Trade Agreements, Home Care and Women's Health

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

March 2004

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National Library of Canada cataloguing in publication data

Hankivsky, Olena

Trade agreements, home care and women's health [electronic resource]

Issued also in French under title: Accords commerciaux, soins à domicile et santé des femmes.
Includes bibliographical references.
Issued also in print format.
Mode of access: Status of Women Canada Web site.

ISBN 0-662-36065-6 No de cat. SW21-109/2004E-PDF

1. Home care services – Government policy – Canada.
2. Women – Health and hygiene – Social aspects – Canada.
3. Canada – Commercial treaties – Social aspects.
4. Medical policy – Canada.
5. Sexual division of labor – Canada.

I. Morrow, Marina Helen, 1963- .
II. Canada. Status of Women Canada.

RA645.37C3H36 2004 362.14'0871 C2004-980033-7

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ABSTRACT

This report seeks to further the understanding of the consequences of trade liberalization for Canadian women in the specific health sector of home care. The report identifies health relevant trade agreements and the sections that have implications for the Canadian health care system. Aspects of the agreements that have particular significance for women's health, women's labour in the health care sector and women's equality are examined. The preliminary analysis reveals the unequal ways in which the provision of, and access to, health promoting public services may be affected by international trade agreements. Specifically, by examining the home care sector as a case study, the report identifies the very concrete and harmful ways in which women may experience changes in the health care system that result directly or indirectly from trade agreements. The report ends with a series of recommendations for how trade policy can be approached and how a comprehensive gender-based analysis can be conducted for existing and future trade policy agreements.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIT	Agreement on Internal Trade
APEC	Asia-Pacific Economic Co-operation
CAP	Canada Assistance Plan
CARP	Canadian Association of Retired Persons
CCAC	Community Care Access Centre
CCJS	Canadian Centre for Justice Statistics
CCPA	Canadian Centre for Policy Alternatives
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHCA	Canadian Home Care Association
CHST	Canada Health and Social Transfer
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CLHIA	Canadian Life and Health Insurance Association
CRO	Contract research organization
CST	Canada Social Transfer
DAW	Division for the Advancement of Women (UN)
DFAIT	Department of Foreign Affairs and International Trade
EI	Employment Insurance
EPF	Established Programs Financing
FTAA	Free Trade Area of the Americas
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GBA	Gender-based analysis
GDP	Gross domestic product
HMO	Health maintenance organization
IGTN	International Gender and Trade Network
ILO	International Labour Organization
IMF	International Monetary Fund
IRPP	Institute for Research on Public Policy
LPN	Licensed practical nurse
NAFTA	North American Free Trade Agreement
NGO	Non-governmental organization
OACCAC	Ontario Association of Community Care Access Centres
OCSA	Ontario Community Support Association
OECD	Organization for Economic Co-operation and Development
OHC	Ontario Health Coalition
OHHCPA	Ontario Home Health Care Providers' Association
PSIA	Poverty and social impact analysis
PSW	Personal support worker
RN	Registered nurse
RNAO	Registered Nurses Association of Ontario

RPN	Registered practical nurse
SAGIT	Sectoral Advisory Groups on International Trade
SAP	Structural adjustment program
SCFAIT	Standing Committee on Foreign Affairs and International Trade
SIA	Social impact analysis
SPS	Agreement on the Application of Sanitary and Phytosanitary Measures
SUFA	Social Union Framework Agreement
TBT	Agreement on Technical Barriers to Trade
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization
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

To date, there has been no gendered analysis of how existing home care policies, and funding and delivery models of home care, interface with trade agreements. Nor has there been adequate attention paid to the constraints these agreements may pose for future reform in our health system and what this will mean for Canadian women in terms of accessibility, affordability, unpaid caregiving responsibilities and employment standards within the home care sector.

This preliminary study underscores the need for a comprehensive gender-based analysis that would provide the evidence for determining the actual impacts of trade agreements on women's health and health care labour. Such knowledge is essential for Canada to retain adequate autonomy to formulate and implement health policies that are congruent with its commitments to social justice and, in particular, gender equity.

The report begins with an explanation of the methods used in the research. We then provide an overview of the Canadian health care system, with a particular focus on home care. We trace important trends and policy changes and outline trade agreements most relevant for health, particularly focussing on the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS). We examine the meaning of NAFTA and GATS for Canada's publicly funded health care system and, in turn, for Canadian women. We review Canadian feminist responses to the threats trade agreements pose to public services and discuss the relevance of gender-based analysis (GBA) for understanding the implications of trade agreements for women.

Using GBA, we outline the current threats and potential constraints of these agreements for future home care reform. This analysis is not meant to make definitive predictions. Instead, it raises a number of possible impacts that international agreements may have for Canada's health care system, which can be used to inform the process of reconciling public policies and programs with trade liberalization. We offer some preliminary conclusions and recommendations, including the need for future research to monitor and evaluate fully the implications of trade agreements, their influence on policy-making autonomy, interaction with international conventions and the resultant gendered effects across the Canadian population. In this way, we hope to demonstrate not only the need for a fully integrated GBA but to show how it can be a catalyst for change in trade policy.

Recently, in a detailed synthesis of 10 years of public opinion data, Canadians were found to temper their support for trade liberalization with concerns about damages to social conditions (Mendelsohn 2002). An integral part of the recommendations put forward in this report is that economic globalization, dominated currently by the interests of transnational corporations and economics, needs to be expanded to include a similar concern for human rights, equity and social justice.

1. INTRODUCTION

Economic globalization is characterized by the "rapid integration of the world into one economic space through the internationalization of goods, capital and money markets" (Bergeron 2001: 983). In this climate, governments are pressured by trade bodies and multinational corporations to maximize exports, curtail state economic regulation, reorganize national economies and reduce social spending (Brodie 1995). Economic globalization**,** which now includes trade in services,[1] covers areas such as health care, education and social services. These services once thought to be outside the parameters of "trade" and within the jurisdiction of national states are now being commodified to open up new markets for economic growth. In general, there is a disjuncture between economic globalization and the ability of countries to set their own health policies including their ability to protect and promote health (Woodward et al. 2001). Trends associated with economic globalization are often seen as having adverse impacts on poverty and human health, in particular, worsening the equity and health status of women (Coburn 2000).

The interface between trade liberalization and health services is of particular importance in the Canadian context. Canada's system is rooted in an ethical commitment to provide health care on the basis of need rather than the ability to pay. It has also been an equalizing force in the lives of Canadian women (CCPA 2002; Statistics Canada 2000a). At the same time, for almost 10 years, the Canadian health care system has undergone a series of changes and reforms, which have included increased experimentation with privatization. What exists is a largely public not-for-profit health care system, albeit with a growing public–private mix, that cannot be adequately protected from further commercialization under the terms of trade agreements such as the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS). Consequently, there are growing concerns about the future of the Canadian health care system in the context of economic globalization.

This report seeks to further the understanding of the consequences of trade liberalization for Canadian women in the specific health sector of home care. Home care has been identified as one of the health care service areas that is most vulnerable to NAFTA and GATS (Epps and Flood 2003; Ostry 2001; Sanger 2001). This study illuminates the distinction between how trade agreements affect health services explicitly covered under the *Canada Health Act* and those like home care that are outside the provisions of the Act. Moreover, because most formal and informal caregivers are women, any changes within the home care sector are particularly significant for them.

Our main argument is that sustaining current services or expanding the Canadian public health care system to include home care has become more challenging under the terms of trade agreements, and these policy constraints have the potential to affect women differentially. These are particularly salient issues given the proposed reforms to the home care system recommended by the Romanow Commission (Romanow 2002) and the changes agreed to by the federal government and the provinces in the 2003 First Ministers' Accord on Health Care Renewal.

The analysis presented in this report reveals the ways in which the provision of, and access to, home care services may be affected by international trade agreements. For-profit models are increasingly being used in the delivery of home care services. Privatization makes home care more vulnerable to the terms of trade agreements. At the same time, trade agreements commit governments to further privatization of health care services. As one of our key respondents noted:

> *Free trade agreements [are like] a ratchet — you only liberalize; you never bring things back into the public sector* (Key informant interview, 2003).

Significantly, for-profit delivery of home care has been shown to be more expensive, to undermine standards, quality, public accountability and patient well-being (Armstrong 1999; Aronson and Neysmith 2001; Browne 2000).

By using a gender-based analysis, the report also identifies the very concrete and harmful ways in which women may experience changes in the health care system that result directly or indirectly from trade agreements. Privatization is of particular concern to women. Women are disproportionately poorer than men (Morris 2002) and are less likely to have the means to access private health care. Moreover, because most caregivers and recipients are women, the home care–trade interface has the potential to affect disproportionately a diversity of women including care recipients, informal/formal caregivers and other home care related health workers — many of whom are women of colour, Aboriginal and immigrant women.

Trade agreements now cover almost every conceivable area of policy, making it more difficult for governments to control decisions affecting the social determinants of health. For instance, adherence to trade agreements may contribute to increased poverty, the degradation of environmental, labour and health protection standards — all of which negatively influence women's health. Finally, the research in this report demonstrates the need to better understand trade agreements and their gendered implications. This preliminary analysis underscores the need for a comprehensive gender-based analysis that would provide the evidence base for determining the actual impacts of trade agreements on women's health.

Background

In the last few years, Canadians have vigorously debated health policy reform. In the area of home care, there have been numerous calls to establish a national publicly funded home care program based on the principles of the *Canada Health Act*. Such a program would ensure access to co-ordinated, appropriate, publicly accountable and culturally sensitive services (National Forum on Health 1997; National Think Tank 2001; Roeher Institute 2000). Recently, the Romanow Commission (2002) proposed expanding the principle of comprehensiveness of the *Canada Health Act* to include targeted home care services (e.g., home mental health case management and intervention services, post-acute home care and rehabilitative care, and palliative care).

Most important in terms of home care reform, in February 2003, the First Ministers' Accord on Health Care Renewal precipitated a five-year, $16 billion Health Reform Fund for

provinces and territories to target primary health care, home care and catastrophic drug coverage. This fund will provide coverage for short-term acute home care, including acute community mental health and end-of-life care. Access to these services will be based on assessed need and by 2006, available services could include nursing/professional services, pharmaceuticals and medical equipment/supplies, support for essential personal care needs, and assessment of client needs and case management.

The Government of Canada has also introduced a six-week compassionate care benefit. Available through the Employment Insurance (EI) program and job protection through the *Canada Labour Code*, this benefit is available for those who need to leave their job temporarily to care for a gravely ill or dying child, parent or spouse. While a positive development, this particular type of leave only benefits caregivers employed at levels that make them eligible for EI. Many caregivers, most of whom are women, work on a part-time basis or do not work at all, because of the demands that caregiving places on their time.

With a few exceptions, most notably the Romanow Commission, policy recommendations and reforms in home care have not been fully cognizant of international trade agreements. Indeed, trade agreements have not always been front and centre in general debates over health reform. As evidenced by the numerous studies and provincial and federal commissions, the future of our health system has been widely debated in the last few years.[2] Discussions have focussed on whether to maintain our public system or to open it up to privatization. Deliberations have also included an examination of the growing tensions in federal/provincial/territorial relations in health policy decision making. Although many researchers have tracked the changes resulting from the introduction of trade agreements, until recently the actual policy constraints that international trade treaties may present for reforming or even maintaining the Canadian health care system have not been carefully examined.

Many politicians, health researchers and policy makers — let alone the general public — are not well informed about trade policy or, for instance, Canada's commitments in terms of GATS or what is going on in the current Doha round of World Trade Organization (WTO) negotiations. Defining trade in broad terms to include trade in services like health care (including the movement of people who provide or wish to obtain these services) reaches well beyond the usual scope of trade liberalization that has focussed on removing tariff barriers for the movement of goods. The increased emphasis on removing non-tariff barriers to trade (e.g., laws, regulations, licensing standards, qualifications, etc.) has serious health policy implications. This is especially the case for women who make up the majority of the health care labour force and are the majority of health care recipients.

Nevertheless, discussions about the health impacts of trade agreements are increasing. To date, there are differing perspectives on their meaning for health policy making. The federal government has maintained that all health services are protected from trade agreements. Indeed, there are those who maintain that the Canadian public health care system is largely shielded from agreements like NAFTA and GATS. They maintain that this will only change if there is an expansion of the system's public component into new areas that adversely affect private economic interests (e.g., Johnson 2002). Others, recognizing the conflicting

values of international treaties and the health care system, have called for integrated approaches that reflect trade concerns while respecting the health care priorities of governments (e.g., Ouellet 2002). Still others have called for fundamental changes to Canada's trade policy and treaty obligations to secure medicare for the future (e.g., CCPA 2002).

What is missing from many of these discussions is a systematic and comprehensive gender-based analysis. There has been little recognition within governments that globalization and trade agreements are women's issues even though they are implemented within the context of existing social inequalities, both nationally and internationally. Some key features of globalization, as they relate to the health care system, have gender, race, ethnicity and class-differentiated effects, with specific impacts on women (White 2001, Armstrong et al. 2001). Numerous studies have called for assessments of the impact of trade agreements on women, and some researchers have begun to develop frameworks for gender and social impact analyses (e.g., Cornia et al. 1987; Gittinger 1985; White 2002b). Despite this, the methodology for developing and conducting such impact studies is still under-theorized and underdeveloped. To date, the federal government has not conducted any studies that would track and evaluate how trade agreements might differentially affect men and women. And, no large-scale studies of this nature have ever been done in Canada or elsewhere.

In 1999, Health Canada (International Affairs Directorate) began to work closely with the Department of Foreign Affairs and International Trade (DFAIT) on trade issues and health. Their partnership has been singled out by the World Health Organization (WHO) and World Trade Organization as a model for policy co-ordination between trade and health to achieve national goals (WHO and WTO 2002). Even though the goal of this collaboration is to ensure that trade negotiating positions reflect domestic policy priorities and objectives (WHO and WTO 2002: 142), a gender-based analysis does not inform these consultations and resultant decisions. Women's organizations and feminist scholars who have been at the forefront of developing frameworks for gender-based analyses have not been key players in trade policy-making processes. Status of Women Canada is the main federal agency promoting women's equality and "is not seen as an important voice within trade negotiations" (Hassanali 2000: 10).

And yet, it is well established that sex and gender-based differences lead to distinct needs and interactions vis-à-vis the health care system. For example, women constitute 80 percent of primary health care givers in both the formal and informal sectors, women use the health care system more than men, and women are overly representative among the poor (Greaves et al. 1999). In 1997, almost 5.2 million people in Canada lived in low-income circumstances, 54.5 percent of them were female (Statistics Canada 2000a). Twenty percent of low-income women are mothers heading lone-parent families, 56 percent of which are below the poverty line (Townson 2000).

Women, especially racialized women, are more highly concentrated in low-paying jobs that do not offer additional health benefits. Any change that alters access to health care services, particularly home care, is especially significant for Canadian women. Beyond the specifics of health care, trade agreements also have an indirect impact on the health of women through

their influence in areas, such as education, social services, employment, the environment and culture.

These are compelling reasons for examining the gendered health effects of trade agreements. Moreover, the Canadian government has formally committed to gender equity in a range of national laws, policies, and international agreements and conventions. The commitment is constitutionally entrenched in the *Canadian Charter of Rights and Freedoms* (1982). Three sections of the Charter — sections 15 (Equality Rights), 27 (Multicultural Heritage) and 28 (Rights Guaranteed Equally to Both Sexes) outline the basis for all Canadians to be treated equally.

In addition to the Charter, in 1995, the federal government adopted a policy of gender-based analysis (GBA) in *Setting the Stage for the Next Century: Federal Plan for Gender Equality* (SWC 1995). It states that all subsequent legislation and policies will include an analysis of the potential for different impacts on men and women. This would necessitate the inclusion of all trade agreements from 1995 onward. Canada is also a signatory to a number of international agreements. Key conventions for women's rights and equality include the *Beijing Declaration and Platform for Action* (1995), the *International Covenant on Economic, Social, and Cultural Rights* (1966) and the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) (1979).

Despite the clear commitment to gender equity, there has been little progress in terms of understanding the potential and real impacts of trade liberalization for Canadian women.

2. METHODS

> *Showing how trade agreements can impinge on areas of health domestically alerts us to their potential problems* (Joseph Stiglitz interview, 2003).

This study involved a comprehensive literature review on globalization, trade agreements, gender and health, interviews with Canadian and international experts, and specialists in globalization, trade agreements, health policy, women's health and home care. To supplement the analysis, information was gathered from provincial ministries of health in Ontario and British Columbia and, in the case of British Columbia, from one of the regional health authorities on the number of private insurance companies operating in home care. Unions representing home care workers were contacted to get demographic information about the home care workforce.

Literature Review

We reviewed literature related to liberalization of trade in services and the implications for Canadian health policy and health service delivery. This included legal and other expert opinion pieces, for example, on how NAFTA and GATS may or may not constrain Canadian health policy development and undermine a health care system that is of high quality and universally accessible (e.g., Epps and Flood 2003; Gould 2002; Johnson 2002; Sanger 2001; Sinclair and Grieshaber-Otto 2002). Literature that describes shifts in Canadian social policy over the past 15 years was used to contextualize the debates taking place in the health care sector. For example, we examined discussions about provincial/territorial jurisdiction over federal transfers and the degree to which national standards should be applied to the delivery of social services (e.g., Romanow 2002). Feminist and other social justice literature that critically appraises the implications of the Canadian government's focus on debt and deficit reduction at the expense of social programs was also reviewed (e.g., Brodsky and Day 1998; Clarkson 2002; Wiseman 1996).

The growing debate about the role of privatization in the health care sector was examined with specific attention to literature on the effects of privatization for women (e.g., Armstrong et al. 2002; Fuller 1998). To this end, comparative pieces that examine the differences in health outcomes in public vs private hospitals, clinics, long-term care institutions and home care settings were also reviewed (e.g., Harrington et al. 2001; Himmelstein et al. 1999). Research that focusses on home care funding and delivery in Canada and on the issues faced both by women workers and care recipients was investigated (e.g., Armstrong et al. 2001; Cohen 2001; Fuller 2001).

International literature on trade agreements and health policy was looked at with a focus on analysts who are concerned about the effects of international trade on women (e.g., Spieldoch 2001; White 2002a). To this end, GBA and social impact analysis (SIA) tools were reviewed for their efficacy and relevance to the health care sector (e.g., World Bank 2002; White 2002b).

The literature review informed our overall analysis, and selected references have been developed into an annotated bibliography found in Appendix A.

Key Informant Interviews

Twenty-seven key informant interviews were conducted in Canada, the United States and Europe, and included experts and specialists in trade agreements, health policy, law, home care, globalization and civil society, women and health care, and gender-based analysis. Face-to-face interviews were conducted with a number of key international informants, including an official from the Organization for Economic Cooperation and Development (OECD) in Paris France, a policy analyst at UNIFEM (United Nations Development Fund for Women) in New York, and a meeting with the director of the Initiative for Policy Dialogue at Columbia University. An informal discussion with German academics working on gender and globalization was held at the University of Mainz, Germany. Academic researchers were also interviewed in Toronto, and discussions were held with members of The Council of Canadians in Ottawa. Additionally, several research associates from the Canadian Centre for Policy Alternatives in Ottawa and Charlottetown were interviewed in person.

Other key informants from international organizations were interviewed by phone, for example, a health specialist from the WTO and officials from the WHO in Geneva, Switzerland, and women and trade specialists with the International Gender and Trade Network (IGTN) and Women's Edge in Washington, DC. Additionally, gender and trade experts in the United Kingdom were interviewed. Joseph Stiglitz, the founder of the Initiative for Policy Dialogue at Columbia University in New York was also a key informant for the study. Further, Canadian experts and Canadian trade and health policy officials at Health Canada and the Department of Foreign Affairs and International Trade were consulted.

Interview participants were recruited through consultation among the research team members and in discussion with the National Co-ordinating Committee on Women and Health Care Reform. The University of British Columbia's ethics review committee approved the research protocol. In most cases, the interviews were audio-taped although in the case of telephone interviews notes were taken. The interviews were then analyzed and summarized for use with the other data. A list of interview participants can be found in Appendix B.

In addition to the interviews, several important conferences and forums focussing on Canadian health care policy and trade liberalization were held during the course of our research. Along with other academics we participated in a presentation, Globalization and Canada's Health Care System, to the Commission on the Future of Health Care in Canada in Vancouver, on September 19, 2002. Additionally, we attended a conference sponsored by The Council of Canadians, the Canadian Centre for Policy Alternatives and the Canadian Union for Public Employees, Prescription for Change: Securing the Future of Public Health Care, held in Ottawa on February 3, 2003. An informal presentation on the progress of the

work was presented to the National Co-ordinating Committee on Women and Health Care Reform in November 2002. We also participated with this group in the review of the Romanow Commission report by analyzing the sections pertaining to globalization, federalism and citizenship.

Gender-Based Analysis of Trade Agreements

Beginning with the assumption that policies have the potential to be differentially experienced by women, our study employed a GBA analysis. "Gender-based analysis (GBA) is a method of evaluation and interpretation which takes into account social and economic differences between women and men, whether applied to policy and program development, or general life activities such as, work/family roles" (Health Canada 2002: 1).

GBA must be applied at each stage of the policy process. In this way, it focusses on actual impacts supported by empirical evidence as well as the examination of the potential differential impact of policies on women and men.

There are two complicating factors in applying GBA to trade agreements. First, there are inadequate methodologies and tools for measuring the effects of trade agreements on women. It is also difficult to distinguish between the gendered effects of pre-existing national policy trajectories and trade policy. As one of our gender and trade experts cautioned:

> *Can you link effects with trade? Can you make the connection? What are the pre-existing social factors? What is the regulatory environment? You need to be clear about what the current environment and how trade agreements impact or will impact on each pre-existing variable* (2003).

The challenge of such research is confounded by the fact that most trade agreements are still under negotiation and development.

Notwithstanding these constraints, we chose to use GBA to begin the process of understanding the potential effects of trade agreements on women. We used the following questions to consider the actual and potential gendered dimensions of NAFTA and GATS for women's health and for women workers in the home care sector.

- What are the health and gender-relevant aspects of the trade agreement?[3] Which aspects are relevant to the home care sector specifically?
- What are the gender-relevant aspects of implementation or enforcement of the trade agreement with respect to the home care sector?
- What might the effects be on women's health and women's labour in the home care sector and on women's equality?

Ellen Gould, an internationally recognized expert on trade and health services, and Dr. Marjorie Cohen, Professor of Political Science and Women's Studies at Simon Fraser

University, reviewed our analysis of trade agreements while Georgia Livadiotakis, Policy Analyst Home Care and Continuing Care, Health Canada reviewed our analysis of home care.

Additionally, we applied the above three questions to other trade agreements that were more broadly relevant across the health care sector: the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), the Agreement on Technical Barriers to Trade (TBT), the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) and the newly formed Free Trade Area of the Americas (FTAA) which has not yet resulted in a specific agreement.[4]

3. TRADE AGREEMENTS, HEALTH, POLICY AND GENDER

In this chapter we provide an overview of the Canadian health care system and background material on the funding and delivery of home care. Important trends and policy decisions affecting the health sector are discussed. We identify the trade agreements most relevant to health services and the sections that we believe are of the most significance for women. Our analysis suggests that increased privatization in the Canadian health care system is opening up the health sector to the rules of international trade agreements. This trend has the potential to undermine Canada's publicly funded health care system and the ability of the Canadian government to pursue health reforms of benefit to women. We conclude with an overview of feminist responses to trade liberalization and make the point that the health–trade interface has been underexamined.

Next, we critically discuss tools that have been developed to analyze and assess the effects of trade agreements on populations. Specifically, we look at social impact analysis and gender-based analysis. We argue that although SIA is an important tool for examining the unequal distributional effects of trade agreements on populations, it has not sufficiently integrated an analysis of gender and the broader social and power relations that form the context in which trade policies operate (Cagatay 2001). Gender-based analysis, on the other hand, has not always adequately captured social inequities based on factors other than gender (e.g., race and class). GBA however, provides an important analytic lens through which to flag critical issues for women, and we argue that it can help inform larger gendered social impact studies. A gender-based analysis of actual and potential effects of trade agreements on the home care sector, an area of particular significance to women, is presented in Chapter 4.

Health Care, Policy and Women

Canada is credited with having one of the best health care systems in the world. The system operates, for the most part, as a public payment, private provision, on a not-for-profit delivery basis. According to the Constitution of Canada, provinces are charged with the responsibility of health care delivery. The federal government has always contributed financially to the system, and through Health Canada is responsible for Aboriginal health care services in Canada. However, the nature of this contribution changed fundamentally with the introduction of hospital insurance and then medical insurance, brought together in the *Canada Health Act*. In 2000–2001, total health expenditures in Canada were $97.6 billion (Health Canada 2002). There are areas where the privatization of health payments is occurring and where public funds are covering privately provided services. These include private insurance that covers many areas not publicly insured (e.g., pharmaceuticals), public funds that cover some for-profit health care services (e.g., for Canadians who travel to the United States for cancer treatments) and private payments by individuals for services not publicly or privately insured. Our tax system minimally offsets costs for individuals who incur large private health expenses. Additionally, private–public partnerships are taking place, involving, for example, hospital construction and support services.

Canadian Institute for Health Information (CIHI) data suggest that the public share of health care spending amounted to 71 percent in 2000 (mostly hospital care and physician services) with private sector spending accounting for 29 percent (mostly those areas not under the *Canada Health Act* — drugs, dental, vision care and home care) (Kirby 2001b). OECD (1999) data show that Canada spends 9.2 percent of gross domestic product (GDP) on health. (The United States is at about 13.9 percent and the European Union is at 8.0 percent.)

It should also be noted that the Canadian health system relies on a great deal of philanthropy, voluntarism and informal care, especially in the hospital sector. Most of the individuals providing this kind of care are women (Armstrong et al. 2001). Over 95 percent of hospitals operate as private, non-profit entities (run by community boards, volunteer organizations, municipalities or regional health authorities). Doctors and specialists negotiate a fixed payment scheme with provincial governments through their professional associations.

The legal framework for the delivery of health is found in the *Canada Health Act*, which is governed by principles to ensure a universal, public, accessible, portable and equitable system. The *Canada Health Act* covers two kinds of health services:

- *insured health care services* — medically necessary hospital services, physician services and surgical-dental services; and
- *extended health care services* — certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

An analysis of women's roles, both as workers in the health care system and as health care recipients, reveals that women are the majority of the recipients of health care. They often use different services and are, in many instances, responsible for the health of their families, especially of children and elderly parents (Armstrong et al. 2001). In terms of health issues, women have higher morbidity rates and outnumber men as they age; currently three quarters of the institutionalized elderly are women (Armstrong et al. 2001). Social circumstances, which are key determinants of health, often differentially impact on women. For example, women experience higher rates of physical and sexual violence than men (CCJS 1993). Women, especially Aboriginal women, single mothers, women with disabilities and elderly women are disproportionately poorer than men (Morris 2000). Few studies have been done on racialized women in the health care sector. It can be assumed, however, that these women face additional challenges associated with their general concentration in lower-paying health sector jobs and their experiences of racism.

With respect to their roles in the health care system, women are highly concentrated in the nursing professions and in lower paying positions, such as health care support services. Health care support workers are the ones who feel government cutbacks first and hardest, and are underrepresented in decision-making positions within the health care system (Cohen 2001). Indeed, restructuring and downsizing has resulted in job losses, especially in the areas that involve the invisible caring and cleaning skills women learn at home. Perhaps the most dramatic gender difference is that women provide 80 percent of all paid and unpaid

primary health care services (Armstrong et al. 2001). Women's unpaid and informal labour in the health care system is increasing and is directly a result of cutbacks to hospitals, which result in more people being cared for in community-based settings or privately in their homes (Armstrong et al. 2001).

At the highest level of policy decision making, the unique needs of women in relation to the health care system and health research have been acknowledged. For example, in 1999, Health Canada introduced a Women's Health Strategy, a framework to guide Health Canada to integrate gender-based analysis into health policies and programs. Generally, Health Canada is responsible for leading the direction of health policy in Canada. It works in the areas of disease prevention, health regulation and healthy living. The Women's Health Strategy, along with the establishment of the Institute for Gender and Health within the newly formed Canadian Institutes of Health Research, can be seen as the culmination of efforts by the women's health movement in Canada and the growing recognition that gender equity is a pressing policy goal. Despite this, a gender-based analysis remains absent in many national health policy forums.

Home Care in Canada

Home care in Canada can be defined as "an array of services enabling Canadians, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives" (Health and Welfare 1990: 2). The range of services includes both health and other social supports that are intended to allow clients, their families/friends and others to cope with both acute and long-term care needs, including palliative care within a community or home setting. Within these settings, there are two principal forms of care: informal and formal. Informal care is unpaid care provided by family and "significant others." Formal care complements informal care and is provided by paid workers.

Home care includes the professional care of nurses, social workers and physiotherapists and the personal care (assistance with the activities of daily living) and home support (assistance with instrumental activities of daily living) provided by workers. Home care also includes palliative care, day programs, self-managed care options and organized volunteer services (e.g., meals on wheels, transportation, other volunteer services).

The specific functions of home care are threefold (Health Canada 1990):

- maintenance and prevention that allows persons with health and/or functional deficits to remain in a home setting, live independently and avoid further health deterioration that would require institutionalization;
- long-term care in which home care replaces care that would otherwise be received within an institution; and
- acute care that meets the needs of persons who would otherwise be placed in an acute care facility.

Home care is the fastest growing segment of health care in Canada (CHCA 2002). Over the last decade, there has been a steady trend toward hospital closures and other institutions providing care, shorter hospital stays and, in general, sending patients home "quicker and sicker." The result has been deinstutionalization — a move to community-based care. At the same time, however, only five percent of the total public health budget is expended on home care (Coyte 2000). In the 1998–99 fiscal year, Canadian governments spent just under $3 billion on home care (CIHI 2002).

Funding and Delivery

Funding for home care has traditionally come from both federal and provincial/territorial governments. The federal government, through the Canada Health and Social Transfer (CHST) established in 1996, contributes funding to the provinces for long-term community care and home care. Previously, such funding was provided under the Canada Assistance Plan (CAP) for social supports and under the Established Programs Financing (EPF) arrangements for extended home care services. Although not explicitly covered under the *Canada Health Act*,[5] each province and territory provides some form of a publicly funded home care program. There are two exceptions. The federal government does provide direct home care services to clients with wartime or special duty area service through Veterans Affairs Canada (Home Independence Program) when such service is not available provincially or territorially. Indian and Northern Affairs Canada offers limited programs for on-reserve First Nations (Adult Care Program and Homemaking Services). The First Nations and Inuit Home Care Program is funded by Health Canada.

Because of home care's exclusion from the *Canada Health Act*, there are different standards, eligibility requirements, administrative mechanisms and costs in each province and territory (Morris 2001). Home care legislation varies, and there is no minimum definition of "comprehensiveness" when it comes to the variety of health and social services that fall under home care, such as needs assessments, case management, professional care, personal care, home support, caregiver support such as respite and advice, organized volunteer services, medical supplies/equipment, day programs, self-managed care options and access to subsidized prescription drugs. Each province and territory provides a different "bundle" of such services. What is consistent, however, is that services are being stretched to their limits, waiting lists are growing and eligibility requirements for services are becoming more restrictive. And because the *Canada Health Act* does not cover home care, provinces have immense power to change policies to reduce funding, increase user fees, restrict eligibility and reconfigure delivery structures.

The Impact of Health Care Restructuring on Women in the Home Care Sector

It was recently reported that there are "at least 663 agencies providing home care services in Canada, with 93% receiving some form of government funding and 50% receiving only government funding" (Health Canada 1999b: 1). Home care workers include a range of professional, paraprofessional, casual, full-time, unionized and non-unionized workers. Ninety-five percent of paid home care workers are women (Lowry 2002). Homemakers,

home health aides, and personal care attendants provide between 70 and 80 percent of home care services. The remainder includes nurses, case managers, physiotherapists, occupational therapists, social workers and respiratory therapists (National Steering Committee 2002). Little is known about the other demographic characteristics of home care workers. For example, no Canadian data are available that would illustrate the composition of this labour force by race and ethnicity.

Formal Home Care Workers

The restructuring of the health care system has affected paid providers of home care services. Hospital bed closures and reduced community supports mean more pressures on home care workers, who have reported "an increase in the number of home care clients with higher acuity levels and complex care needs" (CHCA 2002: 10). Workers are thus undertaking more complex medical care tasks than ever before. Issues of recruitment and retention, wages, working conditions and training/education have also been raised (CHCA 2002). For example, there is a shortage of home care workers, high turnovers and shortcomings in remuneration. When compared to institutional workers performing the same tasks, workers employed by home care agencies have lower wages. At the same time, their workload is often higher.

Informal Home Care Workers

Within this policy milieu, there has been growing pressure on family and friends to provide unpaid care to persons with functional limitations, acute or terminal illness, or who are in post-operative recovery. There is an expectation that a private pool of labourers exists who will provide care outside the public sphere. Indeed, the overwhelming amount of caregiving in Canada and elsewhere is provided in the realm of private households by informal caregivers (Lyons and Zarit 1999). In fact, between 85 and 90 percent of all care is provided informally (Cranswick 1997; Denton 1997). Informal caregivers are predominantly family members although friends, neighbours and volunteers also do a considerable amount of caring work.[6]

More often, informal caregivers — regardless of class, race, culture, age, martial status or sexual orientation — are women. Many caregivers are also providing care for more than two generations (e.g., elderly parents and their own immediate families). There is little recognition of this gender disparity in caring responsibilities in current social policies. Nor is there much recognition that most women doing informal care work also maintain jobs in the paid work force. Despite the contribution of women's work to home care, gender considerations have been marginal in both policy and research (Morris 2001).

Costs of Home Care

Fast and Frederick (1999) estimated the replacement value of the work performed by informal caregivers in Canada as exceeding $5 billion annually. Health Canada provided slightly lower estimates for the 1999–2000 year at $3 billion (CHCA 2002: 7). Not surprisingly, home care is considered, from a governmental perspective, a cost-effective substitute for hospital and other long-term care facilities. Emerging financial data seem to support these conclusions. For example, nationally between 1993 and 1996, hospital care

expenditures fell by $1,205 million while home care spending only increased $452.8 million (Health Canada 1998: 3).

An integrated program of research with 15 studies across Canada (Hollander and Chappell 2000) found that in terms of overall societal costs, home care costs less than residential care for all levels of care even when out-of-pocket expenses of clients, family members and other caregivers, as well as time spent by family caregivers (costed at minimum wage and at replacement wage) are taken into account. However, the studies in this program of research did not consider the full range of burdens, consequences and human costs for the caregiver that extended beyond time and financial outlays. Nor did they measure the quality of care, including continuity of care, provided to the patient in the home. They also failed to account for the long-term costs to women caregivers in relation to their health, jobs and pensions.

Privatization

The focus on cost savings has been enjoined by an investigation of service delivery innovations and more private industry participation in home care, increased competition and a growth of large and complex organizations (Close et al. 1994). In general, there are a number of ways home care services are funded and delivered. They can be publicly funded and publicly delivered, publicly funded and privately delivered, or privately funded and privately delivered. Private services may be for-profit or not. For example, some provinces directly delivery home care services while others rely on external agencies (voluntary, not-for-profit and for-profit agencies). There has always existed a public–private mix in the delivery of home care in the form of homemaking, in-home attendants, home health care, nursing and palliative care that have been available for many years (Nahmiash and Reis 1992). What is increasing is the contracting of services to for-profit organizations. In particular, many corporations consider long-term care to be an important site for profit making (Armstrong and Armstrong 2001).

At the same time, services available through the public system are being reduced. Out of necessity, and for those who can afford it, a growing number of services are being purchased outside the public system. This results in higher out-of-pocket expenses for clients and their families. Canadians are spending more and more on private sector health care. According to Statistic Canada's Survey of Household Spending in 2000, average household spending per year on health care increased from $1,009 in 1996 to $1,357 in 2000 (CIHI 2002). In general, fewer community health services are publicly funded.

Privatization may be understood as "a process whereby activities, assets, costs, or control are shifted from the public to the for-profit sector" (Browne 2000: 2). However, it can also take on more implicit changes when, for example, government discontinues a previously provided service, when it still pays for a service, but does not deliver it, or when in providing a service it levies a user fee (Browne 2000; Armstrong et al. 2001). In the case of home care, we have what others have referred to as "cascading privatization" — services that were once covered by medicare, because they were provided in hospitals and other institutions are now de-listed,

because they are provided in the home. Elsewhere this has been described as "privatization by stealth" (Armstrong 1999).

At the most basic level, the concern is the goal of for-profit organizations — profit maximization, which overrides all other considerations, including public interest and patient well-being (Gibelman and Demone 2002; Browne 2000). In a general observation about the effects of privatization of home care on female clients and workers, a health policy expert we interviewed indicated:

> *There is a huge community of interest that arises between the client and the provider because they are poor and they are female, and they are threatened both by the public policies that are providing a space for corporations to come in and by the companies themselves who make money by paying low wages and providing poor quality and fewer services to clients* (2003).

In sum, the demand for home care is increasing as public support systems continue to erode, technology advances, the population of seniors increases, and the incidents of diseases, such as HIV/AIDS, Alzheimer's, and cancer become more prevalent. The current home care situation is untenable for many Canadians. The burden and negative consequences for caregivers are well documented (Armstrong and Armstrong 2001; Baines et al. 1998; Morris 2001; Parent et al. 2001). In 1998, 85 percent of Canadians wanted to have home care included under the *Canada Health Act* (Price Waterhouse Coopers 1998). In 1999, 80 percent supported the inclusion of home care under medicare (Berger 1999). Fifty-seven percent of Canadians reported feeling that an expanded home and community care program would be one of the best ways to improve the health care system (Ekos 2000). Despite recent changes to home care policy in Canada, we are far from realizing a comprehensive national program.

The Health Care System: Internal Policies and External Pressures

Internal Policies

As evidenced by the home care example, the Canadian health care system has been changed profoundly. Both internal policy decisions and external pressures related to globalization and trade can be seen as the foundation for these alterations. Drawing on the work of Standing (1999), Bernier and Dallaire (2001: 121) pointed out that "the central element in recent health care reform — the shift of many services from institutions into the community — has significantly altered relationships among the government, the public health care system, private health care providers, community organizations and the 'domestic' economy." We would add that health care reform is integrally tied to external trade pressures, which favour the interests of business and call for reduced social spending.

A number of key developments warrant attention. The first came in February 1995 with the introduction of the *Budget Implementation Act*. It allowed the Government of Canada to repeal the Canada Assistance Plan and introduce the Canada Health and Social Transfer in 1996.

For much of Canada's recent history, the federal government has been instrumental in national social programs. Through transfers and shared cost programs started in the 1950s,

the federal government has greatly influenced areas of provincial/territorial jurisdiction, such as health, post-secondary education, social services and social assistance. This was apparent with fiscal arrangements such as the Canada Assistance Plan established in 1966 and then later with the Established Programs Financing introduced in 1977. CAP provided provinces with 50 percent of the costs of social assistance and services. The Established Programs Financing was a consolidated fund for health care and post-secondary education. (The EPF heralded the beginning of "block funding.") Under these arrangements, the federal government established and enforced national standards to ensure all Canadians received the same level of care.

Without any consultation with the provinces/territories, the federal government took a radical change in direction initiated by Paul Martin's 1995 budget and drastically cut social spending with the introduction of the Canada Health and Social Transfer. The CHST is a block fund to provinces for all the areas previously covered by both CAP and the EPF, making it impossible to tell what the federal government gives and/or cuts from any one of its social programs. In many ways, the CHST was the final result of a steady pattern of cuts and freezes on provincial transfers. The consequences of the implementation of the CHST have been significant. Between 1994–95 and 1998–99, Ottawa cut its contribution to health, education and social assistance from $19.3 billion to $12.5 billion. Government funding to health is only now beginning to be restored. Additionally, in 1996 the *Canada Health Act* was also amended to make it conform with the CHST.

> *The* Canada Health Act *was amended in 1996 and nobody even knows it was amended…and it was a detrimental amendment and the reason it was amended was because of the introduction of the CHST. In the* Canada Health Act*, there was a section, section 6 that [covered] extended health services, which are outpatient services, nursing home care, home care, all of these areas that are expanding in the health system. Section 6 basically said that the federal government allocated a specific amount of money for those services, but in return for the money the provinces had to fulfill reporting obligations under the Act. This [is one of the] sections that was repealed* (Interview with health policy expert, 2003).

The only conditions of the CHST are that provinces/territories meet the criteria in the *Canada Health Act* and do not impose any residency requirements for receipt of social assistance. Should the province or territory deviate from the *Canada Health Act*, for instance by charging user fees or extra billing, Health Canada is authorized to penalize that province or territory by deducting from the CHST amount it receives.

Each provincial/territorial government adds to the portion of the CHST that it allocates to its health care system, and the combined sum funds delivery in that province/territory. As a result of the CHST, provinces now have more financial responsibility for social policies. Even though the federal government has made radical cuts to provincial transfers, it continues to demand that provinces adhere to certain federally imposed national standards. Many provinces have argued, however, that the federal government has reduced its political capacity to impose any

vision of social policy and programs on the provinces/territories. Indeed, despite opportunities to do so, the federal government has seldom challenged the provinces or territories under the *Canada Health Act.*

To overcome these tensions, the Social Union Framework Agreement (SUFA) was signed in February 1999 by the federal government, the territories and nine provinces (excluding Quebec). It was meant to improve the way in which federal and provincial/territorial governments worked together in regards to social policies and programs, especially health. Some, like Alain Noël (2000: 2) have argued that SUFA was an attempt to reassert the federal government's authority in regards to health care. "[T]he social union framework recognizes, indeed celebrates, the legitimacy of the federal role in social policy." SUFA, however, has been largely ineffective in re-establishing the federal government's role in health, and the result is that national standards for the health care system are eroding.

In February 2003, three months following the release of the report from the Romanow Commission on the Future of Health Care, the Canadian government agreed to the Accord on Health Care Renewal. The government announced increases in health care spending and committed itself to creating two transfers on April 1, 2004: a Canada Health Transfer (CHT) through which health dollars will flow to the provinces and a Canada Social Transfer (CST) that will cover education and social services. There are also discussions underway about how to increase provincial accountability to the federal government for health care spending.

Despite these developments, provinces continue to experiment with privatizing health care (e.g., building private hospitals in Alberta and British Columbia, for-profit delivery of many home care services in Ontario and contracting out hospital service workers in British Columbia), which jeopardizes the public nature of Canadian health care. Seen in a wider political context, federal transfer payment cutbacks and the CHST effectively enhanced the Canadian climate for trade in goods and services by weakening federal government authority and placing pressures on provinces to consider privatization as a means of funding health and social services.

External Pressures

Reflecting on the relationship between domestic public policy and free trade agreements, a health and trade policy expert we interviewed said:

> *There is a relationship between the free trade agreements, provincial and federal policy and obviously people who invest in the health sector and the health industry, and what concerns me is that there really hasn't been an in-depth assessment done of what has occurred in the health sector since the free trade agreements* (2003).

On an international level Koivusalo (2003: 173) observed: "Health sector reforms introduced at the national level, in such forms as deregulation, privatization and decentralization are restructuring health systems to make them complementary to the emerging global economy."

The creation of the CHST occurred the same year that both NAFTA and the WTO[7] came into being. The groundwork for NAFTA had been laid in 1989 when the Conservative Government of Prime Minister Brian Mulroney struck a trade agreement with the United States: the Free Trade Agreement (FTA). The FTA had substantial health-related trade issues covered in its services chapter and became the first comprehensive agreement on trade in services. It served as an important model for both NAFTA and the General Agreement on Trade in Services (GATS).

The WTO agreements most relevant to health are GATS, the Agreement on Trade-Related Aspects of International Property Rights (TRIPS), the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) and the Agreement on Technical Barriers to Trade (TBT). The Free Trade Area of the Americas (FTAA) is also relevant. It is in the early stages of development and is concerned with removing barriers to trade among a wide range of countries in the Americas.

Table 1: Trade Agreements and Health

Agreement	Health Area
Regional	
NAFTA	Health services
Multilateral (World Trade Organization)	
GATS	Health services
TRIPS	Pharmaceuticals
SPS and TBT	Food safety, environmental protection, consumer and health protection

Together, these agreements cover a range of health services and encompass the wider determinants of health (e.g., education, transport/communications, environment, food security and safety, water, sanitation, air quality and financial services). Overall, these agreements are intended to secure predictability and stability in trade practice through legal frameworks with binding rules and obligations. These uniform rules for global governance in trade, however, also have a homogenizing effect. Member states that vary in size, stages of development, and levels of private and public sector involvement in funding, purchasing and provision of health services may not be left with enough room to maintain system “divergences.” For Canada and its distinct public–private mix in health, this is a critical policy issue.

The Service and Trade Division of the Department of Foreign Affairs and International Trade oversees all trade agreements and determines Canada’s position with respect to these agreements. The service and trade division works with other DFAIT divisions and, in some instances, with other ministries, specifically Health Canada’s International Affairs Directorate. It also consults with experts through the Sectoral Advisory Groups on International Trade (SAGIT). The Medical and Health Care Products and Services SAGIT works closely with DFAIT. However, critics have pointed out that the membership of this SAGIT is industry dominated and, at the time of writing, had no representation from labour

unions, health policy specialists, women's groups or organizations concerned with health and social inequality. A repeated concern with how the federal government negotiates trade has been with their lack of transparency with respect to the process (Sanger 2001; Sinclair and Grieshaber-Otto 2002). For example, with respect to the GATS negotiations, the federal government only provides summaries of the negotiating requests it has received from other countries.

Industry Canada and the Department of Foreign Affairs and International Trade have repeatedly assured Canadian citizens that the health care system is shielded from trade agreements, and health care services are not on the trade negotiating table.[8] Moreover, there is a standing commitment to preserve policy flexibility in health, along with public education and social services, in the context of trade agreement (SCFAIT 2002). Adlung and Carzaniga (2001) of the WTO's Trade in Services Division have similarly argued that under the terms of GATS, all members retain an enormous amount of flexibility in pursuing their policy objectives.

Despite these assurances, the Canadian government has put certain kinds of health services on the table in a number of agreements (e.g., rehabilitation services in the FTA and health insurance in GATS). Reflecting on the effects this has already had on health services, one health policy researcher we interviewed said:

> *There are certain parts of the health care system that I think have really been compromised to the extent that it would be very difficult to reclaim these under the public umbrella and one of them is the area of outpatient services — all of them, but obviously the big one is rehabilitation services* (2003).

In a discussion about the effects privatization is already having on rehabilitation services one health policy specialist indicated:

> *There are specific groups which suffer more than others, of course: elderly people, disabled people, the majority of whom are elderly, people with chronic conditions that require ongoing rehabilitation services. These are the people who are now having to pay directly for services. If they don't pay, they don't get the service* (2003).

Most of the elderly people affected are women. We need to ask to what degree does Canada's commitments to free trade create a social climate where inequities between people and between men and women specifically are deepened?

Canada and Trade in Services

The value of health services in OECD countries has been estimated at approximately US$3 trillion and is expected to rise to US$4 trillion by 2005 (Marconini, 1998). When broadly defined to include investment and the movement of health professionals, predictions are made that "trade" in health services will become more important (Chanda 2001).

This is supported by a number of emerging trends. The processes of cost containment, government retrenchment and the increased presence of the private sector can be observed in most OECD countries. Specifically, the upsurge in the movement of health professionals, the increase in foreign investment by hospital operators and health insurance companies, and the growing interest in "health tourism" (i.e., travelling to another country for a health procedure) indicate that trade in health services is increasing and has substantial growth potential (WHO and WTO 2002).

In 2000, trade in services accounted for 11.9 percent of total exports and 14.7 percent of total imports (Statistics Canada 2000b). Canada already has life and health insurance companies in over 20 different countries (Finance Canada 2001). Three hundred Canadian companies are involved in telehealth (i.e., the new technology allowing remote doctor–patient consultations), and many of these are multinational enterprises (Chanda 2001). Canada's involvement in the international medical drug trade is substantial and expanding rapidly. For example, the value of exports in pharmaceutical and medical manufacturing rose from C$1.562 billion in 1998 to C$2.568 billion in 2002 (Statistics Canada 2003). There is also evidence that Canada has intentions to further expand its health industry into foreign markets (e.g., see SCFAIT 1999).

Canada's imports in 1998 were at $52.1 billion. Health services (which are included in a category with education, business, etc.) represented about 16 percent of that $52.1 billion. Understanding what kind of services Canada imports is critical for any analysis of the effects of trade agreements, and yet, to date the Department of Foreign Affairs and International Trade and other government departments have focussed on exports that form only a very small part of the Canadian economy. Therefore, it appears that the changes being made to internal government policy, which focus on exports, are really only relevant to the economic performance of a very few players in the Canadian economy.

NAFTA and GATS

Among all the agreements, NAFTA and GATS have been singled out as the most relevant to the Canadian health care system, because of their immediate implications for health services (Johnson 2002; Ouellet 2002). We examine specific provisions of these agreements to determine the extent of their effects on the health care system.

Both NAFTA and GATS are distinct but overlapping in breadth and scope. They both have clauses that commit governments to repeated rounds of negotiations to expand liberalization of services. NAFTA is seen as a rigid, top-down agreement (i.e., member countries under this agreement commit to all of its conditions automatically). GATS is generally described as a more flexible bottom up agreement, because member countries voluntarily choose what they commit to (i.e., only those services positively listed by a country are affected by some rules). However, GATS also has top-down features (e.g., the most favoured nation rule, which affects all services whether they are listed or not) (Sanger 2001). Both NAFTA and GATS require that governments treat foreign companies as well as or better than they treat domestic entities.

Under NAFTA and GATS, Canada has not explicitly undertaken obligations under health care services, but these treaties could nonetheless affect health care policy. That is, in NAFTA with the exception of telecommunications and financial services (which have separate chapters) no services are explicitly mentioned; however, all of the sections on investment, competition, monopolies and state enterprises apply to all services. Currently, the Canadian government has committed health insurance under GATS, the implications of which are discussed below. Additionally, the wording in both NAFTA and GATS, with respect to the protection of public services, is contestable.

The North American Free Trade Agreement

NAFTA is a trade agreement signed between Canada, the United States and Mexico in 1994. It covers the delivery of goods and services and extends to all economic sectors including the health sector (except where there are specified exemptions). NAFTA's objectives (set out in article 102) state that trading partners strive to increase investment among themselves by eliminating trade barriers and facilitating the cross-border movement of goods and services. Beyond cross-border trade, NAFTA has broad implications concerning the treatment of foreign investors and service providers through its investment provisions. Its objectives also include providing adequate and effective protection of intellectual property rights and a framework to facilitate future trilateral, regional and multilateral co-operation. These objectives are overarching and come to bear when other provisions within the agreement are being interpreted. Of particular note is the overriding commitment to increased trade liberalization to which all three governments are committed.

NAFTA has its own dispute resolution mechanism that is significant, because it is the first agreement that allows corporations to challenge governments directly and demand monetary compensation (Chapter 11). The impact of this has been felt by Canada in a range of NAFTA trade disputes by U.S. corporations. For example, as a result of NAFTA, the Canadian government backed down on its plan to legislate plain packaging for cigarettes and to ban the toxic gasoline additive MMT (Sanger 2001).

When NAFTA was first signed, public concern arose over the belief that within the agreement there were loopholes that would allow U.S. companies to encroach on Canada's universal health care system. These fears were increased as trade disputes launched by U.S. firms against Canada became public. People began to recognize how the largely private health care system in the United States might take advantage of markets opening up in Canada, especially as federal and provincial cutbacks to the health care system became more vigorous (Boliz et al. 1999). For example, under Chapter 11, NAFTA permits direct foreign investment that may be extended to the health sector. This provision enables foreign corporations to invest to obtain 100 percent ownership of health care facilities (Chanda 2001). In these instances, when a service is not completely protected in the public sector, it is opened up to increased privatization, and competition between the public and private sectors can occur. For example, the government might be treated like a corporation in that, under NAFTA, it could not maintain a "monopoly" over the services it provides, especially if those services are already partly provided privately.

The question of NAFTA's potential to reshape the Canadian health care system is a topic of frequent discussion. When NAFTA was negotiated, some provincial policies and measures were exempted, as long as they were in force when the Agreement was adopted.[9] Yet Alberta's recent allowance of private clinics represents a change to its policy, giving NAFTA an inroad into the system. As Appleton (2000: 2) explained, "once a reservation is lost, by a province changing its old policies or practices, the old reservation is spent and cannot be renewed. It is for this reason that most provinces are very careful when they change their health care policies as their changes can lower the threshold for their NAFTA obligations."

It is clear that NAFTA constrains the ability of the public system to expand (e.g., to include home care, dental care and disability insurance) but, more critically, it allows the private sector to assert its rights once any privatization begins. That is, the public sector is only protected as long as governments do not begin the process of privatization. Privatization clearly undermines the public health system and has particular consequences for women who make up the majority of the labour in the health care system, often bear the responsibility of heath care for their families and use the system more frequently than men.

The World Trade Organization

In 1995, the WTO replaced the General Agreement on Tariffs and Trade (GATT) Forum that was established in 1948. GATT was incorporated into the much expanded set of trade agreements which constitute the WTO agreements; GATT wording is part of the WTO agreements. GATT dealt only with trade in goods while the WTO has expanded rules to cover trade in services and intellectual property (WHO and WTO 2002).

The WTO oversees a wide range of multilateral agreements, including GATS. Essentially, member governments cannot decide which agreements they will abide by under the WTO, but are bound by all WTO agreements. What is most significant is that multilateral trade agreements "concern a much broader array of policy measures than tariffs and customs, and as a consequence have much farther reaching policy implications than is often recognized" (Koivusalo, 2003: 161). The multilateral agreements under the WTO have implications for a wide variety of health issues, including, infectious disease control, food safety, tobacco control and the regulation of genetically modified food (WHO and WTO 2002).

The WTO is also tasked with settling trade disputes through the Dispute Settlement Body that has sole authority to establish panels of experts and also has the power to authorize "retaliation" if a country does not comply (WHO and WTO 2002). Critics have pointed out that the trade dispute resolution process at the WTO is, "both closed to public input and binding" (Ostry 2001: 477). Further, they have observed that although decisions are based on consensus, the "Quad" countries — Canada, the United States, the European Union and Japan — have the most decision-making authority (Ostry 2001). The WTO has unprecedented powers with respect to regulatory and sanction powers, and it is these powers that are thought to infringe on national governments' abilities to make policy. With the WTO agreements, there have been numerous cases concerning health issues and only one, involving asbestos, was ruled in favour of public health.[10]

The General Agreement on Trade in Services

The WTO's General Agreement on Trade in Services came into force in 1995 and applies to all WTO members. GATS represents a new direction for international trade liberalization as it governs trade in services. It has been called the most comprehensive "multilateral, legally enforceable agreement covering trade and investment in services" (White 2001: 1). Services include activities as diverse as health care, education and tourism. Under GATS, the *distribution* of a good (e.g., the supply of water and energy) also counts as a service (White 2001). GATS "has a very broad reach" applying to "all modes of supply that are possible in exchanging services" (Gottlieb and Pearson 2001: 8,9). These modes are cross-border supply, consumption abroad, commercial presence and movement of natural persons.

The rules of GATS are legally enforceable by the WTO's dispute resolution bodies. GATS has a framework of general rules (i.e., most-favoured nation and commitments to transparency) that apply to all services and to specific rules (i.e., national treatment and market access) for services listed by countries in their schedules and sectoral annexes setting out rules for particular sectors (Sanger 2001).

GATS "exemplifies a trade doctrine which construes many critical health policy measures as 'non-tariff barriers' to trade in health services" (Sanger 2001: 109). Indeed, GATS applies to any government measure (e.g., regulations, licensing, standards, qualifications, guidelines) that might affect trade in services. GATS measures also apply to all levels of government: federal, provincial, municipal and regional. Trade in services is being promoted through a variety of modes, which have significant implications for women and for the health of communities more generally.[11] There is an overarching commitment by all member countries (under article XIX.1) to pursue "a progressively higher level of liberalization" so it can be reasonably expected that the level of country-specific commitments, including trade in services, will increase rather than decrease. In reflecting on the pressures that governments face regarding GATS negotiations and the binding nature of commitments, an international gender and trade expert commented:

> *GATS is like closing the door in a room to make sure there are no exits left* (Interview, 2002).

As outlined, decreases in federal funding have placed a significant strain on health care. In some instances, this strain is being used as a rationale for turning to the private sector to make services available or, indeed, make the political climate more "trade friendly." GATS would facilitate this. As Koivusalo and Rowson (2000: 185) emphasized, "the potential for trade in services could well increase in future years, with the global concern with cost-containment in the health sector leading to an incremental process of government retrenchment and growing markets for the private sector."

A new round of GATS negotiations are underway, having begun in January 2000. Members are determining which of their service sectors will be open to foreign providers and, correspondingly, which foreign sectors they want to access. In June 2002, countries began making requests regarding which service sectors they wanted opened up in other countries.

All modes of trade in services are being considered in the negotiations. By March 2003, all countries were expected to submit the lists of service sectors they were willing to open up.

Members have a choice of whether to commit services under their schedule of specific commitments,[12] and the degree to which the markets for these services will be opened. To date, 40 percent of WTO members (over 50 countries) have made some type of commitment on health services (WHO and WTO 2002).

Table 2: WTO Members' Commitments on Medical, Hospital and Other Health Services, and on Health Insurance (3rd quarter 2000)

Medical and Dental Services	Midwives, Nurses, etc.	Hospital Services	Other Human Health	Health Insurance (under financial services)
52	28	42	15	78

Source: WHO and WTO (2002).

Canada has indicated that it will not commit health services in its GATS schedules, although as we will illustrate, the degree to which health services are shielded from the GATS market access rules is debatable. Most recently, Canadian officials have also indicated they will not ask other countries to open up their health services markets in the GATS negotiations (Key informant interviews DFAIT and Health Canada, 2003).

The GATS classification system is important because not all services that make up Canada's health care system are classified as "health services." For example, under the GATS classification system, things like hospital services, long-term care facilities, ambulance services, public health programs and labs, diagnostic and health protection monitoring all fall under "health and related social services." Home care and services provided by physicians, midwives, physiotherapists and nurses fall under "business services" in a subsection called "professional services."[13] Although Canada has not made commitments in these categories, it has committed health insurance, which is categorized under "financial services."

Canada's commitment of health insurance to the GATS means there are no limitations on market access to provincial health insurance plans (Johnson 2002) and, therefore, no regulations safeguarding against a number of practices that may not be congruent with the goals and objectives of the Canadian health care system. For example, some analysts are concerned that in the event that Canada wants to expand its public health insurance, foreign companies may challenge this saying that Canada is denying market access to their private insurers. A trade expert in our study indicated:

> *One clear implication of having listed health insurance under the GATS [is that] when we expand the public health insurance system…the U.S. or European governments would have the option of challenging that as denying market access to their private insurers, and Canada could find itself entangled in a trade dispute* (Interview, 2002).

The privatization of the financing of health insurance has significant implications. For instance, a key principle of insurance is risk pooling to minimize the potential of extensive payouts. In other words, although everyone contributes, only some people will ever need to collect. This encourages providers to insure only the healthy and least "at risk," a practice called "cream skimming." Debra Lipson (2001: 1139) has indicated that, "evidence from countries where private insurers compete indicates that, even with strong regulatory systems, greater competition among health insurers segments and destabilizes the market and undermines the ability to build larger, more equitable risk pools that spread costs between rich and poor, healthy and sick" and among and between women and men.

Canada has also made extensive commitments under data management and information processing, which have implications for many aspects of the health care system. Canada's ability to regulate and ensure the privacy of individuals using the health system could be undermined by these commitments. There is only a very weak exception in GATS for regulations to safeguard privacy. Privacy is a critical issue for women, who need to be able to talk to health care professionals about their experiences of physical and sexual violence, and about issues related to contraception and abortion.

There is concern that national policy flexibility may be undermined by the commitments Canada has already made under GATS, as well as by any new obligations it may undertake in the current round of negotiations. This could have a "chilling" effect on government policy decision making with respect to health reform, because governments may fear being subjected to WTO trade sanctions for possible violations of these commitments. According to Marceline White (2001: 2), "GATS could effectively cede local, state and federal decision making authority to WTO trade panels."

Feminist Responses

Beginning with the FTA, Canadian feminists have raised questions about how trade agreements might negatively affect women (Cohen 1987; Porter 1987). The National Action Committee on the Status of Women was one of the first groups in North America to take up issues related to trade agreements and women, focussing on labour, environmental issues and the potential effects of the privatization of social services (Cohen et al. 2002). This broad-based movement recognized the profound impact of economic restructuring on the lives of women and understood that the struggle for public services would benefit all Canadian women and help them in the struggle for equality.

Initially, most Canadian feminists were primarily concerned with the potential impact of the FTA on women's labour (e.g., Cohen 1987; Porter 1987). After Canada, the United States and Mexico signed NAFTA in 1994 and Canada became a key member of the WTO in 1995, many more feminists began to write about trade agreements and to theorize and document how they affect women and men differently, with a particular focus on the deleterious effects on women (Bakker 1996; Cohen 1987; Cohen et al. 2002; Pierson and Cohen 1995). Analysts have charged, for example, that agreements like NAFTA are "inherently anti-public sector," because they foster the privatization of public services and the reshaping of public programs to reflect commercial aims (Cohen 1995: 97). This research has now established that economic

restructuring has gender-differentiated effects with specific impacts on women who are further marginalized by their socio-economic status, race, ethnicity, culture and ability.

A wide range of literature has documented the social, environmental and economic changes that have resulted from NAFTA, particularly in Mexico where the number of foreign companies has increased dramatically. The differential impact of NAFTA on women has been noted especially with respect to labour standards and the impact on workers, particularly women concentrated in low-paying jobs.[14] Writers have also documented the discriminatory treatment of women in the factories with respect to maternity rights and sexual harassment (Nieves 2002).

Still others have shown how the location of the factories in isolated areas has put women's safety at risk. For example, 75 women working in the city of Ciudad Juarez, Mexico in the *maquiladoras* have been raped and murdered since 1993, and many more have gone missing. The murders have most often taken place in the isolated areas where the factories are located, and the factory managers of the multi-billion dollar U.S.-owned companies have been slow to respond to the need for better security measures for the women workers (Nieves 2002). The pollution and toxic waste resulting from U.S.-owned companies have key health implications for women and children. A current example is that of the abandoned lead smelter in Tijuana owned by the American company Metales y Derivados that has resulted in unacceptable levels of lead contamination leading to multiple health problems for the inhabitants and to serious birth defects in newborns (Sullivan 2003).

Other studies have focussed on the increased mobility of female workers across borders and how this affects their access to health care (e.g., Boliz et al. 1999). Additionally, studies have examined the specific sections of NAFTA to determine the degree to which the agreement puts Canada's health care services at risk for foreign investment and increased privatization (Boliz et al. 1999; Epps and Flood 2003; Fuller 1998).

Feminist scholars and activists have concluded that women's human and equality rights are being significantly eroded by economic globalization and the resultant national economic and social policies. Despite this, there continues to be a resistance to interjecting considerations of gender equality into the current debate about economic restructuring, because people understand gender equality in a very narrow way as pertaining only to issues such as abortion and pay equity (Brodie 1995). Further, the current preoccupation in Canadian politics with the deficit and with shrinking government has completely marginalized women's issues — issues which either require government expenditure or intervention — both of which are currently unpopular (Brodie 1995). In the rhetoric that serves corporate and business objectives, larger social and political issues are individualized. In this climate, the family is idealized as women are urged once again to take up roles as caregivers and look to men for economic support (Mosher 1998).

Despite this activism and ongoing critique, there has been a limited engagement of the health sector with issues related to globalization (Lee 2003). The Canadian women's health movement has carefully documented the effects of privatization on the health care sector and

on women's health; however, it has just begun to turn its attention to the implications of trade agreements for Canadian women and health.

Engendering Trade Agreement Analysis: Social Impact and Gender-Based Analyses

Analysts concerned about how trade agreements may erode Canada's public health care system have called for appraisals of how trade agreements impact health care. Sanger (2001: 113), for example, says, "the Canadian government should conduct a systematic and comprehensive assessment of the health impacts of our commitments under the existing GATS agreement."

Despite these calls, large-scale studies of this nature have not been done, in part, because the methodology for conducting such studies is under-theorized and underdeveloped. Further, in the case of trade agreements and the health care sector, some of the analysis, especially with respect to newer agreements (e.g., GATS) is speculative. We suggest that it is necessary to develop a methodological framework and specific tools to assess the impact of trade agreements on population groups. Large-scale and systematic studies will be able to tell us more precisely about the effects of these agreements on women.

Social Impact Analysis

Social impact analysis was originally developed for examining poverty and the social effects of public action in the development context (Gittinger 1985; Timmer et al. 1983). SIA can be defined as an "analysis of the distributional impact of policy reforms on the well-being or welfare of different stakeholder groups" (World Bank 2002). Since the work conducted in the late 1980s by Cornia et al. (1987), SIA has increasingly been used to analyze the social costs of structural adjustment. Originally, SIA focussed on income measures (World Bank 2002), but has recently begun to consider important non-income measures (e.g., control over resources) (UNDP 2003). The human development paradigm found in the work of Sen (1999) has been critical with respect to this new framing. Feminists have criticized SIA, however, for not adequately considering gender as an important analytic category in its discussion of social costs and because it has not examined "the social relations across and within nations (class, gender, race, etc.) that form the context in which trade policies are enacted" (Cagatay 2001: 5).

With modifications to include gender as part of its analysis, there are a number of reasons why SIA may be appropriate for trade policy analysis. SIA may be able to balance the importance of efficiency and growth with considerations of well-being, social justice and environmental sustainability. Because SIA also prioritizes the use of mixed methods, it levers the benefits of both qualitative and quantitative methods in developing a more complete analysis of the relationship between trade agreements and health. In the context of health, it leads to the examination of how the core values of equity, fairness and solidarity on which the Canadian health care system is premised (Romanow 2002) are affected by trade policy. It also allows for the distributional effects of policy change on various population groups that are themselves gendered (e.g., categorized by income, ethnicity, age, geographic location) to be illuminated. This analysis takes into account not only health status and health services utilization, but also addresses the effects on the political, economic and social determinants

of health and disease. Few studies examine the impact of reducing trade barriers on health equity, efficiency, access and quality (Lipson 2001). Having this type of information is essential if governments are to understand better how to mitigate the harmful effects of trade.

Gender-Based Analysis

Internationally, there is growing pressure for systematic gender mainstreaming and gender-based analyses of all trade agreements (Cagatay 2001; Marchand and Runyan 2000; White 2002a). A number of organizations and gender specialists have started to develop specific tools to assess the impact of trade agreements on women (e.g., O'Regan-Tardu 1999; White, 2002a; Allaert and Forman 1999). In all the approaches and strategies thus far, there have been marked differences in how to engender trade policy. Strategies range from ensuring access and representation, through such means as non-governmental organization (NGO) representatives in trade delegations and gender mainstreaming, to social clauses engendering review mechanisms such as trade policy reviews, and long-term capacity building via trade literacy initiatives.

Although Canada has been involved in some multilateral trading bodies like the Asia-Pacific Economic Co-operation (APEC) and the FTAA (neither of which is an actual trade agreement), which have begun a process of gender integration (e.g., The Framework for Integration of Women in APEC) the focus of these initiatives have not been critical of economic globalization, but rather is designed with the goal of advancing women's economic interests and opportunities through trade liberalization. Indeed, approaches to gender-based analysis are marked by differing ideological perspectives (Hassanali 2000: 24), and to date, no model of best practices has emerged. Specifically, the central debate can be characterized as whether women should work collaboratively with trade bodies (i.e., the belief that efficiency and growth through trade is complementary with social justice) vs. the position that the market-based values underlying trade agreements are incompatible with the values underlying a public sector. What is clear, however, is that neither Canada's trade policy, nor its trade negotiation strategy has systematically reflected an awareness of the gendered effects of trade on women (Blacklock 2000: 20). The absence, in particular, of women's organizations and women's advocates in trade policy-making processes is a key obstacle to integrating a gendered perspective consistently into official trade policy.

We believe, however, that the use of GBA can help to evaluate and interpret the effects of trade agreements on women and the public sector. Gender-based analyses are confounded by the methodological difficulties of teasing out what are effects of trade and what are due to pre-existing social and economic factors and, in the case of analyzing trade in services, by the fact that most of these agreements are still under negotiation, and their effects are not yet fully realized. Despite these limitations, GBA frameworks can be useful at this particular juncture for identifying the trade agreements most relevant to health and women, and for gathering preliminary information about their potential effects on women.

Drawing on the work of others who have developed GBA frameworks (e.g., White 2001) we asked the following questions with respect to each of the trade agreements analyzed in the context of home care.

- What are the health relevant aspects of the trade agreement? Which aspects are relevant to the home care sector specifically?

- What are the gender relevant aspects of implementation or enforcement of the trade agreement with respect to the home care sector?

- What might the effects be on women's health, women's labour in the home care sector and women's equality?

In the next chapter, we use these questions to analyze the home care–trade interface. International trade agreements have an impact on home care delivery primarily through their current and potential capacity to open up either the financing or delivery of home care services to privatization by allowing domestic and foreign companies to take up these roles with a profit motive. Trade agreements are also relevant with respect to the supply of services across borders and the degree of mobility of services and professionals across borders.

4. THE HOME CARE/TRADE INTERFACE

Using home care as a case study, this chapter explores the implications of NAFTA and GATS for future policy reform in our health system. We provide a brief description of models of home care in British Columbia and Ontario, detailed[15] for the purposes of undertaking a gendered analysis of NAFTA and GATS. These two provinces have been chosen, because each represents a distinct model of home care currently in use. Each has also developed its own definitions of home care. The Ontario model is based on contractual managed competition, co-ordinated by the Community Care Access Centres (CCACs). In comparison, British Columbia has devolved its delivery of home care, and uses a regionally based model in which health authorities co-ordinate all home care services. While Ontario has moved to a model that is explicitly conducive to increased for-profit home care delivery, both provinces have made policy choices that have reduced publicly funded home care services and programs. Despite provincial differences, there are similarities in the way home care is already affected and may be further affected if home care reform is implemented without a clear understanding of NAFTA and GATS provisions.

Home Care in Ontario

Over the past decade, in a policy context of cuts to public programs and services, home care in Ontario has undergone considerable change. As in all provinces, there has been a shift from hospital-based services to long-term care and community/home-based services. Home care services in Ontario are classified under two main categories: in-home services and community care services. In-home services typically refer to personal and professional support services and homemaking. Examples include transportation, home-delivered meals, adult day programs and home maintenance.

Home care is regulated predominately by the *Long-Term Care Act*, *1994.* In addition, the *Health Insurance Act* determines eligibility for professional services. In essence, it is not the *Long Term Care Act* itself, but rather a number of service agreements and regulations passed by Cabinet that directly govern home care in the province. The regulations for example, define both the eligibility for homemaking services and the maximum hours for nursing, homemaking and personal support services (Ontario 1994). A person is eligible for homemaking if he or she:

- requires personal support services along with homemaking services;
- receives personal support and homemaking services from a caregiver who requires assistance with the homemaking services to continue providing the person with all of the required care; or
- requires constant supervision as a result of cognitive impairment or acquired brain injury, and the person's caregiver requires assistance with homemaking services (Ontario 1994).

All the services provided by the CCACs have no user fees. In the original Act, there was a maximum level of service clients could access. This was, for instance, four nursing visits per day. In terms of homemaking and personal support services, these could not exceed 80 hours per month for the first month and 60 hours thereafter. Currently, services are based on assessed needs. Pharmaceuticals are partially covered by the government. Home care clients who receive professional services *only* are funded and *some* pharmaceuticals are paid by the drug plan in Ontario. This means home care clients who receive homemaking services *only* do not receive pharmaceutical coverage. A number of community care services may also be available but are not publicly funded. In addition, volunteers give 2.5 million hours of service a year to home and community support agencies (OCSA 2000b).

The provision of home care services in Ontario is facilitated through a system of managed competition implemented in early 1996. The current system involves a variety of providers (for-profit and not-for-profit) that are regulated by government-funded agencies. The government provides funding for personal and professional in-home services, while care recipients must pay user fees for some community support services.

Serving as entry points into long-term care services, the CCACs are primary actors in this system. First announced by the Minister of Health in 1996, they were established across the province by 1998. The CCACs amalgamated 38 home care programs and 36 placement co-ordination services. Before 1998, home care services were purchased by the government, primarily from the Victorian Order of Nurses, St. Elizabeth Health Centre, the Red Cross and the Visiting Homemakers Association — all private, not-for-profit organizations (Armstrong and Armstrong 2001). When the CCACs were first established, they were administered by boards of directors that were eventually elected and intended to represent all key stakeholders in home care, including care recipients, caregivers, and other health care and social service providers and advocates.

Forty-three CCACs are now in operation, dealing with more than 400,000 people every year (Ministry of Health 2001). The centres have numerous responsibilities. They provide general information, client assessments and referrals to all long-term care services, case management, evaluation and monitoring of all services. In accordance with ministry guidelines, the CCACs determine eligibility to receive services. Eligibility is based on criteria that includes Ontario residency and insurance under the Ontario Health Insurance Plan, needs that cannot be met as a hospital outpatient or within the CCAC program of services, appropriateness of the home setting, and willingness and ability of family and other persons to provide care (Ministry of Health 2001).

Using government funds, and following government guidelines and policies regarding requests for proposals, the CCACs are also responsible for purchasing and contracting services, medical supplies and equipment from available providers for any amount exceeding $100,000. This arrangement represents a major instance of public funding of private services in the Ontario health care system. CCACs contract out services in the following areas: professional services (e.g., nursing care, physiotherapy, occupational therapy, speech and language therapy, palliative care, dietetic services, social work), personal support services (e.g., bathing, dressing, meal preparation and feeding), and homemaking and other social services

(e.g., cleaning and laundry, transportation to and from medical appointments, health care equipment). They then arrange for these services to reach individuals requiring home care.

Both not-for-profit and for-profit agencies compete for available tenders. Indeed, the previous non-profit agencies could not retain all the contracts. The Ministry of Health and Long-Term Care has stated that decisions are based primarily on quality issues rather than price issues (an 80/20 ratio) (OHC 2001b: 3). In March 1999, however, the Ontario Home Health Providers' Association noted that "at present, there is no articulated process in the [competitive bidding] document to determine how each provider arrived at the price/quality structures for services." Moreover, the request for proposal process is extremely time consuming, with preparation costs ranging from $10,000 to $20,000 (Browne 2000: 103). This substantially undermines the ability of not-for-profits to compete for available contracts. Significantly, under this system even foreign-owned, for-profit firms are eligible to compete (Ministry of Health 1996: 3-4). Armstrong and Armstrong (2001: 181) have argued that within such a model, it would even be possible for "virtually the entire home care service contract to go to a single, foreign-owned operation."

Moreover, the increasing presence of these companies has translated into a significant shift in the number of registered nurses (RNs) and registered practical nurses (RPNs) moving to for-profit companies from not-for-profit organizations. As an example, in 1995 there were 2,933,735 not-for-profit RN visiting nurses; in 2000 this number dropped to 2,552,400. In comparison, in 1995 there were 360,898 for-profit RNs; by 2000 this number had risen to 1,709,188 (White 2002c). Indeed, it has been reported that an increasing number of U.S.-based for-profit health care companies are bidding on available requests for proposals in the home care sector in Ontario.

Overall, the system is based on a competitive model, and is intended to ensure flexibility, choice and cost effectiveness (Williams et al. 1999). The government's objective in this regard is best quality and best price. The Ontario government has publicly stated that its priority is to ensure that people across the province receive high-quality home care services. In the 2000–2001 fiscal year, the government spent $1.14 billion on home care services and provided care to approximately 500,000 clients (White 2002c). Despite this stated intention, in the 2001–2002 fiscal year, the provincial government announced a funding freeze that cut millions from CCAC budgets, reportedly leaving them $175 million short of what they needed to meet demand (OHC 2001c). Consequently, across the province a range of services have been cut or reduced including homemaking services and personal support. According to the Ontario Association of Community Care Access Centres (OACCAC), data from the Ministry show that on March 31, 1999 there were 11,255 persons across the province waiting for services (OHC 2001b).

In addition, the government introduced Bill 130 (*Community Access Corporations Act*, *2001*) to ensure service standards including training and client assessment across the province. Under this Act, many changes have been made to CCACs. They are now statutory corporations. Community membership in the CCACs has been eliminated and directors appointed by the provincial government have replaced elected boards. There are no specific requirements for

representation on these newly appointed boards. Moreover, the government has created community advisory councils, but these only involve CCAC partners, such as hospitals, community service organizations and long-term facilities in service co-ordination. The public only has access to annual reports of the CCACs. Other information (e.g., who is receiving government money and how it is being spent) is only released as deemed “necessary to the public interest.” The CCACs are exempt from freedom of information legislation with much of the information defined as necessarily secret to protect the bidding process.

Home Care in British Columbia

As early as 1991, the Seaton Commission in British Columbia proposed a “closer-to-home” theme for health care restructuring; care for patients was transferred away from institutions and moved into the community, including homes. Home care in British Columbia refers to services in the home for the elderly or otherwise disabled individuals and their families. Home care is available on a short- or long-term basis. Short-term care is available for those suffering from illness, injury or surgery. Long-term care may include care for those suffering from chronic conditions or disabilities, and those requiring assistance with daily living activities. British Columbia also provides an extensive palliative home care program.

There are two important pieces of legislation that inform the regulation of the home care system in British Columbia. The *Continuing Care Act* addresses residential and home care. It requires health authorities to enter an agreement so the service provider is eligible for funding from the health authority for the provision of designated continuing care services. This agreement outlines the overall respective responsibilities of the health authority and service provider with respect to designated continuing care services, and it documents the terms and conditions of receiving health authority funding (British Columbia 2000). Continuing care consists of the long-term care, home nursing and community rehabilitation programs. Together, these programs integrate the social and medical health services for all eligible clients. The *Employment Standards Act* sets minimum standards for wages and terms of employment for most workers in British Columbia.

The Ministry of Health Services provides health funding to the five health authorities. They are charged with assessing community needs and resources, planning and administering acute care, residential care facilities, and community health services and resources, developing priorities and allocations of resources within their geographic area, and developing and monitoring adherence to health standards and provincial legislation. Health authorities are, in turn, responsible for funding their continuing care programs, which are charged with the actual delivery of home care services.

Regionalization began in 1996–1997, with the introduction of the Better Teamwork Better Care initiative. In 1997, for instance, the province had 11 regional health boards, 34 community health councils and seven community health service societies, referred to as “health authorities.” These were responsible for health planning, policy development and service delivery. In December 2001, new structural changes were introduced. Currently, British Columbia has five regional health authorities, 15 health service delivery areas and one provincial health service authority.

The following services are available through the health authorities and delivered via the continuing care programs in British Columbia.

- **Assessment and Case Management:** Intake and screening, initial assessment, program planning, service authorization, monitoring, evaluation follow-up and reassessment.

- **Community Home Care:** Community home care nursing (comprehensive care available seven days a week, up to 24 hours a day) and community rehabilitation (consultation, occupational therapy and psychotherapy treatment services).

- **Home Support Services:** Provide respite for family caregivers, support services to assist with activities of daily living and meal programs when deemed necessary.

According to the Ministry of Health Services, home support services are intended to:

- assist clients to live in their own homes as long as it is practical and in the best interests of the client and family;
- supplement, but not replace, the care provided by families, other paid caregivers and communities;
- promote the independence and well-being of clients, their families and other unpaid caregivers; and
- provide respite to the family member or other unpaid caregiver ordinarily caring for the person in the person's home.

Home supports are a component of community-based services. Services vary between health authorities. Health authorities are expected to work collaboratively with community stakeholders, as well as with clients, caregivers and their advocacy organizations in the planning, development, operation and co-ordination of community support services. Examples include meal shopping and home maintenance programs, hospice volunteers, and volunteer drivers and visitors (British Columbia 2000).

The health authorities take responsibility for assessment and case management. In general, publicly financed home care services can be delivered by public agencies, such as the regional health authorities, charitable organizations or for-profit businesses (Pollak 2000). Health authorities are expected to be accountable to the Ministry of Health Services, which sets policy and guidelines for all such services regardless of whether they are delivered by non-profit or for-profit organizations.

Case managers who work in the continuing care programs assess, co-ordinate and manage cases. British Columbia does, however, categorize clients as those requiring community home care and home support. Home support is available to those aged 19 and older while persons of all ages are eligible for community home care nursing. Community home care nursing also includes acute and palliative care, in addition to any chronic care needed. Some community and continuing care services, such as home care nursing and preventive nursing

services (deemed medical) are free; many other services, such as home support, have user fees and/or stringent eligibility criteria.

Eligibility requirements for available services vary from case to case. However, for home support, eligibility is based on age as well as health status (chronic illness for a minimum of three months) and service needs, residency (one year for personal/intermediate care, three months for extended care) and citizenship. For example, you have to be a Canadian citizen, or landed immigrant, residing in British Columbia (for at least 12 consecutive months prior) to make an application for personal care/intermediate care, and alternatively after two months for extended care. Client care needs are assessed at different levels, taking into consideration health and service requirements. These levels range from personal care (pc), intermediate care (IC 1, 2 and 3) and extended care (EC).

Personal assistance and housekeeping are provided when required. Personal assistance includes tasks, which may be performed by a home support worker, which assist a client with personal care or activities of daily living, and specific nursing and rehabilitation tasks, such as mobilization, nutrition, lifts and transfer, bathing and grooming. Housekeeping covers the minimum tasks required to maintain a safe and supportive environment for a client including cleaning, laundry and meal preparation and, in rare cases, transportation or shopping. Home maintenance is not included in housekeeping.

Service authorization is based on an assessment of the client's health and functional status and the availability of family and other community supports. By 1999, local health authorities had all but eliminated care for clients assessed as having less serious needs, such as help with cooking, cleaning, laundry, shopping and getting to medical appointments (Vogel et al. 2000: 32). Thus home supports are typically provided to clients who also are eligible for community home care nursing. Some clients, however, are still receiving bathing services in their homes. As Vogel et al. (2000: 31) have noted: "A person's entitlement to public home care is now based on a narrow idea of medical risk (usually of hospitalization) rather than on a well-rounded criteria of prevention and health maintenance."

Moreover, an income testing system exists in British Columbia. Eligible care recipients are required to pay a "client rate" for home services. A client rate is calculated by multiplying the client's income (as defined in the *Continuing Care Act* Regulations) by 0.00138889. In practice, payment is more commonly based on a sliding scale. User fees apply to home support services and are based on an income test. Currently, approximately 30 percent of care recipients pay user fees for such services.

For the 2002–2003 fiscal year, The Ministry of Health Services allocated $508 million to community care and $1.153 billion to residential care. In 2000–2001, there were about 118,310 clients receiving care: 35,450 residential care clients and 82,869 community support clients (Joudin personal communication 2002).

On June 3, 2002, the British Columbia Ministry of Health Services implemented a new policy that expanded the criteria of caregivers eligible to receive financial compensation to include some types of family members. Previously, the provincial government did not

provide payments to individuals in familial relationships with those for whom they provided care.

According to the B.C. government, this policy change is intended to better enable recipients of care to increase their options when selecting a caregiver, and establishes greater consistency across the range of government programs. To ensure acceptable quality of care, the family member must adhere to established standards and requirements, and effort is made to make all parties aware of the risks that accompany financially compensating a family member in exchange for caring services. The health authority is responsible for these aspects of the program.

Not every family member is eligible to receive compensation. If the relative resides with the care recipient, or is a parent, child or spouse (regardless of living arrangements), payment cannot be made. These restrictions are somewhat flexible in recognition of factors and circumstances that may limit the selection of a caregiver. Exceptions may be made on the basis of rural location, behavioural problems, and cultural and language barriers.

A report by the B.C. government (2002), entitled *Public Funds, Family Commitment: A Review of Government Policy Concerning Public Compensation to Family Caregivers in British Columbia,* outlines some significant considerations with respect to the payment of family caregivers. The report explains that expanding the number of potential caregivers in British Columbia, as well as providing caregivers with an emotional connection to the recipient, is advantageous. It also makes reference to potential drawbacks. These include the potential transfer of funds away from the individual requiring care, the vested interest of a family in keeping a care recipient dependent, vulnerability to abuse and the difficulty of training family caregivers. Furthermore, it notes that the lack of knowledge with respect to how sustainable the program is could drain funds.

Despite the compensation available to a limited number of family caregivers, there is evidence that further cuts to home care services are planned as part of a general policy of retrenchment underway in British Columbia. There have been some fundamental shifts in the hospital industry that may eventually occur in the home care sector. For example, hospital support workers are rapidly being privatized as hospitals in British Columbia contract out for these services, and these are being shown to have negative effects on women (Cohen 2001).

Table 3 compares home care programs in Ontario and British Columbia.

Table 3: Comparisons Between Home Care Programs in Ontario and British Columbia

	Ontario	**British Columbia**
Legislation	*Long Term Care Act*, *1994* (Bill 173) *Long Term Care Statute Amendment Act* (Bill 101)	*Continuing Care Act*
Relevant legislation	*Health Insurance Act* *Corporations Act* *Homemaker Nurses Services Act* *Ontario Drug Benefit Act* *Health Care Consent Act*	*Employment Standards Act*
Service delivery model	Single entry Competitive managed contracts	Single entry
Service providers	Mix of for-profit and not-for-profit	Internally provided by continuing care programs. Mix of for-profit and not-for-profit
Assessment	No standardized assessment	Long-term care 1 (LTC1) assessment form
Care level assignments	No care level assignments	Personal care; intermediate care 1, 2, 3; extended care
Service cost	None	Income-tested
Caring for the caregiver	Respite care	Respite care

Table 4 gives an overview of what is known about the formal home care labour force in British Columbia and Ontario. Although gender breakdowns are available, no information on race or ethnicity was found.

Analysis

A number of general observations have been made about the state of home care services in Canada over the last decade. Between 1995 and 2000, there was an increase of 140 percent in the number of people receiving home care (CHCA 2002). And yet the over one million Canadians now receiving home care are facing shortages in services, and their caregivers are faced with providing increasingly complex care in the home, which often requires expensive equipment and supplies (CHCA 2002). Not surprisingly, in his recommendations Romanow (2002: xxxi) argued that “the first step is to establish a national platform of services that would be available to Canadians in all parts of the country under the same terms and conditions.” Because all reform in health takes place within a globalized context, it is imperative that it is understood how current provincial home care programs are already affected and what constraints there may be for future reforms stemming from trade agreements, such as NAFTA and GATS.

Table 4: Formal Home Care Labour Force, Ontario and British Columbia

Number of Home Care Workers	Duties	Salary/Wages	Benefits and Union Membership	Gender
Ontario				
Approximately 43,000 workers are employed in some facet of home care services. The Ontario Home Health Care Providers' Association oversees approximately 30,000 employees. The Ontario Community Support Association oversees approximately 13,000 employees.	RNs provide direct health care services. RPNs provide supplementary care under the supervision of physicians and registered nurses. Personal support workers (PSWs) provide ancilliary services in a patient's home that enable the patient to continue living independently. Duties largely involve personal care, but may extend to homemaking tasks.	Home care RNs earn approximately $20.00 per hour. Home care RPNs earn approximately $13.50 per hour. Home care PSWs earn approximately $10.60 to $11.04 per hour.	Unionized home care workers may receive benefits in their contracts negotiated with private employers and Ontario CCACs. Benefits may include dental and eye care plans, reduced work weeks, improved schedules and vacation time. May be self-employed.	99 percent of home caregivers are female.
British Columbia				
Approximately 882 RNs provide social services including home care. Approximately 528 licensed practical nurses (LPNs) provide social services including home care. Approximately 11,925 visiting homemakers, housekeepers, and home aides are employed in health services.	RNs provide direct health care services. LPNs provide supplementary health care services for patients. Visiting homemakers, housekeepers and related workers provide ancillary services in patients' homes. Responsibilities may include cleaning, shopping and personal care.	RNs earn, on average, $34,200 per annum or $21.00 to $30.00 per hour depending on experience and union membership. LPNs earn, on average, $26,100 per annum or $18.35 to $19.03 per hour depending on experience and union membership. Visiting homemakers, housekeepers and related workers earn, on average, $16,000 per annum.	Benefits are generally contingent on union membership. Bargaining power of unions enables some nurses to receive higher wages and benefits. May be self-employed.	95 percent of RNs are female. 91 percent of LPNs are female. 91 percent of visiting homemakers, housekeepers, and related workers are female.

Sources:
BC and Canada (2000); OACCAC et al. (2000); OCSA (2000a); OHHCPA (2000).

The Current Status of Home Care under International Trade Agreements

Reservations and Exemptions

NAFTA and GATS contain specific reservations and exemptions intended to protect Canada' health care system. Under NAFTA, the Annex II Reservation states that "Canada reserves the right to adopt or maintain any measure with respect to the provision of public

law enforcement and correctional services, and the following services to the extent that they are social services established or maintained for *a public purpose*: income security or insurance, social security or insurance, social welfare, public education, public training, health and child care” (emphasis added).

From Canada’s perspective, health is protected under NAFTA, because it is considered a service established and maintained for a public purpose. However, U.S. trade officials have argued that, “where commercial services exist, that sector no longer constitutes a social service for a public purpose” (Evans et al. 2000). This may undermine the protection of our health care system under which there is already some private services and an increase in public–private partnerships in provinces like Ontario, Alberta and British Columbia. Despite the potential threats, the fact remains that there have not been any challenges to Canada’s NAFTA position on health services or any instance of using NAFTA to gain entry to the Canadian health services sector.

The implication of the Annex II reservation is that it potentially puts at risk services (i.e., hospital support services, nursing, lab services, etc.) that are beginning to be contracted out, but still retain a significant amount of the service in the public sector. It also exposes services not currently covered by the *Canada Health Act* to further privatization (e.g., home care). Susan Joekes and Ann Weston (1994) expressed concern about the inclusion in NAFTA of various health services, because this may increase pressure on Canadian federal and provincial governments to privatize the health sector. Expanding on this, Boliz et al. (1999) suggested that one key issue regarding access to health care under NAFTA are the potential loopholes in the Agreement that might reinstate financial barriers to access and thus threaten Canada’s publicly funded system.

GATS applies to all services except those provided in the exercise of *governmental authority* as defined in article 1.3. Article 1.3 (b) states that all services are covered by the agreement “except services supplied in the exercise of governmental authority” and in paragraph (c) these are defined as “any service, which is supplied neither on a commercial basis, nor in competition with one or more service suppliers.” The terms “on a commercial basis” and “in competition” are left undefined.

The WHO and WTO (2002: 119) have conceded that an exact definition is not known, because there has not been a dispute on the matter and that “while WTO Member governments could seek clarification within the current GATS negotiations, they have not yet expressed the need to do so.” As one trade expert we interviewed commented:

> *I am very uncomfortable that Canada does not have a very clear exclusion for its most cherished social program, because the more convoluted and difficult your argument is, the more chances that you will lose before a trade panel* (Interview, 2002).

In addition to article 1.3, article XIV allows for exceptions to GATS if governments can meet certain defined criteria. The exception related to health is article XIV (b), which states that members are entitled to take any measure *necessary* to protect “human, animal, or plant life or

health," regardless of their obligations under the Agreement. While in theory this may provide protection for health policies, in practice it may not. The WTO Secretariat and WHO have both acknowledged that health policies may be challenged by affected countries if they feel these measures impose unwarranted restrictions on trade in services (WHO and WTO 2002). Indeed, as Lipson (2001: 3) argued, "in practice, WTO jurisprudence (and GATT rulings that preceded the WTO) indicate that to employ such an exemption, the measures would be subject to a narrow interpretation of what is 'necessary' to protect health." *Necessary* might be interpreted as what is least trade restrictive rather than what may best protect or promote health.

In both NAFTA and GATS, the wording of the reservation and exemption does not take into account Canada's mixed public–private health care system. Because the *Canada Health Act* does not cover home care and because in many jurisdictions there is a substantive presence of private not-for-profit and for-profit companies operating in competition or on a commercial basis, home care is not included in NAFTA and GATS reservations and exemptions (Epps 2001; Sanger 2001). As a result, it may be concluded that as currently structured, home care is subject to both agreements.

National Treatment and Most Favoured Nation Clauses

In the case of NAFTA, home care is subject to national treatment and the investment provisions of the agreement. National treatment (1102 (1) and (2)) states: "each Party shall accord its investors of any other Party no less favourable treatment than that it accords, in like circumstances, to its own investors with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments." In the home care sector, national treatment could prohibit favouring a not-for-profit provider over a for-profit provider. It also could affect the ability of the Canadian government to regulate health services, especially if regulations are interpreted as creating disadvantages for foreign health providers. In addition, home care may also be subject to the most favoured nation clauses (1103 and 1203), which necessitates that Canada (including the provinces/territories) must provide NAFTA investors with treatment no less favourable than it extends in like circumstances to the same from any other country.

According to one key informant, in terms of GATS, there are two levels of vulnerability:

> *The extent to which home care services are subject to the general rules of the GATS, and the extent to which home care is subject to other rules as laid out in Canada's schedules*.

Without doubt, there are real challenges for examining home care vis-à-vis GATS, because of its ambiguous classification system. In terms of GATS, home care is not listed explicitly as a separate service in the classification used to make commitments. However, health services associated with home care are, and 26 WTO members including the EU and Mexico have included home care related services within their specific country commitments (Sanger 2001). Health related home care services are not listed in Canada's schedule and are thus not subject to the GATS national treatment and market access rules (Sanger 2001).

Despite not being specifically listed in Canada's country schedule, home care services are nevertheless subject to the general obligation of GATS, specifically the most favoured nation provision (CCPA 2002). GATS article II, most favoured nation applies across all service sectors (except those shielded by article 1.3) regardless of whether they have been included in a member's schedule of commitments and states: "With respect to any measure covered in this Agreement, each Member shall accord immediately and unconditionally to services and service suppliers of any other member treatment no less favourable than that it accords to like services and service suppliers of any other company." This obligates countries not to discriminate among foreign suppliers by offering more privileges or rights to some but not to others. In practice most favoured nation "allows all home care providers to claim a right to the most advantageous deal given to any single foreign-based providers" (Sanger 2001: 99). Further, once a foreign-owned corporation has used NAFTA to gain access to public health funding, the GATS most favoured nation rule would allow all foreign corporations to claim access to the Canadian market and to argue for the same level of public subsidy (Sanger 2001).

Complicating the analysis is the fact that home care covers an array of services. These include health care services but also extend to a range of social and living supports. Delivery of these services is under the jurisdiction of a variety of departments and ministries, ranging form health and social services to health and community services, as in the case of both Ontario and British Columbia. Just as the exemptions in trade agreements are inadequate to protect the Canadian health care system, given its public–private mix of services, they also do not cover the range of services required in an area, such as home care.

Taking GATS as an example, health care services relating to home care may be exempt from country sector-specific commitments. Indeed, Canada has explicitly excluded nursing, physiotherapy, nutritionists and occupational therapy from its GATS commitments.[16] According to the Registered Nurses Association of Ontario, however, the recent rounds of GATS negotiations includes requests that restrictions regarding these services should be relaxed and that foreign companies (with foreign majority ownership) should be allowed to provide these services.[17] Here, it is important to point out that in the GATS classification system these types of services are grouped as professional services in the business sector rather than in the health care sector. This of course further undermines their protection as public health services, because they are distinguished from the category of hospitals, community clinics and other health care services (Sanger 2001). It may therefore be more difficult for the Canadian government to argue that they are a public health service and therefore protected under the governmental authority clause of GATS. As one respondent put it:

> *The way you classify a service, that is, what sector it is said to come under will determine whether or not and how you liberalized it. So it may get liberalized inadvertently under something else, or it may be separately identified to make it easier to liberalize.*

At the same time, building cleaning and food preparation, which may be interpreted to cover social and living support services in the home care sector, have been listed and are therefore subject to GATS national treatment (article XVII). National treatment applies only to those

services listed by countries in their GATS schedule. National treatment requires treating foreign suppliers of like services no less favourably than domestic suppliers. This significantly limits the ability of national governments to decide on the best health care service providers in a particular area or region. For example, national treatment would prevent governments from favouring not-for-profit community-based services over foreign corporations providing the same service. Arguably, local not-for-profit organizations with specific connections to a given community, may be better suited to deliver services such as home care (Key informant interview, 2003).

National treatment also has implications for support services by restricting the ability of hospitals and regional health authorities to contract their services (e.g., food preparation, laundry and cleaning) out only to national organizations or companies. That is, regulations that require local food production may be challenged. Under GATS, foreign companies must be provided with the same opportunities to compete in the market.

Building cleaning and food preparation may also be subject to market access (article XVI). Under market access, a range of restrictions (e.g., limits to the number of service suppliers and the number of people employed, quotas regarding the total value of services, and restrictions on the type of legal entity) are prohibited. On this point a trade expert commented:

> *In areas where you have made specific commitments, [GATS] prohibits certain types of policies…so whether they are non-discriminatory or not and this is where I think trade agreements really overstep their bounds…. Certain types of what they call quantitative restrictions, which basically limit the number of service providers are just prohibited outright whether or not they are discriminatory* (Interview, 2002).

As an example, under full market access commitments, governments cannot maintain exclusive service suppliers for a service, or specify the kind of legal entity — profit or non-profit — that supplies a service. These restrictions are important measures for controlling the costs of, and ensuring access to, publicly funded services (Sanger 2001). Market access therefore has implications for health insurance, specifically the ability to prevent escalating costs and the ability to expand medicare (Sanger 2001). Further, GATS rules restricting monopolies (article VIII.4) might prevent medicare from expanding to include services like home care.

Building cleaning and food preparation, which are integral to health, have been made subject to GATS. So even if the Canadian government is shielding domestic health care services, this does not ensure that trade may not creep into other areas that are key determinants of health. Kickbusch and de Leeuw (1999: 286) explained, "even as countries defend their internal sovereignty over health care policy they are losing sovereignty over policies related to health determinants."

Potential Trade Constraints on Home Care Reform
Given the parameters of NAFTA and GATS, what then is the likelihood that Canada will face a trade challenge if policy changes to home care are attempted? Two recently proposed possibilities include the recommendation put forward by the Romanow Commission to expand medicare to include home care as a cost-sharing program and what has been agreed to under the Accord on Health Care Renewal (2003) — increasing federal funding for a targeted expansion of publicly financed provincial home care programs and services. While the Romanow recommendation has not been taken up, it still remains a viable future policy option.

Each policy change is possible under current trade rules, but unless contained within the parameters of the public system, either could trigger a NAFTA compensation claim or a GATS challenge.

At present a NAFTA threat is more direct. Two key provisions not subject to reservations include expropriation and compensation (article 1110 (1) and minimum standard of treatment 1501(1)).[18] The expropriation and compensation provision states:

> No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party within its territory or take a measure tantamount to nationalization or expropriation of such an investment, except: for a public purpose, on a non-discriminatory basis; in accordance with due process or law and Article 1105; and on payment of compensation in accordance with paragraphs 2 through 6.

This section limits the ability of Canada to nationalize an area or expropriate the business of foreign health insurers who have already entered the Canadian market (Epps and Flood 2001, 2003). It "significantly affects the ability to expand the public component of Canada's health care system" (Johnson 2002: 7). This provision is most controversial, because it makes it difficult for governments to retreat from policies of economic liberalization or privatization.

According to this article, corporations can challenge governments directly and demand monetary compensation through NAFTA's dispute resolution mechanism. Under this provision, investors can demand compensation for measures that restrict private, for-profit provision of health care services (including the expansion of medicare). So, for example, if the Canadian government wanted to expand the *Canada Health Act* to encompass home care, and provinces (who would want to get their transfer payment money from the federal government) decided not to renew contracts with foreign private companies (most likely for-profit), they could be opening themselves to a NAFTA challenge by those companies.

The NAFTA threat was explained effectively by a key informant:

> *NAFTA is a worse threat than the GATS, because the investor can bring the dispute directly and it results in monetary damages. NAFTA trade dispute panels have a lot of discretion regarding what kind of monetary damages they can ask for.*

The degree of risk depends on whether private economic interests adversely affected by such policy changes are significant. Otherwise, as Johnson has argued (2002: 31), the challenge or claim may, in fact, be both limited and manageable. It is therefore important to examine both the funding and delivery of home care services. Specifically, this includes the following.

- To what extent are private for-profit providers/insurers already operating in the Canadian health care system and in home care in particular? Such an analysis includes taking into account the extent to which home care is seen as a growing market for private foreign investors.

- How may foreign commercial providers be adversely affected by policy changes in home care?

- What are the gendered effects and potential gendered effects of the increased involvement of private, for-profit insurers and providers of home care on the quality of home care services, all of its associated services and on health care workers?

It is also important to keep in mind that even if home care is not a huge market at the moment, it is steadily growing. As one respondent put it:

> *It is important from a policy perspective, to look down the road at the potential dangers and vulnerabilities.*

Numerous people interviewed for the study shared this view.

Background

Before examining the funding and delivery of home care in Canada against NAFTA and GATS, it is important to situate the economic significance of home care. As one of our key informants questioned:

> *How much money is there to be made in home care? Is it really a priority for foreign companies?*

Industry Canada sees home health care as an “area of strength” for attracting foreign investors, particularly because there are an increasing number of affluent, older citizens with chronic health conditions (Industry Canada 2000). Senior trade officials in the United States are on record as saying: “The United States is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, assisted living arrangements, and services provided in the home” (Kuttner 1999: 666).

According to Chanda (2001: 59), “US companies in health care and in ancillary services are increasingly looking at entering foreign markets given reforms of state run health care systems and moves towards managed private care in many countries.” Indeed, as one respondent noted:

> *With respect to the health care market, the US expansion of multi-nations usually targets the Canadian market first. With manufacturing, this was the case.*

The HMO industry of the United States, known for its vertical integration of health care services, has also shown interest in Canada. Home care, in particular chronic illness management, could be lucrative enough to be included in this industry’s basket of health services. This was emphasized by a key informant.

> *It could be the case that domicilary, community-based care becomes part of the package of the HMO industry.*

Funding for Home Care Services: The Presence of Private Insurers

Although provincial governments provide funding for certain home care services, individuals and the insurance industry are also key players. There is a steady rise in the number of people who pay directly out of their own pocket for services. Individuals may obtain private insurance, because they are not eligible for public home care services, they do not want to submit to home care assessments or because services that are available through the public system are inadequate (Health Canada 1999b).

As noted earlier, Ontario funds professional services, personal support services, homemaking and other social services. There is however, a cap on the maximum level of service clients can access. In many cases, there are user fees associated with accessing community support services. It has also been estimated that approximately 50 percent of people in need of home care must purchase much of the care they need privately or must rely on the unpaid work of family and friends (Browne 2000). In comparison, British Columbia provides comprehensive professional home care for up to 24 hours a day, seven days a week.

At the same time, home support services in British Columbia and to a similar extent in Ontario (e.g., respite, services to assist with daily living activities and meal preparation) have user fees and stringent eligibility requirements. In 1999, health authorities eliminated assistance with cleaning, cooking and laundry for these clients deemed to have “less serious” health needs. These services now have to be purchased privately for those clients, creating two tiers in the home care system.

As a result of the kind of decrease in public health services evidenced in home care, the presence of private insurers has increased in Canada. Currently, 39 of 140 private insurers operating in Canada are American-based; 10 are European (Epps and Flood 2003). It is estimated that these private insurers receive between $860 million and $2.5 billion in private health premiums (CCPA 2002). At present, more than 20 million Canadians have private

insurance. In British Columbia, 68 percent of the population has such insurance while in Ontario, the figure is slightly lower at 58 percent (CLHIA 2001).

Private insurance covers a variety of benefits including nursing/caregiving in the home. Home care insurance is intended for those between the ages of 40 and 80 and targeted to middle to higher income earners who are preretirement age. A typical basic package costs approximately $130 a month over 20 years and entitles the bearer to $50 in home care services for a lifetime maximum of $75,000 (Fuller 2001). Many insurers are also selling group health insurance sponsored by employers for home care benefits.

While the overall market in home care insurance at the moment is modest, it is growing. For example, there are a significant number of private for-profit long-term care (including home care) insurers in British Columbia and Ontario. British Columbia-based companies include Zlotnick, Lamb and Company, Dave P. Financial, Cheap Life Insurance Canada Insurance Services, S&V Planning Corporation and Equinox Financial Group. On its Web site for example, Zlotnick, Lamb and Company advertises long-term care insurance in the following manner.

> Finally...we have a solution – …Available for decades in the U.S., this coverage has recently been made available to Canadians – and just in time. Long Term Care Insurance covers the expenses of long-term care, either in your own home, or a facility, for periods ranging from a few years to lifetime coverage. If you are between the ages of 30 and 80, you can apply for coverage, and the benefits payable range from $10 per day to $300 – tax free (McNaughton 2003).

Ontario-based companies include Clarica, RBC Insurance, Manulife Financial, Canada Life, Citadel General Insurance Company, Empire Financial Group, Liberty Health, Sun Life Financial, UnumProvident, The Rite Path and PennCorp Canada. Many of these Ontario-based insurers also have offices in British Columbia. Other noteworthy companies include Federated Insurance (Winnipeg head office; Ontario and British Columbia regionals), Maritime Life (Halifax head office; Ontario and British Columbia regionals), Standard Life (Montréal head office; Ontario and British Columbia regionals) and Hughes Trustco Group (Montréal head office; serves all provinces).

Coyte (2000) has projected that the current private spending on home care of $0.7 billion in 2000–2001 will swell by almost 80 percent in the next 20 years, because of demographic changes. This may certainly make the home care market increasingly attractive to foreign investors. In addition, there is some evidence that Canadians are becoming increasingly interested in long-term insurance. In an Ispos-Reid poll conducted on behalf of RBC Insurance in 2002, it was found that only 12 percent of Canadians have long-term care insurance. However, 33 percent of those who did not have the insurance, reported being interested in hearing more about it from a financial advisor (Ipsos-Reid 2002).

Expanding the *Canada Health Act* or bringing aspects of home care under the public purse (as would be the case in both Ontario and British Columbia under the 2003 Accord on Health Care Renewal) may take away the current and potential market share of some of these companies. An affected company may interpret shrinking the private insurance market and setting the rules for what patients can be charged as "indirect expropriation of its business and projected future profits" (Epps 2001: 119, 141). In response, it is possible that a private insurance company could undertake a NAFTA Chapter 11 challenge using the expropriation and compensation provision.

Indeed, the Romanow Commission (2002: 238) concluded that if we want to expand the range of services in the public system (e.g., home care), it is better to do it now while there is still very little foreign presence in health care in Canada, and the potential costs of compensation are low. It is thus conceivable that "one or more U.S. insurers would seek compensation through NAFTA should the Canadian market be closed to them as a result of reform" (Epps and Flood 2003: 37). In terms of the NAFTA threat, "a successful claim would not prevent Canada from extending Medicare, but would make it more expensive to do so"(CCPA 2002: 26).

Under GATS, an attempt to extend medicare to include home care would be most affected by the monopolies provision (article VIII), which could deter governments from directly providing home care services that were covered by private insurers. Article VIII of GATS would require the Canadian government to notify the Council for Trade in Services that it proposes to grant monopoly rights to the government for certain health services. In addition, VIII.4 also may require that Canada negotiate compensation with affected WTO countries whose private insurance providers of home care services are affected by the reform (CCPA 2002). In the case of GATS, the areas that would be of most concern are building cleaning and food preparation as these have been explicitly listed in Canada's schedule of country commitments.

As Epps correctly noted (2001: 113), "as long as US and/or other foreign insurers are active in the Canadian market, the GATS monopolies provision and the NAFTA expropriation provisions may ensure their presence in the Canadian market to the detriment of any proposed reforms to implement national, publicly funded insurance in areas such as home care." Extending medicare's coverage can be seen as directly causing private insurers to lose a share in the home care market and related future profits. These losses in turn may be seen to require some form of compensation. Although it does not preclude making necessary or desirable policy changes, the presence of foreign private insurers already in Canada has to be taken into account when considering medicare reform. This was not the case prior to the implementation of either NAFTA or GATS (CCPA 2002; Epps 2001).

Finally, more attention needs to be paid to the apparent contradiction in Canada's position regarding private insurance. On the one hand, Canada already has life and health insurance companies in over 20 different countries (Finance Canada 2001) and intends to further expand this service export. On the other hand, it seeks to retain the power to protect its own health care system from foreign companies by restricting their presence in the Canadian

market. Indeed, this was raised by a number of key respondents in our study. As one expert explained:

> *I was always struck by the inconsistency when Canada put health insurance under financial services as a way to get access to foreign markets while at the same time claiming to want to protect the public system in Canada.*

This may not be a tenable position over the long run, especially given the commitment of all WTO member countries to further liberalizing trade in services under GATS.

Delivery of Home Care

With the exception of Manitoba, most home care is privately delivered. Privately owned companies, however, are varied. They can be not-for-profit or for-profit. For the most part, home care delivery nationally has been dominated by not-for-profit organizations, such as the Victorian Order of Nurses and the Red Cross. The not-for-profit sector is distinct in its broad public purpose orientation, commitment to public accountability and transparency, and advocacy on behalf of clients and patients (Fuller 2001).

Some private for-profit companies are small operators specializing in a particular locale. Others are Canadian-based companies, and then there are a number of large, American-based commercial home care providers (e.g., publicly traded multinational companies). These include, for example, Caremark, Olsten/Gentiva and others that are partially owned by international investors like Extendicare and Dynacare (Armstrong 2001). In recent years, there has been a marked increase in the use of contracting out of publicly funded services to private-for-profit entities (Epps 2001).

In terms of private investment in home care delivery, cross-border investment is more significant than cross-border trade (e.g., telecommunications and information technologies such as telehealth in home care) (CCPA 2002). However, that is not to say that telehealth will not grow in importance. Ontario for example, is experimenting with the smart home care robot, which replaces home visits with surveillance and monitoring. Forms of telehealth have been identified by both Industry Canada (2000) and the Standing Committee on Foreign Affairs and International Trade (1999) as a growing sector which may make the Canadian market attractive to foreign investors.

For the time being, cross-border investment (i.e., foreign-owned companies currently operating within Canada) presents the more immediate concern for home care reform in the context of international trade agreements.

If the government extends home care coverage and in the process, wants to restrict the number of home care providers, NAFTA expropriation provisions would allow foreign for-profit companies to bring forward a claim for compensation. The claim would be based on the argument that they, as a private provider, stand to suffer a range of losses as a result of this policy reform in home care. The losses claimed may include exclusion from the home care market and reduced profits as a result of lost market share. In terms of GATS, potential

challenges would likely stem from specific building cleaning and housekeeping commitments Canada has made.

Publicly Funded and Privately Delivered

Ninety-three percent of private home care agencies in Canada receive some form of public funding, and 50 percent receive all their funding from public sources (MacAdam 2000). For example, CCACs in Ontario contract out a range of services to private companies. In 1999, for instance, 20 nursing contracts were given by 18 CCACs, 52 percent went to for-profit agencies, 40 percent of therapy contracts went to for-profit agencies and 80 percent of equipment contracts were awarded to for-profit agencies (Sutherland 2001). It has been estimated that $42 million per year of public money is paid out in profit to private owners (e.g., Comcare Health Services, Para-Med Health Services, Olsten Health Services) and to shareholders of for-profit companies (OHC 2001b).

British Columbia has been identified as a desirable market by a number of private for-profit providers (Fuller 2001). In the Fraser Health Authority, one of British Columbia's five health authorities, there is a mix of private for-profit, private not-for-profit and public providers that reflect this interest.[19] Private agencies (accept private clients, may contract with the health authority) include:

- Para-Med Health Services;
- We Care Home Health Services;
- Bayshore Home Support;
- Helping Hands Agency Ltd;
- Comcare, Pacific Rehabilitation;
- Drake Medox Health Care Services; and
- Gentiva Health Services.

In comparison, public or private not-for-profit agencies include:

- Abbotsford Community Services;
- Fraser Cheam Home Support Service Society;
- Burnaby Community Home Support Services Association;
- Simon Fraser Home Support Association;
- Ridge-Meadows Home Support Service Society;
- Delta Home Support Service Society;
- Langley Home Support Service Society;
- Surrey and White Rock Home Support Association;
- West Coast Health Care Services Limited;
- Richmond Health Services Home Support;

- Greater Vancouver Community Services Society;
- St. James Home Support Services;
- Vancouver Community Home Support Services Association;
- Greater Vancouver Home Support Society;
- Bella Coola Home Support;
- Home Support NSHR;
- Powell River and District Home Support Society;
- Sunshine Coast Home Support Society; and
- Howe Sound Home Support Service Society.

For-profit home care service delivery is becoming increasingly linked to other activities relating to the pharmaceutical industry and commercial medical equipment. As an example, there is some evidence that home care companies such as Comcare and Bayshore Health Group (formerly Olsten) are contracting with pharmaceutical companies to recruit and monitor clients in clinical drug trials (Fuller 2001). Drug trials required for the approval of new drugs are essential prerequisites in the lucrative pharmaceutical industry. Removal of home care as an accessible site for these trials may be seen as undermining market access. Home medical equipment has also been identified as another path into the home care sector (Fuller 2001). Fuller also noted (2001: 20) that the U.S. State Department estimated the 1998 value of Canada's medical equipment market, which includes equipment for home care, to be about US$1.1 billion.

If at some point, governments wanted to place restrictions on how home care services can be delivered (e.g., publicly or exclusively by not-for-profits), this may be seen as violating national treatment provisions of both agreements in addition to market access under GATS (especially if Canada decided to extend GATS coverage of home care by directly listing home care or reclassifying home care under the terms of the agreement). Both NAFTA and GATS could prohibit favouring domestic not-for-profit providers of services in all aspects of the government procurement practices (Fuller 2001).[20]

Governments may no longer be able to take, for instance, an established record of providing home care services into account when awarding contracts. Because not-for-profits have historically relied on specialized funding arrangements with provincial authorities where such considerations were key, competitive tendering processes, which are open to both for-profit and not-for-profits, place not-for-profits at a disadvantage and threaten their very existence.

In addition, in the bidding process itself, non-profit organizations find it difficult to compete with for-profit organizations. One key informant explained:

> *In Ontario, the Victorian Order of Nurses began to lose contracts (as did other non-profits), because they did not have the internal resources to participate competitively in tendering.*

Their inability to compete is not due to their inability to provide care but rather, because many transnational companies can direct superior resources to the process of winning bids or they simply bid low for the purposes of outbidding their competitor (Browne 2000). As another one of our respondents noted:

> *Companies can afford to take these losses in the hopes that they will make money later. Home care is also a launching pad for other services, such as clinical trials for drugs, which are lucrative.*

Arguably, governments are restricted in their ability to make reform in health, because the agreements can undermine governments' abilities to provide public funding only to not-for-profit home care providers. According to Sanger (2001: 99), "these restrictions would limit the ability of governments to provide publicly funded home care services in the most cost-effective manner."

If we take Ontario, the expansion of the *Canada Health Act* may displace commercial home care providers who already have a strong presence in the province's managed care system. This would occur for example, if the government as a public provider took over direct provision of services currently being offered by these companies or wanted to award them to not-for-profits. Some analysts have maintained that "where commercially provided services are displaced by direct public provision, the government would be assuming an obligation to provide those services and there would be no taking of property for the benefit of government" (CCPA 2002: 34). Given the general ambiguity in wording of the agreements, this, however, may not necessarily be the case in home care. Sanger (2001: 106) pointed out that "another WTO member country could charge that public provision of home care constitutes an extension of a government monopoly to a service which was part of the commercial home care market covered by Canada's specific commitments." Market access prohibits limitations on the number of providers that could operate to deliver these specific services. These impediments also raise serious concerns about the ability of governments to regulate health care services under both NAFTA and GATS.

Regulation and Home Care

One argument that is made for why for-profit delivery does not undermine the public nature of the Canadian health care system is that governments have strong regulatory powers. Regulation takes on a number of different forms. These can include measures that inhibit the establishment or operation of a service business by applying some form of screening or registration process on foreign investors, restricting the level or share of foreign membership, and requiring case by case assessment of the merits of foreign firms (Epps 2001). Regulation often determines qualification and licensing requirements as well as technical standards. Qualification requirements refer to matters, such as professional accreditation and educational requirement. The term "licensing requirements" covers

professional licensing. Finally, technical standards extend to the rules according to which a service is performed (Epps and Flood 2001; Sinclair 2000).

According to the United States International Trade Commission, the foremost obstacle to increasing trade in health is the existence of strong regulatory controls in foreign health systems, such as in Canada (Luther 1999). Since 1999, the GATS Working Party on Domestic Regulation has been examining how regulatory measures can be limited to what is "least trade restrictive" or "not more burdensome than necessary to ensure the quality of service" (article VI.4). David Luff (2002), in a paper prepared for the OECD, outlined a number of measures that could be construed as "more burdensome than necessary." These include obliging health professionals to provide access for all patients, restricting fees for service, cancelling licences of doctors /facilities for non-compliance with licensing conditions, and requiring hospitals or physicians to operate on a non-profit basis. A trade expert in our study commented:

> *My concern about [domestic regulations] is that in the abstract there is always a less trade restrictive means to accomplish a particular policy end* (Interview, 2002).

Indeed, as Dean O'Hare, Chair of the Coalition of Service Industries, has stated (1999): "In order to pursue meaningful services negotiations, WTO members will have to consider making adjustments to their regulatory regimes." O'Hare's position is consistent with an international trade philosophy and priorities that seek to eliminate what are perceived as unfair "behind-the border" rules that impede services trade. An example of what is considered unnecessarily burdensome may be current regulations in Canada that ensure universal access to services (Luff 2002). This of course includes medicare and any proposed expansion of what is covered by the public purse, such as home care and how it should be delivered.

The CCPA (2002: x) has put forward the argument that "practical considerations suggest that trade provisions are unlikely to significantly constrain reforms to the regulation of home care service delivery, but could make some changes more difficult to reverse." According to the CCPA, regulations encompass direct public provision, competitive tendering and partnership with non-profit providers. At the same time, the Registered Nurses Association of Ontario has argued that current negotiations regarding domestic regulatory disciplines under GATS negatively affect the ability to sustain and enhance Canadian medicare. They refer to the recent U.S. proposal that calls for the adoption of GATS disciplines on transparency in domestic regulation services. They quote the U.K. government that has concluded that such a proposal "would give foreign governments, and perhaps businesses, a legal right under the GATS to be consulted on national regulation proposals (U.K. 2003a: 56).

Changes to GATS regulatory provisions may also undermine the ability of the B.C. government to maintain the terms and conditions for home care outlined in its *Continuing Care Act* and *Employment Standards Act*, if these are deemed unfairly restrictive to trade. In addition, legislation that directed the health minister to "ensure…that health services in

British Columbia continue to be provided on a predominantly not for profit basis" (*Health Authorities Act*, RSBC 1996, 1.3 Provincial Standards) may also be interpreted as unfairly favouring domestic not-for-profit providers.

Ontario's *Community Access Corporations Act, 2001* that ensures service standards across the province may also be challenged. The province may be greatly diminished in its ability to uphold other service agreements and regulations that govern home care and, in particular, regulate its current competitive tendering process. When Ontario changed to a managed competition system, it extended specific protection to not-for-profits in the initial bidding processes.[21] Under the terms of NAFTA and GATS, this type of favoured treatment might not be allowed for Canadian not-for-profit providers over foreign for-profit providers. Currently, requests for proposals in the area of home care services require bidders to be familiar with a particular community and its services. Again, this requirement may also be challenged as "more burdensome than necessary" by a foreign for-profit provider outside the Province of Ontario.

The reduction of risks associated with trade in health and the involvement of private actors depends on the very ability to enforce effective regulatory frameworks (Marconini 1998; WHO and WTO 2002). And, regulation is increasingly shaped by commitments arising from international agreements making it more difficult for governments to prioritize domestic policy objectives (Hart 1998). Koivusalo and Rowson (2000: 185) claimed that, "regulations and standards intended to ensure the quality and safety of health services will increasingly be established on an internationally agreed basis. This means that governments, when framing policy, setting standards and drafting legislation will have to take account of the international context."

NAFTA and GATS may also impede the ability to set eligibility requirements for certification and licensing (e.g., certification requirements for service providers). This may affect Canadian standards for certification of professional and technical people involved in health care. In addition, trade barriers in services are often perceived to be licensing and certification requirements that could affect competition between domestic and foreign suppliers by treating them on an unequal basis (Epps 2001), especially when labour is treated as a tradable commodity. Pressures to "harmonize downward" licensing requirements could endanger the health of the Canadian public (RNAO 2003). Arguably, there is a synergistic relationship between policy means and ends, and this is where trade agreements become most relevant and potentially most disruptive. Not surprisingly, a key informant stressed that we need to ask:

> *What kind of regulatory environment do we want for home care?*

One might add to this question: What kind of regulatory environment may be possible under the terms of trade agreements?

An example from the United States illustrates how regulations in nursing homes might be diminished if they are seen as costly. In 2001, Congress rolled back legal requirements to reduce workplace injuries, usually sustained through heavy lifting, because employers

complained that the rules "required burdensome and costly changes, and many questioned the science behind ergonomics" (Strope 2003: 1). Recently, occupational safety and health administration guidelines have been reintroduced to mitigate against growing ergonomics-related injuries, most often sustained by health service workers, which account for a third of the 1.7 million job injuries annually (Strope 2003). However, pressures from the business sector have meant that these new requirements are "advisory in nature and informational in context. They are not a *new standard or regulation and impose no new legal requirements"* (emphasis added) (Strope 2003: 1).

General and Gendered Effects of Policy Flexibility Constraints

Whether the desire is to expand the *Canada Health Act* or establish national standards for certain home care services as has been agreed to under the Accord on Health Care Renewal 2003, both NAFTA and GATS reduce policy flexibility. As one Canadian health and trade policy expert put it:

> *If you are attempting to expand the system, well then you need to continue an ongoing dialogue...you must continually ask yourself: "Are there any limitations?"* (2003).

Reduced policy flexibility in terms of expanding the public health care system may also solidify and increase the presence of foreign investment and for-profit delivery of home care across the country.

Increased privatization of the health care system has definitive effects in the public provision of home care services. Evidence suggests that the quality of the public system is eroded under these circumstances (Armstrong et al. 2002). In the words of one of our international experts on globalization:

> *Changing the ways that home care is delivered, changes the quality of care. Profit maximizing is about the cheapest labour and minimal work per patient. Trade should not circumvent the ability to set appropriate standards for health care delivery or the ability to monitor these with the right kinds of indicators.*

In the case of the home care sector, gender asymmetries associated with failed policy changes to increase public funding and set national standards in home care delivery are substantial. At the most general level, barriers to implementing national standards for home care mean the current patchwork of home care services and programs would continue. Home care is affected by the province/territory in which one resides. Each province determines the basket of home care services that are available. Standards for home care eligibility requirements are different, and costs to the caregiver and patient vary. In many jurisdictions, user fees are part of support services for home care. Service limits mean that only those with the financial wherewithal are able to purchase needed services and respite. There is ample evidence that women get less care than they need compared to men and that they have fewer resources to pay for such care (Greaves et al. 1999).

Second, increased privatization leads to higher costs to the public including extra costs for government to administer contracting processes, monitor work and evaluate performance of for-profit providers. There is less public accountability and increased opportunities for corruption in the delivery of home care services. For example, Olsten (which has now changed its name) operating in Ontario, recently paid $61 million to the United States Department of Justice for criminal violations in their U.S. home care billings (Sutherland 2001). In addition, there may be fewer possibilities for citizen engagement that are key to informed health policy and decision-making processes.

Higher costs in service delivery may also be experienced along with a loss of continuity of care. When Manitoba experimented with Olsten in the mid-90s, after one year it found that not only was for-profit delivery more expensive, quality was endangered (Shapiro 1997; Vogel et al. 2000). In particular, clients who had used Olsten reported a constant turnover in staff with “different persons coming to the door all the time” (Fuller 2001: 49), thereby undermining continuity of care. Moreover, it was later determined that Olsten home care workers visited clients half as many times as their public home support agency counterparts (Price Waterhouse Coopers 1998). In the final analysis, “it was determined that home care could be better provided and more efficiently by government employees than by contracting to private agencies” (Sanger 2001: 106).

In Ontario, the introduction of managed competition and more foreign private investment has resulted in service duplications, staff inefficiencies, excess administration and profit making, a loss of public control over standards, diminished access, less efficiency, and lower quality of life for patients and caregivers (Browne 2000; OHCb 2001; Sutherland 2001). Highlighting the costs of the system of managed competition, Sutherland (2001) concluded that if the competitive bidding system was dismantled, $247.4 million of the home care budget would be available directly for patient care.

Indeed, there are marked differences in how for-profit and not-for-profit companies deliver patient care. Typically, for-profits institute strict guidelines for patient care including time allocations per patient. Good patient care, however, is based on individual assessments and individual patient needs. Not only do these types of guidelines compromise patient health, home care workers are forced into seeing more patients in less time with fewer resources. This impacts directly on the quality of patient care and in the long run, continuity of care.

Changes to home care services that constrict public funding and delivery of home care also affect accessibility to services for both care recipients and informal caregivers. With the de-listing of services and increased presence of private providers, affordable home care is more difficult to find. As services get cut, more and more of the costs of health care are paid by individuals and their families. User fees create barriers for women, because of their socio-economic position in society (CEDAW 2003). In Ontario, for example, it has been reported that the group with the most unmet caring needs under the system of managed competition is women (Browne 2000).

When cutbacks occur, patients and clients who are able to afford it buy supplemental care from private companies that provide insurance and delivery of service. Private insurers often

target those who have financial resources and provide services that have the best prospects for profit. In a two-tiered system, the private system is geared typically toward providing superior services for individuals with higher disposable incomes, and the public tier is relegated to providing basic services for those with lower incomes, including women (Blacklock 2000). Private insurers also have the ability to turn down coverage to people who are perceived to be a high risk (Epps 2001). Moreover, because the national treatment principle prohibits regulations that discriminate against foreign insurers, governments may have difficulties regulating the private insurance industry in an attempt to circumvent these inequitable outcomes.

Additionally, women are less likely to have supplemental care benefits provided in the workplace (Armstrong et al. 2001). The current gender gap in supplementary medical insurance also demonstrates that if there was increased privatization of home care services, women would have less access to these through private insurance plans. Presently, only 47.3 percent of women vs. 58.9 percent of men have supplementary medical insurance (Fuller 2001). In British Columbia, residents are already required to pay premiums to access the public health care system.

Women find private insurance for home care services more difficult to afford because overall, women have lower incomes than men and are more likely to live in poverty, especially older women and Aboriginal women (Lochhead and Scott 2000). This is not altogether surprising given that the cost of long-term care has been estimated at approximately $3,000 to $5,000 a month (CEDAW 2003). Home care costs about $30 to $38 an hour for an RN or auxiliary nurse and $14 to $19 for a medical services aid (Insurance Canada 2003). Such costs are beyond the income of most Canadian women whose income is on average $23,796 (Statistics Canada 2000a). Aboriginal women have an average annual income of $14,640 (Statistics Canada 2000a), and the majority of elderly Canadian women do not have pensions from their paid work (Statistics Canada 2000a).

As a result, the substantial socio-economic costs and consequences for caregivers and care recipients would rise. Reducing access to public services would increase the caregiving burden of women. In the last decade, health reforms have resulted in more hours of unpaid work for the mainly female informal caregivers and fewer hours of paid work for formal providers (Armstrong et al. 2003). Already, research has shown that for informal caregivers, caregiving has substantial personal, health, economic and employment-related costs and consequences. While many women want to care and are rewarded by the experience of caregiving, there are inadequate resources and a general lack of choice when it comes to undertaking this work (Armstrong et al. 2003; Greaves et al. 2002). Any further retrenchment in the services and programs currently available will only increase the gendered burdens of caregiving.

A decrease in supports and resources to informal caregivers may also increase health care costs due to related injuries and illnesses. This can further strain the health care system and even spill over into other sectors including social services and social assistance. An increased caregiver burden can further impact women’s personal lives and career goals

(Canadian Study of Health and Aging Working Group 1994), including multiple role conflict that female caregivers already report (Higgins et al.1994; Lowe 1989; Neal et al. 1993; Simon 1995).

Third, increased unpaid caregiving would further shape patterns of employment. Caregiving has been shown to interfere with the work environment in terms of absenteeism, increased sick days, more irregular hours and the use of work time for caregiving activities (Parent et al. 2001). Fast et al. (2001) estimated that women caregivers who relinquish their paid employment for unpaid labour may give up between $15,000 and $26,000 annually in income. These employment disruptions and financial consequences can only be expected to worsen.

Almost all those providing formal home care are women, and thus changes in working conditions resulting from privatization mean changes for women. When working for private for-profit companies, formal caregivers experience a decrease in wages, benefits and job security, all important determinants of health (Browne 2000). According to a key informant:

> *As it [home care] is becoming more corporatized, the wages of home care providers and home support workers are going down, and they are really going down…especially in certain areas, I would say in Ontario but if you look in other regions like the Maritimes where people are earning six or seven dollars an hour it's outrageous.*

Formal caregivers are pushed to work harder and faster, with less control over the care they provide (Fuller 2001). In turn, they experience higher levels of stress, leading to work absenteeism and health related ailments. Stress on the job is a well-established cause of a variety of serious ailments such as heart disease and cancer, especially for women (Bosma et al. 1997). In addition, workers are often paid less and, in turn, jeopardize the skills, training and expertise of health care staff in the home care industry. Workers also report a lack of a team approach to care, stress and high turnover rates, and decreased continuity of care for patients (Sutherland 2001).

In Ontario for example, the managed competition system has resulted in specific difficulties related to recruitment and retention. Some of these difficulties are due to the increased wage disparities between hospital and home care workers. For example, as a result of the competitive bidding process for home care in Ontario, wages for home nurses have dropped between three and thirteen percent (Lowry 2002). In turn, this may also jeopardize patient safety (Fuller 2003). Undermining the positive benefits of non-profit services also has implications for social cohesion and social equality (Vogel 2000).

Lower wages and poorer working conditions also extend to women who provide home care support services. Women, new immigrants and people from minority cultures perform the bulk of this labour. National treatment and market access may necessitate the further privatization in this sector and will create a new underclass of health workers who have less job security, fewer benefits and lower levels of remuneration. In particular, licensing requirements, qualifications and other standards may be compromised.

The opening of home care support services (e.g., cleaning and food preparation) to foreign markets ignores the typically higher costs of privatized services and the potential for degradation in service quality (Fuller 2001; Cohen 2001). These types of support services are essential determinants of the health of people in both hospitals and homes. This has been demonstrated in the province of British Columbia where the elimination of housekeeping services for those with a disability and the frail elderly have has occurred (Pollack 2000). In addition, when Hollander (2002) compared two regions in Canada (one that had eliminated housecleaning and the other that had maintained such services) he found that the region that had made the cut was paying $4,000 more on health care per person for those affected by the cuts.

Further, the gains that women health care workers have made could be compromised as standards would tend to drop and health care jobs de-skilled. For example, in Canada privatization of hospital services (food preparation, cleaning, etc.) is taking place, and these jobs are being equated with jobs in the hospitality industry despite the fact that they are critical to the health and well-being of hospital patients (Armstrong et al. 2003; Cohen 2001).

In the end, the lack of flexibility to make policy changes to expand public home care may lead to further privatization and increase the inequities of gendered care work. As one of our gender and trade specialists explained:

> *The impact on women will be negative. If profit is the aim, then quality and quantity will suffer, and wages will go down. No holidays, little status. And what will happen when individuals can't pay for these services or government just decides that they won't? Will people just get sick and die sooner? Responsibility will fall on relatives and neighbours and church groups. Of course, these will mainly be women.*

The potentially different impact of increased caregiving on women needs to be adequately acknowledged in trade and health policy and planning. And under the terms of both NAFTA and GATS, it would be difficult to reverse these trends or indeed decisions (e.g., the introduction of managed competition in Ontario) that led to such trends in the first place (CCPA 2002). It may well be that experimentations in public–private partnerships may eventually cause Canada to be locked into the mechanisms of GATS (Sexton 2001) pitting government interests against corporate interests.

Lessons from Other Jurisdictions

In general, for-profit health care has been linked to higher negative health outcomes, and higher morbidity and mortality rates (Deber 2002). Studies from the United States and Britain have demonstrated that for-profit providers are less efficient, effective or accountable, have lower staff-to-patient ratios, put less money into patient services, and experience higher levels of quality deficiencies (Harrington et al. 2001; Himmelstein et al. 1999). The U.S. system has been referred to as the most "expensive, ineffective, [and] inequitable system in the industrialized world"(Relman 2002).

In the 1990s, non-profit HMOs in the United States spent approximately 90 percent of premium income on payments for their members' health in comparison to the 68 to 76 percent spent by for-profit companies (Fuller 2001). In addition, a study published in the *Journal of the American Medical Association* in 1999 found that for-profits scored lower on 14 quality measures than their non-profit counterparts (Himmelstein et al. 1999).

When for-profit hospitals and not-for-profit hospitals are compared, for-profits are consistently found to provide inferior levels of care. In a study of 15,000 patients published in the *Journal of General Internal Medicine* (Thomas et al. 2000), it was found that those cared for in for-profit hospitals were at least twice as likely to suffer complications following surgery or delays in diagnosing and treating an ailment. After undertaking a systematic analysis of U.S. for-profit and not-for-profit hospitals, Devereaux et al. (2002) concluded that if Canada moved toward a for-profit system, Canadians could expect about 2,000 more in-hospital deaths annually.

In a recent study of 13,693 nursing homes in the United States published in the *American Journal of Public Health,* it was determined that for-profit nursing homes were found to be almost twice as deficient in terms of quality of care than their non-profit competitors. Quality of care was found to be linked to lower staffing levels by licensed nurses and nurses' aides (Harrington et al. 2001). According to Meyer (1997) in 1993, for-profit home care companies in the United States offered an average of 18 visits annually compared to 46 visits for public and not-for-profit providers.

Commenting on the for-profit health care industry in the United States, Kuttner (1999: 665) concluded, "in an industry driven by investor owned companies, the original promise of managed care — a greater efficiency in the use of available resources and greater integration of prevention and treatment services — has often degenerated into mere avoidance of cost." This can lead to reduced or compromised health services that impact negatively on the health of recipients. Avoidance of costs is not cost effective if health is compromised and there are resulting health care expenditures. Privatization and promotion of trade in health services can therefore lead to "less effective, costlier and inequitable health systems" (Koivusalo and Rowson 2000: 185).

Conclusion

Our national health system is being inextricably linked with globalization and trade agreements. All levels of government, whether developing policy, establishing standards or drafting legislation, have to consider this international context (Koivusalo and Rowson 2000). As a direct consequence, they are restricted in their freedom to set domestic policies in health. So while most Canadians may want a publicly funded home care system, there is decreased policy flexibility in health created by NAFTA and GATS. The potential effects, as outlined here, would be experienced differently across the Canadian population.

Specifically, gender inequities would be particularly acute for Canadian women who are the majority of the unpaid and paid caregivers, and who would most benefit from home care reform and more publicly funded home care services. The preliminary analysis demonstrates the need for a systematic gender-based analysis to inform policy decision making in the area of trade agreements and the Canadian health care system.

5. RECOMMENDATIONS

A useful framework for categorizing the recommendations emerging from this report is adapted from the work of Walt and Gibson (1994) and enjoined with a GBA analysis. In their work on health in the context of globalization they recommend four components of policy that need to be analyzed.

- Policy actors (Who makes policy?)
- Policy process (What forms of interaction and relationships determine policy?)
- Policy context (What are the broad factors influencing globalization?)
- Policy content (What are the substantive or content issues that are on the health policy agenda?)

Policy Actors

- Internationally, there needs to be further consultations and research collaborations between the World Trade Organization and the World Health Organization to ensure a balance between trade interests and public health priorities. These collaborations must include policy specialists in the areas of gender and women's health.
- Internationally, there should be improved collaborations between women's groups and social justice NGOs interested in the health and gender dimensions of trade policies.
- Canada should partner with other countries similarly concerned with women's health and with protecting their public health care systems and other social services.
- Nationally, in addition to the key actors currently involved in determining trade policy with respect to health (e.g., DFAIT, Health Canada and the Medical and Health Care Products and Services SAGIT), we need to include gender specialists for example, from Status of Women Canada and the Women's Health Bureau within Health Canada. These specialists should be consistently and meaningfully involved in developing trade policy. This point was underscored by an international expert in gender and globalization.

  > *It is very rare for people to be considering the intersections of women, trade and health. There are few people looking at this area* (2002).

- There should be a greater pluralism of policy actors that encompass the state, the private sector and civil society. In particular, there should be a cross-representation of groups and organizations with a range of expertise in women's, health policy, social inequality, labour issues, gender, diversity and globalization.

- Mechanisms for citizen engagement should be expanded and strengthened, especially to facilitate the involvement of women who are most affected by the health care system. As the majority of consumers and health care workers, women have particular expertise that can inform health policy.

Policy Process

Transparency

- Improve transparency of trade negotiations including all country bids and offers. Presently, "negotiations…lack the transparency required for a balanced incorporation of civil society's views and have been strongly influenced by specific industries and commercial interests" (Ranson et al. 2002: 36). A health and trade policy expert that we interviewed added:

  > *It is generally said that past practice and, to a very large extent, current practices are controlled by trade insiders, that is, by the trade department at the WTO and by trade ministries in member states. It is a hermetically sealed activity* (2003).

- Promote participation of a wide range of women's stakeholder groups including oppositional voices at the trade-negotiating table.

- Improve transparency in trade dispute resolutions. In January 2003, Canada proposed that the panel and appellate body hearings of the WTO be open to the public.

- DFAIT and the intergovernment process should clearly articulate and make visible the mechanisms used to involve women, women's organizations, and provincial and federal ministries responsible for women's issues and, in particular, women's health.

Accountability

- Carefully assess the impact, including a gendered social impact analysis, on the health care system of each and every health-related trade commitment Canada undertakes in future negotiations. A health and trade policy expert we interviewed said:

  > *One thing to ask is the extent to which there is accountability at home, and how the trade agreements are tested. This is crucial, because they are not [tested]. Once agreed to at the WTO, these agreements are presented to parliament without a chance to debate or amend them. There is no parliamentary scrutiny whatsoever.*

  Both the pros and cons of trade liberalization must be fully understood before decisions are made.

- Recognize and use the existing evidence showing that trade liberalization of services disproportionately affects women and continue to study trade agreements for their impact on public services. Arguments for increased trade liberalization and privatization

often rest on the false assumption that economic growth is synonymous with improved health care and health care access, and innovative exchanges of health care technology and expertise can only occur under a privatized system. Evidence already exists to illustrate that privatization erodes health care and labour standards, further ghettoizes already marginalized women workers and puts the health of populations, especially women and children, at risk.

- Expand the evidence base to recognize the evidence put forward by feminist researchers arising from gender-based and gendered social impact analyses.

- Improve communication and information sharing with women's organizations, health associations, unions and other relevant bodies. Recently, the RNAO (2003: 7) stated "that organizations such as ours that would be in a position to advise the government...are being denied the information that would permit us to provide this advice."

- Increase information through various forms of dissemination about trade agreements for Canadian citizens. An internationally renowned globalization and trade expert who we interviewed said:

> *Freedom of information must be strengthened. This is particularly important because we can't vote out international trade players who are in a sense very remote. There must be media coverage and a strong public awareness of what is happening* (2003).

Autonomy of the State

> *The social policy power of nations is being shaped by the international architecture of trade* (Globalization expert, interview 2002).

- As indicated in the above quote, there is a need for improved national autonomy to balance trade with a publicly funded health care system. The degree to which this is possible was questioned by one international trade expert who cautioned:

> W*hatever Canada says, [in terms of trade commitments in health] is not finally up to them; it is dependent on the judgment of the WTO dispute panel* (2002).

Policy Context

- Balance trade interests with women's human rights, social justice and human development priorities. Organizations such as the United Nations (e.g., UNIFEM) and the International Labour Organization need to play a more integral role in trade negotiations.

- Ensure adequate flexibility within trade agreements to allow for health system divergences among WTO member countries. Canada needs to be able to set policy, appropriate regulations and provide subsidies for the delivery of a publicly funded health care system. Further, Canada must have the power to expand its publicly funded health care system.

- Ensure adequate flexibility to change or alter trade commitments without the threat of trade concessions or financial compensation.

- There needs to be greater understanding and accommodation of the inequities caused by economic globalization and its impact on women and other specific population groups and individuals.

- Hold the Canadian government to its national and international commitments to global gender equity (e.g., the *Canadian Charter of Rights and Freedoms* (1982), the *Covenant on Economic, Social and Cultural Rights,* the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) (1979). Status of Women Canada could play a key role in training related to gender mainstreaming in the context of trade agreements.

- All levels of government in Canada must be cognizant of the implications of their policy decisions. Experimentation with public–private partnerships puts services currently protected under the *Canada Health Act* at risk. Moreover, any further privatization of service delivery may leave governments unable to expand the *Canada Health Act* or include more services under the public purse.

Policy Content

- The trade agreement language needs to be clarified especially with respect to what is considered a "service for a public purpose" and "governmental authority." A leading health and trade expert indicated:

  > *The GATS agreements were kept deliberately vague to get agreement from member countries. The general feeling is that it won't be amended but it really does need to be* (2002).

  Indeed, the wording in the agreements is very broad and does not necessarily respond to the public–private composition of the Canadian health care system.

- The Canadian government must safeguard all services in the public sector. One way of doing this with respect to GATS is to reinterpret or amend GATS article I.3 to be "self-defining"; that is, governments should be allowed to exclude what they want in order to strengthen the public system (modelled after the security clause in GATS article 14). A trade and health expert emphasized:

  > *With respect to article I.3, what is included is not entirely up to member governments. It is determined by section I.3 around which there is a great deal of confusion. No one can positively say what the wording means* (2002).

  With respect to NAFTA, Annex II must be interpreted to include all public services regardless of whether they are publicly or privately delivered/financed.

- Protect the *Canada Health Act.* A gender and health care expert explained:

  > *As for opening up the Canada Health Act, I say no…in part because…trade agreements [might put] the Act in question* (2003).

- Make a clear and consistent declaration of what is subject to international trade agreements and what is protected. A Canadian trade expert emphasized:

  > *We need to be clear what Canada's goals are. In the past, we were not clear enough — not aware enough. Whenever governments implement any new programs in health [e.g., home care] they need to make it clear that it is for a PUBLIC PURPOSE.*

- The current protection of our health care system is achieved via exceptions and reservations in NAFTA and GATS rather than being part of the rules of the agreements. This should be changed, because the apparent hierarchy of rules over exceptions (Ouellet 2002) may place Canada in the position of being reactive rather than proactive in terms of protecting the current health care system. In commenting on the government's delineation for health, an expert on globalization commented:

  > *The government carve-out is weak in terms of health; [it] would be better to have the same protection as currently exists for national security* (Interview, 2002).

Next Steps: An Agenda for Research

Trade is becoming increasingly complex and multi-faceted. Without proper analyses, specifically, gender-based analyses, the constraints of trade agreements may continue to encroach on the Canadian health care system. The effects will most likely be experienced most keenly by women and across socio-economic groups in society.

Monitoring and Evaluation

Recently, the federal government accepted the recommendation of the Standing Committee on Foreign Affairs and International Trade (2002) to "undertake, and render public, an examination of the impact of Canada's existing commitments under the GATS on the effective provision by Canadian governments of health, education, and social services and on the regulatory structure affecting them." Such research is particularly important as Canada continues with subsequent rounds of trade negotiations.

It is not enough to examine the relationship between Canada's current trade commitments and the ability to set domestic health policies. Monitoring and evaluation must also include a consideration of how trade and trade treaties affect the health status and health determining conditions of the entire population, particularly those who tend to be most directly affected by social policy changes (e.g., populations identified by gender, class, race, ethnicity).

Research on women specifically could be derived from questions proposed by the WHO (2002) in its attempt to assess GATS and trade in health services. Appropriate questions would include the following.

- Where does a foreign commercial presence occur?
- What are the effects of a foreign commercial presence on health services and women?
- What are the broader social, economic and environmental effects of increased trade in services for women?
- How are governments' ability to meet public health goals and fulfill their responsibilities to women in the health sector affected by international trade agreements?

Specific gendered indicators must be identified for measuring such effects, be they positive or negative. A gendered social impact analysis framework, with its specific focus on the distributional impact of policy reforms on women, can play a critical role.

With respect to the health sector, there are virtually no empirical studies on the gendered impacts on equity, access or quality in Canada resulting from trade in health services. What is required is solid evidence that illustrates the actual effects of trade liberalization on Canadian society and the distributional effects on marginalized and vulnerable population groups including women. Integral to this is a better understanding of the strengths and limitations of existing gender-based and social impact analyses frameworks as well as the relationship between the two.

According to Women's Edge (2002) and its model for a gendered social impact analysis, key questions for research that would inform a comprehensive gendered impact analysis of trade agreements such as NAFTA and GATS should include the following.

- At what rate are services in health being traded across the four modes outlined in GATS?
- How are trade agreements affecting governments' regulatory abilities to create healthier social and environmental conditions, especially those influencing the burden of disease for women?
- Have there been changes in provision of public health services? How have these affected women's consumption of these services?
- Have user fees been introduced? If so, is this affecting the ability of women to access health care services?
- How do the changes in public services affect key indicators of welfare and well-being across the population and for women specifically?

- Has employment for women expanded or contracted in the public sector? Have labour standards eroded?

To answer these questions the following is needed:

- data that would show changes in the provision of public health services;
- expenditures per capita and per relevant populations, specifically women;
- data on user fees within the health care system;
- health indicators including mortality, reproductive health, child health and welfare, education and poverty statistics disaggregated by sex and gender;
- changing patterns and conditions of women's work including paid and unpaid work;
- changes in women's wages; and
- household survey data.

Trade and Human Rights Analysis

Recently, The UN Sub-Commission on the Promotion and Protection of Human Rights (August 2001) passed a resolution that recognizes the potential human rights implications of liberalizing trade in services through GATS (Spieldoch 2001). Indeed, the relationship between trade agreements and human rights needs to be closely interrogated. One research direction would consider the possible interactions between particular trade agreements and domestic laws and international covenants that protect women's rights and equality. For example, one could consider how trade agreements interface with Canadian national laws and international conventions (e.g., the *Canadian Charter of Rights and Freedoms* (1982), the *Covenant on Economic, Social and Cultural Rights,* the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) (1979). As White (2002: 6) correctly noted: "Trade rules should be constrained and bound by existing international trade agreements that promote human rights and women's rights, ecological sustainability, human dignity, and life."

Conclusion

The challenge of balancing the benefits of trade with considerations of women's health and well-being will continue to be a pressing policy issue. As Sen (1999) reminded us, good health is not simply a product of economic improvement; it depends on the quality of health policies and health investments. The Canadian government will need to continue to seek out ways to plan, co-ordinate and manage health policy within the globalized context without compromising what is considered Canada's most important social policy — health. A publicly funded health care system is a defining characteristic of Canadians' sense of national identity and citizenship. It is also integral to the promotion of women's health and gender equity rights more specifically. Sarah Sexton (2001: 60) put it best when she stated, "human rights [including the right to health] and public health policies are indispensable. Trade policies, however, are negotiable."

APPENDIX A: TRADE AGREEMENTS AND WOMEN'S HEALTH SELECTED ANNOTATIONS

Globalization and Trade Agreements

Cameron, D.R. and J.G. Stein. 2002. *Street Protests and Fantasy Parks: Globalization, Culture and the State.* Vancouver: University of British Columbia Press.

> This book focusses on two dimensions of globalization: the cultural and social realities of global connection and the shifting role of the state. While global processes are fusing societies and economies more deeply than ever before, the editors argue that obituaries for the state are premature, if not wholly inappropriate. These essays examine a series of compelling case studies — the entertainment industry, citizenship, social activism and wired communication — to assess the choices states have and the consequences of those choices for culture and society.

Hart, M. 2002. *A Trading Nation: Canadian Trade Policy from Colonialism to Globalization.* Vancouver: University of British Columbia Press.

> Taking the view that to understand the present and better prepare for the future, we must first comprehend the past, the author guides readers through more than three centuries of Canadian trade history. This narrative explains how Canadians, who currently enjoy one of the highest standards of living in the world, have largely come to accept that a country that derives much of its wealth from international commerce has much to gain from an open, well-ordered international economy. The author argues that close attention to trade and related economic policy choices is crucial if Canada intends to adapt to the challenges of the new, globalized economy.

Khor, M. 2001. *Rethinking Globalization: Critical Issues and Policy Choices.* London: Zed Books.

> This book explains what economic globalization means in trade, finance and investment. It shows how globalization is not increasing economic growth in most countries, or reducing inequality and poverty. The book criticizes Western governments for their undemocratic domination of the international policy process. It refutes the one size fits all policy prescriptions of the World Bank, International Monetary Fund and World Trade Organization on developing countries and argues that these countries must be allowed to decide when and how to open their economies to the global system.

McBride, S. 2001. *Paradigm Shift: Globalization and the Canadian State.* Halifax: Fernwood Publishing.

> The author argues that an overwhelming upsurge of public debate now surrounds the idea of globalization. Many of the key issues involving globalization are hotly debated: what it is, how new it is, whether it is an inevitable force or a political construction by powerful states and what, if any, alternatives might exist. The author evaluates this debate through a Canadian lens, and by placing Canada at the forefront of his analysis. The book looks at the history of Canadian involvement with globalism and examines the strategies for managing Canadian interaction with global forces.

Sauvé, P. and R.M. Stern (eds.) 2000. *GATS 2000: New Directions in Trade Services Liberalization.* Washington, D.C.: Brookings Institution.
This book examines the services that account for more than 70 percent of production and employment in advanced industrial societies, and the services of many of the world's developing economies, which are fast approaching that same level. With the negotiation of the General Agreement on Trade in Services (GATS), policies affecting access to, and conditions of competition in, service markets are today firmly rooted in the multilateral trading system. Written with policy makers and practitioners in mind, the essays in this volume address many of the most pressing questions arising in services trade today, some of which did not confront the first generation of GATS negotiators. The book aims to inform the key policy- and rule-making choices that both developed and developing country members of the World Trade Organization will need to make as they resume negotiations under GATS.

Sinclair, S. 2000. *GATS: How the World Trade Organization's "Services" Negotiations Threaten Democracy.* Ottawa: Canadian Centre for Policy Alternatives.
The author argues that negotiations behind closed doors are expanding the General Agreement on Trade in Services (GATS). He explains that the ultimate goal is to commercialize every service sector in every World Trade Organization (WTO) country, including essential services, such as health care, education and drinking water. Regulations that protect the environment and consumers will also be threatened. This book holds up the WTO's services agreement to the light of public scrutiny. It explains the meaning and intent of technical treaty clauses in understandable terms.

Shrybman, S. 2001. *The World Trade Organization: A Citizen's Guide.* Second Edition. Ottawa: Canadian Centre for Policy Alternatives.
This book analyzes the scope and influence of the World Trade Organization (WTO). The author shows how the WTO is using its extraordinary powers to force governments, including Canada's, to change their policies to cater to corporate interests. Canada has already felt the impact of WTO rulings, most recently when our policy on split-run magazines was challenged. The author explains how the key trade, investment and intellectual property agreements enforced by the WTO threaten our culture, environmental and labour standards, and our sovereignty itself.

International Trade and Health Care

Adams, O. and C. Kinnon. 1998. "A Public Health Perspective." *International Trade in Health Services: A Development Perspective.* Edited by S. Zarilli and C. Kinnon. Geneva, United Nations Committee on Trade and Development/World Health Organization: 35-50.
This article examines trade in services as a rapidly growing activity that is opening up new possibilities in the health sector. Although it is difficult to quantify the volume of such trade for lack of consistent, disaggregated data, there is growing awareness of its potential for both developing and industrial countries. In a generalized context of rising health care costs, coupled with a growing trend to reduce public spending in the social sectors, the advantages of exporting health sector skills and technology, or of attracting

higher spending foreign customers to health facilities become apparent. The authors argue that trade of health services offers countries the opportunity to enhance their health systems through the generation of additional financial resources, to improve the infrastructure by using the resources resulting from satisfying foreign demand, and to upgrade medical knowledge and technological capacities.

Adams, O. and C. Kinnon. 1997. *Health Economics Technical Briefing Note: Measuring Trade Liberalization Against Public Health Objectives: The Case of Health Services.* Geneva: WHO Task Force on Health Economics, December.

This briefing note is intended to complement a commercial viewpoint of trade in health services with a qualitative public health dimension. It analyzes systematically the four modes of trade identified in the General Agreement on Trade in Services from the standpoint of health systems in developing countries. To make a preliminary appraisal of the potential impact of this trade, three policy objectives are taken as a yardstick: equity of access, quality of services and efficient use of resources. The authors argue that health authorities will need, in particular, to strengthen their regulatory framework to ensure that national health systems derive maximum benefit from trade in health services in terms of equity, quality and efficiency, while reducing potential social cost to a minimum.

Adlung, R. 2001. "Effects of World Trade on Public Health." *The Lancet*. 357(9268): 1626.

The author responds to various reports that have been published in *The Lancet* on perceived health impacts of the General Agreement on Trade in Services (GATS). He argues that they offer an opportunity to fill information gaps and to familiarize interested readers with the Agreement and ongoing negotiations. According to Adlung, this opportunity has been squandered. He states that the reports are more notable for the researchers' zeal than for objectivity and factual accuracy. In his view, article VI establishes principles for the use of regulation, but has no bearing on the status of public services that are provided in the "exercise of governmental authority." Such services are exempt from GATS, and this exemption has never been questioned in the World Trade Organization.

Adlung, R. 2001. "The General Agreement on Trade in Services: Application to the Health Sector." (5): 3-5.

In this article Adlung takes up the debate about the degree to which the General Agreement on Trade in Services (GATS) is relevant to public services. He argues that GATS excludes all public services (i.e., services provided in the exercise of governmental authority). This applies whenever a service is provided neither on a commercial basis nor in competition with other suppliers; free medical treatment in public facilities is a case in point. He concludes that such services are not covered by the Agreement, and will not be made subject to future negotiations.

Adlung, R. and A. Carzaniga. 2001. "Trade in Health Services Under GATS — Past and Future." *Bulletin of the World Health Organization*. 79(4): 1-21.

The authors argue that the potential for health services trade has expanded rapidly over the past decades. More efficient communication systems helped to reduce distance-

related barriers to trade, rising incomes and enhanced information increased the mobility of patients, and internal cost pressures led various governments to consider possibilities for increased private participation. Nevertheless, the authors maintain that health services have played only a modest role in the General Agreement on Trade in Services (GATS) to date. Education aside, no other services sector has drawn fewer commitments on market access and national treatment than health. The novelty of the Agreement, co-ordination problems between relevant agencies, widespread inexperience with concepts of services trade, a traditionally strong degree of government involvement in the sector as well as concerns about basic quality and social objectives might have prevented World Trade Organization members from undertaking access commitments.

American Institute of Medicine. 1997. *America's Vital Interest in Global Health — Protecting Our People, Enhancing Our Economy and Advancing Our International Interests.* Washington: National Academy Press.

This report argues that America has a vital and direct stake in the health of people around the globe. For the United States to engage successfully in global health, co-ordination among the multiple U.S. agencies with statutory responsibilities in the area will be needed, as well as the formation of partnerships with the U.S. industrial and academic sectors and non-governmental organizations, other nations and international organizations. This report stresses the areas of U.S. global health engagement that are most likely to benefit the health of the U.S. population and recommends changes in policy and implementation that can enhance the health of Americans and other peoples of the world, provide economic benefit, and advance U.S. global leadership.

Appleton, B. 1996. "NAFTA, Healthcare and the Agreement on Internal Trade." Appleton & Associates International Lawyers. <http://www.appletonlaw.com/6dinternal.htm>. Retrieved July 25, 2002.

In response to a request from the Canadian Health Coalition for a legal opinion on the question of changes to international trade as they affect our social services, especially medicare, this report examines the major policy issues and implications in the debate on internal trade. The author argues that it is in the interest of the Canadian public to know what's going on in these negotiations and to pressure elected officials to secure and protect our social services.

Ascher, B. 2002. "The Case of the United States of America." In *Trade in Health Services: Global, Regional, and Country Perspectives*. Edited by C. Vieira and N. Drager. Washington, DC: Pan American Health Organization, pp.185-191.

This article presents the perspective of the United States on health services with respect to forthcoming negotiations. The author discusses the fact that services are relatively new to trade agreements, whereas goods have been subject to trade rules for 50 years. Over those five decades, the General Agreement on Tariffs and Trade was successful in reducing tariffs for goods by about 75 percent. This resulted in a 15-fold growth of trade and was accompanied by phenomenal world economic expansion over that period. The author presents the hope of the United States that reducing barriers to trade in services will make a similar contribution to the world economy.

Bettcher, W., D. Yach and G. Guidon. 2000. “Global Trade and Health: Key Linkages and Future Challenges.” *Critical Reflection*. 78(4): 521-534.

Globalization of trade, marketing and investment has important implications for public health, both negative and positive. This article considers the implications of the single package of World Trade Organization agreements for public health research and policy, focussing on three themes: commodities, intellectual property rights and health services. The main aims of the analysis are to identify how trade issues are associated with the trans-nationalization of health risks and possible benefits, to identify key areas of research, and to suggest policy-relevant advice and interventions on trade and health issues.

Boliz, M. (ed.) 1999. *Access to Health Services under the NAFTA.* Washington: Public Policy Program, Division of Health and Human Development, Pan American Health Organization.

In this book, contributors discuss NAFTA-related concerns about meeting the health care needs of people who move from one member country to another. This publication analyzes the legal implications of the access to health care by individuals from NAFTA countries who are temporarily working or residing in another member country. The book compares the health systems of Canada, the United States, and Mexico, focussing on their principles and objectives, legal framework, institutional structure, operational modalities, and outcomes. Detailing the similarities and differences among the systems of these three countries, this publication attempts to anticipate the treaty’s potential benefit or detriment to access to health care services and examines the expectations and concerns that free trade generates in this respect.

Bolwell, D. 1999. *The WTO and the General Agreement on Trade in Services: What Is at Stake for Public Health?* Ferney-Voltaire, France: Public Services International.

The author argues that trade in health services has been discussed since 1994 and there is every indication that in the next year this process will accelerate. The World Trade Organization says countries should reconsider the “depth and breadth of their commitments” on health and social services, which are currently “trailing behind other sectors.” The health industry, already battered by cost control and commercialization measures, is in for a shake-up. The author argues that for these last two sets of reasons, it is very important for health workers and public sector trade unions to understand the issues raised in this booklet and to act on the suggestions for action outlined at the end.

Butkeviciene, J. and D. Diaz. 1998. “GATS Commitments in the Health Services Sector and the Scope for Future Negotiations.” In *International Trade in Health Services: A Development Perspective.* Edited by S. Zarilli and C. Kinnon. Geneva: United Nations Committee on Trade and Development/World Health Organization, pp. 135-155.

This paper reviews specific commitments in health services negotiated in the World Trade Organization as an integral part of the General Agreement on Trade in Services. The analysis of commitments does not provide a full picture of the actual trade regime in health services. Furthermore, some important players in the health services market have not made any specific commitments in the sector. The commitments in health services

made by most countries have had no policy implications so far, since countries have either recorded the status quo of their trade regimes, provided partial information, or left sensitive aspects out of their schedules of commitments. However, future rounds of multilateral negotiations are likely to come closer to exerting pressure for changes in the trade regime by seeking a higher degree of openness in specific areas of commitment in health services.

Cardelle, A.J.F. 2000. "Democratization, Health Care Reform, and NGO-Government Collaboration: Catalyst or Constraint?" In *Health and Human Development in the New Global Economy: The Contributions and Perspectives of Civil Society in the Americas.* Edited by A. Bambas, J.A. Casas, H.A. Drayton and A. Valdés. Washington: Pan American Health Organization, pp. 203-229.

This paper examines the experiences of 20 different projects promoting non-governmental organization (NGO) –government collaboration in Guatemala, Chile and Ecuador. It is divided into three parts. The first part reviews the global trends within which the policies are being implemented and assesses the degree to which different factors, such as civil society–state relations, democratization, state reform and international pressure, have catalyzed or constrained policies promoting NGO–government collaboration. The second part analyzes how the goals, objectives, resources and planning processes associated with the implementation of collaborative projects influence project sustainability. The third section identifies the different ways in which NGOs and governments collaborate (e.g., funding, co-ordinated planning and training) and examines how each affects the project's outcome. The paper concludes with a set of policy recommendations for the implementation of future collaborative projects.

Cardelle, A.J.F. 2000. "Globalisation, International Health and a New International Relations Framework." In *Health and Human Development in the New Global Economy: The Contributions and Perspectives of Civil Society in the Americas.* Edited by A. Bambas, J.A. Casas, H.A. Drayton and A. Valdés. Washington: Pan American Health Organization, pp. 121-126.

The fundamental argument of this paper is that in practice there has been an intricate and reciprocal relationship between international public health and the practice of international relations. However, unlike the reality, the study of international relations has neglected the idea that health is an international issue. And while the discipline has been able to get away with this thus far, the current process of globalization is going to present a serious threat and challenge to some of the basic notions of international relations — basically the country centred perspective of international relations. The paper begins with a very quick review of the historical relationship between the two fields, and then looks at how the existing theories of international relations are inadequate and incapable of integrating health considerations. The paper concludes by proposing four areas in which public health practices and problems will pose a threat to the primacy of the nation-state.

Chanda, R. 2001. *Trade in Health Services.* Paper No. WG4: 5, Commission on Macroeconomics and Health Working Paper Series.

The objective of this study is to provide an overview of the nature of international trade in health services and the lessons that can be learned from the national, regional and multilateral experience in this context. This study discusses the various ways in which health services can be traded, the main global players in this trade, and the positive as well as negative implications of this trade for equity, efficiency, quality and access to health services. It also outlines some of the main barriers constraining trade in health services. The study highlights the experiences of various countries as well as regional trading blocs with regard to trade in health services and the progress made thus far in liberalizing trade in health services under the World Trade Organization's General Agreement on Trade in Services. Based on the national, regional and multilateral experience with trade in health services, the study draws broad conclusions about the main issues and concerns which characterize this trade and recommends policy measures to ensure that gains from trade in health services are realized while mitigating the potential adverse consequences of such trade.

Cornia, A., R. Jolly and F. Stewart. 1987. *Adjustment with a Human Face.* Oxford: Clarendon Press.

This study draws on 10 country case studies and UNICEF experience to illustrate the severity of the debt crisis and point to ways to avoid or alleviate the ill effects of economic adjustment on vulnerable groups. It highlights some successes in protecting vulnerable populations during adjustment, with policies that have generated employment, raised the incomes of the poor and maintained and even expanded basic health and education services, and supported nutrition among children. It underscores that policies to protect the vulnerable can and must become part of national planning even when the economy is in difficulties. The strategy of adjustment with a human face combines the promotion of economic growth, protection of the vulnerable and macro-economic adjustment.

De Wel, B. 2000. *WTO and Health: A National Perspective.* Conference on the World Trade Organization (WTO): Implications of EU Global Trade Policy on Health, Brussels.

The author argues that nobody can deny that international trade contributes to development. Generally, rich people have better health and live often in a better environment. Poor people have less access to health services and quite often live in degraded environmental conditions. The important question therefore is one of the distributions of the benefits of international trade and of the environmental sustainability of this trade. It is clear that a fair and equitable distribution of the trade benefits and the protection of the environment is not some kind of automatism. There is no efficient "trickle-down" of welfare to poorer groups in society, nor are the gains of free trade automatically used to preserve and protect the environment. International trade has become a complex business, organized with many rules. The problem is that these are not always focussed on protecting people's health and the environment.

Diaz Benavides, D. 2002. "Trade Policies and Export of Health Services: A Development Perspective." In *Trade in Health Services: Global, Regional, and Country Perspectives.* Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 53-69.

In this paper, the author argues that international trade in health services is opening many possibilities for increasing the economic contribution of the health sector to the national economy. Governments from both developed and developing countries are exploring different options including the implementation of export strategies for health services and the liberalization of business ownership to maximize their resource endowment and competitive advantages. This endeavour requires facing the challenge of reconciling trade objectives like foreign currency generation with those of granting their populations universal access to quality health care at an affordable cost.

Dollar, D. 2001. "Is Globalization Good for Your Health?" *Bulletin of the World Health Organization.* 79(9): 827-33.

This article makes four points about globalization and health. First, economic integration is a powerful force for raising the incomes of poor countries. In the past 20 years, several large developing countries have opened up to trade and investment, and they are growing well — faster than the rich countries. Second, there is no tendency for income inequality to increase in countries that open up. The higher growth that accompanies globalization in developing countries generally benefits poor people. Since there is a large literature linking income of the poor to health status, we can be reasonably confident that globalization has indirect positive effects on nutrition, infant mortality and other health issues related to income. Third, economic integration can obviously have adverse health effects as well: the transmission of AIDS through migration and travel is a dramatic recent example. The authors argue that the practical solution lies in health policies, not in policies on economic integration. Global integration requires supporting institutions and policies. Fourth, the international architecture can be improved so it is more beneficial to poor countries.

Drager, N. 1999. "Editorial: Making Trade Work for Public Health." *British Medical Journal*. 319: 1214.

Drager states that World Trade Organization (WTO) talks in Seattle offer an opportunity to get public health on the trade agenda. He maintains that recent trade disagreements over hormone-treated beef, genetically modified foods, and antiretroviral drugs have captured the public interest, and revealed the tensions between national public health policies and the need to comply with trade agreements overseen by the WTO. Trade openness can contribute toward a more equitable distribution of economic benefits and a just society, but this requires linkage of the trading system to sound social policies, including the recognition of health as a global public good. By developing a closer relationship with the WTO, the World Health Organization is trying to ensure that public health interests are represented on the trade agenda.

Hall, D. 2001. *Globalisation, Privatisation and Healthcare.* London: Public Services International Research Unit, January.

This paper distinguishes between globalization, which may have a negative development impact in any sector, and privatization, which specifically damages public services. Various channels are identified where globalization influences the privatization of health

care, including international institutions, government policies and the activities of multinationals themselves.

Hilary, J. 2001. *The Wrong Model: GATS, Trade Liberalisation and Children's Right to Health*. London: Save the Children.

This analysis suggests that liberalization of trade in health services is the wrong model to follow if countries wish to develop strong public health systems for all their people. In addition, the specific provisions of the General Agreement on Trade in Services undermine the ability of countries to implement their own public health priorities, and the Agreement must be reformed so national policy objectives are explicitly protected. Governments must ensure that public health concerns are guaranteed absolute precedence over the economic aspects of services trade, to fulfill their responsibilities to children and to society as a whole.

Johnson, J.R. 2002. *How Will International Trade Agreements Affect Canadian Health Care?* Discussion Paper 22, Commission on the Future of Health Care in Canada, Saskatoon.

This paper responds to the following questions posed by the Commission on the Future of Health Care in Canada: Given that there are conflicting legal opinions concerning the extent to which Canada's public health care system is exempted or protected from the obligations imposed by international trade liberalization agreements, what options exist to ensure that Canadian governments may continue, if they so choose, to maintain a public health care system that is consistent with Canada's international trade agreements?

Kickbusch, I. and E. de Leeuw. 1999. "Global Public Health: Revisiting Healthy Public Policy at the Global Level." *Health Promotion International*. 14(4): 285-288.

This article argues that health, which at first instance seems to be the field most destined for joint action independent of territory, remains a policy domain most protectively linked to the nation state. But even as countries defend their internal sovereignty over health care policy they are losing sovereignty over policies related to health determinants: the marketing, distribution and sale of consumer goods and lifestyles (e.g., tobacco and food), the growth of a global health industry (e.g., pharmaceuticals and insurance), the global spread of environmental pollution and infectious disease, and the health impact of the global financial system. The authors ask how governments can respond other than through new forms of protectionism or extreme competition to attract the global players into their own front yard.

Kierzkowski, H. 2002. "Trade and Public Health in an Open Economy: A Framework for Analysis." In *Trade in Health Services: Global, Regional, and Country Perspectives*. Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 47-52.

This paper argues that the optimal health system, be it on the national or the international level, has to balance and weigh the various objectives of different actions. People may have different views as to the appropriate weight of objectives and which should be given more importance. But a health system cannot go to extremes and centre only on

efficiency or even equity. It has to be a balanced package. Most people will agree that health is a special sector. But it also happens to be part of the economy. Thus, it must reflect certain general rules of economic behaviour, given that productive resources in the economy are limited.

Kinnon, C. 1998. "World Trade: Bringing Health into the Picture." *World Health Forum*. 19: 397-406.

In this article, Kinnon discusses whether the new multilateral trade agreements have implications for health and well-being. She argues that the relationship needs to be understood to put trade and health objectives into proper perspective. This introductory article looks at some of the areas in which international trade and public health interact.

Kluge, E.-H.W. 1991. "Competition and Function: The Canada–U.S. Free Trade Agreement and the Philosophy of Health Care." *Business and Professional Ethics Journal*. 10: 29-52.

This paper examines one area of the Free Trade Agreement in which reconciliation may prove extremely difficult. It is health care. The Free Trade Agreement contains provisions for an active interrelationship between the two countries in the delivery of health care. More specifically, the Free Trade Agreement provides that the health care industry of the one country must be accorded access to the market represented by the other, and vice versa. These clauses may pose a problem, because Canada and the United States have distinct perspectives on the philosophy of health care. This difference is rooted in a fundamental difference of perspective about the relationship of the individual to society.

Koivusalo, M. 1999. "World Trade Organization and Trade Creep in Social Policies." Helsinki: STAKES.

This paper argues that international trade agreements are an important part of globalization in setting out rules and entitlements for trade practices at the global level, and may have direct or indirect implications to health and social policies. A major share of implications is based on contents of agreements and what these imply for poverty, income distribution and food security in the global scene. In addition, there may be implications that interfere with the contents and scope of health and social policies across countries. These implications of international trade agreements emerged only gradually and, in many cases, through the settlement of trade-related disputes between countries or through debates concerning interpretations of stipulations made.

Koivusalo, M. 2000. *GATS and Services*. Conference on the World Trade Organization (WTO): Implications of EU Global Trade Policy on Health, Brussels.

This presentation discusses the GATS definition of services: any service in any sector except services supplied in the "exercise of governmental authority." When trade in services is of concern, one needs to consider a broad range of services to be traded. In health, problematic trade issues are likely to emerge (e.g., in terms of insurance, occupational, professional, clinical, laboratory, infrastructure and support services as well as in terms of broader management of health services and pressure to do so on an area or population basis). These trade-related interests and concerns extend beyond traditional professional or clinical services.

Koivusalo, M. and M. Rowson. 2000. "The World Trade Organization: Implications for Health Policy." *Medicine, Conflict and Survival*. 16(2): 175-191.

The authors argue that agreements negotiated at the World Trade Organization already have important implications for health and health policy. They impact on the ability of governments to regulate trade in the interests of health, on national and international governance and public health standards, and on the future of the precautionary principle. Agreements on trade-related aspects of intellectual property rights and trade in health services could benefit the multinational health care and pharmaceutical industries, and impact negatively on cost and equity.

Krajewski, M. 2001. *GATS and Public Services.* Geneva, Seattle to Brussels Network: 4-5.

The central question in this paper is whether public services are excepted by article I.3, or whether they fall within the scope of the General Agreement on Trade in Services (GATS). While this question may seem technical, it is of great importance in the context of GATS and democracy. The supply of public services is often the necessary basis for a democratic and open policy-making process in a country, most obviously in the cases of education and communication. Access to services, such as water or health care, is often seen as a human right. Yet other public services are also supplied to ensure that certain basic needs of the entire population are met, such as transport or energy.

Krajewski, M. 2001. "Public Services and the Scope of the General Agreement on Trade in Services." Centre for International Environmental Law. <http://www.gatswatch.org/docs/markus.html>. Retrieved July 5, 2002.

The author responds to questions about the extent to which the General Agreement on Trade in Services (GATS) rules may affect the supply of "public services." The answer to these questions depends on the coverage of public services by GATS. (Are public services covered, and if so, to what extent?) It also depends on the content of current and possible future GATS disciplines. (For those public services that are covered, what does GATS require?) A clear understanding of the scope of GATS is therefore important for governments negotiating and for civil society groups monitoring these negotiations. This research paper examines the scope of GATS. It focusses on GATS article I:3, the provision determining whether public services are covered by the agreement, and adopts a legal perspective, only suggesting some policy considerations at the very end.

Labonte, R. 1998. "Healthy Public Policy and the World Trade Organization: A Proposal for an International Health Presence in Future World Trade/Investment Talks." *Health Promotion International*. 13(3): 245-256.

This paper proposes creation of a strong public health lobby, both nationally and internationally, to join with other public interest non-governmental organizations in the social clause campaign. It begins by defining and critiquing some basic tenets of neo-liberal economic orthodoxy, which underpin the push toward global free trade and investment agreements. It then describes the current status of these agreements, and provides examples of how such agreements might imperil public health. The paper discusses the social clause initiative and concludes by advancing a proposal for a public

health lobby presence at those forums where trade and investment agreements are negotiated and monitored.

Labonte, R. 2000. "Healthy Public Policy and the World Trade Organization." In *Health and Human Development in the New Global Economy: The Contributions and Perspectives of Civil Society in the Americas*. Edited by A. Bambas, J.A. Casas, H.A. Drayton and A. Valdés. Washington: Pan American Health Organization, pp. 105-120.

This article calls on the public health community to join in lobbying efforts at national and international forums to include "social clauses" in global trade/investment agreements. These clauses, based on existing multilateral declarations monitored by United Nations agencies, are unenforceable. Their attachment to enforceable multilateral trade and investment agreements, however, would help to ensure that the benefits of a global economy are health-promoting by being socially just and environmentally sustainable.

Labonte, R., M. Sanger and D. Thompson. 2000. *Economic Globalization, Trade Liberalization, Governance and Health.* Ottawa: Canadian Society for International Health.

This paper argues that with the growth of the Internet, new technologies and the expanding global marketplace, people, goods and services are crossing borders at ever-increasing rates. Economic globalization, aided by the growth of new technologies, has provided new opportunities for economic growth. This has created enormous economic and social benefits for some countries, but not for others, and disproportionately to some groups within those countries. It has also reduced the regulatory authority of national and sub-national governments (the public sector) and increased the power and influence of transnational corporations (the private sector). The planet may be shrinking as far as business interests are concerned, but the gap between rich and poor within and between most nations is going in the opposite direction. This has profound implications for the health of people in both the developed and developing world.

Lee, Kelley (ed.). 2003. *Health Impacts of Globalization: Towards a Global Governance.* Houndsmills, Basingstoke, Hampshire: Palgrave Macmillan.

This book brings together an interdisciplinary group of researchers to analyze specific case studies that provide much needed empirical analysis of the impact of globalization on health. The range of issues covered — AIDS, tobacco control, BSE/CJD (bovine spongiform encephalopathy/Creutzfeldt-Jakob Disease), nutrition, cholera, anti-microbial resistance, World Trade Organization, global governance — is intended to be illustrative, rather than representative, of the diverse health impacts of global change.

Lipson, D.J. 2001. "The World Trade Organization's Health Agenda: Opening Up the Health Services for the Poor." Editorial. *British Medical Journal*. 323(7322): 1139.

Lipson comments on the focus of the World Trade Organization (WTO) to open many industries and services to foreign competition. This could adversely affect public health, because many insurance companies would only insure healthy people, leaving the public sector to care for the rest. Agreements made by the organization also shape national policies and regulations on issues ranging from food safety and imports of hazardous goods to duties on tobacco. She argues that the WTO's negotiations in 2000 to further

liberalize trade in services under the General Agreement on Trade in Services could increase the organization's influence on financing and delivery of health care.

Lipson, D.J. 2001. "GATS and Trade in Health Insurance Services: Background Note for WHO Commission on Macroeconomics and Health Paper No. WG 4: 7." Commission on Macroeconomics and Health. <http://www.cmhealth.org/docs/wg4_paper7.pdf>. Retrieved May 23, 2002.

This note provides background on the treatment of health insurance services by the General Agreement on Trade in Services (GATS) of the World Trade Organization and explains the relevance of current GATS negotiations for the health insurance trade. It begins with a general description of GATS, indicates how health insurance is classified in GATS-defined service sectors, and outlines options countries have when making insurance-related market access commitments. It then explains why GATS commitments made to date have not yet had any measurable effect on changes in insurance markets. It reviews some of the issues addressed in current GATS negotiations and their potential implications for market-access commitments covering health insurance. It concludes by reviewing the opportunities, risks and challenges presented by GATS for national policies and regulations affecting health insurance.

Lister, G. 2000. *Global Health and Development: The Impact of Globalisation on the Health of Poor People.* London: Department for International Development (DFID).

This paper was commissioned by the Department for International Development to support the preparation of a white paper identifying policy responses to the threats and opportunities posed by globalization for poor people. It draws on the work of the recently completed review "Global Health: A Local Issue" supported by the Nuffield Trust and the Royal College of Physicians. In summarizing the conclusions of the review and papers, it first defines the concepts of globalization, global health and health as a global public good. It then examines the processes whereby globalization affects the health of poor people and summarizes the overall impact. Finally, it presents an agenda for action to address the issues identified by the reviews.

Luff, D. 2001-2002. *Domestic Regulation of Health Services and International Trade Law.* Report to the project Regulatory Reform and Trade Liberalization in Services. Paris: World Bank/Organization for Economic Co-operation and Development.

This study confronts regulation in the sector of health services with the application of current World Trade Organization (WTO) rules. Developments in this regard are drawn primarily from a European experience. The study then delineates the margin of discretion left to domestic regulators by WTO rules. It concludes that the General Agreement on Trade in Services (GATS) is the relevant WTO agreement and that it is characterized by its total flexibility. Obligations imposed on governments pursuant to GATS mostly depend on individual commitments taken. It is argued that the latter must be appropriately crafted.

Marconini, M. 1998. “Domestic Capacity and International Trade in Health Services: The Main Issues.” In *International Trade in Health Services: A Development Perspective*. Edited by S. Zarilli and C. Kinnon. Geneva: United Nations Committee on Trade and Development/World Health Organization, pp. 55-61.

The author argues that, like in no other sector, successful policy making in the health sector involves delicate balancing of often competing interests and concerns, all of which find a prominent place in the complex web of policy options. The relationship which is established between social and commercial elements, not to mention the interface between those elements and scientific, professional, efficient or ethical considerations, attests to the special nature of the health services sector and all its activities. International trade in health services is necessarily, therefore, just an element of consideration among many others. As such, its consideration must follow the widely accepted premise that any policy, in touching on health matters, has to be guided first and foremost by the objective of improving the health and living conditions of the population.

Mattoo, A. 2001. “Shaping Future Rules for Trade in Services: Lessons from the GATS.” The World Bank. <http://econ.worldbank.org/files/1716_wps2596.pdf>. Retrieved May 18, 2002.

In this article, Mattoo maintains that the General Agreement on Trade in Services (GATS) is justifiably credited with having created a more secure environment for trade in services. But even though it has put in place a useful framework to deal with explicit protection, it has not generated either the negotiating momentum to reduce such protection or the rules to ensure that it takes a desirable form. In dealing with the trade-impeding impact of domestic regulations, the Agreement has achieved even less. The paper suggests possible improvements in the rules of the Agreement, in the specific commitments made by countries and in the negotiating methodology.

McMichael, A.J. and R. Beaglehole. 2000. “The Changing Global Context of Public Health.” *The Lancet.* 356 (9228): 495-499.

This article posits that future health prospects depend increasingly on globalization processes and on the impact of global environmental change. The authors suggest that economic globalization — entailing deregulated trade and investment — is a mixed blessing for health. Economic growth and the dissemination of technologies have widely enhanced life expectancy. However, aspects of globalization are jeopardizing health by eroding social and environmental conditions, exacerbating the rich–poor gap and disseminating consumerism.

Ontario Health Coalition. 2001. “Round by Round: Are International Trade Deals Knocking Out Medicare?” *OHC Newsletter*. (January): 1-2.

This report states that what makes the General Agreement on Trade in Services (GATS) so critical is its breathtaking scope and complexity. GATS applies to measures of all governments: federal, provincial, First Nation, regional and municipal. It deals with the environment, culture, natural resources, health care, education and social services. It covers virtually all government measures including laws, regulations, guidelines and even unwritten practices. It restricts the actions of governments regarding protection of services through legally enforceable constraints backed up by trade sanctions. And it has

a built-in escalator. National governments — including Canada's — have already committed to successive rounds of negotiation intended to broaden and deepen the agreement.

Ostry, A. 2001. "The New International Trade Regime: Problems for Publicly Funded Healthcare in Canada?" *Canadian Journal of Public Health.* 31(3): 475-480.

This paper discusses the potential for the World Trade Organization (WTO), through its influence on the trade in health and ancillary services, to impact publicly funded health care delivery systems directly. The WTO is emerging as an important player in the trade in health and ancillary services. This is of particular concern for nations like Canada with publicly funded health care systems. There are two main areas for potential concern. First, over the past 15 years, as drugs have become the fastest-growing component of health care costs, the power of provincial governments to control these costs has been eroded due to restrictive trade and patent rules initially introduced through the Free Trade Agreement and consolidated under the WTO. Second, the WTO, as well as representatives of the American health care industry, have targeted publicly funded health care systems, such as Canada's, as a potential market for increased trade in health care services.

Ouellet, R. 2002. *The Effects of International Trade Agreements on Canadian Health Measures: Options for Canada with a View to the Upcoming Trade Negotiations*. (Discussion Paper 32). Saskatoon: Commission on the Future of Health Care in Canada.

This position paper argues that Canadians are wondering if, with the economic agreements signed during the last decade, our governments still have the necessary latitude to maintain health systems that respond to their expectations. Canada has, to date, consistently excluded the application of these agreements to our health systems using a variety of approaches. On the multilateral level, the General Agreement on Tariffs and Trade rules apply, with rare exceptions, to all products including those related to health. The *General Agreement on Trade in Services* is built around a quite different approach, one of specific commitments. Access to a national market of a particular services sector is possible only if a World Trade Organization member has specifically undertaken to provide access to its market for that sector of services. Canada has made no such commitment in regard to health services.

Pan American Health Organization. 2002. "Toward a Positive Multilateral Trade Agenda for Developing Countries: Meeting Conclusions and Recommendations." *Trade in Health Services: Global, Regional, and Country Perspectives*. Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 223-226.

This paper presents the conclusions of meeting participants that trade is essential for development, and well-articulated policies regarding trade in health services may contribute to economic well-being. A special concern is that, historically, the health sector has suffered disproportionately in times of economic crisis and the poor are the most affected. The meeting recommended that the health sector take an active role in services negotiations to help fashion the possible benefits while protecting the most vulnerable segments of the population from inequities.

Pan American Health Organization, Division of Health and Human Development, and World Trade Organization. 2002. "Trade in Health Services in the Region of the Americas." In *Trade in Health Services: Global, Regional, and Country Perspectives.* Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 121-141.

This working document provides an overview of recent trends and some issues involved in the commercialization of medical and health services in the Americas. The traditional trade relations between South and North have been shifting rapidly and a far more complex web of alliances is superseding them. The health care "industry" and myriad health-related services are among the sectors where change is occurring most swiftly. The direct private purchase of specialized medical services abroad always has occurred as a relatively sporadic activity, whose impact on the wealthy consumers' country was negligible. Today, however, new forces are realigning the form of access to biotechnology, information technology, pharmaceuticals, direct health services, insurance coverage schemes and the employment opportunities they entail.

Peabody, J.W. 1996. "Economic Reform and Health Sector Policy: Lessons From Structural Adjustment Programs." *Social Science Medicine*. 43(5): 823-835.

According to Peabody, from a purely economic perspective, structural adjustment programs (SAPs) and economic reform policies are viewed as short-term austerities that lead to long-term growth and development. These intertemporal trade-offs, however, are not always acceptable in health. Health policy makers need to understand the expected and unexpected impacts of economic reform on health outcomes in individuals and on the population. The interactions are complex, involve multiple sectors, and can be better understood by looking at the experience of developing countries over almost 15 years of SAP experience. Health care budgets may be vulnerable to reduced government spending, quality of care deteriorates, nutrition will suffer more likely in urban areas, and cost-effective preventive programs may stop if labour and capital are not properly matched.

Pollock, A. and D. Price. 2001. "Effects of World Trade on Public Health." *The Lancet*. 358(9287): 1097.

In this book, the authors argue that the World Trade Organization (WTO)'s General Agreement on Trade in Services (GATS) covers public health care, because it targets for removal any government measure that affects entry into any service market of commercial providers and investors. The WTO Secretariat and the European Community have raised concerns about this lack of clarity, and note that the interpretative methods of the *Vienna Convention on the Law of Treaties* can give the article a narrow or broad meaning. This paper shows that a WTO committee has argued for a narrow interpretation that could bring all public services under GATS.

Saltman, R.B. 1997. "Globalization and the Future of Public Funding for Health Care Services." *Eurohealth*. 3(3): 34-36.

Over recent years, Saltman argues, ministers of health have found themselves confronted by a new justification for why publicly financed health care systems cannot be allowed access to additional financial resources, and why existing levels of public spending on health care systems — however calculated — have to be reduced. The justification can be summarized in two words: economic globalization." Despite continued high levels of

wealth in developed countries, there apparently is not enough money to fund additional or even existing levels of health care. This belief, in turn, stimulates a growing interest among policy makers in not just increased effectiveness and efficiency in health care, but in off-loading public expenditure for health onto private budgets, In effect, the issues of economic globalization, along with economic regionalization, challenge the long-term sustainability of public finance for health care services.

Sanger, M. 2001. *Reckless Abandon: Canada, the GATS and the Future of Health Care.* Ottawa: Canadian Centre for Policy Alternatives.

This report assesses the implications of the General Agreement on Trade in Services (GATS) for Canada's health care system. It examines both Canada's commitments in the existing GATS, which came into effect in 1994, and the agenda of the current round of GATS negotiations, known as GATS 2000. The report provides an overview of GATS implications for health care, then assesses its impacts for health insurance, hospital services and home care. The analysis of these three critical health services suggests the full range of GATS impacts. One goal is to demonstrate that more comprehensive exploration and full public debate, of the potentially profound implications of GATS for the Canadian health care system are urgently required.

Sbarbaro, J.A. 2000. *Trade Liberalization in Health Insurance: Opportunities and Challenges: The Potential Impact of Introducing or Expanding the Availability of Private Health Insurance within Low and Middle Income Countries*. Paper No. WG 4:6, Commission on Macroeconomics and Health Working Paper Series.

The author argues that investment opportunities, new technologies and the expansion of global trade rules to cover services have expanded opportunities for international trade in health insurance. Globalization of health, insurance is highly relevant to the issue of macroeconomics and health because health insurance is one model — and a powerful one — by which health services (doctors, nurses and other personnel) and pharmaceuticals are financed. As health services are much more complex public outputs than intermediate goods and services, they are subject to increasing challenge on both efficiency and equity grounds. These challenges are exacerbated with the introduction of private health insurance. Moreover, there are no patent issues to delay cross-border implementation.

Sexton, S. 2001. "GATS and Health Care." *GATS and Democracy*. Geneva: Seattle to Brussels Network, 18.

In this paper, Sexton argues that the General Agreement on Trade in Services (GATS) could facilitate the development of health care markets where health care services are bought and sold: bought by those who have the money to do so, and sold by those aiming to make a profit for their shareholders. Those who don't have the money — or whom insurers consider too risky, too old or too sick — lose out. What gets sold, moreover, is not health care to society but health products and procedures to individual consumers. In a health market, a two-tier system quickly develops. The for-profit sector creams off healthy and wealthy patients, public subsidies and staff, leaving a reduced public sector to deal with emergencies, to train staff and to cope with the elderly, the chronically sick and the poor — those who most need health care.

Sexton, S. 2001. "Trading Health Care Away?" The Cornerhouse Briefing 23. <http://cornerhouse.icaap.org/briefings/23.html>. Retrieved May 18, 2002.

Sexton argues that the United States, European Union, Japan and Canada are trying to revise the General Agreement on Trade in Services (GATS) so it could be used to overturn almost any legislation governing services from the national to the local level. Domestic policy making, even on matters such as shop opening hours or the height and location of new buildings, could, in effect, be turned over to the World Trade Organization. All legislation would primarily be aimed at increasing trade. Particularly under threat from GATS are public services, such as health care, education, energy, water and sanitation. These are already coming under the control of the commercial sector as a result of privatization, structural adjustment and reductions in public spending. A revised GATS could give the commercial sector further access and make existing privatizations effectively irreversible.

Sikes, L. 1998. *On the Triennial Review by the World Trade Organization on the Application of Sanitary and Phytosanitary Measures (the "SPS Agreement")*. Public Citizen, Global Trade Watch.

The author argues in response to the Office of the United States Trade Representative's request for comments with respect to the review by the World Trade Organization (WTO) Committee on Sanitary and Phytosanitary Measures (the SPS Committee) of the Agreement on the Application of Sanitary and Phytosanitary Measures (the SPS Agreement), 62 Fed. Reg. 64618 (December 8, 1997). These comments focus on concerns the SPS Agreement does not adequately safeguard a country's right to adopt and implement regulations to protect human, animal and plant life or health, and to establish the level of protection of life and health that it deems to be appropriate.

Sinclair, S. and J. Grieshaber-Otto. 2002. "WTO Services Treaty Expanding into Public Services and Domestic Regulation, Areas Thought Off-Limits to International Trade Agreements." Canadian Centre for Policy Alternatives. <http://www.policyalternatives.ca/publications/comment41.html>. Retrieved July 2, 2002.

In this report, the authors argue that unknown to most Canadians, senior government officials have just returned from a negotiating session in Geneva to expand the reach of the World Trade Organization's services agreement into areas usually considered the exclusive prerogative of domestic policy making. On the table are public services, such as education and health care, and public interest regulations, such as tobacco control and environmental protection laws. While still largely unknown to the general public, the binding treaty is deservedly controversial. Its subject matter — services — is almost unimaginably broad. GATS affects how governments regulate services — from water testing to heart surgery. It restricts actions taken by all levels of government, whether central, regional or local.

United Nations Development Programme. 2003. *Making Global Trade Work for People*. New York and United Kingdom: Earthscan Publications.

This report suggests that trade can, and must, be made to work as an engine of growth and human development. What is needed to do this is a serious, systematic effort to apply the lessons of history, which show that, with very few exceptions, today's rich

countries enjoyed many of the protections they now seek to deny developing countries, only dismantling them after growing wealthier and more powerful. It is also important to ensure that the multilateral trade regime is better aligned with broader objectives of human development: helping poor people everywhere gain the tools, opportunities and choices to build a better life for themselves, their families and their communities. This is the only way to reverse the current disaffection with globalization.

Vellinga, J. 2001. *International Trade, Health Systems and Services: A Health Policy Perspective*. Ottawa: Health Canada.

This paper explores some of the links between international trade and health services from a health policy point of view. Trade in health services can have far-reaching consequences for the health sector and health, and can create conflict between trade/economic goals and health/social objectives. It is, therefore, important for the health policy and research communities, as well as the trade policy community, to identify and address the key issues raised by trade in health services. A framework is suggested for considering the interrelationships between international trade and health. The core issue is the significance of international trade for achieving health objectives. How trade impacts on health involves both trade in goods (health and non-health goods) and trade in services. But the relationship goes much further. International trade can influence key determinants of health as well.

Vellinga, J. 2002. "An Approach to Trade and Health at Health Canada." In *Trade in Health Services: Global, Regional, and Country Perspectives*. Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 193-196.

In this article, the author outlines the approach Health Canada is putting in place to address the issue of health and international trade aims. Specifically, Health Canada wants to ensure that trade discussions reflect its health perspective and concerns. In this context, Health Canada's activities in 1999 had their origins in past trade events, where important lessons were learned. This paper indicates not only what Health Canada is trying to do, but also why and how.

Waghorne, M. 2000. "Health Services for Trade." Conference on the World Trade Organization (WTO): Implications of EU Global Trade Policy on Health, Brussels.

This paper addresses the implications of the General Agreement on Trade in Services (GATS) for health services and discusses how to keep health services in public hands and under the public control of national governments. While some of the issues discussed are approached from a European perspective, many have a global implication. Indeed, the position of the European Commission and its pressure for greater liberalization of health services under GATS in developing countries, while seeking to maintain the status quo in Europe, highlights this European and global dichotomy.

Woodward, D., N. Drager, R. Beaglehole and D.J. Lipson. 2001. *Globalisation and Health: A Framework for Analysis and Action*. Paper No. WG4: 10, Commission on Macroeconomics and Health Working Paper Series. <http://www.cmhealth.org/docs/wg4_paper10.pdf>. Retrieved May 23, 2002.

This article proposes a framework for understanding and analyzing globalization, especially its economic aspects, and its impacts on health. It also presents a set of objectives for action at the national and international levels for the protection and promotion of health in the context of globalization, particularly for poor populations. First, an agreed analytical framework is essential for a reliable assessment of the health effects of globalization, the development of a research agenda and of appropriate policy responses. Second, the indirect effects of globalization operating through the national and household economies are important for health outcomes, as well as the more obvious and direct effects on health risks and the health sector. Third, the effects of globalization will be optimized only when improvements in health and well-being become central objectives of national economic policy making, and the design and management of the international economic system.

Woodward, D., N. Drager, R. Beaglehole and D.J. Lipson. 2002. "Globalization, Global Public Goods, and Health." In *Trade in Health Services: Global, Regional, and Country Perspectives*. Edited by C. Vieira and N. Drager. Washington: Pan American Health Organization, pp. 3-11.

This chapter focuses on economic globalization, which is a key element of the globalization process as a whole, a major driving force behind it and a critical determinant of its impact on health. It provides a description of the key linkages between globalization and health, and introduces the concept and possible applications of global public good for health as a pro-health counterpart to the globalization process.

World Bank. 2002. "A User's Guide to Poverty and Social Impact Analysis." Washington: The World Bank Poverty Reduction Group (PRMPR) and the Social Development Department (SDV), work in progress, draft for comment.

This draft guide provides an approach to conducting poverty and social impact analysis (PSIA) and outlines a menu of available tools and techniques for carrying out a PSIA. It does not suggest a mini-standard for World Bank staff, nor does it represent Bank operational policy. The draft guide is a work in progress, and will be updated eventually to reflect cutting-edge country experience and newly minted techniques.

World Health Organization and World Trade Organization. 2002. *WTO Agreements and Public Health: A Joint Study by the WHO and WTO Secretariat*. Geneva: WHO/WTO.

This study explains how World Trade Organization (WTO) agreements relate to different aspects of health policies. It is meant to give a better insight into key issues for those who develop, communicate or debate policy issues related to trade and health. The study covers areas, such as drugs and intellectual property rights, food safety, tobacco and many other issues, which have been subject to passionate debate. In this joint effort, the first of its kind, the World Health Organization and the WTO Secretariat endeavour to set out the facts.

Gender and International Trade/Globalization

Afshar, H. and C. Dennis (eds.). 1992. *Women and Adjustment Policies in the Third World.* Women's Studies at York/Macmillan Series. London: Macmillan Academic and Professional Ltd.

In this book, contributors find that the changing political and economic circumstances of the 1980s have resulted in a radical change of policy in many developing countries. Although the countries of the Organization for Economic Co-operation and Development and the newly industrialized ones have made a recovery from the recession of the early 1980s, the developing countries have not. This is in part the result of the debt crisis and deteriorating terms of trade as well as the weakness of state policy and the profligate use of international borrowing in the earlier decade. As a result, many developing countries have had to move toward a contraction of public sector expenditure and a series of market-oriented development policies. Women in general, and the poorest among them in particular, have borne, to a disproportionate extent, the brunt of the ensuing hardships. This volume addresses the general shortcomings of the current gender-blind analytical frameworks of government and international financial organizations.

Allaert, B. and N. Forman. 1999. "Gender, Trade and Rights: Moving Forward." *WIDE Bulletin.* Brussels.

The authors argue that however slow, the progressive acknowledgment of, and the commitment to, women's rights by international, regional and national bodies stands as a testimony to a promising exit from the 20th century for women. Still, they argue that the imminence of the new millennium is a momentum for us to evaluate the success of women worldwide in the struggle for the recognition of rights and, more important, the practical application of this recognition. This bulletin is a continuation of the work on gender and trade WIDE has carried out over the years. In this collection of articles, it appears there is a need for even closer partnership, networking, solidarity and collective effort from partners striving for a more equitable and sustainable world.

Antrobus, A., B. Cranney and A. Isla. 2002. *Canadian Woman Studies: Women, Globalization and International Trade*. 21/22 (4/1).

This volume argues that we need to draw on the varied knowledge and experience of diverse groups of women in Canada and abroad, especially those most immediately and negatively affected by current processes of neo-liberal trade and globalization, to understand fully the nature of these processes, our own varied position within them, and the possibility of building strong alliances and movements to resist and transform them.

Ashworth, G. 1992. "Politicising Gender and Structural Adjustment." In *Women and Adjustment Policies in the Third World*. Edited by H. Afshar and C. Dennis. London: Macmillan Academic and Professional Ltd, pp. 233-252.

The author argues that if the purpose of research is to reveal, the purpose of advocacy is to see the revelation into wider consciousness and then into policy and remedial actions. This chapter is concerned not with an analysis of the impact of structural adjustment on women, but of the process of making that impact known, and postulating damage

limitation and even preventive measures, as well as proposing alternatives to current forms of adjustment.

Baden, S. and A.M. Goetz. 1998. "Who Needs [Sex] When You Can Have [Gender]? Conflicting Discourses on Gender at Beijing." In *Feminist Visions of Development: Gender Analysis and Policy*. Edited by C. Jackson and R. Pearson. London, New York: Routledge, pp. 19-38.

This chapter is inspired by the challenge to gender and development (GAD) from grass-roots development workers and women activists in the South. This challenge is linked to the current debate over the institutionalization of gender in development policy and practice, and relates to the perceived depolitization of the concept of gender. The authors explore a completely different critique of gender from conservative groups, who attacked gender during the Beijing process on the grounds that it is an over-radical and unrepresentative approach to thinking about social relations. They consider the ways the conservative critique illuminates contradictions in feminist theorizing about gender. Underlying both sections are questions about what happens to feminist concepts in activist and policy arenas, and about the authors' role in this process, as gender and development researchers.

Bakker, I. 1996. *Rethinking Restructuring: Gender and Change in Canada*. Toronto: Toronto University Press.

During the past decade, Canadian policy makers have been forced to re-examine familiar governing instruments and established programs in the face of growing budget deficits, economic instability and a rapidly changing global economy. This collection of 18 original essays presents a critical exploration of the question of political and economic restructuring from the vantage point of gender. The authors argue that the present shift in the global order is revealing the contradictory effects of what is a dual process of both gender erosion and intensification. With the convergence of male and female job experience in polarized labour markets, gender appears to be less important in understanding the global political economy. At the same time, gender becomes more of a determining factor in the transformation of politics and markets, owing to the changing role of women as workers, caregivers and consumers.

Barndt, D. (ed.). 1999. *Women Working the NAFTA Food Chain: Women, Food and Globalization*. Women's Issues Publishing Program. Toronto: Second Story Press.

This book argues that there is a special connection between women and food. In most cultures, women have played major roles in growing and preparing food. In the continental food system, which is the focus of this book, women are central to its production and consumption — from those who cultivate, pick and pack fresh produce in agribusinesses to those who work in assembly lines processing food into cans and bottles; from the cashiers who scan and weigh, price and package our purchases to the cooks and waitresses in restaurants who chop and cook and serve us meals. The experiences of women in the food system offer a window on the restructuring of work in the new global economy. The authors also find that it is women who are leading their communities in creating local alternatives to the increasingly globalized food system.

Beneria, L. and A. Lind. 1995. “Engendering International Trade: Concepts, Policy and Action.” GSD Working Paper Series 5.

> This paper is an attempt to address both the engendering of the trade debate and the gender implications of trade policies and actions. It has been written with the objective of conceptualizing some of the relevant issues for future policy research on gender and trade. An initial question is the extent to which gender is a notion that is relevant in trade discussions. The paper explores the various areas in which connections between the two can be traced. They range from the effects of trade on employment (specifically women’s employment) to issues of gender and technology, the feminization of the labour force, free trade zones (FTZs), and the gender and trade aspects of structural adjustment. Efforts to promote women’s micro-enterprises may be fruitless, for example, if such enterprises cannot survive the competitive pressures arising from trade liberalization. It is important to discuss the gendered implications of trade policy with issues such as this in mind.

Berger, S. 2001. “Political Economy Discourses of Globalization and Feminist Politics.” *Signs: Journal of Women in Culture and Society*. 26(4): 983-1006.

> In this article, the author questions conventional representations of globalization and investigates their implications for imagining feminist subjectivity within, and resistance to, global capital. She focusses on the construction of subjectivities in the political economy literature on gender and globalization. Contemporary thinking about globalization is not, of course, limited to its forms in political economy. Perspectives on this topic span academic, activist, cultural, literary, and other disciplinary practices and sites. Still, political economy knowledge has participated in the construction of these perspectives. Thus, feminists working in all areas have to negotiate the various meanings of the political economy of globalization.

Blacklock, C. 2000. *Women and Trade in Canada: An Overview of Key Issues*. Ottawa: Status of Women Canada.

> This paper discusses the progression of trade throughout the previous decade and its impact on Canadian women’s lives, and highlights the varied perspectives of feminists concerning the benefits of trade and best responses. It explains that the pressures that trade liberalization has placed on government often forces reductions in public expenditure, with negative implications for female users of social programs including universal health care. Gendered effects of trade liberalization concentrate on the areas of health care, education, entrepreneurship and agriculture selected for their dual role as significant aspects of trade policy and factors for many Canadian women. With respect to health services, the potential impact of the General Agreement on Trade in Services is mentioned, noting the potential for women to benefit although deeming the negative effects more likely.

Cagatay, N. 2000. *Trade, Gender and Poverty*. New York: United Nations Development Programme.

> This paper focusses on the relationship of trade, on the one hand, with gender and poverty, on the other, within the context of the human development paradigm.

Specifically, it examines the impact of trade liberalization on gender inequalities (primarily via employment, wages and the care economy) and the impact of gender inequality on trade performance. These interactions are discussed in light of mainstream literature on trade, growth and poverty reduction, which defines poverty in terms of income or consumption, and largely ignores gender. The paper also considers the policy implications of a gender-aware approach to international trade analysis and the current world trade regime.

Cohen, M.G. 1987. *Free Trade and the Future of Women's Work: Manufacturing and Service Industries*. Toronto: Garamond Press.

This study was a response to the Canadian government's lack of concern about what free trade with the United States would mean for women. The author suggests that this initiative to negotiate free trade with the United States began because of pressure from big business, and Canada rushed into the agreement without public debate and without a clear understanding of what it would mean for people. This study is not comprehensive in that the author has not been able to cover all industries and all occupations in which women's work is threatened by a free trade arrangement. She suggests, however, that in some sectors, particularly in manufacturing, the impact will occur in a fairly short period of time. However, in others, such as in the public services, changes will be more gradual and will occur in response to the necessity to harmonize social policy over a fairly long period of time.

Cohen, M.G., L. Ritchie, M. Swenarchuk and L. Vosko. 2002. "Globalization: Some Implications and Strategies for Women." *Women's Studies/les cahiers de la femme: Women, Globalization and International Trade*. 21(22): 6-14.

The focus in this paper is on two specific areas which feminists have not yet devoted significant attention to but are indicative of the direction in which globalization is taking us. The first section looks at the ways in which the new legal processes that are emerging as a result of globalization threaten our democratic institutions as they currently exist. The main point is that, at both the international and national levels, the legal processes that epitomize our notions of democracy are being shifted from those that are accessible, open and public processes, to secret proceedings, which exclude public scrutiny. The new institutions that are being established are not democratic, do not replace the market-controlling functions of nations and shift power decidedly in favour of international corporations.

Dewan, R. 1999. "Gender Implications of the 'New' Economic Policy: A Conceptual Overview." Women's Studies International Forum. 22(4): 425-429.

This article examines the effects of globalization on opening up the Indian economy for international trade. Economic reforms under the New Structural Adjustment Programme (1991) include the deregulation of the economy to allow free market forces to operate unfettered. With increasing global economic competition, employment conditions have declined and government spending on social and welfare services has decreased. This article demonstrates the impact on women, and how policy makers assume the burden of social services can be "costlessly" transferred from the "productive" economy to the "non-productive" economy, that is, to women within the household. The author concludes that

women's multiple roles in production and reproduction are negated by the absence of gender analysis in economic policy making.

Durano, M.F.B. 2001. "Gender Issues in International Trade, Centre of Concern." <http://www.coc.org/pdfs/coc/gender_issues.pdf>. Retrieved July 8, 2002.

This report states that the widening scope of international trade negotiations in recent decades forces those on the periphery of policy making to take a comprehensive approach to analyzing the impact of these developments. This paper begins to show the many ways the impact of trade can be felt by women and men, and suggests that further research is needed to better understand gender issues in international trade.

Evers, B. 1999. "Engendering the Trade Policy Review Mechanism of the WTO." In *Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation; pp. 91-99.

The author argues that among the criticisms of the World Trade Organization (WTO) is the lack of accountability to national economies and its failure to represent women and women's interests. The lack of accountability of the WTO to the UN mandates on gender equity and the absence of a gender analysis of trade issues within the WTO is worrying. The present paper focusses specifically on improving the gender awareness of the trade policy review process. It suggests ways to integrate gender into the key policy documents of member countries and the WTO in this process.

Evers, B. 2002. "Gender, International Trade and the Trade Policy Review Mechanism: Conceptual Reference Points for UNCTAD." Gapresearch.org, Institute of Development Studies. <http://www.gapresearch.org/governance/BE%20evers%20unctad%20paper1.pdf>. Retrieved August 6, 2002.

This paper examines the extent to which the national trade policy process is transparent and includes the interests of the poor, with a particular focus on women involved in the horticulture sector as workers and as contract farmers. It aims to explore the extent to which it is possible for the broad concerns of women workers to be reflected in the international trade and development agenda. The author is in full agreement with the need to improve the capacity of developing countries to participate in the World Trade Organization (WTO) and to benefit from new trade rules and globalization in general. However, it is argued that strengthening developing country members' capacity for meaningful participation within the WTO is not sufficient for strengthening the accountability of national governments to the poor and marginalized groups, and especially not for the poor women.

Foerde, J.G. 1999. "Giving Trade a Human Face: Gender and Development Action on International Trade — Strategies, Work and the WTO Focus of the IWGGT." In *Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 115-141.

The author argues that the realization of economic, social and cultural rights should be the fundamental framework for, and goal of, all multilateral and bilateral trade, investment and financial agreements and rules. This article takes its point of departure in

a rights-based approach to mainstreaming the crosscutting concern of gender and women and development into international trade work and rules, and the WTO. It also gives the background and status of the international "gender action focus" on the WTO and international trade as expressed in the international network, Informal Working Group on Gender and Trade.

Fontana, M., S.P. Joekes and R. Masika. 1998. "Global Trade Expansion and Liberalization: Gender Issues and Impacts." *BRIDGE Report Institute of Development Studies*. 42: 1-81.
This paper argues that gender analysis is important in understanding why some countries, sectors or regions are unable to capitalize on potential trading opportunities, which relates, in part, to rigidities and distortions, including gender distortions in factor markets. It finds that the benefits of trade expansion are differentiated between women and men, as well as between different groups of women, with implications for both gender equality and poverty reduction goals. The consequences of trade liberalization and expansion for women both absolutely, and relative to men, have been mixed, with both positive and negative features, depending on a range of factors and preconditions.

Fontana, M. and A. Wood. 2000. "Modeling the Effects of Trade on Women, at Work and at Home." *World Development.* 28(7): 1173-1190.
Foreign trade affects women's wages and jobs, their household work and leisure. This paper develops a model which covers not only all the sectors of the market economy, but also social reproduction and leisure activities, for women and men separately. The model, which in other respects is a standard computable general equilibrium model, is applied to a simplified set of data for Bangladesh. Its use is illustrated by simulating the gendered effects of changes in trade policies and capital flows.

Granada, D. 2000. "A Response by Women to the Rapid Diminution of Health and Other Social Services." *Health & Human Development in the New Global Economy: The Contributions and Perspectives of Civil Society in the Americas*. Edited by A. Bambas, J.A. Casas, H.A. Drayton and A. Valdés. Washington: Pan American Health Organization, pp. 305-308.
The author argues that the Nicaraguan government is a willing player in the international economic system that fosters individualism and greed, and abdicates responsibility for the welfare of its people. Following dictates of structural adjustment laid down by the International Monetary Fund and the World Bank to service the foreign debt, for every US$5 spent on external debt, US$1 goes to social services and education. The authors argue that the government is rife with accusations of corruption, some linked to drug trafficking and that the health policies of the government, in agreement with the Roman Catholic church are anti-women.

Hale, A. 1999. "The Voice of Experience: What Women Know About the Impact of the New Trade Agenda." In *Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 55-66.
This paper argues that trade policy is developed and implemented by high-level officials in remote forums, but the impacts are experienced in the daily lives of people at all

levels of society. They are experienced by men and women differently, because they hold different positions in relation to the productive and distributive processes.

Hassanali, S. 2000. *International Trade: Putting Gender into the Process Initiatives and Lessons Learned*. Ottawa, Status of Women Canada.

This paper examines how structures and processes within which trade policy is formulated may be conducive to putting gender issues on the agenda, and to reviewing past efforts to integrate gender concerns in the formulation of trade policy. The second section examines various consultation mechanisms that are already in place and analyzes the extent to which such mechanisms have facilitated women's participation. The third section reviews the efforts of women's organizations in Canada and globally to influence the trade policy agenda, focused on the Canada–United States Free Trade Agreement, the North American Free Trade Agreement, the General Agreement on Tariffs and Trade, the World Trade Organization and the Free Trade Area of the Americas. The fourth section examines more closely a slightly different approach taken within the Asia-Pacific Economic Cooperation forum: the gender mainstreaming approach.

Henriquez, J.D. 1999. *The Illusion of Inclusion: Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 100-114.

This paper argues that the Lome Convention has given the 71 developing countries the "illusion of inclusion" through partnership with the European Community. Past Lome Conventions have failed to address the problem of poverty in countries adequately. The participation of stakeholders, in particular women, has been neglected.

Keller-Herzog, A. 1996. *Discussion Paper: Globalisation and Gender Development Perspectives and Interventions*. Ottawa: Canadian International Development Agency, Women in Development and Gender Equity Division, Policy Branch.

This paper argues that Canada's official foreign policy statement recognizes that globalization has dramatic economic effects. Canada's national policy makers have to take account of globalization, and its effects on Canadians, both as constraints and opportunities for domestic and foreign policy. Globalization similarly has implications for policy makers in developing countries. This discussion paper approaches globalization and its implications for developing countries from a gender perspective. The approach is intended to strengthen the Canadian International Development Agency's ability to fulfill its partnership roles and responsibilities in developing countries.

Konig, S. 1999. "Embracing Women as Full Owners of Human Rights." In *Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 15-39.

The author argues that human rights are a political–economic ideology. Human rights norms and standards set out and expand on a particular cultural, ideological and political praxis that promises a future of dignity and peace for humanity. This chapter briefly explains the contours of that praxis and how we can begin to realize it. The premise of this essay is that if all women, men and children knew they were owners of human rights

and adopted the human rights framework in their struggles for economic and social justice, a new political economic system would emerge.

Lamy, P. 2001. *Trade Liberalisation and Globalisation – What Are the Impacts on Women's Lives?* EWL seminar, Barcelona, European Women's Lobby.

In this speech, Lamy argues that the neutrality of international trade law on gender issues (and neutrality must govern obligations between states) does not exclude discussion of the overall purpose of negotiations, whether on trade or other matters. For the European Union, global governance makes development possible that is socially, economically and environmentally sustainable. Seen in this perspective, it is policies that provide suitable responses to gender-based issues, whether they are domestic policies, backed, where need be, by appropriate international aid, common policies such as those forming the building blocks of the European Union, or international commitments.

Marchand, M.H. and A.S. Runyan (eds.). 2000. *Gender and Global Restructuring: Sightings, Sites and Resistances*. Routledge/RIPE Series in Global Political Economy. London and New York: Routledge.

Taking us beyond the narrow limits of conventional approaches to globalization, this book reveals the complexities and contradictions inherent in global restructuring. Restructuring does not just relate to the material but also relates to identity and geography. Gender-blind analyses have previously ignored the differing national and regional contexts of restructuring states, markets, civil society as well as in the household, profoundly affecting the daily lives of men and women.

Marsden, L. 1992. *Timing and Presence: Getting Women's Issues on the Trade Agenda.* Working Paper GSD No. 3. Toronto: International Federation of Institutes for Advanced Study.

This working paper examines a series of multilateral and bilateral trade agreements that have changed the nature and substance of action in the social sector in a number of countries. This appears to have had an impact on the lives of women although, because the impacts are often indirect, it is difficult to quantify these changes. In this paper, special attention is paid to the Free Trade Agreement between Canada and the United States that was negotiated in the late 1980s. This serves as a model for the examination of the process by which the social sector is dealt in, or out, of consideration. Reference is made to the European Economic Community Single European Market process by way of comparison.

Morris, M. 2000. "Women, Poverty and Canadian Public Policy in an Era of Globalization, Canadian Research Institute for the Advancement of Women." <http://www.criaw-icref.ca/Poverty_and_globalization.htm>. Retrieved June 14, 2002.

This presentation discusses the structural reasons for the continued overrepresentation of women among the poor in Canada. It analyzes the social and economic impact of poverty on society, on children and on women themselves, and shows how Canadian public policies implemented in recent years have contributed to poverty among women. The paper discusses how globalization and trade agreements exert both a direct and indirect influence on Canadian public policy, and proposes individual and collective strategies and resources for change.

Munro, D. 2002. “NAFTA and the Maquiladoras.” <http://www.u.arizona.edu/ic/mcbride/ws200/munr-heal.htm.>. Retrieved May 17, 2002.

The author argues that the overall impact of the Border Industrialization Program on the U.S.–Mexico border and the *maquiladora* industry has been manifold, resulting in increases in the *maquiladora* border population, environmental pollution, and human social and health concerns. It is also important to recognize that prior to ratification of NAFTA, the Clinton administration demanded, under pressure by environmental and labour groups, the attachment of two side agreements concerning labour and the environment. The author suggests that although it is still too early to tell, NAFTA appears to be amending some of the inherent problems that exist along the U.S.–Mexico border.

Ongile, G. 1999. “International Trade and Gender: A Research Agenda for East Africa.” In *Gender Focus on the WTO.* Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 40-54.

This chapter argues that the benefits of international trade can be realized by opening up Africa through trade liberalization. Trade liberalization has been viewed as one of the means through which trade expansion can be achieved. Regional integration is one of the key mechanisms through which a regionally co-ordinated trade liberalization program can be implemented.

O’Regan-Tardu, L. 1999. *Gender Mainstreaming in Trade and Industry: A Reference Manual for Governments and Other Stakeholders*. London: The Commonwealth Secretariat.

This guide is directed to helping ministries of trade, through a concerted, regularly monitored cycle, to formulate realistic strategies aimed at fostering gender equality within the government sector itself, and to help promote the greater involvement of women, and their advancement to higher managerial levels, in all aspects of the country’s trade development objectives and operations. Such strategies must involve both the public and private sectors, and be carried through over a number of years if success is to be achieved.

Pearson, R. 2000. “Moving the Goalposts: Gender and Globalisation in the Twenty-First Century.” *Gender and Development*. 8(1): 10-19.

Development institutions saw their work challenged by those working on gender and development in the last third of the 20th century. The author argues that the new century will witness an assertion of the global relevance of gender in development, and see gender analysis applied in new contexts, and to men as well as women.

Porter, A. 1987. *Impact of Free Trade on Women in Manufacturing.* Ottawa: Canadian Advisory Council on the Status of Women.

This paper looks at the industries that will either gain or lose from a free trade agreement between Canada and the United States. The author predicts that the industries that will benefit from an agreement are those that are technologically advanced and employ few women. Those that will lose as a result of an agreement are labour-intensive and employ a high proportion of women. The author also examines how free trade will affect

working conditions in Canada. She speculates that employers seeking to become more competitive internationally may cut benefits to employees, be unwilling to introduce pay equity, reduce wages to compete with low-wage U.S. workers, and reduce employer contributions to unemployment and medical insurance.

Riley, M. 2001. *Women's Economic Agenda in the 21st Century*. Occasional Paper Series on Gender, Trade and Development. Geneva: World Health Organization.

This paper argues that the shift from Women in Development (WID) to Gender and Development (GAD) was particularly important because it transformed the women's agenda. The WID agenda focussed on two main goals: to generate discussions and research on the role of women in development, and to institutionalize a women's focus within development agencies and governments with the mandate to integrate women into development. The GAD approach uses gender, rather than women, as an analytic category to understand how economic, political, social and cultural systems affect women and men differently. Gender is understood as the social roles, expectations and responsibilities assigned to women and men because of their biological differences. It is an ideological and cultural construct that shapes women and men's realities.

Runyan, A.S. 1999. "Gender, Free Trade Culture, and Cultures of Resistance." In *Gender Focus on the WTO*. Edited by E. Haxton and C. Olsson. Sweden: Global Publications Foundation, pp. 7-14.

This paper contends that despite decades of feminist criticism that focusses on the deleterious effects on women of the multiple facets of economic globalization as well as decades of women's resistance to these assaults, *The Economist* makes no mention of this resistance or of women at all. Instead, the "woman problem" is subsumed under the categories of labour, child labour and environmental problems, which *The Economist* goes to great pains to explain are not the result of free trade, but rather are social and political problems that should not be dealt with through trade or other economic sanctions.

Sen, G. 1997. "Globalization, Justice and Equity: A Gender Perspective." *Development*. 40(2).

The author examines the impact of globalization on women, looking in particular at the role of the government. She argues that as well as understanding and challenging the detrimental dimensions of globalization, it is also necessary to aim to transform the state so governments can begin to serve people and women in today's configuration of power. In this reshaping, women can play a role as power brokers in their activities in civil society at local, regional and global levels.

Shiva, V. nd. "The Effects of WTO on Women's Rights, Third World Network." <http://www.twnside.org.sg/title/women-ch.htm>. Retrieved July 18, 2002.

This paper argues that with the advent of a new regime of globalization as a result of the conclusion of the General Agreement of Tariffs and Trade (GATT) final agreement and the establishment of the World Trade Organization (WTO), a new era of gender politics has begun. Gender analysis in the new era requires a paradigm shift away from the domestic realm to the global arena. The completion of the Uruguay round of trade

talks and the establishment of the WTO on January 1 1995, have drawn all domestic issues into the global economy, and all matters related to life — ethics, values, ecology, food, culture, knowledge and democracy — into the global arena as matters of international trade. The perspectives and position of women in the remotest villages of developing nations have thus come into direct collision with the perspectives and power of men who control global patriarchal institutions.

Sparr, P. 2001. Making the Connections Between Debt, Trade and Gender. *Economic Justice News Online.* 4(3): 1-5.

The author argues that one of the important and exciting developments in debt advocacy work is the increased attention to international trade and investment issues. This has come in part as a result of a strategic shift in the movement toward focussing more energy on the underlying root causes of high foreign indebtedness and global poverty. For those who may be new to trade and investment issues, this article attempts to provide some basic background on links between debt, trade and investment, as well as some of the ways to extend a gender analysis into this new arena.

Spieldoch, A. 2001. "GATS and Healthcare — Why Do Women Care?" International Gender and Trade Network, Secretariat. <http://www.genderandtrade.net/GATS/GATS%20and%20Healthcare.pdf>. Retrieved June 6, 2002.

This paper explains that women are concerned with the General Agreement on Trade in Services (GATS), because it will potentially affect many levels of their lives. The World Trade Organization (WTO)'s focus on trade in services, including health care services, dates back to the Uruguay round in 1994. But the trend to privatize health care services has been developing over the last 20 years. It is important to recognize that although not all WTO countries have scheduled commitments on health care services (approximately 100 to date), women are aware of the potential impact of these negotiations, because they have already experienced the negative impacts of privatization of health care globally. As the world's primary providers of these services, women have been most affected when public access to these services is denied. Further privatization and liberalization of health care services will do harm to women if their basic needs are left to the whims of the market.

van Staveren, I. 2001. "Gender Objectives in EU Trade Policy: Extract Taken from Gender and Trade Indicators, WIDE." <http://www.eurosur.org/wide/EU/Trade/Gender_Objectives.htm>. Retrieved July 8, 2002.

This paper discusses the European Union (EU)'s gender policy that derives from outside as well as from internal commitments to gender equality. Hence, the EU gender policy evolved partly from commitments made at the UN Conferences on Women and Development held in 1975, 1985 and 1995. At the same time, EU gender policy evolved from internal commitments to gender equality, starting with a directive on equal pay in 1975, as well as from cases brought to the European Court of Justice. In 1995, the European Commission accepted a resolution on gender issues in development co-operation, which was turned into a council regulation in 1998. In this regulation, micro,

meso and macro policies are mentioned including structural adjustment policies, which should take women and men's roles into account.

Waterman, P. 1997. *Critical Globalization Theory and the Global Women's Movement? Some Propositions of Solidarity, Communication and Citizenship.* The Hague: Institute of Social Studies.

This paper argues that the global — level, process, epoch, ideology and episteme — provides an increasingly central terrain for the women's movement. He contends that this flies in the face of the idea that while capitalism is increasingly global, women's social movements are inevitably national, or even more local. The international women's movement needs to be reconceived in terms of globalization. A theoretically critical and socially committed understanding of globalization can provide the basis for such a reconceptualization. Globalization processes imply for women and women's movements threats, promises and seductions. Success here requires not only a new worldview, but a new understanding of women's global citizenship, of women's global solidarity and of women's global communication/culture.

White, M. 2001. GATS and Women. *Foreign Policy in Focus*. 6(2): 1.

White explains that since December 2000, members of the World Trade Organization have continued negotiations to expand the General Agreement on Trade in Services (GATS). She argues that GATS aims to expand dramatically the ability of multinational corporations to provide services on a for-profit basis and creates a new regulatory framework for trade in services. GATS could have enormous implications for domestic laws, for developing countries and for sustainable development, particularly for women living in poverty in developing countries.

White, M. 2002. "Analysis of USTR Proposals for the FTAA from a Gender Perspective." Women's Edge. <http://www.womensedge.org/trade/usproposalsftaa2002.htm>. Retrieved July 12, 2002.

This paper explains that while trade could lift women and their families out of poverty, to date, too many women are being left behind. The current proposals in the Free Trade Area of the Americas (FTAA) do not ensure that trade acts as a tool to achieve gender equity, social justice and sustainable development. Rather, they codify the increasing dominance of corporate-led free trade, which places profits and economic growth above basic human needs. The negotiations to create the FTAA have been preceded by economic reforms and structural adjustment policies that were mandated by the World Bank and International Monetary Fund. These reforms include privatization of companies, of health, education and children's services, as well as reductions in government budgets for the provision of social services, the deregulation of labour markets and other policies.

White, M. 2002. "Making Trade Work for Women: Opportunities and Obstacles." Women's Edge. <http://www.womensedge.org/trade/tradeprimer.htm>. Retrieved July 8, 2002.

In this primer, Women's Edge looks at trade liberalization through a gender lens. How are macroeconomic policies that are negotiated by government officials actually affecting women in their daily lives? What types of policies and programs could be

implemented to ensure that increased trade does benefit the poor, particularly poor women? For the majority of women living in poverty to benefit from trade liberalization, negotiators must reorient policies so the goal of trade becomes higher levels of economic security, food security and greater protection for social, political, cultural and human rights, rather than simply increased profits and economic growth.

Williams, M. 2001. *Gender and Trade in the International Economy: A Brief Overview.* Financing for Development: New Tendencies, New Exclusions and New Strategies for Women in the Region, Cartagena de Indias, Colombia, REPEM-DAWN.

This presentation argues that, from the vantage point of gender and trade policy, it is important to be clear about at least four issues. What exactly is trade policy? What are the impacts on, and how is the policy impacted by, existing gender realities in the economy? What are the directional shifts in trade policy? What are the implications of such shifts for sustainable development, gender and social equity? This presentation briefly sheds some light on these four questions. Part I attempts to answer questions one to three by highlighting the gender dimensions of trade policy analysis and trade liberalization. Part II addresses the fourth question with a brief outline of some regional, as well as sectoral, similarities and differences.

Home Care and Health Care

Armstrong, P. 1999. *Caring for Women in the New Global Economy.* Keynote address, annual conference of the Canadian Research Institute for the Advancement of Women. Sudbury. October.

The author explains that 80 percent of those who provide paid and unpaid care are women, and so suffer an enormous impact of the "privatizing by stealth" of the health care system. She debunks the myth that a parallel private system would reduce pressure on the public system and reduce waiting lists. A private system doesn't change the number of doctors or patients. It only changes the order of who gets treated first: people with money, over people with the greatest medical need. The "treat 'em and street 'em" attitude of U.S.-style "drive-by surgery" is taking a foothold here in Canada, where Alberta is considering private hospitals and where home care in some provinces is largely private, poorly paid and poorly regulated. The author argues that waiting list problems are best resolved by a reinvestment in the public system.

Armstrong, P., C. Amaratunga, J. Bernier, K. Grant, A. Pederson and K. Wilson. 2002. *Exposing Privatization: Women and Health Care Reform in Canada*. Ontario: Garamond Press.

This book is a collection of articles addressing what is happening in Canadian health care reform, and what it means for women. Women are the main providers of care, whether the care is paid or not, institutional or home-based. Women are also the main recipients of care, especially among the elderly. Although women are involved in much of the daily decision making about health care, they are much less visible among senior policy makers and managers. Given that women make up 80 percent of health care providers, paid and unpaid, and a majority of patients, it would be expected that the

question of the impact on women would be at the top of the policy agenda. This, however, is not the case.

Armstrong, P. and H. Armstrong. 2001. *Thinking It Through: Women, Work and Caring in the New Millennium*. Halifax: Maritime Centre of Excellence for Women's Health.

This report draws on both Canadian and international literature to help understand the forces, structures and relationships that construct women as caregivers and undervalue care work. The purpose of this analysis is to develop guidelines for thinking about caring. It is designed as a companion piece to *One Hundred Years of Caregiving in Canada*. Based on the Canadian research on caregiving among adults, that paper outlines what kinds of care are provided and who provides different kinds of care, leading to a framework for assessing policy. The authors argue that the guidelines set out here should be combined with that framework to understand and assess women's caring.

Armstrong, P. and O. Kits. 2001. *One Hundred Years of Caregiving*. Ottawa: Law Commission of Canada.

This paper focusses on what is often called informal caregiving. Such care is usually unpaid, done with little formal training and based on an existing relationship. Yet even the distinction between formal and informal care is far from simple. Some relatives are paid for such informal care; some begin as strangers; many have become quite skilled at caregiving and share the job with those who are part of the formal system. To help sort through this complexity, the paper begins with a discussion of the diversity in caregiving relationships. It then moves on to consider what changed and did not change significantly in these relationships throughout the 20th century. On the basis of this exploration of history and diversity, the final sections set out a framework for assessing legislation, regulations and policy that influence caregiving among adults.

Armstrong, P., M. Boscoe, B. Clow, K. Grant, A. Pederson, K. Wilson, O. Hankivsky, B. Jackson and M. Morrow. 2003. *Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care in Canada for Women.* Ottawa: The National Coordinating Group on Health Care Reform and Women.

This report analyzes some major issues for women raised by the release of the Romanow Report. The authors provide a detailed analysis of the issues in the Romanow Report and comment on the recommendations. Throughout the Romanow Report, Romanow repeatedly asks what health reforms mean for Canadians. The authors challenge policy makers to think also about what health reforms mean specifically for women.

Aronson, J. and S.M. Neysmith. 2001. "Manufacturing Social Exclusion in the Home Care Market." *Canadian Public Policy*. 27(2): 151-165.

This paper examines how the health care perspective, which dominates home care, obscures the broader processes of social exclusion that play out in this arena of public policy. A study of elderly women and women with disabilities receiving home care in Ontario reveals how managed community care generates and reinforces service users' social isolation and their spatial, institutional and political exclusion. Analysis of study participants' experiences points to the challenges of moving away from a market discourse and a health framework to develop home care policy, which achieves the

inclusion and participation of elderly citizens and citizens with disabilities in need of assistance at home.

Baird, K.L. 1998. *Gender Justice and the Health Care System*. New York and London: Garland Publishing Inc.
Despite women's overall greater use of medical services, gender justice in the U.S. health care system still is lacking. In this dissertation, Baird probes policy inequalities and proposed reforms in light of utilitarianism, feminist theories, medical research and access to heath care insurance. She proposes a framework for a gender-just health care system based on recognition of women's unique needs.

Baranek, P.M., R. Deber and A.P. Williams. 1999. "Policy Trade-Offs in Home Care: The Ontario Example." *Canadian Public Administration*. 42(1): 69-92.
The authors explain that as Canada enters the 21st century, its highly prized program, medicare, is undergoing radical transformation. With technological change and the restructuring of health systems, the locus of care is shifting from institutions to the home. As a result, care that was formerly publicly financed under the *Canada Health Act* is technically becoming de-insured. This paper analyzes the reform of community-based long-term care services in Ontario from 1985 to the present. Underlying the debate in Ontario was a fundamental disagreement about the role of government, reflected in views about the responsibilities of individuals and their families, and the appropriate place of for-profit organizations within a publicly funded system. The reform of this sector has significance that goes beyond its boundaries, with wider implications and warnings for health care in general.

Barlow, M. 2002. *Profit Is Not the Cure*. Ottawa: Council of Canadians.
The author argues that "profit is not the cure" for the Canadian medicare program and that every Canadian has a right of citizenship to publicly funded, accessible, universally delivered health care. She argues that Canadians can afford to maintain and even strengthen the health care system, if they eliminate the current for-profit components that are causing some costs to spiral, such as patented drugs, fee-for-service, and overpaid administrators, and turn to a primary care, community-based, fully public model run more equitably and more efficiently. Further, the right of Canadians is the right of every human being on the planet; Canada must work with other governments and the United Nations to see that universal, public health care is provided to the world.

Bartlett, H.P. and D.R. Phillips. 1996. "Policy Issues in the Private Health Sector: Examples from Long-Term Care in the U.K." *Social Science Medicine*. 43(5): 731-737.
This paper contends that the international trend toward private markets in health care can be illustrated very clearly by developments over the last decade in the United Kingdom where the balance of health care provision has shifted from a predominantly free, public and comprehensive system to more of a mixed economy model. The shift can be attributed to a variety of factors, and not government policy alone. The relationship between the private and National Health Service sectors of health care is not a simple one, and there are both positive and negative implications of the public–private mix. The

growth of private hospitals and acute beds has dominated debates about private health care, but further policy issues have emerged in relation to the significant growth in private residential and nursing home care.

Braen, A. 2002. *Health and the Distribution of Powers in Canada.* Ottawa, Commission on the Future of Health Care in Canada.

This study deals with the constitutional distribution of powers in the area of health services. It analyzes the applicable provisions in Canada's Constitution as well as their interpretation by the courts. By describing the state of the law relating to health, it seeks to inform the Commission on the Future of Health Care in Canada about the legal principles underlying federal and provincial intervention in the field of public health and to enable the Commission to provide the federal government with recommendations on the policies and measures needed to ensure the long-term sustainability of a universally accessible, publicly financed system of health care.

Browne, P.L. 2000. *Unsafe Practices: Restructuring and Privatization in Ontario Health Care*. Ottawa: Canadian Centre for Policy Alternatives.

This book argues that Ontario today is witnessing piecemeal privatization in health care with the introduction of private-sector business strategies and management ideologies into the public health care system, reductions and stagnation in public spending in the sector, the restructuring and rationing of publicly delivered services, and costs shifting from the public purse to the individual household. The author shows how these unsafe practices have pervaded Ontario's health care system, from hospitals to home care, laboratory to ambulance services, long-term care to primary care. He argues that privatization, spearheading the neo-liberal attack on social citizenship, is robbing Canadians of their common heritage of universal public services.

Canadian Home Care Association. 2002. "Formal Submission from the Canadian Home Care Association." Ottawa, Commission on the Future of Health Care in Canada.

This brief to the Romanow Commission from the Canadian Home Care Association addresses the four major themes: Canadian values, sustainability, managing change and co-operative relations, as identified by the Commission, as they relate to home care as an integral component of the health care system. It further recommends ways in which a strong home care system will support the long-term sustainability of a high quality, universally accessible, publicly administered health care system, for all Canadians.

Casas, J.A., R.D. Casco and C.T. Parodu. 2000. "Governability and Governance: Toward Health and Human Development." In *Health & Human Development in the New Global Economy: The Contributions and Perspectives of Civil Society in the Americas*. Edited by A. Bambas, J.A. Casas, H.A. Drayton and A. Valdés. Washington: Pan American Health Organization, pp. 231-255.

The authors find that governance in health — when determining policies and priorities for allocating societal resources as a whole within the economic and political spheres — requires a strategic vision in which leadership is shared, leading roles are agreed upon, and sectoral proposals are submerged in broader processes and agendas than those of past public management. The complexity resulting from this expansion of actors is

intensified by the addition of two increasingly important dimensions in which health action scenarios are generated: at the sub-national level, the decentralization of state activities including its responsibility for providing health services; and at the supra-national level, the impact of globalization and the emergence of new economic and political integration schemes, which have important consequences for health.

Cranswick, K. 1997. *Canada's Caregivers.* Ottawa: Statistics Canada.

Recent changes in the health care system and social services have put further pressure on the caregiving capabilities of families. For instance, shorter hospital stays and greater use of outpatient treatment have increased the need for care at home. These new demands occur at a time when the majority of women — traditionally the primary caregivers — now participate in the labour force. As such, Canadians face the burden of multiple responsibilities to employers, their own spouse and children, and to parents, relatives or friends requiring care.

Day, S. and G. Brodsky. 1998. *Women and the Equality Deficit: The Impact of Restructuring Canada's Social Programs*. Ottawa: Status of Women Canada.

This study investigates whether recent social program changes (e.g., the introduction of the Canada Health and Social Transfer in 1995) adhere to Charter and international commitments that federal and provincial governments have made to Canadian women. The authors conclude that Canada has violated women's rights under section 15 of the Charter, and under international law.

Deber, R.B. 2002. *Delivering Health Care Services: Public, Not-for-Profit, or Private?* Discussion Paper no. 17. Saskatoon: Commission on the Future of Health Care in Canada.

This paper looks at the following question: How should the Canadian system determine whether government, non-profit organizations or for-profit organizations deliver which programs and services? The focus is on delivery rather than on financing or allocation — with an emphasis on the best way to *deliver* health care services, regardless of payment for them.

Evans, R., G. Morris, L. Barer, S. Lewis, M. Rachlis and G.L. Stoddart. 2000. *Private Highway, One-Way Street: The Decline and Fall of Canadian Medicare*. Vancouver: University of British Columbia, Centre for Health Services and Policy Research, Health Policy Research Unit.

Medicare has two meanings for Canadians: the entire range of health care services, or only those (mainly physicians and hospitals) mandated and governed by the *Canada Health Act*. This paper focusses on the narrower legal meaning of medicare, as does the recent Alberta proposal to fund *Canada Health Act*-mandated services delivered on an overnight stay basis in privately owned and operated facilities. The authors explore the implications for the health care system of changes in provinces like Alberta.

Fast, J., J. Eales and M. Keating. 2002. *Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors*. Ottawa: Status of Women Canada Policy Research Fund.

The authors explain that the extent and consequences of elder care are well documented. However, they contend that little is known about how individual policies actually influence the economic well-being of informal caregivers or about their collective effect across policy domains and jurisdictions. The first objective is an analysis of the economic impact of current health, income security and labour programs by type of informal caregiver, and region of the country. The second objective is to develop a policy analysis framework to facilitate ongoing evaluation of the impact of any policy instrument on the economic costs to informal caregivers of frail seniors.

Flood, C. 1999. *Unpacking the Shift to Home Care*. Halifax: Maritime Centre of Excellence for Women's Health.

Home care has recently become a significant policy issue in Canada and in many other developed countries. This paper focusses on the factors that have and are fuelling the recent and rapid shift from the provision of care in hospitals and institutions to home care. The goal is to analyze which members of society will bear the costs of this shift and to explain why the distribution of these costs has largely been ignored. Unpacking the larger forces causing the shift to home care will help Canadian citizens, particularly Canadian women, better understand why this shift is occurring and its likely impact on their lives. Having this information should also help women analyze arguments for and against different home care policies, and identify and advocate against those policies that will have a detrimental effect on vulnerable women.

Flood, C. and T. Epps. 2003. "The Implications of the NAFTA for Canada's Health Care System: Have We Traded Away the Opportunity for Innovative Health Care Reform?" *McGill Law Journal*. 47: 747-790.

There are two sharply contrasting perspectives on the implications of NAFTA for medicare. Critics argue that, rather than helping the government support and improve medicare, NAFTA will force Canada to open up medicare to entry by foreign (particularly U.S.) service providers and commercial insurers. It is feared that such an opening of the health care market will inevitably result in the erosion of medicare and a slide into a U.S.-style system of health care driven by for-profit insurers and providers. By contrast, the federal government has given a number of assurances that NAFTA protects the health care sector and therefore poses no threat to the integrity and sustainability of medicare. The authors assess which, if either, of these two contrasting perspectives is correct and closely examine Canada's obligations under NAFTA to determine what constraints it might impose on various proposals for the reform of medicare.

Fuller, C. 1998. *Caring for Profit: How Corporations Are Taking Over Canada's Health Care System.* Ottawa, Canadian Centre for Policy Alternatives.

The author argues that the federal government is committed to assisting the private sector in the development of Canada's health information technology and telecommunications sector. This is being done by extending generous financial support and creating the "right" political and regulatory environment for corporations doing

business in the sector. Both provincial and federal governments are trying to steer a public policy course that will sanction health information as private property (thereby attracting high-tech investors), yet still protect the privacy of patients as required under human rights legislation. Health information is thus being defined primarily as a private good. The author highlights the fact that there is no public policy debate in the media or among politicians and public officials about the benefits of prohibiting corporate ownership and control over health information altogether.

Fuller, C. 2001. *Home Care: What We Have, What We Need*. Ottawa, Canadian Health Coalition.

The author argues that the overriding tension in the home care debate, like that which has dominated Canada's health care system since the first discussions about medicare emerged, is between those who want a home care program to provide a service, and those who want it to provide a return on investment. This study looks into the way that tension has influenced federal and provincial policies that determine how and whether home care is delivered in every part of the country. During medicare's early years, such divisions shaped the health care terrain, at once galvanizing public opinion and immobilizing politicians until an election was called. However, as this report illustrates, the lack of decisive political action, especially at the federal level, today is set against a backdrop of trade agreements, globalization and powerful investors, on the one hand, and home care recipients, their families, caregivers and taxpayers on the other.

Greaves, L., O. Hankivsky, C. Amaratunga, P. Ballem, D. Chow, M. De Konick, K. Grant, A. Lippman, H. MacLean, J. Maher and B. Vissandjeé. 1999. *CIHR 2000: Sex, Gender and Women's Health*. Vancouver: British Columbia Centre of Excellence for Women's Health.

This paper investigates the issues of sex, gender and women's health in health research. The authors argue that the advent of the Canadian Institutes for Health Research (CIHR) planned for April 2000 offers a tremendous opportunity for Canada to reorient its health research system to include sex, gender and women's health in a more systematic and effective manner. It will also foster the integration of basic biomedical, applied clinical, health systems, and social and cultural dimensions of health research in a new research environment. Both of these directions will contribute to the transformation of the substance and process of health research in Canada. Clearly addressing and including sex, gender and women's health in this plan from the outset will position Canadian health research in the forefront internationally. It will also improve the quality of science in the health research field and decrease knowledge gaps related to the impact of sex and gender in human health and in particular, women's health.

Gustafson, D.L. 2000. *Care and Consequences: The Impact of Health Care Reform*. Halifax: Fernwood.

This paper discusses how health care in Canada has shifted from a cure-care model to a business model. Disguised behind talk of community, care closer to home, consumer choice, patient rights, cost containment and improved efficiencies, the business model has ushered in "bottom line" financial management which has brought us steadily deteriorating health care services. Framed within a clear analysis of this new health care

model, the articles in this collection illustrate how diverse groups in various social and institutional contexts are navigating through a changing health care system — a system upon which women in particular rely for their well-being as caregivers and care recipients, and one that operates more and more on the logic of scientific management.

Himmelstein, D.U., S. Woolhandler, I. Hellander and S.M. Wolfe. 1999. "Quality of Care in Investor-Owned vs. Not-for-Profit HMOs." *Journal of the American Medical Association*. 282(2): 159-163.

This paper discusses the fact that the proportion of health maintenance organization (HMO) members enrolled in investor-owned plans has increased sharply, yet little is known about the quality of these plans compared with not-for-profit HMOs. It attempts to compare quality-of-care measures for investor-owned and not-for-profit HMOs. It finds that, compared with not-for-profit HMOs, investor-owned plans had lower rates for all 14 quality-of-care indicators.

Hollander, M. and N. Chappell. 2000. *Synthesis Report: Final Report of the National Evaluation of the Cost-Effectiveness of Home Care: A Report Prepared for the Health Transition Fund.* Ottawa: Health Canada.

This report is a synthesis report of key findings and implications for care providers, administrators and policy makers. The program of research was designed to determine whether home care is a cost-effective alternative to institutional care (i.e., care in long-term care facilities and acute care hospitals). However, the program of research was also designed to provide an educational function to inform decision makers and the public about home care, and to provide advice about issues related to implementing new and cost-effective home care initiatives.

Hurd, L. 2000. "Women Live in Fear Following Ontario Home Care Cuts." *Herizons*. 14(2): 11-12.

This article highlights a study presented at an Ontario Association of Community Care Access Centres conference, which characterized existing home care services in the province. It discusses the activities of the Community Care Access Centres, the implications of home care cuts on women dependent on such services and home care recipients' assessment of the quality of care they receive.

Lowry, J.A. 2002. "Why Having a National Home Care Program Is a Women's Issue." *Canadian Women's Health Network Magazine.* 5 (2/3): 1-5.

This article argues that there is a virtual crisis state of home care in Canada. Home care is becoming an increasing concern for governments, health care providers, family members and individuals who need such care. But the burden rests especially on women, who give and receive the vast majority of home care.

MacAdam, M. 2000. *Human Resource Issues in Home Care in Canada: A Policy Perspective*. Ottawa: Health Canada.

This report explains that very little Canadian data are available describing the home care work force. As a result, much of the information used for this paper is anecdotal. The growing importance of home care in the total Canadian health delivery system certainly

underscores the importance of improving the accuracy and range of many types of home care data, not the least of which is better information about the home care work force.

Morris, M., J. Robinson, J. Simpson, S. Galey, S. Kirby, L. Martin and M. Muzychka. 1999. *The Changing Nature of Home Care and Its Impact on Women's Vulnerability to Poverty*. Ottawa: Status of Women Canada Policy Research Fund.

The authors explain that the majority of home care recipients, home care personnel and persons responsible for the care of elderly, disabled or ill family members are women. The extreme gender imbalance in every aspect of home care means that home care policies and practices have a significant and varied impact on women's lives. This research builds on previous studies that show women's roles as unpaid and underpaid caregivers contribute to the income gap between women and men. It also examines whether current home care policies and practices have any impact on women's vulnerability to poverty.

Morris, M. 2001. "Gender-Sensitive Home and Community Care and Caregiving Research: A Synthesis Paper." Second draft. Ottawa: Health Canada Women's Health Bureau.

This paper constructs a gendered picture of home and community care by reviewing gender-sensitive research. The authors argue that this evidence can then be used to develop policy that is equitable for women and men. The purpose of gender-based analysis is to develop good, evidence-based policy founded on a complete picture of how women and men are affected. The author argues that it is important that policies result in expected outcomes for both women and men and reduce, rather than exacerbate, inequalities.

National Forum on Health. 1997. *Final Report Canada Health Action: Building on the Legacy*. Ottawa: National Forum on Health.

Based on what was heard and on the analysis, the authors are confident that the health care system can be preserved through change, and that the health of Canadians can be improved. In the report, the authors outline the steps to accomplish this. They argue that not everything can be done at the same time. A step-by-step approach with clear directions that are well understood by the public and stakeholders will be key to garnering their support. The authors also emphasize the importance of co-operation and partnership between governments, and with organizations and individuals involved in health and health care, as action is taken.

National Steering Committee for the Canadian Home Care Resources Study. 2002. *Phase I Report: Setting The Stage: What Shapes the Home Care Labour Market?* February.

Phase I of this report assesses the current and anticipated state of the home care sector in Canada. It examines the factors affecting the home care sector, including social trends, policies and regulatory frameworks, economic and fiscal pressures and technological change. During this phase, key stakeholder groups were consulted about what they believe to be the factors that have and will continue to shape home care in Canada. Interviews with federal, provincial and territorial representatives took place. A range of professional and provider associations, employers and unions, voluntary care givers,

consumers, informal caregivers, educators, labour market researchers and social policy analysts were also asked for input.

Ontario Health Coalition. 2001. *"Dip and Skip" A Supplement to the June 2001 Report on Homecare Reform in Ontario.* Ontario: Ontario Health Association.

This supplement argues that far from actually reforming the home care system set up by the provincial Conservative Government in 1997, Bill 130 serves to silence the boards and CEOs of the Community Care Access Centres (CCACs) who have recently become some of the government's most vociferous critics. However, the coalition argues that the provincial Conservatives cannot silence the people who work in the system. Privately, workers have begun to refer to the Community Care Access Centres as "No Access Centres" for obvious reasons. Home care has become "dip and skip," a reference to the scant amount of time personal support workers are given to bathe clients. While this Bill may achieve a censorship of the CCACs, the critical and worsening problems resulting from the province's short-sighted health care reforms are not going away.

Ontario Health Coalition. 2001. *Secrets in the House: Home Care Reform in Ontario 1997-2000*. Ontario: Ontario Health Association.

This study argues that the driving forces behind the government's restructuring of health care are an ideological commitment to privatization and an attempt to cut funding. To make room for profit taking in the context of inadequate funding, the government has forsaken patient rights, stability and any semblance of coherent outcome-based planning. The changes have been accomplished covertly, veiled by purposeful exclusion from freedom of information legislation, and with notable avoidance of normal democratic processes and accountability. Community care, the fastest growing sector in our health care system is in the midst of a process of wholesale privatization, and access to the care we need — the most fundamental and critical element of the publicly funded system — is eroding.

Organization for Economic Co-operation and Development. 1999. *Trends in Health Expenditure 1970-1997*. Paris: OECD Employment, Labour and Social Affairs Committee, Working Party on Social Policy.

This article provides an overview of current trends in health expenditures in 29 OECD countries and recent revisions of OECD health accounts. U.S. health expenditures are compared with those of other OECD countries. The interactions of cost-containment measures with changes in the public–private mix of financing and in the composition of health care spending are discussed.

Parent, K., M. Anderson, W. Gleberzon and J. Cutler. 2001. *CARP's Report Card on Home Care in Canada, 2001: Home Care by Default Not by Design*. Toronto: CARP.

Although more people are receiving home care than ever before, and more money is being directed to home care, relatively little is known about it compared to the other health sectors. As this report discusses, policy makers have to make increasingly difficult resource allocation decisions around how, where and when to spend public dollars on home care when faced with growing fiscal pressures. There are also

increasing demands for accountability in health care generally and home care specifically. These demands are difficult to address when there is a lack of evidence and limited quality data upon which policy can be guided and subsequently developed.

Romanow, R. 2002. *Building on Values: The Future of Health Care in Canada*. Ottawa: Commission on the Future of Health Care in Canada.
In this report Romanow demonstrates that Canadians are clear that they strongly support the core values on which our health care system is premised: equity, fairness and solidarity. These values are tied to their understanding of citizenship. Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Building from these values, Canadians have come to view their health care system as a national program, delivered locally but structured on intergovernmental collaboration and a mutual understanding of values. They want and expect their governments to work together to ensure that the policies and programs that define medicare remain true to these values.

The National Forum on Health. 1997. *Final Report Canada Health Action: Building on the Legacy*. Ottawa: National Forum on Health.
This report shows how addressing the needs of children with disabilities and their families requires action on a number of fronts: from child care, income security and labour market systems to health care, education and assistive technology programs. Based on extensive research, this publication lays out the dimensions of policy that would foster the full inclusion and development of children with disabilities and which would ensure that their families receive necessary supports in the community.

Vogel, D., M. Rachlis and N. Pollak. 2000. *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*. Vancouver: Canadian Centre for Policy Alternatives (B.C. Office), B.C. Government and Service Employees' Union, B.C. Nurses Union and B.C. Hospital Employees Union.
The three studies in this report reveal how a fractured and partially privatized community and continuing care sector undermines medicare. They find that inadequate public funding of community and continuing care has created a growing gap between British Columbians' health needs and the public services to which they have access. Rather than becoming more focussed on prevention and early intervention, health care services in all sectors have become increasingly crisis-oriented. Today, only people with serious care needs are able to access public community and continuing care.

APPENDIX B: KEY INFORMANT INTERVIEWS

Canada:
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APPENDIX C: TRADE AGREEMENTS TABLE

INTERNATIONAL

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
General Agreement on Tariffs and Trade (GATT) 1947	This agreement created a permanent negotiating body, responsible for the monitoring and regulation of international trade. The first rounds of negotiations held under GATT, dealt mainly with tariff reductions but later negotiations included other areas such as anti-dumping and non-tariff measures. The last round — the 1986-94 Uruguay round — led to the WTO's creation, which replaced the GATT forum. With the establishment of the WTO, GATT became enforceable under international law.	Article XX(b) states that nothing in this Agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures necessary to protect human, animal or plant life or health. However, the application of this (above) provision must be justifiable to the WTO. If challenged, a dispute resolution body is responsible for resolving the issue. However, decisions of panels may not be made on the basis of the judgments of health experts.	
World Trade Organization (WTO) 1995	Created during the Uruguay round. It becomes the successor to the GATT forum. It is the only international organization dealing with the global rules of trade among states. Its main function is to ensure that trade flows as smoothly, predictably and freely as possible. The WTO: • administers trade agreements including GATT, GATS, TRIPS, TRIMS, SPS and TBT; • acts as a forum for trade negotiations; • settles trade disputes; • reviews national trade policies; and • assists developing countries in trade policy issues.		

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
Technical Barriers to Trade (TBT) 1973-79 1995	Works to minimize and prevent protectionism and to enhance trade liberalization with the view that technical regulations for products can operate as barriers to trade.	Allowances for governmental authority in the health care sector must be based on science, technology and product end usage. Bans related to workplace health and the usage of particular products can be challenged and lifted if the dispute resolution panels decide. Women may experience compromised workplace standards should regulations be challenged by other members and removed by dispute resolution bodies. Products used and consumed may not be under the exclusive regulation of the national government. The scientific and technical data used in determining the appropriateness of a regulation may not be formulated with a regard to women.	The federal government has indicated the need for a social impact analysis of WTO agreements including the TBT agreement.
Agreement on Trade-Related Investment Measures (TRIMS) 1995	Deals with the investment practices of member countries.	Facilitates and protects investment interests; potential for extension into health care sectors. Investment initiatives impact small to medium businesses, where the majority of female entrepreneurs are found. Women entrepreneurs can face competition from foreign corporations.	The federal government has indicated the need for a social impact analysis of WTO agreements including TRIMS.

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
General Agreement on Trade in Services (GATS)	GATS established the first worldwide liberalization rules for trade in services. It allows countries to set out which service sectors of markets are open to foreign business and to make requests for access to other members' service sectors. However, GATS contains built in obligations to expand continuously and deepen coverage of services through regular negotiating rounds.	Women will be severely impacted by the privatization expected to stem from GATS. Cost of some services will increase, due to loss of government monopoly and the cross-subsidization that occurs within a sector such as between expensive and inexpensive health care procedures. Less affluent women will not have sufficient funds to pay for private services or insurance. Areas of health care provision particularly relevant to women's health may not receive funding. Service providers will establish themselves in urban areas and so rural women may suffer from limited services of poor quality. When services are dismantled, it is women who are obligated to provide health care, education and safe food and water for their families. Women are highly concentrated in the public service sectors where jobs are often highly skilled and well paid. Job loss, or lower pay and poor conditions are likely with privatization.	The federal government has indicated the need for a social impact analysis of WTO agreements including GATS.

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) 1995	Works to protect intellectual property (patents and technology) and ensures that they do not function as trade barriers.	Patents protecting corporate property rights allow for only those who can afford drug therapy to receive it. The government provides significant amounts of research funding, yet corporations will hold the patent and profit. Thus public funds do not directly work to improve public health. There is potential for protection of trademark advertising of products that negatively impact human health, such as tobacco. Pressure is being placed on members to include diagnostic, therapeutic and surgical methods. Areas of pharmaceutical research that affect women may not be lucrative enough to attract profit-seeking corporations. Low-income women will be unable to purchase highly priced pharmaceuticals.	The federal government has indicated the need for a social impact analysis of WTO agreements including TRIPS.
Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) 1995	Pertains to food safety, and animal and plant health as affected by international trade. It establishes guidelines and precautions that member countries must follow when formulating domestic policies.	Reconciles the protection of consumer health with the aims of a liberalized trading system. Attention to public health and the implementation of regulations that exceed minimums is discouraged. Foreign standards must be accepted if they can be shown to uphold an equal standard. National governments do not exclusively determine what is an acceptable level of risk for public health. Guidelines make significant policy change difficult to implement. Risk assessment to determine the admissibility of a standard does not necessarily have to take women and other particular social groups into account. The scientific rationales that justify standards may not take the health of specific groups into account.	The federal government has indicated the need for a social impact analysis of WTO agreements including the SPS agreement.

REGIONAL

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
North America Free Trade Agreement (NAFTA) 1994	An agreement between Canada, the United States and Mexico which covers both goods and services. There are additional objectives that include increasing investment among the parties, enforcement of intellectual property rights, a dispute resolution mechanism and a framework to facilitate future trilateral, regional and multilateral co-operation.	Clauses that allow Canada to reserve the right to adopt or maintain any measure with respect to health care and other social services, may in fact not be sufficient. In chapter 12 for example, there are provisions that encourage the development of mutually acceptable standards for professional service providers. Foreign direct investment in the health sector is possible. Alberta's Bill 11 could open up all of Canadian health care to NAFTA, and hence for direct investment. If private enterprise co-exists with public provision, the area can be opened to foreign providers. Loss of jobs for Canadian women as companies move to areas with cheaper labour. Harsh, unsafe, low-paying work for the predominately female workers in the export zones in Mexico called the *maquiladoras*. They face discrimination against being pregnant and demeaning practices such as forced pregnancy tests. Increased mobility of female workers across borders.	The federal government has not conducted any studies that would track and evaluate how the NAFTA might differentially impact on men and women.

Name and Date	Description	Health and Gender-Relevant Aspects of Implementation	Gendered Social Impact Analysis
Free Trade Area of the Americas (FTAA) 1994 (start of negotiations)	34 western hemisphere countries. Aim to eliminate barriers to trade and investment. Will affect goods and services.	The same concerns expressed for NAFTA are applicable to the FTAA. Working conditions for those in export industries are often harmful to health. Clauses concerned with intellectual property rights could reduce access to pharmaceuticals. Agriculture: Latin American women in particular are pushed into low-paying employment in export industries. Services: When governments retract social services, women are usually the first fired. Often, their unpaid workload will increase to compensate diminished public services. The distribution of water could have an effect on women and children. Government procurement: current proposal could render competition more difficult for female business owners. Investment clauses will create more jobs for indigent women, but will not necessarily improve their lives or bring more money that will remain in the host country.	At present, the federal government has not conducted a social impact analysis with respect to the FTAA.

APPENDIX D: TRIPS, SPS AND TBT (WTO AGREEMENTS) AND THE FTAA: THEIR IMPLICATIONS FOR WOMEN

TRIPS

The Agreement on Trade-Related Aspects of Intellectual Property Rights was developed during the Uruguay round of GATT negotiations, and has been in effect since January 1, 1995. It pertains to rules governing and protecting intellectual property, most commonly found in the forms of patents, copyrights, trademarks and technological developments. The Preamble to the Agreement articulates the objective of "reduc[ing] distortions and impediments to international trade, and taking into account the need to promote effective and adequate protection of intellectual property rights, and to ensure that measures and procedures to enforce intellectual property rights do not themselves become barriers to legitimate trade" (TRIPS Preamble, 1994). According to Bettcher et al. (2000: 526), "the scope of the TRIPS Agreement is much broader that any previous international agreement in this field." Critics have argued that the origins of the TRIPS agreement can be found in the profit-seeking aims of multinational corporations wanting to globalize international property rights (Drahos 1997).

With respect to intellectual property, the Agreement implements two main principles found in many WTO agreements: national and most-favoured nation treatment. The most-favoured nation clause states that, "with regard to the protection of intellectual property, and advantage, favour, privilege or immunity granted by a Member to the nationals of any other country shall be accorded immediately and unconditionally to the nationals of all other Members" (Part I, article 4). The Agreement gives members one year to remove barriers, but developing countries received four years, and least-developed countries could take up to 10 years. Under the TRIPS Agreement, intellectual property is classified under several categories found in sections one to seven of Part II. These classifications pertain to copyright, trademarks, geographical indications, industrial designs, patents, topographies of integrated circuits and protection of undisclosed information. As discussed below, patents represent one of the most contentious aspects of the Agreement.

Paragraph 4 of TRIPS states that "the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and in particular, to promote access to medicines for all." Similar to the other agreements, TRIPS also includes an article allowing for the protection of human health and safety. It states: "Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and promote public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement" (article 8). As is the case with other agreements, however, the inclusion of these clauses does not act in all cases as a watertight guarantee that health will always take precedence over trade interests.

The atmosphere surrounding the TRIPS Agreement, in existence since the initial negotiation round, is highly controversial. As the WHO and WTO (2002: 41) pointed out: "Patent protection for pharmaceutical products is an area where the problem of finding a proper

balance is particularly acute, namely, between the goal of providing incentives for future inventions of new drugs and the goal of affordable access to existing drugs." Supporters of TRIPS argue that without protection of intellectual property, there will be no efforts to continue innovation, thus preventing growth and progress in the development of new drugs and techniques (Bettcher et al. 2000). Others, however, contest that the monopoly that transnational corporations are given as a result of the agreement promotes human suffering as access to the benefits of the technology can be limited to those who can pay for it. Koivusalo and Rowson (2000: 182) claimed that "the distributional impacts of TRIPS may in practice shift resources from consumers, the public sector, and developing countries to multi-national research based industries." Furthermore, questions have been raised about whether the patent rights of pharmaceuticals actually belong to corporations given that a considerable amount of research funding is provided publicly by governments (Bettcher et al. 2000). This, however, would seem to create tension with the Agreement's view that "intellectual property rights are private rights" (TRIPS Preamble, 1994). It would appear, as Bettcher et al. (2000: 527) emphasized, that "the balance between innovation and accessibility of new technology is a crucial policy issue."

It should be noted that the research landscape is rapidly changing, with implications for how research priorities are decided. Research is increasingly being privatized through the use of contract research organizations (CROs). In the United States 60 percent of industry grants go to CROs and increasingly the research needs of corporate clients in the developing world (e.g., obesity, balding, impotence) are superceding the health needs of the majority (Koivusalo 2003: Koivusalo and Rowson 2000).

Trade in intellectual property and services are the fastest growing trade sector among developed nations (Ostry 2001). TRIPS requires all WTO members to adopt U.S.-style patent laws. One key result of this has been to force Canada to extend drug patent protection to multinationals from the current 17 years to the 20 years required under U.S. patent law (Ostry 2001). Ultimately, this gives the power to control drug prices over to multinationals and out of the hands of governments. One key fiscal pressure on the Canadian health care system is the rise in the costs of prescription drugs (Barlow 2002). The increasing cost of drugs has been a problem that provincial governments have been struggling to control through the bulk purchasing of generic drugs. TRIPS will make this process much more difficult and may ultimately deter provinces that do not already have these programs from starting them.

As Koivusalo and Rowson (2000: 183) explained, "the clearest health implications of the TRIPS agreement flow from its impact on pharmaceutical policies, the allocation of patent rights and the cost of drugs." A frequently cited dispute between South Africa and the United States illustrates the potential conflicts between TRIPS and public health. In this case, 39 pharmaceutical companies challenged the South African government on the *South African Medicines and Related Substances Control Amendment Act, 1997*, which they saw as restricting their patent rights. Some drugs essential to public health are exempted from the Agreement, yet other newer drugs crucial to HIV treatment fall under the jurisdiction of TRIPS, rendering them subject to patent laws. Of the 5.5 million people needing treatment

for HIV/AIDS in South Africa, only about 300,000 are receiving it due to the unaffordable prices of antiretroviral drugs (Fosse 2002).

In Doha in November 2001, members decided to allow developing countries to override drug patents (TRIPS article 31 for compulsory licensing) and make and/or import generic copies of pharmaceutical products to meet their public health needs. This decision can be found in the agreement (The Declaration on the TRIPS Agreement and Public Health) adopted at that meeting on November 14, 2001 (WHO and WTO 2002). At the same time, how these countries would obtain these licences was not answered. Negotiations continue around these issues, and it appears that in the latest round of meetings in Sydney in November 2002 the United States, the European Union, Japan and Switzerland regressed. Implementation issues are still unresolved including the definition of pharmaceutical products, public health problems, and eligible importing and exporting countries. For example, the United States wants exceptions to be limited to HIV/AIDS, tuberculosis, and malaria in select countries. In addition, developed countries are placing onerous restrictions and conditions that undermine potential changes or relaxation of compulsory licensing tools (Fosse 2002).

TRIPS does allow members to exclude diagnostic, therapeutic and surgical methods for the treatment of humans or animals from patents, but Koivusalo and Rowson (2000) indicated that pressure to include these in future is a possibility. They also expressed concern at the potential for protection of trademark advertising (such as tobacco logos) to impact public health, and the risks of limiting access to information particularly with respect to licensing medicines and new chemicals.

The Implications of TRIPS for Women

The International Gender and Trade Network (IGTN 2001) suggested several implications of the TRIPS agreement for women. For example, TRIPS gives corporations increased power to monopolize the knowledge of indigenous women. Examples of this include disputes over seeds that have been used by local communities for centuries and that corporations now want rights to patent. TRIPS undermines governments' abilities to develop health policy and service delivery. In its latest assessment (2002: 7), the IGTN has argued that "TRIPS places several constraints on the production of generic drugs making pharmaceutical products expensive and unaffordable for men and women in poverty."

Mariama Williams and Maria Riley (2001: 2) suggested that a priority area for assessing TRIPS concerns "gender and food security/nutrition which [they] see as expanding beyond the focus on HIV-AIDS dimension to include other drugs and medicine that are important for women's health." They also pointed out that "at stake in the IPR/TRIPS implementation discussion is the continued viability of rural development, which is the base for income and sustainable livelihood generating activities of small farmers, many of whom are women."

Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement) and the Agreement on Technical Barriers to Trade (TBT)

The SPS and TBT agreements do not directly concern health care services, but are significant for their ramifications with respect to consumer health, specifically things like food safety, and animal and plant life.

These agreements have in common the prevention of "unnecessary" trade barriers, but their rights and obligations differ. Under SPS, measures may be imposed only to the extent necessary to protect life or health on the basis of scientific information. The TBT Agreement, on the other hand, permits the introduction of technical regulations to meet a variety of objectives like national security, the prevention of deceptive practices, and the protection of human health and safety. While the SPS applies to a narrower range of health protection measures, it places strict requirements based on scientific justification. The TBT Agreement covers a wide range of technical regulations and only notes the use of available scientific evidence as one criteria (WHO and WTO 2002). Issues related to food safety, the labelling and use of genetically modified food and traditional medicines are all areas that might fall under SBS and TBT.

Both the SPS and TBT have statements embedded in them with respect to the use of scientific evidence. Feminists have long challenged western scientific paradigms as androcentric and, therefore, of limited utility for understanding women's experiences. The development of uniquely feminist scientific practices have resulted in forms of evidence that are often dismissed or rejected by the scientific community; yet, it is precisely these forms of evidence that are needed to understand the implications of these agreements on women's health.

The SPS Agreement

The SPS Agreement was established in Marrakesh on April 15, 1994 as part of the Uruguay round of negotiations that created the World Trade Organization. In effect as of January 1, 1995, the Agreement is concerned with eliminating trade barriers as they relate to food safety, and animal and plant health. The aim is to reconcile the protection of consumer health with the maintenance of an open trading system free of protectionist barriers. The SPS scheme entails movement toward harmonized international standards, as specified in SPS article 3, diminishing national and local authority to set desirable standards (the same goal exists in the TBT, article 9). The SPS does not constitute a primary set of regulations pertaining to these areas, but establishes guidelines that member countries must follow when formulating domestic policies. The SPS states that regulations used by governments to restrict the products entering their country must be based on scientific evidence and a reasonable assessment of the risks posed so safety standards are not unjustifiably used as a means to discriminate against other members. The WTO (1998b: 2) is concerned that health protection measures will threaten trade and specifically that governments may be "pressured to go beyond what is needed for health protection.… A sanitary or phytosanitary restriction which is not actually required for health reasons can be a very effective protectionist device and because of its technical complexity, a particularly deceptive and difficult barrier to challenge."

Although the SPS offers a degree of protection for domestic policies, it encourages WTO members to harmonize their domestic policies through adherence to internationally developed standards. This issue was raised, for example, in the dispute settlement of the European ban on hormone beef and in the Canadian appeal against stricter regulations against the regulation of asbestos in France (Butter and Spurgon 1997; WTO 1997). The agreement provides for three kinds of precautions. It gives safety margins for acceptable levels of risk; it permits responses to national concerns when establishing precautions; and allows a precaution to be taken even if sufficient scientific evidence is not available (WTO 1998b). Yet, despite these measures, governments may not exercise complete autonomy in establishing standards for foreign products. Regulations that exceed what is necessary to protect health should not be implemented, and governments need to accept foreign standards if they demonstrate an equal level of protection. Furthermore, if a member's rules are challenged, it must be transparent in providing information concerning how the risk was determined and what criteria constitute "acceptable risk" (WTO 1998b).

Despite the inclusion of the precautionary principle, the danger of a challenge remains, which could place a domestic policy decision that affects women's health in the hands of a WTO dispute resolution body. As a result, the possibility that trade interests will take priority over health concerns cannot be fully mitigated. It is not for certain that in all circumstances, a member country would be allowed to regulate in its own interest, which could compromise women's health. As Koivusalo and Rowson (2000) confirmed, "the nature of these necessary public health measures is not defined, and in the process of dispute settlement, there is a danger that the decisions of the WTO dispute settlement body will prioritize the interests of trade and restrict definitions of what are considered to be necessary public health measures" (Koivusalo and Rowson 2000).

The Implications of SPS for Women

Under the SPS there is "a fundamental requirement that Members have a scientific basis to justify trade measures aimed at mitigating a health risk" (WHO and WTO 2002: 12). The reliance on scientific evidence to justify the implementation of a standard can be problematic given the gaps in knowledge regarding sex and gender differences with respect to side effects of certain drugs or reactions to various products that might be traded. Although the SPS allows the adoption of provisional measures on the basis of other forms of available information regarding health effects, this provision is very limited. For example, it might allow the restriction of the trade of a good thought to be associated with an infectious disease before scientific evidence is fully available. It is less clear, however, whether the SPS might allow other forms of evidence (as yet, unproven) related to women's health.

With regards to the SPS Agreement's reliance on risk assessment to determine the permissibility of a standard, Consumers International (1999: 4) highlighted a further consideration that can be related to women. "Evaluations need to be made on how the risk is distributed e.g. if risk falls disproportionately on infants, pregnant women, low income people, this information is critical to developing and implementing risk management

options." Research needs to be conducted with regards to risk assessment to determine if the risk is greater to particular social groups.

The TBT Agreement

The Agreement on Technical Barriers to Trade was developed as part of the Uruguay round of negotiations, and builds on the measures of an earlier version of the Agreement established in the 1973–79 Tokyo round (WHO and WTO 2002). Similar to other agreements reached as part of the Uruguay round, the TBT implements rules to minimize or prevent protectionism and to enhance a liberal trading system. The Agreement commits all WTO members to particular rights and obligations surrounding how technical regulations are developed and applied, and how products are assessed to determine if they conform to standards. The Department of Foreign Affairs and International Trade (DFAIT 2001: 1) defines technical regulations as "mandatory measures required by government to ensure products do not adversely affect legitimate public policy concerns such as the protection of human health and safety and the environment."

The TBT Agreement operates on the basis that technical regulations requiring a product to have certain characteristics can be a barrier to trade. As they are put into place by governments, there is concern that technical regulations may be used as devices in the trading system for purposes inconsistent with the aims of the WTO. To prevent this, the Agreement's provisions, highlighted in article 2 include a requirement that members not use technical regulations as barriers to most favoured nation treatment, and not to develop or implement regulations that will serve as barriers. Members are required to use international standards if applicable, and to justify, on request, any regulations that may impact another member's trade activities. They must also make efforts to harmonize regulations with other members and to recognize different regulations if the end result is the same.

A degree of governmental autonomy is permitted in protecting human health and safety, and animal and plant life or health, but it must not be used as a protectionist device. Furthermore, any regulations passed under this article must be justifiable based on science, technology and the end uses of products (TBT article 2.2) (WTO 1994).

DFAIT (2001: 2) acknowledges that there are different viewpoints in Canada regarding the adoption and implementation of the TBT. It reports that while the private sector upholds the Agreement, provinces and territories have expressed concern "with respect to how the disciplines apply to them as these governments play a large role in regulatory activity including health, safety and environmental measures." Also calling the Agreement into question, some non-governmental organizations are concerned about the government's capacity to regulate in the public interest (DFAIT 2001: 3).

The Implications of TBT for Women

Gender implications of the TBT Agreement are not specifically documented in trade literature. There are, however, similarities between the TBT and the SPS agreements, and critiques of the latter also apply in several instances to the TBT and can be linked to implications for women. These include domestic policy decisions potentially being in the

hands of a WTO dispute resolution body, and the reliance on scientific and technical data to justify a regulation's implementation.

The most important case related to health, although not specific to women, is that of Canada's case against France's asbestos ban. This was the first case ever brought to dispute resolution under the TBT. Canada, a major asbestos producer, wanted the ban to be declared contrary to the TBT and removed, angering many in the European Community that public health (primarily in the workplace) was being subverted by corporate interests. According to Vogel, Canada was attempting "to use free trade rules against public health in the asbestos dispute" (Vogel nd: 11). Canada was unsuccessful in the dispute, but it does show that there is at the very least a risk of public health being undermined by the TBT Agreement.

The Free Trade Area of the Americas

Involving 34 democracies of the western hemisphere, the FTAA negotiations officially began at the 1994 Summit of the Americas in Miami, Florida. This initial meeting produced the *Miami Summit's Declaration of Principles and Plan of Action*, representing the decision of these countries to eliminate barriers to trade and investment. After this point, a series of ministerial meetings and negotiation rounds ensued, with the aim of reaching an agreement by January 2005 that will be in effect by December 2005. The FTAA negotiations process is in a developmental stage. At present, only a draft agreement has been produced, representing what the Department of Foreign Affairs and International Trade (DFAIT 2001b) calls a series of preliminary negotiating positions to determine what various countries want from these negotiations.

The Agreement's chapter on services will resemble GATS and NAFTA. In accordance, it will contain a most favoured nation clause, a national treatment clause and provisions for market access (DFAIT 2001b). Canada supports the inclusion of services in the negotiations, and has stated that it will "ensure that it preserves its ability to adopt or maintain regulations, administrative practices or other measures in sectors such as health, public education, social services and culture" (DFAIT 2001a).

The political circumstances surrounding the Agreement can be described as highly charged. This atmosphere of discontent is illustrated by the protests that took place at the Québec City Summit in 2001. Many of the health care-based criticisms of the FTAA resemble those around other trade agreements. Specifically, the agreement will constrain domestic policy flexibility and "may make access to affordable health care, education and clean water, which many believe is a basic human right, impossible" (White 2002a: 5-6).

The Implications of the FTAA for Women

At the Quebec Summit, parties released a statement proposing to "integrate a gender perspective into the programs, actions and agendas of national and international events, to ensure that women's experiences and gender equality are an integral dimension of the design, implementation and evaluation of government and inter-American policies and

programs in all spheres" (Summit of the Americas Workplan, 2001: 35 as cited in White 2002b: 2).

White (2002a: 1-2) has argued that this statement is ineffectual and finds that "by failing to incorporate an analysis of how the FTAA may affect women and men differently, the recently released text is likely to increase many women's workloads and deepen their indigence throughout the hemisphere." Furthermore, White (2002a: 2-3) argues that as trade negotiators have failed to study differential impacts of trade agreements on women and men, "the FTAA agreement is likely both to widen the gender gap and to increase poverty and exclusion for many women in the Americas." It is White's view (2002a: 12), for example, that "the FTAA text will create more jobs for indigent women but will not necessarily improve women's lives or bring more money that will remain in the host country."

APPENDIX E: DESCRIPTION OF KEY INTERNATIONAL ORGANIZATIONS AND TRADE BODIES

International Monetary Fund

The International Monetary Fund is an international organization created in 1945, which currently consists of 183 member countries. The IMF was conceived in July 1944 at a United Nations conference held at Bretton Woods, New Hampshire. Representatives from 45 governments agreed on its framework for economics co-operation, which was designed with the intent to avoid the disastrous economics policies that had contributed to the Great Depression of the 1930s.

There are three main areas of activity for the IMF: surveillance (i.e., appraisal and advice to member countries on their economic policies); financial assistance (i.e., credits and loans for countries experiencing short-term difficulties) and technical assistance and training in monetary and fiscal policy, and statistics.

The World Bank

The World Bank was set up at Bretton Woods in 1944. It is a development organization, hence its official name: International Bank for Reconstruction and Development. Its mandated "strategy is based on two main pillars: building the climate for investment, jobs, and sustainable growth; and investing in poor people and empowering them to participate in development. The Bank undertakes poverty reduction at both the country and global levels" (World Bank 2002c).

In fiscal year 2002, the Bank provided more than US$19.5 billion in loans to its client countries. It works in more than 100 developing economies (World Bank 2002b).

There is considerable emphasis on the loans the World Bank extends to poor, developing countries. However, the scope of its activities is larger than giving loans. It also gives policy advice that can have influence in places like Canada.

The IMF and the World Bank require loan recipients to implement structural adjustment policies that restructure areas of public spending, including social services delivery systems. These policies commonly reduce the state's involvement in the economy and facilitate private markets. Structural adjustment policies have gendered implications where they affect areas of specific relevance to women. For instance, if social programs are limited, the responsibility for providing adequate health care and education may fall to women. If the cost of essentials, such as food and water, increases as a result of deregulation, the burden may fall on women who must provide these for families.

The World Bank funds and directs some initiatives of particular relevance to women. For instance, the World Bank worked with the Government of Bangladesh to establish the Female Secondary School Assistance Project. Other gender-related projects include helping women combat poverty in Kyrgyzstan, fighting HIV/AIDS in Chad and providing legal aid for poor

women in Ecuador and teaching women to read and write in Senegal. The World Bank has also published reports that implement a gender-based analysis. Titles include *A New Agenda for Women's Health and Nutrition*, *Engendering Development* and *Enhancing Women's Participation in Economic Development*.

The World Health Organization

The World Health Organization falls under the umbrella of the United Nations, with membership of 192 states. Regulation and policy development are provided by the World Health Assembly. The Director-General and Secretariat are supported by regional offices such as the Pan American Health Organization. Created by the UN in 1948, the objective of the WHO "is the attainment by all peoples of the highest possible level of health...defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2003).

Current Director-General Dr. Gro Harlem-Bruntland defined principal policy directions: reducing excess mortality, morbidity and disability, promoting healthy lifestyles and reducing risk factors to human health, developing health systems, framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and development policy (WHO 2003).

The WHO conducts research that specifically pertains to gender. There is a Gender and Women's Health Department. On the subject of women's health, the WHO produces activities, research, fact sheets and assorted publications. These include, but are not limited to *Gender Disparities and Mental Health*, *Female Genital Mutilation*, *Women and Tobacco*, *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women* and an *Anthology on Women, Health and the Environment*.

The United Nations

The United Nations was set up on October 24, 1945. There were 51 original signatories, a number that has grown to 189 countries today. The UN is an international body of nations and affiliated organizations. In its own words, "day in and day out, the UN and its family of organizations work to promote respect for human rights, protect the environment, fight disease, foster development and reduce poverty"(UN 2003).

The main bodies of the UN are the General Assembly and the Security Council. Each member nation is represented in the General Assembly, where one nation equals one vote. The Assembly meets from September to December, but can convene at any time if required. The Security Council is primarily responsible for international security and has 15 members. Five of these (China, Great Britain, the United States, the Russian Federation and France) are permanent members, while the other 10 seats are filled by other members elected by the General Assembly to fulfill a two-year term. To pass measures, nine members must vote in favour, but each permanent member has veto power. Other bodies of the UN include the

Economic and Social Council, the Trusteeship Council, the UN Secretariat and the International Court of Justice.

The UN operates under four main objectives: the maintenance of international peace and security, the development of good relations among countries, the solving of issues of international concern, and the promotion of respect for human rights. It also seeks to serve as a centre for harmonizing relations among nations (UN 2003). As a result, the responsibilities of the UN are multi-faceted.

The UN Division for the Advancement of Women (DAW) operates under the UN Secretariat's Department of Economic and Social Affairs. DAW was created in 1946. According to its mission statement, DAW "advocates the improvement of the status of women of the world and the achievement of their equality with men. It aims to ensure the participation of women as equal partners with men in all aspects of human endeavour" (DAW 2003: 1). DAW conducts research, formulates policy, monitors and contributes to UN initiatives, and held the Fourth World Conference on Women in 1995.

The United Nations Development Fund for Women (UNIFEM) is the UN fund that is specific to women. It was created in 1976 following the First World Conference on Women. UNIFEM's role is to "promote gender equality and link women's issues and concerns to national, regional and global agendas by fostering collaboration and providing technical expertise on gender mainstreaming and women's empowerment strategies" (UNIFEM 2002: 1). UNIFEM's projects are numerous, and include research, expert consultations and articulation of gender-based perspectives. UNIFEM funds projects and communicates with other UN and external agencies in pursuit of its objective of furthering issues that pertain to women.

International Labour Organization

The International Labour Organization (ILO) was founded in 1919, and is the only remaining part of the Treaty of Versailles that also created the League of Nations. It was set up the following year, and later became the first specialized agency of the United Nations in 1946.

The ILO has a tripartite structure. It comprises the Governing Body, the International Labour Conference and the International Labour Office. The Governing Body is responsible for policy and budget, and is formed by members with the following allocations: 28 governments, 14 employers and 14 workers. The Conference and the Office are responsible for standards and secretariat activities respectively (ILO 2000).

The ILO Constitution is governed by the philosophy that "universal and lasting peace can be established only if it is based upon social justice" (ILO 1946: preamble). In accordance, the ILO identifies five main objectives that govern its policies and actions. It seeks to promote and realize fundamental principles and rights at work, create greater opportunities for women

and men for employment and income, enhance the coverage and effectiveness of social protection and strengthen social dialogue (ILO 1996-2001).

Organization for Economic Co-operation and Development

The Organization for Economic Co-operation and Development (OECD) was set up in 1961 and comprises 30 member countries that come together under a shared commitment to democracy and market economies. Its purpose is to "provide a setting for reflection and discussion, based on policy research and analysis, that helps governments shape policy that may lead to a formal agreement among member governments or be acted on in domestic or other international fora." (OECD 2003). The OECD Council is the main governing body that makes economy-focussed decisions and recommendations to member and associated countries.

The OECD directorates oversee research and policy making in key theme areas. Trade is a primary concentration for the OECD's work, and it supports and recognizes benefits of international trade. It focusses consultations with civil society organizations, export credits, international trade statistics, economic issues, trade and agriculture/competition/ environment, competition, dialogue, and development and capacity building.

The World Trade Organization

The World Trade Organization was created during the Uruguay round of GATT negotiations in 1995. It became the successor to the GATT Forum. Whereas GATT deals only with trade in goods, the WTO encompasses trade in goods and services. It regulates intellectual property and product standards. The WTO is the only international organization dealing with the global rules of trade between states. Its main function is to ensure that trade flows as smoothly, predictably and freely as possible.

The WTO administers trade agreements including GATT, GATS, TRIPS, TRIMS, the SPS and TBT. These agreements are binding contracts. The WTO acts as a forum for trade negotiations, and settles trade disputes between member countries. Part of the WTO's mandate is to review national trade policies, and assist developing countries in trade policy issues.

APPENDIX F: THE GATS MODES: THEIR IMPLICATIONS FOR WOMEN

A number of health related issues for women are relevant to each of the four modes of supply found in GATS (i.e., cross-border supply, consumption abroad, commercial presence and movement of natural persons). In our view, mode 3 (commercial presence) raises the most immediate and significant issues in terms of its effects on women.

Mode 1: Cross-Border Supply

Cross-border supply is when a service itself crosses the border from one country to another. It includes services provided by telecommunications (e.g., telehealth), mail or fax. Telehealth includes medical advice given to patients in one country by a health professional in another country or where one health professional advises another health professional through the use of video conferencing technology. Telehealth therefore includes not only medical advice but the potential for medical diagnosis as well. It has been used, for example, to overcome geographic barriers and provide services to remote or rural regions. The WTO states that telehealth may also include "hospital management functions, data collection for statistical or educational purposes, and back-up advisory facilities for local staff abroad" (WTO 1998a: 5).

Telehealth has been identified both by Industry Canada (2000) and the Department of Foreign Affairs and International Trade (Health Canada 1999c) as a sector with potential for dramatic growth and as a priority for Canada's export promotion activities in the health services sector. Canadian companies are already involved in telehealth, and many of these are multinational enterprises (Chanda 2001). In Canada, uses for telehealth are emerging in a variety of areas. For example, Ontario is experimenting with the smart home care robot from Japan, which replaces home visits with surveillance and monitoring.

With respect to telehealth, one of the key questions is the impact it will have on quality of care, accuracy of diagnosis and on the interactions between health care professionals and their patients. Research on women and quality of care suggests that many women favour health care models which take a holistic approach to health, allow co-ordination between care providers and allow for privacy and empathic relationships with the physician and other health professionals (Anderson et al. 2001). One central question therefore is will the technology of telemedicine diminish the relationship between health care providers and women? The concern is that the contextual and cultural nature of health and care will be ignored or undermined in the rush to implement new technologies.

In some jurisdictions (e.g., the United States), call centre models are being used to deliver health care information over the phone or via the Internet. If these models begin to be expanded, they raise similar concerns regarding quality of care and patient/provider interaction as well as issues about the labour conditions of the individuals providing the service.

It is not yet established how telemedicine will be regulated and what standards will apply. A critical issue will be whether regulations and standards will take account of the evidence base regarding women's specific health care needs. Concerns have also been raised with respect to the implications of telemedicine for privacy and health rights. Privacy is particularly important to women who need to be able to talk to health care professionals about their experiences of physical and sexual violence and about issues related to contraception and abortion. For example, medical standards differ between countries and how conflicts between what might be counselled by one health professional and opposed by another might be resolved. This is especially relevant regarding women's reproductive rights, where there are no agreed upon international standards (Spieldoch 2001).

Mode 2: Consumption Abroad

Consumption abroad refers to services supplied in one member's country to a service consumer of another country. An example of this mode of delivery that is relevant to health would be an individual travelling to another country for medical treatment, for example, well off people in developing countries seeking access to "higher" quality services in a developed country, or people from developed countries seeking treatments only available in developing countries and/or treatments that are cheaper (e.g., cosmetic surgery). Or, as has been most common in the Canadian context, patients travelling to the United States to receive treatment (e.g., for cancer) when waiting times in Canada have been too long. Consumption of health services abroad raises issues related primarily to equitable access to health services. For example, privatized hospitals might choose better-qualified doctors and providers for foreigners who can pay more or they may lower their costs to attract foreign consumers while denying access to local consumers. Women as a group are disproportionately poorer than men, especially single mothers, and therefore are less able to pay for health services abroad (Spieldoch 2001). Women often have primary responsibility for their children, and for their partners and aging parents, making it more difficult for women to travel to receive care. The provision of services to wealthy elites in privatized hospitals may drive down the quality of care and labour standards in the public health care system (WHO and WTO 2002). This particular mode of trade, especially, "health tourism" is growing (WHO and WTO 2002). Finally, the provision of services abroad also raises questions about social support and the role women play in giving this support. That is, in removing care from the social and cultural context of individuals' lives, will this change the very nature of care and undermine some of the supports that help to foster people's ability to cope with and recover from illness?

Mode 3: Commercial Presence

The WTO online course, *GATS in The World Trade Organization: A Training Package,* states that commercial presence "involves direct investment in the export market through the establishment of a business there for the purpose of supplying a service." [22] Full commercial presence commitments in health care would mean providing rights to foreign corporations to own hospitals, nursing homes, clinics or laboratories in other countries and be treated as favourably by governments as domestic health providers. Mode 3 commitments encourage the privatization of health services and constrain the abilities of national governments to maintain and regulate standards governing the delivery of services that are normally

nationally determined (Spieldoch 2002). Currently, over 40 WTO members have scheduled GATS commitments in Mode 3 for the hospital services sub-sector (WHO and WTO 2002).

Private companies in Canada have begun to take on the delivery of certain outpatient services (e.g., rehabilitation services) that have been moved out of the acute care sector (Fuller 2002). De-listing of services from the Medical Insurance Plan (e.g., prescription drugs, physiotherapy) may also result in increased involvement of private insurers. In Canada, examples of managed competition and more private investment in Ontario in the home care area have resulted in an erosion of labour standards for workers and a lower quality of life for patients (Browne 2000; OHC 2001a,b).

Women are not only the majority of health care service recipients, but they are also the majority of providers of health care services. Thus any changes in how and where these services are provided will affect women. Marceline White (2001: 5) commented that "the public service sector has been associated with more highly skilled and waged jobs for women. These public sectors include areas such as health care, education, and social services...." Women are also highly concentrated in the hospital services sector providing food services, cleaning and laundry work for hospitals and other health care facilities. Privatization has the potential to drives wages and labour standards down in these sectors (Cohen 2001).

Privatization of health care services often shifts the costs of health care to individuals and concomitantly the likelihood that those who cannot pay for care will rely on family members (primarily women) to meet their care needs (Armstrong et al. 2001). According to Farah Fosse (2001: 3), "it is women who suffer most under the privatization and dismantling of services. When the state and the market fail families it is women who are obligated to provide health care, education and safe food and water for their families" (Fosse 2001).

Mode 4: Movement of Natural Persons

Mode 4 involves people travelling from one country to another to provide a service. This mode of supply will have application to the movement of health professionals. The issue here is the degree to which mode 4 will be used to fill supply gaps in the health care sector and reduce cost pressures in the health care system. One concern that has been raised about promoting this form of trade in services is the degree to which movement of professionals will leave some countries with a shortage of health care professionals. There is some evidence to suggest that this is already happening; for example, Jamaican nurses have been leaving their home country to work in North America creating a shortage of nurses in Jamaica (Speildoch 2001). The resulting "brain drain" could have serious consequences for the health of people especially in developing countries and especially for women and children unable to access costly services outside of their own country (WHO and WTO 2002). Further, people in the home country may receive a lower quality of care.

With respect to women, the movement of nurses is a key issue and tied to the question of professional accreditation. Within Canada, for example, there are many foreign trained

nurses who might be able to relieve the current nursing shortage if their qualifications were recognized. For example, nurses from the Philippines have been actively campaigning to have their accreditation recognized (Filipino Nurses Support Group 2003).

While accreditation for foreign nurses trained to Canadian standards is desirable, there is the danger that the process of accreditation can become driven by strictly commercial considerations. This has critical implications for the de-skilling of health care workers and for health care standards more generally. There is already evidence in GATS requests that some countries are asking others to “remove unnecessary training from licensing requirements for nurses” (UK 2003b).

Given that women are under pressure to migrate for work, what kind of protections and rights will be afforded to them in the countries recruiting them? Further, given women’s responsibilities for children what will happen to the children left behind while their mothers pursue work in other countries? Spieldoch (2001) has argued that women’s jobs in health care are particularly at risk in this growing industry, especially as developed countries try to drive down health care costs by bringing in nurses and other health workers from developing countries at lower wages and with fewer benefits. Further, mode 4 is also likely to be applied unevenly, allowing professionals from developed countries more freedom with respect to choice and conditions of movement (White 2001).

The WTO Secretariat views mode 4 to have the greatest potential benefits in the health services sector:

> It appears reasonable to assume that for many medical, health and social services, mode 4 restrictions are particularly significant. This is based mainly on three observations: (i) the scope for other modes of supply, especially cross-border trade and consumption abroad, tends to be limited; (ii) the activities concerned are generally labour and/or human capital intensive and, in a similar vein, (iii) while commercial presence may be highly relevant in some sectors, the most significant benefits from trade are unlikely to arise from the construction and operation of hospitals, etc., but their staffing with more skilled, more efficient and/or less costly personnel than might be available on the domestic labour market (WTO 1998a)

Clearly, it is critical for the Canadian government to be carefully assessing the effects of its involvement with the GATS agreements on women as health care providers, as recipients of health care and as key contributors to the health of all Canadians through their informal roles as family caregivers. Specifically, the four modes of the GATS affect the mobility of health providers and health services, and Mode 3, in particular, has the ability to undermine Canada’s publicly funded health care system.

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ENDNOTES

[1] During the Uruguay round of negotiations, and with the establishment of the World Trade Organization in 1995, the emphasis in trade shifted from goods to services.

[2] See for example, The Clair Commission in Quebec (2001), Ontario Health Services Restructuring Commission (2000), the Fyke Commission (2001) in Saskatchewan, Mazankowski Commission (2001) in Alberta, Kirby Report (2001a) and the Romanow Commission (2002).

[3] A summary of this analysis can be found in the Trade Agreements Table in Appendix C.

[4] A summary of this analysis can be found in Appendix D.

[5] According to the Act, home care is an "extended health service" and, therefore, not an insured health service for the purposes of the Act.

[6] It is estimated that approximately 20 percent of caregiving is done by friends and neighbours (Keating et al. 1999).

[7] See Appendix E for a description of international organizations and trade bodies.

[8] Trade Minister Pettigrew maintains that health services are simply not on the trade table. For example, in 2000, Pettigrew told a parliamentary committee that "public health and education are not on the table in any international trade negotiations. My government will maintain our right and ability to set and maintain the principles of our public health and education" (Pettigrew 2000). DFAIT officials that we interviewed reiterated Pettigrew's view in January 2003.

[9] This protection has been eroded by the Agreement on Internal Trade (AIT) signed by all the provinces and territories in 1994 and, in particular, as a result of the 1999 "MASH Annex" which deals with non-discrimination with respect to public sector procurement. "MASH" entities include, municipalities, municipal organizations, school boards and publicly funded academic, health and social service entities. Although debate exists around the implications of the AIT for the health sector, Appleton (1996) has argued that the MASH Annex changes pre-existing measures that were exempted from NAFTA.

[10] In this instance, France launched a challenge against Canada's refusal to ban the use of all types of asbestos. Canada argued that "controlled use" of asbestos would not endanger the health of workers. The WTO ruled in favour of France (Castleman 1999).

[11] See Appendix F for a description of these modes and an analysis of their implications for women.

[12] Countries retain power to place sector-specific or horizontal limitations on these commitments. In addition, they may, after a three-year period, modify or withdraw a commitment but not without equivalent commitments in compensation.

[13] It is interesting to note that DFAIT has indicated that "professional services" are a priority in terms of expanding trade in the area of services (Key informant interview, January 2003).

[14] See, for example, Barndt's work on the Mexican food industry, (1999) and Munro's (2002) work in the export processing zones in Mexico called the *maquiladoras*.

[15] Material in this section has been drawn from the CHCA (1998).

[16] These are classified under services provided by midwives, nurses, physiotherapists and paramedical personnel, and Canada has made no commitments to this category of health services.

[17] This information was obtained by the Association from the European Union, which has provided a list of services where requests have been made in the latest round of GATS negotiations. See UK (2002, 2003a).

[18] This section ensures that proper legal recourse is available to all private corporations in the case of disputes. It states: "Each party shall accord to investments of investors of another Party treatment in accordance with international law, including fair and equitable treatment and full protection and security."

[19] This information was derived from a list of companies in British Columbia that have been issued a provider number allowing them to bill for the provisions of home care services. This information was provided by Jennifer Erickson (BC Ministry of Long Term Health, 2003).

[20] There is an exclusion for government procurement under GATS (article XIII), but negotiations are underway to have it covered by the agreement. As well, there is a lack of clarity about what "government procurement" actually means.

[21] This was short-lived as the government amended the *Independent Health Facilities Act* in 1996 and formally removed any preference for Canadian-owned, non-profit groups in funding and licensing arrangements (Fuller 2001).

[22] <(http://www.wto.org/english/thewto_e/whatis_e/eol/e/wto06/wto6_11.htm)>.

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