that will lead to ballooning health care wait lists, more out-of-pocket costs, and unsafe conditions for Ontario patients.

"The funding levels for health care services in the provincial budget are worse than expected," noted Natalie Mehra, director of the Ontario Health Coalition. "Funding levels announced for hospitals and long-term care are far less than what is needed to maintain existing services, let alone address backlogs. The result will be major cuts to needed care services, longer wait lists for long-term care and unsafe conditions in our hospitals.

"The good news is a substantial increase per year in home care funding, up from the pattern of the last decade which has seen home care shrink as a proportion of health care spending," she said. "With the new investment, it is time to create a public non-profit home care system. Otherwise this budget is a recipe for privatization by stealth: moving care from public and non-profit hospitals to for-profit home care companies and nursing homes."

"While increases in home care are needed and will help those who are eligible and appropriate for such services, they are not a total "trade-off" with the hospital cuts," she explained. "To pretend otherwise is simplistic and manipulative, and ignores the real health needs of thousands of Ontarians."

"Furthermore, red flags should be raised by the budget announcement of "more flexibility" within long-term care homes' funding for operators to spend money where they choose, since most of these facilities are owned by for-profit companies, including large multinational profit-seeking chains," she warned. After years of corporate tax cuts, the provincial budget proposes to pay for the ensuing deficit by, not only the impending hospital cuts and burgeoning long-term care wait lists, but also by freezing the minimum wage and social assistance, worsening income inequality, one of the most significant social determinants of health.

Key issues:

- Prior to the provincial election, the government projected 3.6% annual funding increases for health care. Don Drummond proposed 2.5%. This budget announces 2.1%.

- The budget announces a hospital funding freeze. Hospital global budgets are set at 0%; less than inflation and population growth/aging factors. This will result in hospital deficits and another round of major hospital cuts across Ontario. Ontario has cut more than 18,500 hospital beds since 1990 and now has the fewest hospital beds per capita of any province in Canada and funds hospitals less than all other provinces but one. The evidence is clear that hospital cuts have already gone too far. Already hospital occupancy rates average 98% across Ontario – a level that is so unsafe as to be unheard of in developed countries. Ontario has extraordinarily long wait times for patients waiting in emergency departments to be admitted into hospital because we have such a severe shortage of beds into which to admit patients. This budget puts rural hospitals at serious risk.

- There are more than 30,000 Ontarians on long-term care wait lists. This budget contains nothing new to alleviate these waits which Health Quality Ontario reports have tripled since 2005.

- The budget is almost entirely focused on moving patients into the cheapest mode of care, not on meeting need for care.

- At the same time as the government is severely curtailing hospital funding, they are introducing a new funding formula. British physicians wrote an open letter to Canadian governments warning about the new payment for procedure system that Ontario is adopting, citing its destabilizing and privatizing effects.

- The budget announces new user fees for high-income seniors receiving Ontario Drug Benefits. The OHC is concerned about eroding universality in our health care system – the principle that holds that "judge" and "janitor" should share a hospital ward, ensuring that the judges have an interest in keeping good quality services for everyone. If the government is willing to introduce user fees for wealthy seniors, why not just tax the wealthy?

For more information: Natalie Mehra 416-230-6402 or OHC office 416-441-2502.

Protecting Public Health Care in the 2014 Health Care Accord www.canadians.org/healthcare/

Canada is facing an important next step in our medicare history. In 2014, the current health care accord – the deal that sets funding and health care service delivery agreements between the federal and provincial and territorial governments – expires and must be renegotiated. In the lead-up to these negotiations, we need to remind federal politicians of how much Canadians need and value our public health care system.

Politicians have already begun meeting to talk about what the new accord should include. Instead of being at the table, and taking a leadership role in discussions, the Harper government announced in December 2011 it would provide limited federal financial transfers to the provinces and territories for the delivery of health care services. Essentially, the Harper government has reduced its role in Canada's health care system to writing cheques (and not even ones that would cover the costs of the health care services Canadians need.) The Harper government has stated that health care is a "provincial jurisdiction," signalling it does not support a national public medicare program.

The Council of Canadians has always fought for strengthened public health care. We believe that everyone – Provincial and territorial governments, First Nations and the federal government – should come together to ensure the 2014 Health Care Accord delivers better, more efficient, quality public health care that includes a national pharmacare program and better home care and long term care for our aging population. All Canadians should have access to the same services and quality of care provided by a national, public system.
We are holding town halls, press conferences, organizing rallies, producing materials and lobbying politicians across Canada to help make this happen. We hope you will join us in the important fight for public health care.

Take action!

Send a letter today to Federal Health Minister Leona Aglukkaq, Health Critic Libby Davies, your Premier and provincial Minister of Health asking them to improve public health care for all Canadians through the 2014 Health Care Accord at **www.canadians.org/2014accord**.

Five Things You Should Know About Wait Times

www.canadians.org/healthcare/

Supporters of private, for profit health care have used concerns about wait times to push for private finance and for-profit health care delivery. They argue that letting people who can afford to pay for private health care purchase medical services from private clinics will reduce waiting times across the country by removing patients from the public system. While governments continue to talk about wait time problems, they ignore the real issues causing medical delays.

Here are five things you should know about the real problems causing wait times:

1. **There are no accurate statistics about wait times.** According to leading health policy analyst Dr. Michael Rachlis, there is very little information available on wait times. Some provinces have made efforts to establish Internet-based lists, but these numbers are typically provided by doctors and are not independently verified. Doctors, in general, keep individual wait lists and often there is no coordinating body to help share this information.

2. **Canada has a serious shortage of health care providers.** One of the main reasons for longer wait times in Canada is the fact that we do not have enough doctors, nurses, radiologists and other health care providers. In some areas of the country, 60 per cent of people have no family doctor, and the problem is worse in rural areas. The proposed use of for-profit private clinics would pull health care providers into the private system, making wait times even longer in the public system, as shown at Winnipeg's Maples Surgical Centre. The centre is offering MRI scans for $695, and these are being done by two technologists who left jobs at the public Health Sciences Centre in Winnipeg to work at Maples. According to media reports, the public facility had to cut back its own MRI operations because of the resulting staffing shortage.

The Council of Canadians / Le Conseil des Canadiens

3. **"Guarantees" are no guarantee.** When he was first elected, Prime Minister Stephen Harper promised the government would "work with the provinces" on a health care guarantee so patients could receive essential medical treatment within clinically acceptable waiting times. If they don't get care within that time, they could go to another province, to the United States or to a private clinic and the government would pick up the tab. But at a conference organized by the Canadian Health Coalition, Manitoba Health Minister Tim Sale said the provinces have already spent a year discussing health care guarantees and have concluded they can't meet guarantees without addressing other problems in the public system. Dr. Brian Postl, Federal Wait Times Advisor, also confirmed that moving patients from one province to another, or into private clinics, only displaces the problem.

4. **Money alone won't solve the problem.** The 2004 First Ministers Health Accord committed $41 billion to health care system improvements, including $5.5 billion over 10 years to reduce wait times. Benchmarks were established in December 2005 in five key health care areas that have been prone to longer waiting times. But Dr. Postl cautioned that it's not just about putting money in the system. He says creating centralized wait lists, getting away from a paper system and using electronic technology to share information, addressing the staffing shortage and in some cases, the facility and equipment shortages, are all key to reducing wait times.

5. **Wait lists can be reduced in the public system.** There is a growing list of examples of how wait times can be addressed in the public system. The B.C. based Richmond Hip and Knee Reconstruction Project is one of them. By providing centralized assessment clinics, patients were seen, on average, 17 days after referral from a family physician. Wait times to see a specialist were decreased from 35 weeks to six weeks, and wait times for surgery went from 47 weeks down to less than five weeks. Patients also experienced shorter stays with coordinated follow-up by their family physicians. Evidence has shown that sending patients to private clinics not only costs more, it also results in inferior care.

Profit is not the cure: Contrary to what the private health care advocates would argue, wait times are not the problem, and pouring public dollars into private health care is definitely not the solution. Addressing doctor, nurse and other health care professional shortages, creating centralized waiting lists, and building on "success stories" in the public system are all ways to strengthen Canada's public health care system. The solutions to wait lists are readily available in the public system. What is needed is the political will to implement them.

Take action!
Demand that Prime Minister Stephen Harper and the government stand up for quality, timely, publicly funded health care. Public dollars should never pay for private health care.
Contact Prime Minister Harper today!

E-mail: pm@pm.gc.ca
Fax: 613-941-6900
Mail: Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

For more information about the Council of Canadians' campaign in support of public health care, visit our website at www.canadians.org, or call us toll free at 1-800-387-7177.

Learn About Your Options

It's your health care system. Learn about options and programs that help you get the most out of it. **http://www.health.gov.on.ca/en/public/programs/hco/options.aspx**

Walk-in/After Hours Clinic: At a Walk-in or After Hours Clinic you can see an experienced nurse or doctor, often without an appointment. They offer convenient access to advice, assessment and treatment for minor illnesses and injuries such as cuts, bruises, minor infections, sprains and skin complaints.

Tip: Always call the clinic first to see if you need an appointment.

Use this option when:
- You're in a non-urgent situation
- Your family doctor's office is closed or if you don't currently have a family doctor

Urgent Care Centre

An Urgent Care Centre (UCC) can provide diagnosis and treatment for most injuries and illnesses through emergency trained doctors and other health care professionals.

Tip: Some Urgent Care Centres may offer follow-up appointments to see how your recovery from illness/injury is progressing.

Use this option when: You have an urgent, but non life- threatening illness or injury like sprains or strains, if you think you need stitches or have a minor burn that needs treatment.

Community Health Centre

Each of Ontario's Community Health Centres (CHCs) is unique. CHCs offer clinical care from doctors, nurse practitioners, nurses, dietitians, social workers and other kinds of health providers under one roof. They offer care to those populations that have, for whatever reason, traditionally faced barriers accessing health care.

Tip: CHCs offer culturally-adapted programs for the needs and preferences of the communities they serve including delivering services in many different languages.

Use this option:

- When you do not have a health care provider
- When you are a newcomer to Canada
- To access health care services when facing barriers like language, culture, physical disabilities, homelessness and poverty
- If you have mental health or addiction issues
- If you require counseling or need some help with housing issues
- When you're without health insurance in Ontario.

Family Health Team

A Family Health Team can provide ongoing health care through a team of family doctors, registered nurses and other health care providers like dietitians and social workers. Each team is set up based on local health and community needs, and focuses on chronic disease management, disease prevention and health promotion.

Tip : You can receive a wide range of health services from a Family Health Team, including advice and guidance on living healthier to avoid illness.

Use this option when you need:

- Diagnosis and treatment for common illnesses and injuries
- Support in managing a chronic condition
- A referral to a health care specialist
- A checkup including routine screening tests for cancer, etc.

Public Health Unit

Public Health Units (PHUs) provide support for healthy communities.
Each PHU has a medical officer of health and qualified staff to protect and promote community health. PHUs administer health promotion and disease prevention programs to inform the public about healthy lifestyles, sexual health education in preventing STIs/AIDS, vaccinations, addictions, healthy growth and development including parenting education, health education for all age groups and selected screening services.

Tip: One of the programs offered by Public Health Units is Healthy Smiles Ontario, a no-cost dental program for eligible kids 17 and under available in your community.

Use this option when:

- You're looking for information on immunization
- You're looking for information on food safety
- You're looking for information and services on sexually transmitted infections (STIs)

Nurse Practitioner-Led Clinic

A Nurse Practitioner-Led Clinic can provide ongoing care while helping promote disease prevention and healthy living. Nurse practitioners can diagnose and treat common injuries and illnesses, write some prescriptions and order blood and diagnostic tests. You can also find nurse practitioners working throughout the province in Family Health Teams and other types of clinics.

Tip: If you're without a family doctor, try Health Care Connect. They can help you find a nurse practitioner or family doctor in your area.

Use this option:

- As an alternative to a traditional doctor's office or walk-in clinic
- To schedule a checkup including routine screening tests for cancer, etc.
- When you need support in managing a chronic condition.

Family Health Care Provider

A family health care provider can offer you and your family ongoing care such as family health advice, vaccinations, examinations and prescriptions. They also have a complete understanding of your health history.

Tip If you don't have a family health care provider, try Health Care Connect. They can help you find a family doctor or nurse practitioner in your community.

Use this option when you need:

- Diagnosis and treatment for common illnesses and injuries
- Support in managing a chronic condition
- A referral to a health care specialist
- A checkup including routine screening tests for cancer, etc
- Flu shots or other routine vaccines

FAMILY HEALTH CARE

Emergency Room

Emergency Rooms treat patients with serious illness or injuries, 24 hours a day, 365 days a year. At the ER, a doctor or nurse will assess your condition and decide on a course of treatment.

Tip: You can find length of stay information for emergency rooms near you at www.ontario.ca/waittimes.

Use this option or call 911 when you need emergency care for symptoms like:

- loss of consciousness
- pain not relieved by pain medication
- confusion
- persistent, severe chest pain
- breathing difficulty

Breast Screening Centre

Clinical guidelines recommend regular mammograms (breast x-rays) to enable early detection and treatment of breast cancer. Breast screening using a mammogram is advised for women aged 50 and older who are at average risk for breast cancer.

In Ontario, women can receive a screening mammogram in one of two settings :

Ontario Breast Screening Program (OBSP) - The Ontario Breast Screening Program does not require a referral from a doctor or nurse practitioner to provide screening for women aged 50 and over who are at average risk for breast cancer. Women enrolled in the Ontario Breast Screening Program will be notified of their test results. You will also be automatically sent a reminder when your next mammogram is due. If follow-up is necessary, it is coordinated by either the screening site or your family doctor or nurse practitioner. The OBSP also provides screening for women aged 30 to 69 who are at high risk for breast cancer. A doctor's referral is needed for screening for women at high risk.

Breast Screening Centre - Hospitals or Independent Health Facilities that are not part of the Ontario Breast Screening Program can also provide screening mammography services for

women of all ages. These breast screening locations require you to have a referral from your family doctor or nurse practitioner.

Tip : Women 50 years of age and older should have a mammogram, generally every two years. If you're under 50 or if you have any questions about your risk for breast cancer, speak with your family doctor or nurse practitioner to find out more about breast cancer screening and breast awareness.

Use this option: To be screened for breast cancer if you are a woman over 50 who is at average risk for breast cancer, or if you are under 50 and your family doctor or nurse practitioner has requested that you be screened for breast cancer.

Diabetes Education Program

A Diabetes Education Program provides the tools and skills needed to support people living with diabetes so that they can lead a more full and healthy life. In both group settings and one-on-one counselling, individuals learn self-management skills from a team of health care professionals - including Diabetes Nurse Educators and Registered Dietitians - and can develop life plans to help both minimize their symptoms and delay or prevent the onset of diabetes complications.

Tip: If you or a family member is living with diabetes, contact a local Diabetes Education Program to help you acquire the skills you need to effectively manage your diabetes

Use this option when:

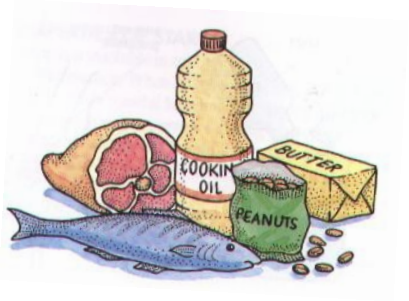
- You've been diagnosed with diabetes
- You have a family member that's been diagnosed with diabetes
- You are trying to better manage your diabetes

FATS: The Good, The Bad and The Ugly

http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/med/fats-gras-eng.php

The type and amount of fat you eat are important. You need some fat in your diet, but too much can be bad for your health. Also, some types of fat (saturated and trans fats) may increase your risk of developing heart disease and should be limited.

What is fat? Fat is an important nutrient for your health. It plays many different roles in your body:



- It gives you energy (also called calories).
- It helps your body absorb vitamins A, D, E and K.
- It helps your body grow and develop.

There are different kinds of fat in foods:

- **the good:** unsaturated (like monounsaturated fat and polyunsaturated fat)
- **the bad:** saturated
- **the ugly:** trans

While you do need some fat in your diet, it is important not to eat too much and to choose the right type.

The good: unsaturated fats - Unsaturated fat is a type of fat found in the foods you eat. Replacing saturated and trans fats with unsaturated fats has been shown to help lower cholesterol levels and reduce the risk of heart disease. Unsaturated fat also provides omega-3 and -6 fatty acids. Choose foods with unsaturated fat as part of a balanced diet using 'Eating Well with Canada's Food Guide'.

Even though it is a "good fat," having too much unsaturated fat may lead to having too many calories. This may cause weight gain and increase your risk of developing obesity, type 2 diabetes, heart disease and certain types of cancer.

There are two main types of unsaturated fats. **Monounsaturated fat,** which can be found in avocados, nuts and seeds (like cashews, pecans, almonds and peanuts) and vegetable oils (like canola, olive, peanut, safflower, sesame and sunflower).

Polyunsaturated fat, which can be found in fatty fish (like herring, mackerel, salmon, trout and smelt), fish oils, nuts and seeds (like cashews, pecans, almonds and peanuts) and vegetable oils (like canola, corn, flaxseed, soybean and sunflower).

The bad: saturated fats - Saturated fat is a type of fat found in food. It has been shown to raise LDL or "bad" cholesterol levels. Having high LDL-cholesterol levels increases your risk for heart disease.

Saturated fat is found in many foods, including animal foods (like beef, chicken, lamb, pork and veal), coconut, palm and palm kernel oils, dairy products (like butter, cheese and whole milk), lard and shortening.

Choosing lower-fat meat and dairy products can help reduce the amount of saturated fat in your diet. Use vegetable oil or soft margarines that are low in saturated and trans fats instead of butter, hard margarine, lard and shortening.

The ugly: trans fats - Trans fat is made from a chemical process known as "partial hydrogenation." This is when liquid oil is made into a solid fat. Like saturated fat, trans fat has been shown to raise LDL or "bad" cholesterol levels, which increases your risk for heart disease. Unlike saturated fat, trans fat also lowers HDL or "good" cholesterol. A low level of HDL-cholesterol is also a risk factor for heart disease.

Until recently, most of the trans fat found in a typical Canadian diet came from margarines (especially hard margarines), commercially fried foods, bakery products made with shortening, margarine or oils containing partially hydrogenated oils and fats (including cakes, cookies,

crackers, croissants, doughnuts, fried and breaded foods, muffins, pastries and other snack foods). If a product has less than 0.2 grams of trans fat AND less than 0.5 g of saturated fat, the food manufacturer can say that the product is trans-fat-free. Learn more about nutrition claims.

Our food supply is rapidly changing and the trans fat content of many of these products has now been reduced. But it is still important to look at the Nutrition Facts table to make sure the food product you are buying has only a little or no trans fat.

General Health Tips:

- Eat a small amount of unsaturated fats each day. Limit your intake of saturated and trans fats. Examples of foods with unsaturated fats include: nuts and seeds, fatty fish (like mackerel and salmon), and vegetable oils.
- Use the % Daily Value (% DV) in the Nutrition Facts table on food product labels to find out how much fat there is in the food you buy.

At the grocery store:

- Always look at the Nutrition Facts table to choose and compare foods.
- Choose leaner cuts of meat, skinless chicken and turkey. Or remove the skin before cooking.
- Buy fish every week, like herring, mackerel, salmon, sardines and trout.
- Choose lower-fat dairy products.
- Choose soft margarines that are low in saturated and trans fat.
- Buy fewer pre-packaged foods and "ready-to-eat" meals.
- Buy vegetables, fruit and whole grain products with no added fat.

Centre for Independent Living

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