

Canadian Women's Health
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**It's time
to act on
Home Care**

**A Woman's
Guide to Health
Care Debates**

BAR CODE

Health care reform continues to be in the news as, for instance, the Romanow Commission seeks Canadians' vision of a future for our health care system. This issue of *Network* highlights some less recognized problems women need to watch for—such as, “Why having a national home care program is a women’s issue.” We also include a handy “Woman’s Guide to Health Care Debates.” We invite you to photocopy this for relatives, friends and co-workers. Or send us names and addresses of those you know would be interested and we’ll send them a copy of this issue. Use it to ask questions and make your views known!

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Good News! Women’s Health Research Gets Renewed Federal Funding!

In February 2002, the Centres of Excellence for Women’s Health received the welcome news that Health Canada has renewed its funding for the program for an additional six years—2002-2008. Health Canada, through its Women’s Health Bureau, initially funded the program for a six-year period, beginning in 1996. Within the program there are four Centres of Excellence, the Canadian Women’s Health Network, and a variety of national cooperative initiatives. The central aim is to inform the policy process and narrow the knowledge gap on gender and health determinants, particularly social determinants. Based in Halifax, Toronto, Winnipeg and Vancouver, the Centres are multi-disciplinary and operate as partnerships among academics, community-based organizations and policy makers. The Canadian Women’s Health Network is responsible for national networking and communication.

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To subscribe see the information enclosed, or contact the address below. Back issues are \$5. Memberships in the CWHN are available to individuals (\$10) and organizations (\$10 for groups of 50 or less, \$20 for groups of more than 50). All women regardless of their income are welcome to join the CWHN. Contact us about low-income rates. We welcome your ideas, contributions and letters. All requests for information and resources, as well as correspondence related to subscriptions and undeliverable copies, should be sent to:

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The evidence is in... it's time to *act* on HOMECARE

BY PAT ARMSTRONG

ALMOST FIVE YEARS AFTER THE LAST COMMISSION ON HEALTH CARE RECOMMENDED THE FEDERAL GOVERNMENT AND THE PROVINCES ESTABLISH A CANADA-WIDE HOMECARE PROGRAM AS AN URGENT PRIORITY, CANADIANS ARE STILL WAITING.

Too many Canadians, mostly women, are left with nowhere to turn when a parent can no longer care for themselves, or a disabled child requires their full attention around the clock every day without a break—a real example of the 24/7/365 work world. With little recognition, no pay, and with almost no outside support or training, the toll of caring increases with every passing year.

In spite of wide recognition of the problem and the solution, there has been no response. So, why the delay?

Could it be that we simply don't have enough solid research to support the move to homecare? The answer is clearly no. We know more about homecare and the consequences of being without a system than we know about most things government spend millions on.

Hundreds of studies and research reports have been produced. Dozens of surveys, roundtables, focus groups have been conducted. Taken together they paint a picture of a costly problem that is shouldered primarily by Canadian women. Consider:

- 80% of paid and unpaid caregivers are women
- Caregivers often end up in poor health themselves
- Caring for others often blocks women from the paid workforce or has other negative life consequences and long-term costs for Canada
- Although women make many of the daily decisions related to health care, they are only a minority of the policy and management decision makers
- Women receiving or giving care are subject to violence and other physical risks

Instead of acting on the evidence, decisions taken by governments have made the situation for caregivers and

patients worse, not better.

Patients are now ejected from the health system quicker and sicker, conscripting women into delivering ever more complex medical and nursing care at home, even when research shows that these providers have a profound need for training and support.

Homecare and myriad other health care issues are being studied again by new commissions of inquiry launched by Ottawa. Senator Michael Kirby leads one while former Saskatchewan Premier Roy Romanow heads up a second.

Canadians can hope that these separate but similar exercises aren't covering the same ground. But we should be worried that while these two Honourable gentlemen criss-cross the country, Premiers like Alberta's Ralph Klein and B.C.'s Gordon Campbell are working to shift more of the burden of health care on to individuals through user fees and privatization of health services.

Dozens of Canada's leading homecare experts brought together in Charlottetown by the Centres of Excellence for Women's Health recently reviewed the body of homecare research. Their conclusion: enough evidence exists to design and implement a homecare system that will work and work for women. It's time to transform the research into government policy and action, while continuing to fill the research gaps that remain.

The experts were able to bridge gaps arising from the diverse interests and experience they each brought to the table. In an example of consensus building the Premiers could well learn from, the experts signed on to a "Declaration on the Right to Care."

Time to Act

The Declaration represents a fresh vision for Canada's health care system that recognizes the role played by unpaid caregivers, and the interests of patients. It's a renewed statement of our collective responsibility to each other as Canadian citizens and an articulation of principles that would renew our health care system.

The Declaration states, in part:

"Canadian society has a collective responsibility to ensure universal entitlement to public care throughout life without discrimination as to gender, ability, age, physical location, sexual orientation, socioeconomic and family status or ethno-cultural origin. The right to care is a fundamental human right.

"The right to care requires: access to a continuum of appropriate, culturally sensitive services and supports; appropriate conditions; the choice to receive or not to receive, or to provide or not provide unpaid care; access to reasonable alternatives and sufficient information and there is no assumption of unpaid care.

The prescription for a modern health care system that serves the needs of all Canadians is well documented and supported. Action to deliver the homecare services all Canadians desperately need is long past due.

We're waiting for political will. We cannot afford not to care. 

Pat Armstrong, Ph.D. is Chair of the Centres of Excellence for Women's Health National Coordinating Group on Health Care Reform and Women.

This editorial was originally submitted to major newspapers across Canada. In this issue of the newsletter, the impact of health reform and restructuring is discussed. The CWHN is very interested in hearing from the women's community. We are maintaining a list of contacts and groups working on health reform issues for women.

An expanded version of the Charlottetown Declaration on the Right to Care with background notes is available at no charge from the CWHN or can be downloaded from the Centres of Excellence web site www.cewh-cesf.ca/indexeng.html

Why Having a National Home Care Program is a Women's Issue

BY JEAN ANN LOWRY

A secretary whose mother is severely disabled by Parkinson's pays \$2800 a month in home care fees, over and above the publicly funded hours of care, puts in 11 hours day commuting and at her paid job, and then does her mother's feeding, bathing, lifting and treatments the remaining hours of her day.

A single mother, caring for a chronically ill child at home, does the daily work of three shifts of nurses, doing regular heavy lifting alone, and carrying out highly complex medical procedures, with her child's life literally in her hands 24 hours a day. Her full-time care giving responsibilities force her to live on social assistance.

A home care worker works eight different, irregular one-hour shifts a day, going by bus from home to home from 8:30 a.m. to 10:30 p.m., working for three home care agencies to earn sufficient regular income.

These few examples illustrate the 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.

Why has home care become such an issue now?

Several significant changes have increased the pressures and expectations on the home care system. Health care reforms—acute hospital bed closures, increased use of day surgery, shorter stays and early discharge—mean more home care patients now require pre- and post-surgery and medical treatments at home. Mothers are going home within a day of having a baby.

Demographic changes such as longer life spans of people with disabilities and the population in general, the growing proportion of seniors, and diseases such as HIV/AIDS and Alzheimer's, have also led to an increase in demand for long-term care.

Patients, especially those living with chronic conditions or physical disabilities, are also demanding care closer to home if not in their home.

The movement to 'community-based care' often called deinstitutionalization, has meant an unprecedented number of people are now cared for in the home, in unprecedented ways.

All of this requires a level of care few families are prepared for, physically or financially. At the same time more women than ever are in the paid labour force and families are smaller with fewer human resources to rely on.

Throughout these massive changes, the one thing that remains constant is women's responsibility for unpaid and paid home care giving.

Haven't governments been spending more on community (home) care?

Not really. There have been large decreases in hospital-based spending, but resources put into community-based care have not kept up with the acute care cuts.

For example, despite an Ontario Government commitment to increase

support for home care and community health, the proportion of funds devoted to these areas has remained relatively constant (4.7% in 96-97, 4.9% in 97-98, and 5.1 % in 98-99). At the same time, half the acute care beds in Ontario were removed.

In the early days of health care restructuring in Alberta, the government cut \$749 million from acute care beds, but added only \$110 million to home care over three years.

In Newfoundland and Labrador, informal family support amounts to about 80% of the care provided. Eligibility for publicly funded home care is based on levels of income just above the poverty line; only 1.2% qualify.

Saskatchewan has doubled its spending on home care to \$67 million since 1991, but dropped acute care spending by \$585 million. One in four home care recipients receive treatment formerly provided in hospitals.

So who is picking up the tab?

You are. Costs to individuals resulting from changes to the health care system have not been calculated, but there is certainly ample evidence that health care cuts are now being compensated for by the individual, who now has greater responsibilities to pay and provide for herself.

Medical services, supplies and drugs, once paid for in hospital, are no longer fully covered in the community.

When politicians talk about shifting health care to "rely more on home and community-based health care," do you hear them say, "unpaid work"? That's what they mean. Family members provide 70-88% of personal care and services for the aged.

In BC, the Ministry of Health acknowledges that unpaid caregivers provide the majority of care at home. In Quebec, the work done by family members to support dependent seniors at

home represents more than half the total cost of such supports.

The combined contributions of community agencies and government are only 10% of the total cost. A Saskatchewan study showed that family members keeping an elderly relative at home save the health care system \$24,000 per year per person.

How does this affect women?

Home care is an urgent issue for women for three reasons:

- women are far more likely to rely on home care services;
- we make up the vast majority of home care workers, and; and
- we also provide 80% of unpaid care to relatives.

Two-thirds of home care recipients are women. Yet several studies have shown that women receive lower levels of home care than men, even when they have the same level of need.

Three out of four home caregivers are women between the ages of 50-65 years, 10% are over 75.

Women are more likely to help with personal care and domestic chores, while men are more likely to provide transportation, home maintenance, or money management. In other words, the responsibilities of female caregivers are more intense, deeply personal and consistent, while men's duties are less intimate and more intermittent.

Care giving duties performed by women are more likely to affect their jobs, already at lower pay levels than men. Women lose work time, quit jobs, and work part-time, losing not only present income, but also future pensions and security in their own old age, when they themselves may need home care. In one survey, 50% of unpaid home caregivers had left employment or taken part-time work to look after a relative at home.

National Home Care Program

How are unpaid caregivers coping with all this?

Not very well. A number of studies demonstrate that unpaid home caregivers are experiencing financial, physical, and emotional strain as a direct result of their home care responsibilities.

In some provinces, to be eligible for publicly funded home care services, people must first have exhausted the care giving and support capacities of relatives, friends and community services.

Even before the most recent cutbacks in services, research indicated that caregivers have higher rates of depressive and anxiety disorders and use mental health services twice as much. Older, unpaid caregivers reported increased stress, high blood pressure, exhaustion, and susceptibility to physical illnesses.

Home-based caregivers are providing ever-increasing amounts of care, at ever-higher levels. Pushing unpaid workers beyond their ability to cope leads to stress and depression, increases their risk of mental or physical breakdown, and reduces the quality of patient care.

What about paid home care workers?

Their salaries and job security have dropped. Many female institutional employees, laid off as a result of hospital restructuring, are now forced to work in the home care field. Now they are mostly non-unionized, and lack benefits, adequate sick leave or access to injury prevention programs and equipment. They must now pay for their own professional updating, immunizations, insurance and transportation from home to home.

95% of paid home care workers are women. Home care workers are disproportionately women of colour, Aboriginal and immigrant women. An

increasing number are trained, experienced nurses imported from countries such as the Philippines as low-paid domestic workers. They are allowed entry only through Canada's "Live-in Caregiver Program" and kept on 'temporary' work permits.

Privatization of home care has led to lower wages for providers and loss of control over standards. LPNs in home care are getting half of what they received in institutions. In Newfoundland and Labrador, the average wage for a home care worker is \$6 per hour. As a result of the competitive bidding process for home care in Ontario, wages for home care nurses have dropped 3-13%.

Workers are being required to work more and faster. In Quebec, the number of visits a home care nurse must make each day has increased about 50%. The numbers and types of client care are increasing, meaning workers must deal with more severe illnesses, medical conditions or levels of disability.

There is pressure to de-professionalize home care work, assigning professional duties to less expensive, less skilled workers.

Workers are facing safety hazards. Home care workers must work alone, moving individuals and machinery within the home, without the help and equipment available when providing institutional care.

24% of nurses in long-term care reported they had suffered an injury in the previous six months. One study found that home care assistants suffered 48% of all work-related injuries, although they account for only 13% of the work force.

Home care workers are facing increased risks of harassment and verbal, even physical aggression from clients.

What needs to be done?

People responsible for long-term home care giving situations say they desperately need more hours of publicly supported home care.

They want dependable home care providers who are properly trained and adequately paid to provide caring, professional help, not custodial supervision, to their loved one.

They need more information about the home care system, less confusion and easier access. They want continuity and promptness.

They want an operational long-term care act with an independent complaints office.

They want more sub-acute beds and diligent monitoring of the quality of care by home care agencies.

Also needed are flexible work policies and family leave in the work place to accommodate care giving.

So, it all adds up. A national home care program is a women's issue, and the need is urgent. 

In November 2001, a National Think Tank on Gender and Unpaid Care Giving was held by the Centres of Excellence for Women's Health (CEWH). The Report of the Think Tank and a comprehensive analysis of gender sensitive home care research prepared by Marika Morris are available from the CWHN or on the CEWH website www.cewh-cesf.ca/indexeng.html.

A new easy to read booklet on women and home care will be published soon and will be available from the same sources.

Jean Ann Lowry, former Communications Coordinator for the CWHN, now works in the field of long term care in Ontario.

Health Care Privatization: WOMEN *are* PAYING *the* PRICE

d DURING THE 1990S, CANADA'S HEALTH CARE SYSTEM UNDERWENT A MASSIVE TRANSFORMATION, IN A DECLARED EFFORT BY ALL PROVINCES AND THE FEDERAL GOVERNMENT, TO CUT COSTS AND MAKE THE HEALTH CARE SYSTEM "MORE EFFECTIVE". RECENT RESEARCH CONDUCTED BY THE CENTRES OF EXCELLENCE FOR WOMEN'S HEALTH NATIONAL COORDINATING GROUP ON HEALTH CARE REFORM AND WOMEN DEMONSTRATES THAT PRIVATIZATION IS A PRIMARY COST-CUTTING STRATEGY IN CURRENT HEALTH CARE REFORM AND THAT PRIVATIZATION IS MOVING SWIFTLY, QUIETLY AND DEVASTATINGLY INTO THE HEALTH CARE SYSTEM IN CANADA IN MULTIPLE WAYS. HEALTH CARE IS RAPIDLY BEING DEFINED AS A PRIVATE RESPONSIBILITY OR EVEN A MARKET COMMODITY, THE ROLE OF THE PUBLIC SECTOR IS BEING LIMITED, AND PRIVATE SCHEMES, WHETHER THROUGH METHODS OF PAYMENT OR PROVISION OF SERVICES, ARE GRADUALLY TAKING ITS PLACE. BECAUSE IT IS HAPPENING IN DIFFERENT AND GRADUAL WAYS, AND UNDER SUCH DIFFERENT NAMES, PRIVATIZATION HAS CONFOUNDED CLEAR EVALUATION, CONFUSED PUBLIC DEBATE AND CREPT INTO THE HEALTH CARE LANDSCAPE WITHOUT SIGNIFICANT NOTICE OR COMMENT.

The Coordinating Group's research identifies five primary ways that Canada's health care system is being privatized: by shifting payment to individuals; by expanding opportunities for private, for-profit companies in the health "business"; by shifting care from public institutions to community-based institutions; by shifting work from full-time professional health care staff to unpaid family members or casual, low-paid home workers; and by adopting management strategies of private businesses, treating health as a market commodity. And the Coordinating Group shows that the effects of these changes are most severely felt by women, as primary providers and recipients of health care.

You would think, given the high level of political, public and media concern about health care, that information on the extent and impact of this trend would be readily available. You would be wrong. While all provinces have adopted most of these strategies, the process, types, depth and influence varies considerably across the country. And the changes have happened so quickly and so massively, and with so little public information, that no one seems to have a clear idea what has happened where, and why, and what the real impact has been.

But analysis yields dozens of province-by-province indica-

tors of the variety and effect of privatization. In several provinces, overall private sector sources of spending on health care now more than a quarter of total health care expenditures. In 2000, a Canadian Institute of Health Information report on health care expenditures spelled out private spending on health care as a proportion of all health care expenditures: Ontario's was the highest in Canada at 34%, followed by Alberta, P.E.I. and New Brunswick at 31%. Between 1990 and 1996, private expenditures for health care increased 43% in Saskatchewan, and 33% in Manitoba. In Quebec, private health care spending as a proportion of total health care spending increased from 25% in 1989 to 30.9% in 1998. The majority of private funding—55%—comes from direct outlays by individuals and 35% from private insurance. Private health care insurance is doing quite well too, as people scramble to get coverage for health care no longer publicly funded. Health insurance premiums as a proportion of all insurance premiums collected by Sun Life in Quebec rose 45.6% between 1987 and 1996. Alberta had a sudden upward jump of 11% in private health insurance coverage in 1997, more than double the national average.

Privatization has included everything from de-listing or

Women are Paying the Price

cutting back on professional services such as vision care and physiotherapy; to contracting out essential aspects of hospital services (now referred to as “hotel” services) such as dietary, laundry, housekeeping, waste management and even health information systems; to moving people out of hospitals quicker, so that drugs, medical devices, supplies and personal assistance, once covered in hospitals, are now paid by the individual at home; to, in Ontario, putting all home care services up for tender in a competitive bidding process, with the requirement that contracts be awarded to a “mix” of non-profit and for profit contractors. In Newfoundland, the health information system is being contracted out to a private corporation known as SmartHealth, a joint venture between the Royal Bank and EDS Canada Inc. In Ontario, an estimated 90% of nursing homes are operated by for-profit firms, often organized into national or international chains. In B.C., the use of private physiotherapy clinics increased 23% between 1994 and 1998. These are only a few examples of the numerous and varied incursions of private enterprise into the health care field.

Does the shift to privatized health care save money? Not according to studies so far. Manitoba tried transferring three components of the health care system to private corporations—a food services corporation to supply all Winnipeg hospitals, a privately run health and drug electronic information network, and a large contract to a private U.S.-based home care provider. All three contracts were terminated after the corporations were unable to meet the cost or performance goals. A Quebec study showed that the cost of a meal served by a privatized food service was

10.5% higher than the same meal served by a government-run service. And Robert Evans in *Going for Gold: The Redistributive Agenda Behind Market-Based Health Care Reform* concludes, “International experience over the last forty years has demonstrated that greater reliance on the market is associated with inferior system performance—inequality, inefficiency, high cost and public dissatisfaction”.

Worse, there is little information about how this massive move to privatization will transform into practice under current and future international trade agreements, and whether Canada could ever retrieve its public health care system from the increasing grasp of international corporations, without having to repay hugely for these firms’ loss of potential profits.

Gender analysis suggests women are bearing the brunt of health care reform privatizations. Women provide more than 80% of paid and unpaid health care in this country and are the most frequent users of the health care system—as patients themselves, or taking children and relatives, especially seniors, to care. The women who comprise 80% of the paid health care work force—nurses, aides, dietary and housekeeping staff—faced staggering job loss under massive hospital closures and restructurings of the ’90s, losing many of the economic advances gradually accrued over past decades.

Additionally, health care reforms such as community-based care and shorter hospital stays were based on the assumption that families would pick up the slack in looking after their relative at home. Once health care moves outside hospital walls, it is no longer an insured service, and services available from provincially funded home care fall far

short of demand. For example, in Ontario and Quebec, publicly funded programs pay for about 2 hours of care at home per day, leaving the individual or the family to provide or pay for the rest.

In short, privatization in all its forms characterizes much of health care reform and women are making up for the “savings” to the public system. There need to be real choices, based on real investigations into current and long-term impact, on such a fundamental transformation of the nation’s health care system. So far, from the perspective of Canadian women, who have had little opportunity for input into these sweeping changes, privatization has reduced their incomes and job security, left them with more support to provide at home, and reduced their choices and access to quality care. Health care reform, as currently being implemented, is a problem, not a solution for women. 

This article is summarized from the book Exposing Privatization: Women and Health Care Reform in Canada by Pat Armstrong, et al., published Nov. 2001 by Garamond Press, \$24.95. To order: Garamond Press, 63 Mahogany Court, Aurora, Ontario L4G 6M8. Tel.: (905) 841-1460, Fax: (905) 841-3031, E-mail: Garamond@web.ca, www.garamond.ca

A plain language booklet, Women and Health Care Reform, is available in English or French, free of charge, from your closest Centre of Excellence for Women’s Health or from the CWHN. Bulk orders accepted. Download from www.cewh-cesf.ca/healthreform/ This booklet also contains a full list of regional research reports from the Centres.

A WOMAN'S GUIDE *to* HEALTH CARE DEBATES

BY PAT ARMSTRONG

WWE ARE BEING FLOODED WITH OFFICIAL REPORTS AND MEDIA COVERAGE ON HEALTH CARE, ALL OFFERED AS A WAY TO THE FUTURE OF HEALTH CARE IN CANADA. A LOT OF NUMBERS AND TERMS ARE USED IN THESE DISCUSSIONS OF HEALTH CARE REFORM. THEY CAN BE CONFUSING FOR THOSE NOT HEAVILY INVOLVED IN HEALTH POLICY OR ECONOMICS. THIS GUIDE IS INTENDED TO HELP WOMEN SORT THROUGH SOME OF THE NUMBERS AND TERMS, SO THEY TOO CAN BE PART OF AN INFORMED DISCUSSION ON PLANNING FOR CARE.

Why a woman's guide?

Women make up over 80% of those who work for pay in the health care system.

Women also provide close to that much of the unpaid personal care provided at home and increasingly in institutions as well.

Women are the majority of those who receive care. According to the Ontario Women's Health Council's Submission to The Commission on the Future of Health Care in Canada (the 'Romanow Commission') "even factoring out childbirth, women are admitted to hospital more often, have longer lengths of stay when admitted, and are prescribed more drugs." This is because they are the ones who have the babies and because they tend to live longer than men.

Women are more likely than men to take others for care, and thus have more contact with the system than do men.

The kind of care women provide, where they provide the care and the kinds of health issues they face are often different from those of men. Moreover, there are significant differences among women in terms of the care they seek, require and receive.

Yet, despite this, and even with a woman as Federal Minister of Health, women are still under-represented as decision makers in this important debate.

Women, then, have a particular interest in health care.

How much do we spend on care?

There is a great deal of talk about how health care costs are out of control and it is often difficult to sort through the numbers, in part because there are various ways of calculating how much is spent on health care.

First, there are numbers on the percentage of Gross Domestic Product or GDP spent on health care. GDP simply means the total of all that is spent on goods and services in Canada. This way of presenting the numbers helps us see how the amount we spend on care is related to the amount we spend on other things. So if there is a lot of spending going on in other areas and we do not increase the amount we spend on care, then the percentage will go down. Of course, the reverse is also the case. In a recession, the proportion spent on health care will go up even if the actual amount we spend remains the same.

The number we hear most often is that we are spending just over 9% of GDP on health care. This is the same percentage we were spending in 1995 and just a tiny bit higher than in 1990.¹ By contrast, the United States spent almost 13% of their GDP on health care and that keeps going up.

However, these figures include both public and private spending; that is, they include everything we count as health care expenses. Public spending is what comes from government funds raised through taxes while private spending

refers to both the money we pay directly out of our pockets and the money we pay indirectly through our insurance companies.

So that 9% of GDP is not what the government spends. What the government spends is considerably less. In 1998, our tax dollars accounted for 6.6% of GDP and this is less than they did at the beginning of the 1990s. This compares to the 6.1% of GDP the U.S. government spent. Yet for that money we covered everyone and the U.S. covered only the old, the very poor and disabled, and the military for some of their expenses.²

Second, there are the numbers based on per capita expenditures, or the amount spent per person. Of course, per capita expenditures are not the actual amount we spend on each individual but rather the total expenditure divided by the total number of people in the country. Per capita numbers allow us to look at expenses in a different way, one not linked to overall changes in the economy.

Here, too, the figures are usually given for all expenditures, including both what we pay privately and what comes from government funds. In 1999, Canadians spent just under \$2,500 per person while Americans spent more like \$4,400.³

But only 71% of that per person expenditure in Canada was government money. And during the 1990s, the amount the government spent per person actually went down.⁴

What then do these numbers tell us about health care spending? They tell us that during the last half of the 1990s, governments spent less on care—both on a per person basis and as a percentage of GDP. However, government spending has increased somewhat in the last couple of years. This is in line with

other countries and in keeping with increases in overall spending. But this increase has not been enough to replace previous cuts.

What these numbers do not tell us is the cost to women of providing unpaid care. There is no calculation of earnings lost when women drop out of the labour force or take part-time work in order to provide care at home. There is no calculation of how much that unpaid labour is worth. There is no calculation of what this costs women in terms of promotion, and pensions in the future. These ‘lost opportunity costs’ are not calculated when the impact of transferring care back into the home is calculated. And they only tell us about money, not about the impact on the health and well being of women who have to make these choices.

What costs are rising?

The short answer to this question is drugs. In 1975, drugs accounted for just over 8% of health expenditures and 15% in 1999, and these increases do not include what hospitals spend on drugs.⁵ We now spend more on drugs prescribed and paid for outside of hospitals than we spend on doctors. Hospitals’ share of spending has gone down significantly. Now hospitals account for less than 33% of all health spending, just over twice as much as drugs, and way down from 45% in 1975.

What does the *Canada Health Act* say?

We increasingly hear suggestions that the *Canada Health Act* needs to be changed. To assess these suggestions, it is necessary to know what the *Canada Health Act* says and does.

The *Canada Health Act* is a very short piece of federal government legis-

lation that sets out the five principles provinces must follow in health care. Although provinces have responsibility for health care, the federal government has considerable power to raise money through taxes. The federal government used this power to introduce and enforce the *Act*. Initially, the federal government said to the provinces that it would pay half of what the provinces spend on doctors and hospitals if the provinces follow the principles of the *Canada Health Act*.

These five principles are:

1. **Universality.** Everyone must be covered, under uniform terms and conditions. This means that you cannot have what is often called a two-tier system that provides different kinds of services for those who pay more or provide faster service for those who pay. Women are less likely than men to have the means, either through insurance or through direct payment, to access extras or even necessary care that costs money, so universality is particularly important for them.
2. **Accessibility.** Not only must everyone be covered under uniform terms and conditions but services must also be provided in a way that “does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services.” The *Act* also provides for “reasonable compensation” for medical practitioners and dentists. Extra charges, or what are often called user fees, are thus banned. Like universality, this principle is critical for women because more women than men are poor, more women are sick and fewer women have the financial means to pay for care. Moreover, universality and accessibility help reduce differences among women by reducing the

reliance on personal financial resources.

3. **Comprehensiveness.** The provinces must pay for all medically necessary services provided in hospitals and by doctors. The *Act* also refers to “other health care practitioners” and specifies that all tests, drugs and accommodation needs in the hospital must be covered. The *Act* does not define ‘medically necessary’. Who defines medically necessary and how it is defined is therefore very important. Women are less likely than men to be in a position to make these decisions, although the increasing number of women doctors is shifting some of the balance.

5. **Public Administration.** Provinces must have a non-profit agency to administer the public health care plan. In practice, and by law in some provinces, hospitals are also non-profit.

Provinces have some choices about how care is delivered as long as they follow these five principles. Because the *Act* most clearly applies to hospitals and doctors, there is even greater variety among provinces once care is provided by someone other than a doctor or in someplace other than a hospital. This means provinces and territories have considerable flexibility in how they organize care and room for innovation. It also means, however, as we are seeing

Some of the money was paid in the form of tax points. This basically means the federal government allowed provinces to collect some of the taxes to pay for care. As a result, the federal contribution was harder to calculate and the federal government had less money to use as a means of enforcing the five principles. The transfers were gradually reduced. Then several years ago, the federal government put all the money for health, education and welfare into one package called the Canadian Health and Social Transfer and significantly reduced the money available. It became even harder to see how much the federal government gave to care and harder to withhold funds as a means of enforcing

There is no calculation of earnings lost when women drop out of the labour force or take part-time work in order to provide care at home.

4. **Portability.** This mainly refers to the capacity to take your coverage with you from province to province. However, because the public system pays for services rather than for individuals, Canadians have the right to move from service to service and from job to job without restrictions or penalties. This means women have some choices about care, and can seek services that respond to their particular needs. This contrasts sharply with some other countries, where coverage is linked not only to employment but also to a particular job. Other systems reduce choice of practitioner or have strict controls about whom patients can see.

in current debates, that there are different interpretations of the *Act*. It should be noted that there is nothing about affordability in the *Act*, even though some of the public discussion suggests this is the case.

Which government pays for what?

The federal and provincial governments have been blaming each other for problems in care. Much of the debate is about money.

The federal government rather quickly moved away from paying for half of all doctor and hospital costs. Instead, a formula based on past per capita costs and on the need to provide extra support to some provinces was developed.

the principles. Under the 1999 Social Union Agreement with the provinces, the federal government gave a large amount of additional money on the condition that the provinces promise to use it for care.

With all these changes, it should not be surprising that provinces/territories and the federal government calculate the amount of the federal contribution differently. What cannot be questioned is that the amount has changed, is paid differently and does not guarantee regular funding from the federal government.

What does privatization mean?

Privatization is used to refer to a number

of different things in health care in Canada. To understand what is being discussed, it is first necessary to understand what we mean by public care in Canada.

When the federal government introduced the public funding of care, the strategy was to pay for services out of government funds. Care was to be delivered on the basis of need, not ability to pay. The hospitals were almost all non-profit organizations run either by local governments or independent, non-profit religious organizations or charities. Today neither the provincial nor the federal government owns many hospitals. Few doctors are directly employed by government. Rather they function as private businesses—billing the government on a fee for services basis.

Medicare, then, was really about paying others to deliver services, although virtually all those who are paid are either non-profit and charitable organizations or self-employed independent professionals. In other words, we already have many private organizations and individuals delivering care. We already have what some call a purchaser-provider split because the government pays but does not directly provide.

One form of privatization being suggested these days is the privatization of care delivery. Given that we already have private delivery by non-profit organizations or independent professionals, what is meant by privatization of delivery is delivery by for-profit organizations. This would be a fundamental change in the way care is delivered not because private organizations would do it but rather because they would need to make a profit when they do deliver care.

It is often argued that for-profit companies are more efficient and provide better care because they have to compete effectively in order to keep their

business. However, there are only a limited number of ways to make a profit and thus stay in business. One is to charge more; another is to cut the labour costs by paying people less, by hiring fewer people or by making them work harder; and a third is by reducing quality. There is very little evidence to support the claim that for-profit companies can provide the same quality of care at the same price as not-for-profit companies, and some evidence that for-profit companies either provide poorer care or have greater costs. When the focus is on cutting labour costs, it is women who feel the impact first because they are four out of five of the people employed to provide care. When the focus is on cutting quality—a process that usually means changing the way providers work—women also suffer because they make up the majority of those receiving care.

Another form of privatization that is increasingly offered as a solution to cost increases relates to payment. User fees that would make individuals pay for services is one kind of payment privatization. The idea is that fees would both discourage people from misusing the system and raise money for care. However, all the evidence suggests it does not add much money and only discourages the poor and the sick from seeking care. Another way of privatizing costs is ‘delisting’, which basically means particular kinds of care are no longer covered. Some forms of care have never been covered under the public system and some have always involved fees, although the shift in costs to individuals or their insurance companies is increasingly obvious. In 1990, the public system paid for three-quarters of the costs of care; by 1999, the public share was down to 71%.⁶ Over half of this money comes directly out of individuals’ pockets.

The two biggest personal expenditure items are dental care and prescription drugs, although insurance companies still pay more than half these costs. Leaving a hospital usually means leaving the public provision of drugs, although some provinces have pharmacare plans that cover some drugs or provide a ceiling at which costs will be covered. Such plans can not only help individuals get the drugs they need; they may also help control costs overall by using the regulation and purchasing power of the government to reduce prices. Most of this insurance coverage comes from workplace plans. A significant number of Canadians have no coverage for these costs, however. Women are less likely than men to have such plans.⁷ Where individuals carry the biggest load is in the cost of care in institutions such as nursing homes. Women are the majority in these homes and thus the majority of those carrying this cost of care.

Yet another form of privatization is seldom described as such but is a form that is particularly important for women. This involves the shift of care work and responsibility for care to the household. When care is sent home, women are expected and increasingly required to provide the care.

What are the issues in home care?

Homecare has become a central issue for several reasons.

One reason is the changes in health policy that are sending care home. Hospital care has been redefined to include only those who require the most immediate and acute care. Patients are sent home quicker and sicker, while they still require a great deal of care. More surgery is done on an outpatient basis, with patients released the same day and sent home for care. More services are provided on an outpatient

basis, with services once provided in the hospital now provided at home. And finally, institutions that once were homes to people with a variety of disabilities have been closed. This is particularly the case for those with mental disabilities. All these policy changes mean more care is required at home—if the patient has a home. Furthermore, once people are released from hospital, the principles of the *Canada Health Act* apply only to insured services, not to the work and costs of care borne by the household. And by household we usually mean women.

Second, technologies have changed in ways that make it possible to provide

want paid work, they still provide a great deal of care in the home and are doing more every day. Indeed, a smaller proportion of the population is cared for in institutions today than was the case a hundred years ago. At the same time the demands for care are rising. Estimates indicate that around 90% of health care is provided at home by unpaid providers, indicating that women in particular are carrying heavy caring workloads along with their paid jobs.

What about the aging population?

Although a decade ago the main issue was costs that were out of control, today the main issue seems to be an aging

health care practices. It is quite possible to assess how care is delivered to seniors within the system as a means of improving care while controlling costs. Drug prescribing provides just one example. We could involve pharmacists more in advising both doctors and seniors on drugs, and in the process save millions of dollars on adverse drug reactions.

Third, the boomers are in general healthier than the generation that is now old, in part because they have grown up with a public health care system and with other social supports absent before the Second World War. They are also more likely to have had relatively secure employment and pensions plans at work,

Although the transfer of care work to the household is often described as a return of care to the household, it is clear that our grandmothers never inserted catheters, hooked up IVs or attached oxygen tents.

complicated care at home. Although the transfer of care work to the household is often described as a return of care to the household, it is clear that our grandmothers never inserted catheters, hooked up IVs or attached oxygen tents. Indeed, some women provide care in the home that can only be done in the hospital by those with years of formal training. Technologies, along with social support programmes, have also made it possible for women and men to live longer with chronic illness or disability. This means that home based acute care, such as dialysis, may be done over many years.

Homecare has not become an issue because women have abandoned their traditional care work in order to pursue careers. While most women need and

population. The argument is that we will not be able to afford care for the baby boomers who are growing old, especially with lower birth rates that mean the younger generation will not be large enough to support the elderly. Most of the elderly are women. Moreover, women are a large majority of those who need public care because they usually outlive their spouses.

However, there are reasons to challenge the notion of an impending crisis caused by all those aging women.

First, even if we keep spending the same amount we do now on the elderly, the increase will be gradual and about 1% per year during the period when the baby boomers become seniors.

Second, these figures assume current

although this is more likely for the men than the women.

What is primary health care reform?

Primary health care is most often defined as your first point of contact with the health care system. While many people access health care through the emergency room, primary health care usually refers to doctors, clinics and health centres. Indeed, recent reform discussions have focused on primary care reform, at least in part as a means of keeping people out of emergency rooms.

Sometimes primary care reform is mainly concerned with encouraging doctors to work together with other doctors in group practices. Such group

practices, it is assumed, could better handle the need for care all day every day or what is often called 24/7 care.

Sometimes primary care reform is concerned with creating clinics or centres that would include a broader range of care providers. Nurse practitioners in particular have been suggested as a means of sharing the workload, of decreasing costs because they are paid less than doctors and of encouraging health promotion strategies because they spend more time with each patient. Midwives may also be part of the team, but there is less talk about the role of other care providers.

Most primary health care reform is concerned with moving away from the fee-for-service means of paying physicians. The assumption here is that payment by the number and kind of services provided encourages more prescriptions, more tests, more complicated treatment and less time spent with each patient. Various alternative forms of payment are suggested, each of which has different implications for doctors, others who provide care and for patients.

What is 'rostering' and 'capitation'?

'Rostered' refers to a system that requires individuals to make a commitment to only see a particular doctor/practice group or clinic for a period of time. This time can vary between a few months and a year. This is supposed to reduce extra doctor visits or 'doctor shopping'. Physicians are given financial incentives to keep their patients on this roster, the implication being that if individuals are satisfied with the care they won't go elsewhere. This is a big assumption.

Rostered is often combined with 'capitation' payments. This means that the doctor or clinic is paid on the basis of the number of people signed up

rather than on the number of services provided or fee-for-service payments. The capitation fee is based on the average cost of providing health care services to a person of a set age and sex. The physician or clinic receives—and gets to keep—the fee regardless of the amount of service provided to an individual. It is often justified as a means of encouraging doctors to provide more health information, health promotion, discouraging over treatment or misuse and ensuring a higher quality care. It is one method that allows for the hiring of staff other than doctors to provide care.

However, there is very little evidence demonstrating that women currently misuse the system or that rostering guarantees the gender sensitive care that women have been seeking.

Rostered does appear to reward physicians for seeing generally well people since they get paid a flat fee no matter how frequently they provide services and therefore penalizes them when they carry a case load of those with chronic mental or physical health problems—often those who are poor or elderly.

Rostered does mean a fundamental shift away from our current system which signs individuals up with the provincial health service and allows them to use any services covered by the plan. 

For more on health care reform

See the *Canadian Women's Health Network's Submission to the Commission on the Future of Health Care in Canada* regarding health reform at www.cwhn.ca/resources/romanow/index.html or the *Women's Health Clinic Brief to the Standing Senate Committee on Social Affairs, Science and Technology* at www.cwhn.ca/resources/whc-brief/index.html

Exposing Privatization: Women and Health Care Reform in Canada by Pat Armstrong et al. (Toronto: Garamond, 2001) provides extensive research from the Centres of Excellence for Women's Health across Canada.

A plain language pamphlet, *Women and Health Care Reform*, can be ordered from the CWHN.

Follow the activities of the Commission on the Future of Health Care in Canada (Romanow Commission) at <http://www.healthcarecommission.ca/>. You can also subscribe to a newsletter that can be mailed or faxed.

Pat Armstrong, Ph.D., is Chair of the Centres of Excellence for Women's Health National Coordinating Group on Health Care Reform and Women and an internationally recognized scholar on women and health reform in Canada.

Notes:

1. Canadian Institute for Health Information (CIHI). 2001. *National Health Expenditure Trends 1975-2001*. Ottawa: Canadian Institute for Health Information, Table A1.
2. Conference Board of Canada, *The Future Cost of Health Care in Canada, 2000-2020: Balancing Accountability and Affordability*, Ottawa: Conference Board of Canada, 2001
3. CIHI. 2001. Table 7b.
4. CIHI. 2001. Figure 7.
5. CIHI. 2001. Pg.18.
6. CIHI. 2001. Table B.3.3.
7. CIHI. 2001. Table 4.

THE INSTITUTE OF GENDER AND HEALTH: A YEAR IN REVIEW

BY KIKE EHIGIATOR, INSTITUTE LIAISON, CANADIAN INSTITUTES OF HEALTH RESEARCH

The background: A new era in health research

In June of 2000, the former Minister of Health, Allan Rock, officially launched the Canadian Institutes of Health Research (CIHR), Canada's premier agency for health research. The objective of the organization is to excel nationally and internationally in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system. CIHR was created to support multidisciplinary, integrated health research as well as a wide spectrum of health research—biomedical; clinical; health services and systems; and population health research. The CIHR mandate emphasizes the generation of knowledge and development of research capacity that will contribute to improvements in health and health systems for all Canadians.

The CIHR Institutes and the Campaign for Women's Health

Part of the mandate of the Interim Governing Council, appointed by Parliament, was to create Institutes. To accomplish this, a Canada-wide consultative process was launched to obtain input on the initial slate of institutes. The virtual nature of these Institutes meant that they would reside at the research site of each Scientific Director within Canada. Each Institute would also focus on a specific field of research such as circulatory and respiratory health, health services and policy, and Aboriginal peoples' health.

A group of women's health researchers and activists from across Canada—The Working Group on the CIHR, Gender and Women's Health Research—submitted a proposal for an institute dedicated to women's health. This proposal built on an earlier document, "CIHR 2000: Sex, Gender and Women's Health". These efforts were successful. In July 2000, former Minister of Health Allan Rock and CIHR President, Allan Bernstein, announced the creation of 13 CIHR

Institutes, including the Institute of Gender and Health.

The Institute of Gender and Health

The mandate of the CIHR Institute of Gender and Health is "to support research that address how sex (biological factors) and gender (socio-cultural experiences) interact with other factors that influence health to create conditions and problems that are unique, more prevalent, more serious or different with respect to risk factors or effective interventions for women and girls, men and boys." Consistent with this mandate, the IGH supports research capacity building and research initiatives.

The objectives of the Institute of Gender and Health are: generating new knowledge about health status, health behaviour and health services use of males and females across the lifespan, and the influence of gender and sex on these, and their interactions with other determinants of health; providing evidence to inform the design of programs, policies, and practices for women and men, boys and girls in Canada; enhancing research capacity and training in gender and health research; exerting international impact through strategic research and research capacity building; and advancing the gender and health perspective.

Late in 2000, Allan Rock announced the appointments of the Scientific Directors who would lead the Institutes. The Scientific Director of IGH is Dr. Miriam Stewart, Professor in the Faculty of Nursing and in Public Health Sciences, Faculty of Medicine, University of Alberta. Dr. Stewart is former Director of the University of Alberta Centre for Health Promotion Studies and the Atlantic Health Promotion Research Centre, and a co-principal investigator and co-founder of the Atlantic Centre of Excellence for Women's Health. In the last decade, she has been awarded over \$10 million in research grants in her field of study—social support and other social factors that affect health and how better understanding of these can improve programs for people in

A YEAR IN REVIEW

vulnerable circumstances.

In February of 2001, the Institute Advisory Board was announced. The members of the Advisory Board come from across Canada, and reflect diverse disciplines such as women's health, sociology, psychology, medicine, nursing, and anthropology and expertise in practice, policy and public arenas. For example, members include Penny Ballem, Vice-President, Children's and Women's Health Centre, B.C.; Ian Manion, Director of Research, Mental Health Patient Service, Children's Hospital of Eastern Ontario (CHEO); Sandra Bentley, Senior Policy Advisor on the Status of Women, P.E.I.; Irving Rootman, Director, Centre for Health Promotion, University of Toronto and Madeline Boscoe, Executive Director, Canadian Women's Health Network.

In the spring of 2001, IGH engaged in extensive consultations with varied stakeholders across the country, to generate input about priority directions in gender and health research. This process shaped the Institutes' five research priorities and "top ten" themes: *Improved Access and Equity for Marginalized Populations and Vulnerable Groups* (gender, health equity and access to health services for vulnerable groups; gender, violence and health across the lifespan); *Promoting Health in the Context of Chronic Conditions* (gender and chronic conditions over the lifespan; gender and cardiovascular health); *Gender and Health Across the Lifespan* (gender and healthy child development; gender and healthy aging; gender, work, leisure and health; gender and mental health in a changing society; gender and reproductive and sexual health); *Promoting Positive Health Behaviours* (gender, promoting health behaviours and preventing addictions); *Gender and the Environment*.

IGH launches strategic initiatives in 2001-2002

In their first year of operations, all Institutes have launched strategic research and research capacity building initiatives. These initiatives have increased funding opportunities for researchers in all the four CIHR research pillars, particularly in areas of health services, policy, and population health research.

Strategic Initiatives launched by IGH in partnership with other CIHR

In the spring of 2001, IGH engaged in extensive consultations with varied stakeholders across the country, to generate input about priority directions in gender and health research.

Institutes include: *New Perspectives on Gender and Health* (Seed Grants, Opportunity Grants, and Re-training Awards to stimulate research and build research capacity relevant to the five research priorities of the Institute); *New Emerging Teams (NET)* program (to promote growth of small existing research teams or formation of new teams to focus on research priorities in

gender, violence and health and chronic conditions); *Improving Access to Appropriate Health Services for Marginalized Groups* (to support innovative projects that will inform policy, program and management decisions related to this research priority), and *CIHR Health Research Training Initiative* (to support the development of innovative, trans-disciplinary training programs in health research that increase the capacity of health researchers in Canada and that reflect the scope of research priorities across Institutes).

Watch for opportunities, upcoming events and activities

- Launch of 2002-2003 strategic initiatives focused on the five research priorities (e.g., *New Perspectives on Gender and Health*, *Improving Access to Appropriate Health Services for Marginalized Groups*) and initiatives focused on research training and capacity building;
- International Think Tank on Sex, Gender and Health and Symposium for IGH Award Recipients planned for late August 2002;
- Cross-Institute collaborations (e.g., Tobacco Control Research Summit, National Workshop on Environmental Influences on Health, Rural Health Research Strategy);
- Launch of a listserv to communicate with researchers and people in policy, program planning and the community. 

For more information on the CIHR, check their website at www.cihr.ca or the IGH website: www.cihr.ca/institutes/igh/igh_e.shtml. To register on the CIHR mailing list: www.cihr.ca/institutes/igh/igh_contact_us_e.shtml.

FROM FLOODS TO INFERTILITY: *New Research from the Centres of Excellence for Women's Health*

British Columbia Centre of Excellence for Women's Health (BCCEWH)

Lesbian and Bisexual Women's Health

In its commitment to focusing on the health needs of specific groups of women, particularly marginalized women, the BCCEWH has piloted three recent research projects on lesbian and bisexual women's health.

The Lesbian and Bisexual Women's Health Project, designed to raise awareness about the health needs of lesbian and bisexual women, and improve their access to quality health care, has produced three new resources. *Caring for Lesbian Health: A Resource for Canadian Health Care Providers, Policy Makers and Planners* is a revised national edition of a popular booklet originally published by the Province of British Columbia. The booklet reviews the legacy of homophobia and heterosexism within the health care system, identifies the unique health concerns of lesbian and bisexual women and describes ways to improve their access to quality health care.

Empower Yourself postcards address health issues important and specific to lesbian and bisexual women: parenting, maintaining healthy friendships, looking for a doctor and making healthy choices.

A *Tip Sheet for Health Care Providers* outlines how providers can improve health care for lesbian and bisexual women patients.

Out in the Cold: The Context of Lesbian Health in Northern British Columbia (by Lynda Anderson, Theresa Healy, Barbara Herringer, Barbara Isaac and Ty Perry) investigates lesbians' experiences of the formal health care

system in northern British Columbia by addressing three primary questions: How do lesbians describe their experiences of formal health care services? What barriers do they experience? And how do lesbians negotiate these barriers and address their health and wellness needs inside and outside of the formal health care system?

This qualitative study illuminates the impact that the anti-lesbian/anti-gay social climate of the north has on health care services. For lesbians living in this context, considerations of personal safety and personal freedom are intricately intertwined with health. *Out in the Cold* reveals the complexities and contradictions of this reality, and recommends changes needed in services and in the community to bring down barriers to health care for lesbians. Adding to the growing body of literature on lesbian health, this report documents a uniquely collaborative participatory action research process that blurred conventional boundaries between researcher and researched and has led to social action initiated by participants.

Making Choices/Taking Chances: Lesbian/Bi/Queer Women, Assisted Conception and Reproductive Health (by Jacquelyne Luce) focuses on queer women's experiences of trying to get pregnant and/or become parents within the context of new developments in assisted reproductive technologies and lesbian, gay, bisexual, and transgender rights legislation. The researcher shows the complex ideas, expectations and experiences that inform lesbian/bi/queer women's reproductive health and well being.

Based on ethnographic fieldwork conducted over almost two years, this paper is a narrative of the researcher's own experiences as a queer woman doing

research on other queer women and reproductive health, as well as an account and analysis of the stories of lesbian/bi/queer women who had tried or were planning to try to get pregnant. Fieldwork took place in a variety of geographical and cultural contexts throughout British Columbia, which prompted the researcher to address the effects homophobia and heterosexism have on this type of research and the methodological as well as the daily challenges faced by queer health researchers.

Apprehensions: Barriers to Treatment for Substance-Abusing Mothers

This study, by Nancy Poole and Barbara Isaac, interviewed women living in Vancouver and Prince George who were pregnant or mothers of children under 16, and who had problems with alcohol and/or other drugs. The researchers were careful to plan and conduct the study to look at how systems can better provide women-centred care, rather than from blaming the individual women.

The women identified key barriers to access to treatment for substance abuse as shame, fear of losing their children if they identified as needing treatment, fear of encountering prejudice because of being mothers or pregnant and having substance abuse problems, feelings of depression and low self-esteem, believing they could handle the problem without treatment, lack of information about treatment available, and waiting lists for treatment.

The women identified five key factors that helped them use treatment facilities—the support provided by a wide range of professionals, supportive family members, friends, and people they met in the recovery movement, their motivation to get help because of their children, and having programs in the alcohol and drug system that are appropriate for women's needs.

The Lesbian and Bisexual Women's Health Project was funded by Health Canada and Status of Women Canada and coordinated by the BCCEWH. Caring for Lesbian Health: A Resource for Canadian Health Care Providers, Policy Makers and Planners, Empower Yourself postcards, and the Tip Sheet for Health Care Providers are all available in French and English. Hard copies can be ordered free of charge from Health Canada Publications, Postal Locator 0900C2, Ottawa, K1A 0A9, phone (613) 954-5995, fax (613) 941-5366.

Out in the Cold: The Context of Lesbian Health in Northern

British Columbia, Making Choices/Taking Chances:

Lesbian/Bi/Queer Women, Assisted Conception and Reproductive Health are available from the BCCEWH, E311-4500 Oak St., Vancouver, BC, V6H 3N1, Ph: 604-875-2633, Fax: 604-875-3716, Email: bccewh@cw.bc.ca, www.bccewh.bc.ca **Apprehensions: Barriers to Treatment for Substance-Abusing Mothers can be obtained for \$15 from the BCCEWH or via www.bccewh.bc.ca/pub.htm**

Prairie Women's Health Centre of Excellence (PWHCE)

Women, Disability Rights and Prenatal Technologies

The Ethical and Human Rights Implications of Prenatal Technologies: The Need for Federal Leadership and Regulation explores the increased use of prenatal technologies from both a disability rights and feminist perspective. This thought-provoking research paper, by Yvonne Peters and K. Lawson, points out that such technologies that have rapidly become routine practice in the care of pregnant women, in the absence of any regulatory framework or reflection on the myriad social, legal and ethical issues raised.

The authors point out that the most frequently given reason for prenatal testing is to prevent or ameliorate disabling conditions that are genetically based. They argue that discrimination against persons with disabilities is so pervasive and the penalties associated with raising children with disabilities are so grave that refusing to abort a potentially disabled foetus is not a choice that many pregnant women feel is in reality available to them.

It is the assumption of abortion as the logical follow-up procedure when prenatal testing indicates a possible disability that is of particular concern for disabled people. Disability is currently considered the only legitimate grounds for selective abortion, which suggests that it is primarily concerned with reducing the incidence of disability in society.

Economic and scientific resources are far more concentrated on refinement of prenatal technologies than on finding treatment for defects thus detected. We should question the concentration on identification of defective genes, rather than eliminating poverty, improving prenatal nutrition, and reducing environmental toxins, which are leading causes of health problems in infants.

A crucial aspect of disability is the attitudes and norms of a society constructed only for able-bodied people. The authors criticize both the cost benefit view of disability and the "qual-

ity of life” argument, which assumes that no life is preferable to life with a disability.

Use of prenatal testing is widely varied. Current patterns have the potential to disproportionately situate the majority of disabled people within certain geographically isolated, low income and minority segments of society. What will happen to programs for people with disability when people with money and power no longer identify with the issue?

Prenatal testing technologies, by forcing a decision to abort, may in fact restrict rather than enhance women’s reproductive autonomy. The routinized use of testing has the potential to cast women as the genetic gatekeepers of society, not only responsible, but accountable for, the birth of disabled children. The authors argue that disability rights and women’s reproductive rights are not opposing concepts, but may well be linked casualties in a world obsessed with genetic perfection.

The paper examines the Canadian Human Rights Law and the Canadian Constitution and identifies legal bases for discriminatory use of prenatal technologies. The authors recommend that the federal government take a leadership role in establishing uniform national standards for prenatal testing, include prenatal testing reproductive technologies legislation and promote public and professional education on this issue.

Left In The Cold: Women, Health and The Demise of Social Housing Policies

Left in the Cold, by Darlene Rude and Kathleen Thompson, is a new study of the links between housing policies and women’s health, particularly in light of governments’ withdrawal from social housing since the early 1990’s. The study focused on the effect of gender on accessing and maintaining adequate housing, rather than the typical focus on income. The report includes a review of the literature on links between housing, health and gender, an overview of housing policy and practice changes in Canada over the last decade, and data on the influence of housing on health status.

The researchers interviewed women in Regina and Winnipeg who had first-hand experiences of difficulties in accessing or maintaining adequate housing. They also interviewed professionals working in housing policy or providing front-line housing services. All of the participants in this study had lived in or were currently living in unaffordable, unsuit-

What will happen to programs for people with disability when people with money and power no longer identify with the issue?

able or sub-standard housing. Women, especially women with children, reported particular difficulties in affording and getting into suitable housing. The majority had been struggling with housing issues for years and had been displaced multiple times. The women reported stress due to sub-standard and unsafe housing, and felt their health and the health of their children was affected by danger and difficulties in neighbourhoods, plumbing and heating problems, infestations of rodents and insects, and air-quality problems. Most of the women felt harassed, including sexually harassed or mistreated by their landlords, with inadequate processes to deal with this harassment.

The researchers found that women are considerably more likely than men to be in need of housing, particularly women living alone and female lone parents. For example, 64% of female-headed lone-parent families are in need of housing, compared to 36% of male-headed lone-parent families. A relationship was also found between gender and ethnicity, as Aboriginal women are more than twice as likely (35%) as non-Aboriginal women (15%) to be in need of housing.

Several areas for action were identified, including the need to address the shortage of adequate and affordable housing for women, particularly women raising young children, and to ensure basic health and safety regulations are followed in rental housing. Heating systems and insulation are particularly essential, so that women and children are not living without heat in winter. There is a need for housing policies and programs that recognize the particular challenges of women and children in the housing market. Training and resources to help women do simple home maintenance tasks are suggested, as well as a mechanism to mediate safety and harassment issues between landlords and female tenants.

The Ethical and Human Rights Implications of Prenatal Technologies: The Need for Federal Leadership and Regulation is available online at <http://www.pwhce.ca> or from PWHCE, 56 The Promenade, Winnipeg, MB R3B 3H9 Ph: (204) 982-6630, Fax: (204) 982-6637, E-mail: pwhce@uwinnipeg.ca **Left In The Cold: Women, Health and The Demise of Social Housing Policies is available online at <http://www.pwhce.ca/left-cold.htm> or from PWHCE.**

National Network on Environments and Women's Health

The Flood Of the Century: Stories Women Tell

The Red River flood of 1997 inundated large areas of agricultural and urban land in southern Manitoba, exacting considerable toll, not only in loss of property, but a variety of psychosocial losses as well. The effects of this flood will stay with those most affected for years to come.

In most studies of disasters, little attention is focussed specifically on women. Instead, women's experiences are subsumed in the analysis or are ignored altogether. Under circumstances of collective stress brought on by disasters, understanding women's roles is important because their actions will frame how and how well others adapt and adjust to dislocation and loss, and even how communities recover.

This study explored women's experiences in "The Flood of the Century," specifically the nature of women's work during the flood, the health and social impacts of the flood on a sample of women and their families, and contributes to our understanding of women's experiences of disasters.

Stories were gathered from women who experienced the flood in the Rural Municipality of Ritchot and Roseau First Nation located in Ritchot, an area just south of the city of Winnipeg hard hit by flood waters. Also interviews were conducted with women working for relief organizations active in the flood area.

Key findings of the study included major concerns and issues about flood information, resources and preparedness. Commonly cited concerns related to the accuracy and adequacy of flood information; the flood preparedness of the municipality; the coordination of the flood response; the coordination of flood relief; and the insensitivity of city, provincial and federal politicians. All of the women believed that the flood had been mismanaged at some level. Insufficient resources and poor coordination of resources were common complaints.

Many women indicated that in the future, they would defy any mandatory evacuation notices. Politicians, in particular, were held out for significant criticism. Virtually everyone was frustrated by the compensation process and the changing rules of entitlement. After three years, several women still had outstanding claims to be settled and many were living in houses that were only partially finished.

Women's work was found to be vital but invisible. Women reported working from early morning until late at night, for

weeks and months on end. They talked about the endless preparation of meals not only for families but for armies of volunteers. They described their frequent and frustrating searches for sand and sand bags.

Women were responsible for managing the stress and social psychological dimensions of the flood for their families. They were instrumental in facilitating a sense of community within their neighbourhoods. Women spent many hours negotiating and mediating with official agencies. They were responsible for putting lives back together, rebuilding a sense of home, and forging a sense of community.

Despite these key roles, the researchers reported that the women interviewed seemed puzzled that their experiences of the flood were of interest. This caring work that women told researchers about was essential, yet somehow invisible even to them.

Women spoke about effects of the 'The Flood of the Century' on their health, whether they had developed new health problems, and whether they had increased their use of medications. Almost all of the women indicated feeling worried, upset, sad, fearful, lonely or depressed. Tension was particularly acute, and almost all said they suffered from fatigue all the time. Three years after the flood, most of the women stated that their health had been compromised by the flood, and that other family members were experiencing health problems that they attributed to the flood.

It is clear that these women played a significant role in this flood—working to prepare for the flood, making decisions about living through the flood or working to recover from it. All of the women stated they had not realized how strong they were and that they had developed new skills and confidence because of the flood. They displayed enormous resilience in the face of disaster and committed themselves to recovery in every sense of the word.

Breast Cancer and Infertility

Beliefs, Attitudes and Behaviours Towards Breast Cancer and Infertility uses breast cancer and infertility as cases to study the role of quantitative and qualitative methods in women's health research. Women and men were surveyed to determine what they believed were leading causes of these diseases, and to find out what treatments they would choose if they or someone they loved were at risk. The study surveyed 750 men and women in Winnipeg, conducted focus groups in three other regions of the country, and included very diverse populations.

In the survey both men and women believed that having a mother diagnosed with breast cancer, genetic predisposition and environmental toxins were leading causes of breast cancer. 46% of those surveyed had ever used clinical breast exam, 44% regular BSE, 35% mammography and 17% alternative forms of healing. Less than 1% practiced exercise or change in diet as a breast cancer preventive.

Regarding infertility, both sexes believed that problems with sperm, sexually transmitted diseases, and hormonal imbalances were leading causes. Those in the survey who had tried any treatment for infertility clearly preferred low-tech supports such as alternative healing methods and ovulation charting and timed intercourse. No survey respondents had ever used assisted reproductive technologies, although many women in the focus groups had. Women were six times more likely than men to report being infertile or knowing someone who was, and women were more likely than men to list adoption as an option they would consider.

The study provides valuable direction to the development of policies and practices relating to breast cancer and infertility. The low use of BSE and clinical breast exams shows a need for improved breast health education. Gender differences in knowledge and attitude make the case for widespread interventions. The limited awareness of the ways sexually transmitted diseases contribute to infertility suggests a need for more education in this area, as does the reluctance to discuss infertility and confusion about its causes and treatments. The survey participants' emphasis on low-tech treatments suggests a mismatch between public practice and the high level of public policy supporting assisted reproductive technologies. Greater attention to improving alternative treatments and adoption may be warranted.

The Flood Of the Century: Stories Women Tell, by Dr. Karen Grant and Dr. Nancy Higgitt, was co-funded by the University of Manitoba's UM/SSHRC Research Grants Program. It is available online at www.yorku.ca/nnewh or can be ordered from the NNEWH, c/o Centre for Health Studies, York University, 4700 Keele Street, 214 York Lanes, Toronto ON M3J 1P3, Ph: (416)736-5941, Fax: (416)736-5986, email: nnewh@yorku.ca

Does Gender Count? Differences in English-Canadian beliefs, attitudes and behaviors towards breast cancer and infertility by Dr. Gina Feldberg, Lisa Strohschein, Dr. Karen R. Grant, and Dominika Wranik-Lobrenz is available online at <http://www.yorku.ca/nnewh/english/nnewhind.html>

Atlantic Centre of Excellence for Women's Health (ACEWH)

A Healthy Balance: A Community Alliance for Health Research on Women's Unpaid Caregiving

The Healthy Balance Research Program is a five-year program of research funded by the Canadian Institutes for Health Research investigating the relationships between women's health and well-being, family life, and earning a livelihood. The lead organizations are the Atlantic Centre of Excellence for Women's Health and the Nova Scotia Advisory Council on the Status of Women. More than 25 researchers from universities, the public policy domain, and health organizations work with other community and government partners that have provided various modes of support.

The central focus is to acquire a better understanding of the impact of unpaid caregiving on women's stress and health status in Nova Scotia—whether this caregiving work is done on its own or combined with paid work. How is caregiving organized? How does caregiving affect people's sense of empowerment in their lives and their health and well being? What is the relationship between social and economic factors, the interaction with paid work, and the relationship between caregiving and ethnicity, culture, location, age, and income?

The first step in the research was a background paper, *Thinking It Through: Women, Work and Caring in the New Millennium* by Pat Armstrong and Hugh Armstrong. Care work is women's work. Paid and unpaid, located at home, in voluntary organizations or in the labour force, the overwhelming majority of care is provided by women. It is often invisible, usually accorded little value and only sometimes recognized as skilled. *Thinking It Through* draws on both Canadian and international literatures to help understand the forces, structures and relationships that construct women as carers 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* (Pat Armstrong & Olga Kits, Ottawa: Law Commission, 2001). 

Thinking It Through: Women, Work and Caring in the New Millennium can be ordered from the Atlantic Centre of Excellence for Women's Health, PO Box 3070, Halifax, NS B3J 3G9.

Ph: 902-420-6739, Fax: 902-420-6752,

E-mail: acewh@dal.ca, or via www.medicine.dal.ca/acewh

Your Personal Health Series: Eating Disorders: Anorexia Nervosa, Bulimia, Binge Eating and Others

Jim Kirkpatrick and Paul Caldwell

This book is a comprehensive, A-Z guide for anyone who has, or knows someone with, and eating disorder. The authors offer expert advice on the causes, effects and treatment of anorexia nervosa, bulimia nervosa, binge-eating disorder and a host of less familiar eating disorders. 2001. \$19.95. English.

Published by: Key Porter Books
70 The Esplanade
Toronto, ON M5E 1R2
Tel: (416) 862-7777
Fax: (416) 862-2304
www.keyporter.com

Birth Right: New Approaches to Safe Motherhood

The Panos Institute

At least 525,000 women still die every year from complications relating to pregnancy, and most of these are in the developing world. This report outlines the reasons why women are suffering, and puts them firmly on the human rights agenda. It shows that effective strategies do exist to secure women's well-being, often within existing resources. It also stresses the importance of informed public, professional and political voices in creating that change. 2001. Free. English.

Available from: The Panos Institute
9 White Lion Street
London N1 9PD
United Kingdom
Tel: +44 (0)207 278 1111
Fax: +44 (0)207 278 0345
E-mail: panos@panoslondon.org.uk
Download:
www.panos.org.uk/briefing/birth_rights_files/birth_rights_cover.htm

Women Take Care: Gender, Race and the Culture of AIDS

Katie Hogan

Self-sacrificing mothers and forgiving

wives, caretaking lesbians, and vigilant maternal surrogates – these “good women” are all familiar figures in the visual and print culture relating to AIDS. The author describes how texts on AIDS reproduce this historically entrenched paradigm of sacrifice and care that reinforces biases about race and sexuality. While caretaking is a fundamental human obligation, the book demonstrates how it currently falls primarily to those members of society with the least power.

2001. \$39.95US (Cloth), \$15.95US (Paper). English
Published by: Cornell University Press
Sage House, 512 E. State Street
Ithaca, NY 14850
Tel: (607) 277-2211
Fax: (800) 688-2877
www.cornellpress.cornell.edu

Rebel, Rogue, Mischievous Babe : Stories About Being a Powerful Girl
Sharlene Azam

This book, written for and by girls and young women from across Canada, is a collection of personal stories that addresses the coming-of-age issues facing every girl and young woman. Topics include image, body, family, dating, sex & sexuality, boys, depression, drugs, drinking & smoking, friends, jobs, high school, bullying, violence & racism, and creativity & work.

2001. \$19.95. English
Published by: HarperCollinsCanadaLtd
55 Avenue Road, Suite 2900
Toronto, ON M5R 3L2
Tel: (416) 975-9334
Fax: (416) 975-5223
www.harpercanada.com

Migraine (Your Personal Health Series)
Valerie South

This revised edition provides much needed, relevant, and up-to-date information on the medical nature of migraines. The author examines the identification and avoidance of migraine triggers, steps for

self-management, the link between migraine and menstruation, and complementary therapies such as meditation, massage, acupuncture and yoga. 2001. \$19.95. English.

Published by: Key Porter Books
 (See first listing)

The Migraine Cookbook: More Than 100 Healthy and Delicious Recipes for Migraine Sufferers

Michele Sharp

Endorsed by The Migraine Association of Canada, this cookbook features more than 100 recipes that are specially created to help migraine sufferers eat well while avoiding the foods that can trigger migraine. It is designed to help learn more about which foods can trigger migraine, how to evaluate one's own triggers, and how to maintain a well-rounded and enjoyable diet while keeping the risk of migraine to a minimum. 2001. \$24.95. English.

Published by: Key Porter Books
 (See first listing)

Sudden Menopause: Restoring Health & Emotional Well-Being

Debbie DeAngelo

Menopause is a natural part of aging, but sometimes it comes too soon, precipitated by hysterectomy, chemotherapy, radiation, anorexia, premature ovarian failure and other conditions. This book is written for young women facing unanticipated menopause, and tackles topics of immediate concern, such as hot flashes and emotional and cognitive changes, as well as long-term health issues, including osteoporosis and heart disease. 2001. \$24.95 (Trade paperback). English.

Published by: Hunter House Inc.
PO Box 2914
Alameda, CA 94501-0914
Tel: (510) 865-5282
Fax: (510) 865-4295
E-mail: ordering@hunterhouse.com
www.hunterhouse.com

Manmade Breast Cancers

Zillah Eisenstein

In this book, Ms Eisenstein brings together a critique of environmental damage and the health of women's bodies, gains perspective on the role race plays as a factor in breast cancer and in political agendas, links prevention and treatment, and connects individual support and political change.

2001. \$17.95US (Paper). English.

Published by: Cornell University Press

(See *Women Take Care*)

Histoires de dire

Produced by Josianne Lapointe and Pauline Voisard. Behind a curtain of carefully selected images to maintain anonymity, this documentary presents women infected with HIV. They talk about the steps they took and the questions they had after discovering their disease and about the importance of talking about it.

Available at Vidéo-Femmes

291 Saint-Vallier Street East, suite 104

Quebec (QC) G1K 3P5

Tel: (418) 529-9188

Fax: (418) 529-4891

E-mail: info@videofemmes.org

<http://videofemmes.org/accueil/>

Power Camp: Model and Project Tool

Power Camp/Fille d'action

This engaging manual is designed to provide tools for either organizations or young women to create Power Camp programs, to provide young women with an opportunity to come together in a youth and female-centred environment, to address real issues in their lives, to raise awareness, skill build, develop critical thinking skills and together develop action-oriented strategies towards change. It takes into consideration that the process of adapting the model requires that it grows from the grass roots and responds to the needs of the community.

2001. Free. English

Available from: Power Camp

Tel : (514) 948-1112

E-mail: Power_camp@videotron.ca

Download: www.tgmag.ca/powercamp/manual.html

Of Note: Reports and Publications *written by Barbara Bourrier-LaCroix, CWHN Clearinghouse Coordinator.*

Unpaid Home Caregiving a Violation of Human Rights?

A single mother in Saskatchewan, who is caring for her chronically ill child at home, has launched a claim to the Saskatchewan Human Rights Commission, stating that the demands on her as an unpaid caregiver are well beyond those of motherhood, and are a violation of her human rights. The mother was providing highly specialized 24-hour-a-day care to her child, at least 387 hours a month, which she has calculated would cost the health care system over \$9000 a month if performed by paid caregivers. Advocates at the Universities of Saskatchewan and Regina are supporting this mother in advancing her claim. At first, the Human Rights Commission rejected the claim, determining there was "no probable cause". However, recently the Commission has withdrawn that determination and states it will continue to investigate the claim. The outcome of this case could have widespread implications for unpaid caregivers and the home health care system.

At Long Last...Federal Laws on Reproductive Technologies?

After a decade of reports, discussions and draft legislation, Canada is again in the midst of creating legislation to regulate assisted reproductive technologies and related research. The new Bill has been introduced in the House of Commons – www.hc-sc.gc.ca/english/protection/reproduction/index.htm.

It has been a long time coming- the original Royal Commission on Reproductive Technology was constituted in 1993; this is the third attempt at national legislation to regulate this medically, socially and morally critical field of health care.

In 2001, the draft of the new legislation was reviewed by the Standing Committee on Health, who heard dozens of briefs from range of groups. The proposed legislation addresses assisted human reproduction activities that might help some Canadians have children and the use of human embryos in research that might advance knowledge in various fields. The draft legislation covers activities that are prohibited in all circumstances, such as cloning of humans, and those that can only be carried out under controlled conditions, such as contract ('surrogate') pregnancies. The Health Committee released its own comments on this draft legislation. These can be found at <http://www.parl.gc.ca/InfoComDoc/37/1/HEAL/Studies/Reports/healrp01-e.htm>.

CWHN presented to the House Standing Committee on Health, outlining areas of the proposed legislation of particular concern to women. For a summary of CWHN recommendations see www.cwhn.ca/hot/policy/reproduction.html. Keep an eye on our website for commentary and updates on the legislation.

Update from the Working Group on Women and Health Protection (WHP) BY ANNE ROCHON FORD

The Working Group on Women and Health Protection was the brainchild of DES Action Canada and grew out of the National Network on Environments and Women's Health. It is now funded through the Centres of Excellence for Women's Health program of the Women's Health Bureau. One of the Working Group's main areas of concentration has been on fighting the move to direct-to-consumer advertising (DTCA) of prescription drugs, which has particular implications for women's health. With the recent release of a study by Barbara Mintzes and colleagues at UBC, (Influence of direct to consumer pharmaceutical advertising and patient' requests on prescribing decisions: two site cross-sectional survey. B Mintzes, ML Barer, RL Kravitz, A Kazanjian, K Bassett, J Lexchin, RG Evans, R Pan, SA Marion. *British Medical Journal* 2 February 2002, Vol. 324: 278 Available at: <http://bmj.com/cgi/content/full/324/7332/278>). The Group has continued to keep the issue alive in the media and will be submitting a brief to the Romanow Commission on the subject.

Watch for a booklet on the disturbing trend towards "chemoprevention" at the expense of better public health measures written by Sharon Batt for the WHP. (Chemoprevention in breast cancer management is the use of drugs to block the action of estrogen in the development of the disease.) This will be out in the summer along with a booklet on International Harmonization of pharmaceuticals and what this means for women's health, based on a discussion paper written by John Abraham.

Women and Health Protection has two other research projects on the go: one on where women go for drug information and what they find out there, written by Linda Levesque, and a second on Canada's Adverse Drug Reactions Reporting Program and how this can be harmful to women's health, written by Colleen Fuller. Both projects will yield discussion papers in late Spring. Also look for updates on our website, a hotlink from either the CWHN site or the DES Action site (www.whp-apsf.ca). For inquiries about Women and Health Protection activities or for copies of our existing publications, contact Anne Rochon Ford in Toronto at annerf@web.ca or Carla Marcelis in Montreal at carla@web.ca. Mailing address: Women and Health Protection, c/o DES Action Canada, 5890 Monkland Ave, Suite 203, Montreal, Quebec, H4A 1G2.

Publications (in English and French) of WHP that can be ordered from the DES Action office or by e-mail from the staff:

- 1) *How Safe Are Our Medicines: Monitoring the Risks of Drugs After They Are Approved for Marketing*
- 2) *Direct to Consumer Advertising of Prescription Drugs: When Public Health Is No Longer a Priority*
- 3) *Illegal Direct-To-Consumer Prescription Drug Advertising in Canada, 1999 To 2001: When Drug Companies Skirt the Law and the Government Refuses to Enforce, Who Pays?*
- 4) Working Group on Women and Health Protection, general information brochure.

Filipino Nurses Win Victory

Registered Nurses trapped under the Live-in Caregiver Program (LCP) can now apply to the BC Provincial Nominee Program (PNP) without jeopardizing their immigration status thanks to the work of the Filipino Nurses Support Group (FNSG).

Lobbying FNSG members were originally told by provincial government officials that Registered Nurses doing 24-hour domestic and home support work under the LCP were not allowed to apply to the PNP. "I was told that the government did not want to put one employer before another," explained RN Cielo Ebio. "But who do they need most after all, nannies or nurses?"

Nurses have also been told by Citizenship and Immigration Canada that if they leave the LCP to enter the PNP, they would imperil their chances of being granted landed immigrant status. But after further lobbying efforts, FSNG received word from CIC in January 2002 that Filipino and other foreign-trained nurses' right to apply to the PNP without jeopardizing their application for permanent residency was upheld.

For more information see FNSG at www.kalayaancentre.org and "Filipino Nurses in Canada," CWHN *Network* (Summer 2001) available from CWHN or at www.cwhn.ca/network-reseau/4-3/4-3pg7.html. See also Louise Langevin and Marie-Claire Belleau, *Trafficking in Women in Canada: A Critical Analysis of the Legal Framework Governing Immigrant Live-in Caregivers and Mail-Order Brides* (Status of Women Canada, October 2000) available at <http://www.swc-cfc.gc.ca/publish/research/020215-066231252X-e.html>.