Women with Disabilities:

Accessing Trade

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ACRONYMS

ADP	Assistive Devices Program (Ontario)
CCDS	Canadian Centre on Disability Studies
CCRA	Canada Customs and Revenue Agency
CNIB	Canadian National Institute for the Blind
CPI	Consumer Price Index
CPI-P	Consumer Price Index for Pharmaceuticals
CSA	Canadian Standards Association
DAWN	DisAbled Women's Network of Canada
DFAIT	Department of Foreign Affairs and International Trade
ERDCO	Ethno-Racial People with Disabilities Coalition of Ontario
FTA	Canada-United States Free Trade Agreement
FTAA	Free Trade Area of the Americas
GATS	General Agreement on Trade in Service
GATT	General Agreement on Trade and Tariffs
GST	Goods and Services Tax
HRDC	Human Resources Development Canada
IDEA	*Individual with Disabilities Education Act*
ILRC	Independent Living Resource Centre
IPPI	Industrial Product Price Index
MSI	Medical Services Insurance (Nova Scotia)
NAFTA	North American Free Trade Agreement
NAIC	North American Industry Classification
NED	Network of Entrepreneurs with Disabilities
NEWD	Network for Entrepreneurs with Disabilities
OHIP	Ontario Health Insurance Plan
PALS	Participation and Activity Limitation Survey
PMPI	Patented Medicine Price Index
PMPRB	Patented Medicine Prices Review Board
ROW	Rest of the World (apart from the United States)
SAIL	Saskatchewan Aids to Independent Living
SMD	Society for Manitobans with Disabilities
TTY	Teletypewriter
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 in order 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.

EXECUTIVE SUMMARY

For women with disabilities, Canada's entry into trade agreements has meant a further erosion of their already marginal status in Canadian society. While proponents of trade liberalization promised that costs related to assistive devices, health services and pharmaceuticals could decrease, this has not happened. In addition, as an indirect effect of trade liberalization and in the more general context of neo-liberal economic policies, there has been a reduction in scope and number of public programs designed to support the participation of people with disabilities in community life. Trade liberalization has also created, indirectly, a disincentive to enter the paid labour force. While the best avenue for escaping low income is employment, for women with disabilities the rising cost of pharmaceuticals and other disability supports has simply increased the financial barriers to participating in the paid labour force and thus made labour force participation impossible.

This study investigates how trade in health services and assistive devices affected women with disabilities and how women entrepreneurs with disabilities are able to access trade services and information. The project looks historically at the changes to these three areas over the past decade and identifies obstacles and benefits for women with disabilities from trade relationships, particularly with the United States. This report addresses the key research question: How can Canadian trade policies ensure access and inclusion for women with disabilities? It also highlights the major issues of concern to women with disabilities both as consumers and as entrepreneurs. In doing so, this report adds to our knowledge about the particular concerns of women with disabilities in relation to trade agreements and policies, and brings a richness and depth to our understanding of how trade differentially affects various groups of people. The report makes policy recommendations for concrete measures that can be undertaken by governments and private sector organizations to address these concerns.

The research team drew from a number of different data sources, both qualitative and quantitative. The qualitative data were gathered through focus groups, individual interviews and key informant interviews. The research team undertook quantitative analysis of the relevant trade statistics. In total, 42 women with disabilities participated in either focus groups or interviews. Six identified themselves as entrepreneurs, eleven as ethno-racial women and two as Aboriginal women. We met with women who experienced a wide range of disabilities including physical and sensory (i.e., those who are deaf, have low vision or are blind), mental health disabilities and many others. To get different perspectives on access to trade, we also interviewed seven vendors of assistive devices in Manitoba, Ontario and Newfoundland and Labrador, four program co-ordinators in Manitoba and Saskatchewan, and two Manitoba-based brokers.

Policy Recommendations on Assistive Devices

1. All assistive technology and devices for people with disabilities should be exempt from duty, brokerage fees and tax.

2. The Canada Customs and Revenue Agency (CCRA) should create a registry of people who receive the disability tax credit and use that to approve duty-free status related to each person with disabilities.

3. Separate commodity classification codes for assistive technology should be created by Statistics Canada following significant, participatory discussions with the self-representational disability community.

4. There needs to be a greater harmonization of standards between the United States and Canada so assistive technology bought in one place can be used in the other.

5. The CCRA should create an accessible, user-friendly Web site and fact sheets on importing assistive technology and aids, and people with disabilities.

6. The CCRA and the Canadian Society for Customs Brokers should provide information about the role of brokers in importing assistive devices and technology, the costs associated with importation and the possibilities for getting the brokerage fee returned if the devices are exempt from duty.

7. The federal, provincial and territorial governments should co-ordinate a Canada-wide information system on aids and devices, which is accessible and understandable by the general public, policy makers, program personnel, etc.

8. Mechanisms should be put in place to enable parents and individuals with disabilities to reclaim the Goods and Services Tax (GST) charged on products for persons with disabilities coming into Canada from the United States. Currently, professionals can reclaim this GST on these types of items while parents and consumers are unable to do so.

9. Incentives to strengthen Canadian assistive technology industries should be developed.

Policy Recommendations on Trade in Health Services

10. In developing trade policies, the Department of Foreign Affairs and International Trade (DFAIT) needs to recognize the lack of access issues created by the disparity in costs in health products between Canada and the United States, and create an appropriate mechanism to address this variation for people with disabilities who require these products.

11. DFAIT should ensure that, within existing and developing trade policies, common accessibility standards (including the provision of interpreters in emergency health care settings) that support existing national legislation are implemented.

12. DFAIT should ensure international trade agreements, both those existing and those still to be implemented, do not disrupt access to publicly funded home care.

13. Companies from the United States selling health care products and assistive devices should be encouraged to set up franchises in Canada to increase the accessibility and affordability of these items to the consumers.

Policy Recommendations on Access to Trade Information and Services for Women Entrepreneurs with Disabilities

14. DFAIT should undertake a systematic analysis of all its trade policies using a disability lens to identify the challenges and opportunities for women and men with disabilities.

15. DFAIT and private industry should develop and advertise a Web site about international trade policies and their impact on women and men with disabilities. Information should be available in multiple formats.

16. The CCRA, other federal agencies, non-profit organizations and private industry should provide workshops on customs regulations associated with importing goods and services, and how to complete the necessary paperwork.

17. The CCRA should develop a user-friendly, accessible Web site with relevant customs information for entrepreneurs, including a list of telephone/teletypewriter numbers to call for clarifications or questions.

18. The Canadian Trade Commissioner Service's Businesswomen in Trade section should provide and include in its Web site specific information about access and inclusion issues for women entrepreneurs with disabilities who want to engage in trade.

19. Entrepreneurs with disabilities should create a national network of support and networking, with particular emphasis on recruiting and supporting women entrepreneurs with disabilities.

1. INTRODUCTION

Increased international trade has been one of the most momentous aspects of the Canadian economy over the past decade. Since 1992, Canada has experienced a rapid increase in trade: exports have grown by 179 percent and imports by 126 percent (see Table 2). As a result, 40 percent of Canada's gross domestic product is now accounted for by exports. This expansion in trade has affected the lives of all Canadians, but it has been distinctively important for women with disabilities.

Women with disabilities are a significant proportion of the Canadian population, and more women than men live with disabilities. In 2001, 55 percent of all adults with disabilities were women. Women and girls with disabilities made up 13.3 percent of the Canadian population and 15.7 percent of all adult women. As women age, a greater proportion live with disabilities; 42 percent of women 65 years and older identify themselves as experiencing disabilities (Statistics Canada 2002). The incidence of disability among Aboriginal people in Canada is more than twice the national rate (HRDC 2002).

Women with disabilities comprise more than half of Canadians who say they require aids or devices for their daily activities. The most recent data from 2001(Statistics Canada 2003) illustrate that of the 1.6 million Canadians 15 years and older who said they needed aids and devices for daily activities, 895,590 (56 percent) were women. Approximately 40 percent (369,430) of these women said they needed more aids than what they had or had no aids. Among the reasons for their unmet needs for assistive aids and devices, approximately 35 percent said the device was not covered by insurance, 47 percent said the assistive aid was too expensive and 13 percent said they didn't know where or how to obtain it.[1]

Yet, women with disabilities have limited access to income, lower incomes and a significant reliance on government income support programs. Household income for persons with disabilities between 1993 and 1998 was roughly three quarters of the household income of people without disabilities. For Aboriginal persons with disabilities, the household income is roughly one half of the population of non-Aboriginal households. Twenty-five percent of people living in low-income households are people with disabilities. In 1998, of working age adults (16 to 64 years of age) with disabilities, 48 percent had government programs as their primary source of income. Women with disabilities were three times more likely to rely on government programs than women without disabilities and more likely than men with disabilities (HRDC 2002).

Women with disabilities are among those who, as consumers, rely heavily on assistive devices, pharmaceuticals and health services. From this point of view, increased trade has promised lower prices and greater availability. On the other hand, with trade liberalization has also come a greater dependence on the market to distribute resources. This leaves women with disabilities at potentially greater risk. Since women with disabilities tend to have lower incomes and are more reliant for their income on government programs, they may have to allocate a significant portion of their income to assistive devices or health services or go without.

Women with disabilities are uniquely affected by how Canada undertakes and promotes trade, yet issues of concern to them are not on the table in trade negotiations nor in assessments of existing trade agreements. This report highlights the key issues of concern to women with disabilities, both as consumers and as entrepreneurs. In doing so, it adds to our knowledge about the particular concerns of women with disabilities in relation to trade, provides a richness and depth to our understanding of how trade differentially affects various groups of people, and gives policy recommendations for concrete measures that can be undertaken by governments to address these concerns.

The Trade Environment

In 1987, Canada began a process toward trade liberalization when it entered into a bilateral trade agreement with the United States. Implementation of the Canada–United States Free Trade Agreement (FTA) two years later resulted in the gradual elimination of tariff and non-tariff barriers to trade in a wide range of goods. The North American Free Trade Agreement (NAFTA), signed in 1994, superseded the FTA and extended coverage to Mexico. Negotiations are underway to strike a broader Free Trade Area of the Americas (FTAA) that would include 34 countries in the western hemisphere.

In retrospect, the FTA and NAFTA merely anticipated changes occurring on a multilateral basis. In 1995, successful conclusion of the Uruguay round of negotiations of the General Agreement on Tariffs and Trade (GATT) led to the Marrakesh Agreement establishing the World Trade Organization (WTO). Canada's participation in the WTO involves it in a far-reaching multilateral trade agreement among 125 original participating countries covering most merchandise goods and some services. Where the FTA committed Canada to the gradual elimination of duties on most trade with the United States, the WTO Agreement effectively extended similar (most-favoured nation) treatment to the rest of the world. Both NAFTA and the General Agreement on Trade in Services (GATS) reached by the WTO define parallel rules and procedures governing a range of commercial services.

Canada's entry into trade liberalization negotiations, first with the United States, subsequently with Mexico and other countries in the Americas, and then multilaterally under the WTO Agreement, was expected to generate several benefits for Canadians. By removing tariff and non-tariff barriers to the international movement of commodities, it was suggested that consumers would see lower prices on their goods and services. This would be achieved by eliminating the import tax on goods and services and, indirectly, by increasing productivity and efficiency for companies. By rationalizing production in certain industries, we expected to generate economy-wide benefits in the form of faster economic growth, lower unemployment rates and slower rates of inflation (Cox and Harris 1986).

Others had significant concerns, in large part about the workers whose jobs would be lost as a result of these changes. Consumers also had concerns that lower prices would only happen if there were increased competition, not in the case where there were fewer companies controlling the markets.

One important concern was the increased pressure on governments, as a response to trade liberalization, to privatize previously public services. Both NAFTA and the WTO Agreement

place obligations on Canada that go beyond eliminating tariffs and other barriers to trade, to protecting the rights of foreign investors (under NAFTA's "national treatment" provisions), protecting intellectual property rights and dispute resolution mechanisms. To eliminate programs that may be seen as an unfair trade practice or hidden subsidy favouring domestic producers, trade agreements exert pressure to harmonize government policies between countries. In large part, this has meant greater pressure for privatization (Johnson 2002: 4).

Since many of these government programs were specifically targeted to replace the *private* allocation of resources with *public* delivery, individuals who had previously benefited from publicly funded programs would be left more vulnerable to the whims of the market. Women with disabilities are among those for whom this is a significant concern.

The Research

Guiding the research of this project was one key question: How can Canadian trade policies ensure access and inclusion for women with disabilities? To answer this question, the research team examined three distinct areas in detail: trade in assistive devices and technology, trade in health services and products (including pharmaceuticals), and access to trade information and services for women entrepreneurs with disabilities. The report is structured using these three areas.

Our research was nurtured by an advisory committee, which met throughout the project. Its members included representatives of our partner organizations — the Council of Canadians with Disabilities, the DisAbled Women's Network of Canada, the Network of Entrepreneurs with Disabilities, Collaborative Learning Strategies (which became a partner when the Cowichan Economic Development Cooperative withdrew) as well as from the Assistive Devices Industry Office of Industry Canada, Western Economic Diversification, the Centre for Women in Business at Mount St. Vincent University and Kartini International (a company with considerable experience related to trade and women's issues).

To gather data, we drew from a number of different sources both qualitative and quantitative.[2] The qualitative data were gathered through focus groups, individual interviews and key informant interviews. The research team also undertook quantitative analysis of the relevant trade statistics.

To learn the trade concerns of women with disabilities and women entrepreneurs with disabilities, we held in-person focus groups with women with disabilities in Halifax, Toronto and Winnipeg. All but one were held in English; the exception was held in American Sign Language. One focus group was held on-line with women with disabilities on Vancouver Island. Individual interviews were held with women with disabilities in Calgary. In Toronto and Winnipeg, we also interviewed ethno-racial women with disabilities, with translation from their first language as required.

In total, 42 women with disabilities participated in either focus groups or interviews. Six identified themselves as entrepreneurs. Eleven identified themselves as ethno-racial women and two as Aboriginal women. We met with women who experienced a wide range of disabilities including sensory disabilities (deaf women, those with low vision, or those who

are blind or hard of hearing), mental health disabilities, women with multiple and invisible disabilities and many others. Their frustrations, questions and concerns provide much of the content of this report.

To get different perspectives on access to trade, we also interviewed seven vendors of assistive devices in Manitoba, Ontario and Newfoundland and Labrador; four program co-ordinators in Manitoba and Saskatchewan, one assistive devices researcher in Ontario and two Manitoba-based brokers.

General Findings

For women with disabilities, Canada's entry into trade agreements has meant a further erosion of their already marginal status in Canadian society. While proponents of trade liberalization promised that costs related to assistive devices, health services and pharmaceuticals could decrease, this has not happened. In addition, as an indirect effect of trade liberalization, there has been a reduction in scope and number of public programs designed to support the participation of people with disabilities in community life. This leaves women with disabilities more and more vulnerable to market forces in which they have little or no say.

Trade liberalization has also created, indirectly, a disincentive to enter the paid labour force. While the best avenue for escaping low income is employment, for women with disabilities the rising cost of pharmaceuticals and other disability supports has simply increased the financial barriers to participating in the paid labour force and thus made entry impossible for many. In this regard, trade liberalization has likely contributed to the further marginalization of women with disabilities and to a less inclusive society.

Not only do women with disabilities face these systemic barriers to full inclusion, they also have little knowledge of, or access to, information on the effects of trade on their lives. This further reduces their capacity to address their exclusion from Canadian society.

This study found significant and detailed information that will help us understand how trade affects women with disabilities as consumers and entrepreneurs, and how to change trade and other policies to ensure better access and inclusion for women with disabilities. The following three chapters provide detailed findings related to trade in assistive devices and technologies, trade in health services, and access to trade information and services for women entrepreneurs with disabilities.

2. WOMEN WITH DISABILITIES AND INTERNATIONAL TRADE

While international trade agreements have made headlines for the past two decades, there is nothing written specifically about women with disabilities and trade. In our literature review, we came across no studies, articles or even general information that addressed the specific situations of women with disabilities in relation to trade.

There is a growing body of literature on women and trade generally, much of which examines the effects of the current global environment of economic policy, trade agreements and competition on women. Some of the issues this literature examines include the effects of economic processes on women (Afshar and Dennis 1992; Beneria and Feldman 1992; Joekes and Weston 1995), explanations for the economic impacts of trade in terms of gender relations, ideologies or bias (Elson 1991; Fernandez-Kelly 1989; Moghadam 1993; Pearson 1992; Redclift and Stewart 1991) and the gendered aspects of economic restructuring, for example, the way that gender shapes the labour process, and the impact of women's employment on gender relations (Blumberg et al. 1995; Feldman 1992; Moghadam 1995; Tiano 1994; Ward 1990).

The work of women, both waged and unwaged, in formal sectors and within the home, in manufacturing, and in public and private services, is important to global accumulation and trade. The increasing globalization of production has led to an increase in companies' pursuit of flexible forms of labour to gain a competitive advantage in trade. The prevalence of women in these new labor pools has been termed the "feminization of labour" by feminist academics studying the global economy (Moghadam 1999; Macdonald 2003). Changing job structures in industrial enterprise favour the feminization of employment. In Canada, large corporations have responded to the pressures of increased competition by shifting toward more "flexible" production strategies including contracting out work to smaller companies, using more flexible part-time labour often based out of the home, and paying workers at minimum wage levels with little or no benefits (Macdonald 2003). This tends to lead to an increase in the number of women in the labour force, but also to a deterioration of work conditions. Labour standards, income and employment status deteriorate as women accept these concessions in exchange for flexibility of working conditions and hours.

As a result of the effects of increased trade, women have been gaining an increasing share of many kinds of jobs, but their labour-market participation has not been accompanied by a redistribution of domestic, household and child-care responsibilities. Laura Macdonald (2003: 49), writing about gender and Canadian trade policy, argues: "Export promotion strategies may thus sap women's energies both in the sphere of production (where they are forced to supplement family income or as the main income earner), and of reproduction (where they are forced to economize by cutting back on the family's basic purchases)." Women are still disadvantaged in the new labour markets in terms of wages, training and occupational segregation. They are also disproportionately involved in forms of labour used to maximize profits, increase productivity and competitiveness in the work economy and in temporary, part-time, casual and home-based work.

According to Moghadam (1999), the situation is better or worse depending on the type of state and the strength of the economy. Hassanali (2000: 8) emphasized the "increasing skepticism about the promises of trade liberalization and whether trade-led economic growth, privatization and market de-regulation, and a diminished role for governments have led to a highter quality of life in Canada and elsewhere." Even in the developing world, vast numbers of economically active women lack formal training, work in the informal sector, have no access to social security and live in poverty.

There is also a burgeoning literature on trade generally, including trade in health services, which we will not review here.

Yet many of the women with disabilities we met expressed a lack of knowledge about trade and lack of confidence in their own judgment about how international trade agreements with the United States affected their lives.

> *There needs to be more outreach in terms of getting the information out there to people with disabilities about free trade and trade policies. That is one aspect. They also need to keep in mind issues that would adversely affect people with disabilities. What are the implications to limiting free trade to different countries? Women with disabilities need to be part of the policy development process related to free trade to make sure that access issues are included, that it is not thought of after the fact or that we are completely left out. We should be an integral part of the policy-making process* (Ethno-racial woman in Toronto).

> *Barriers are a lack of information, lack of communication as to what was needed and lack of responsibility. If there could be something set up in the government (like a standard rule) re accessing assistive devices* (Woman in Calgary).

The lack of information about trade was closely linked with access to information about services. As one ethno-racial woman in Winnipeg (through a translator) noted, there are unique issues for ethno-racial women with disabilities, including access to information in a language they can understand.

> *There is also insufficient information about the rights of people with disabilities, the Canadian system and services available to ethno-racial people with disabilities and people with disabilities in general which she can understand. There is no place where ethno-racial women with disabilities can go to get information about rights, services, the Canadian system with the exception of SMD's [Society for Manitobans with Disabilities] ethno-cultural program.*

Another woman, in Calgary, noted that it is difficult to get information about assistive technologies that is relevant to her geographical area.

The provision of information re suppliers (could be improved) and why the cost is so high. Information can be found on the Internet, but often based in the U.S. or Eastern Canada.

3. TRADE IN ASSISTIVE DEVICES AND TECHNOLOGY

Assistive technology is "any item, piece of equipment, or product system whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities."[3] In the 2001 Participation and Activity Limitation Survey undertaken by Statistics Canada, assistive aids or devices were defined as "specialized aids or devices used or needed by persons with activity limitations to help them perform daily activities or tasks" (Statistics Canada 2003: 5). Many women with disabilities use assistive devices and technology in their personal, educational, work, recreational and social lives.

Assistive technology can help women with disabilities increase their independence, build self-confidence and self-esteem, improve their quality of life, and break down barriers, while providing the tools for possible employment and educational opportunities. New technologies also allow women who previously required hospital or nursing home care to be cared for at home. For example, with oxygen available now in many long-term care facilities or at home, more women with disabilities who require oxygen can live in the community rather than in hospital (Shapiro 1997). The basic commercially available equipment, however, is often not enough. Adaptive computer technologies such as braille printers, portable note-taking devices, and screen reading software are examples of products that are not always accessible to women with disabilities and certainly not always affordable (Barile 2001).

With some advances to technology, what began as technology for people with disabilities has become commonplace. For example, voice input software was created for people with physical impairments, but software like Dragon NaturallySpeaking is now used by many people who prefer to input their data with their voice rather than their fingers. Increased access may bring down the prices on this type of software, but it can also create confusion about what assistive technology is.

What We Know about Patterns in Trade in Assistive Devices

Trade data illustrate some of the complexities of addressing assistive devices and technologies. Only a few specific devices are included in commodity classifications and these are all included under medical technology (see Table 1). These commodity classifications are established by Statistics Canada in consultation with the Department of Foreign Affairs and International Trade (DFAIT). The Advisory Committee to the Minister of Industry on Assistive Technology has been investigating the possibility of a new set of codes for assistive technology, de-linked from the medical system. Existing codes (including their current trade status) are as follows.

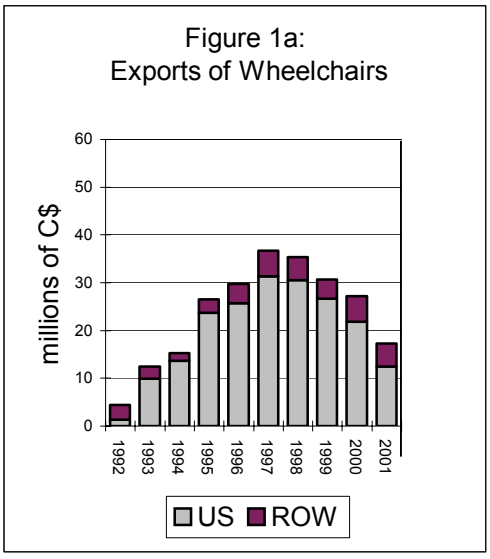
- Wheelchairs (commodity code HS 8713) includes both "mechanically-propelled" and non-motorized varieties. These products were generally subject to an import duty of 9.2 percent prior to the implementation of the FTA in 1989, and the duty was to be gradually phased out over a 10-year period by 1999. The WTO agreement extends similar duty-free treatment to other countries.

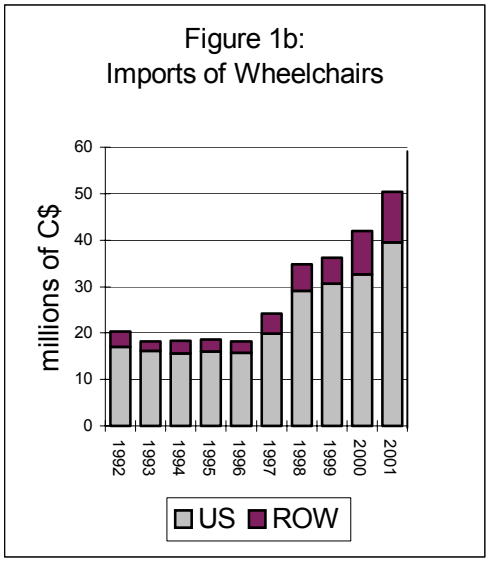
- Mechano-therapy appliances (HS 9019-20) refers to a wide range of products, but the most important quantitatively is artificial respiratory equipment. This latter item was subject to an import tariff of 4.8 percent which, under both the FTA and WTO agreement, was to be phased out over 10 years by 1999.

- Orthopaedic appliances (HS 9021) includes commodities ranging from artificial joints and prostheses to hearing aids and pacemakers. Import tariffs varied, but were generally in the range of 9 to 10 percent, to be phased out over 10 years by 1999.

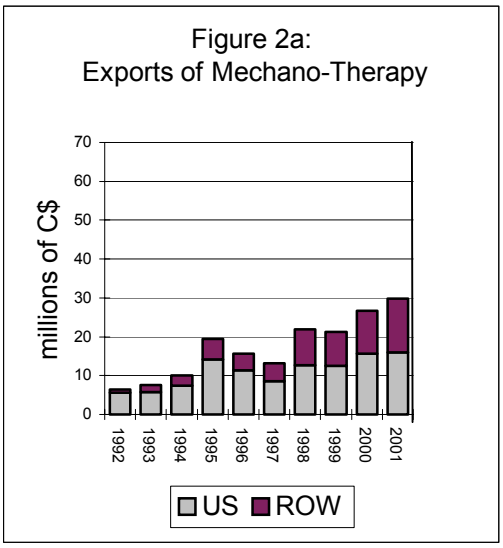
Since these appliances are recognized as assistive devices, they have been addressed in trade agreements. Yet many devices and technologies that women with disabilities require for their daily life are not included in these categories and have not been dealt with in trade agreements. Those that are recognized in the classification code reflect the medical assumptions about disability or illustrate successful lobbying for inclusion. We discuss this in a later section.

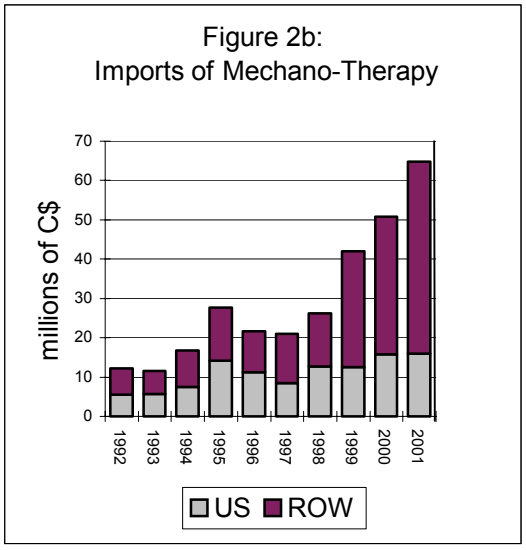
Of the devices that are currently included in trade data, we can see several patterns over the past decade.[4] The export of wheelchairs was very small at the beginning of the period (under $10 million), grew to over $35 million by 1997, and then fell to under $20 million by the end of the period (Figure 1a). Imports, in contrast, increased steadily after 1997, rising from roughly $20 million to $50 million (Figure 1b). Almost all of Canada's trade in wheelchairs is with the United States.



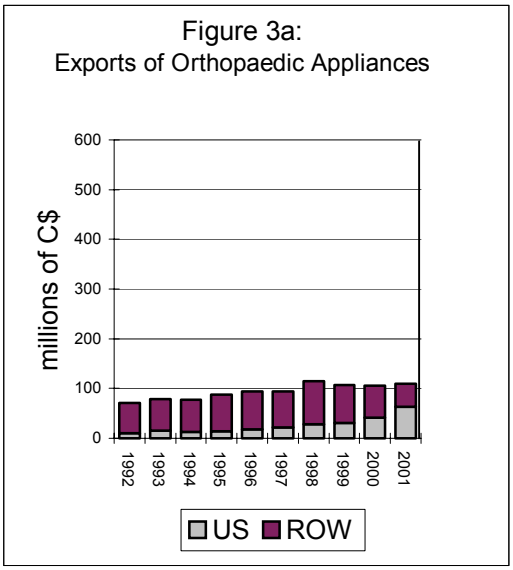


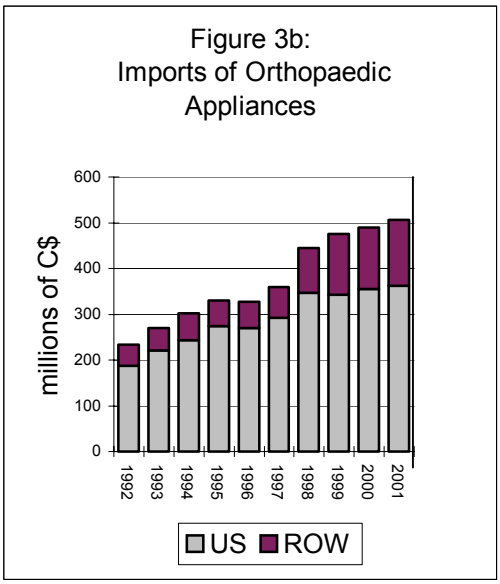
The exports of mechano-therapy appliances increased from under $10 million to over $30 million during the decade (Figure 2a), while imports increased some sixfold, from roughly $10 million to nearly $70 million (Figure 2b). Surprisingly, it is trade with the rest of the world (ROW) that accounts for most of the increase.



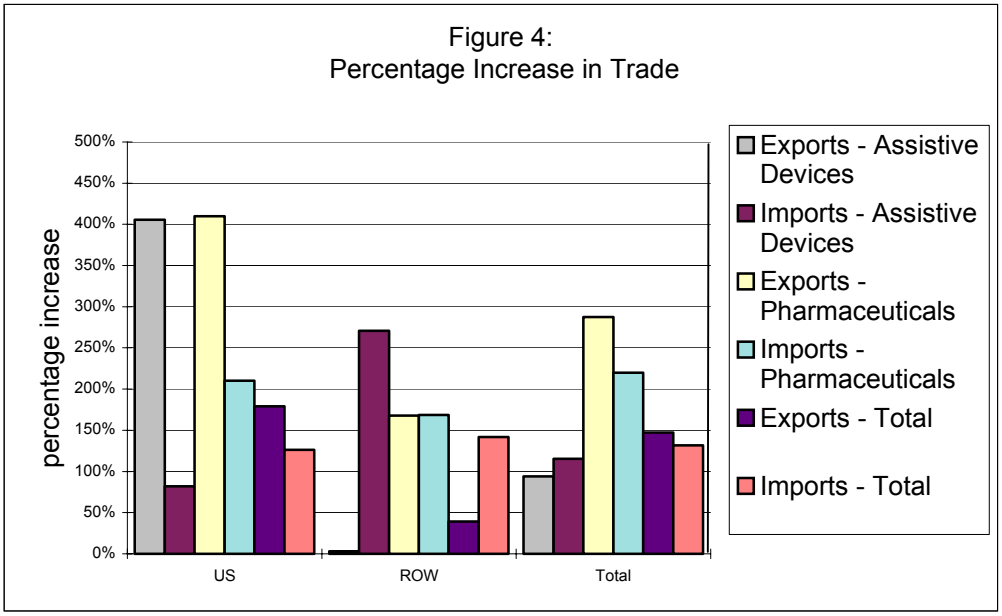


The value of trade in orthopaedic appliances was much larger, with exports rising modestly to over $100 million (Figure 3a) and imports roughly doubling to $500 million (Figure 3b). Most exports are to the ROW, while imports are largely from the United States.



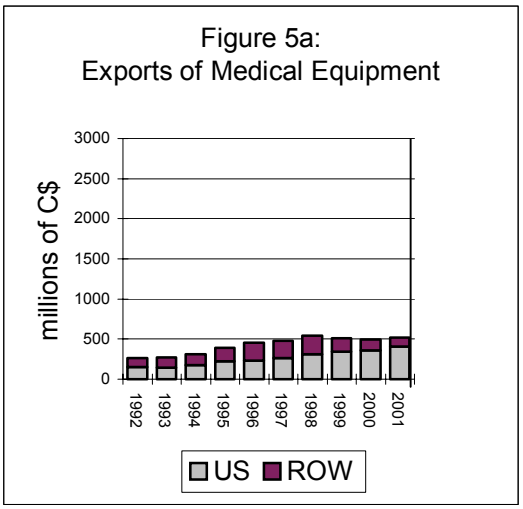


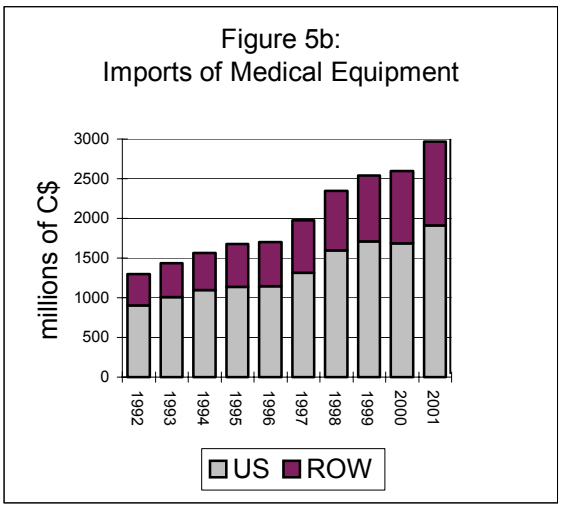
Taken together, the most obvious trend in recent trade in assistive devices is the significant increase in imports and fairly constant exports (Figure 4). As a result of this trade imbalance, Canada's trade deficit (or the excess of imports over exports) in assistive devices increased from roughly $150 million to over $470 million.



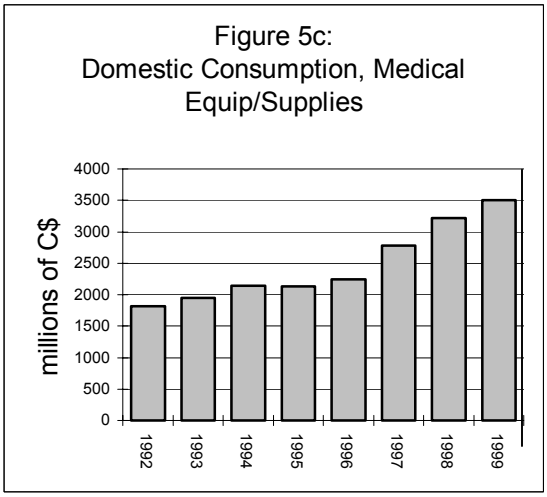
There is no information about prices on these assistive devices. While rising imports may suggest the possibility of lowered prices, we cannot draw any conclusions without the relevant information. The vendors we interviewed who sell assistive technology and computer hardware for persons with visual impairments suggest that there has been no change in prices as a result of trade liberalization.

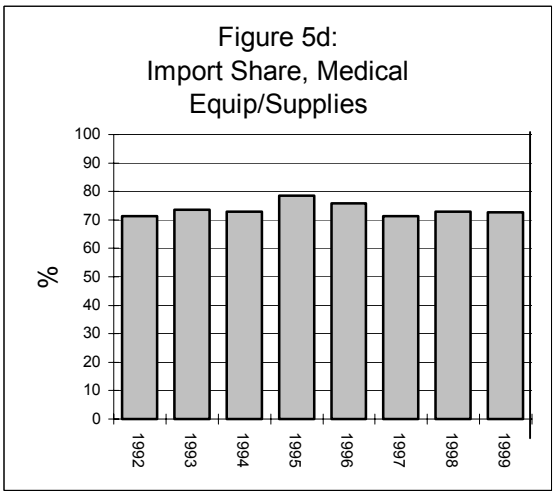
The same patterns hold true when we look at the industries associated with assistive devices. While assistive devices are produced by a variety of different industries, the most closely associated industry is Medical Equipment and Supplies Manufacturing (North American Industry Classification also known as NAIC 339110). The value of Canada's exports was relatively small in 1992 ($261 million) and doubled to $521 million by 2001 (Figure 5a). The increase was due almost exclusively to shipments to the United States. The value of Canada's imports rose rapidly from $1.3 billion to nearly $3.0 billion (Figure 5b). Imports from both the United States and the rest of the world grew significantly; however, imports from the ROW increased the fastest in percentage terms.





The expansion in trade can be placed in perspective by considering the size of the Canadian market and the relative importance of imports. Domestic consumption grew from $1.8 billion to $3.5 billion (Figure 5c), or at roughly the same rate as imports, such that the share of the market captured by imports remained largely unchanged. The important observation, however, is that imports account for approximately 70 percent of the Canadian market (Figure 5d), and this rate has remained relatively stable since 1996.





The high reliance on imports and limited exports suggests a relatively inefficient domestic industry. The Canadian industry is dominated by a large number of small firms: in 1999, there were some 800 establishments employing 2,275 people in the medical equipment and supplies manufacturing industry (Industry Canada nd). Larger American and European firms appear to enjoy a significant competitive advantage over their Canadian counterparts. This may be due to progressive legislative measures, such as the *Americans with Disabilities Act* (1990), that have allowed American firms to develop the expertise and innovative capacity that cede to them a "first" mover advantage. Without similar government support for the Canadian industry,

domestic firms are likely to continue to lag behind their international competitors in terms of innovation and product development.

Assistive Devices and Women with Disabilities

In the focus groups and interviews we conducted with women with disabilities in Toronto, Halifax, Calgary, Winnipeg and Vancouver Island, several key issues were raised again and again. Most importantly, there was a significant disparity among women with disabilities in their ability to access assistive devices and technology depending on where they lived and their province's policy about providing assistive devices.[5] For many, provincial policies create the biggest barriers that women face in terms of accessing adaptive technology or aids to daily living. As one participant in Winnipeg noted:

> *I find with assistive devices the issues are not so much the trade issues but rather policies that exist in our own provinces.*

A researcher in Toronto suggested the same obstacles.

> *International free trade agreements are not the problem. The barriers relate to the inter-provincial policies and trade between provinces and the fact that each province has different policies with respect to accessing assistive devices. Most of the assessments for devices are carried out within a medical model framework, which involves assessments by physicians, therapists, social workers, etc. to verify what consumers need. This can be more costly than simply providing subsidies to consumers to enable them to purchase the devices.*

For women who either do not fit under the provincial programs, or who live in provinces where there are no programs, they must rely on private insurance coverage, or their own incomes, which in most cases are inadequate to buy the devices they require.

Government Assistive Devices or Other Programs

Across Canada, each province has a different approach to providing assistive technologies (see Table 10). Many provinces and territories have no assistive device programs, or a series of scattered programs related to particular aids.

Alberta, Ontario, Saskatchewan, Quebec and Prince Edward Island have specific programs which cover a variety of assistive devices. Ontario's Assistive Devices Program is the most comprehensive. It covers everyone in the province, although it only covers 75 percent of the total costs and requires that you go through authorized agents to obtain equipment. Alberta's program also covers everyone who has a chronic disability, but has a more limited number of devices covered by the program. Prince Edward Island's program is the most recent, is individualized and requires a contribution by the person with disabilities or the family to the cost of the device.

Yet, even in provinces where there are assistive devices programs, women with disabilities continued to face barriers. Because of the range and diversity of programs across Canada and the considerable disparity in the availability of appropriate access to assistive technology.

Many women are unaware of the available government programs. This is especially true for ethno-racial women with disabilities whose first language is neither French nor English.

> *Everything I need to know about the system I usually know after doing it once. I paid for my own crutches for a long time, because I didn't know about ADP [Assistive Devices Program]. Then somebody told me* (Ethno-racial woman with disabilities in Toronto).

Most government programs require some kind of assessment of the needs of the person with disabilities by a medical professional. As one ethno-racial woman in Toronto suggested, this can be time consuming and include additional expenses.

> *In order to get my devices, I had to apply for the Assistive Devices Program for my manual wheelchair and my scooter. I knew about the program, as I got my crutches through them. Dealing with the program is getting more and more difficult. I learned that you have to get this assessment done. Someone other than your doctor has to come and check you in your own environment. They have to be certified to do that kind of work and they have to decide what you need. This is fine but there is the time scheduled with that person and then they charge you money for that ($100 or something). Then you have to wait for the results. The person doing the assessment takes the papers and submits them to ADP themselves. Then you just have to wait to see what happens.*

Some of the devices women with disabilities feel they require are not considered eligible under a government program. One participant in Halifax described her situation.

> *Social Services are awfully, awfully hard to, I find it hard for myself to assert myself and I have to have these items and however I have to kiss their feet to get any kind of service with them especially filters and all the rest of it.*

Another woman in Winnipeg illustrated how assistive devices to one person may not be considered eligible under government programs.

> *I also needed a medical device but not for medical reasons. I cannot allow my hip to fall below a 90 degree angle when I am sitting. I had to raise up my chair in the living room and my bed. I had to purchase concrete blocks, which I had to pay for. They cost less than $25, which wasn't a big problem, but it was the argument that they wouldn't cover it.*

Government programs also work with approved vendors for specific equipment. This may mean a limited selection of possible devices. In Manitoba, wheelchairs are provided for people with mobility impairments, but most of the wheelchairs provided are made by Everest-Jennings. One Manitoba participant spoke of the limitations.

> *When I first went into my manual wheelchair, I had fallen a lot in my life and my shoulders were pretty bad, so pushing myself in a manual wheelchair was pretty difficult for me. I specifically requested a lighter wheelchair; they said*

> *they would give me one, and it's just as heavy as the one that they gave me initially. I mean it's really heavy, and I also don't have a van, I can't afford a van, and so lifting it in and out of the car for my husband is a really big problem…. And then you end up with SMD [Society for Manitobans with Disabilities], who won't provide a walker, they don't provide walkers, only provide an Everest-Jennings wheelchair, which is like carrying, it's heavy. Can't have an electric wheelchair, if you've got a manual.*

Government programs may also provide a generic device, rather than one uniquely adapted to the person's needs. One ethno-racial woman with disabilities in Winnipeg described, through a translator, her situation.

> *The cost of the braces and the corset is covered by Social Assistance, but there is a lack of choice in the types of braces and corsets she can buy. There are not many types available and those which Social Assistance will cover are not very durable. The corset is too big for her, and there is no other choice available. The vendor was asked if he would make a corset which would fit better, but he could not do this within the limitations of what Social Assistance would cover. Even if he could make something more suitable, [the participant] is not allowed to return the corset which doesn't fit her, and she can't afford to buy two corsets. Wearing something too big for her causes pain and makes moving around more difficult. Part of this may be a limitation on the types of products that Social Assistance will cover and the other part that the vendor buys a limited number of corsets, for example, because he buys in bulk. This is a cheaper option. The consumer didn't know whether the vendor buys a limited number of corsets because it is cheaper to do this, but this could be a factor in explaining the limited choice.*

The officials we interviewed who were responsible for provincial assistive devices programs were, for the most part, unaware of the impact of international trade agreements on the ability of people with disabilities to access assistive devices. They indicated that, wherever possible, they tried to obtain devices and technology in Canada. In situations where this was not possible, products were purchased from the United States. The majority of the devices were exempt from duty with the exception of things such as wheelchair parts like batteries. This was because the general population could use these items. Most respondents noted they maintained the services of brokers to facilitate the process of bringing equipment into Canada. One criteria of the Ontario's Assistive Devices Program was that devices and assistive technology were purchased from authorized suppliers in this country.

Private Insurance Coverage of Assistive Devices

For those women with disabilities who have private health coverage, either through their employer, their spouse or because they have the resources to pay the costs, they may be able to obtain some of their assistive devices through this plan. One ethno-racial woman in Toronto illustrated how she used both the government Assistive Devices Plan and her private plan to meet her needs.

> *I got my scooter from the Assistive Devices Program (ADP) and my wheelchair through my drug plan, because you can only get one thing through ADP. I had to pay the difference for my scooter, because ADP pays only 75 percent. I had to pay the rest. The scooter was $4,000 so the amount I had to pay wasn't that much. My plan paid 85 percent for the manual wheelchair and I had to pay 15 percent. There was quite a lot of money I had to pay. I didn't have a choice. In order to keep up with my lifestyle — my job, my health and all that, I had to have those things.*

Buying Assistive Devices

Most of the women we spoke with, however, had to rely on their own income to purchase their assistive devices. Most often, they were constrained by not having sufficient income to get the devices they required. But other barriers, some trade-related, also shaped their choices in assistive devices.

For many, there was little selection in Canada; what was available was very expensive, and there was little competition between suppliers. As a result, many women with disabilities feel their only recourse is to buy their assistive devices from the United States. One deaf-blind participant from Winnipeg gave a specific example.

> *We have one choice of a vibration device for hearing the door or the phone. I went to a conference in the United States and they recommended one that is not available in Canada. There is a vibration device, which assists people with diabetes, and the vibration is less on it. It is not available in Canada. I have tried to get someone in Winnipeg to supply it but no one will. Across Canada, the Alert Master is approved for use, but, in the United States, they say the Silent Call is better.*

Another participant in the deaf focus group in Winnipeg suggested the challenges of buying your own assistive devices.

> *When you order devices, they are terribly expensive. Many seniors are not able to afford those kinds of devices. Then if you have to add on things to the devices to make them work, then the price goes up even there. Canada needs to look at setting something up so that the devices are accessible here rather than ordering them Stateside.*

For some women with disabilities, trade agreements with the United States are perceived to be the obstacle to obtaining the least expensive assistive device, even though these agreements do not impose duty on goods coming from other countries.

> *We should be able to purchase the braille printers from other countries. (They are also manufactured in Germany.) When there is competition, things are cheaper. Because we are stuck getting stuff from the U.S., we have to pay so much more. There is a lack of choice. If you go to the CNIB [Canadian National Institute for the Blind], everything is from the States. Since I have travelled, I know you can get these things cheaper in other countries. If I*

> *wanted to buy something from the Royal National Institute for the Blind in England, I could get it cheaper myself if I ordered it on the Internet. Because there is a trade agreement with the U.S., we have to pay 100 percent duty on things coming from other countries* (Ethno-racial woman with disabilities from Toronto).

Trade policies together with the underdeveloped Canadian assistive devices industry will continue to make it difficult for women with disabilities to get affordable assistive devices. The Government of Australia recognized a similar problem in its own industry in a 1990 report outlining its recommendations for the most effective mechanism for the provision of assistive devices for people with disabilities. The Industry Commission's primary recommendation was that by reducing government involvement, the quality and range of goods and services could be improved, waiting times reduced, and their costs to the consumer would decrease (Industry Commission of Australia 1990).[6]

In buying assistive devices from the United States, women with disabilities find several complications that have not been addressed in our trade agreements. As a woman from Winnipeg described, prices escalate when you have to pay duty, brokerage fees and customs charges.

> *There is a much greater range of choice in the States than we can access here in Canada or that any of the places here will carry. You have to pay brokerage, duty and tax, even if it's a prescribed item. So something that would cost like $40 in the United States, which is still more Canadian, but I mean by the time you actually get it up here, and especially if you try to order it as an individual, by the time you get it, it's nearly $100.*

A woman from Toronto confirmed this statement.

> *You can get anything, if you purchase through American [the United States], like there's a broader range of things available, but if they're U.S. based products, you can't get any funding or support for the purchase of them, so the cost is usually prohibitive, although it may be more available.*

Another woman from Winnipeg suggested, contrary to the trade data described earlier:

> *There's duty on assistive devices, there should just be a waiver of duty, because there are countries that have waiver of duty that would be a basic free trade thing.*

A woman in Calgary described her solution to getting assistive devices from the United States.

> *My dad purchased most of it because funding is so hard to get. I went to an interview to get some special things, but it hasn't come through yet — it's a computer for my college classes. My dad is faster at getting me stuff. It is more expensive to just buy it and it is not the same quality as the USA. Software, for example, one program may be from the U.S. and one from*

> *Canada. The U.S. software can do better, and the Canadian software is junk…well some, not all.*

Women with disabilities have also had some unique challenges when they buy their assistive devices from the United States. One participant in the deaf focus group in Winnipeg outlined her concerns.

> *I am scared to order a TTY [teletypewriter] from the United States, because if something goes wrong with it, I have to pay postage to send to the U.S.A., even if it is on warranty. I have no choice, so I must buy a TTY in Canada, which is very expensive. I want Canada and the United States to charge equal prices for all devices.*

Another deaf woman in Winnipeg suggested that differing standards are getting in the way of her access to goods.

> *The assistive devices selling in the U.S. need to be approved in Canada, as they are not Canadian Standards Association (CSA) approved. Most of the time, we have to pay brokerage fees to check whether the devices have been CSA approved. This is a waste of time. When we order from the United States, it takes two weeks or more to arrive because of brokerage fees and custom duties.*

Trade in Assistive Devices and Policy Recommendations

The access women with disabilities have to assistive devices is directly related to trade policies. The linking of assistive devices with medical devices, the lack of a separate classification for assistive technology, the lack of a link between the women with disabilities and the assistive devices they require, and the lack of information about duty, brokerage fees and taxes in relation to assistive devices all impede access to assistive devices for women with disabilities.

Assistive devices and technology are classified for trade purposes as medical technology. This has a dual effect of contributing to the medicalization of disability and putting individuals with disabilities who must access this technology in the same category as hospitals, institutions and clinics that purchase medical technology. It can be much more difficult for individuals than for institutions to access this technology. Lumping medical and assistive devices together in one classification also has the effect of making unclear, for both the user and brokers that manage the trade interactions, which devices have duty applied. Under the trade agreements, assistive devices do not have duty applied, but some medical devices and technologies do have duty applied.

One solution to this confusion is to create a separate classification category for assistive devices and technology. This would eliminate the assumption that all devices that can assist people with disabilities are necessarily medical. It would also allow flexibility in what assistive technology can look like, and recognize that different technology may have different functions. A separate category also ensures that all assistive technology will

have no duty applied, rather than making ad hoc cases about specific technologies as is currently the case.

When we recognize that assistive technology is different from medical technology, we also recognize that what is defined as assistive technology is shaped by the end user of that technology. For example, voice recognition software can be used as office technology by a doctor, in which case it is not assistive technology. When, however it is used by a person with quadriplegia it is assistive technology. To manage this individualized recognition of assistive technology, a registry of people with assistive technology needs, drawn from those who claim the disability tax credit, can be maintained by the Canada Customs and Revenue Agency (CCRA). Given that the CCRA currently responds on an ad hoc basis to assistive technology claims, this approach would reduce and rationalize the system. It would also ensure better access in terms of reduced duty, clearer information about what is assistive technology, and the inclusion of aids and devices needed by people with disabilities that have not been included under the existing classification codes.

These barriers can then limit the capacity of women with disabilities to participate fully in Canadian society.

As one ethno-racial woman in Toronto put it:

> *If it costs more to get devices, such as crutches, wheelchairs, or whatever, because of free trade, then someone had better be watching. At the end of the day, if I can't afford to get a wheelchair, I am not going to be able to work. That means I am going to be home and a burden on the system only because of barriers put there by the system.*

Women with disabilities consistently said they were the best ones to decide which devices they needed, whether that was in the context of government programs, private programs or spending their own money.

Two women in Winnipeg outlined their perspectives.

> *I think that policy has to be developed that allows women with disabilities to determine for themselves what's best for them.*

> *I think it's important that policy be developed so that women with disabilities feel that they have control over what their choices are in terms of getting their assistive devices, getting whatever it is they need to accommodate their disability.*

From our data, some specific trade policy recommendations can be made. Many other recommendations came forward that are not listed here, because they addressed areas other than trade.

1. All assistive technology and devices for people with disabilities should be exempt from duty, brokerage fees and tax.

2. The Canada Customs and Revenue Agency (CCRA) should create a registry of people who receive the disability tax credit and use that to approve duty-free status related to each person with disabilities.

3. Separate commodity classification codes for assistive technology should be created by Statistics Canada following significant, participatory discussions with the self-representational disability community.

4. There needs to be a greater harmonization of standards between the United States and Canada so assistive technology bought in one place can be used in the other.

5. The CCRA should create an accessible, user-friendly Web site and fact sheets on importing assistive technology and aids and people with disabilities.

6. The CCRA and the Canadian Society for Customs Brokers should provide information about the role of brokers in importing assistive devices and technology, the costs associated with importation and the possibilities for getting the brokerage fee returned if the devices are exempt from duty.

7. The federal, provincial and territorial governments should co-ordinate a Canada-wide information system on aids and devices, which is accessible and understandable by the general public, policy makers, program personnel, etc.

8. Mechanisms should be put in place to enable parents and individuals with disabilities to reclaim the Goods and Services Tax (GST) charged on products for persons with disabilities coming into Canada from the United States. Currently, professionals can reclaim the GST on these types of items while parents and consumers are unable to do so.

9. Incentives to strengthen Canadian assistive technology industries should be developed.

4. TRADE IN HEALTH PRODUCTS AND SERVICES

Women with disabilities are significant consumers of health products and health services and, as such, have some significant buying power. While no specific statistics illustrate the extent of their use, several studies describe people with disabilities as high-end users of health services (Batavia and DeJong 2001; DeJong 1997). Based on the National Population Health Survey, McColl and Shortt (2002) determined that adults between 35 and 64 with chronic illnesses and disabilities are the most intensive users of health services in Canada. In addition, the Canadian Community Health Survey indicates that 24 percent of adults with disabilities said that in the previous 12 months they did not receive all the health care they needed (HRDC 2002). In comparison, only 10 percent of adults without disabilities said they did not receive the care they needed. There are not yet any statistics about pharmaceutical usage among women with disabilities, but we can project that with their use of health services, it is likely they are also high users of pharmaceuticals. From all angles, women and men with disabilities rely extensively on the health care system. As a result, trade in health products and services will have a direct impact on their lives and health.

In this section, we consider two aspects of trade in health products and services: trade in pharmaceuticals and trade in health care services.

Patterns in Trade of Pharmaceuticals

With the free trade agreements with the United States and the World Trade Organization, there has been a gradual elimination of duty on pharmaceuticals imported into Canada. With this, we would expect a decrease in drug prices in Canada. Yet, this has not happened. While there has been an astronomical increase in the trade in pharmaceuticals over the past decade (figures 6a and 6b), there has been no significant decrease in price. In fact, over the past decade there has been a steady increase in the spending on all drugs.

Figure 6a:
Exports of Pharamaceuticals

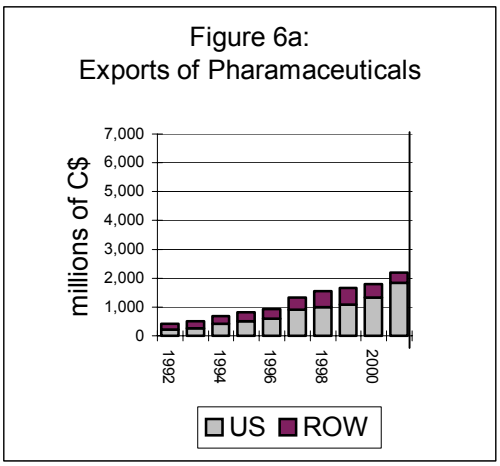
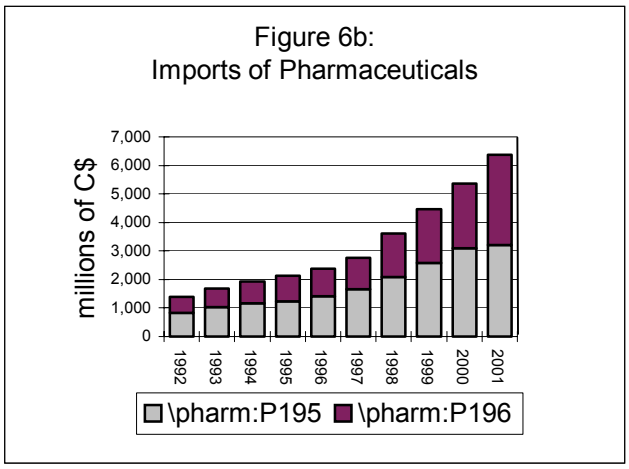


Figure 6b:
Imports of Pharmaceuticals



The revisions to Canada's policy on patented medicine account for the rapid expansion in trade. In response to escalating drug prices, in 1969 the Canadian government adopted a policy that allowed drug companies to produce a "generic" version of a patented medicine.

While this approach was widely deemed to be successful in lowering drug costs in Canada, it was reversed in 1987 under pressure to satisfy terms of the FTA and GATT, which dictated more stringent protection of intellectual property rights. Drug patent holders were given seven to ten years of protection from competition from generic copies and, in 1993, the monopoly period was extended to up to 20 years. Protection from competition from generics was justified on the grounds that the monopoly profits would be an incentive for greater innovation and foster more research and development in Canada. The potential costs, on the other hand, were to be ameliorated by the establishment of the Patented Medicine Prices Review Board (PMPRB), empowered to ensure that prices were not "excessive" (Jones et al. 2001: 948–949).

Created in 1987, the PMRB is an independent, federal, quasi-judicial board that establishes and enforces guidelines that determine the maximum prices at which manufacturers can sell brand name drugs (PMPRB 2000). Under these guidelines, the introductory prices of "breakthrough" drugs must not exceed the median of the prices of the drugs in other industrialized countries. The Canadian pricing system results in brand name drugs that are an average of 38 percent lower than prices in the United States (PMPRB 2000). While increased patent protection may have harmed domestic firms, price regulations under the PMPRB were designed to ensure the consumer was not faced with higher drug costs.

Some have argued that trade agreements did not require that Canada dismantle its compulsory licensing policies, which led to increased drug prices. Rather, these analysts suggest the government made changes to the *Patent Act*, including through Bill C-91, and did not include them in the trade agreements. In contrast, others argue that changes to the *Patent Act* in Bill C-91 were introduced while the preparations for the Uruguay round of GATT talks were underway.

> At the time, the federal government specifically used this and the Canada–US Free Trade Agreement as the primary justification for eliminating compulsory licensing for generic drugs. It was claimed that Canada's patent legislation had to be brought into line with 'new international obligations' for the treatment of intellectual property rights (CLC 1997).

The government suggested the changes to the *Patent Act* in Bill C-91 were deemed necessary to comply with the intellectual property rights provisions in NAFTA.

> In 1991, as part of the GATT negotiations, the "Dunkel Text" was released. The direction of international policy for the protection of intellectual property was clear to the government of the day. The movement was towards 20-year patents based on patent-filing dates, and discrimination based on the field of technology was not allowed. Drugs could not be subject to exceptional provisions (CLC 1997).

The Romanow Commission recommended in its 2002 report:

> The federal government should immediately review the pharmaceutical industry practices related to patent protection, specifically, the practices of

> *evergreening* and the notice of compliance regulations. This review should ensure that there is an appropriate balance between the protection of intellectual property and the need to contain costs and provide Canadians with improved access to non-patented prescription drugs (Romanow 2002: 208).

Since most new patented drugs were produced outside Canada, and a large share of generic drugs produced in Canada, the extension of longer patent protection resulted in a sharp increase in imports and little growth in the domestic industry (figures 7a–7d).

Figure 7a:
Exports, Pharmaceutical Industry

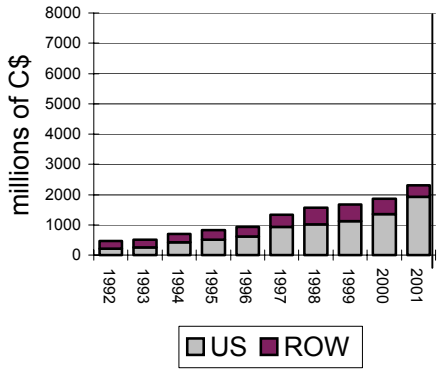


Figure 7b:
Imports, Pharmaceutical Industry

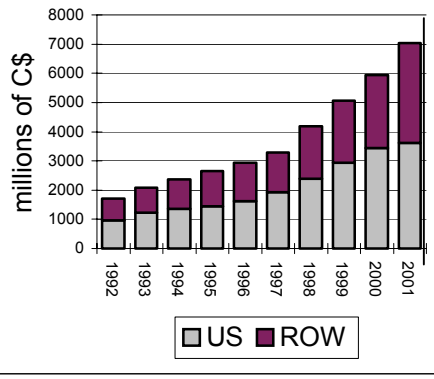


Figure 7c:
Domestic Consumption,
Pharmceuticals

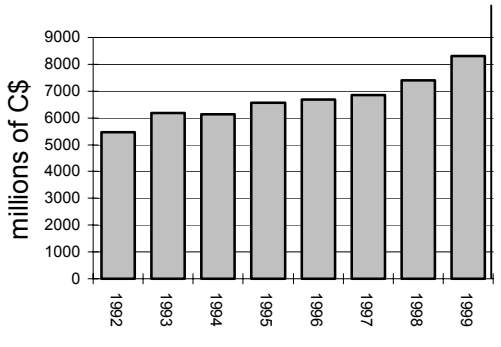
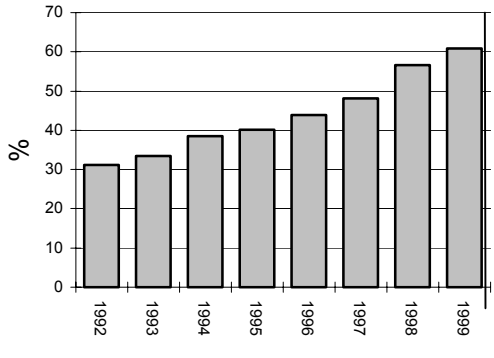
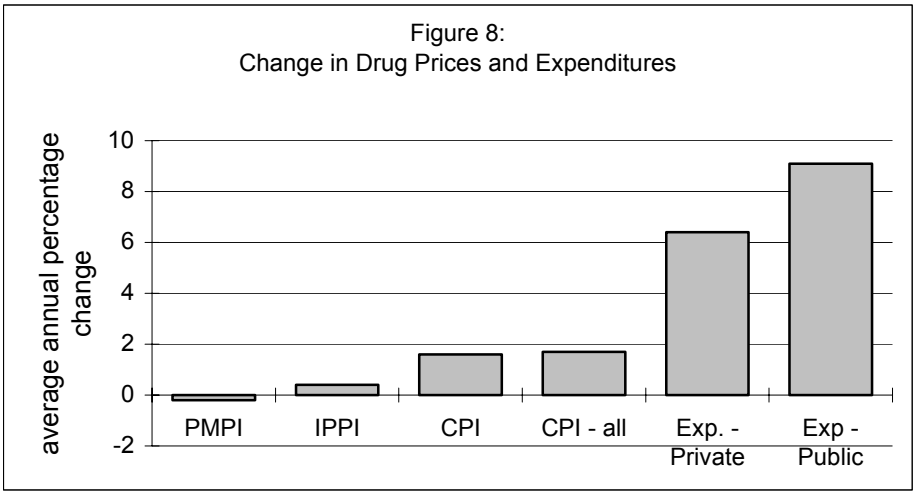


Figure 7d:
Import Share, Pharmaceuticals



Drug prices in Canada — whether measured in terms of new patented medicines, the average price on all domestically produced drugs at the factory level, or the average price for all drugs paid by consumers — remained remarkably stable over the past decade, generally growing at a slower rate than the average price of all goods and services in Canada.

Figure 8 and Appendix tables 7 and 8 summarize the annual rate of increase in drug prices and the rate of increase in expenditures on drugs over the period 1992–2001. The price of drugs can be measured according to three different indices: the Patented Medicine Price Index (PMPI), the Industrial Product Price Index (IPPI, or the cost of domestically produced drugs as they leave the factory gate), the Consumer Price Index (CPI-P) for pharmaceuticals, and the overall Consumer Price Index (CPI) for all goods and services. The apparent stability in prices, however, contrasts sharply with evidence of rising expenditures on drugs.



There has been a marked increase in the spending on drugs. As Figure 8 illustrates, expenditures by both private consumers and public health care plans increased at an alarming rate over the decade. On a per capita basis, expenditures by consumers rose from $182 to $306 annually, while public spending more than doubled from $91 to $195 per year. In both cases, there was a significant increase in the percentage of total health care spending on drugs.

This is evidence of a dramatic shift in the *composition* of drug consumption, in favour of newer patented medicine and away from older patented drugs and generics. As Green Shield Canada (1998), a private insurer, first pointed out, much of this change in the composition of drug consumption occurred through the practice of physicians substituting newer, more expensive drugs for older, less costly ones and the average cost of a prescription rose as a result.

In short, the promised benefit to consumers of lower prices through the elimination of tariff barriers has not materialized. To the contrary, extended patent protection on pharmaceuticals, produced largely outside Canada, has resulted in a dramatic increase in the cost of medicine to Canadians, through both their own private consumption and the costs imposed on provincial health insurance plans.

Patterns in Trade of Health Services

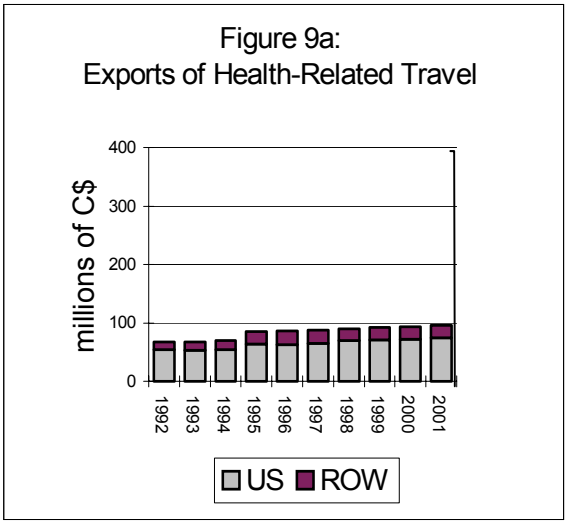
In both NAFTA (chapters 11 and 12) and the WTO's GATS, Canada accepted several specific obligations concerning international trade and investment in services. In addition,

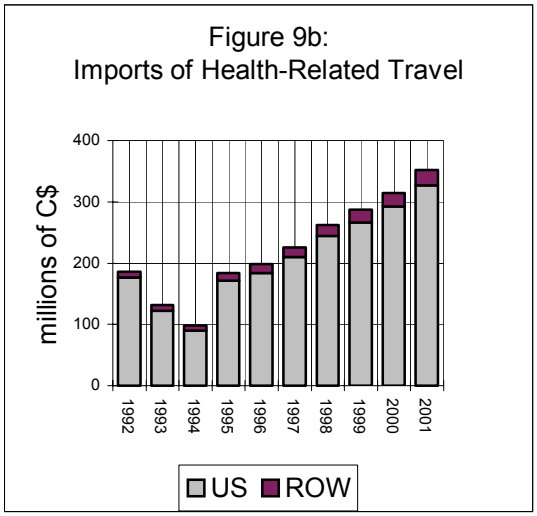
the current negotiations in the Doha round of the WTO and in the FTAA are largely concerned with expanding the scope of trade in services, including such areas as health care and education.

Under these agreements, in return for Canadian businesses gaining greater access to foreign markets, Canada must permit the entry of foreign firms. This brings the commercial interests of foreign companies directly into conflict with many publicly funded social programs, and raises the spectre of the erosion of the government's ability to provide or regulate directly services in education and health care.

The vulnerability of Canada's public health system has received the greatest attention in this regard. Johnson (2002: 29) noted that the current "core" of Canada's health care system — services currently covered by provincial health insurance plans — is shielded in Annex 1 of NAFTA, which exempts them from specific commitments regarding market access to foreign firms. He adds, however, that Annex 1 represents a "one-way street": the government's ability to expand into areas currently supplied by private producers is impeded, while in the event of an erosion in public coverage, the "national treatment" and "market access" provisions of NAFTA (and GATS) become effective. In other words, if continued financial pressures on provincial governments' ability to maintain an adequate level of health care services results in further reductions in the coverage of provincial health insurance plans and increased privatization of some services, foreign firms must be accorded the same treatment as domestic suppliers in competition to deliver private services. This implies that governments would be unable to discriminate in favour of not-for-profit hospitals and other service providers as opposed to for-profit institutions. As Johnson (2002: vi) warned, "the trade liberalizing agreements present more challenges than opportunities."

These changes represent future threats to Canada's public health care program arising out of trade agreements. The current trade statistics, however, do not illustrate any of these changes, although as figures 9a and 9b suggest, there has been a significant increase in the extent to which Canadians travel to the United States for health-related services. But the trade agreements do illustrate pressure for greater privatization of services, which has, and is, leading to the entry of foreign-owned firms into the health care industry. As provinces close hospital beds, remove various forms of care and medication from public health insurance coverage, and out-source services ranging from food preparation to home care, the "national treatment" and "market access" provisions of NAFTA and GATS commit Canada to allowing foreign firms into the industry. By accelerating the pressure toward a private health care system, trade liberalization intensifies the economic insecurity of the most vulnerable members of society by obliging them to compete in the marketplace for necessary health care services.





Trade in Health Services and Products, and Women with Disabilities

The women with disabilities who contributed to this study had much to say about the extent to which drug prices affected their lives and some trade issues related to pharmaceuticals. Most, however, had not used private health care services. This in itself reinforces the patterns noted above: that while there is a threat to services under the trade agreements, significant privatization has not yet occurred.

Medications and Women with Disabilities

Costs of drugs and coverage by public health plans were the two most critical issues for the women with whom we talked. For some, like one ethno-racial woman in Toronto, coverage by a provincial health plan dictated which medicine she was able to use.

> *I only use medications that are covered by OHIP [Ontario Health Insurance Plan]. If something that is prescribed is not covered, then I have to change it for an alternate medication that is covered.*

A woman in Halifax noted that Nova Scotia fails to cover her medications completely.

> *With the medication I've tried, there's only one I can use and it's not completely covered by MSI [Medical Services Insurance] and it costs me, there's two medications [which] cost me almost $50 a month out of pocket that they don't cover, and that's big time.*

For an Aboriginal woman in Halifax, some, but not all, of her medications are covered under the federal plan for Aboriginal peoples.

> *I have medications, but I don't know in reference to trade what it means, but they're medications that I need that won't be paid for by Community Services, but I am fortunate enough that I am of Aboriginal descent so I can get some*

> *things through my status, that way. But there are medications that would be helpful that will not be paid for at all.*

There was considerable disparity in costs for medication when women with disabilities were employed rather than on a public income assistance plan. For women with disabilities on provincial social assistance programs, prescription drugs are usually covered. This is not true for those who receive income under the Canada Pension Plan/Disability. Once women with disabilities enter the labour force, they usually lose this coverage and add some considerable expenses to their lives.

> *You may have to be a person who is on social assistance for instance to have any drugs covered at all, whereas if you're a working disabled person and we know this, you are the working poor. How are you going to afford your medications and all the things you need* (Woman in Winnipeg)?

But accepting support for medications from a public program can have its drawbacks. One woman from Halifax suggested that she has to buy older and less effective medicine if she wants to keep her costs covered.

> *I don't use private health care services, because I can't afford it, that's my barrier, but it's certainly available if I had the money. My situation is that I'm working right now and paying my bills and so on, but my medications are paid for by Community Services, and if I earn more than what I would have been budgeted before when I was with Community Services for my rent and food and medication, everything together, if I make more than that I'm going to end up paying for my medication which is $300 a month, whereas if I keep making sort of a low amount of money they'll continue to pay for them, but there have been times when for example, I need medication for cholesterol and I can't get the best medication because, well I could if I wanted to pay for it, so now I'm on an older medication which isn't so good but it is covered, so my choices are somewhat limited that way.*

As a result of this disparity, many women with disabilities feel they have little choice but to remain out of the labour force to ensure their medication costs are covered.

One woman with disabilities from Winnipeg suggested that the changes to patent laws linked to the trade agreements make her situation much more difficult.

> *Because I'm working, again it's the working poor thing, because I'm working I don't have access to free drugs or whatever. Some of the newer [drugs] that have less side effects are more expensive than the ones that they used to use or that are older. And again there's the patent laws and so they might not even be covered, there are quite specific drugs at least in my experience that I need that are related specifically to my disability and they are very very expensive and often not covered, and I just have to give it up…. I substitute with a less-effective medication perhaps, or not at all and try to cope, go*

> *without for a week because I can't afford it this week, because the medications cost $200 for a month and that affects my day-to-day life.*

Trade affects not only price, but also perceived access to appropriate drugs for some women with disabilities. For one woman in Winnipeg, to get what she needed, she had to go across the border.

> *I would wish that with our trade agreements that there could be sort of a better flow of drugs that are accepted in Canada, and I'll give you an example. With my disability…I get migraines, lots of migraines. There's a drug I can buy over the counter in the U.S. and it's just fabulous, because if I didn't have that there's many, many days I wouldn't be able to work, like every second day of my life. So I have to go down to the U.S., and then I can buy the biggest bottle I can get.*

For another in Halifax, getting it from the United States posed problems, but she wasn't sure of the trade obstacles.

> *There is a medicine that I need to have that's available in the States but not in Canada. You can't buy it in Canada, you can go to the States and buy an amount for your personal use and bring it back, but you're not allowed to order it by mail, something about customs.*

Access to appropriate medications for women with disabilities includes not only access in terms of costs, but also availability of appropriate medications within the Canadian health system or at minimum, across the U.S. border. As the woman from Winnipeg illustrates, there are different drug approval processes in Canada and the United States. This means that some medications may be available in one country but not in the other. Some may argue that this is not a trade policy issue. Yet as the women point out, if our trade policies recognized and reflected the disparities in access for women and men with disabilities, they would have to also address the disparities in the drug approval processes.

Health Services Privatization and Women with Disabilities

Most of the women with disabilities we talked with had not had any experience with the privatization of health services. But, as one woman in Winnipeg noted, this doesn't mean they do not see it coming as a result of the trade agreements.

> *My understanding about the issue is that there has been pressure from medical companies in the States to move into Canada, and they've been saying that since we have free trade they should be able to just move in here and that's unfair trade practice.*

Nor does it mean they agree with the privatization or potential privatization of health care, as one ethno-racial woman from Toronto says.

> *I have never used private health care, thank God. If we pay for health care through our taxes, why do we have to go with private health care? Something must be going wrong or missing from our process. If you have to use private*

> *health care because you can't use the public system, then there should be limits on how much you pay for it. The government should cover most of the cost. If I need a service that is not available through the public system, what other choices do I have especially in terms of health? It is unfair for me to support public health care and then have to pay extra for private health care, as well. There is something missing there.*

An ethno-racial woman from Toronto argues that the trade policies pursued by the federal government affect the provincial and local government policies, which, in turn, affect her life.

> *The governmental policies with the United States affect the local agencies. It is a cycle. The policy gets made and then it is passed down to the local agencies which pass it on to their clients. One effect triggers everything.*

Many of the women with disabilities also recognized that for them to continue to be a part of society they would need to have consistent health services provided. As one woman in Calgary described, there is some worry that privatization would create further barriers to access to health care.

> *Privatization is setting up a two-tier system and it will be for people who are employed and employer costs…. Can be very limiting that is [in] what is covered, what doctors you can go to. I would rather see the money stay in public health care.*

While privatization of health products and services was not a big issue at this point, the women with disabilities were clear that most of them were not interested in losing their public health care system.

Trade in Health Services and Products, and Policy Recommendations

For women with disabilities, the increased pharmaceutical prices that are related to Canada's entry in international trade agreements, together with the move to increasing privatization of health services, have both had significant impacts.

As significant users of pharmaceuticals, many women with disabilities face enormous monthly costs to cover medications. Many rely on public programs, including provincial social assistance, to cover these costs. But eligibility for these programs, in most provinces, is limited to those who are unable to work. As a result, women with disabilities who face high drug costs must either remain out of the labour force and have the public support for their pharmaceuticals, or go into the work force and become part of the "working poor" — using a high proportion of their income to pay their drug costs. This lack of support for medication costs provides a disincentive to work for many women with disabilities, and reinforces the idea that they cannot be productive members of Canadian society, even though many would choose to work if they had the appropriate supports.

Uncertainty about the status of public health services also has an impact on women with disabilities. For most of the women we spoke with, private health services were not yet a

significant part of their lives, but they worried about what would happen if they began to lose some of the pieces of the health care system that currently provide significant support. The future possibility of privatized health care, coupled with an increased interest by people with disabilities in managing their own care, leaves women with disabilities more vulnerable to market forces in obtaining their care, and may undermine or further reduce public programs.

As a result of these concerns, women with disabilities identified several areas for further policy work.

10. In developing trade policies, DFAIT needs to recognize the lack of access issues created by the disparity in costs in health products between Canada and the United States, and create an appropriate mechanism to address this variation for people with disabilities who require these products.

11. DFAIT should ensure that, within existing and developing trade policies, common accessibility standards (including the provision of interpreters in emergency health care settings) that support existing national legislation are implemented.

12. DFAIT should ensure international trade agreements, both those existing and those still to be implemented, do not disrupt access to publicly funded home care.

13. Companies from the United States selling health care products and assistive devices should be encouraged to set up franchises in Canada to increase the accessibility and affordability of these items to the consumers.

5. ACCESS TO TRADE INFORMATION AND SERVICES FOR WOMEN ENTREPRENEURS WITH DISABILITIES

The economic situation, in addition to personal inclination, of many women with disabilities may lead them to consider entrepreneurship as an option. As Gail Fawcett (1999) illustrated, women with disabilities experience greater poverty rates than women without disabilities or men with or without disabilities. A significant proportion of women and men with disabilities remain out of the paid labour force entirely. Between 1993 and 1994, over half (56.8 percent) of working-age women with a disability remained out of the paid labour force for the entire two-year period, compared to only 15.3 percent of women without disabilities. Women with disabilities typically earn less than either women without disabilities or men with disabilities. Women and men with disabilities are more likely to be the sole providers of family income than women and men without disabilities. Almost one in ten women with disabilities is a single parent (Fawcett 1999). For women and men with disabilities, employment is often reliant on employer attitudes and willingness to accommodate their situations (Bunch and Crawford 1998). This has led an increasing number of women with disabilities to consider self-employment as an option.

More and more women are embarking on the challenges and opportunities of entrepreneurship. In 2000, women entrepreneurs held majority ownership in 15 percent (and some degree of ownership in 45 percent) of Canada's small and medium-sized enterprises (Industry Canada 2003). However, statistics on the number of women with disabilities who are self-employed were virtually non-existent. In a review of the literature (Neufeldt et al. 1999), only one study on women with disabilities and self-employment was uncovered. In May 1996, Employment Action (a non-profit society) undertook research on women entrepreneurs with disabilities for the Women's Enterprise Society of British Columbia. The main objectives of the project were to raise awareness among women with disabilities of generic business supports and services on self-employment as a viable option and to develop strategies to support these entrepreneurs. The study provided no statistics on the number of women with disabilities across Canada or in British Columbia who were self-employed at the time and, to the knowledge of researchers at the Canadian Centre on Disability Studies, no follow-up has been done by the Women's Enterprise Society of British Columbia.

In May 1997, the Network for Entrepreneurs with Disabilities (NEWD) undertook a study of its 171 members to update their information on the barriers experienced by entrepreneurs with disabilities and to make recommendations for overcoming these barriers (NEWD 1998). Of the 61 responses received, 31 percent were women with disabilities. Respondents expressed a desire for independence, understanding and respect, the removal of disincentives to pursuing self-employment, especially on a part time basis, and help to level the playing field with non-disabled entrepreneurs. Recommendations were offered to address these issues.

Entrepreneurship for people with disabilities and for women has been supported by federal and provincial governments and by private sector organizations. For example, Western Economic Diversification funds business loans and training programs to assist entrepreneurs with disabilities living in urban and rural areas of the western provinces to develop and launch their own businesses while the Atlantic Canada Opportunities Agency funds NEWD in Nova

Scotia to offer similar supports. The National Network for Mental Health assists those with mental health disabilities who wish to pursue self-employment, and the Opportunities Fund of Human Resources Development Canada has supported entrepreneurship-related projects. Associations of entrepreneurs with disabilities, such as the Network of Entrepreneurs with Disabilities Manitoba and NEWD, have also formed. Generic resources, such as Canada Business Service Centres and Women's Enterprise Centres, have begun to increase the accessibility of their services to those with disabilities. However, focus group participants noted that the entrepreneurship resources for those with disabilities do not address the specific concerns of women entrepreneurs with disabilities.

Entrepreneurs who are interested in trade can access resources through the Canadian Trade Commissioner Service, which includes a special section on Businesswomen in Trade.[7] Our analysis of this site indicates it does not address issues of specific concern to women with disabilities nor does it indicate that it meets current accessibility guidelines.

Despite these services, the women with disabilities in our study, both those who identified themselves as entrepreneurs and those who did not, expressed a lack of knowledge generally on trade agreements and specific information about the requirements especially around importing (or exporting) assistive technology.

Information about Entrepreneurship

Several women were interested in how they could become entrepreneurs and felt they did not know where to begin or where (or even if) they could get the necessary supports and training.

> *If I were going to set up my own business, I would need devices and computer programs. I want to be able to facilitate that including how to develop and build. The costs are also an issue. I would like to be an entrepreneur, but there are barriers preventing me from doing that* (Deaf woman in Winnipeg).

> *I want to run my own business as a home care worker. I am not sure how to start with that process* (Deaf woman in Winnipeg).

Information about Visas and Insurance

For those women who already identified themselves as entrepreneurs, there were specific issues around working across borders. Some women in Winnipeg worried their disability could be a detriment to getting a visa and insurance to do work in the United States, which raises an issue of whether there is a bias inherent under the trade agreements that limit the mobility of certain segments of the population. This concern is not new or unique. Macdonald (2003, 48) found that "[n]ew trade agreements like NAFTA and the General Agreement on Trade in Services (GATS) also contain provisions on services that allow the migration of certain categories of highly educated, well-paid professionals (usually men) while restricting the movement of other categories of workers". The woman from Winnipeg found this bias to be directly related to her disability.

> *I know for insurance, for instance, if something happens to me I just cannot be insured anymore, because of [my disability]…. What I'm concerned about too, is I may decide I want to go to work in the U.S. and getting health insurance, whatever, that could be an issue, I don't know if it's possible [because of my disability]. That is a trade issue as far as people with disabilities crossing the border* (Woman entrepreneur in Winnipeg).

> *One of the things that I'm planning to do is to do both workshops and consultation in the U.S. One of the issues is the kind of visas that you need to go and do that kind of work. Other people I know actually do this and it's a little bit scary, because let's say I was going to do a workshop down there, it's a T1 Visa it's called and you can't get it until you're actually crossing the border. So you book this workshop and it's that day as you're crossing the border that you apply for it and then the person at Immigration at the border gives it to you. So I'm a little bit concerned about that, but other people say oh no, no, no problem, but I just think, whew.*
>
> Another participant: *What if they refuse?*
>
> *Well, you go back home. Then there would be another kind of visa that you would have to get, like if I was going to go down there for two weeks to do a consultation that would be a kind of a different visa, so I'm in that process of looking into it but its not straightforward. In fact I'm going to have to go to an immigration kind of a lawyer because I don't have my ducks in order. So those are the kind of issues I'm concerned about* (Woman entrepreneur in Winnipeg).

What the participant does not make explicit are the problems with this type of visa process for some people with disabilities. For example, if someone had mobility challenges or fatigue, undertaking the process described above could be impossible to do independently.

Information about Customs, Tariffs or Standards

Information about how U.S. and Canadian customs, tariffs or standards worked were also difficult to access for one entrepreneur when she was importing from the United States.

> *I didn't get enough information about how the customs process worked, how imports and exports worked, etc. when I started my shop. More information could be provided through training courses, perhaps through the ILRC [Independent Living Resource Centre]. SEED Winnipeg did not cover anything to do with exports and imports, permits, etc. When you are shipping goods to some locations, you need special permits. That information should be readily available without having to dig for it. It is also difficult to get information from Canada Customs on the phone, as sometimes you get tied up in their automated phone system. Customs needs to offer a training course offering information about how to do your paperwork correctly, how to streamline things. The course could be done through the Urban Entrepreneurs Program*

> *at ILRC or through Canada Customs. It could also be done through NED [Network of Entrepreneurs with Disabilities]. Anyone going into business needs this type of information. Unless you can find all your suppliers in Canada (which is next to impossible) you need a course like this. You may get better prices from the U.S.*
>
> *Depending upon the goods you are importing, there are different tariff laws. The laws differ with the situation. It would be difficult to put this kind of information on a Web site, as it is too complicated. I imported goods to put in my product. Customs wanted to know if these goods had passed CSA standards and if they were labelled correctly. There are different duties and tariffs depending upon the products. This stuff is really frustrating.*
>
> *If Canada Customs were going to establish a Web site, they could provide information on what is required to import and export to different places and a number to call for further information. That might be impossible, because it would take person hours to do. Getting someone on the phone who knows something about these issues is also very important* (Woman entrepreneur in Winnipeg).

Another challenge related to customs was the required paperwork. This is especially challenging for people with visual impairments or difficulties using their hands. It could also pose a problem for those with learning disabilities.

> *Customs can also simplify some of their forms. We need a certificate for Customs which comes with the goods to say they were manufactured in the U.S. If that paper happened to be missing from your shipment, your goods could be tied up in Customs for days until they got the documentation from the United States. Why do Customs need that certificate if the imports are covered under NAFTA unless the goods are coming from another country? Customs should penalize those companies that do not provide certificates or they establish a database of companies that produce goods in the U.S. so the certificate won't be necessary. That is the only way I can see around it* (Woman entrepreneur in Winnipeg).

Information about Brokers

Few of the women we spoke with knew anything about the role of brokers in trade and the benefits or drawbacks in using their services. Licensed customs brokers are responsible for collecting the duty for goods imported into Canada. They charge a fee for their services.

One entrepreneur from Winnipeg describes her experiences.

> *I had no difficulties when it came to importing the products themselves. Part of the agreement was that the company I bought the products from paid for the shipping and the brokerage fees. Brokerage relates to the fact that a company does the paperwork and passes it through customs for you. If you use a broker, and it is not covered by the company shipping the goods to you,*

> *then you have to pay a fee yourself. If I used a broker, this formed a financial barrier, particularly when struggling to start a business. If I bypassed the broker and did the customs paperwork myself, I would have to redo it if it was not exactly the way customs wanted it. This was a waste of time.*

Not using a broker, which was, for this woman more financially viable, meant that she had greater barriers as a result of her disability.

> *Then I would have to pick up the shipment from customs myself and, when I asked them to help me carry a box to my car because of my disability, they would say it wasn't in their job description. Customs paperwork is very confusing unless you do it all the time or have someone show you how to do it. If you don't know how to do the paperwork, you are better off to use the broker, which costs more and is a financial barrier. When you are importing thousands of dollars worth of goods, the fee is assessed on a percentage basis. After I factor in the cost of my goods, this makes it harder to compete.*
>
> *To fix the problems around getting through customs, customs should set up a training course on their regulations and how to do their paperwork. The course could be given at ILRC, NED or somewhere else. They could also make an exception for entrepreneurs with disabilities where you could send your paperwork to customs and they allow you to have your shipment couriered to you instead of having to go there yourself, stand in line and perhaps find out that you had not done the paperwork correctly* (Woman entrepreneur in Winnipeg).

People with mobility, visual, learning or hearing disabilities may all face similar challenges without changes to the existing customs systems. They may be unable to access the offices of or get appropriate accommodations like sign language when visiting a broker. Most brokers do not have the resources to make the relevant paperwork available in multiple and alternate formats for people who are print disabled. An alternative as noted in the recommendations is to eliminate brokerage fees for entrepreneurs with disabilities and have those costs taken on by the government.

Access to Trade Information and Services, and Policy Recommendations

Women with disabilities generally knew little about trade and how it affected their lives. More women are interested in becoming entrepreneurs, but feel they need additional supports or training. Some were aware of training that had taken place earlier, but weren't sure if it was still available. Several mentioned networks of entrepreneurs with disabilities in their own region, but none mentioned the Canadian Trade Commissioner Service's Businesswomen in Trade program.

Women entrepreneurs with disabilities felt they had little information about importing and exporting or undertaking work in the United States. They felt that they faced additional barriers as a result of their disabilities. Ethno-racial women had even further challenges associated with obtaining relevant information in a language they understood. As a result,

many women with disabilities failed to see themselves as engaged or able to speak authoritatively about trade issues and the impact on their lives. Even as entrepreneurs, they felt they did not have enough information or appropriate access to be able to engage successfully in international trade.

14. DFAIT should undertake a systematic analysis of all its trade policies using a disability lens to identify the challenges and opportunities for women and men with disabilities.

15. DFAIT and private industry should develop and advertise a Web site about international trade policies and their impact on women and men with disabilities. Information should be available in multiple formats.

16. The CCRA, other federal agencies, non-profit organizations and private industry should provide workshops on customs regulations associated with importing goods and services, and how to complete the necessary paperwork.

17. The CCRA should develop a user-friendly, accessible Web site with relevant customs information for entrepreneurs, including a list of telephone/teletypewriter numbers to call for clarifications or questions.

18. The Canadian Trade Commissioner Service's Businesswomen in Trade section should provide and include in its Web site specific information about access and inclusion issues for women entrepreneurs with disabilities who want to engage in trade.

19. Entrepreneurs with disabilities should create a national network of support and networking, with particular emphasis on recruiting and supporting women entrepreneurs with disabilities.

6. CONCLUSIONS

Trade policies often seem removed from the lives of people in general and, more particularly, the lives of women with disabilities. This research has shown, however, that there is a direct link between trade policies and practices, and the quality of the lives of women with disabilities. Women with disabilities have failed to benefit from the liberalization of trade with the United States over the past decade. Rather, their lives have become more difficult as a result of the liberalization of trade. For some women with disabilities, the changes that have resulted from trade have been ones that affect their survival.

Many women with disabilities rely on public programs for their income and supports. One indirect feature of trade is the reduction in support for public programs. As a result, these women with disabilities have had to bear the direct costs of obtaining assistive technologies, health services and products. Trade has not reduced the costs in these three areas. As a result, women with disabilities have faced additional barriers that prevent them from entering or remaining in the paid labour force. This makes them more reliant on public programs or unable to get the appropriate devices or services.

Trade for women with disabilities, and likely for all people with disabilities, is shaped by inappropriate assumptions about the role of the medical profession in their lives. Assistive devices have been defined exclusively using medical categories, rather than reflecting the usage and experiences of people with disabilities. Medical professionals have become gatekeepers for accessing assistive technologies, even when they have no expertise in the area. Those who are most knowledgeable about their own needs, the consumers, are prevented from obtaining their own devices, unless they are willing and able to incur the related expenses.

Women with disabilities are also disadvantaged by their own lack of knowledge about trade and their confidence in speaking about the impact trade can have on their lives and in effectively using their buying power as consumers. Few Canadians know or feel they can speak confidently on trade, but for women with disabilities, their lack of knowledge can mean they are left with fewer options in an area that greatly affects their lives.

This lack of knowledge about the effects of trade on women with disabilities is reflected in the general literature on trade. As far as we are aware, this is the first study of its kind looking at how women with disabilities, or people with disabilities generally, are affected by trade. As such, it is an initial foray into new research territory.

Much more can and should be written, including studies that reflect more broadly on the situation of all Canadian women and men with disabilities. This means looking at the situation of women in Quebec, a more focussed look on issues for Aboriginal women with disabilities, issues for women at different points in the life cycle, the differences that arise when women have responsibility (especially as sole support parents) for children, and a comparison of the issues for women and men with disabilities. Additional data are needed

to strengthen our understanding of the trade issues that affect women with disabilities, including data by province on privatization of home care services, sample surveys of people with disabilities which document out-of-pocket expenses related to disability; and health outcomes data for women with disabilities across the life cycles. Detailed data tracking linking the data on disability supports available through the Participation and Activity Limitation Survey (PALS) to the source for these aids and devices, and income would be useful.

This study illustrates that trade policy affects the lives of individual Canadians; trade is not simply about the exchange of goods and services. It reminds us to ensure that when we look at trade we need to listen to how trade practices affect people differently. The participants remind those responsible for developing and implementing trade policies in both the public and private sectors, that they need to be involved in these discussions. Their interests have not been represented to date, and they are the ones who live with the ongoing costs of this exclusion.

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APPENDIX A: METHODOLOGY

Research Objectives

How can Canadian trade policies ensure access and inclusion for women with disabilities? This was the research question for the study.

To find the answer, the project examined how women with disabilities from a variety of backgrounds (including regions, types of disabilities and ethno-racial backgrounds) were affected as consumers of health services and assistive devices, and as entrepreneurs involved in trade as a result of the changes to trade between Canada and the United States during the 1990s (including the adoption and implementation of the North American Free Trade Agreement in 1994). The study had the following objectives.

- Identify any changes to the provision of health services and support and their implications for women with disabilities over the past decade.
- Identify any changes to trade in assistive devices and their implications for women with disabilities over the past decade.
- Identify any changes to the access and capacities of women entrepreneurs with disabilities to engage in trade-related activities over the past decade.
- Assess the access and inclusion for women with disabilities within existing trade policies with the United States.
- Identify changes to existing policies and criteria for future trade policy development to ensure access and inclusion for women with disabilities.

Project Personnel

Project personnel included the following individuals: Dr. Deborah Stienstra, Royal Bank Research Chair, Canadian Centre on Disability Studies, (CCDS) project team leader and principal investigator; Dr. Aileen Wight Felske, research co-investigator; and Colleen Watters, Research Associate with the Canadian Centre on Disability Studies and project manager.

Four research assistants were hired to conduct focus groups in Winnipeg (for participants who were deaf), Halifax, Toronto and on Vancouver Island. They included Rita Bomak in Winnipeg, Nadia Stuewer in Halifax, Rabia Khedr in Toronto and Cathy La France on Vancouver Island. These individuals were responsible for identifying participants, and organizing, facilitating and reporting on the focus groups held in their respective cities. Rabia Khedr also recruited five ethno-racial women with disabilities for individual interviews in Toronto. The project manager organized and conducted the focus group for women with disabilities in Winnipeg and undertook the individual interviews with ethno-racial women in Winnipeg. Aileen Wight Felske, was responsible for data gathering from women with disabilities in Calgary.

Hui-Mei Huang, a graduate student and Hugh Grant, a faculty member of the Department of Economics at the University of Winnipeg, undertook the economic data analysis of trade statistics. Lindsey Troschuk, a CCDS research assistant, conducted the literature review and assisted with other research gathering tasks as required.

Project Advisory Committee

An advisory committee was constituted to offer overall direction and advice to the project, and review and comment on data gathering tools, data analysis, recommendations and reports. All advisory committee work took place via four conference calls. Partner groups included the Council of Canadians with Disabilities, Disabled Women's Network Canada, the Network for Entrepreneurs with Disabilities and the Cowichan Community Economic Development Cooperative. These organizations were provided with honorariums of $500 per group for their participation. Mary Frances Laughton of the Assistive Devices Industry Office of Industry Canada, Gerry Martin, Director, Centre for Women in Business at Mount St. Vincent University, Shannon Campbell of Western Economic Diversification and Dana Peebles of Kartini International (with expertise in the area of gender and trade) also joined the committee. Attempts were made to locate a representative from the Atlantic Canada Opportunities Agency, but these efforts were unsuccessful.

Project Activities

The project began in April 2002 and concluded on March 31, 2003.

At the outset, the project was reviewed for ethical considerations and approved by the CCDS Ethical Review Task Force.

Project activities included the following.

Literature Review
In an extensive literature review, the researchers located literature on assistive devices and people with disabilities in relation to trade, gender and trade, women and trade, and health services. However, there was very little pertaining to women with disabilities and trade, so it was necessary to draw correlations. In addition, the research assistant examined government programs related to entrepreneurship and disability, and the provision of assistive devices to people with disabilities. Much literature was located in relation to the privatization of health care services.

Focus Groups
The focus groups investigated how trade policies in relation to assistive devices and health care services affected the lives of women with disabilities. In addition, the groups explored how trade affected women entrepreneurs with disabilities in terms of the goods and services they needed to purchase (particularly from the United States) to operate their businesses.

Four focus groups were held in Winnipeg, Halifax and Toronto. These included three sessions for women with disabilities and women entrepreneurs with disabilities and one focus group in Winnipeg for women who are deaf, which was conducted in American Sign

Language. Aileen Wight Felske experienced some difficulty in recruiting and organizing a focus group in Calgary, so she conducted interviews with four women with disabilities.

The research assistant in British Columbia chose to conduct the focus group on Vancouver Island as an on-line session to accommodate the participation of women with disabilities living at a distance from one another. She had some difficulty getting this group up and running, as it took time to find a listserv that was accessible to consumers with a variety of needs related to adaptive technology, and recruiting was also challenging. An accessible listserv through Yahoo Groups was set up, and three women participated.

The Advisory Committee recommended that a seventh focus group be convened to review the findings once data analysis was completed. This session took place in March 2003 and enabled participants to verify the findings and suggest changes to the draft project report, which was distributed to them prior to the focus session.

Interviews with Ethno-Racial Women

With the assistance of the Ethno-Cultural Program of the Society for Manitobans with Disabilities in Winnipeg, interviews were conducted with three ethno-racial women. Program facilitators were present to provide translation services, since the participants' first language was not English. The Ethno-Racial People with Disabilities Coalition (ERDCO) in Toronto recruited and interviewed five participants in August 2002. Summaries of the findings of the interviews with the ethno-racial women with disabilities are integrated into the data analysis section of this report.

E-Mail Discussion Group

Due to the fact that only a select number of women with disabilities across the country could participate in the focus groups and individual interviews, the Project Advisory Committee recommended that an e-mail discussion group be set up to enable a greater number of women to share their views on how trade policies affect their lives. Disabled Women's Network Canada offered to assist in facilitating this group.

As a means of testing the waters to see how many women with disabilities might be interested in participating in this type of group, we extended an invitation to subscribers to both the DAWN Canada and DAWN Ontario listservs. The response was disappointing, as only two individuals were interested. Due to the low response rate, the listserv was not set up. It may be that some women with disabilities on the DAWN lists have basic needs for food, shelter, transportation, employment, etc., which are not being met and to which they must devote a great deal of attention. It may also be that, despite the circulation of background material, many women with disabilities have a difficult time conceptualizing how issues such as free trade have an impact on their lives.

Economic Data Analysis

Mei-Hui Huang, a graduate student and Hugh Grant, a faculty member in the Department of Economics at the University of Winnipeg, undertook the economic analysis of recent Canadian trade statistics and their implications for Canadians with disabilities. The findings are included in this report. Their anaysis was subject to the following limitations. The focus on people with disabilities was restricted to their role as *consumers* of particular commodities and

did not consider their role as producers; only two broad merchandise commodity categories (assistive devices and pharmaceuticals) and their associated industries (medical supplies and devices and pharmaceutical manufacturing) were examined due to data availability, and coverage was restricted to the period between 1992 and 2001, which includes implementation of the FTA in 1989, NAFTA in 1994 and completion of the Uruguay round of negotiations under the WTO in 1995.

Interviews With Vendors, Program Co-ordinators and Policy Makers in the Assistive Devices Area

During January 2003, we conducted 12 interviews with vendors, program co-ordinators/policy makers of assistive devices for persons with disabilities, brokers and those knowledgeable in the area of border issues. Respondents included four program co-ordinators/policy makers (three in Manitoba and one in Saskatchewan), one assistive devices researcher/developer in Ontario, seven vendors (four in Manitoba, one in Ontario and two in Newfoundland and Labrador) and two Manitoba-based brokers. Unfortunately, one vendor and the two brokers did not submit signed consent forms (despite requests to do so), so they cannot be quoted in the analysis. The vendors included three who sold products for persons who are blind or visually impaired (two also handled devices for those with learning disabilities), two facilities that dealt with mobility, orthopaedic and prosthetic devices (one also carried mastectomy and ostomy supplies), a vendor that stocked one specific product for individuals with learning disabilities and one company marketing several varieties of devices for children. Among other things, these included Dragon NaturallySpeaking and transfer boards.

Project Advisory Committee members and contacts known to the CCDS in British Columbia, Saskatchewan, Ontario and Nova Scotia were approached to provide names of possible interviewees. The Assistive Devices Industry Office compiled a list of 40 vendors of aids and devices for persons with hearing, visual, learning and mobility devices for people with disabilities, and we contacted three Manitoba vendors known to the research team. In selecting potential respondents, we attempted to choose two or three vendors in each of the above-mentioned categories to interview and then approached them by telephone and e-mail. In making selections, we endeavoured to achieve representation from as many of the 10 provinces as possible. Attempts were also made to reach policy makers/program co-ordinators in all the provinces.

Unfortunately, many of the vendors did not return phone calls or respond to e-mails. Despite several attempts, we were unable to interview a company that manufactured or sold hearing devices. We successfully interviewed program co-ordinators/policy makers in Manitoba and Saskatchewan, but a contact with the Alberta Aids to Daily Living Program felt that participating in the current project was not a priority for her. The director of the B.C. government program did not return phone calls and the contact at the Assistive Devices Program (ADP) in Ontario indicated he could not sign the consent form but instead referred the researcher to the communications section of his department to obtain a signature. However, he provided the address of the program Web site where a wealth of information was available. We were unable to obtain the names of program co-ordinators and policy makers in Quebec, Nova Scotia, Newfoundland and Labrador, and New Brunswick.

Questions for Focus Group Participants and Individual Interviews

1. If you have purchased assistive devices such as specialized software, screen readers, magnification equipment, scanners, wheelchairs, walkers, etc., how easy or difficult has it been for you to obtain these aids and devices?

If you experienced difficulties obtaining them, what barriers did you encounter?

Do you know whether these barriers are related to trade agreements, particularly between Canada and the United States?

What steps can be taken to eliminate these barriers?

2. If you have used private health care services and products (such as private home care services or drugs not covered under publicly funded programs), how easy or difficult has it been for you to obtain these?

If you have experienced difficulties using these products and services, what barriers did you encounter?

Do you know whether these barriers are related to free trade agreements, particularly between Canada and the United States?

What steps can be taken to eliminate these barriers?

3. Can you think of ways in which Canadian trade policies can be changed to increase the accessibility of assistive devices, health care products and services and information about trade for you as a woman with a disability?

4. Some of you who are entrepreneurs mentioned that you buy goods and services from United States companies or sell your own goods and services to the United States. How easy or difficult is it for you to work with U.S. firms?

What barriers do you encounter along the way?

Do you know whether these barriers are related to free trade agreements, particularly between Canada and the United States?

What steps can be taken to eliminate these barriers?

Consent Form for Participants in Focus Groups and Individual Interviews

July 2002

I _____ agree to take part in the project entitled: Women with Disabilities Accessing Trade, which examines how Canadian trade policies can ensure access and inclusion for women with disabilities.

This project looks at how women with disabilities from a variety of backgrounds (including regions, types of disabilities, and ethno-racial backgrounds) have been affected as consumers of health services and assistive devices, and as entrepreneurs involved in trade as a result of the changes to trade between Canada and the United States during the 1990s (including the adoption and implementation of the North American Free Trade Agreement in 1994).

I understand that this research is being conducted by a research team led by Deborah Stienstra at the Canadian Centre on Disability Studies (CCDS), and that interviews are being carried out by CCDS research assistants. This research is funded by Status of Women Canada and has been approved by the CCDS Ethics Review Committee.

I understand that my taking part involves answering a series of questions (either in an individual interview or in a focus group about women with disabilities and trade). The focus group will last approximately two hours. The questions will be distributed to me prior to the focus group/interview.

No direct quotations from the interview/focus group attributed to me will be used without my prior written permission.

I agree that the interview/focus group will be tape recorded to allow the researchers to review and transcribe the discussion. The audio tape will be erased after the discussion has been transcribed. Names of focus group participants, unique personal characteristics, etc. will not be included in any research reports or other publications without the participants' written permission.

Data obtained in focus groups or individual interviews will be kept confidential, and focus group participants will be asked not to reveal the identities of other participants. I understand, however, that the CCDS cannot guarantee that other participants will comply with this request.

I understand that the principal investigator, the project manager and the research assistants conducting the focus groups and interviews will have access to the gathered data. I also understand that the written focus group and interview data will be stored at the CCDS for a period of three years following completion of the project and then will be destroyed.

I understand that the focus group and interview data will be analyzed and will be included in a report on the project, which will be provided to the funders, Status of Women Canada.

I understand that my participation is voluntary and that I may withdraw from the study at any time without penalty by contacting the researchers. I also know that I may refuse to answer any questions.

I understand that I will receive an honorarium of $50 for my participation.

I understand that if I have any further questions about the study, I can contact the researchers by phone at the Canadian Centre on Disability Studies, 287-8411 or by e-mail at ccds@disabilitystudies.ca. I can also contact the Principal Investigator, Deborah Stienstra at the same number or by e-mail at d.stienstra@uwinnipeg.ca.

I understand that, if I have any ethical concerns about the research, I can contact the Chairperson of the CCDS Research Committee at 56 The Promenade, Winnipeg, Manitoba, R3B 3H9.

In situations where informed consent cannot be obtained in writing due to the nature of a disability, tape recorded consent will be accepted.

Participant signature _____

Contact information _____

_____

_____

Date _____

Researcher signature _____

Date _____

One copy to participant and another to the researcher.

Questions for Vendors, Program Co-ordinators and Policy Makers of Assistive Devices Programs for Persons with Disabilities

Questions for Vendors

1. A. What aids and devices do you currently sell?

   B. How are decisions made in terms of the brands of products you carry, price, number of items ordered, process of getting items to the consumers, etc.?

   C. Do you know whether international trade agreements have an impact on the types of products you carry, number of each item purchased, price, etc.?

   D. Do you know whether international trade agreements have an impact on customers in terms of price, selection, etc.?

2. Do you plan to make any changes in the types of products you sell? If yes, what changes do you plan to make and why?

Questions for Co-ordinators of Assistive Devices Programs

1. A. What aids and devices, assistive technology, etc. does your program currently fund for consumers?

   B. What percentage of the costs of these devices does your program fund?

   C. How are decisions made with respect to program policies, the devices you fund, who is eligible, the vendors chosen to carry your devices, etc.?

2. What information about the availability of aids and devices and funding options does your program provide to consumers with disabilities, disability organizations, income support programs, community groups, vendors, etc.?

3. Do you know whether international trade agreements have an impact on the types of devices your program covers and other policy decisions within your program with respect to funding, eligibility criteria, the vendors chosen to carry your devices, etc.? If international trade agreements have an impact, what is the nature of this impact?

4. What changes do you feel could be made in your program to enhance its ability to address the needs of consumers with disabilities?

Questions for Those with Knowledge of Customs and Border Issues

1. When devices and assistive technology for persons with disabilities are ordered from the United States, on what types of products will duty be charged? What products are exempt?

2. A. How are decisions made with respect to duty, customs charges, brokerage fees, etc. and on which products these will be applied?

B. What are the policies with respect to brokerage fees, duty and customs on aids and devices and assistive technology?

C. If individuals with disabilities are charged brokerage fees or customs duty on aids and devices which are exempt, is there a process whereby these fees can be recovered? If so, what is this process?

3. A. What information is provided to individuals with disabilities about customs, brokerage fees, duty, exemptions on aids and devices and assistive technology?

   B. What information is provided to persons with disabilities about the process for recovering those fees (where applicable)?

   C. What changes would you recommend in the types of information that is provided to consumers?

4. Do you know whether international trade agreements have an impact on customs charges, duty and brokerage fees on aids and devices? What is the nature of this impact?

5. What policy changes would you recommend with respect to duty, brokerage and customs fees applied to assistive devices for persons with disabilities?

6. A. Should uniform standards be implemented on aids and devices for persons with disabilities available in Canada and the United States? If yes, please explain. If no, please explain.

   B. What types of uniform standards should be implemented?

Consent Form for Individual Interviewees Assistive Devices Program Co-ordinators, Policy Makers and Vendors

November, 2002

I _____ agree to take part in the project entitled, Women with Disabilities Accessing Trade, which examines how Canadian trade policies can ensure access and inclusion for women with disabilities.

This project looks at how women with disabilities from a variety of backgrounds (including regions, types of disabilities, and ethno-racial backgrounds) have been affected as consumers of health services and assistive devices, and as entrepreneurs involved in trade as a result of the changes to trade between Canada and the United States during the 1990s (including the adoption and implementation of the North American Free Trade Agreement in 1994).

I understand that this research is being conducted by a research team led by Deborah Stienstra at the Canadian Centre on Disability Studies (CCDS), and that interviews are being carried out by the project manager. This research is funded by Status of Women Canada and has been approved by the CCDS Ethics Review Committee.

I understand that my taking part involves answering a series of questions in an individual interview about the accessibility of assistive devices and technology to women with disabilities. The interview will last approximately 30 to 45 minutes. The questions will be distributed to me prior to the interview.

No direct quotations from the interview attributed to me will be used without my prior written permission.

I agree that the interview will be tape recorded to allow the researchers to review and transcribe the discussion. The audio tape will be erased after the discussion has been transcribed. Names of interviewees, unique personal characteristics, etc. will not be included in any research reports or other publications without the participants' written permission.

Data obtained in individual interviews will be kept confidential.

I understand that the principal investigator and the project manager conducting the interviews will have access to the gathered data. I also understand that the written interview data will be stored at the CCDS for a period of three years following completion of the project and then will be destroyed.

I understand that the interview data will be analyzed and will be included in a report on the project, which will be provided to the funders, Status of Women Canada.

I understand that my participation is voluntary and that I may withdraw from the study at any time without penalty by contacting the researchers. I also know that I may refuse to answer any questions.

I understand that if I have any further questions about the study, I can contact the researchers by phone at the Canadian Centre on Disability Studies, 287-8411 or by e-mail at ccds@disabilitystudies.ca. I can also contact Deborah Stienstra, Principal Investigator, at the same number or by e-mail at d.stienstra@uwinnipeg.ca.

I understand that, if I have any ethical concerns about the research, I can contact the Chairperson of the CCDS Ethics Review Committee at 56 The Promenade, Winnipeg, Manitoba, R3B 3H9.

In situations where informed consent cannot be obtained in writing due to the nature of a disability, tape recorded consent will be accepted.

Participant signature _____

Contact information _____

_____

_____

Date _____

Researcher signature _____

Date _____

One copy to participant and another to the researcher.

APPENDIX B: TABLES

Table 1: Selected Tariff Rates Under WTO Agreement

Tariff Item Number	Description of Products	Base Rate of Duty		Bound Rate of Duty		Initial Negotiating Right	Other Duties and Charges	Final Implementation Date
		Ad Valorem (%)	Other U/B	Ad Valorem (%)	Other			
1	2	3		4		5	6	7
8713	***Invalid carriages (wheelchairs)***							
8713.10.00	Not mechanically propelled	9.2	B	0.0				1999
8713.90.00	Other	9.2	B	0.0				1999
9019-20	***Mechano-therapy appliances***							
9019.10	Mechano-therapy appliances; massage apparatus; psychological aptitude-testing apparatus							
9019.10.10	Mechano-therapy appliances; power-operated massage apparatus; psychological aptitude-testing apparatus	9.2	B	0.0				1999
9019.10.20	Manually operated massage apparatus	13.6	B	0.0				1999
9019.20.00	Ozone therapy, oxygen therapy, aerosol therapy, artificial respiration or other therapeutic respiration apparatus	4.8	B	0.0				1999
9020.00.00	Other breathing appliances and gas masks, excluding protective masks having neither mechanical parts not replaceable filters	0.0	B	0.0				
9021	***Orthopaedic appliances***							
	Artificial joints and other orthopaedic or fracture appliances:							
9021.11.00	Artificial joints	9.2	B	0.0				1999
9021.19.10	Plaster bandage splints	10.0	U	0.0				1999
9021.19.20	Surgical trusses and suspensory bandages; orthopaedic abdominal supports	17.5	B	0.0				1999
9021.19.30	Other orthopaedic or fracture appliances	0.0	B	0.0				
	Artificial teeth and dental fittings:							
9021.21.00	Artificial teeth	0.0	U	0.0				
9021.29.10	Dental fittings but not including dental prostheses	0.0	U	0.0				
9021.29.20	Dental prostheses including dentures, bridges and crowns	10.2	U	0.0				1999
9021.30.00	Other artificial parts of the body	0	B	0.0				
9021.40.00	Hearing aids, excluding parts and accessories	0.0	B	0.0				
9021.50.00	Pacemakers for stimulating heart muscles, excluding parts and accessories	9.2	B	0.0				1999
9021.90.00	Other	9.2	B	0.0				1999

Source: WTO, Tariff Schedule V - Canada. Part I - Most-Favoured Nation Tariff.

Table 2: Canada's International Trade, 1992-2001, Total Trade and Selective Commodities (millions of Canadian dollars)

Commodity	Trade	Area	1992	2001	% Change (1992 base year)	% Change (2001 base year)
Assistive Devices	Exports	US	18	91	406.0	80.2
		ROW	64	66	3.1	3.0
		Total	81	157	93.9	48.4
	Imports	US	253	462	82.6	45.2
		ROW	55	204	271.0	73.0
		Total	309	666	115.5	53.6
Pharmaceuticals	Exports	US	213	1,833	761.0	88.0
		ROW	214	363	70.0	41.0
		Total	428	2,196	413.0	81.0
	Imports	US	816	3,175	210.0	67.8
		ROW	556	3.120	169.0	62.8
		Total	1,372	6,295	385.0	68.7
All Merchandise Trade	Exports	US	125,670	350,734	179.1	64.2
		ROW	37,158	51,731	39.2	28.2
		Total	162,828	402,466	147.2	59.5
	Imports	US	96,470	218,306	126.3	55.8
		ROW	51,548	124,687	142.0	58.7
		Total	148,018	342,993	131.7	56.8

Source: Derived from Statistics Canada data, available on Industry Canada's Strategis Web site <http://strategis/gc/ca>. Accessed October 2002.

Table 3: Trade by Commodity Classification, 1992-2001, Selected Assistive Devices (millions of Canadian dollars)

Commodity (Code)	Tariff			1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Wheelchairs (HS8713)	9.3	Exports	US	1	10	14	24	26	31	30	27	22	12
			ROW	3	3	2	3	4	5	5	4	5	5
			Total	4	12	15	27	30	37	35	31	27	17
		Imports	US	17	16	16	16	16	20	29	31	33	40
			ROW	3	2	3	3	2	4	6	6	9	11
			Total	20	18	18	19	18	24	35	36	42	50
Ozone, oxygen or aerosol therapy (HS 901920)	Free	Exports	US	6	6	7	14	11	9	13	12	16	16
			ROW	1	2	3	5	4	5	9	9	11	14
			Total	6	8	10	19	16	13	22	21	27	30
		Imports	US	49	50	42	43	40	48	57	66	54	61
			ROW	7	6	9	13	10	13	14	30	35	49
			Total	55	56	51	56	50	61	70	96	89	109
Orthopaedic appliances (HS 9021)	Free	Exports	US	11	15	13	15	17	21	28	31	41	63
			ROW	60	63	64	73	76	72	86	76	65	47
			Total	70	78	77	87	94	94	115	107	106	110
		Imports	US	187	221	244	274	270	292	347	343	355	362
			ROW	46	49	59	56	58	68	97	132	135	145
			Total	233	270	303	330	328	360	444	475	490	507
Total		Exports	US	18	31	34	53	54	61	72	70	79	91
			ROW	64	67	68	81	85	82	101	89	81	66
			Total	81	98	102	133	139	144	172	159	160	157
		Imports	US	204	237	259	290	285	312	376	373	388	401
			ROW	49	51	61	58	61	72	103	138	145	156
			Total	302	339	363	391	386	432	536	577	586	618

Source: Derived from Statistics Canada data available on Industry Canada's Strategis Web site. <http://strategis.g.ca>. Accessed October 2002.

Table 4: Trade by Industry Classification, 1992-2001, Medical Equipment and Supplies (NAICS 339110)
(millions of Canadian dollars)

Trade	Area	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Exports	US	151	146	178	219	230	263	309	342	358	406
	ROW	109	128	131	175	224	217	232	168	137	114
	Total	261	273	309	394	454	480	542	510	495	521
Imports	US	900	1,008	1093	1,139	1,142	1,311	1,597	1,706	1,688	1,912
	ROW	398	428	469	535	558	668	750	835	907	1,055
	Total	1,298	1,436	1562	1,674	1,700	1,979	2,347	2,541	2,595	2,967
Apparent domestic market		1,818	1,953	2,141	2,132	2,243	2,777	3,219	3,502	3,838	4,287
Exports/Domestic Market		14.3%	14.0%	14.4%	18.5%	20.2%	17.3%	16.8%	14.6%	12.9%	12.1%
Imports/Domestic Market		71.4%	73.5%	73.0%	78.5%	75.8%	71.3%	72.9%	72.6%	67.6%	69.2%
Estimated Domestic Production*		781	791	888	853	996	1,278	1,413	1,470	1,738	1,841
Production/Consumption		43.0%	40.5%	41.5%	40.0%	44.4%	46.0%	43.9%	42.0%	45.3%	42.9%

Note:
*Estimated as (Apparent Domestic Market) – (Imports) + (Exports).

Source: Industry Canada, Strategis <http://strategis.gc.ca>. Accessed February 1, 2004.

Table 5: Trade by Commodity Classification, 1992-2001, Pharmaceuticals (millions of C$)

Commodity (Code)	Tariff	Trade	Area	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Organo-sulphur compounds (HS 2930)	10-12.5	Exports	US	4	3	5	6	7	7	9	12	7	7
			ROW	5	5	7	8	5	6	8	8	3	1
			Total	8	8	12	13	12	13	16	20	10	8
		Imports	US	23	28	40	41	43	50	61	48	39	37
			ROW	19	21	18	26	23	38	36	67	123	94
			Total	42	49	58	67	66	88	97	115	161	131
Sugars, chemically pure, their ethers, esters and salts (HS 2940)	9.2-10	Exports	US	0	0	0	0	0	0	0	0	0	0
			ROW	0	0	2	1	0	3	5	3	2	2
			Total	0	0	2	1	0	3	5	3	2	2
		Imports	US	2	0	1	1	5	1	1	1	9	18
			ROW	3	5	3	3	4	4	7	10	7	5
			Total	6	5	4	4	9	4	8	11	15	23
Glands and other organs; heparin and its salts; human or animal substances not elsewhere stated - therapeutic uses (HS 3001)	9.2-10.2	Exports	US	49	59	70	80	60	63	124	113	114	141
			ROW	1	2	2	1	2	2	0	0	1	1
			Total	50	61	72	82	61	64	125	114	115	142
		Imports	US	4	5	4	7	6	5	8	7	8	9
			ROW	2	2	3	3	3	6	8	5	5	6
			Total	5	7	7	10	10	11	16	12	13	15
Blood and blood preparation (HS 3002)	0-9.8	Exports	US	35	34	36	39	34	36	56	140	113	148
			ROW	48	51	47	51	52	61	50	49	42	39
			Total	82	85	83	90	86	97	106	189	155	187
		Imports	US	117	156	184	145	140	175	253	301	254	338
			ROW	24	26	35	40	49	66	104	75	120	298
			Total	140	182	219	185	189	241	357	375	375	635

(Table 5 cont'd)

Commodity (Code)	Tariff	Trade	Area	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Medicament (HS 3003)	0-9.5	Exports	US	20	21	32	29	30	49	71	77	98	42
- not put up in measured doses			ROW	23	30	21	20	20	20	18	26	9	5
nor packed for retail use			Total	44	52	53	49	50	69	89	103	107	47
		Imports	US	25	22	37	38	67	98	144	157	159	92
			ROW	16	16	13	24	28	32	26	27	19	27
			Total	41	39	50	61	95	130	170	184	178	119

Source:
Derived from Statistics Canada data available on Industry Canada's Strategis Web site <http://strategis.gc.ca>. Accessed February 1, 2004.

Table 6: Trade by Commodity Classification, 1992-2001, Pharmaceuticals (continued)
(value in millions of Canadian dollars)

Commodity (Code)	Tariff	Trade	Area	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Medicament (HS 3004)	0-9.5	Exports	US	81	115	243	314	418	690	648	636	880	1,398
			ROW	98	119	119	153	172	220	342	313	247	247
			Total	179	234	362	467	590	910	990	949	1,127	1,645
		Imports	US	536	385	734	823	949	1,130	1,430	1,864	2,379	2,471
			ROW	468	537	653	768	818	908	1,260	1,623	1,878	2,562
			Total	1,004	922	1,387	1,591	1,767	2,038	2,690	3,487	4,257	5,033
Dressings and similar articles (HS 3005)	9.5-22.5	Exports	US	16	17	24	37	33	43	47	53	61	35
			ROW	1	3	3	20	13	21	17	18	4	5
			Total	17	20	28	57	45	64	65	70	65	41
		Imports	US	27	30	31	38	45	54	58	61	63	77
			ROW	10	13	10	16	16	22	30	27	33	36
			Total	37	43	41	54	62	76	88	89	96	113
Other - chemical preparations for pharmaceutical use	0-12.5	Exports	US	8	7	12	10	13	27	37	55	45	63
			ROW	38	40	65	60	82	81	120	110	106	62
			Total	46	46	77	70	95	108	157	165	151	125
		Imports	US	83	87	107	113	131	107	105	122	159	132
			ROW	15	16	22	23	24	34	34	39	66	92
			Total	97	102	129	136	155	141	139	161	224	225
Total*		Exports	US	213	256	422	515	595	913	993	1,086	1,318	1,833
			ROW	214	250	266	314	345	414	560	528	414	363
			Total	428	505	689	829	940	1,327	1,553	1,614	1,732	2,196
		Imports	US	816	714	1,138	1,206	1,386	1,620	2,061	2,562	3,070	3,175
			ROW	556	636	757	903	965	1,110	1,505	1,873	2,250	3,120
			Total	1,372	1,350	1,895	2,109	2,351	2,730	3,566	4,435	5,320	6,295

Notes:
*n “Total” includes “pumps (with measuring device) other than for dispensing fuel or lubricants.”

Source:
Derived from Statistics Canada data available on Industry Canada’s Strategis Web site <http://strategis.gc.ca>. Accessed October 2002.

Table 7: Trade by Industry Classification, 1992-2001, Pharmaceutical and Medicine Manufacturing (NAICS 3254) (millions of Canadian dollars)

Trade	Area	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Exports	US	205	259	430	516	607	929	1,012	1,114	1,360	1,932
	ROW	262	257	265	300	333	398	550	567	494	374
	Total	467	516	694	816	940	1,327	1,562	1,681	1,853	2,307
Imports	US	975	1,236	1,359	1,448	1,628	1,925	2,395	2,928	3,452	3,617
	ROW	729	836	1,001	1,195	1,300	1,373	1,801	2,126	2,477	3,428
	Total	1,704	2,072	2,360	2,643	2,928	3,298	4,196	5,054	5,929	7,045
Apparent domestic market		5,474	6,189	6,123	6,577	6,680	6,857	7,408	8,336	9,556	11,531
Exports/consumption		8.5%	8.3%	11.3%	12.4%	14.1%	19.3%	21.1%	20.2%	19.4%	20.0%
Imports/consumption		31.1%	33.5%	38.5%	40.2%	43.8%	48.0%	56.6%	60.6%	62.0%	61.1%
Apparent domestic production*		4,237	4,623	4,458	4,749	4,692	4,886	4,774	4,962	5,480	6,793
Production/consumption		77.4%	74.8%	72.8%	72.2%	70.2%	71.2%	64.4%	59.5%	57.4%	58.9%

Note:
*Estimated as (Apparent Domestic Market) – (Imports) + (Exports).

Source:
Derived from Statistics Canada data available on Industry Canada's Strategis Web site <http://strategis.gc.ca>. Accessed February 2004.

Table 8: Pharmaceutical Prices in Canada, 1992-2001
(annual percentage change)

	Pharmaceuticals			All Commodities
Year	**Patent Medicine Prices**	**Industry Prices**	**Consumer Prices**	**Consumer Prices**
1992	2.1	3.6	2.2	1.5
1993	0.1	0.9	2.9	1.8
1994	-0.7	-0.4	0.9	0.2
1995	-1.9	-0.7	-0.1	2.2
1996	-2.2	0.0	0.4	1.6
1997	-0.1	-0.2	-0.4	1.6
1998	-0.1	-0.7	2.2	0.9
1999	0.2	0.4	2.0	1.7
2000	0.4	1.0	2.8	2.7
2001	0.1	0.3	3.0	2.6
Average	-0.2	0.4	1.6	1.7

Sources:
Patent Medicine: Patented Medicine Price Index (PMPI), Canada. Patent Medicine Prices Review Board.
Industry: Industrial Product Price Index (Pharmaceuticals), Statistics Canada.
Consumer: Consumer Price Index (Pharmaceuticals), Statistics Canada.
All Consumer Goods: Statistics Canada.

Table 9: Public and Private Expenditure on Drugs
(millions of dollars and as a % of total health care spending)

	Total Expenditures		Per Capita Spending		As % of
Year	$ million	% change	$ million	% change	Health Care Spending
Private					
1992	5,610	10.0	198	8.7	31.0
1993	6,135	9.4	214	8.1	31.4
1994	6,350	3.5	219	2.3	31.0
1995	6,737	6.1	230	4.9	31.7
1996	7,029	4.3	237	3.2	32.1
1997	7,811	11.1	261	10.0	33.5
1998	8,511	9.0	282	8.0	34.8
1999	8,905	4.6	292	3.8	34.0
2000	9,162	2.9	298	2.0	34.1
2001	9,496	3.6	306	2.7	33.9
Average		6.5		5.4	
Public					
1992	2,854	11.7	101	10.4	5.5
1993	2,958	3.6	103	2.4	5.7
1994	2,998	1.3	103	0.2	5.7
1995	3,262	8.8%	111	7.6	6.2
1996	3,214	-1.5	108	-2.5	6.1
1997	3,467	7.9	116	6.8	6.3
1998	3,863	11.4	128	10.4	6.5
1999	4,418	14.4	145	13.4	7.0
2000	5,150	16.6	168	15.6	7.5
2001	6,054	17.5	195	16.4	8.1
Average		9.2		8.1	

Table 9 (cont'd)

Year	Total Expenditures		Per Capita Spending		As % of
	$ million	% change	$ million	% change	Health Care Spending
Total					
1992	8,464	10.6	299	9.3	12.1
1993	9,093	7.4	317	6.2	12.7
1994	9,348	2.8	322	1.6	12.8
1995	9,999	7.0	341	5.8	13.5
1996	10,243	2.4	346	1.3	13.7
1997	11,278	10.1	377	9.0	14.4
1998	12,374	9.7	410	8.7	14.8
1999	13,323	7.7	437	6.8	14.9
2000	14,312	7.4	466	6.5	14.9
2001	15,550	8.6	501	7.6	15.2
Average		7.4		6.3	

Source:
Canadian Institute for Health Information.

Table 10: Trade in Health-Related Travel,* 1992-2001
(millions of C$)

Trade	Area	1992†	1993†	1994†	1995	1996	1997	1998	1999	2000	2001
Exports	US	55	53	55	64	63	65	70	71	72	75
	ROW	13	14	15	21	23	22	20	21	22	21
	Total	68	67	70	85	86	87	90	92	94	96
Imports	US	176	122	90	171	184	210	244	266	292	327
	ROW	10	10	8	13	14	16	18	21	22	25
	Total	186	132	98	184	198	226	262	287	314	352

Notes:
*"Health-Related Travel" refers to all expenditures in another country by medical patients.
†Data prior to 1995 is limited to hospital and physician charges paid under provincial health plans for Canadian residents and is, therefore, not strictly comparable to figures for 1995-2001.

Source:
Statistics Canada (2002b).

Table 11: Assistive Devices Programs

Name of Program	Administered by	Devices Covered	Eligibility Criteria
Alberta			
Alberta Aids to Daily Living (AADL)	Ministry of Health and Wellness	Back supports, bathing and toileting equipment, catheter supplies, compression garments, custom made footwear, dressing supplies, electro-larynx, hearing aids (under age 18 or over 65), hospital beds, incontinence supplies, injection supplies (not provided for insulin injections), patient lifters, mastectomy prostheses, ostomy supplies, oxygen, orthotic braces, prosthetic devices, respiratory equipment, specialized seating devices, wheelchair cushions, wheelchairs (manual and power), walkers	People who have a chronic disability (six months or more) or illness, and terminally ill people: Alberta resident with a valid personal health care number
British Columbia			
SET-BC	Ministry of Education of BC	Equipment ranges from access enhancing tools, to screen review software, speech output devices, and adapted computer systems. SET-BC selects equipment for the Loan Bank according to a variety of factors, including student need, cost, durability, technical support and availability	Students from Kindergarten to Grade 12 who are residents of British Columbia.
Adult Services Program	NA	Special technology	Post-secondary education students with disabilities and employees with disabilities who use adaptive technologies
Manitoba			
No comprehensive program, only special programs noted below			
The Breast Prosthesis Program	Manitoba Health	Breast prostheses and surgical brassieres	Persons who have had a single mastectomy may claim two prostheses every four years and two surgical brassieres every year
Eyeglasses Program	Manitoba Health	Eyeglasses	All Manitoba residents over the age of 65

Table 11 (cont'd)

Hearing Aid Program	Manitoba Health	Hearing aids (analog or digital; ear molds and ear impressions)	Manitoba residents under the age of 18 who require a hearing aid, as prescribed by an otolaryngologist or audiologist
Orthopaedic Shoes Program	Manitoba Health	Orthopaedic shoes (stock or custom made)	All Manitoba residents under 18 years of age
Prosthetic Eye/Infant Contact Lens Program	Manitoba Health	Prosthetic eyes and infant contact lenses (single or bilateral)	All Manitoba residents who require artificial eyes or cosmetic shells as prescribed by a physician, or corrective contact lenses as prescribed by a medical practitioner; Manitoba Health will provide one lens per eye, per infant
Prosthetic and Orthotic Program	Manitoba Health	Limb and spinal orthotic or prosthetic devices and services	All Manitoba residents who require these services, as prescribed by medical practitioner
Telecommuni-cations Program	Manitoba Health	Telecommunications equipment, including TTYs and pagers	All Manitoba residents who are profoundly deaf or speech impaired. Only 80% rebate is given, once every five years
Transportation Subsidy	Manitoba Health	Covers transportation costs to the nearest approved facility where treatment is available	Manitoba residents who have been referred out of Manitoba by Manitoba specialists
Aids to the Blind	Canadian National Institute for the Blind (CNIB)	Brailled watches, tape recorders	Residents who are blind or with severe visual impairments
Manitoba Community Wheelchair Program	Society for Manitobans with Disabilities (SMD)	Wheelchairs and other mobility devices	Based on medical need; referral by physician
New Brunswick			
Health Services Program	Department of Health	Certain basic items not ordinarily covered by Medicare or private health plans (wheelchairs, bathroom aids, patient lifts, walkers, repairs, replacement parts, hearing aids, orthopedic items, ostomy supplies, prosthetic items, oxygen and other respiratory equipment, etc.)	Social assistance clients and their dependants; individuals who have special health needs and qualify under Section 4.4 of the *Family Income Security Act* and Regulations for extended health care; children with special needs who are clients of the Community Based Services for Children with Special Needs Program (CBSCSN), where the family demonstrates financial need

Table 11 (cont'd)

Vehicle Tax Reimbursement Program	Department of Finance	Refund the 8% provincial portion of the Harmonized Sales Tax (HST) or 15% Provincial Vehicle Tax (PVT) on private sale transactions for persons with disabilities	Vehicle is specially equipped with a device to enable a wheelchair or scooter to enter or leave the passenger vehicle; or the vehicle is specially equipped with auxiliary driving controls
Seniors Rehabilitation Equipment Program	Funded by the Department of Health and Community Services but administered by the Canadian Red Cross	Standard and specialized equipment on loan to aid functional capacity for everyday living to maintain seniors' ability to remain in the community; mobility equipment	Seniors over 65 in nursing homes
Training and Employment Support Services (TESS) for Persons with Disabilities program	Department of Training and Employment Development	Training and employment services that enable persons with disabilities to achieve their occupational goal or obtain employment	Application process; physician referral
Financial Assistance for People with Disabilities	Dept of Transportation	Financial assistance with the purchase and installation costs of vehicle equipment/ features required due to driver(s) or regular passenger(s) disability, such as a wheelchair/scooter lift for the vehicle, ramps, floor/door alterations, restraint tie-downs, special needs seating, handcontrols, etc.	Requests must be approved by Dept of Transportation
Newfoundland and Labrador			
None	NA	NA	NA
Northwest Territories			
None	NA	NA	NA

Table 11 (cont'd)

Nova Scotia			
Community Transportation Assistance Program	Ministry of Transport	Includes transportation services in rural and semi-rural Nova Scotia	Individuals with a long-term disability who can't use public transportation
Nunavut			
None	NA	NA	NA
Ontario			
Assistive Devices Program and Home Oxygen Programs	Administered by the Operational Support Branch of the Ontario Ministry of Health and Long-Term Care	Covers over 8,000 separate pieces of equipment or supplies in 11 device categories, including prostheses, wheelchairs/mobility aids and specialized seating systems, enteral feeding supplies, monitors and test strips for insulin-dependent diabetics, hearing aids, respiratory equipment, orthoses, visual and communication aids, and oxygen and oxygen deliver equipment. The program pays up to 75% of the cost of equipment such as artificial limbs, orthopaedic braces, wheelchairs, breast prostheses, and breathing aids. For hearing aids, it contributes a fixed amount. Home oxygen supplies and equipment.	Residents of Ontario (with a provincial health number) who have had a disability for six months or longer
Prince Edward Island			
Disability Supports Program	Disability Supports and Services, Dept of Health and Social Services	Based on individual assessments, includes a contribution by the individual or family based on ability to pay down to a minimum as outlined in a Client Contribution Schedule. Can include bathroom aids, bedroom aids, ostomy supplies, communication devices, feeding equipment supplies, hearing aids, orthotic devices, prosthetic Devices, visual aids, wheelchair, positioning and ambulation aids, and applied behaviour analysis materials.	People up to age 64 who have a functional limitation as a result of disability which limits their ability to carry out activities for independence and well-being. Disabilities exclude mental illness, must be continuous or recurrent and likely to last more than 1 year

Table 11 (cont'd)

Quebec			
Hearing Devices	Regie de l'Assurance Maladie	hearing aid	Persons with hearing loss; coverage varies by age and level of hearing loss
Visual Devices	Regie de l'Assurance Maladie	Reading aids, such as tape recorders, closed-circuit television systems, optical systems and calculators, writing aids (such as conventional typewriters and braillers), mobility aids (such as white canes and electronic obstacle detectors)	Persons insured under the Quebec Health Insurance Plan who are blind or have low vision
Ostomy Appliances	Regie de l'Assurance Maladie	Ostomy appliances	Persons insured under the Quebec Health Insurance Plan who have undergone a permanent colostomy, ileostomy or urostomy of which the permanent nature is attested to by a medical certificate
Devices that Compensate for Physical Deficiencies	Regie de l'Assurance Maladie	Purchase, adjustment, replacement, repair and, in certain cases, adaptation of walking aids, standing aids, locomotor assists and posture assists as well as their components, supplements and accessories; the purchase, adjustment, replacement and repair of orthotics and prosthetics. The program does not cover three-wheeled or four-wheeled scooters, but does cover the adjustment and repair of these devices if they were paid for by the Office des personnes handicapées du Quebec prior to November 12, 1998.	Persons insured under the Quebec Health Insurance Plan who have a physical deficiency and meet the program's eligibility requirements
External Breastforms	Regie de l'Assurance Maladie	For each breast, the amount of $200, payable every two years beginning with the date of the operation or, in the case of aplasia, the date of the medical report.	All women insured under the Quebec Health Insurance Plan who have undergone a total or radical mastectomy, and for women age 14 and over who have a total absence of breast formation, medically diagnosed as aplasia
Ocular Prostheses	Regie de l'Assurance Maladie	For each eye, a reimbursement for the cost of purchasing or replacing an ocular prosthesis once per five-year period, to a yearly allowance for the repair and maintenance of the prosthesis.	Any person insured under the Quebec Health Insurance Plan who requires an ocular prosthesis (artificial eye)

Table 11 (cont'd)

Saskatchewan			
Saskatchewan Aids to Independent Living (SAIL)	Ministry of Health	Othopaedic services (prosthetic appliances, orthotic devices, specialized adaptive seating and custom built footwear), and home respiratory services (home oxygen therapy, respiratory equipment), excluding persons eligible under other departments or agencies of the government of Canada, the Workers' Compensation Board Saskatchewan Government Insurance or residents of general rehabilitation or extended care hospitals.	Referral by specialist, physician or physiatrist
Paraplegia Program	Ministry of Health	Financing for certain drugs, incontinence supplies, specialized rehabilitation equipment, hand controls, ramps and wheelchair lifts	Referred by physiatrist
Cystic Fibrosis Program	Ministry of Health	Certain drugs, food supplements and digestants	Referred by physician
End Stage Renal Disease Program	Ministry of Health	Certain drugs are covered	Referred by the dialysis unit at a hospital
Ostomy Program	Ministry of Health	Reimbursement for ostomy supplies	Referred by enterstomal therapists
Aids to the Blind Program	SAIL provides funding to CNIB	Braille watches, talking calculators and low-vision eyewear	
Special Needs Equipment Program	operated by the Saskatchewan Abilities Council under contract with SAIL	Mobility aids, environmental aids	
Yukon			
None	NA	NA	NA

ENDNOTES

[1] There are not significant differences in the percentages of men and women citing these reasons for unmet needs for assistive devices.

[2] For full details, please see Appendix A.

[3] *Individuals with Disabilities Education Act* (IDEA) 20, USC, Ch. 33, 1401, 25, US.

[4] See Table 3 for details.

[5] See Table 10 for the details on the assistive devices program in each province.

[6] We could not verify to what extent this system has been successful in Australia, but from the accounts we were able to locate, there has been some transfer of government funds to private sector manufacturers to support this.

[7] <http://www.dfait-maeci.gc.ca/businesswomen/moreabout-en.asp>. Accessed December 15, 2003.

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