Trade Agreements, the Health-Care Sector and Women's Health

by

Teresa L. Cyrus and Lori J. Curtis

The research and publication of this study were funded by Status of Women Canada's Policy Research Fund. This document expresses the views of the authors and does not necessarily represent the official policy of Status of Women Canada or the Government of Canada.

August 2004

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Status of Women Canada thanks those who contribute to this peer-review process.

National Library of Canada cataloguing in publication data

Cyrus, Teresa L.

Trade agreements, the health-care sector and women's health [electronic resource]

Issued also in French under title: Les accords commerciaux, le secteur des soins de santé et la santé des femmes.
Mode of access: Status of Women Canada website.

ISBN 0-662-37421-5
Cat. no. SW21-113/2004E-PDF

1. Medical policy – Canada.
2. Women – Health and hygiene – Social aspects – Canada.
3. National health insurance – Canada.
4. Canada – Commercial treaties – Social aspects.
I. Curtis, Lori J.
II. Canada. Status of Women Canada.
III. Title.
IV. Title: Les accords commerciaux, le secteur des soins de santé et la santé des femmes.

RA412.5C2C97 2004 362.1'0971 C2004-980216-X

Project Manager: Madina Nicolas and Jo Anne de Lepper, Status of Women Canada
Publishing Co-ordinator: Cathy Hallessey, Status of Women Canada
Editing and Layout: PMF Editorial Services Inc. / PMF Services de rédaction inc.
Translation: Linguistica
Comparative Read: France Boissonneault
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ABSTRACT

This report explores the effects that Canada's trade agreements may have on the health of Canadian women. A content analysis of the North American Free Trade Agreement and the General Agreement on Trade in Services shows that Canada's trade obligations may have the power to bring its health care system into the private realm; in addition, future reforms of the public health care system may be more difficult. A data analysis indicates that women working in the service sector are more likely to have poor health than other workers, and low-income workers are less likely to have health insurance. These workers are the most likely to be harmed by a degradation of Canada's health care system, and so would require the most assistance.

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ACRONYMS

CCPA	Canadian Centre for Policy Alternatives
CIHI	Canadian Institute for Health Information
FAMEX	Family Expenditure Survey
FTA	Free Trade Agreement
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GSS	General Social Survey
NAFTA	North American Free Trade Agreement
NPHS	National Population Health Survey
SHS	Survey of Household Spending
WTO	World Trade Organization

PREFACE

Good public policy depends on good policy research. In recognition of this, Status of Women Canada instituted the Policy Research Fund in 1996. It supports independent policy research on issues linked to the public policy agenda and in need of gender-based analysis. Our objective is to enhance public debate on gender equality issues to enable individuals, organizations, policy makers and policy analysts to participate more effectively in the development of policy.

The focus of the research may be on long-term, emerging policy issues or short-term, urgent policy issues that require an analysis of their gender implications. Funding is awarded through an open, competitive call for proposals. A non-governmental, external committee plays a key role in identifying policy research priorities, selecting research proposals for funding and evaluating the final reports.

This policy research paper was proposed and developed under a call for proposals in August 2001, entitled Trade Agreements and Women. Research projects funded by Status of Women Canada on this theme examine issues such as gender implications of Canada's commitments on labour mobility in trade agreements; the effect of trade agreements on the provision of health care in Canada; the social, economic, cultural and environmental impacts of free trade agreements on Canadian Aboriginal women; building Canadian models of integrating gender perspective into trade agreements; the repercussions of the trade agreements on the proactive employment equity measures for women that are applicable to private-sector employers in Canada; and the effects of trade agreements on women with disabilities.

A complete list of the research projects funded under this call for proposals is included at the end of this report.

We thank all the researchers for their contribution to the public policy debate.

ABOUT THE AUTHORS

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EXECUTIVE SUMMARY

Canada's participation in multilateral trade agreements, such as the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS), has raised questions regarding the potential effects of these agreements on social policy in Canada. In particular, researchers, advocacy groups and the public have expressed concern over the future of the Canadian health care system.

This report scrutinizes the wording of the trade agreements to determine how health care in Canada might be affected by the agreements, and analyzes health status, possession of health insurance, and health spending for women and men in various occupation, age, and income groupings. We find that Canadian women, particularly those with low incomes and those working in the service sector, are at risk of adverse changes in the Canadian health care system.

We perform a content analysis of NAFTA and GATS to determine which parts could have implications for the provision of health care in Canada. We find that the standard requirements of trade agreements — of national treatment (NAFTA Article 1102, GATS Article XVII), most favoured nation treatment (NAFTA Article 1103, GATS Article II), the minimum standard of treatment (NAFTA Article 1105) and prohibition of performance requirements (NAFTA Article 1106) — force the Canadian government to treat foreign firms the same as domestic firms, thus preventing any additional requirements on foreign investors or foreign service providers. However, these requirements do not apply in the case of government procurement (NAFTA Article 1108), so if health is purely publicly provided, it does not fall under the scope of the trade agreements. The expropriation and compensation rules require that the Canadian government compensate any foreign investors if their markets are taken over by the government (NAFTA Article 1110). Several parts of the agreements exempt health care, but only to the extent that it is publicly provided (NAFTA Article 1401, NAFTA Annex II-C-9, GATS Annex on Financial Services Article 1(b)).

Two areas of the Canadian health care system may be affected by Canada's participation in multinational trade agreements. First, the commercialization and privatization of hospital and clinic services may bring some aspects of the Canadian health care system into the reach of the trade agreements. Once services become commercialized, the safeguards inherent in NAFTA will fail. Purely public provision of a service is covered, but if the service is offered privately or involves competition, then the market can be opened to foreign investors. The wording of the trade agreements is sufficiently vague that only a trade tribunal will be able to decide this matter for certain. But at that point, it may be too late to protect the public nature of the Canadian health care system.

Second, the extension of public health insurance to cover additional services such as pharmacare or home care may become more difficult, because of the expropriation and compensation requirements in NAFTA. If medicare is expanded and this results in a reduction of the private insurance market, U.S.-based insurance firms might be successful in filing an expensive claim for compensation from the Canadian government.

An examination of several datasets was performed with the goal of determining which Canadians have the worst health status, are less likely to have health or drug insurance, and spend the most on health care. We found that married females working in the industry, service or health sectors had worse health status than married males in those sectors in 1998. As compared to 1986, in 1998 the health status of most married individuals had improved, although there were some exceptions. Those who were unemployed, service-sector workers and secretarial workers had the poorest health across both years. For unmarried individuals, in general, males reported better health status in 1998 than in 1986. But for many groups of females, health status declined over that period.

A high proportion of individuals report having health and drug insurance. However, for both married and unmarried individuals, female industry and service-sector workers have the lowest rates of coverage, as well as those reporting no occupation. We then examined expenditures on health as a percentage of income. For all groups, a general pattern holds that the proportion of income spent on health increases with age and decreases with income.

The following policy recommendations arise from this research project.

- We must prevent hospital and clinic services from being privatized. It is far too risky to allow for-profit private clinics to operate, given that it is still not certain whether this action will bring all of the Canadian health care system into the reach of Canada's trade agreements. For-profit institutions have been found to provide worse health care than not-for-profit institutions, thus adversely affecting women, who tend to use the health care system more than men.

- Canada did not explicitly exclude medicare in either NAFTA or GATS, but Canada should make an effort to exempt medicare from these and any future agreements. This would allow the Canadian government to expand medicare at will (to cover pharmacare and home care, for example) to improve the health of Canadians, without the need for a costly compensation claim from U.S. insurers. Such an expansion of medicare would be most beneficial to those without supplemental health insurance, who tend to be women.

- It is of the utmost importance that those Canadians most at risk from being hurt by free trade be protected by the government. Both women and men working in the service sector or in the industrial sector, those without jobs, and those with low income are most likely to be harmed. These individuals must be protected. It is essential that the government consider this segment of society before agreeing to further trade agreements, and impose policies to help this group of Canadians.

1. INTRODUCTION

The past half century has been a period of globalization and increased ties among nations. After World War II, multinational organizations, such as the World Bank and the International Monetary Fund were set up to govern economic interactions, and the General Agreement on Tariffs and Trade (GATT) began to shape trade between countries. The major industrial nations agreed, in principle, to rebuild the damaged economies of Europe and to improve economic conditions in the rest of the world, while increasing trade and helping their own economies to grow.

In addition to its multilateral obligations, Canada pressed for bilateral and regional agreements. In 1988, the Canadian government passed Bill C-130, the Canada-U.S. Free Trade Agreement (FTA), which ended the system of tariffs between the two countries. This FTA was later expanded to include Mexico in the North American Free Trade Agreement (NAFTA), which came into effect in 1994.

Until the last 20 years, virtually all trade among nations was in the production and sale of goods. Services gained significance, especially in industrial markets, due in part to technological advancements, making them easier to move across borders. The United States began to push for services to be protected by trade agreements in the same manner as GATT protected exporters and importers of goods. Eventually, the U.S.-led push resulted in the Uruguay round of negotiations on trade which created the World Trade Organization (WTO), strengthened GATT, and added the General Agreement on Trade in Services (GATS), which over 140 countries have signed.

Now that these agreements appear to have become embedded in Canadian law, some groups have begun to wonder what effects they will have on Canadian society. We are particularly concerned here with health care, which is protected by the 1982 *Canada Health Act*, which promises universality, accessibility, comprehensiveness, portability and public accountability. Canada's system of medicare is a source of great pride to many Canadians, and it is of essential importance both that this system be maintained and that future reforms are not prevented by trade agreements. If the provision of health care in Canada is adversely affected by Canada's participation in trade agreements, then those most likely to be hurt are those who have low-paying jobs and lack health insurance, who tend to be women.

In this report, we first analyze the content of NAFTA and GATS. We list the sections of these agreements that may have some bearing on the provision of health care services in Canada, and we outline exactly how health care might be affected by the agreements. Next, we describe the academic literature and news reports that discuss the linkages between trade agreements, health and women's outcomes. We then use data from the General Social Survey, the National Population Health Survey, the Family Expenditure Survey and the Survey of Household Spending to describe which groups of Canadians have the worst health status and are most likely to be harmed by negative changes in the Canadian health care system.

We find that the Canadian health care system is in some danger of being adversely affected by Canada's participation in its trade agreements, since the public funding of for-profit clinics may allow foreign for-profit institutions to operate in Canada. In addition, the agreements may limit the ability of the Canadian government to expand the medicare system. The Canadians who would be most affected by this outcome are female service-sector workers and low-income workers.

2. CONTENT ANALYSIS

Privatization of the Canadian Health Care Sector

It is important to distinguish between the *financing* of health care and the *delivery* of health care. Canada has never had a completely public health care system, as even public funding has always gone along with delivery by private physicians, for example. However, over the last decade, the general push toward balanced budgets has often resulted in drastic cuts or smaller increases in public health expenditures. As a result, many provinces have begun to move toward increased privatization of health care to lower their financial responsibilities.

Canadian law has traditionally required physicians to either opt completely in or completely out of the public system. Privately funded practice is not illegal, but the goal has been to prevent the public sector from subsidizing the private sector (Flood and Archibald 2001). This is changing, however. One form of privatization is the institution of private clinics that perform "lucrative, high volume, and low risk diagnostic and therapeutic services (such as magnetic resonance imaging, bone densitometry, cataract surgery, and arthroscopic surgery)" (Lewis et al. 2001: 927). This has occurred in several provinces, including Alberta, Ontario, Quebec and Nova Scotia.

Alberta has taken privatization to the next step with the passage of Bill 11, the *Health Care Protection Act*, in 2000. Under this legislation, privately owned for-profit health institutions are allowed to be paid by the government, using public funds, for providing certain services.

One worry about this change is the very real possibility that it will lead to a two-tier health care system, in which those who are able to pay for any enhanced, non-covered services will be served first, and those with less ability to pay will be forced to wait and/or receive a lower standard of care. An additional fear is that this change will lead to the incursion of international trade tribunals into Canadian domestic health policy.

Trade Agreements and Health

Since the FTA between Canada and the United States, the Canadian service sector has been part of negotiations to liberalize markets and promote international trade. This has led to bilateral agreements between Canada and Israel, Chile, Costa Rica and others, the trilateral NAFTA with Mexico and the United States and, most recently and significantly, GATS, which has been signed by over 140 countries around the world. These negotiations have been subject to a serious public outcry against the possible effects of such treaties on national sovereignty and the protection of national values.

A threat posed by the inclusion of services in trade agreements is that many services provided by the government in some countries are provided by the private sector in others. The most contentious service in Canada in relation to multilateral agreements has been the public provision of health care. Canada has a hard-won system of public health insurance, run by each province with financial help from, and minimum standards set by, the federal

government. The 1982 *Canada Health Act* guarantees that all citizens receive all medically necessary health services at no out-of-pocket cost. Such a system would normally ensure that health care and health insurance fall outside of the scope of GATS and NAFTA.

The international agreements on trade in services confer obligations on their signatories to open domestic private markets to foreign investment or direct participation (NAFTA articles 1102 and 1103, and GATS Article II). The trade agreements require national treatment, which means that foreign providers must receive the same access and treatment as domestic providers. The impact of a provincial bill that would establish a private market in the health sector is thought to bind the Alberta government to allowing foreign investment. It is unclear in the agreements if there is any requirement for differential treatment of separate regional governments.

Sectors that are opened to foreign participation and investment are not impossible to close, as is often suggested. Provisions of GATS however, can make it difficult, lengthy and costly to close markets or introduce restrictive measures. A member country may request arbitration to seek the removal of new or amended measures that are viewed to impair that country's business actions in the territory. Such arbitration can result in the award of financial compensation for real and inferred financial losses due to the action. Under GATS, a member may modify one of its commitments to opening a sector only after three years have passed since it was opened, and acceptable compensation has been given to affected foreign parties if they have requested and been awarded compensation. It appears to be impossible to open a sector only for domestic investment due to the national treatment requirement of NAFTA.

These constraints on governmental initiatives are eased by their ability to opt out of certain obligations in specific sectors. The effectiveness of these options and the degree to which the Canadian government has used them is of greatest importance to the protection of our right to regulate the health care system. Governments are not allowed to use discriminatory criteria to prevent foreign providers from entering the market, but they are fully able to require all providers, domestic and foreign, to meet criteria that would ensure quality service. However, where the quality of health services puts the health of Canadians at risk, the government has control to deny that service or provider the right to practise in Canada, or on Canadians through government insurance coverage, without providing compensation.

The two agreements, GATS and NAFTA, clearly do not require that the Canadian health sector be opened to foreign participation. They do, however, allow foreign participation once a sector has been opened to competition. Compensation awards could make it costly to close a sector once foreign investment has entered it. The Council for Trade in Services under the WTO, through GATS, has the authority to prevent a member from nationalizing or regulating a sector or subsector. This authority would be practised through compensation awards or the denial of benefits to that country's service providers in foreign markets.

The General Agreement on Trade in Services covers all services — a blanket coverage described as "top-down" — "except services supplied in the exercise of government authority" (Article I:3b). This exception is narrowly defined by Article I.3c, by which

public services supplied on a commercial basis or in competition with one or more service suppliers are moved back within the scope of GATS. Health services, if supplied on a commercial basis or in competition with one or more service suppliers, are placed within the scope of GATS obligations. Adlung and Carzaniga (2001: 356) suggested, in what seems to be a hypothetical tone, that public and private health service providers are not in competition by virtue of the existence of the private sector itself. They suggested the two suppliers "do not compete directly, which means that they do not provide the same services." If their interpretation is correct, then it would follow that governments would be able to maintain full control for regulating the public hospitals as they would not be subject to any GATS provisions.

Health has the least number of commitments of any other sector besides education. Canada is one of 40 countries that do not offer any direct commitments on health services, so the sector is not subject to review of measures by the Council for Trade in Services. This may remain true only so long as the sector remains closed to any private investment. Opening a sector through negotiations and agreements with other countries is acceptable under GATS, but it does not state whether this type of official process is the only way to "commit" to opening a sector and thus place it under the scope of GATS. The process of committing to a sector then becomes important for the protection of health care across the country.

Of the two agreements, NAFTA could pose a greater threat to health care, because it does not have the blanket protection (however strong) afforded to public services that GATS has. It has a section of exemptions that reserve certain "measures" (legislation, statues, regulations, policy, etc., by either the government or its agencies and departments) from the national treatment, most favoured nation treatment and local presence clauses. Provinces could exempt any measures they would like from NAFTA before a deadline, two years after the Agreement entered into effect. In the final week before the deadline, provinces were scrambling to exempt their health policies despite federal assurances that they were already protected by Annex II-C-9, which covers measures related to health services "to the extent that they are social services established or maintained for a public purpose." Also in spite of those assurances, in that final week, the federal government announced it had reached an "agreement in principle" with the United States and Mexico that ensured that health care was outside the scope of NAFTA.

A general exception is made for government provision of social services, explicitly including health, but it only protects those measures "that are not inconsistent with (the) Agreement." The double negative would mean that government provision of health should be in accordance with the principles of the Agreement including those that protect foreign investments in Canada. If a government wishes to close a sector or regulate it in a manner that decreases its profitability, it could be subject to a claim by that company for financial compensation. It is this rule that some claim makes it "impossible" to close a sector once it has been opened. It is clear that it is not technically impossible, but it is very likely financially impossible to close a sector due to the compensation awards that could follow. Domestic companies are not allowed to make the same claims against the government.

Sections of NAFTA and GATS that May Affect Health

The following sections of NAFTA and GATS have some bearing on the provision of health services in Canada.

NAFTA
Chapter 11 covers investment.

Article 1102: National Treatment
This article requires countries to treat foreign investors the same as domestic investors.

> 1102.1: Each Party shall accord to investors of another Party treatment no less favorable than that it accords, in like circumstances, to its own investors with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments.

However, according to the reservations listed in Annex I, the national treatment rule does not apply to health-related investment measures in existence when NAFTA went into effect.

Article 1103: Most Favoured Nation Treatment
This article requires the Canadian government to treat all foreign investors equally.

> 1103.1: Each Party shall accord to investors of another Party treatment no less favorable than that it accords, in like circumstances, to investors of any other Party or of a non-Party with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments.

Again, due to the Annex I reservation, the most favoured nation rule applies only to health-related investment measures that came into effect after January 1, 1994.

Article 1105: Minimum Standard of Treatment

> 1105.1: Each Party shall accord to investments of investors of another Party treatment in accordance with international law, including fair and equitable treatment and full protection and security.

Article 1106: Performance Requirements
This article prohibits governments from imposing performance requirements on new investments. This would preclude the Canadian government from imposing preferences for Canadian goods and services in the health care sector.

> 1106.1: No Party may impose or enforce any of the following requirements, or enforce any commitment or undertaking, in connection with the establishment, acquisition, expansion, management, conduct or operation of an investment of an investor of a Party or of a non-Party in its territory:
> (a) to export a given level or percentage of goods or services;

(b) to achieve a given level or percentage of domestic content;
(c) to purchase, use or accord a preference to goods produced or services provided in its territory, or to purchase goods or services from persons in its territory;
(d) to relate in any way the volume or value of imports to the volume or value of exports or to the amount of foreign exchange inflows associated with such investment;
(e) to restrict sales of goods or services in its territory that such investment produces or provides by relating such sales in any way to the volume or value of its exports or foreign exchange earnings;
(f) to transfer technology, a production process or other proprietary knowledge to a person in its territory, except when the requirement is imposed or the commitment or undertaking is enforced by a court, administrative tribunal or competition authority to remedy an alleged violation of competition laws or to act in a manner not inconsistent with other provisions of this Agreement; or
(g) to act as the exclusive supplier of the goods it produces or services it provides to a specific region or world market.

Article 1108: Reservations and Exceptions
This article exempts subsidies, grants and procurement of the federal government from rules regarding national treatment, most favoured nation, minimum standard of treatment and performance requirements.

1108.1: Articles 1102, 1103, 1106 and 1107 do not apply to:
(a) any existing non-conforming measure that is maintained by
(i) a Party at the federal level, as set out in its Schedule to Annex I or III.

1108.7: Articles 1102, 1103 and 1107 do not apply to:
(a) procurement by a Party or a state enterprise; or
(b) subsidies or grants provided by a Party or a state enterprise, including government-supported loans, guarantees and insurance.

Article 1110: Expropriation and Compensation
This article stipulates that governments can expropriate foreign-owned investments only if it is for a public purpose and if compensation is provided. This article could come into play if there is an extension of medicare, which could cause a U.S. investor, for example, to lose its private health insurance market.

1110.1: “No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment (“expropriation”), except:
(a) for a public purpose;

(b) on a non-discriminatory basis;
(c) in accordance with due process of law and Article 1105(1); and
(d) on payment of compensation in accordance with paragraphs 2 through 6.

Chapter 14 covers financial services, and specifies how the above rules apply to these kinds of services.

Article 1401: Scope and Coverage
This article defines financial services rules, but exempts medicare, as it is a "statutory system of social security."

> 1401.3: Nothing in this Chapter shall be construed to prevent a Party, including its public entities, from exclusively conducting or providing in its territory:
> (a) activities or services forming part of a public retirement plan or statutory system of social security; or
> (b) activities or services for the account or with the guarantee or using the financial resources of the Party, including its public entities.

Chapter 15 discusses restrictions on monopolies and exclusive service suppliers. If a government wants to designate a new monopoly in a covered sector, they may be required to provide compensation; this may be a problem with expanding public health insurance.

Article 2101: General Exceptions
This article describes exceptions that governments may use if their existing measures are necessary to protect health.

> 2101.2: Provided that such measures are not applied in a manner that would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail or a disguised restriction on trade between the Parties, nothing in:
> (a) Part Two (Trade in Goods), to the extent that a provision of that Part applies to services,
> (b) Part Three (Technical Barriers to Trade), to the extent that a provision of that Part applies to services,
> (c) Chapter Twelve (Cross-Border Trade in Services), and
> (d) Chapter Thirteen (Telecommunications),
> shall be construed to prevent the adoption or enforcement by any Party of measures necessary to secure compliance with laws or regulations that are not inconsistent with the provisions of this Agreement, including those relating to health and safety and consumer protection.

Annex I-C-7
This annex exempts non-conforming government measures in existence when NAFTA went into effect on January 1, 1994. However, once any of these measures is removed, Annex I protection is permanently eliminated.

> Type of Reservation: National Treatment (Article 1102)
> Description: Investment
> Canada or any province, when selling or disposing of its equity interests in, or the assets of, an existing state enterprise or an existing governmental entity, may prohibit or impose limitations on the ownership of such interests or assets, and on the ability of owners of such interests or assets to control any resulting enterprise, by investors of another Party or of a non-Party or their investments... For purposes of this reservation: any measure maintained or adopted after the date of entry into force of this Agreement that, at the time of sale or other disposition, prohibits or imposes limitations on the ownership of equity interests or assets or imposes nationality requirements described in this reservation shall be deemed to be an existing measure; and "state enterprise" means an enterprise owned or controlled through ownership interests by Canada or a province and includes an enterprise established after the date of entry into force of this Agreement solely for the purposes of selling or disposing of equity interests in, or the assets of, an existing state enterprise or governmental entity.

Annex II-C-9
This annex allows the Canadian government to exempt health care from certain NAFTA rules, to the extent that health care is a "social service for a public purpose."

> Sector: Social Services
> Type of Reservation: National Treatment (Articles 1102, 1202); Most-Favoured-Nation Treatment (Article 1203); Local Presence (Article 1205); Senior Management and Boards of Directors (Article 1107).
> Description: Cross-Border Services and Investment
> Canada reserves the right to adopt or maintain any measure with respect to the provision of public law enforcement and correctional services, and the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care.

GATS
GATS Supplement 1 (GATS/SC/16/Suppl.1)
This supplement commits Canada to including "life, accident and health insurance services" within its GATS obligations.

Article I: Scope and Definition
Article I:3 allows for the exclusion of government-provided services, which are services provided neither on a commercial nor on a competitive basis.

> In fulfilling its obligations and commitments under the Agreement, each Member shall take such reasonable measures as may be available to it to

> ensure their observance by regional and local governments and authorities and non-governmental bodies within its territory;
> - "services" includes any service in any sector except services supplied in the exercise of governmental authority;
> - "a service supplied in the exercise of governmental authority" means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers.

Article II: Most-Favoured-Nation Treatment
This article requires the Canadian government to treat all foreign agents equally.

> With respect to any measure covered by this Agreement, each Member shall accord immediately and unconditionally to services and service suppliers of any other Member treatment no less favourable than that it accords to like services and service suppliers of any other country.

Article VI: Domestic Regulation
This article aims to ensure that regulation is not overly burdensome.

> With a view to ensuring that measures relating to qualification requirements and procedures, technical standards and licensing requirements do not constitute unnecessary barriers to trade in services, the Council for Trade in Services shall, through appropriate bodies it may establish, develop any necessary disciplines. Such disciplines shall aim to ensure that such requirements are, *inter alia*:
> - based on objective and transparent criteria, such as competence and the ability to supply the service;
> - not more burdensome than necessary to ensure the quality of the service;
> - in the case of licensing procedures, not in themselves a restriction on the supply of the service.

Article VIII: Monopolies and Exclusive Service Providers
This article entails restrictions on monopolies and exclusive service suppliers. If a government wants to designate a new monopoly in a covered sector, they may be required to provide compensation.

> If, after the date of entry into force of the WTO Agreement, a Member grants monopoly rights regarding the supply of a service covered by its specific commitments, that Member shall notify the Council for Trade in Services no later than three months before the intended implementation of the grant of monopoly rights and the provisions of paragraphs 2, 3 and 4 of Article XXI shall apply.

Article XIV: General Exceptions
This article allows governments to adopt measures to protect health, even if those measures are inconsistent with other GATS obligations.

> Subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where like conditions prevail, or a disguised restriction on trade in services, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any Member of measures...necessary to protect human, animal or plant life or health.

Article XVI: Market Access

This article prohibits governments from making certain restrictions on the supply of services. As Canada has not listed health care services under GATS, this Article does not apply, except to health insurance, which Canada has listed.

> In sectors where market-access commitments are undertaken, the measures which a Member shall not maintain or adopt either on the basis of a regional subdivision or on the basis of its entire territory, unless otherwise specified in its Schedule, are defined as:
> (a) limitations on the number of service suppliers whether in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test;
> (b) limitations on the total value of service transactions or assets in the form of numerical quotas or the requirement of an economic needs test;
> (c) limitations on the total number of service operations or on the total quantity of service output expressed in terms of designated numerical units in the form of quotas or the requirement of an economic needs test;
> (d) limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ and who are necessary for, and directly related to, the supply of a specific service in the form of numerical quotas or the requirement of an economic needs test;
> (e) measures which restrict or require specific types of legal entity or joint venture through which a service supplier may supply a service; and
> (f) limitations on the participation of foreign capital in terms of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment.

Article XVII: National Treatment

This article requires countries to treat foreign suppliers the same as national suppliers. This does not apply to Canadian health services, as they were not listed by Canada, but it does apply to health insurance.

> In the sectors inscribed in its Schedule, and subject to any conditions and qualifications set out therein, each Member shall accord to services and service suppliers of any other Member, in respect of all measures affecting the supply of services, treatment no less favourable than that it accords to its own like services and service suppliers.

Article XXI: Modification of Schedules
This article would allow Canada to withdraw its 1994 GATS commitment covering health insurance, as countries can withdraw commitments at any time after three years from which the commitment entered into force.

> A Member (referred to in this Article as the "modifying Member") may modify or withdraw any commitment in its Schedule, at any time after three years have elapsed from the date on which that commitment entered into force, in accordance with the provisions of this Article.

Annex on Financial Services Article 1(b)
This annex defines financial services rules, but does not apply to medicare, which is considered "a statutory system of social security."

> For the purposes of subparagraph 3(b) of Article I of the Agreement, 'services supplied in the exercise of governmental authority' means the following...other activities conducted by a public entity for the account or with the guarantee or using the financial resources of the Government.

Implications for the Canadian Health Care System

Services Performed by Hospitals and Clinics
The current movement toward the private financing of services, as well as the advent of for-profit institutions in Alberta and other provinces, may bring some aspects of the Canadian health care system under the purview of Canada's trade agreements. It is important to consider the inherent danger in the move to commercialize and privatize the provision of health care services.

The NAFTA safeguards will fail to hold if services are commercialized. Annex I of NAFTA protects non-conforming services that were in place prior to January 1, 1994, but if such services are commercialized, they are no longer protected. For example, once MRIs are provided privately, these services must conform to all NAFTA rules.

Annex II-C-9 of NAFTA allows the Canadian government to exempt health care from certain NAFTA rules, to the extent that health care is a "social service for a public purpose." It is questionable whether a publicly funded health service that is privately delivered will meet the "public purpose" criterion. If not, Annex II-C-9 would no longer protect these services. The term "public purpose" is undefined, but the danger is that it may be defined narrowly. For example, if services are provided both publicly and by a private firm, then the reservation may not apply.

Purely public provision of a service is protected under GATS Article I:3. This article is clearly worded to protect all services not provided in competition with other services, with other providers, or for profit. What is not clear is how far this article goes to protect the grey areas relating to a public service. Can it be argued that emergency ambulance services are provided for profit in Canada as a result of user fees? Not likely. Can it be argued that

private surgical facilities authorized to treat patients overnight are private hospitals? Perhaps. If private hospitals are allowed to operate alongside the public sector, then hospitals are possibly no longer exempt by Article I:3. That implies that a foreign hospital administration or company could run a hospital, for profit, in Canada.

In addition, it is argued that not-for-profit provision of health services could open the market via the agreements if it involves competition, or even if there is room for profit. The Canadian Centre for Policy Alternatives (CCPA 2002a: 2) stated that "the U.S. has argued that 'services supplied by a private firm, on a profit or not-for-profit basis' are entirely subject to NAFTA's rules." Canadian hospitals are already run on a not-for-profit basis, but they would probably not be interpreted as being run by a private firm. While people and governments may have opinions on the correct interpretation of Article I:3, the actual interpretation only exists when a dispute is brought to a WTO tribunal, and they decide how it should be interpreted, case by case. In the past, disputes have seldom been decided in Canada's favour, resulting in costly settlements to the federal government and the voluntary withdrawal of regulations.

According to Pollock and Price (2000: 1996), "in November, 1999, the WTO's Council for Trade in Services debated the application of this article (Article I:3) to health services, and members decided that exceptions provided in Article I:3 of the Agreement needed to be 'interpreted narrowly' and did not cover the whole sector." However, Pollock and Price (2000: 1996) pointed out that "official assurances carry little long-term weight because the whole point of GATS is to make services tradable." In any case, while the WTO (1998) states the right of nations to do so, it also says no nation has used Article I:3 to defend or challenge another country's regulations.

It is not clear whether the operation of for-profit clinics in one province could affect the rules for Canada as a whole. Some researchers believe that, since the definition of national treatment is the best treatment by that province, then other provinces need not follow the policies of one particular province. Others claim that, if the federal government does not prevent privatization in one province, a national treatment benchmark could be set for the entire country. This is an area that will have to be decided eventually by a NAFTA tribunal.

Many Canadians strongly oppose bringing the health-care system into the private sphere. Canadians value the public health system as embodying the principles of equality, compassion and generosity. A private system, even a mixed system, it is felt, would not be able to represent such ideals. "For-profit health care is an oxymoron. The moment care is rendered for profit, it is emptied of genuine caring. This moral contradiction is beyond repair. It entails abandoning the values acquired over centuries of professionalizing health care into a humanitarian service" (Lown 1999, quoted in Evans et al. 2000). A private system is motivated by profit, and many Canadians are not comfortable with the idea that their health would be subject to financial interests.

Studies have shown that health care is not affected by market incentives and that private hospitals are actually less efficient and more costly than public hospitals (Evans 1993).

Evans et al. (2000) provided a thorough investigation of the economic conflicts between private health care and the public interest, not the least of which is that maximizing profit margins may mean increased use of unnecessary or questionable treatment. More important, research, while not absolutely conclusive, seems to show that health outcomes are worse at for-profit as opposed to not-for-profit hospitals. Devereaux et al. (2002) conducted a review of 15 studies involving more than 38 million patients in U.S. hospitals, and found clearly that private for-profit hospital ownership results in a significantly higher risk of mortality.

In terms of expenditure-to-health outcome ratios, countries generally do better where there is public health care. The United States is the only industrial country without a public health care system, and has the highest ratio of spending on health to gross domestic product of industrialized nations (Helliwell 2001), and some of the poorest outcomes. In fact, U.S. health outcomes are worse than even some developing nations such as Sri Lanka, which only spends a fraction of U.S. per-capita spending (WTO 1998).

It is quite clear, therefore, that the move to a private for-profit system is likely to result in higher spending and worse health outcomes.

Health Insurance

Health insurance is considered part of the financial services sector, not the health services sector, so it falls under NAFTA Chapter 14 on financial services. Chapter 14 discusses how the standard NAFTA rules (most favoured nation, national treatment and so on) apply to financial services, but also incorporates some rules from other chapters. In particular, Chapter 14 incorporates Article 1110 from the investment chapter, which discusses the rules regarding expropriation and compensation.

Canada did not explicitly exclude medicare in either NAFTA or GATS. Instead, the Canadian government claims that medicare is a “statutory system of social security” and so is not part of the financial services sector according to the GATS Annex on Financial Services Article 1(b) and NAFTA Article 1401. The problem with this argument is that it has not been tested, and is purely a matter of interpretation.

An expansion of medicare to cover home care or prescription drugs would reduce the private health insurance market, thus harming foreign-owned insurers. If this is considered expropriation, these insurers would then be entitled to seek compensation according to NAFTA Article 1110. The term “expropriation” has not been clearly defined, so it is not evident that this would be the result. Further, the rules do not prevent such expropriation in any event. However, the need to compensate American insurers would make the expansion of medicare a costly proposition.

If a pharmacare system were financed by private sources, or by a mixed public–private system, there would be less scope for a compensation claim now. However, a private or mixed system would expand the size of the insurance market for U.S. insurers and thereby increase potential compensation costs. This could limit the ability of the Canadian government to change the method of financing in the future.

According to GATS Article XXI, a country is allowed to withdraw commitments after three years from which the commitment entered into force. Canada may wish to use this article to withdraw health insurance from being covered under GATS.

Implications for Canadian Women

These potential changes in the Canadian health care system would affect Canadian women in several ways. Since women use the health system more than men (Tudiver and Hall 1996), they would be more affected by reduced service or worse outcomes. Women are overly represented among the poor, making up 70 percent of all people living in poverty (Grant-Cummings and Phillips 1998). Since those living in poverty have worse health outcomes, then a move to a private for-profit health care system would have the most adverse effects on women.

Since the advent of free trade, the United States has forced Canada to accept longer patent times and has required Canada to ban compulsory licensing, so prescription drugs have become much more expensive (Lexchin 2001). In fact, prescription drug costs rose twice as quickly as overall health expenditures between 1985 and 1998 (CIHI 2001). This particularly affects Canadians without supplemental health insurance. Since women are less likely than men to have private insurance (as shown in the analysis later in this report), they bear the brunt of these rising drug prices.

A national pharmacare program would help to lower drug prices since the government could bargain for lower prices, and people without private insurance would now be covered. However, as discussed above, such a program would likely be difficult, if not impossible, to achieve under NAFTA and GATS rules. Again, women, who are less likely to have private insurance, are affected more strongly.

The same is true for home care. If home care is not covered by insurance, it is most likely performed by women, who tend to be the principal caregivers (Anderson 1993). In addition, two thirds of home-care recipients are women (Armstrong and Armstrong 1999). Again, moving this program under the public umbrella may be more difficult due to Canada's trade agreements, and those who lack or whose families lack supplemental health insurance will be in an even worse position.

3. REVIEW OF LITERATURE

In this section, we review the literature on globalization and the effect of trade on women.

Globalization

Academic Literature

One threat of globalization is job losses due to the relocation of production in more efficient or lower wage countries. Not only goods, but also services, can be produced abroad. In theory, a global marketplace increases competition and forces companies to improve efficiency. However, the result has been layoffs, a shift to flexible part-time or contract work, and decreased pay (Ostry 2001; Blacklock 2002). The ease of moving low-skilled jobs to low-wage countries has placed a great deal of pressure on industrial nations to specialize in skilled-labour-intensive production (Wood 1995). Women are disproportionately overrepresented in low-wage, part-time and unskilled jobs. Since these jobs bear the brunt of "efficiency improvements," increased trade hurts women the most. Richardson (1995: 47) stated that "trade-displaced workers are disproportionately female." Beach and Finnie (1998: 20) found a "growing role of non-permanent or marginal attachment workers in the male earnings distribution and over the lower region of the female earnings distribution, but for women as a whole the proportion who are permanent workers has risen slightly." Improvements in women's upward earnings mobility were mainly the result of improvements for middle- and upper-income earnings groups. While there may be benefits, such as higher average wages, women have experienced the most trade-related losses.

It is interesting to note, however, that firms competing globally through exports have tended to pay higher wages and have a greater incidence of unionization than do firms that do not export (Richardson 1995; Harcourt 2001). One study referenced by Harcourt (2001) found that exporting firms not only tend to pay 60 percent higher wages, but also invest more in education and training, have a higher incidence of collective bargaining and full-time, permanent jobs, and a greater commitment to occupational health and safety. Similar results have been found by research performed in Bulgaria, Chile and Taiwan (Harcourt 2001).

Newspaper Articles on Trade and Health

In the 1980s, the major fear appeared to be the possibility that public health care could be considered a subsidy and therefore subject to dispute settlement procedures and trade retaliation. According to one article (Patterson 1985), the United States has already taken the stance that unemployment insurance is an unfair subsidy. Some authors criticize the delay in defining acceptable subsidies (Hickl-Szabo 1985). Pressure to decrease government spending in favour of the market is expected to mount with the trade deal in place (Godsoe 1988). The Canadian and U.S. administrations (Howard 1989; Ritchie 1988; *Globe and Mail* 1985), along with many others (Patterson 1985), have denied that social programs would be affected. Some claim that GATT subsidy rules allow programs providing universal coverage and thus remove any subsidy-related threat from our health care system (Ritchie 1988). One advocate points out that Canada has more than 200 agreements and arrangements with the

United States, but has not seen a downward convergence of its social programs (Canadian Alliance for Free Trade 1988a). In addition, those who suggest that social programs and spending are at risk as a result of the agreements are accused of using scare tactics (Warnock 1985). The opposition is also accused of ignoring the text of the agreements (Ritchie 1988).

More recently, writers have claimed that health care is not only under attack as a subsidy, but also as a publicly provided service. They believe NAFTA provides a threat through the privatization of health services, thus opening the sector to the rules and obligations of the Agreement (*Winnipeg Free Press* 1999; Schoffield 2000). According to NAFTA's investor rights, some warned that, once the sector is opened, we would have "to treat foreign and domestic firms alike in terms of subsidies and government contracts," and we would not be able to reverse this change (Schoffield 2000: A1). A newspaper editorial claimed that, if one province opens its health care sector to foreign for-profit activity, this would result in forcing all provinces to privatize health care (*Winnipeg Free Press* 1999). Others claimed that NAFTA does not have the potential to affect health care (*Globe and Mail* 1988; Canadian Alliance for Free Trade 1988b).

Trade and Women

Academic Literature on Women's Wages and Jobs

Adrian Wood (1995) defined skilled labour as workers with greater than a basic education. There is a high concentration of women in low-paying, presumably unskilled jobs (Soroka 1999). The proportion of women obtaining higher levels of education is, however, growing. The proportion of Canadian women between the ages of 25 and 44 with university degrees grew from 13 to 26 percent from 1976 to 1988, while the proportion of men with degrees rose from 17 to 22 percent (Helliwell 2001). Thus, women are contributing at a greater rate to the number of skilled workers than men are. While this is encouraging, "the ratio of earnings of university graduates relative to those of high school graduates has...fallen slightly in Canada during the 1980s and 1990s," with the increase in supply of educated workers diminishing the "education premium" in the country (Helliwell 2001: 114). The participation rates for women are higher for those with higher education levels than those with less education.

Thankfully, in spite of the diminished reward for education, women in Canada are estimated to have experienced an earnings growth of at least 10 percent from 1985 to 1995 (Wolfson and Murphy 1998), helping to close the income gap between men and women from 2.53 in 1980 to 2.02 in 1990 (Soroka 1999). Women's incomes are reportedly distributed more unequally than men's incomes (Soroka 1999). Wolfson and Murphy (1998) found inconclusive evidence that female income inequality is increasing or decreasing, but women may have less of an increase than men. They also found that earnings inequality and earnings polarization overall in Canada fell between 1985 and 1995. The polarization of Canadian women's earnings was increasing from 1974 to 1985, but has fallen since.

Beach and Finnie (1998) examined Canadian data on earnings mobility and distribution from 1982 to 1994. Although the beginning of this period predates the FTA, the authors split the sample into two six-year sub-periods. Entry-level workers saw a decrease in income, but

all other income groups saw an average rise. They found that women are more likely to drop, and less likely to move to a higher wage category, than men. Their findings reinforced the belief that women fare worse in the job market than men. The report also showed that, proportionally, women's upward mobility is improving and their downward mobility is decreasing, while men's upward mobility is decreasing and their downward mobility is increasing. These gains by women are concentrated on the older and higher-paid workers. Younger women have greater downward mobility than younger men and are less likely to reach the top income level. We can then hypothesize that women have a greater tendency to be marginal workers, receiving lower pay and being the most likely to experience a drop in income. It is not likely that we can interpret any direct damage from increased trade. However, we may still assume that women are more likely to bear a disproportionately large share of any job or income losses due to trade, and that young and lower-paid women would be affected the most. When we add to this evidence the fact that the jobs most at risk for loss or decreased wages tend to be low-paying, entry-level jobs, the assumption is strengthened.

Daniel Schwanen (2001) examined the effects of formal and informal trade-increasing events. He focussed on the FTA, NAFTA and the Uruguay round, which revamped GATT and created the WTO and GATS. He claimed that 1989 to 1996 was a period of "decline in manufacturing employment, which has since reverted back to near its pre-1989 levels" (Schwanen 2001: 168). Schwanen therefore submits that employment and job losses due to trade have been reversed. Schwanen also analyzed who was affected by the restructuring occurring in industries after the FTA and showed that industries that experienced the most trade-related losses were those with a higher percentage of workers with lower education levels. There was a higher proportion of females than males only in the least trade-sensitive industries. This would suggest that women, especially those with less education, form a higher percentage of the workers in sectors that experienced job and earnings losses since the FTA, although these are the sectors that have been the least affected by trade.

An ongoing trend in Canada is a shift from the manufacturing sector to the service sector. This is relevant to our discussion, because service industries have recently been included in trade agreements and because this shift appears to have a differential impact on men and women. Unexpectedly, according to Richardson (1995: 49), "recent reports show service-sector wages are only slightly behind manufacturing wages and closing," but this is based on American data. There is a lower concentration of middle-wage jobs in the service sector than in manufacturing and a low concentration of women in those jobs (Soroka 1999). Soroka (1999: 572) also found that "in 1990, both male and female income distributions become more unequal as service-sector employment increases relative to manufacturing employment; the effect, however, is marginally stronger for females."

Newspaper Articles on Trade and Women

Analyses of the gendered effects of the agreements were rare; the articles mentioning gender mainly stress the negative impact on women due to their high presence in industries which have been protected from trade (Hurtig and Cameron 1988; Warnock 1985; Sheppard 1987; Morris 1989). One article (Morris 1989) claimed that 44 percent of the manufacturing jobs held by women are in the most trade-sensitive industries. The Canadian service sector constituted 70 percent of our economy in 1988 (*Globe and Mail* 1988), and it was feared that American

service providers would flood the market (Sheppard 1987). Another article (Philp 1994) related to wages and unemployment insurance benefits, showed drastic decreases in real income for minimum wage earners. It is also claimed single parents are the most likely to be poor and are the fastest-growing segment of the population to go on welfare (Philp 1994). An article on the 1994 GATT agreements expressed concern over the possibility of an equitable “distribution of economic prospects, jobs and resources” (McKenna 1994: B12).

4. DATA ANALYSIS

In this section, we examine health-related information for Canadian women and men in 1986 and 1998. First, we examine self-reported health status by occupation and age group, finding that, among married individuals of both sexes, most people are better off in 1998 than in 1986, although the unemployed, service-sector workers, and secretarial workers are the worst off. Among unmarried individuals, women tended to report worse health status than men, and were worse off in 1998 than in 1986. Second, we determine which Canadians have health and drug insurance, again dividing the population by occupation and age group. We show that female industry and service-sector workers have the lowest rates of coverage. Last, we see which Canadians have higher health expenditures, finding that expenditures rise as age increases; as well, lower-income women spent more of their income on health care in 1998 than in 1986.

As stated, our analysis is for 1986, two years before the FTA was signed, and 1998, four years after the implementation of NAFTA. It would, of course, be most useful to be able to determine which changes in health outcomes are *solely* the result of the trade agreements, and which have merely occurred simultaneously. However, this issue of causality is extremely difficult, if not impossible, to determine. Under economists' definition of causality (Granger 1969), one variable is said to cause the second, if the first variable precedes the second in time. In this sense, Canada's increased trade due to participation in trading agreements does cause the changes we describe below.

Data

The quantitative analysis for this study uses the 1986 General Social Survey (GSS), the 1998 National Population Health Survey (NPHS), the 1986 Family Expenditure Survey (FAMEX) and the 1998 Survey of Household Spending (SHS).[1] They are all nationally representative surveys collected by Statistics Canada. Public-use files, obtained through the Data Liberation Initiative, were used. Survey weights are provided and used in all analyses in this study. The GSS and NPHS collected information on individuals regarding their health status, health behaviours and demographics. The FAMEX and SHS surveys collected information on spending habits of the respondent's family for the year prior to the survey date. The sampling frame for all of the surveys is Statistics Canada's Labour Force Survey.

The target population for 1986 GSS consisted of all individuals aged 15 and over living in a private household in one of the provinces. The survey was carried out in February and March 1987 and refers to calendar year 1986. The 1986 survey was designed to provide information for families and unattached individuals (spending units) living in private households in the 10 provinces of Canada as well as Whitehorse and Yellowknife.

The SHS is carried out across Canada in the 10 provinces. It obtains detailed information about household spending during the reference year (previous calendar year). The survey reports dwelling characteristics and household appliances and equipment owned, as of

December 31 of the reference year. The SHS integrates most of the content found in FAMEX.

The analysis for this study uses individuals aged 20 to 65, that is, the working-age population. The study investigates married and unmarried (single, separated, divorced, widowed) individuals separately. The tables are further subdivided by sex and occupational status or income quintile.[2] Occupational status was available in the health surveys but not the expenditure surveys. The information on health and insurance expenditure is subdivided by income quintiles. Income is adjusted for family size, that is, divided by the square root of household size.

Occupational status was condensed from 16 occupational codes in the NPHS, FAMEX and SHS and 25 codes in the GSS to just six occupations, and those who responded "not employed" or "no occupation." "Administrative and Professional" includes those with administrator and professional designations. "Public Sector" workers include teachers and public servants. "Industry and Construction" includes all codes indicating work in primary or secondary industry or the construction field. "Service Sector" includes those codes indicating sales and service positions and "Secretarial" includes administrative assistant and secretarial-type descriptions.

The intent of the tables is to indicate which groups of individuals will be most affected by possible privatization of the health care sector. Where information was available, the data are presented for 1986 (prior to the introduction of free trade) and 1998 (the most recent data available for health statistics). Caution should be taken with some of the statistics, as some cell sizes were extremely small. Those with less than five observations were not reported.

Health Status

The health status variable is self-reported health status obtained from the health surveys. In 1986, the respondents could claim their health status to be excellent, good, fair or poor. In 1998, the available responses were excellent, very good, good, fair or poor.

Table 1 indicates the self-reported health status of married males and females by age and occupational status in 1986. First, we examine the health status of females as compared to males by occupational status. In the administrative and professional group, females report higher levels of excellent health status across the age distribution and, except for those aged 40 to 54 years, females report less fair or poor health. Public sector workers report similar health status for the older age group (40 to 54), but females report better health in the youngest group and lower levels in the second youngest age group. Female health workers report worse health status than male health workers in the youngest and middle age groups, and similar health status in the 30 to 39 year range. It is interesting to note that there are too few male health workers in the oldest age group to report. The industry and construction group indicates, for the youngest two groups, that males and females have a similar self-reported health status. For the 40 to 54 year olds, females report higher levels of health than males, and the opposite is true of the oldest age group. Male and female service sector workers report similar distributions

of health status. However, for the youngest age group (20 to 29 years), substantially fewer women report excellent health status, 26.85 percent compared to 45.31 percent of males. The notable difference for secretarial workers is that males report more poor health status, particularly for the oldest groups, where 25.84 and 26.12 percent of males, respectively, report low levels of health compared to 5.49 and 12.99 percent of females, respectively. Thus, for married males and females, no consistent or striking conclusion can be drawn about differences in health status by gender for different occupational status.

Table 2 displays the health status of males and females by age and occupational status in 1998. Generally, males have at least as good a health status as females, and in some cases their health status is better. For administrators, fewer older females report excellent health status, and more report very good or good health status than males in the same group. Female administrators in the 30 to 39 and 40 to 54 age groups report substantially higher percentages of lower health status (fair and poor), 8.32 and 9.55 percent, respectively, compared to 3.75 and 1.23 percent, respectively, for males. For public sector workers, a lower proportion of the youngest group of females report excellent or good health status, but more report very good health status. The opposite pattern exists for the next two age groups. The two middle age groups of female health workers report worse health status than their male counterparts, as do all age groups of industrial/construction workers, except for 30 to 39 year olds, who report similar health to their male counterparts. In the service sector, the youngest group of females reports lower health status, the middle two groups similar, and the oldest group of females reports better health status than do males in the same groups. Finally, for those reporting no occupational status, males report substantially more fair and poor health status than do females, except for the youngest age group. In 1998, females working in the industry, service or health sectors seemed to be worse off when it came to self-reported health status than males in the same sectors.

Can we say anything about the difference in health status across the years before and after the trade agreements? Due to the difference in available responses between the 1986 and 1998 health surveys, we concentrate on those reporting fair or poor health, because the response is common in both years and these individuals would be the most likely to need the health care system.

For married males, the results are absolutely consistent for every age group/occupation cell; a smaller proportion reported fair or poor health in 1998 than in 1986. Only for those reporting no occupation do the two middle age groups report higher levels of poor/fair health status in 1998 than 1986. In most cases, the differences in the percentage reporting fair/poor health status are substantial. In the administration category, the percentage reporting low health status in 1986 ranged from about 7.5 percent for 40 to 54 year olds to 16.5 percent for the oldest group. In 1998, the reports of low health status ranged from 0 percent for the youngest group to a high of 3.75 percent for the second-youngest group. The 40 to 54 year olds reported only 1.23 percent and the oldest group 2.45 percent. For this group, secretarial and service sector workers seemed to have the highest proportions reporting poor health status in both years (after those with no occupation).

For married females, the picture is similar but less consistent. Most age/occupation groups reported similar or better health status, on average, in 1998 compared to 1986. The exceptions were 30 to 39 year-old administrators, and the youngest and second oldest groups of construction workers. Females who were not employed in 1986 had the lowest levels of health across the age distribution, with service sector workers next. For the oldest age groups, administrative workers had the third poorest health, but for the youngest age groups, secretarial workers reported lower health status than administrative workers.

In summation, for both married males and females, the health status of most workers in most age/occupation groups was better in 1998 than in 1986. However, those who were unemployed or had no reported occupation, service sector workers, and secretarial workers seemed to fare the poorest in both years and for both sexes.

Table 3 presents the results for unmarried individuals in 1986. Females have lower levels of self-reported health status in many occupation/age groups. For those claiming to be administrators, females reported better health status than males in the youngest group and second oldest group, about the same in the 30 to 39 age range and worse in the oldest age group. In the public sector occupations, females reported better health status in the youngest and oldest age groups. The middle two groups showed mixed results: fewer females reported excellent health status but more males reported fair health status. Female industrial, construction and secretarial workers reported poorer health status than males across the age distribution, and the same holds for service sector workers except for the 40 to 54 year olds. Here fewer males reported excellent health status than females, but females reported higher levels of fair and poor health status (the opposite of the public sector workers). Those who were not employed reported fairly similar health status.

When we investigate differences in health status across the sexes in 1986, females fared worse in general, and particularly for the industrial/construction sector, secretarial and service sector workers.

Table 4 presents the results for 1998, and the picture is similar. Female administrators reported less excellent health status than males, except for the oldest age group. In the public sector, the youngest group of females reported lower health status than males, but the opposite is true of the next age group. Female health workers reported lower health status than males, and the same is true for service sector workers (except for the oldest age group), although more females reported very low levels of health status than males. Female industrial workers were worse off in the youngest two groups, and better off in the 40 to 54 year-old group. The oldest industrial group had a lower percentage of males reporting excellent health status and a higher percentage of female workers reporting fair health status. Female secretarial workers in the three younger categories reported worse health status than males, while the oldest age groups reported similar health status. Finally, those reporting no occupation showed similar patterns, with females generally reporting worse health status. Thus, in 1998, unmarried females appeared to be generally worse off when it came to health status than males in similar age/occupation categories.

Now we compare 1986 (Table 3) to 1998 (Table 4) for unmarried individuals. The results are not as consistent as those for married individuals. In general, males did better in 1998 than in 1986 for self-reported health status. (Again, we examined fair and poor health status for reasons reported earlier.) The only groups of males that fared worse in 1998 than in 1986 were the oldest administrators. The picture is not as promising for females; 40 to 54 year-old administrators, the youngest and oldest public sector workers, all but the youngest health workers, and the two oldest groups that do not report occupational status all reported, on average, higher percentages of workers in fair or poor health status in 1998 than in 1986. So, in general, unmarried females reported lower levels of health status compared to males in similar age/occupation groups, and unmarried females fared somewhat worse in 1998 than in 1986.

Insurance Coverage

Next we explore the proportion of individuals, by sex and occupation, with drug and health insurance coverage. This information is available from self-reports in the 1998 NPHS and is found in Table 5 for married individuals and in Table 6 for unmarried individuals. First, it is not surprising, given the decreased public health expenditures in the 1990s, that in most age/occupation groups, a high proportion of the individuals, on average, reported having health and drug insurance. The notable statistic is that, for both married and unmarried individuals, female industry and service sector workers had the lowest rates of coverage. Those reporting no occupation, whether married or not, also fared poorly when it came to health insurance. These groups are, in general, the groups that report the worst health status.

Health Expenditures

Finally, we investigate, by income quintiles, expenditures on health care and health insurance as a proportion of income. The income is adjusted for family size. First, we examine Table 7 (married, 1986) and Table 8 (married, 1998). For married males, the results are extremely consistent; the proportion of income spent on health increased with age and decreased as income increased (the first quintile contains the lowest incomes and the fifth quintile contains the highest incomes). In the oldest age group, the percentage of income spent on health care decreased from 4.7 to 2 percent. For the lowest income quintile, the percentage of income spent on health increased from 2.2 percent in the youngest group to 4.7 percent in the oldest group. Patterns were similar in 1998, but the percentage of income spent on health was higher in every group except the younger groups in the highest quintile, where it was similar.

For females, the patterns were similar but not as consistent. In 1986, 40 to 54 year olds spent less as a percentage of income than 30 to 39 year olds (who could have been having children), but in 1998, for the bottom quintiles, this age group spent more than the oldest group. In general, the percentage of income spent on health care was more in 1998 than in 1986. However, the differences are not as extreme as for males in similar groups.

Finally, we examine expenditures on health by unmarried individuals. Again, the general pattern is that, as age increases, so does the percentage of income spent on health, and as

income increases, the proportion of income spent on health decreases. Of particular note is that lower income females spent substantially more, as a percentage of income, in 1998 than in 1986. Older females spent 2.8 and 4.0 percent of their income on health care in 1986, but 4.0 and 14.2 percent in 1998 (lowest quintile).

In conclusion, the service sector and low-income sectors are the worst off, and these tend to be the groups with the greatest proportion of females.

5. CONCLUSIONS AND POLICY RECOMMENDATIONS

We have shown in this report that Canadian women, particularly those with low incomes and those working in the service sector, are at risk of adverse changes in the Canadian health care system.

We analyzed NAFTA and GATS to determine which sections could have implications for the provision of health care in Canada. It was found that the standard requirements of trade agreements — of national treatment (NAFTA Article 1102, GATS Article XVII), most favoured nation treatment (NAFTA Article 1103, GATS Article II), the minimum standard of treatment (NAFTA Article 1105) and prohibition of performance requirements (NAFTA Article 1106) — force the Canadian government to treat foreign firms the same as domestic firms, thus preventing any additional requirements on foreign investors or foreign service providers. However, these requirements do not apply in the case of government procurement (NAFTA Article 1108), so if health is purely publicly provided, it does not fall under the purview of the trade agreements. The expropriation and compensation rules require that the Canadian government compensate any foreign investors if their markets are taken over by the government (NAFTA Article 1110). Several parts of the agreements exempt health care, but only to the extent that it is publicly provided (NAFTA Article 1401, NAFTA Annex II-C-9, GATS Annex on Financial Services Article 1(b)).

There are two areas of the Canadian health care system that may be affected by Canada's participation in multinational trade agreements. First, the commercialization and privatization of hospital and clinic services may bring some aspects of the Canadian health care system into the reach of the trade agreements. Once services become commercialized, the safeguards inherent in NAFTA will fail. Purely public provision of a service is covered, but if the service is offered privately or involves competition, then the market can be opened to foreign investors. The wording of the trade agreements is sufficiently vague that only a trade tribunal will be able to decide this matter for certain. But at that point, it may be too late to protect the public nature of the Canadian health care system.

Second, the extension of public health insurance to cover additional services such as pharmacare or home care may become more difficult, because of the expropriation and compensation requirements in NAFTA. If medicare is expanded and this results in a reduction of the private insurance market, U.S.-based insurance firms might be successful in filing an expensive claim for compensation from the Canadian government.

In the second main part of the project, several data sets were analyzed to determine which Canadians have the worst health status, are less likely to have health or drug insurance, and spend the most on health care. We found that married females working in the industry, service or health sectors had worse health status than married males in those sectors in 1998. As compared to 1986, in 1998 the health status of most married individuals had improved, although there were some exceptions. Those who were unemployed, service-sector workers, and secretarial workers had the poorest health across both years. For unmarried individuals,

in general, males reported better health status in 1998 than in 1986. But for many groups of females, health status declined over that period.

A high proportion of individuals reported having health and drug insurance. However, for both married and unmarried individuals, female industry and service-sector workers had the lowest rates of coverage, as well as those reporting no occupation. We then examined expenditures on health as a percentage of income. For all groups, a general pattern holds that the proportion of income spent on health increases with age and decreases with income.

Based on this research, we make the following policy recommendations.

- We must prevent hospital and clinic services from being privatized. It is far too risky to allow for-profit private clinics to operate, given that it is still not certain whether this action will bring all the Canadian health care system into the reach of Canada's trade agreements. For-profit institutions have been found to provide worse health care than not-for-profit institutions, thus adversely affecting women, who tend to use the health care system more than men.

- Canada did not explicitly exclude medicare in either NAFTA or GATS, but Canada should make an effort to exempt medicare from these and any future agreements. This would allow the Canadian government to expand medicare at will (to cover pharmacare and home care, for example) to improve the health of Canadians, without the need for a costly compensation claim from U.S. insurers. Such an expansion of medicare would be most beneficial to those without supplemental health insurance, who tend to be women.

- It is of the utmost importance that Canadians most at risk from being hurt by free trade are protected by the government. Both women and men working in the service sector or in the industrial sector, those without jobs, and those with low incomes are most likely to be harmed. These individuals must be protected. It is essential that the government consider this segment of society before agreeing to further trade agreements, and impose policies that will help this group of Canadians.

APPENDIX: TABLES

Table 1: Health Status by Occupation for Married Males and Females, 1986

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Excellent	30.37	37.41	41.86	31.56	54.07	45.85		36.08
Good	53.86	52.34	50.51	52.01	41.72	48.95	53.04	39.93
Fair	15.77	9.24	6.96	16.43	4.21	5.20	34.89	23.99
Poor	0.00	1.00	0.67	0.00			12.07	
Public Sector (teachers and public servants)								
Excellent	20.72	54.20	53.05	---	64.62	23.11	50.45	---
Good	79.28	43.14	41.03	---	35.38	74.80	37.93	---
Fair	0.00	2.65	5.92	---	0.00	2.08	11.62	---
Poor	0.00	0.00	0.00	---	0.00	0.00	0.00	---
Health Workers								
Excellent	50.57	41.85	50.90	73.21	41.76	43.66	40.92	58.74
Good	37.52	43.01	49.10	26.79	48.29	47.66	48.24	40.00
Fair	11.90	15.14	0.00	0.00	9.95	8.68	10.84	1.26
Poor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Industry and Construction								
Excellent	33.14	32.76	31.25	27.56	30.51	29.80	44.76	6.28
Good	55.40	56.52	47.63	49.36	67.17	61.55	51.74	77.06
Fair	10.94	8.95	17.99	20.92	2.32	8.65	3.50	16.66
Poor	0.52	1.77	3.13	2.16	0.00	0.00	0.00	0.00
Service Sector								
Excellent	45.31	32.64	33.83	30.60	26.85	37.92	36.28	23.14
Good	47.36	54.93	46.50	42.13	65.38	53.02	46.68	56.43
Fair	6.72	11.51	16.63	26.25	7.07	8.51	15.95	20.43
Poor	0.61	0.93	3.04	1.01	0.71	0.55	1.08	0.00
Secretarial								
Excellent	26.90	55.90	36.28	55.01	29.31	47.30	42.29	43.96
Good	56.30	33.85	37.88	18.87	59.18	45.44	52.23	43.05
Fair	16.80	10.25	25.84	19.05	8.93	5.63	5.49	12.26
Poor	0.00	0.00	0.00	7.07	2.59	1.62	0.00	0.73
Not Employed								
Excellent	36.51	31.48	30.00	18.42	33.94	33.33	28.08	23.19
Good	55.56	48.15	26.67	37.72	54.74	53.10	51.71	45.78
Fair	6.35	16.67	26.67	28.07	9.12	11.50	16.10	23.80
Poor	1.59	3.70	16.67	15.79	2.19	2.06	4.11	7.23

Note:
All responses are weighted.

Source:
Data from Statistics Canada's General Social Survey, Health Files, 1986.

Table 2: Health Status by Occupation for Married Males and Females, 1998

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Excellent	23.46	28.37	32.50	38.05	47.81	29.43	29.46	13.01
Very good	59.45	41.89	42.34	34.73	42.95	38.57	43.63	47.30
Good	17.09	25.99	23.94	24.78	5.76	23.68	17.36	35.73
Fair	0.00	3.75	1.23	0.52	3.49	7.26	9.55	3.96
Poor	0.00	0.00	0.00	1.93	0.00	1.06	0.00	0.00
Public Sector (teachers and public servants)								
Excellent	45.60	32.06	25.43	42.12	35.57	38.94	36.02	38.20
Very good	33.06	57.15	55.56	24.90	59.52	49.36	40.80	35.54
Good	21.34	8.74	18.78	23.40	4.91	11.16	20.41	19.89
Fair	0.00	2.06	0.00	9.58	0.00	0.54	2.77	6.37
Poor	0.00	0.00	0.23	0.00	0.00	0.00	0.00	0.00
Health Workers								
Excellent	25.79	47.87	41.43	33.50	45.50	34.82	17.21	53.55
Very good	0.00	49.23	29.92	21.83	41.83	40.85	50.18	19.16
Good	74.21	2.90	28.65	28.43	12.67	20.70	31.40	27.29
Fair	0.00	0.00	0.00	5.78	0.00	3.63	1.21	0.00
Poor	0.00	0.00	0.00	10.45	0.00	0.00	0.00	0.00
Industry and Construction								
Excellent	32.63	26.14	24.93	21.45	18.91	23.46	17.28	10.63
Very good	38.30	42.05	41.01	38.64	56.19	37.97	34.83	36.40
Good	24.40	27.92	27.33	33.78	21.18	33.23	36.77	46.96
Fair	3.17	3.58	5.92	6.13	3.72	5.35	11.12	6.01
Poor	1.51	0.29	0.81	0.00	0.00	0.00	0.00	0.00
Service Sector								
Excellent	34.88	28.87	32.65	22.15	22.81	24.23	23.75	11.90
Very good	45.32	45.44	40.65	31.85	44.12	47.79	42.39	37.22
Good	16.47	24.86	21.16	30.94	30.38	23.73	28.20	46.97
Fair	3.33	0.83	5.13	14.71	2.69	3.19	4.21	3.92
Poor	0.00	0.00	0.40	0.35	0.00	1.06	1.44	0.00
Secretarial								
Excellent	48.14	28.71	21.40	3.65	28.72	31.66	26.81	18.67
Very good	47.92	38.45	51.34	50.99	56.70	44.30	46.65	47.11
Good	3.94	27.70	25.22	25.02	13.07	20.16	22.26	31.87
Fair	0.00	1.21	2.03	20.33	1.52	3.89	3.62	2.34
Poor	0.00	3.93	0.00	0.00	0.00	0.00	0.67	0.00

(Table 2 cont'd)

No Reported Occupation								
Excellent	38.59	17.53	14.62	15.60	28.40	28.91	15.68	12.10
Very good	21.84	20.43	17.25	25.46	40.87	42.63	32.24	39.55
Good	33.99	30.35	20.35	29.54	25.22	19.17	37.61	30.89
Fair	5.57	28.89	33.75	19.19	4.77	6.50	9.13	13.77
Poor	0.00	2.81	14.02	10.21	0.74	2.80	5.34	3.68

Note:
All responses are weighted.

Source:
Data from Statistics Canada's National Population Health Survey, 1998.

Table 3: Health Status by Occupation for Unmarried Males and Females, 1986

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Excellent	37.67	46.62	45.07	81.49	44.21	42.09	61.76	69.50
Good	54.05	41.03	41.05	18.51	55.00	47.33	38.24	27.11
Fair	8.28	10.13	8.57	0.00	0.80	8.88	0.00	3.38
Poor	0.00	2.23	5.31	0.00	0.00	1.70	0.00	0.00
Public Sector (teachers and public servants)								
Excellent	52.27	59.00	71.32	---	61.38	35.56	49.96	73.62
Good	47.73	16.45	12.75	---	38.62	51.10	40.13	26.38
Fair	0.00	24.55	15.93	---	0.00	13.34	9.91	0.00
Poor	0.00	0.00	0.00	---	0.00	0.00	0.00	0.00
Health Workers								
Excellent	19.67	10.05	---	---	27.79	36.64	47.77	34.90
Good	75.38	84.04	---	---	65.92	55.43	52.23	65.10
Fair	4.95	5.91	---	---	6.30	2.11	0.00	0.00
Poor	0.00	0.00	---	---	0.00	5.82	0.00	0.00
Industry and Construction								
Excellent	36.98	27.64	34.47	44.24	27.79	22.17	25.04	42.73
Good	54.67	57.48	46.70	43.90	65.92	64.93	56.65	34.17
Fair	8.35	13.86	17.78	6.19	6.30	5.71	18.30	23.10
Poor	0.00	1.02	1.06	5.66	0.00	7.19	0.00	0.00
Service Sector								
Excellent	36.93	46.27	17.63	20.80	25.81	35.99	30.87	14.30
Good	51.45	49.88	65.60	64.57	63.25	51.94	37.12	72.48
Fair	8.96	3.85	15.78	14.63	9.90	5.39	20.72	4.02
Poor	2.66	0.00	0.98	0.00	1.04	6.68	11.30	9.20
Secretarial								
Excellent	31.09	41.66	36.02	---	32.30	34.52	34.54	14.21
Good	66.04	30.06	24.92	---	55.98	56.92	45.96	55.75
Fair	2.88	16.83	39.06	---	11.72	2.39	16.12	20.45
Poor	0.00	11.45	0.00	---	0.00	6.17	3.38	9.59
Not Employed								
Excellent	34.48	32.26	9.09	11.63	26.88	32.18	19.23	17.57
Good	55.17	41.94	39.39	32.56	54.38	39.08	39.74	39.19
Fair	10.34	19.35	27.27	34.88	15.63	19.54	32.05	29.73
Poor	0.0	6.45	24.24	20.93	3.13	9.20	8.97	13.51

Note:
All responses are weighted

Source:
Data from Statistics Canada's General Social Survey, Health Files, 1986.

Table 4: Health Status by Occupation for Unmarried Males and Females, 1998

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Excellent	38.41	48.98	50.92	13.44	24.38	26.47	24.01	31.04
Very good	34.52	32.44	29.62	57.02	59.41	54.94	49.43	43.46
Good	25.60	17.36	18.25	26.49	16.05	14.05	18.86	25.50
Fair	1.46	1.23	1.21	3.05	0.16	4.54	7.69	0.00
Poor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Public Sector (teachers and public servants)								
Excellent	43.58	26.77	35.91	---	23.63	39.69	32.12	9.75
Very good	47.96	49.70	30.95	---	50.61	41.35	41.70	33.36
Good	7.27	9.00	22.27	---	21.85	12.32	21.42	47.28
Fair	1.19	2.03	10.88	---	3.90	5.67	4.77	9.61
Poor	0.00	12.50	0.00	---	0.00	0.97	0.00	0.00
Health Workers								
Excellent	28.42	52.20	36.00	---	25.96	26.17	21.33	23.25
Very good	52.39	31.62	29.75	---	46.06	36.75	50.29	51.29
Good	19.19	16.19	34.25	---	27.98	16.15	18.35	11.90
Fair	0.00	0.00	0.00	---	0.00	20.93	10.03	13.56
Poor	0.00	0.00	0.00	---	0.00	0.00	0.00	0.00
Industry and Construction								
Excellent	35.35	31.32	24.12	28.90	14.10	20.37	54.23	45.53
Very good	41.27	44.75	43.17	35.88	47.20	45.40	17.48	20.27
Good	20.34	19.84	26.90	29.85	32.24	28.75	19.24	10.15
Fair	3.04	4.09	4.57	5.37	6.46	5.48	9.05	24.04
Poor	0.00	0.00	1.24	0.00	0.00	0.00	0.00	0.00
Service Sector								
Excellent	36.29	32.51	20.18	4.46	22.22	25.23	12.64	11.45
Very good	41.42	40.62	33.84	37.31	47.40	41.19	38.77	36.08
Good	17.37	22.35	39.23	56.28	26.48	26.51	34.89	41.54
Fair	4.92	4.51	3.90	1.94	3.53	5.13	13.24	10.94
Poor	0.00	0.00	2.85	0.00	0.37	1.95	0.45	0.00

(Table 4 cont'd)

Secretarial								
Excellent	51.29	31.79	24.51	9.10	34.54	25.11	16.35	14.68
Very good	33.29	45.63	45.99	43.10	37.38	53.49	43.95	48.72
Good	13.50	22.57	28.03	47.80	20.79	21.06	29.61	33.38
Fair	1.92	0.00	1.47	0.00	7.29	0.35	9.48	3.22
Poor	0.00	0.00	0.00	0.00	0.00	0.00	0.61	0.00
No Reported Occupation								
Excellent	36.99	19.10	8.27	26.29	16.58	12.87	12.04	11.47
Very good	26.03	11.68	20.98	11.36	29.82	22.45	14.12	26.57
Good	28.20	50.03	32.48	38.31	36.98	36.65	17.46	27.89
Fair	8.78	12.81	25.37	14.03	10.02	24.38	38.69	25.53
Poor	0.00	6.38	12.90	10.01	6.60	3.65	17.68	8.55

Note:
All responses are weighted.

Source:
Data from Statistics Canada's National Population Health Survey, 1998.

Table 5: Health and Drug Insurance for Married Males and Females, 1998

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Hospital insurance	67.62	77.05	84.72	73.58	67.11	81.06	65.71	91.37
Drug insurance	73.81	81.36	87.65	81.81	88.74	86.59	76.12	88.51
Public Sector (teachers and public servants)								
Hospital insurance	49.30	65.05	75.11	94.01	87.96	84.80	80.17	86.68
Drug insurance	61.20	65.87	81.39	89.56	90.90	90.06	84.86	91.50
Health Workers								
Hospital insurance	89.60	71.48	79.25	67.49	94.04	80.04	87.20	85.44
Drug insurance	89.60	68.69	72.58	77.94	96.45	90.92	91.93	75.56
Industry and Construction								
Hospital insurance	46.73	65.69	69.23	64.32	45.30	58.05	80.52	43.05
Drug insurance	63.27	79.06	76.84	72.26	66.40	70.17	85.99	50.02
Service Sector								
Hospital insurance	49.65	69.09	68.82	70.32	54.63	65.77	66.28	58.01
Drug insurance	64.01	77.98	80.81	77.56	63.25	73.75	74.93	70.51
Secretarial								
Hospital insurance	94.37	71.23	83.54	91.78	67.30	77.09	81.78	69.13
Drug insurance	97.48	88.44	84.98	83.90	77.11	81.44	84.41	79.48
No Reported Occupation								
Hospital insurance	17.03	24.15	38.54	59.06	55.22	52.07	60.97	60.09
Drug insurance	52.41	65.34	73.64	69.89	70.72	69.40	71.02	72.70

Note:
All responses are weighted.

Source:
Data from Statistics Canada's National Population Health Survey, 1998.

Table 6: Health and Drug Insurance for Unmarried Males and Females, 1998

	Male (%)				Female (%)			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional								
Hospital insurance	54.86	59.54	69.48	56.22	52.67	70.96	73.60	81.29
Drug insurance	63.73	72.96	76.05	69.61	77.55	77.76	82.58	68.63
Public Sector (teachers and public servants)								
Hospital insurance	39.49	61.27	84.52	100.00	63.34	77.19	70.54	65.79
Drug insurance	42.84	65.67	81.76	100.00	77.83	86.88	86.15	81.14
Health Workers								
Hospital insurance	40.01	93.41	84.66	0.0	70.30	77.95	85.64	58.62
Drug insurance	49.45	93.41	74.59	0.0	81.84	85.14	89.56	48.73
Industry and Construction								
Hospital insurance	44.20	50.25	61.79	50.07	44.39	32.19	28.59	24.04
Drug insurance	55.55	65.07	74.65	64.33	68.36	65.07	71.39	67.80
Service Sector								
Hospital insurance	48.20	38.66	48.12	48.26	37.59	44.94	42.32	42.92
Drug insurance	63.28	63.59	74.42	51.81	59.87	64.82	60.68	63.87
Secretarial								
Hospital insurance	59.38	81.03	78.28	80.00	58.63	73.38	74.60	92.52
Drug insurance	74.15	75.80	82.14	80.00	79.59	78.51	86.26	92.62
No Reported Occupation								
Hospital insurance	31.15	31.15	35.31	35.85	27.34	14.22	17.92	37.24
Drug insurance	40.83	71.73	62.87	71.68	64.12	65.98	62.44	61.16

Note:
All responses are weighted.

Source:
Data from Statistics Canada's National Population Health Survey, 1998.

Table 7: Expenditures on Health and Health Insurance for Married Males and Females, 1986

	Male				Female			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First Quintile								
Medical expenditures ($)	292.00	471.58	434.91	494.68	257.70	368.24	609.33	776.5
Medical insurance ($)	66.65	156.36	110.35	155.66	63.68	52.29	182.89	295.1
Medical/income	0.022	0.030	0.046	0.047	0.021	0.033	0.117	0.060
Second Quintile								
Medical expenditures ($)	467.48	578.61	754.74	694.69	443.14	619.14	582.89	902.76
Medical insurance ($)	162.90	227.30	273.52	168.69	189.95	209.24	162.75	396.47
Medical/income	0.022	0.024	0.031	0.034	0.023	0.029	0.028	0.049
Third Quintile								
Medical expenditures ($)	573.74	648.14	859.53	808.03	596.31	772.87	682.29	723.21
Medical insurance ($)	236.21	241.78	274.31	251.74	257.55	409.90	263.08	333.47
Medical/income	0.021	0.021	0.027	0.032	0.023	0.027	0.022	0.032
Fourth Quintile								
Medical expenditures ($)	557.09	752.94	932.75	864.09	572.43	901.71	991.02	1,072.10
Medical insurance ($)	232.03	294.33	318.58	288.80	237.11	287.63	377.64	477.50
Medical/income	0.017	0.019	0.023	0.025	0.018	0.023	0.025	0.033
Fifth Quintile								
Medical expenditures ($)	661.81	862.35	1,079.80	1,057.70	883.80	1,055.30	844.96	681.28
Medical insurance ($)	288.65	353.96	388.71	372.89	370.86	434.53	275.99	338.39
Medical/income	0 .015	0.016	0.018	0.020	0.021	0 .019	0.015	0.014

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Family Expenditure Survey, 1986.

Table 8: Expenditures on Health and Health Insurance for Married Males and Females, 1998

	Male				Female			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First Quintile								
Medical expenditures ($)	535.71	784.28	682.43	927.32	483.79	708.96	849.13	719.08
Medical insurance ($)	221.98	179.02	161.24	234.87	168.48	230.10	146.94	186.58
Medical/income	0.030	0.044	0.052	0.094	0.033	0.038	0.084	0.046
Second Quintile								
Medical expenditures ($)	731.73	1,035.20	1,161.70	1,141.60	1,014.20	1,025.60	1,441.70	1,100.10
Medical insurance ($)	215.87	338.68	383.87	397.46	362.20	304.16	470.15	287.82
Medical/income	0.025	0.030	0.035	0.045	0.032	0.030	0.046	0.042
Third Quintile								
Medical expenditures ($)	855.63	1,279.10	1,512.70	1,324.60	1,100.10	1,297.20	1,649.20	1,574.20
Medical insurance ($)	301.14	427.39	548.53	411.04	472.72	351.54	576.89	472.98
Medical/income	0.023	0.028	0.034	0.036	0.027	0.027	0.036	0.047
Fourth Quintile								
Medical expenditures ($)	779.75	1,614.80	1,654.10	1,512.20	1,056.10	1,278.50	1,691.70	1,346.40
Medical insurance ($)	311.30	440.56	520.46	472.73	344.59	478.61	460.00	428.44
Medical/income	0 .017	0.028	0.029	0.031	0.019	0.022	0.029	0.028
Fifth Quintile								
Medical expenditures ($)	916.93	1,296.50	1,865.30	1,789.00	1,392.40	1,529.60	1,951.10	2,026.50
Medical insurance ($)	386.73	540.40	699.22	504.79	477.54	531.48	625.66	758.29
Medical/income	0.014	0.012	0.022	0.022	0.021	0.019	0.022	0.027

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Survey of Household Spending, 1998.

Table 9: Expenditures on Health and Health Insurance for Unmarried Males and Females, 1986

	Male				Female			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First Quintile								
Medical expenditures ($)	159.10	99.03	118.78	156.19	189.56	197.39	202.56	272.03
Medical insurance ($)	28.81	44.51	38.883	27.466	31.31	15.304	19.77	50.53
Medical/income	0.048	0.012	0.016	0.052	0.023	0.031	0.028	0.040
Second Quintile								
Medical expenditures ($)	270.03	290.66	446.88	460.31	343.68	447.24	444.33	494.52
Medical insurance ($)	143.68	100.31	144.26	80.46	68.61	153.69	122.23	106.27
Medical/income	0.018	0.021	0.028	0.030	0.025	0.026	0.026	0.036
Third Quintile								
Medical expenditures ($)	366.99	456.60	495.22	366.00	456.87	512.68	614.71	463.21
Medical insurance ($)	152.77	231.72	170.26	104.76	146.3	168.72	208.13	125.97
Medical/income	0.020	0.024	0.026	0.018	0.025	0.025	0.028	0.024
Fourth Quintile								
Medical expenditures ($)	373.08	507.60	582.11	511.96	623.92	622.43	884.95	650.41
Medical insurance ($)	156.09	208.76	258.30	262.50	166.06	156.68	239.55	202.48
Medical/income	0.015	0.022	0.021	0.021	0.025	0.024	0.030	0.026
Fifth Quintile								
Medical expenditures ($)	540.05	523.52	914.04	961.17	659.20	598.91	908.76	624.00
Medical insurance ($)	262.21	237.28	328.47	305.50	269.25	222.89	272.34	266.48
Medical/income	0.015	0.015	0.025	0.026	0.017	0.019	0.021	0.018

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Family Expenditure Survey, 1986.

Table 10: Expenditures on Health and Health Insurance for Unmarried Males and Females, 1998

	Male				Female			
	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First Quintile								
Medical expenditures ($)	177.41	156.66	224.96	488.51	440.00	399.30	385.86	692.37
Medical insurance ($)	57.70	24.45	37.94	143.17	90.34	76.21	79.24	96.18
Medical/income	0.021	0.025	0.099	0.051	0 .042	0 .048	0.040	0.142
Second Quintile								
Medical expenditures ($)	509.42	636.60	679.10	706.47	539.28	824.96	878.25	932.87
Medical insurance ($)	93.96	238.72	222.26	189.63	160.52	217.42	215.74	192.99
Medical/income	0.026	0.030	0.033	0.040	0.026	0.031	0.036	0.050
Third Quintile								
Medical expenditures ($)	478.29	602.62	740.33	984.39	847.96	1,001.50	1,313.90	1,015.90
Medical insurance ($)	180.45	202.94	226.15	233.56	337.94	289.89	325.56	281.09
Medical/income	0.017	0 .020	0.026	0.034	0.032	0.032	0.042	0.036
Fourth Quintile								
Medical expenditures ($)	839.31	758.64	886.48	1,013.80	948.52	1,063.90	1,374.50	1,152.70
Medical insurance ($)	306.15	299.09	295.77	295.33	271.19	228.67	444.32	327.14
Medical/income	0.020	0.019	0 .022	0.033	0.024	0.030	0.034	0.032
Fifth Quintile								
Medical expenditures ($)	769.84	947.67	1,36.00	1,67.80	1,63.50	1,00.80	1,18.20	1,47.70
Medical insurance ($)	271.29	307.20	353.82	614.25	490.72	246.46	491.62	483.36
Medical/income	0.012	0.018	0.024	0.026	0.021	0.022	0.027	0.022

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Survey of Household Spending, 1998.

Table 11: Number of Observations by Occupation for Married Males and Females, 1986

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and Professional	75	190	138	47	64	87	53	12
Public sector (teachers and public servants)	9	24	26	3	19	39	23	4
Health workers	5	25	13	5	41	70	39	14
Industry and construction	225	306	237	84	37	41	42	15
Service sector	71	109	99	44	112	119	104	47
Secretarial	259	47	20	11	157	157	119	42
Not employed	63	54	60	114	274	339	292	77

Table 12: Number of Observations by Occupation for Married Males and Females, 1998

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and professional	56	196	291	84	30	102	106	23
Public sector (teachers and public servants)	22	59	110	32	47	120	161	29
Health workers	6	17	26	12	45	100	101	18
Industry and construction	159	425	563	211	44	94	99	30
Service sector	73	128	176	70	165	262	289	75
Secretarial	23	74	105	24	87	245	316	64
Not employed	15	29	90	217	83	225	264	340

Table 13: Number of Observations by Occupation for Unmarried Males and Females, 1986

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and professional	91	52	40	10	51	46	23	9
Public sector (teachers and public servants)	6	9	6	3	27	25	13	5
Health workers	9	7	4	2	35	21	22	8
Industry and construction	182	85	56	27	22	16	18	5
Service sector	97	49	25	9	87	42	33	29
Secretarial	33	18	10	4	135	66	47	24
Not employed	116	31	33	43	160	87	78	148

Note:
All responses are weighted.

Source:
Data from Statistics Canada's General Social Survey, Health Files, 1986.

Table 14: Number of Observations by Occupation for Unmarried Males and Females, 1998

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
Administrative and professional	99	89	76	13	44	54	75	14
Publis sector (teachers and public servants)	35	30	28	4	77	57	82	19
Health workers	12	13	10	0	36	33	46	14
Industry and construction	262	163	195	44	44	43	37	6
Service sector	181	73	57	24	297	127	135	41
Secretarial	59	40	40	5	107	118	129	29
Not employed	52	38	89	82	83	95	133	196

Table 15: Number of Observations for Expenditures on Health and Health Insurance for Married Males and Females, 1986

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First quintile	123	141	127	105	37	17	18	10
Second quintile	202	334	223	113	43	29	19	17
Third quintile	197	432	339	174	42	31	38	19
Fourth quintile	178	391	468	212	44	52	42	16
Fifth quintile	145	314	529	266	49	66	75	18

Table 16: Number of Observations for Expenditures on Health and Health Insurance for Married Males and Females, 1998

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First quintile	65	172	227	121	60	135	124	83
Second quintile	62	293	344	211	89	273	208	115
Third quintile	70	339	439	200	78	268	293	100
Fourth quintile	64	288	464	192	70	249	329	91
Fifth quintile	60	254	520	227	52	190	405	106

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Survey of Household Spending, 1998.

Table 17: Number of Observations for Expenditures on Health and Health Insurance for Unmarried Males and Females, 1986

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First quintile	73	39	60	43	170	151	123	131
Second quintile	63	35	34	26	82	84	87	77
Third quintile	77	43	27	21	90	85	78	65
Fourth quintile	86	55	53	28	66	69	55	44
Fifth quintile	62	105	75	30	20	55	62	33

Table 18: Number of Observations for Expenditures on Health and Health Insurance for Unmarried Males and Females, 1998

	Male				Female			
Age	20-29	30-39	40-54	55-65	20-29	30-39	40-54	55-65
First quintile	63	115	185	113	129	296	289	191
Second quintile	52	81	121	36	53	135	191	107
Third quintile	32	76	88	28	40	91	160	69
Fourth quintile	60	114	116	39	29	76	135	54
Fifth quintile	44	113	148	38	16	48	107	43

Note:
All responses are weighted.

Source:
Data from Statistics Canada's Survey of Household Spending, 1998.

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ENDNOTES

[1] For detailed information on the surveys, see Statistics Canada's Web site <www.statcan.ca>.

[2] Originally, the intent was also to examine the occupational status by part-time/full-time status, but data constraints and small cell size prohibited this analysis. The number of observations per cell is recorded in tables 11 to18.

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* Some of these papers are still in progress and not all titles are finalized.