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WOMEN'S HEALTH IN ATLANTIC CANADA
JANUARY, 2003 UPDATE

VOLUME 1: SOCIAL DETERMINANTS OF WOMEN'S HEALTH IN ATLANTIC CANADA

Prepared for the Atlantic Centre of Excellence for Women's Health
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EXECUTIVE SUMMARY

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1. Introduction & Background

1.1 The 2000 Women's Health in Atlantic Canada Report

In 1999, GPI *Atlantic* prepared its first statistical profile of women's health in Atlantic Canada for the Maritime Centre of Excellence of Women's Health. That 62-page report was released in February 2000, and published in edited form as chapter 1 of Amaratunga, Carol (ed.), *A Portrait of Women's Health in Atlantic Canada, Volume 1,* 2000, pages 9-41.[1] At that time, the most recently available data for most indicators were from 1996-97.

The 2000 profile did not pretend to provide a comprehensive overview of women's health in the four Atlantic provinces, but aimed to demonstrate, through illustrative examples, the utility of a health determinants approach to assessing the status of women's health in the region. The report noted the highly interactive nature of the determinants of health, the significant existing data limitations and gaps, the need for further research, and the necessity for particular strategic investments that could help improve women's health in Atlantic Canada.

The 2000 report outlined three key reasons for a gender-based analysis of health issues:
(1) *descriptive* – to identify particular health determinants, patterns, outcomes, interventions, and treatment needs that affect women's health differentially;
(2) *normative* – to enhance equity, and eliminate traditional biases that have impeded women's wellbeing;
(3) *practical* – to assist policy makers to identify effective actions to improve health, and to target scarce health care dollars more accurately to high risk groups.

Among key results in the 2000 report were:

- ***Stress and mental health***. Women were more time-stressed than men, partly due to women's double burden of paid and unpaid work. The report noted a sharp increase in time stress rates throughout Canada, with potentially adverse impacts on physical and mental health. Among the Atlantic provinces, Nova Scotian women had the highest rate of chronic stress. Newfoundland had the lowest stress rate in the country and the highest level of mental health.

- ***Income, equity and education*** are key health determinants. Despite relative educational parity, Atlantic Canadian women earned only 81% of the hourly wages of men in 1998, and had higher rates of low income than men. Among the Atlantic provinces, Nova Scotia and Newfoundland had the highest rates of female low income. PEI had the lowest rate of low income for both sexes and the smallest male-female wage gap. Single mothers and unattached elderly women had particularly high rates of low income, adversely affecting health. Social and income supports for single mothers were seen as a key investment priority.

[1] Both the book and the report are available from the Atlantic Centre of Excellence for Women's Health at: http://www.medicine.dal.ca/mcewh/.

- ***Lifestyle, screening, prevention.*** Women had lower rates of smoking and obesity than men, but Atlantic Canadian women had higher rates of smoking, obesity, and physical inactivity than other Canadian women. Atlantic region women had high rates of Pap smear testing, but were less likely than other Canadian women to have been tested recently. Newfoundland and Nova Scotia had the country's lowest rates of mammogram testing. All four Atlantic provinces had dramatically reduced teen pregnancy rates from the highest to the lowest in the country.

- ***Disease.*** The 2000 report noted high rates of cancer mortality in the four Atlantic provinces. Nova Scotian women had the country's highest rates of high blood pressure, 80% above the national average for women, and 43% above the next highest province, PEI.

- ***Social supports*** are a key buffer against stress and ill-health and aid recovery from illness. Atlantic Canadians had the highest levels of voluntary work in the country, when informal voluntary work is included, and strong networks of community and social support. The report noted the increasing burden on family caregivers, particularly women.

A gender-based analysis goes well beyond simple male-female statistical comparisons to an understanding of the differential social, structural, and power relations among men and women. To that end, the 2000 report focused particularly on the health impacts of differential work roles, including what Statistics Canada has called "gender-based labour market discrimination," and the unequal gender division of household labour that has produced higher rates of time stress for women.

1.2 Three Kinds of Update

As noted, the 2000 report on women's health in Atlantic Canada was far from comprehensive both in indicators selected and in the extent and depth of gender-based analysis that accompanied the statistical profile. Many key indicators were missing; there were significant data gaps; and we still have very limited knowledge of the pathways between health determinants and health outcomes. There are also far more dimensions to a gender-based analysis than were attempted in the 2000 report. In particular, that report noted that our understanding of the interactions among the different determinants of health and of the causal links between them remains largely conjectural.

For these reasons, this update attempts not simply to update some earlier statistics, but to take a small step towards remedying some earlier data and conceptual deficiencies. We may never achieve a comprehensive analysis or definitive understanding of women's health issues. But it is our hope that each new update of this statistical profile over time will add a few new pieces to the puzzle, so that our knowledge can gradually deepen, and so that action to improve women's health can become ever more effective. To this end, three kinds of update are attempted in this report:

1.2.1 Updating the Numbers

Some of the statistics available three years ago are now out of date. Even in this short period, there have been some dramatic shifts and changes of direction, some of which are clearly good news. For example, comprehensive tobacco control strategies instituted in the last few years including higher taxes, smoke-free places legislation, and graphic cigarette package warnings, are clearly having an effect, with sharp reductions in smoking rates. Even more remarkably, there are now far fewer single parent families living in poverty. On the other side of the ledger, the obesity epidemic continues to grow, with the Atlantic provinces still leading the way.

This report will therefore attempt to update some of the key statistics from the 2000 report, and to indicate trends since that time and their potential impact on women's health. In order to focus on the new indicators described below, we shall not repeat the descriptive and explanatory analysis contained in the 2000 report. Instead the simple statistical updates and trends will be presented with minimal commentary here, and the reader is referred to the earlier report for more detail. For example, the analytical material on women's double work burden, and on the health impacts of poverty, inequality, and long work hours will not be repeated here.

Statistical updates on health status, health behaviours and lifestyle determinants, and disease rates are drawn primarily from the 1998/99 National Population Health Survey (NPHS), and the 2000/01 Canadian Community Health Survey, as well as from more specialized sources like Canadian Cancer Statistics 2002. These results have become available since the 2000 report, which was based largely on NPHS 1994/95 and 1996/97, was prepared. Income and employment updates are drawn primarily from Statistics Canada's 2001 *Labour Force Historical Review,* released in February, 2002, and from Statistics Canada's recent *Income in Canada* report, released in November, 2002.[2] Updates on voluntary work, an important indicator of social supports, are from the 2000 National Survey on Giving, Volunteering and Participating, released in August, 2001.[3]

1.2.2 New Data Sources and Indicators

A number of important new data sources have become available in the intervening three years since the 2000 statistical profile was published. This allows the addition of new indicators, analyses, and subject areas not covered in the earlier report. Again, there is no pretence that this additional information provides a comprehensive portrait of women's health, but it does allow a modest expansion of the earlier material. The following new sources and indicators have been selected for inclusion and emphasis in this report:

- ***Intra-provincial analysis***. We have long suspected that provincial averages mask deep differences in health status within each of the four Atlantic provinces. We have known for example that Cape Bretoners have higher smoking and cancer rates and shorter life

[2] Statistics Canada, *Labour Force Historical Review,* catalogue no. 71F0004XCB, February, 2002; Statistics Canada, *Income in Canada,* catalogue no. 75-202-XIE, November, 2002.
[3] Statistics Canada, *Caring Canadians, Involved Canadians: Highlights from the 2000 National Survey of Giving, Volunteering and Participating,* catalogue no. 71-542-XIE, Ottawa, August, 2001.

expectancies than residents of Halifax. But information has been sparse, scattered, and episodic, and no systematic analysis of regional differences has been possible. This deficiency has also hampered an effective gender-based analysis, which must account for diversity and differences among sub-groups of women.

The 2000/01 Canadian Community Health Survey (CCHS), with a total sample of 130,000 respondents throughout Canada, is the first systematic national effort to collect data at the health region level. It provides detailed first-time information for 139 health districts in Canada, including 6 in Nova Scotia, 7 in New Brunswick, 2 in PEI, and 6 in Newfoundland and Labrador. Socio-demographic data on the percentages of Aboriginals, immigrants, and visible minorities within each health district, and on health determinants like employment, income, housing, education and a wide range of other socio-economic characteristics, will provide vital information to researchers and policy makers concerned to target health interventions effectively.

Because of the importance of this new data source released in 2002, the main focus of this report is a gender breakdown of CCHS results by health district for the four Atlantic provinces, comparing results with both provincial and Canadian averages. This is hopefully a first step towards more detailed future gender-based analyses that account for the diversity among Atlantic Canadian women.

- ***Financial Security.*** It has long been accepted that income and employment are key determinants of health. But these characteristics provide only a partial indicator of financial security. In the case of prolonged illness, disability, job layoff, death of spouse or partner, or other crisis, a family may depend largely on its own financial resources to weather the storm and to provide needed care. Substantial cuts to social programs in the 1990s, including a 50% cut in the proportion of unemployed workers eligible for unemployment benefits, have made household financial security and health even more dependent on personal assets than a decade ago. Until recently, no current information was available to assess this vital aspect of security, and it is therefore absent from the 2000 women's health report.

  In 1999, Statistics Canada conducted a Survey of Financial Security (SFS) – the first such assessment of the debts, assets, wealth, and net worth of Canadians since 1984. An overview of results became available in 2001, but very limited regional or provincial information was publicly available until December, 2002, except in highly aggregated form.[4] The Canadian Centre for Policy Alternatives has now released specially commissioned regional data runs from the SFS that for the first time reveal the wealth gaps within Atlantic Canada by family characteristics, and allow an assessment of the financial status of different family types including female lone-parent families.[5]

  In addition to updating data from the 2000 report on employment, low-income rates, and gender-based wage gaps, this report therefore also incorporates important new information

[4] Statistics Canada, *The assets and debts of Canadians: an overview of the results of the Survey of Financial Security*, catalogue no. 13-595-XIE, Ottawa, March 15, 2001.
[5] Kerstetter, Steve, *Rags and Riches: Wealth Inequality in Canada,* Canadian Centre for Policy Alternatives, Ottawa and Vancouver, December, 2002, particularly Appendices A-D.

on financial security from the SFS. This will expand our understanding of the socio-economic determinants of women's health in Atlantic Canada.

- ***Family Violence.*** Although the serious health costs of family violence have long been understood, this important dimension of women's health was not included in the 2000 statistical profile. Since that report was published, new information from Statistics Canada's 1999 General Social Survey on Victimization has been released by the Canadian Centre for Justice Statistics (CCJS) in three separate statistical profiles of family violence in Canada (July 2000, June 2001, and June 2002).[6] Although very limited regional and provincial data are available in these publications, the Canadian data point to the importance of including an indicator on spousal violence in assessments of women's health in Atlantic Canada.

  To supplement information from the victimization survey, 2001 Atlantic regional data from the Uniform Crime Reporting Survey (UCR), released in July 2002, are referenced for information on police-reported sexual assaults.[7] Those data are compared with historical trends compiled from the UCR by Joan Campbell for Health Canada's Health Promotion and Programs Branch, Atlantic Regional Office.[8] Although police-reported incidents of sexual assault likely represent only 10% of cases, they are probably the most serious ones, and can be combined with the more complete data from the 1999 victimization survey to indicate the dimensions of violence against women and its potential impact on women's health.

- ***Mental Health.*** The 2000 statistical profile of women's health in Atlantic Canada included some data on stress and psychological wellbeing from the 1994/95 National Population Health Survey. Some of this information will be updated using results from the 2000/01 Canadian Community Health Survey, which also contains new information on rates of depression both by province and by health district. These data will also be supplemented in this report with important new information contained in Health Canada's recently released *Report on Mental Illnesses in Canada* (October, 2002).[9] While that report does not contain provincial or regional data, it does provide gender breakdowns by type of mental illness, as well as hospitalization rates for men and women, based on the Hospital Morbidity File of the Canadian Institute for Health Information.

  Despite this new information, however, there is still very little evidence on the incidence and prevalence of most mental illnesses in Canada; their association with socio-economic status, education, ethnicity and other variables; their impacts on physical health and wellbeing; associated risk and protective factors; and access to mental health services.[10] Fortunately, Cycle 1.2 of the Canadian Community Health Survey, specifically on mental health and wellbeing, has just been administered to 30,000 Canadians (May-November, 2002), and results will be released by Statistics Canada at the end of summer, 2003. This survey will

[6] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile,* catalogue no. 85-224-XIE, July 2000 (59pp), June 2001 (50pp), and June 2002 (49pp).
[7] Savoie, Josée, "Crime Statistics in Canada 2001," *Juristat* volume 22, no. 6, Statistics Canada, Canadian Centre for Justice Statistics, catalogue no. 85-002, particularly Table 3, page 16.
[8] Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Promotion and Programs Branch, Atlantic Regional Office, Health Canada, April, 1999.
[9] Health Canada, *A Report on Mental Illnesses in Canada,* Ottawa, October, 2002.
[10] Idem.

therefore soon provide detailed first-time provincial and regional information on the mental health of Canadians that will allow far more comprehensive updates on the mental health of Atlantic Canadian women than have hitherto been possible.

- ***Access to health care services*** is recognized by Health Canada as one of the key determinants of population health. Until this time, however, there has been very limited information available on potential barriers to health service access, and this indicator was therefore not included in the 2000 statistical profile of women's health in Atlantic Canada. Again, a new source has recently become available that allows the addition of this indicator to the current update. In 2001, Statistics Canada conducted its first Health Services Access Survey, and released those results in June 2002. By joining those results with patient satisfaction data from the 2000/01 CCHS, we find that Atlantic Canadians often have a harder time than other Canadians getting health care services, but are more satisfied with them when they do.[11]

- ***Other New Sources.*** This update also draws on other sources released since GPI *Atlantic*'s 2000 statistical profile of women's health in Atlantic Canada. These include the following:
  - Statistics Canada's *Women in Canada 2000,* released in September, 2000, updates and expands data from its 1995 report. In particular, we have drawn from the "Work Chapter Updates" to *Women in Canada 2000,* released in April, 2002.
  - Statistics Canada's 2001 Annual Report, "How Healthy are Canadians," published in the April 2001 issue of *Health Reports* (volume 12, number 3), focussed specifically on differences in health between men and women. This report is based primarily on data from Statistics Canada's 1998/99 National Population Health Survey, which were not yet available when GPI *Atlantic*'s 2000 report was prepared. As noted above, data from the 2000/01 Canadian Community Health Survey are also now available.
  - The Romanow Commission report was released in November, 2002, and is referenced in this report particularly in the section on access to health care services in Atlantic Canada.

It is not possible to survey all major indicators of women's health in Atlantic Canada. So the major focus in this report will be on the first of these new data sources – a gender breakdown for the 21 Atlantic Canadian health regions from the 2000/01 Canadian Community Health Survey. New sections and indicators have also been added on financial security, family violence, mental health, and access to health services to take advantage of the other new data sources and information noted above that have become available since the 2000 report. It is hoped that successive updates of this report will continue to add new indicators, to expand the analysis, and thereby to gain an ever-deeper understanding of the interaction among the determinants of women's health in Atlantic Canada.

1.2.3 Analytical Tools

The most challenging part of any update is not only to refresh numbers, add new indicators, and incorporate material from new sources, as described above. It is to improve analytical tools,

[11] Statistics Canada, *Access to Health Care Services in Canada 2001,* catalogue no. 82-575-XIE, June, 2002, and Statistics Canada, *CANSIM II* database.

clarify pathways between health determinants and health outcomes, and thus deepen understanding of women's health issues. The authors make no claim to have achieved this goal, but they can at least point to some of the directions that are desirable. In particular, the following appear to be increasingly salient conceptual issues in the analysis of women's health indicators:

- ***Gender-based analysis and diversity.*** As noted above, it is now understood that gender-based analysis must go beyond a mere listing of male-female differences in health determinants, health status, and health service utilization. Rather, understanding must be grounded in analysis of gender roles, social-cultural contexts, power and economic relationships, structural and systemic biases, and diversity (including the particular circumstances of Aboriginal, immigrant, visible minority, and disabled women). While this report does not undertake this task beyond merely pointing to a few key issues, it is hoped that the descriptive data presented here will facilitate such analysis by other researchers.

  A modest step towards a "diversity" approach is taken here with the presentation of sub-provincial health district data that recognize distinct differences among sub-groups of women in each province. While falling far short of a full diversity analysis, as described above, this report at least overcomes the tendency of the 2000 statistical profile to assume that the women of each Atlantic province form a cohesive whole. Hopefully, future analyses will shed more light on the particular health determinants, outcomes, and service needs of women with disabilities, Aboriginal women in Labrador, Black women in Halifax, immigrant women, and other sub-groups.

- ***Social exclusion/inclusion.*** The 2000 statistical profile of women's health in Atlantic Canada pointed to socio-economic determinants of health such as education, income, equity, and employment, and it provided some statistical information on these variables. But it treated them largely as stand-alone economic and social indicators. In the last three years, the Atlantic Centre of Excellence for Women's Health and other agencies and research institutions have done some ground-breaking work on "social exclusion" and "inclusion" that goes beyond such single-factor analysis.[12]

  This new research recognizes that social and economic disadvantages tend to be clustered to create a negative feedback loop. Rather than speculate on linear cause-effect relationships, social exclusion theorists posit that illiteracy, low income, unemployment and underemployment, disabilities, racial minority status, the difficulties of single parenthood, and other factors reinforce each other. Together, these disadvantages create a psycho-social syndrome that undermines self-esteem and excludes particular groups from society in a wide range of ways.

  This analysis may have advantages over earlier, narrower, more uni-dimensional inquiries, in pointing to systemic and mutually reinforcing biases that may adversely affect health and produce high social costs. It can also assist policy makers in targeting interventions where needs are greatest, thus enhancing the cost effectiveness of scarce resource allocations. The

[12] See for example Amaratunga, Carol (ed.), *Inclusion: Will our Social and Economic Strategies Take Us There?* Volume 2 of *Women's Health in Atlantic Canada Trilogy,* Atlantic Centre of Excellence for Women's Health, Halifax, 2000.

analysis may potentially be counter-productive if it justifies inaction on any one of the clustered disadvantages. From a policy perspective, it is essential to recognize that a single intervention like job creation may break the cycle of disadvantage and foster a wider sense of inclusion.

While this report does not systematically undertake the kind of analysis described here, the perspective of social exclusion and inclusion can help the reader view the indicators and statistics that follow as interconnected and potentially mutually reinforcing. For example, Cape Breton has some of Canada's highest rates of unemployment, long-term unemployment, out-migration, and dependence on government transfers, as well as low average income. Cape Bretoners spend more years living with disabilities than residents of any other health district in Canada.[13] From the perspective of social exclusion/inclusion analysis, it may be understandable that Cape Bretoners have depression rates 40% in excess of the national average and frequently feel "excluded," neglected, and alienated from policies emanating from Halifax and Ottawa.

One caveat must be added here. Despite the potential strengths of recent analyses based on social exclusion and inclusion, there is a subtle danger that the goal of "inclusion" may be translated into a questionable normative value. There is no problem reducing exclusion and alienation, and thus enhancing health prospects. But if the definition of "inclusion" is materialistic and becomes defined by high levels of income and consumption, then we may be encouraging a lifestyle that over-consumes scarce resources and *ipso facto* "excludes" future generations from the advantages enjoyed by the present generation. Thus the language of exclusion and inclusion may divert attention from the potential to enhance equity not only by increasing the prosperity of those currently excluded from systemic advantage but also by reducing the over-consumption of the advantaged. While it overcomes the deficiencies of uni-dimensional indicators like income, the language of exclusion and inclusion may create a subtle uni-directionality of its own. The analysis can be highly useful if used with caution.

- ***Interactive nature of health determinants.*** The 2000 statistical profile noted the highly interactive nature of the determinants of women's health and gave some concrete examples from among the indicators presented in that report. For example, stress has adverse physical outcomes for both men and women, but may have particular origins in women's social-structural roles. Stress can be occasioned both by the financial pressures of pay inequity and single parenthood, and by the double burden of paid and unpaid work, which in turn may lead to time stress and unhealthy lifestyle behaviours. In this case, a wide range of health determinants, including employment, income, gender, lifestyle, marital status, and stress may interact to produce physical health problems. The authors therefore again caution that the following indicators should not be seen in isolation, but as highly dynamic, interactive, and suggestive of needed research into the pathways between the key health determinants and health and disease outcomes.

- ***Policy.*** Finally, the purpose of all research is to provide benefit to society and individuals. Any "update" must therefore seek to shed light on the potential policies and actions that flow

[13] Shields, Margot, and Stephane Tremblay, "The Health of Canada's Communities," Supplement to *Health Reports,* Statistics Canada, catalogue no. 82-003.

naturally from the data presented. This may take the form of building on success, such as reinforcing and strengthening comprehensive tobacco control strategies that have reduced smoking rates. Or it may identify gaps and weaknesses suggestive of particular remedies. For example, the data that follow identify particular health districts in the Atlantic provinces that have low rates of Pap smear testing and mammogram screening. Unnecessary deaths from cervical and breast cancer may be avoided by a combination of mobile clinic visits and education.

Beyond such specific health interventions, this report also adds a short concluding chapter on three macro-policy social interventions that together may improve women's health in Atlantic Canada on a societal basis. That chapter draws on data from both the 2000 report and this 2003 update to identify practical best practices that may address some of the deeper underlying determinants of women's health.

In sum, an "update" must go beyond simply refreshing numbers and adding new statistics, and must acknowledge both conceptual advances in the field and practical policy implications that flow from the data. This 2003 update of the original statistical profile of women's health in Atlantic Canada expresses the aspiration to provide an update in this larger sense. Hopefully each succeeding update will take another modest step towards greater comprehensiveness and understanding.

2. Income, Equity, and Health

The 2000 statistical profile of women's health in Atlantic Canada noted that poverty is one of the most reliable predictors of poor health; that low income Canadians have poorer health status and die earlier; and that low-income women have far higher hospitalization rates than higher income women. That report noted that single mothers have poorer health outcomes than married women and that low-income children have higher rates of ill-health, injuries, and developmental problems.[14]

Since that time, new evidence has become available that confirms the connections between poverty, illness, and premature death. A September, 2002, Statistics Canada analysis of urban neighbourhoods, for example, confirms that the poorer the neighbourhood, the shorter the life expectancy of its residents at birth. For both men and women in all years, the poorest neighbourhood income group was particularly disadvantaged.[15]

A November, 2001, York University study found poor Canadians at higher risk of heart disease. The study attributed 6,366 Canadian heart disease deaths a year to poverty, and nearly $4 billion a year in health care costs to poverty-related heart disease.[16] Extrapolating from these figures, it can be estimated that if all Nova Scotians were as heart-healthy as the richest Nova Scotians, the province could avoid 200 deaths and $124 million a year in costs due to heart disease. These findings confirm studies conducted in other countries. For example, a Norwegian study found that coronary heart disease risk was 2.5 times higher among those in the lowest income and education class than in the highest.[17]

Cardiovascular diseases are highly correlated with behavioural risk factors, and so it is not surprising to find that poverty and unemployment are also associated with adverse lifestyle factors, including higher tobacco use, higher rates of obesity, poorer nutrition, and less physical exercise. Those in the lowest income bracket are two and a half times more likely to smoke than those in the highest income bracket. Wealthier individuals have a lower incidence of high blood pressure and high blood cholesterol, and they live longer. A study in Alameda County, California, found that those living in poor neighbourhoods had a 50% higher rate of hypertension than those living in affluent neighbourhoods, after controlling for age, race, risk factors, access to

[14] Colman, Ronald (2000), *Women's Health in Atlantic Canada: A Statistical Profile,* Atlantic Centre of Excellence for Women's Health, Halifax, February, 2000, pages 15-24.
[15] Wilkins, Russell, Jean-Marie Berthelot, and Edward Ng, "Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996," *Supplement to Health Reports,* volume 13, September, 2002, Statistics Canada, catalogue no. 82-003.
[16] Raphael, Dennis, *Inequality is Bad for our Hearts,* York University, 2001. An expanded version of this report, titled "Social Justice is Good for Our Hearts: Why Societal Factors – Not Lifestyles – Are Major Causes of Heart Disease in Canada and Elsewhere" can now be read and downloaded from http://www.socialjustice.org/ ; and see "Having Healthy Heart is Often a Question of Income," *The Toronto Star,* 9 November, 2001, page F02.
[17] Kabat-Zinn, Joh, "Psychosocial Factors: Their Importance and Management," in Ockene, Ira, and Judith Ockene, *Prevention of Coronary Heart Disease,* Little, Brown, and Company, Boston, 1992, page 304.

medical care, social interaction, and range of other variables.[18] In all these cases, there is a clear gradient by social class.[19]

Across North America, improvements in lifestyle behaviours (eating, drinking, smoking, and exercise patterns), and consequent declines in heart disease incidence and mortality, have occurred at a much lower rate among the less educated, less affluent, strata than among higher socio-economic groups.[20]

A 1997 survey conducted by the Ottawa-based National Institute of Nutrition concluded that limited income constitutes a major barrier to adequate nutrition: "20% of households with incomes under $25,000 believe their household does not have enough money for a healthy diet, up from 14% in 1994."[21] In the U.S., a 1998 Department of Agriculture study found nearly one-fifth of American children are "food insecure," – either hungry, on the edge of hunger, or worried about being hungry.[22] And in the U.K., an 18-month inquiry in the mid-1990s blamed mounting poverty for a rise in malnutrition on a scale unseen since the 1930s.[23] The problem is clearly not a shortage of food – in Canada, estimates suggest that 20% of the food supply is wasted.[24]

The health costs of poverty translate into economic costs through increased use of health services. One Nova Scotia study found a clear and substantial inverse association between socio-economic status (measured by education and income) and use of physician services. In fact, a clear gradient was found in both measures: the lower the status, the more services used. Those with no high school diploma use 49% more physician services than do those with a B.A., and those with a high school diploma use 12% more. Lower income groups use 43% more services than upper income groups, and lower-middle income groups use 33% more.[25]

Since socio-economic status is modifiable, the excess use of health care services by low income groups is as avoidable as that incurred through unhealthy lifestyles. Improving the status of lower socioeconomic groups and closing the income gap between rich and poor can therefore lead to improved health outcomes and substantial cost savings to the health care system.

Dr. George Kephart and his colleagues at Dalhousie University calculated that excess use of physician services associated with educational inequality in Nova Scotia amounts to 17.4% of

[18] Kabat-Zinn, Joh, "Psychosocial Factors: Their Importance and Management," in Ockene, Ira, and Judith Ockene, *Prevention of Coronary Heart Disease,* Little, Brown, and Company, Boston, 1992, page 304.
[19] Health Canada, *Toward a Healthy Future,* page 119, and Exhibit 5.7; Health Canada, *Statistical Report on the Health of Canadians,* Ottawa, September, 1999, page 267; Chernomas, op. cit., page 9.
[20] Stamler, Jeremiah and Rose, preface to Ockene, Ira, and Judith Ockene, *Prevention of Coronary Heart Disease,* Little, Brown and Company, Boston, 1992, page xiv.
[21] National Institute of Nutrition, "Tracking Nutrition Trends 1989 - 1994 – 1997," 10 November, 1997, available at: http://www.nin.ca/Media/Archives/newsnov10_97.html.
[22] Gardner, Gary, and Brian Halweil, "Nourishing the Underfed and Overfed," chapter 4 in Worldwatch Institute, *State of the World 2000,* W.W. Norton and Company, New York, 2000, page 62.
[23] "Poverty is Blamed for Diet Crisis," *Guardian,* 28 January, 1996, cited in Province of British Columbia (1996), page 11.
[24] Norman, Diane, "Access to Food for the Elderly," *Rapport* 6 (1): 4-5, January, 1991.
[25] Kephart, George, Vince Salazar Thomas, and David MacLean, "Socioeconomic Differences in the Use of Physician Services in Nova Scotia," *American Journal of Public Health,* 88 (5): 800-803, May, 1998.

total expenditures, or $42.2 million per year out of a total of $242.4 million. Excess use associated with income inequality is estimated at 11.3%, or $27.5 million annually.[26] These are the amounts that would be saved in avoided physician services if all Nova Scotians were as healthy as those with university degrees and higher incomes.

Yet these savings represent just a fraction of the total savings that would accrue to the health care system from improving the socio-economic and health status of low income, poorly educated Nova Scotians. Physician costs amount to just 22% of hospital costs in Nova Scotia, and 9% of total direct health care expenditures in the province.[27] If all health care expenditures are considered, it is clear that very substantial savings would accrue by narrowing the current socio-economic gap and by reducing income and educational inequality in Atlantic Canada. In health care – as in justice – poverty and poor education are clearly costly.

2.1 Costs of Social Exclusion and Vulnerability

The evidence clearly indicates that lower socio-economic groups suffer from a cluster of disadvantages that reinforce each other and prevent full participation in the larger society. As noted in the introduction, the concept of exclusion goes beyond conventional measures of poverty and low income, and incorporates lack of education, poor health and nutrition, lack of decent housing, higher rates and longer duration of unemployment, political powerlessness, and more frequent contact with the law. It also includes psychological dimensions such as vulnerability, fear, voicelessness, and a pervasive sense that one is not a valued and respected member of the community. Certain groups are particularly vulnerable to exclusion. These include single mothers and their children, youth, aboriginal people, racial and cultural minorities, the disabled, the unemployed, and the homeless.[28]

The various dimensions of social exclusion are closely related to adverse health outcomes. Aboriginal people have far higher rates of chronic disease than other Canadians; unemployment is linked to stress and poor health; single mothers and youth suffer higher rates of mental distress and depression; and poor education is linked to a range of risk behaviours, including smoking, obesity, poor nutrition, and lack of physical activity. For example, those with less than a high school education are 64% more likely to be overweight than those with a university degree.[29]

The York University study cited above found three groups of Canadians at particularly high risk for poverty and increased heart disease – women (particularly the elderly and single parents), new immigrants, and members of visible minorities. Visible minorities "experience a persistent income gap, above average levels of living on low income, higher levels of unemployment and underemployment, and under-representation in higher paid jobs."[30] More than twice as many

[26] Ibid., page 802.
[27] Health Canada, *Economic Burden of Illness in Canada 1998,* Ottawa, 2002.
[28] "Social Inclusion," *Health Promotion Atlantic,* 7 (1), Spring,. 2001, pages 10-12.
[29] Health Canada, *Statistical Report on the Health of Canadians,* page 267.
[30] Raphael, Dennis, *Inequality is Bad for our Hearts,* York University, 2001. An expanded version of this report, titled "Social Justice is Good for Our Hearts: Why Societal Factors – Not Lifestyles – Are Major Causes of Heart Disease in Canada and Elsewhere" can now be read and downloaded from http://www.socialjustice.org/ ; and see "Having Healthy Heart is Often a Question of Income," *The Toronto Star,* 9 November, 2001, page F02.

elderly Canadian women (one in four) live below the low-income cut-off (LICO) line as elderly men, as do 21% of unattached elderly women, and 38% of children in families headed by single mothers.[31]

For these and other groups, clusters of variables contribute to social exclusion and powerlessness, with low income just the most material and measurable manifestation of a wider range of disadvantages. For example, a detailed Statistics Canada study on the gender wage gap found that women earn substantially less than men even when they have identical work experience, education, and job tenure, and when they perform the same job duties in the same occupations and industries for the same weekly hours. The study found that about 50% of the gender wage gap could not be explained by any of 14 different factors, and could therefore be seen as "gender based labour market discrimination."[32] In short, there is an element of gender-based "social exclusion" that underlies and goes beyond income issues.

The concept of "vulnerability" is even broader than that of social exclusion. One analysis includes the following examples of vulnerability: low income; food insecurity; lack of family, friends, and social support systems; illiteracy and poor education; inadequate or insecure housing; migrant status and language difficulties; working or living in dangerous, isolated, or stressful places; being born with a chronic disease or disability; lack of health knowledge; inability to cope with problems; difficult childhood or birth; lack of access to health services. Many of these vulnerabilities are experienced as a lack of control over one's life.[33]

Most aspects of vulnerability and social exclusion are modifiable, or can at least be attenuated through social policy. According to the analysis cited above:

> *"Preventing and reducing vulnerability is as important as dealing with the effects of vulnerability…. Dealing with the causes of vulnerability is less costly than dealing with the serious effects of vulnerability. Reduced vulnerability has long-term economic and social gains."*[34]

In sum, there is a tendency in an analysis such as this to examine various indicators of women's health as if they stood alone. The concept of exclusion warns against this, and recognizes the need for a comprehensive and holistic health promotion strategy that acknowledges the full range of socio-economic and cultural determinants of health and the synergistic interaction between them. The good news in this approach is that reducing disadvantage and exclusion in even one area may produce positive spin-off benefits across a wide range of linked dimensions.

[31] Statistics Canada, *Income in Canada,* catalogue no. 75-202-XIE, Ottawa, November, 2002, Table 8.1, page 93.
[32] Drolet, Marie, "The Persistent Gap: New Evidence on the Canadian Wage Gap," Income Statistics Division, Statistics Canada, December, 1999, catalogue no. 75F0002MIE-99008, page 13, and table 3.
[33] Alberta Association of Registered Nurses, *Position Paper on Vulnerability,* Edmonton, September, 1998, page 1, available by contacting aarn@nurses.ab.ca.
[34] Ibid., page 2.

2.2 Trends in Gender Wage Gap and Low Income Rates

Despite the importance of linking the different aspects of exclusion in analytical work, most quantitative data are still available according to the conventional categories of income, employment, education, and so on. Accepted composite quantitative indicators of exclusion are not yet available. Since income and employment are closely related to health outcomes in their own right, this update therefore provides those data separately in order to update the 2000 report, while recognizing their conceptual links to other aspects of social exclusion.

GPI Atlantic's 2000 statistical profile of women's health in Atlantic Canada noted that the persistent male-female wage gap, and higher rates of low-income among women, posed health risks for women in general, and low income women in particular. Single mothers and unattached elderly women are especially vulnerable to adverse health outcomes, due to their higher rates of low income.

At that time the most recent available data were 1998 wage gap data, and 1997 low income data. The 1998 wage gap data showed Atlantic Canadian women earning about 81 cents an hour for every one dollar earned by men. The low income data showed more than one in five Nova Scotia and Newfoundland women living below the low-income cut-off line. In Nova Scotia, the female low-income rate was 36% higher than the male rate, the widest gap in the country. Poverty rates among children in single mother families were 72% in Newfoundland, 71% in Nova Scotia, and 59% in New Brunswick. Prince Edward Island showed both the smallest male-female wage gap in the country and the lowest rates of low income in the country for both sexes and for children.

New data are now available for the 2001 gender wage gap, and for 2000 low-income rates, allowing an assessment of trends in the last three years. The news here is both good and bad. Across the country, and in Atlantic Canada, low-income rates have dropped sharply, particularly for single parents and their children. On the other hand, there has been no progress in narrowing the gender wage gap, which has actually widened slightly in the Atlantic region.

2.2.1 Gender wage gap remains wide

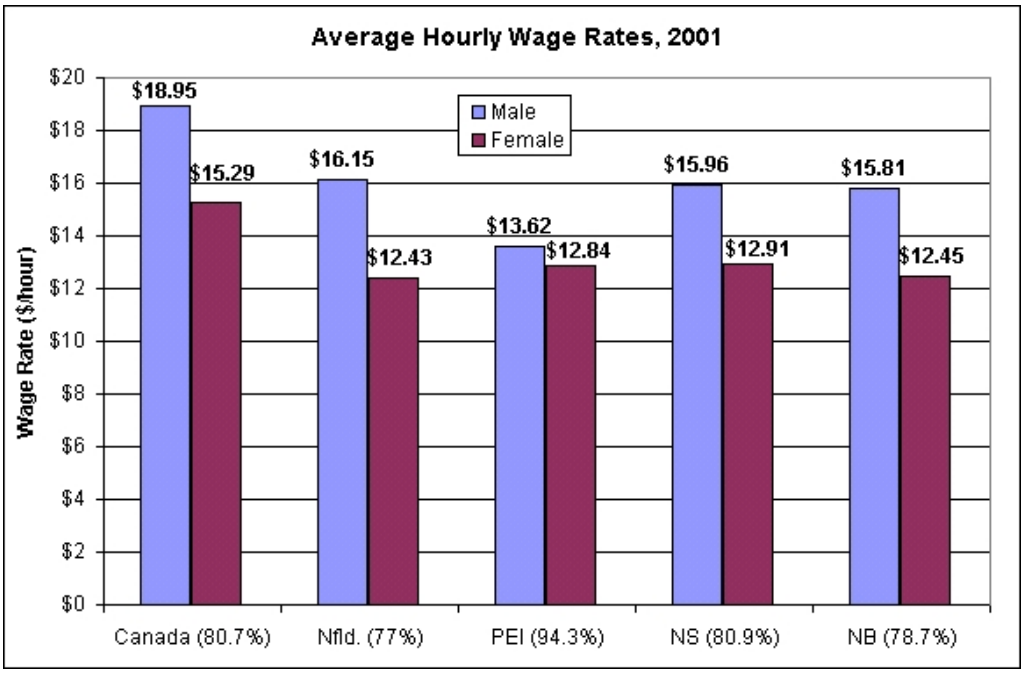
In 2001, Atlantic Canadian women were earning less than 80 cents an hour on average for every dollar earned by men, down from 81 cents an hour in 1997. Wage inequality grew most in Newfoundland and New Brunswick where women earned 77 cents and 78.7 cents an hour for every dollar earned by men, down from 78.8 cents and 81.3 cents in 1997 (Table 1, Figure 1).[35]

Table 1. Change in average hourly wage gap: 1998–2001 (ratio of female to male hourly wages)

	Canada	Newfoundland	PEI	Nova Scotia	New Brunswick
1998	81.3%	78.8%	93.5%	80.4%	81.3%
2001	80.7%	77.0%	94.3%	80.9%	78.7%

[35] Statistics Canada, *Labour Force Historical Review,* catalogue no. 71F0004XCB, February, 2002.

Figure 1. Average hourly wage rates, Canada and Atlantic provinces, 2001, ($), and female hourly wages as percent of male hourly wages.



Source: Statistics Canada, Labour Force Historical Review 2002.

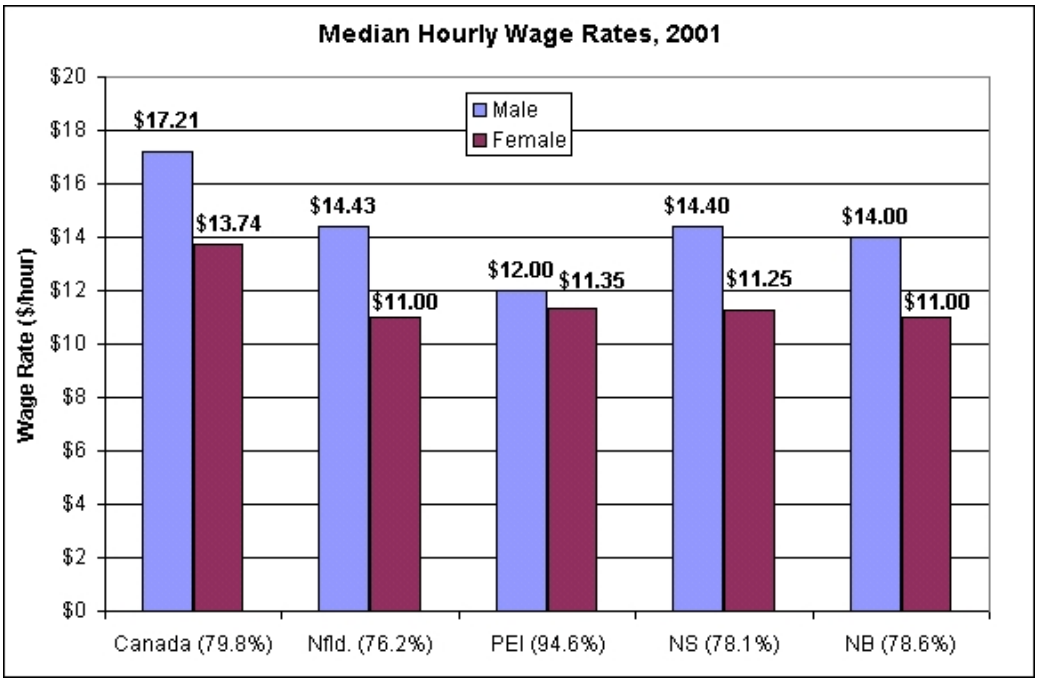
When *median* rather than *average* wages are examined, the hourly wage gap is even larger, especially in Nova Scotia, indicating that inequity among women is greater than inequity among men (Figure 2). [The *median* wage is the representative wage of a group, calculated as the middle value, where 50% of earners receive more and 50% receive less. The *average* wage is always higher than the median wage because it is skewed upwards by the higher earnings of the rich.]

Just as in 1998, Prince Edward Island in 2001 remains the commendable exception, with the smallest gender wage gap in the country. In 1998, PEI women earned 93.5 cents an hour for every dollar earned by men. In 2001, the gap narrowed further and they earned 94.3 cents an hour for every dollar earned by men. In every province except for PEI, the gap in median wages accentuated the gender wage gap, but in PEI the median hourly wage was 94.6% of the male hourly wage.

As noted earlier, Statistics Canada has determined that more than 50% of this wage gap cannot be explained by any of 14 employment, industry, education, or demographic factors, and it has labelled the remaining gap "gender based labour market discrimination."[36] For example, it is likely that women's higher rate of part-time work, where wages are generally lower, explains a substantial portion of the wage gap. Using labour force statistics to compare the hourly wages of *only* full-time workers, however, we see that this adjustment removes only a small portion of the wage gap. Even among full-time workers, women earned an average of about 82 cents for every dollar earned by men.

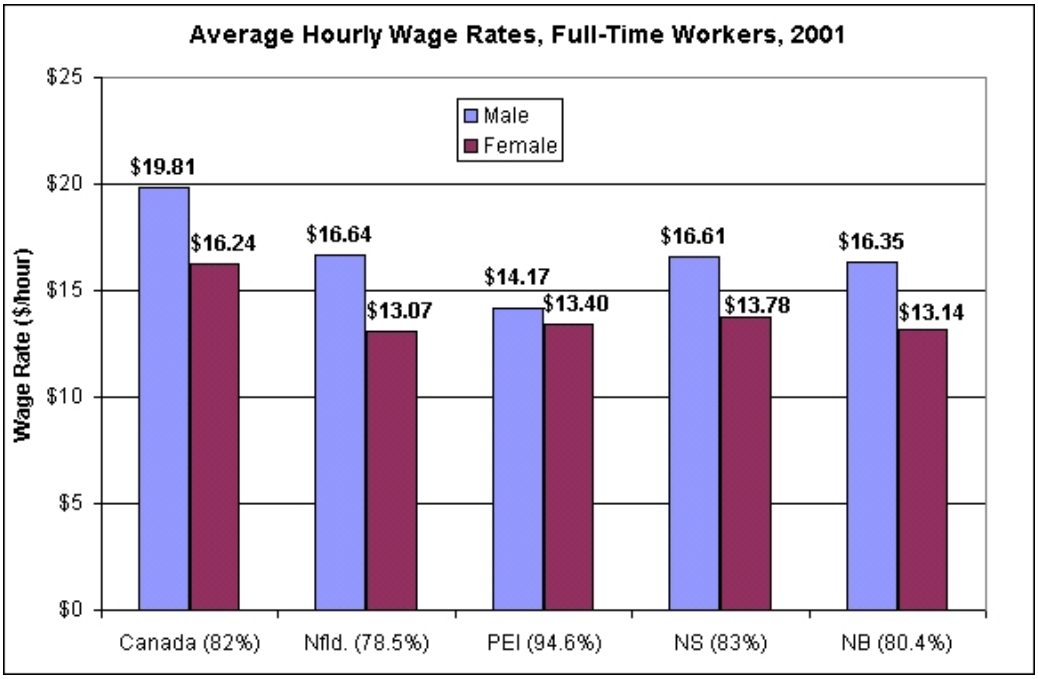
[36] Drolet, Marie, "The Persistent Gap: New Evidence on the Canadian Wage Gap," Income Statistics Division, Statistics Canada, December, 1999, catalogue no. 75F0002MIE-99008, page 13, and table 3.

Figure 2. Median hourly wage rates, Canada and Atlantic provinces, 2001, ($), and female hourly wages as percent of male hourly wages.



Source: Statistics Canada, Labour Force Historical Review 2002.

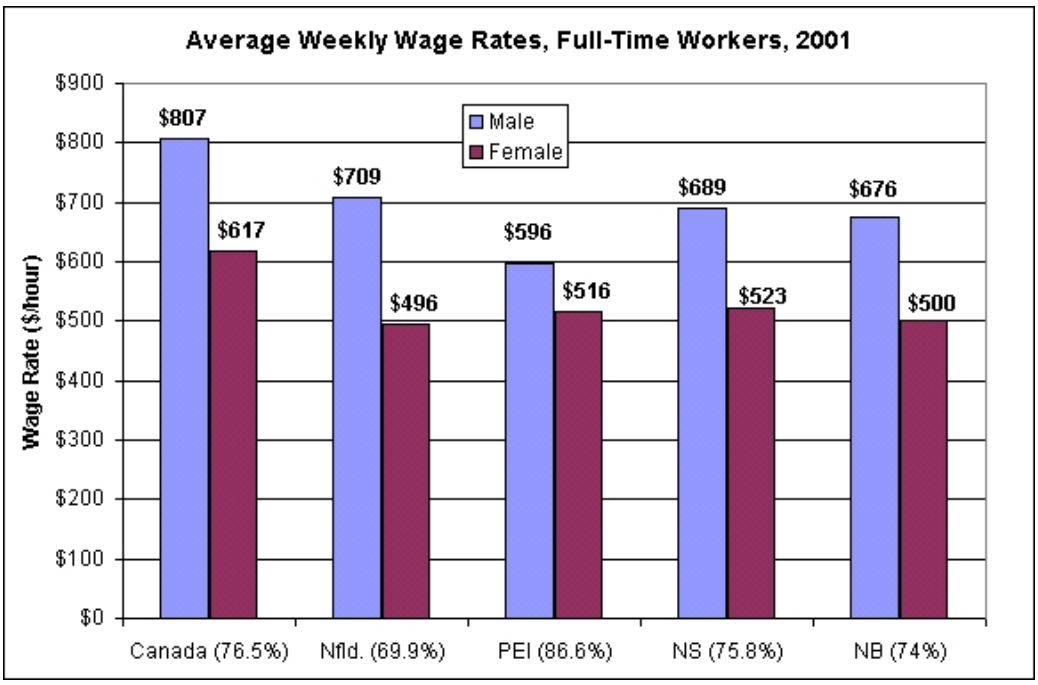
Figure 3. Average hourly wage rates, full-time workers, Canada and Atlantic provinces, 2001, ($), and female full-time hourly wages as percent of male full-time hourly wages.



Source: Statistics Canada, Labour Force Historical Review 2002.

Hourly wages are the most accurate and conservative gauge of gender wage equity, since women average fewer weekly paid hours than men. When weekly wages are examined, therefore, the male-female gap appears even larger. Again for the sake of fairer comparison, only the weekly wages of full-time male and female workers are compared (Figure 4). If the wages of all workers were counted, including part-timers, the gap would be about seven percentage points wider than indicated below.

Figure 4. Average weekly wage rates, full-time workers, Canada and Atlantic provinces, 2001, ($), and female full-time weekly wages as percent of male full-time weekly wages.



Note: Wages are rounded to the nearest dollar.

Source: Statistics Canada, *Labour Force Historical Review 2002.*

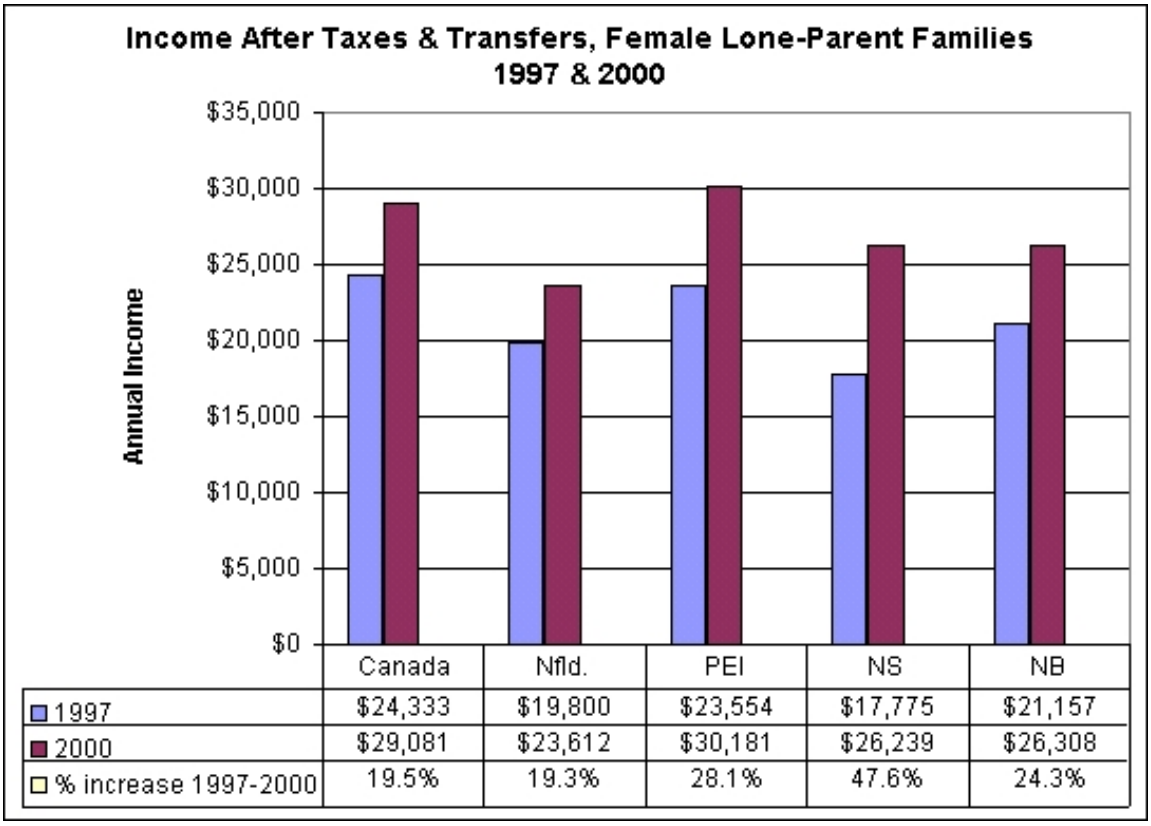
2.2.2 Employed single mothers increase incomes

In sum, the gender wage gap remains substantial, and recent years have seen no progress in narrowing the gap. On the other hand, rates of low income have dropped sharply right across the country in the last three years, and single mothers, in particular, have made very significant gains. While their incomes remain less than half those of two-parent families, and while they still have the highest rates of low income of any family group, single mothers have seen the largest percentage increase in after-tax income of any group.

Nova Scotia saw the most dramatic changes in the financial status of single mothers of any province in the country. In 1997 Nova Scotian single mothers had by far the lowest after-tax income in the country, compared to single mothers in other provinces. That in turn meant that

children of single mothers in Nova Scotia had the highest poverty rates in the country, with fully 71% living below the low-income cut-off line. By 2000, the after tax income of Nova Scotian single mothers had increased by almost 50%, and the prevalence of low income among their children had fallen by more than half to 35%, the fourth lowest rate in the country, and the sharpest drop of any province (Figures 5-7). [37]

Figure 5. Income after taxes and transfers, female lone-parent families, 1997 and 2000, Canada and Atlantic provinces, (2000 constant dollars) ($)



	Canada	Nfld.	PEI	NS	NB
1997	$24,333	$19,800	$23,554	$17,775	$21,157
2000	$29,081	$23,612	$30,181	$26,239	$26,308
% increase 1997-2000	19.5%	19.3%	28.1%	47.6%	24.3%

Source: Statistics Canada, *Income in Canada 2000*

Again, Prince Edward Island stands out for its gender equity, its low rates of low income, and the relatively high income of single mothers. Just as in 1997, PEI in 2000 still had the smallest gender wage gap, the lowest rate of low income, and the lowest rate of child poverty in the country. Even in absolute terms, the after tax income of single mothers was the second highest in Canada, after Ontario.

These averages, and the marked improvement over time, conceal significant differences among single parents with and without earnings, and they take no account of the trade-off that working single mothers make when they take a job, especially a full-time job. Four out of every five

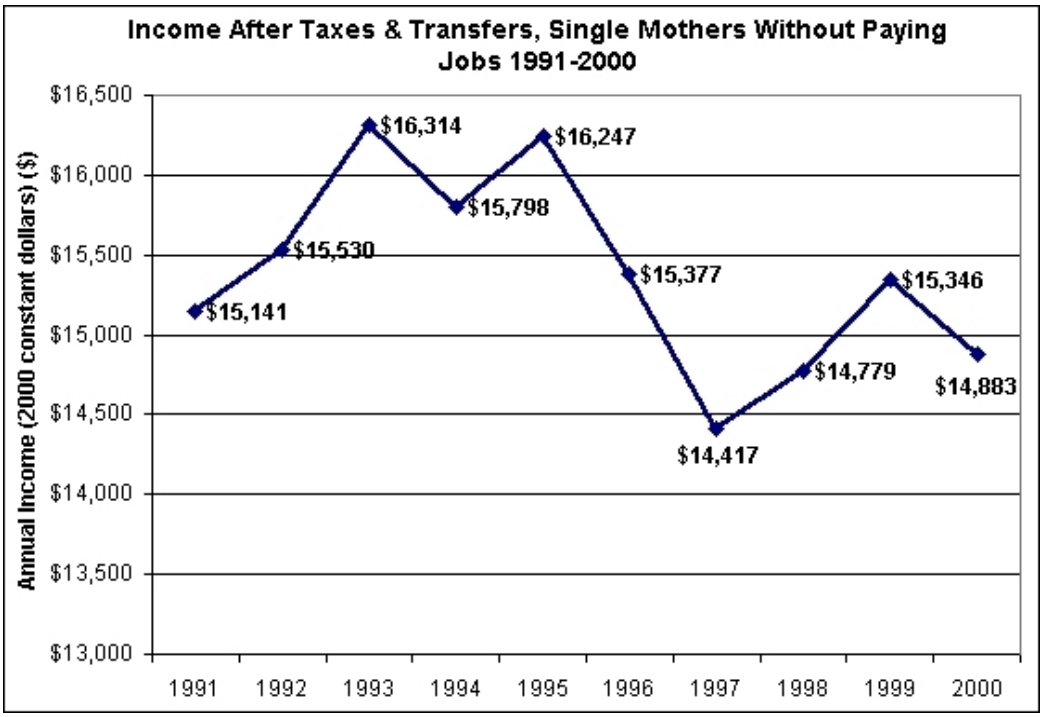
[37] Statistics Canada, *Income in Canada 2000,* catalogue no. 75-202-XIE, Tables 6.1 and 8.1

single mothers in Canada had earnings in 2000. However, the low income rate of these employed single mothers (25.1%) was still greater than three times the average for all families (7.9%). Still, the low income rate of employed single mothers was small compared to that of single mothers without earnings (87.8%).[38] In fact, since federal government cuts to social transfers in the 1990s, the real incomes of Canadian single mothers without jobs have actually fallen and their low income rates have increased (Figures 6 and 7).

Since the first major cuts in 1993, Canadian single mothers without jobs have seen their incomes after taxes and transfers fall by 8.8% and their rate of low income jump by 15.2%. Since 1996, this low-income rate has remained consistently high, and impervious to the stronger economy of the late 1990s. In Nova Scotia, despite very substantial gains for single mothers with jobs, single mothers without jobs saw their incomes, after taxes and transfers, drop 5.6% from $15,653 in 1996 to $14,779 in 1999 (figures are not available for 2000).

In other words, the dramatic gains noted above are entirely due to the higher incomes of employed single mothers, and they are strongly influenced by reductions in social assistance benefits in the 1990s. By contrast, rising social assistance benefits in the 1980s acted as an employment disincentive for those single mothers who preferred to raise their own children and to avoid reliance on paid child care.[39]

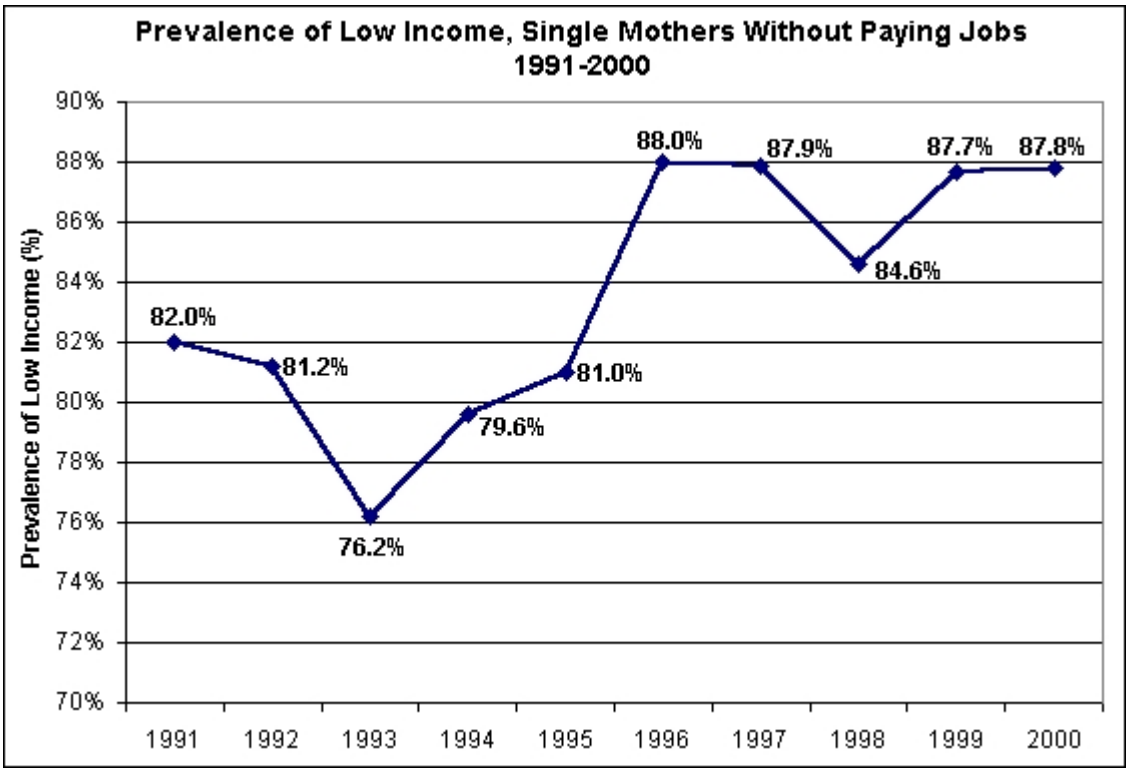
Figure 6. Average income after taxes and transfers, single mothers without paying jobs, Canada, 1991 – 2000 (2000 constant dollars) ($)



Source: Statistics Canada, *Income in Canada 2000*

[38] Ibid., page 90. Low-income rates in this chapter always refer to income after taxes and transfers.
[39] Heisz, Andrew, A. Jackson, and G. Picot, *Winners and Losers in the Labour Market of the 1990s,* Statistics Canada, catalogue no. 11F0019, no. 184, March, 2002, page 26.

Figure 7. Prevalence of low income, single mothers without paying jobs, Canada, 1991 – 2000 (%)



Source: Statistics Canada, *Income in Canada 2000.*

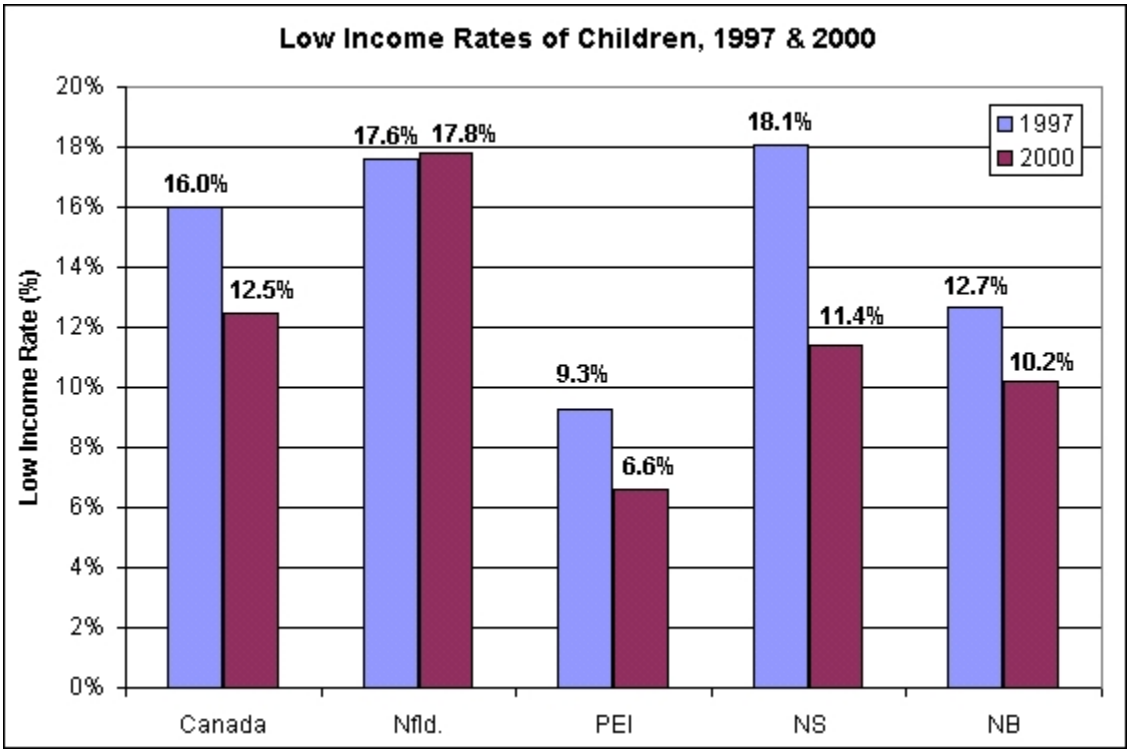
The average Canadian single mother without a job lived $6,666 below the low-income cut off line in 2000 – this is the amount in after-tax dollars she would have needed to reach that low-income cut off line. In other words, single mothers without paying jobs are almost certain to be living deeply in poverty, so taking a job is literally the only way that single mothers can attempt to work their way out of poverty. Since 1994, the number of single mothers in Canada without jobs has fallen by more than 40% from half a million to less than 300,000; while the number of employed single mothers has jumped 32% from 700,000 to 925,000.[40]

2.2.3 Child poverty declines

Child poverty has also fallen across the country in recent years. The percentage of low-income children in 2000 (12.5%) is among the lowest rates recorded over the past 20 years.[41] In 2000, PEI's low-income rate for children was 6.6%, again the lowest in the country, and just over half the national average (12.5%). Newfoundland and Labrador has the highest rate of low income for children in the country (17.8%), nearly three times the rate of PEI (Figure 8).

[40] Statistics Canada, *Income in Canada 2000,* Tables 8.3 and 9.1, pages 120 and 124. On depth of poverty, see also page 89.
[41] Statistics Canada, *Income in Canada 2000,* page 90.

Figure 8. Low income rates of children, Canada and Atlantic provinces, 1997 and 2000

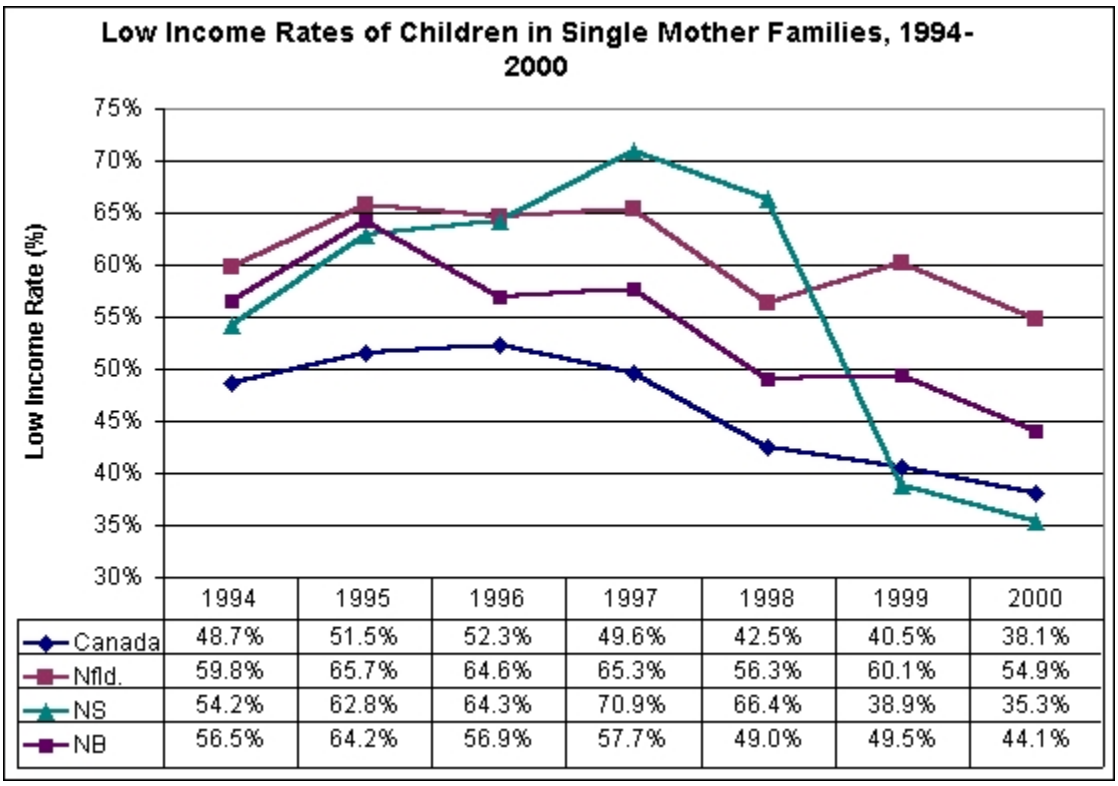


Source: Statistics Canada, *Income in Canada 2000*

The size of the drop in child poverty is directly related to the higher incomes of employed single mothers. Nearly half the children in low-income families still live in single parent families. The low-income rate of children of single mothers in 2000 was 38.1%, four a half times greater than that of children in two-parent families (8.5%). Nevertheless, the higher incomes of employed single mothers have helped reduce the overall child poverty rate by 22% nation-wide and the poverty rate of children of single mothers by a third (Figure 9).

Nova Scotia saw the largest decline in low-income rates for children in the country (down 37% since 1997), and the largest decline in low-income rates for children of single mothers (down by more than half). In 1997, fully half of children living in poverty in Nova Scotia were in single parent families, so the dramatic drop in child poverty is again due largely to the sharp increase in income for employed single mothers. Again, the caveat must be added that these significant drops in child poverty do not apply to children of single mothers without paying jobs, whose incomes after taxes and transfers have actually fallen since the mid-1990s, as noted above.

Figure 9. Low income rates of children under 18 in single mother families, Canada, Newfoundland, Nova Scotia, and New Brunswick, 1994-2000 (percent)



	1994	1995	1996	1997	1998	1999	2000
Canada	48.7%	51.5%	52.3%	49.6%	42.5%	40.5%	38.1%
Nfld.	59.8%	65.7%	64.6%	65.3%	56.3%	60.1%	54.9%
NS	54.2%	62.8%	64.3%	70.9%	66.4%	38.9%	35.3%
NB	56.5%	64.2%	56.9%	57.7%	49.0%	49.5%	44.1%

Source: Statistics Canada, *Income in Canada 2000.* Due to small sample sizes, PEI data are unavailable.

2.2.4 PEI remains most equitable province in Canada

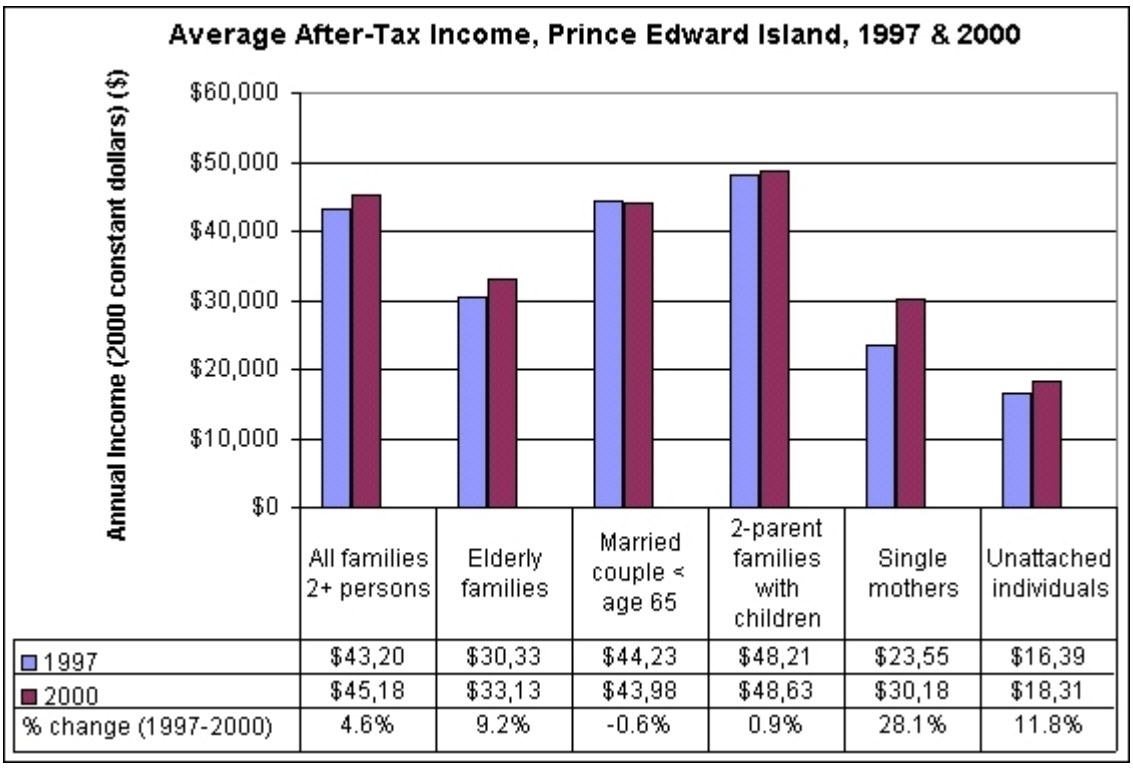
Due to small sample sizes, rates of low income for children of single parents are not available for Prince Edward Island for all years – clearly a good sign! The only two years for which PEI data on this indicator are available are 1994, when PEI's low-income rate for children of single mothers was 38.3%, the lowest rate in the country, and 1997 when it was 43.3%, the third lowest rate in the country. As these are the only two reported years, they are likely the years when low-income rates for children of single mothers were highest on the Island.

Since 1997, however, after-tax income for single mothers in PEI has climbed at a much faster rate than for any other family type (Figure 10). Based on those figures, and the fact that PEI in 2000 recorded the lowest rates of low income for men, women, and children, it is likely that PEI also had the country's lowest rate of low income for children of single mothers – certainly under 30%.

It is remarkable that the province with the second lowest household income in the country has the lowest rates of low income in the country. Prince Edward Islanders on average are not as rich as most other Canadians, but their poor are not as badly off as the poor in other provinces. By any measure, PEI is the most equitable province in the country, with the smallest income gap

both between the sexes and between rich and poor. PEI has the smallest income gap in the country between the richest 20% of households and the poorest 20% of households, the smallest gap between the richest 40% and the poorest 40%, and the smallest GINI coefficient, which computes the income gap over the *entire* income spectrum.[42]

Figure 10. Average after-tax income by selected family types, Prince Edward Island, 1997 and 2000 (2000 constant dollars) ($)



	All families 2+ persons	Elderly families	Married couple < age 65	2-parent families with children	Single mothers	Unattached individuals
1997	$43,20	$30,33	$44,23	$48,21	$23,55	$16,39
2000	$45,18	$33,13	$43,98	$48,63	$30,18	$18,31
% change (1997-2000)	4.6%	9.2%	-0.6%	0.9%	28.1%	11.8%

Source: Statistics Canada, *Income in Canada 2000*

2.2.5 Health impacts of the income-time trade off are unknown

Lower poverty rates for single mothers are clearly a sign of genuine progress. But the gains have come almost entirely by increasing employment rates for single mothers. Low-income rates for single mothers have fallen sharply only for those with jobs, and *because* more single mothers are now working for pay. As noted above, the low-income rate for single mothers without jobs in 2000 was a staggering 87.8%. In fact, it was likely the cuts in federal budget transfers to the provinces in the 1990s – and consequent reductions in social service payments – that forced more single mothers into the market economy.

What this means is that higher incomes and reduced poverty rates for single mothers have come at a price – reduced parenting time and higher rates of time stress. Earlier GPI *Atlantic* reports

[42] Dodds, Colin, and Ronald Colman, *Income Distribution in Nova Scotia,* GPI Atlantic, Halifax, July, 2001, Tables 5 and 6, pages 15 and 19. The equity measures are based on disposable household income after taxes and transfers.

have noted that working single mothers have much less time to spend with their children than both their non-employed counterparts and working mothers in two-parent families.[43] That is because they carry the sole burden of unpaid household work in addition to their paid work responsibilities. When they come home from their paid jobs, employed single mothers have to shop, cook, and clean without assistance. Not surprisingly, Statistics Canada's time stress surveys show working single mothers to be the most highly time-stressed demographic group.[44]

Robin Douthitt defines "time poverty" as the time below the minimum necessary for basic household production, including cooking, cleaning, laundry, and shopping. When time and income are both considered, Douthitt finds that poverty rates of working single mothers in Canada are 70% higher than official estimates.[45] According to Statistics Canada's time use surveys, full-time working single mothers put in an average 75-hour work week when paid and unpaid work are both counted.[46] In sum, single mothers make a significant trade-off when they take a job.

In addition, when they do work for pay, employed single mothers have significantly higher child care expenses than their married counterparts, since they cannot share child care responsibilities and schedules as readily. Those with pre-school aged children also spend 12% of their income on paid child care – nearly three times the proportion of working mothers in two-parent families (4.4%).[47] Although these issues were discussed in more detail in the 2000 statistical profile of women's health in Atlantic Canada, they bear repeating here, albeit more briefly, since they provide an important context for the significant reduction in poverty rates observed above.

The net effects of these changes on women's health are unclear. On the one hand, poverty is highly correlated with ill-health. So any reduction in low-income rates for women in general, and for single mothers and their children in particular, should signify a health gain. On the other hand, a wide-ranging review of the literature by the *American Journal of Health Promotion* found stress to be the most costly of all modifiable risk factors in terms of its wide-ranging health impacts.[48] According to Statistics Canada, time stress rates are rising across the country, with women consistently recording significantly higher rates than men of life stress in general and time stress in particular.[49]

A landmark Statistics Canada study found that longer work hours increased the likelihood of negative health behaviours that carry significant risks for cancer, heart disease, hypertension,

[43] Colman, Ronald (1998), *The Economic Value of Unpaid Housework and Child Care,* GPI *Atlantic*, Halifax, October, 1998.
[44] Statistics Canada, *The Daily,* November 9, 1999, catalogue no. 11-001E, pages 2-4, and Statistics Canada, General Social Survey, Cycle 12, 1998, Housing, Family, and Social Statistics Division, special tabulation.
[45] Douthitt, Robin, "The inclusion of time availability in Canadian poverty measures," in ISTAT, *Time Use Methodology: Towards Consensus,* Istituto Nazionale di Statistica, Roma, Italy, 1993, pages 88 and 90.
[46] Statistics Canada, *The Daily,* November 9, 1999, catalogue no. 11-001E, pages 2-4, and Statistics Canada, General Social Survey, Cycle 12, 1998, Housing, Family, and Social Statistics Division, special tabulation.
[47] Statistics Canada, *Women in the Workplace,* catalogue no. 71-534, pages 50 and 55.
[48] Goetzel, Ron (ed.) "The Financial Impact of Health Promotion," *American Journal of Health Promotion* 15 (5), May/June, 2001.
[49] Life stress rates from Statistics Canada, *Canadian Community Health Survey* 2000/01. Time stress rates from Statistics Canada, *The Daily,* November 9, 1999, catalogue no. 11-001E, pages 2-4, and Statistics Canada, General Social Survey, Cycle 12, 1998, Housing, Family, and Social Statistics Division, special tabulation.

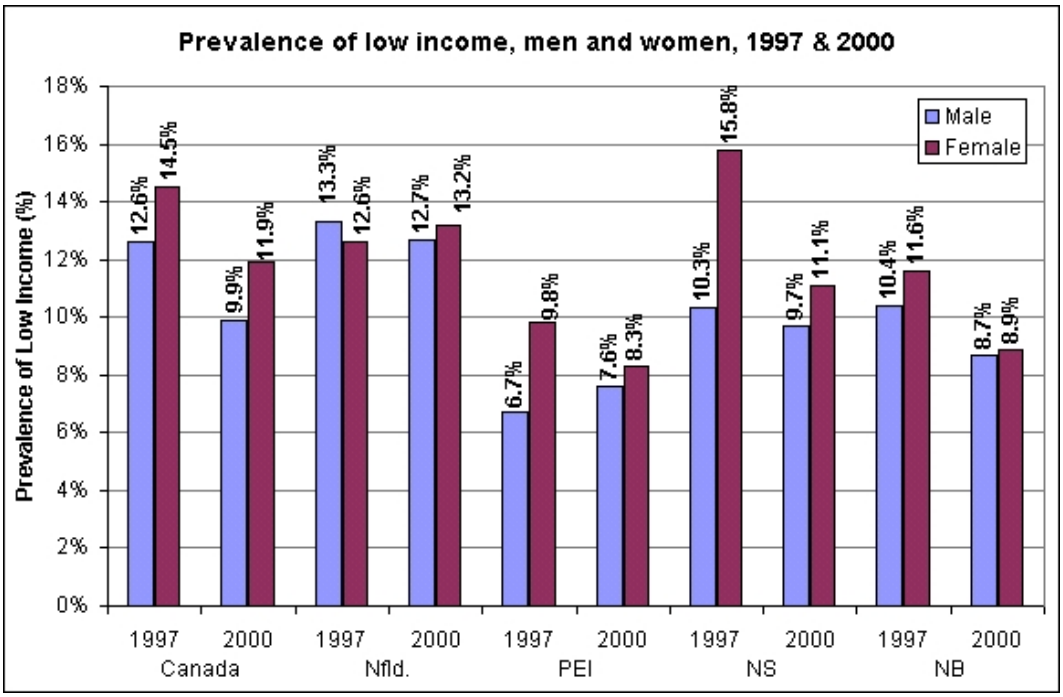
diabetes, and other chronic illnesses. Women moving to longer work hours were four times as likely to smoke more, twice as likely to drink more, 40% more likely to decrease their physical activity, and more than twice as likely to suffer major depression, compared to women working standard hours. Women with high levels of job strain were also 1.8 times more likely to experience an unhealthy weight gain than those with low job strain.[50]

Any assessment of the health impact of the stress associated with long work hours must account for the double burden of paid employment and unpaid household work, child-care, and care-giving that most employed mothers and caregivers bear. Whether the beneficial health impacts of a reduction in the poverty rate of employed single mothers outweighs the adverse impacts of increased time stress is unknown, and certainly worthy of careful study.

2.2.6 Low income rates for men and women narrow

While women still have higher rates of low income than men, these major changes in the status of single mothers have also narrowed the low-income gap between men and women, especially in Nova Scotia. Not only has the prevalence of low income fallen across the country for all groups, it has generally fallen more sharply for women in most provinces. In Newfoundland and Labrador, low income rates for men and women have been roughly equal since 1996 (Figure 11).

Figure 11. Prevalence of low income, men and women, Canada and Atlantic provinces, 1997 and 2000 (%)



Source: Statistics Canada, *Income in Canada 2000*

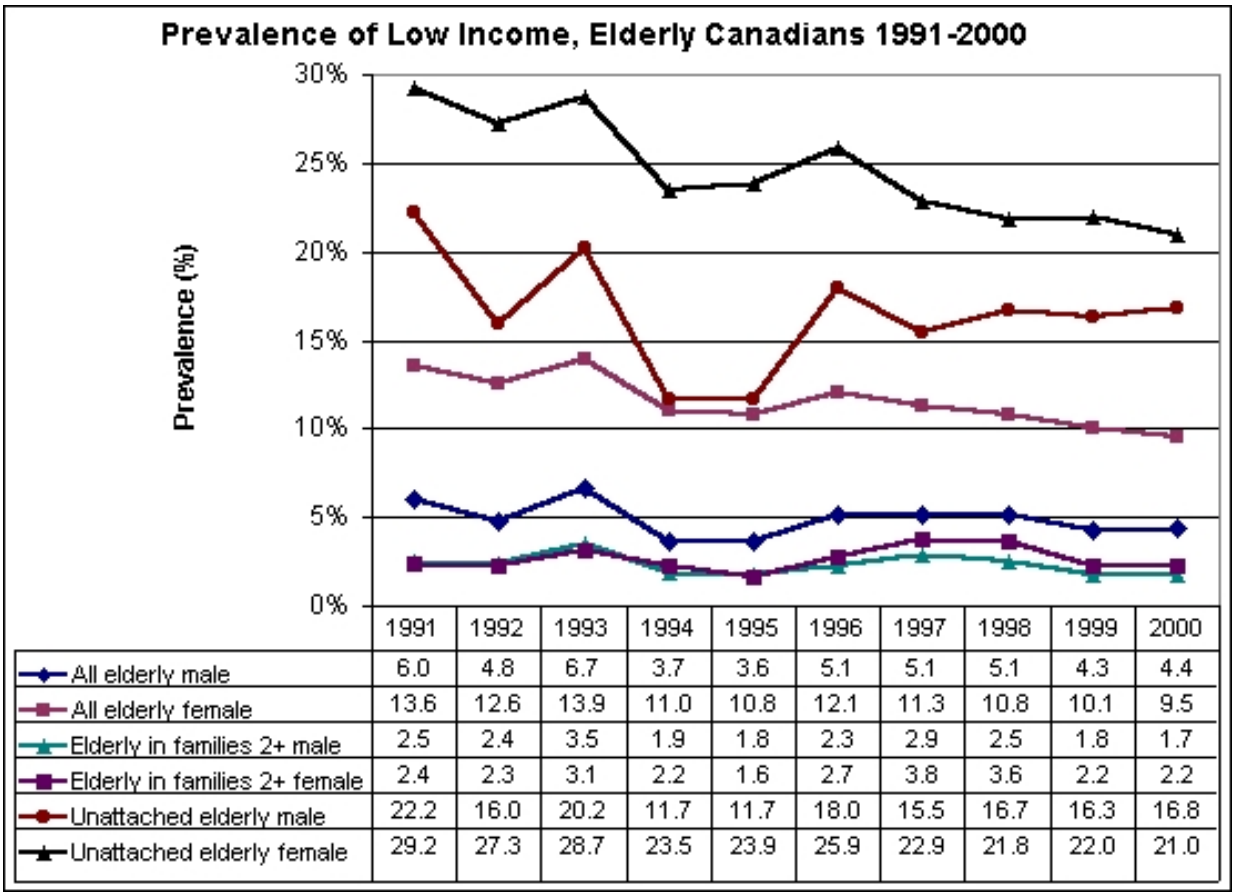
[50] Shields, Margot, "Long Working Hours and Health," Statistics Canada, *Health Reports,* volume 11, no. 2, Autumn, 1999, pages 33-48.

In 1997, the gap between male and female rates of low income was wider in Nova Scotia than in any other province, with over 50% more women than men living below the low-income cut-off. This was partly due to the fact that the incomes of Nova Scotian single mothers were the lowest in the country. By 2000, that male-female low-income gap in Nova Scotia had narrowed from 53.4% to 14.4%, the most dramatic change in the country. As noted above, PEI has consistently had the lowest rates of low income in the country for both men and women. In 2000 PEI's low-income rate for women was 8.3%, which was 30% below the national average (11.9%).

2.2.7 Low income among elderly men and women

Low income rates among Canadian women 65 and over have historically been more than double those of elderly men, and were almost three times higher in the mid-1990s. Since 1996, low income rates among elderly women have declined gradually each year, from 12.1% in 1996 to 9.5% in 2000. But this is still more twice the low-income rate of elderly men (4.4%) – a rate that has remained roughly stable since 1994 (Figure 12).[51]

Figure 12. Prevalence of low income, elderly Canadians age 65 and over, 1991-2000 (%)



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
All elderly male	6.0	4.8	6.7	3.7	3.6	5.1	5.1	5.1	4.3	4.4
All elderly female	13.6	12.6	13.9	11.0	10.8	12.1	11.3	10.8	10.1	9.5
Elderly in families 2+ male	2.5	2.4	3.5	1.9	1.8	2.3	2.9	2.5	1.8	1.7
Elderly in families 2+ female	2.4	2.3	3.1	2.2	1.6	2.7	3.8	3.6	2.2	2.2
Unattached elderly male	22.2	16.0	20.2	11.7	11.7	18.0	15.5	16.7	16.3	16.8
Unattached elderly female	29.2	27.3	28.7	23.5	23.9	25.9	22.9	21.8	22.0	21.0

Source: Statistics Canada, *Income in Canada 2000.*

[51] Statistics Canada, *Income in Canada 2000,* page 91.

Again the averages are deceptive, since both the rate of low income and the male-female gap are accounted for almost entirely by unattached seniors often living alone, whose rate of low income (19.9%) is more than 10 times higher than seniors living in families (only 1.9%). In 2000, unattached older women had a low income rate of 21%, down from a peak of 25.9% in 1996. This compares to a 2000 low income rate of 16.8% for unattached elderly men – relatively unchanged in recent years. The male-female gap has narrowed somewhat. In 1994 and 1995, the low income rate for unattached elderly women was twice that of unattached senior men.

2.3 Financial Security

Income is only one aspect of financial security. But unexpected events – sudden illness, disability, injury, death of main earner, layoff, or other job loss – can threaten income and leave families dependent on their accumulated assets. Cuts in federal social transfers in the 1990s reduced social assistance payments to levels well below the low-income cut-off line, and left more families dependent on their own resources for survival. The percentage of unemployed workers receiving unemployment insurance benefits was cut in half during the 1990s. The illness of a spouse, partner, child, or elderly parent may not only reduce income, but may sharply increase financial needs for proper care. Drug costs can be a particular financial drain. In Canada overall, nearly 30% of medical costs are privately financed, but 65% of drug expenditures are paid for privately.[52] Individual or family assets are often the only recourse to weather such a crisis.

Until very recently, current information on the financial assets of Canadians was unavailable. But in 1999, Statistics Canada conducted a Survey of Financial Security (SFS) – the first such assessment of the debts, assets, wealth, and net worth of Canadians since 1984. An overview of results became available in 2001, but very limited regional or provincial information was publicly available until December, 2002, except in highly aggregated form.[53] The Canadian Centre for Policy Alternatives has now released specially commissioned regional data runs from the SFS that for the first time reveal the wealth gaps within Atlantic Canada by family characteristics, and allow an assessment of the financial status of different family types including single mothers.[54]

The Survey of Financial Security counted both financial assets (e.g. RRSPs, savings plans, bank accounts, mutual and investment funds, stocks and bonds) and non-financial assets (house, real estate, vehicles, furnishings, valuables). Among debts it counted mortgages, credit card and instalment debt, student loans, vehicle loans, lines of credit, and unpaid bills. Wealth simply means assets minus debts, and is the same as "net worth." For example, the market value of a house minus the mortgage is the wealth tied up in the house. If a household has more debts than assets, it has "negative wealth" or a net debt load.

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[52] Canadian Institute for Health Information (CIHI), Figure 5, Public and Private Shares of Total Health Expenditure, by Use of Funds, Current Dollars, Canada, 2000, at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_18dec2002_fig5_e.

[53] Statistics Canada, *The assets and debts of Canadians: an overview of the results of the Survey of Financial Security*, catalogue no. 13-595-XIE, Ottawa, March 15, 2001.

[54] Kerstetter, Steve, *Rags and Riches: Wealth Inequality in Canada,* Canadian Centre for Policy Alternatives, Ottawa and Vancouver, December, 2002, particularly Appendices A-D.

This new information on financial security allows us to expand our understanding of the socio-economic determinants of women's health in Atlantic Canada beyond what was possible in the 2000 statistical profile. Before exploring issues of particular relevance to women and their health, we shall summarize some of the key findings of the new Survey of Financial Security, to provide a context for the discussion.

2.3.1 Wealth distribution in Canada

The Survey of Financial Security showed that the wealthiest 10% of family units in Canada now hold 53% of the wealth, and the wealthiest 50% control 94.4% of all wealth, leaving just 5.6% for the bottom 50%.[55] The poorest one-quarter of Canadian households own 0.1% or one-thousandth of the wealth in Canada. Not surprisingly, many Canadians live in a state of chronic financial insecurity that leaves them unable to weather a financial storm. Statistics Canada found that among the poorest 20% of households, nearly one-third fell behind two months or more in a bill, loan, rent, or mortgage payment in 1998.[56]

But financial insecurity extends beyond the poorest families. Canadians in the middle of the spectrum have most of their wealth tied up in housing, which is not easy to "cash in" at a time of financial crisis.[57] The financial assets that provide more solid financial security are held almost entirely by the wealthiest households. Thus the wealthiest 20% of Canadians hold 72% of the wealth in RRSPs and other registered savings plans, 81% of mutual and investment funds, and 94% of stocks. RRSPs, savings plans, capital gains, and stock dividends all get preferred income tax treatment. When housing is excluded, the richest 20% of households hold 76.2% of the country's wealth. When housing is included, they own 70.4%. Excluding housing, the richest 40% own 90.8% of the wealth, leaving 9.2% for the remaining 6%.[58]

Examining the distribution of both financial and non-financial assets, the Canadian Centre for Policy Alternatives concludes that "financial insecurity may actually be the norm these days and financial security the exception to the rule."[59]

Since 1984 the wealth gap between rich and poor Canadians has grown wider, with the bottom 30% losing wealth and the top 30% increasing their wealth by more than 30%. The poorest 10% of Canadian households have more debts than assets, and saw their median net debt load (i.e. "negative wealth") grow by $3,876 dollars from $1,824 in 1984 to $5,700 in 1999 (constant 1999 dollars). In other words, they wound up deeper in debt. At the same time, the richest 10% of Canadian households saw their median wealth grow by 35% from $464,376 to $628,100.[60]

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[55] Kerstetter, op. cit., Summary, page 4.
[56] Pyper, Wendy, "Falling Behind, *Perspectives on Labour and Income,* Statistics Canada, catalogue no. 75-001-XIE, July, 2002, page 18.
[57] Kerstetter, op. cit., pages 4 and 31.
[58] Kerstetter, op. cit., pages 4 and 41.
[59] Idem.
[60] Morissette, Rene, Xuelin Zhang, and Marie Drolet, *The Evolution of Wealth Inequality in Canada, 1984-1999,* Statistics Canada, catalogue no. 11F0019, no. 187, February 22, 2002, Table 4, page 25; and Statistics Canada, *The Daily,* February 22, 2002. Statistics Canada has adjusted the 1999 Survey of Financial Security figures to be comparable to 1984 data from the 1984 Assets and Debts Survey. So the 1999 figures given here are not entirely

The "median" is the mid-way point at which 50% of households within that group have more wealth and 50% have less wealth. In other words, the median represents the "typical" household within that group. By contrast, the "average" value is derived by simply dividing the total wealth in the group by the number of households in the group. Thus the average wealth of the top 10% will be heavily influenced by the very great wealth of those in the top 1%.

When average values are examined, the richest 10% of Canadian households had $980,903 in wealth in 1999, an increase of 122% in constant dollars since 1970, and an increase of 47% since 1984. By contrast, the poorest 10% in 1999 had an average of $10,656 more in debts than they had in assets, an increase in net debt of 28% since 1970, and of 79% since 1984.[61]

2.3.2 Regional wealth disparities in Canada

But these averages also conceal major regional disparities. The average wealth in Atlantic Canada is less than half that in British Columbia, and about 56% of that in Ontario (Figure 13).[62]

In fact, the gap between the rich and poor provinces has grown in the last 30 years, with the Atlantic region registering the slowest rate of wealth growth in the country. The gap has grown particularly large since the mid-1980s. In 1984, the four Atlantic provinces together had 5.4% of the nation's wealth. By 1999, they had just 4.4%, despite having 7.8% of the country's population. In 1984, average personal wealth in Atlantic Canada was 61.6% of that in Ontario. In 1999, it was just 52.8% of that in Ontario.[63]

All four Atlantic provinces have registered declining shares of national wealth, with Newfoundland the biggest loser. Newfoundland's share of the national wealth dropped by 36% to just 0.7% of the national total. PEI's share dropped by 20%; Nova Scotia's share dropped by 14%, and New Brunswick's by 12% (Figure 14).[64] A disproportionate share of wealth is concentrated in just three provinces in Canada: Ontario has 40.5% of the country's wealth with just 36.7% of households; British Columbia has 17.6% of the wealth and 13.8% of households; and Alberta has 11.6% of the wealth and only 9.5% of households.[65]

comparable with the 1999 figures from the Survey of Financial Security used elsewhere in this chapter. The adjustment is necessary because the 1999 survey included some items not covered in 1984, such as contents of the home, collectibles and valuables, annuities, and Registered Retirement Income Funds. In order to assess whether the total wealth of different groups increased or decreased between 1984 and 1999, those items were therefore excluded from the 1999 data for comparative purposes.

[61] Kerstetter, op. cit., pages 4 and 13, especially Table 1-4.

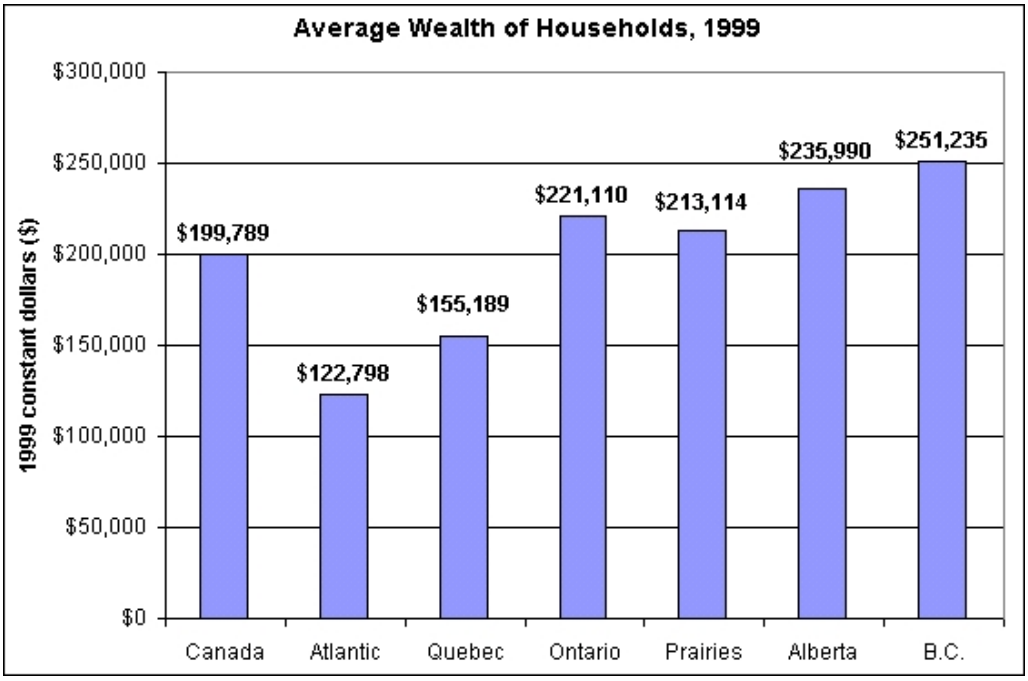
[62] Kerstetter, Appendix A, pages 1-6 and Appendix B, page 7.

[63] Percentages are derived from Kerstetter, op. cit., Tables II-5 and II-6, pages 20-21

[64] Kerstetter, op. cit., Table II-6, page 21.

[65] Kerstetter, op. cit., Table II-6, page 21

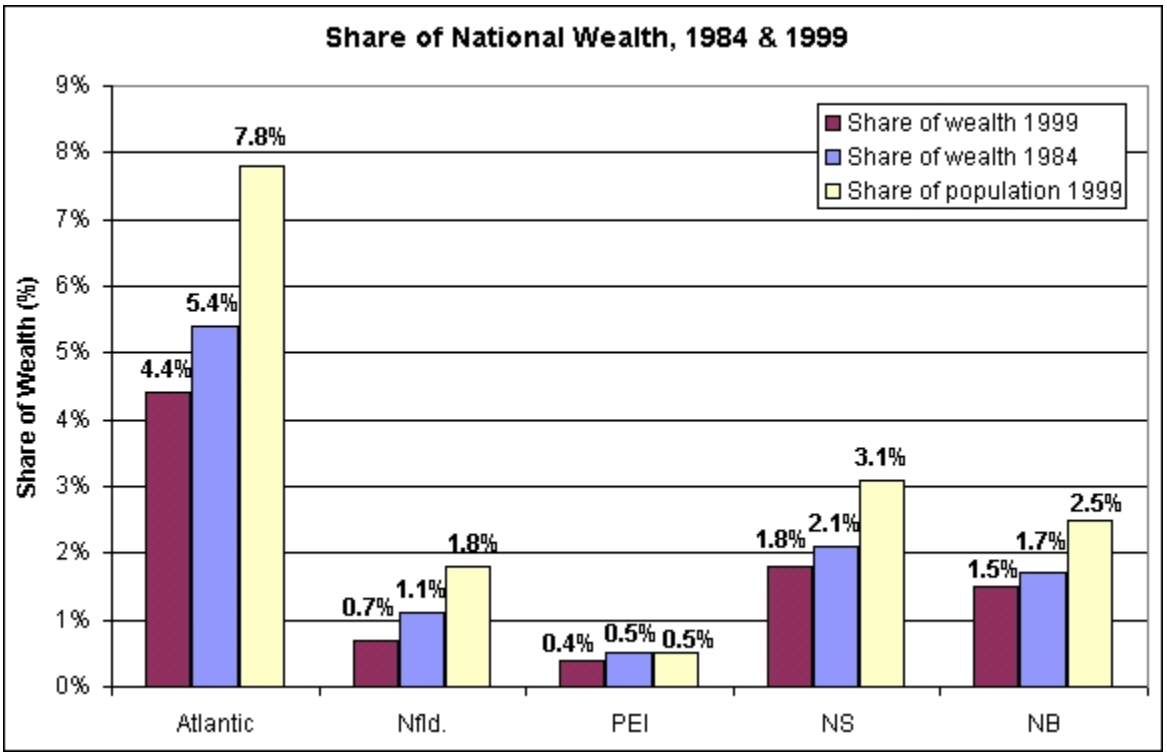
Figure 13. Average wealth of households by region, 1999 (1999 constant dollars) ($)



Note: The Prairies here include Alberta, which has considerably higher average wealth than Manitoba or Saskatchewan, and is therefore also listed separately.

Source: Statistics Canada, *Survey of Financial Security,* cited in Kerstetter, *Rags and Riches.*

Figure 14. Share of national wealth, Atlantic provinces. 1984 and 1999 (%)



2.3.3 Wealth Distribution in Atlantic Canada

Atlantic Canada's $122,798 in average household wealth is far from evenly distributed. The Survey of Financial Security showed that 7.8% of Atlantic Canadian family units, 72,591 in all, had more debts than assets, with an average net debt of $10,607. Another 9.5%, or 88,439 households, had minimal wealth averaging just $1,628, and another 7.4%, or 68,720 households, had net average wealth of $9,037. Taken together, this one-quarter of Atlantic Canadian households controls 0% of the region's wealth, since debts exactly balance assets. The bottom 44% of Atlantic Canadian family units controls just 5% of the region's wealth.[66]

At the top end of the wealth spectrum in Atlantic Canada, 8.3% of family units holds 22.5% of the region's wealth, with an average value of $332,227. That, of course, includes the region's wealthiest families. According to Canadian Business Magazine, the Irving family of New Brunswick, with its oil, forestry, media, and other interests, is the third wealthiest in Canada, with a net worth of $4 billion. Harrison McCain, also of New Brunswick, with frozen food interests, is worth a reputed $1.65 billion, while the Sobey family in Nova Scotia is worth a modest $342 million.[67]

In Atlantic Canada, the richest 10% owned 49% of the region's wealth, compared to 53% in the Prairies, 55% in British Columbia, and 56% in Quebec.[68] The difference between the poorest and richest halves of family units was also somewhat less extreme in Atlantic Canada than in other parts of the country. The richest 50% of Atlantic households control 92.2% of the region's wealth, leaving 7.8% for the poorest 50%. By contrast, the richest 50% in Ontario own 93.8% of the wealth, leaving 6.2% for the poorest 50%, and the richest 50% in British Columbia control 95.7% of that province's wealth, leaving only 4.3% for the poorest 50%.[69]

But the real difference between Atlantic Canada and the rest of the country in terms of wealth distribution is in the proportion of family units in the middle and top groups. Aside from a small number of extremely wealthy families, Atlantic Canada on the whole has fewer wealthy households than most other regions of the country, and therefore has a somewhat less extreme concentration of wealth at the top.

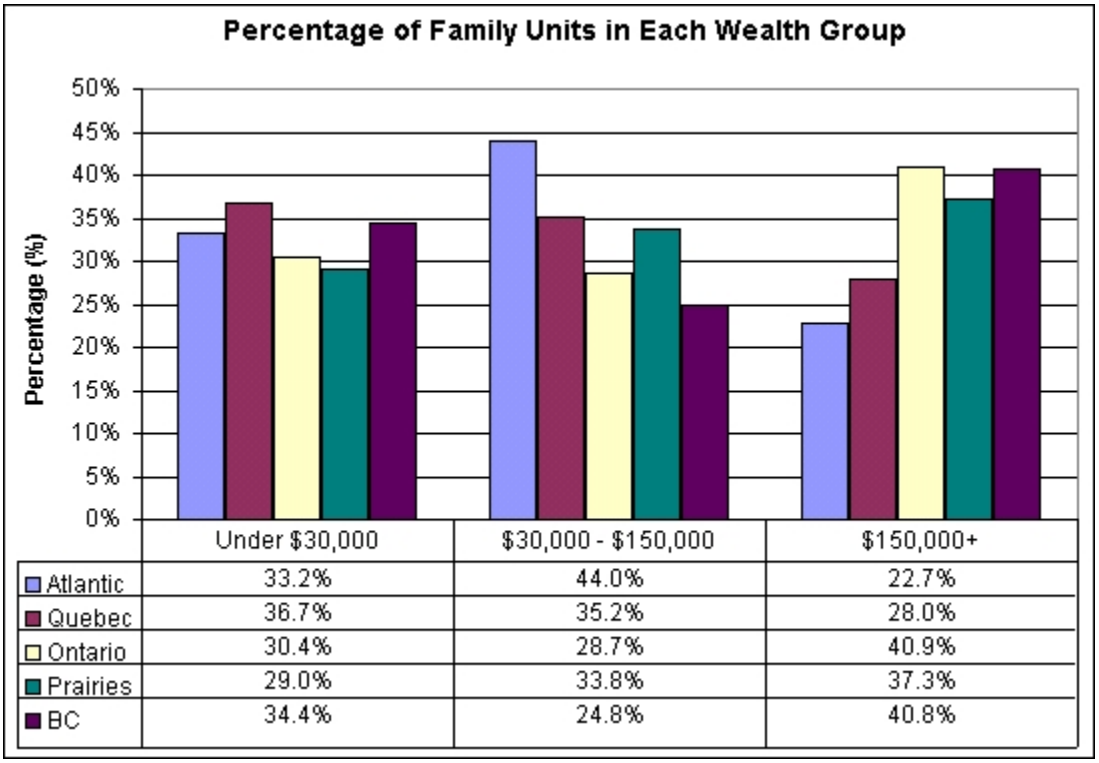
About one-third of Atlantic Canadians have net wealth worth less than $30,000, a similar proportion to other regions of the country. But the Atlantic region has significantly fewer households with wealth in excess of $150,000, and therefore a significantly larger proportion of its family units with net wealth between $30,000 and $150,000, and (Figure 15).[70]

While the gap between rich and poor in Atlantic Canada is large by any standards, the region could be considered marginally more equitable than other regions, but only because it has fewer wealthy households, and is not quite as "top-heavy" as other regions. If we break down the middle category ($30,000 to $150,000) further, we find that 21.7% of Atlantic Canadian

[66] Kerstetter, op. cit., Appendix A, page 1.
[67] *Canadian Business Magazine,* December 9, 2002; National Post, May 25, 2002, "Canada's fifty richest."
[68] Kerstetter, op. cit., Table II-1, page 17, and Appendix A.
[69] Kerstetter, op. cit., pages 16-17, especially Table II-1, page 17.
[70] Kerstetter, op. cit., Table II-3, page 18, and page 19.

households had an average net worth between $30,000 and $75,000 (including the value of their house).

Figure 15. Percentage of family units in each wealth group, by region



	Under $30,000	$30,000 - $150,000	$150,000+
Atlantic	33.2%	44.0%	22.7%
Quebec	36.7%	35.2%	28.0%
Ontario	30.4%	28.7%	40.9%
Prairies	29.0%	33.8%	37.3%
BC	34.4%	24.8%	40.8%

Note: Numbers do not add to 100% because the $150,000+ category includes the $500,000 category.

Source: Statistics Canada, *Survey of Financial Security,* cited in Kerstetter, *Rags and Riches.*

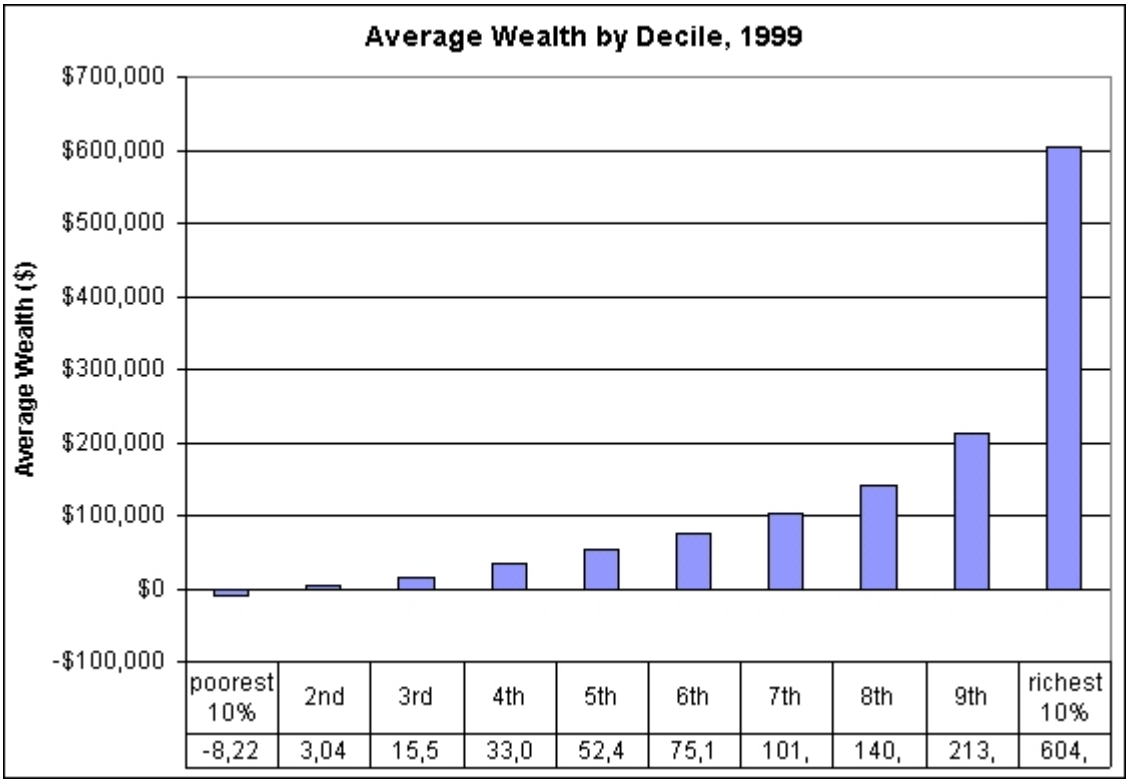
This means that 55% of Atlantic Canadians had less than $75,000 in wealth, with most of their assets tied up in their homes. As noted earlier, the modest wealth in the middle is mostly not in the form of liquid assets that can be used in a time of crisis – it is more likely to be a house, car, furnishings, or personal valuables that are not easy to give up or convert into cash.

In interpreting the data below, it is important not to take the numbers as meaning that wealth is relatively evenly distributed towards the middle, or that Atlantic Canadians in the middle of the wealth spectrum have more assets than those in the middle in other regions. That is not the case. What the numbers mean is that the "millionaires' club" is considerably smaller in Atlantic Canada, and that there are therefore larger numbers of households with smaller amounts of wealth. In other words, the wealth spectrum, on average, doesn't go as high at the top end, and so a smaller proportion of households fall into the $150,000+ and $500,000+ categories. The numbers mean that, with few exceptions, the wealthy in Atlantic Canada are *less* wealthy than the wealthy in other parts of the country.

Thus Atlantic Canada has 10,673 millionaire households – or 1.1% of all households in the region. By contrast, 1.8% of households in Quebec, 2.5% in the Prairies, 3.1% in Ontario, and 3.3% in British Columbia have wealth in excess of $1 million. Ontario's 138,022 millionaire households have average wealth of nearly $2 million. Each of the other regions has more than 50,000 millionaire households with average wealth greater than $2.5 million.[71] Atlantic Canada has 7.8% of the country's population and 3.4% of millionaire households.[72]

If we break down the Atlantic region's average household wealth of $122,798 by deciles, ranging from the poorest 10% of households to the richest 10%, we find staggering wealth disparities in this region, as in all others (Figure 16). In fact, the poorest 10% of Atlantic Canadian households are deeper in debt in absolute terms than the poorest 10% in any other region. The average net debt (or negative wealth) of the poorest 10% of households in Atlantic Canada is $8,227 – more than $1,000 more indebted than the poorest 10% in Quebec and Ontario, and more than $2,500 more indebted than the poorest 10% in the Prairies.
As well, a higher percentage of Atlantic households (7.8%) had negative wealth, or debts that exceeded assets, than in any other region. By comparison, 5.5% of family units in Quebec, 6.8% in Ontario, 6% in the Prairies, 6.4% in Alberta, and 7.3% in British Columbia had negative wealth. Among those Atlantic Canadians with negative wealth, average net debt was $10,607.

Figure 16. Average wealth by decile, Atlantic Canada, 1999 ($)



Source: Statistics Canada, *Survey of Financial Security,* cited in Kerstetter, *Rags and Riches.*

[71] Kerstetter, op. cit., Table II-4, page 19.
[72] Kerstetter, op. cit., page 11.

The richest 20% of Atlantic Canadian households own two-thirds of the wealth, and the richest 40% own 86% of the wealth, leaving just 14% of the wealth to the poorer 60% of households. The poorest 40% of households hold just 3.6% of the region's wealth.

The poorest 20% have an average net debt of $2,602, and the second poorest 20% have an average net wealth of only $24,290. But that modest wealth is not easily convertible to cash. 54.4% of this group's assets are tied up in housing. When vehicles, household furnishings, and personal valuables are added, these non-financial assets amount to 85.4% of all assets. In other words, there is very little in the bank or in any other form that can be used at a time of financial crisis. The middle 20% of family units in Atlantic Canada have an even larger share of their wealth tied up in housing – fully 60% of their wealth is in the market value of their homes.

It is only at the very top that the balance changes. Only a quarter of the wealth of the richest 20% of Atlantic Canadian households is in housing. But they own nearly 80% of all financial assets, including 77% of RRSPs and other registered savings plans, and 84% of mutual and investment funds. Their average financial assets alone ($161,449) are six times greater than those of the second richest 20% of Atlantic region households, 12.4 times greater than those in the middle 20%, and 26 times greater than those in the second poorest 20%. In addition to financial assets, the richest 20% also controls 95% of all equity in business. The richest 20% have an average wealth of $408,106.

The distribution of wealth in Prince Edward Island is different from that in the other Atlantic provinces in having nearly 40% of all assets on the island tied up in equity in a business. This compares to just 9.4% in Newfoundland, 9.1% in Nova Scotia, and 21.5% in New Brunswick. As a percentage of all households, more than twice as many Islanders have equity in a business (23.3%) as in the other provinces (12% in Newfoundland, 11% in Nova Scotia, and 11.5% in New Brunswick). While data from the Survey of Financial Security on are not available to explain this disparity, it seems likely that a significant percentage of Prince Edward Island family units have their wealth tied up in family farms and related businesses.[73]

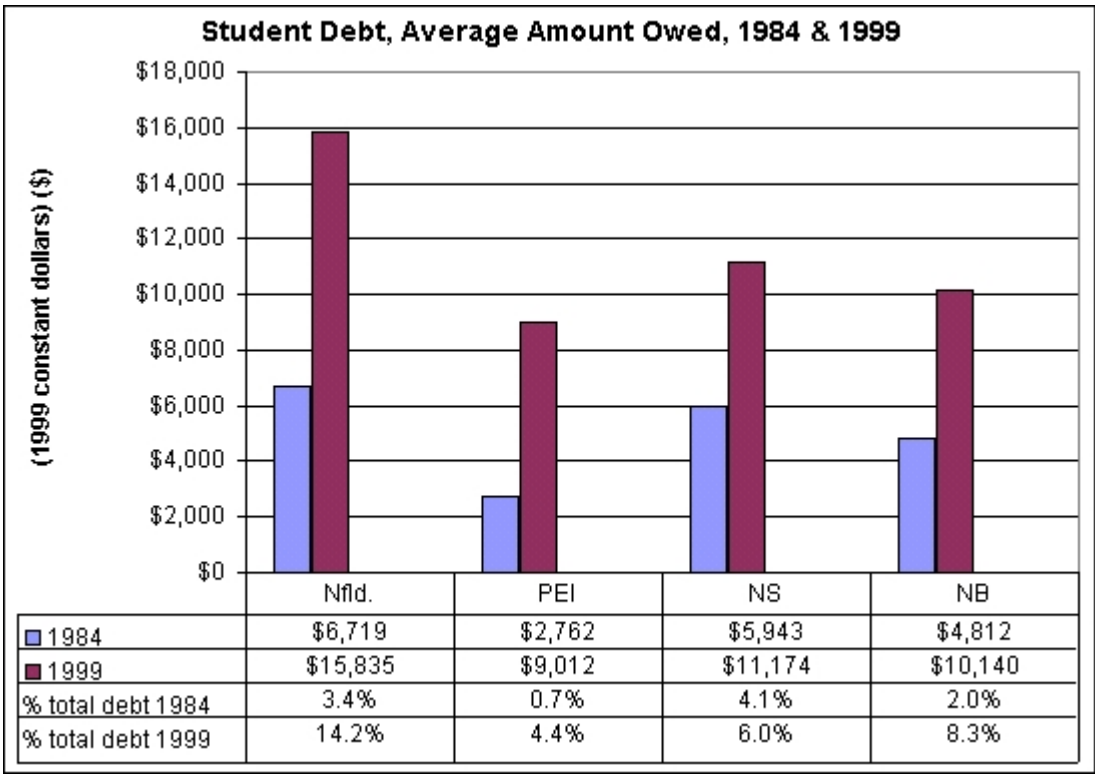
Households in Atlantic Canada are also distinguished from other regions by their high ratios of student debt to total debt. Student debt in Newfoundland amounted to 14.2% of all debt in the province. Those with students debts owed an average of $15,835, a massive increase from the average $6,719 in student debt owed in 1984 (both in constant 1999 dollars). Average student debt in Nova Scotia amounted to $11,174, and constituted 6% of all debt in the province. The amount owed also more than doubled from $5,943 in 1984. In New Brunswick, student debts amounted to 8.3% of all debts in the province in 1999, and those with student debt owed an average of $10,140, up from $4,812 in 1984. Student debts in Prince Edward Island amounted to 4.4% of all debt, with the average amount owed $9,012, up from $2,762 in 1984 (Figure 17).[74]

All these proportions are considerably larger than the Canadian average, where student debts accounted for just 3.2% of all debts. In Canada as a whole, 5% of family units carried student debt in 1984, with an average value of $4,899. In 1999, 12% of family units carried student debt and owed an average of $10,361. The marked increases in student debt are clearly a reflection of

[73] Percentages derived from Kerstetter, op. cit., Appendix D, pages 51-54.
[74] Idem.

the massive rise in university tuition in the 1990s, which has left many young people carrying major debt loads.

Figure 17. Student debt, average amount owed, Atlantic provinces, 1984 and 1999 (1999 constant dollars) ($)



	Nfld.	PEI	NS	NB
1984	$6,719	$2,762	$5,943	$4,812
1999	$15,835	$9,012	$11,174	$10,140
% total debt 1984	3.4%	0.7%	4.1%	2.0%
% total debt 1999	14.2%	4.4%	6.0%	8.3%

Source: Statistics Canada, *Survey of Financial Security,* cited in Kerstetter, *Rags and Riches*

For the poorest 20% of family units in Atlantic Canada, student debt was by far the largest debt item, amounting to 40% of all debts owed by those households. Among the poorest 20% of Atlantic Canadians, 36% of households carried such debts and owed an average of $12,671.

Between 1984 and 1999, wealth distribution in each of the four Atlantic provinces became more unequal, as it did in Canada as a whole. That can be gauged by the relative changes in median and average wealth, since the former represents the amount owned by the typical household in the middle of the wealth spectrum, while the group average can be skewed upwards by gains at the top. In Newfoundland, Nova Scotia, and PEI median wealth fell between 1984 and 1999 while average wealth increased, which means that the typical household saw its real wealth decline while the rich saw major gains. In New Brunswick average wealth increased by 30% while median wealth increased by only 14%, meaning that the gains of the richest New Brunswickers were substantially greater than those of the typical household in that province.

In Newfoundland and Labrador, median wealth fell by 22.5% from $52,108 in 1984 to just $40,400 in 1999, while average wealth grew very slightly during this period. This means that the

gap between rich and poor within Newfoundland grew substantially, with a growing number of Newfoundlanders seeing their wealth decline while a few have increased their holdings.

Similarly in Nova Scotia, average wealth increased by 24% to $105,124, while median wealth declined slightly to $50,700 between 1984 and 1999. This again means that the gains in wealth are entirely attributable to gains made by the wealthiest Nova Scotians, while most Nova Scotians have seen no increase in their wealth during this period.

This pattern is not different from the rest of Canada. Examining the national data, the Canadian Centre for Policy Alternatives study concluded that "the huge increases in personal wealth over the years have gone primarily to the family units at the very top and very little has trickled down to family units below the median."[75]

2.3.4 Gender and wealth in Atlantic Canada

We know that equity and financial status are key determinants of health, so Statistics Canada's recent Survey of Financial Security – the first such assessment of wealth distribution in Canada in 15 years – is a vital new source of information. Key results for Atlantic Canada can now be provided for the first time, thanks to special regional custom tabulations ordered by the Canadian Centre for Policy Alternatives, and are therefore presented here in some detail. But while income indicators are more amenable to gender analysis, because the information is gathered from individuals, wealth is measured by family units. That presents particular challenges in assessing the impacts of unequal wealth distribution on women and on women's health in particular.

Most households consist of husband-wife families, where the spouses supposedly share the family wealth. But that is an assumption that must be independently tested rather than taken for granted. Whether the stocks, bonds, mutual fund investments, business equity and other assets currently attributed to husband-wife families are in fact fully shared, and whether they provide similar levels of financial security to both partners is unknown. Unfortunately, the new Statistics Canada data currently provide no way of assessing the impact of unequal wealth distribution on such traditional families from a gender perspective.

But gender differences in relation to wealth distribution are possible to assess for three groups – lone parents, unattached seniors, and unattached individuals under age 65, since these are listed separately by sex and family type in the Statistics Canada wealth data.[76] Families with two earners tend to be much better off than both people living alone and lone-parent families, primarily because the two incomes can more easily be used to build up assets. In addition, as noted earlier, single mothers with infants spend three times as large a proportion of their incomes on paid child care as married mothers, and often take on low-paying, part-time jobs in order to juggle their work schedules with their child-rearing responsibilities.

[75] Kerstetter, op. cit., page 22.
[76] Supplementary data on the wealth of single mothers was separately supplied by Statistics Canada in special custom tabulations ordered by the Canadian Centre for Policy Alternatives.

Canada's half million single mothers and 2.9 million unattached individuals under age 65 have the lowest median wealth of any family types – $11,355 for single mothers, $11,240 for unattached men, and $12,000 for unattached women under 65. This amounts to about 11% of the median wealth of couples under 65 with children, and 9% of the median wealth of childless couples under 65. Though they represent 23.5% of all family units, unattached individuals under 65 collectively own only 8.7% of the nation's wealth. Single mothers represent 4.2% of all family units in Canada, but own just 1.2% of the country's wealth.[77]

The financial security of single mothers is probably more precarious than that of most unattached individuals, because they are supporting one or more children. In the event of a child's sickness or special needs, single mothers may need to forego income and may have greater need of financial resources than unattached younger individuals. Adjusting the 1999 wealth data for comparability, the median wealth of single mothers in Canada rose only marginally between 1984 and 1999, from $1,870 to $3,656.[78]

The numbers are even starker in Atlantic Canada. Median wealth for unattached individuals under 65 is markedly lower – just $6,218. This is not enough to weather any kind of financial crisis in the event of sickness, disability, or job loss. It amounts to just 8.7% of the median wealth of couples under 65 with children, and 7.2% of the median wealth of childless couples under 65. Unattached individuals under 65 represent 18% of all family units in the Atlantic region but they own just 7% of total wealth.

Single mothers in Atlantic Canada have lower median wealth than their counterparts in any other region – just $8,200 per family (Figure 18). This amounts to 11.4% of the median wealth of couples with children and 9.5% of the median wealth of childless couples in the Atlantic region. Again it is worth noting that the median represents the typical household within this group, and the point at which 50% of this family type have greater wealth and 50% have less. The average wealth of single mothers in Atlantic Canada is more than four times greater than the median wealth, indicating that a minority of wealthy single parents is pushing up the group average. The huge 11-fold disparity between the average and median wealth of single mothers in British Columbia similarly indicates a massive wealth gap within that group, with the majority of single mothers having minimal wealth, and a small minority having very substantial wealth.

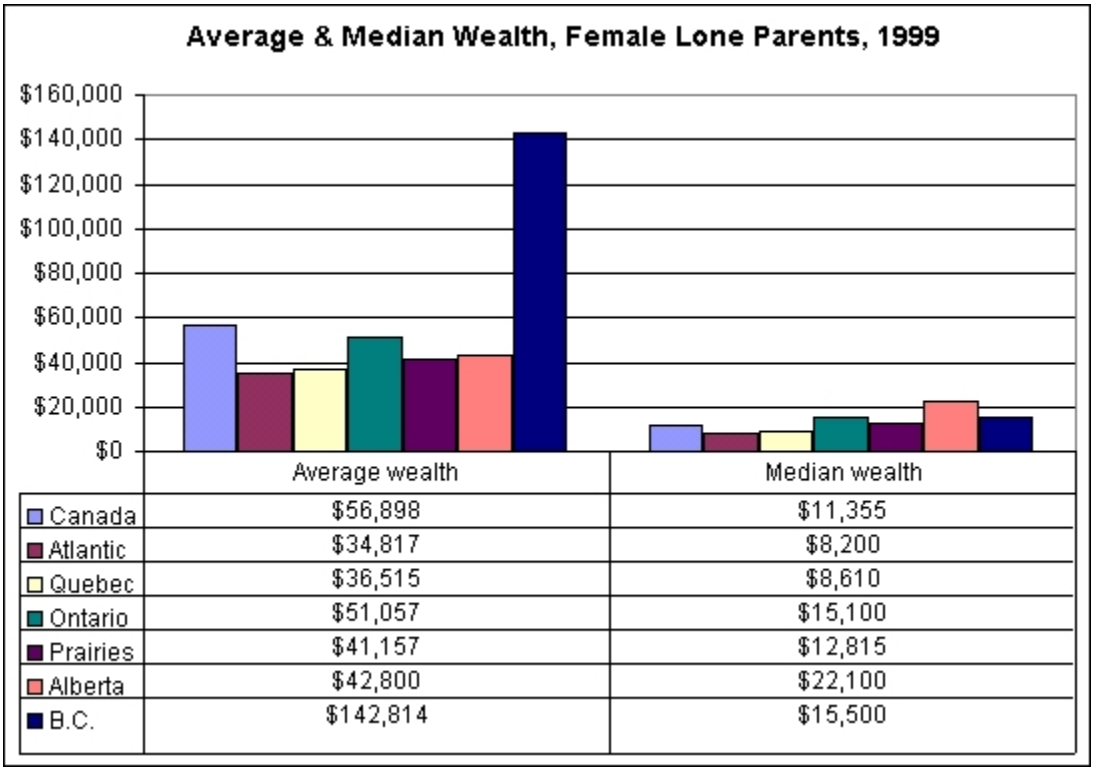
Older people tend to have more wealth, as they have had longer both to accumulate assets and to pay off mortgages and other debts. Families 65 and older represent 9.7% of family units in Canada but they own 16% of the country's wealth, with a median wealth of $202,000, and an average wealth of $329,804, the largest of any family type.

But marked gender differences become apparent in the data on unattached seniors. Unattached elderly men in Canada have median wealth of $111,000, which is 45% greater than that of unattached elderly women ($76,600). The average wealth of unattached elderly men is $214,594, compared to $152,685 for unattached elderly women.

[77] Kerstetter, op. cit., pages 42-45, and Appendix C, pages 44-50.

[78] Kerstetter, op. cit., Table VI-4, page 57. Note that comparisons between 1984 and 1999 wealth omit the value of household furnishings, collectibles and valuables, annuities, and Registered Retirement Income Funds, since those items were not counted in 1984. These items are therefore subtracted from the 1999 data for comparative purposes. The figures given here are therefore not comparable to data drawn directly from the 1999 survey.

Figure 18. Average and median wealth, female lone parents, Canada and regions, 1999



	Average wealth	Median wealth
Canada	$56,898	$11,355
Atlantic	$34,817	$8,200
Quebec	$36,515	$8,610
Ontario	$51,057	$15,100
Prairies	$41,157	$12,815
Alberta	$42,800	$22,100
B.C.	$142,814	$15,500

Source: Statistics Canada, *Survey of Financial Security,* cited in Kerstetter, *Rags and Riches.*

There are 266,600 unattached elderly men in Canada, representing 2.2% of all family units, and they hold 2.3% of all wealth, roughly in proportion to their numbers. However, there are three times as many unattached elderly women – 786,000 in all – largely because women live longer. These senior women represent 6.4% of all family units in Canada, but own only 4.9% of the wealth.[79]

Gender breakdowns are not available by region, but unattached seniors in Atlantic Canada have a median wealth of $59,700 and average wealth of $133,983.[80] While the assets of older people are considerably greater than those of younger people, the much higher proportion of sickness, disability, and activity limitations that afflict the elderly may require drawing on these resources more readily. From that perspective, $60,000 in net wealth may not stretch very far to cover the costs of necessary supplementary care that is not provided through the public health care system.

The generally high averages for elderly people also conceal the fact that significant numbers of seniors have little or no wealth. More than one in five seniors in Canada has wealth of less than $30,000, and 15.4% own less than $15,000 in wealth. Even that very modest wealth may consist primarily of a house or car that is not easy to convert to financial wealth in time of need.[81]

[79] Kerstetter, op. cit., pages 43-47.
[80] Kerstetter, op. cit., Appendix C, page 44.
[81] Kerstetter, op. cit., Table V-5, page 47.

3. Employment

Income, while widely accepted as a key determinant of health, is itself largely dependent on employment. In the previous chapter, for example, we saw that the major decline in low income rates for single mothers is entirely due to sharp increases in the number with paid jobs. Single mothers without paid jobs still have a low-income rate close to 90%. We have also noted that dual earner families are far more likely to accumulate wealth and create financial security than unattached individuals and single mothers dependent on one income.

Employment not only determines absolute levels of income, but is a key determinant of equity, which has also been shown to have an impact on health.[82] A Statistics Canada study found that the polarization of working hours in Canada in the 1980s was the key factor in increasing the level of inequality in weekly earnings.[83] A decline in the standard work week had led paradoxically both to larger numbers of workers putting in longer hours, and larger numbers unable to get the hours they needed to make ends meet.

In addition to determining income and affecting equity, employment has been demonstrated to have an independent effect on both physical and mental health, with the unemployed consistently having worse health outcomes than those who are employed.[84] Marie Jahoda's seminal studies of the 1930s Depression showed that employment provides far more than income:

> *"Employment makes the following categories of experience inevitable: it imposes a time structure on the waking day; it compels contacts and shared experiences with others outside the nuclear family; it demonstrates that there are goals and purposes which are beyond the scope of an individual but require a collectivity; it imposes status and social identity through the division of labour in modern employment; it enforces activity..."*[85]

Conversely, Jahoda demonstrated that unemployment damages mental health because of the *psychological* deprivation of these unintended consequences of employment, which normally function as psychological supports.

But unemployment is not the only work-related health determinant. Job strain, overwork, lack of control or decision latitude in one's work, and job dissatisfaction can all have adverse health impacts. A survey of 3,000 young people over eight years in Australia found that those who were

[82] For example, a British Medical Journal review of evidence concluded: *"What matters in determining mortality and health in a society is less the overall wealth of the society and more how evenly wealth is distributed. The more equally wealth is distributed, the better the health of that society."* In "Editorial: The Big Idea," *British Medical Journal* 312, April 20, 1998, page 985.
[83] Morissette, Rene, "Why has inequality in weekly earnings increased in Canada?" Analytical Studies Branch research paper series, Statistics Canada, Catalogue No. 11F0019MIE1995080, July 30, 1995.
[84] On the health impacts of unemployment, see Canadian Public Health Association, *The Health Impacts of Unemployment: A Position Paper,* CPHA, Ottawa, 1996; Evans, R, *Why are some people healthy and others not?* Canadian Working Paper No. 20, Institute for Advanced Research, Program in Population Health, December, 1992.
[85] Jahoda, Marie, *Employment and Unemployment: A Social-Psychological Analysis,* Cambridge University Press, 1982.

employed but dissatisfied with their jobs were indistinguishable in terms of mental health scores from those who were unemployed.[86]

Both in the previous chapter and in the 2000 statistical profile of women's health in Atlantic Canada, we have cited Statistics Canada's seminal study, based on longitudinal data in the 1994/95 and 1996/97 National Population Health Surveys, examining the impact of long working hours on health. The study demonstrated clearly that both men and women who moved to longer working hours showed significant increases in adverse health behaviours and risk factors, with women more than doubling their risk of suffering major depressive episodes.[87]

Both overwork and unemployment can therefore be stressful. One Japanese study found that the underemployed and overworked had equally elevated risks of heart attack.[88] For women in particular, the health impact of work cannot be examined in isolation from their unpaid work burden. While women have doubled their labour force participation rates in recent decades, time use studies demonstrate that they still do almost two-thirds of the household work. Employed mothers in general, and employed single mothers in particular, have the highest rates of time stress of any demographic group, and put in an average 75-hour total work week when both paid and unpaid work are counted.[89]

In short, employment can affect physical and mental health in many and diverse ways, both directly and indirectly. For this reason, any analysis of women's employment patterns must go beyond simple rates of employment and unemployment, and examine also changes in type of employment, job security, work hours, job satisfaction and control, and other factors.

Statistics Canada's Canadian Community Health Survey now includes questions on decision latitude at work, since that has been reliably identified as a key factor in generating stress and job strain. Since those results are now available by health district, they are reported separately in the chapter on Atlantic regional health variations. This chapter presents the latest employment results from Statistics Canada's new report on *Women in Canada: Work Chapter Updates,* released in April, 2002, along with trends for the four Atlantic provinces from the 2001 *Labour Force Survey* and Statistics Canada's *Labour Force Historical Review 2002.* This overview will therefore update and expand the data on women's employment in Atlantic Canada provided in the 2000 statistical profile of women's health in Atlantic Canada.

This analysis is unable to explore the pathways between particular employment characteristics and health outcomes, but the data presented here will hopefully be useful to researchers attempting such an analysis.

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[86] Fryer, David, "Unemployment: A Mental Health Issue," C.S.Myers lecture, British Psychological Society, annual conference, Brighton, U.K., in *The Jobs Letter* 24:9, September 1995.

[87] Shields, Margot, "Long working hours and health," Statistics Canada, *Health Reports* 11 (2), Autumn, 1999, pages 33-48. This article was also adapted for Statistics Canada's *Perspectives on Labour and Income,* catalogue no. 75-001-XPE, Spring, 2000, pages 49-56.

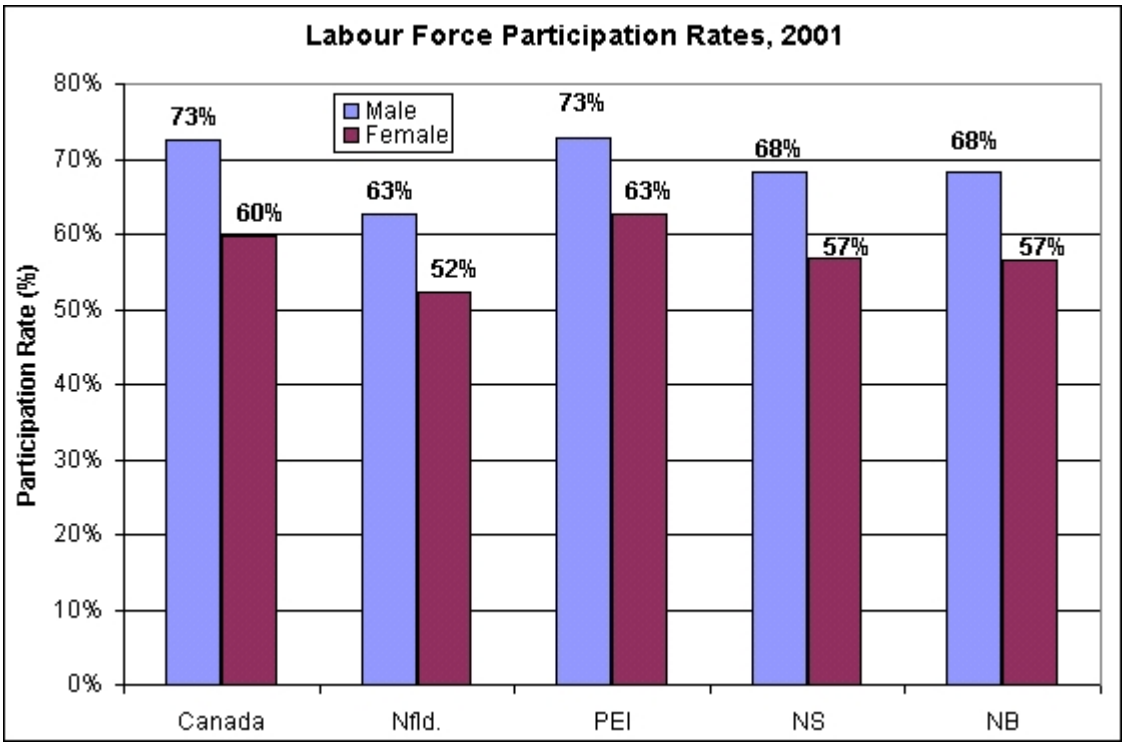
[88] Sokejima, S. and S. Kagamimori, "Working hours as a risk factor for acute myocardial infarction in Japan: Case Control Study," *British Medical Journal* 317, 1998, pages 775-780.

[89] Statistics Canada, *Overview of the time use of Canadians in 1998,* General Social Survey, catalogue no. 12F0080-XIE, November, 1999; and Statistics Canada, *The Daily,* catalogue no. 11-001E, November 9, 1999, page 4.

3.1 Increases in women's employment rates

Labour force participation includes both those who are working, and those who are actively looking for work. The proportion of Canadian women who participate in the paid labour force has more than doubled in the last forty years, from 27% in 1961 to 45% in 1981 to 60% in 2001.[90] In the Atlantic provinces, female labour force participation rates range from a low of 52.3% in Newfoundland and Labrador – the lowest rate in the country – to a high of 62.8% in Prince Edward Island, the second highest rate in the country after Alberta (Figure 19).

Figure 19. Labour force participation rates, Canada and Atlantic provinces, 2001 (%)



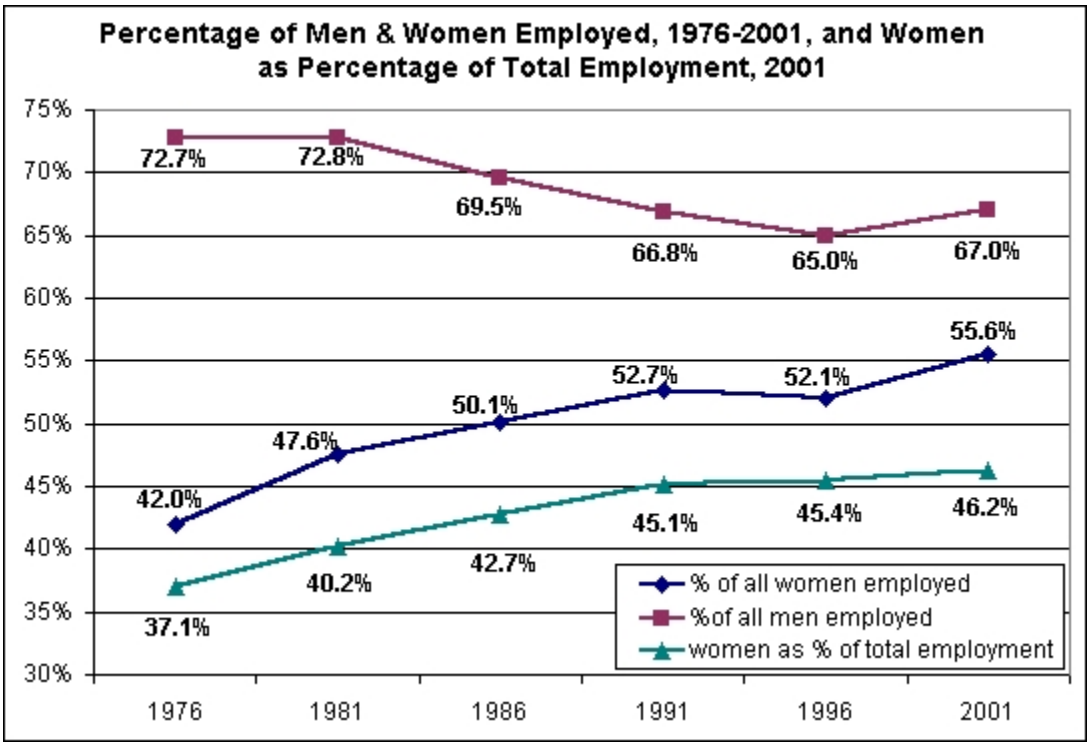
Source: Statistics Canada, Labour Force Historical Review 2002.

Throughout Canada, there has been a clear and steady convergence between male and female shares of total employment in the last 25 years. The female employment rate has increased by one-third in that period, while the male employment rate has fallen. In 2001, 56% of all women aged 15 and over had jobs, up from 42% in 1976. By contrast, 67% of all men had jobs in 2001,

[90] Historical labour force participation rates from Statistics Canada, *Charting Canadian Incomes: 1951-1981,* catalogue no. 13-581E, pages 10-11; Statistics Canada, *Women in Canada,* 3rd edition, catalogue no. 89-503E, page 88; Statistics Canada, *Women in the Workplace,* 2nd edition, catalogue no. 71-543E, page 10. 2001 labour force participation rates from Statistics Canada, "Labour force estimates by education, age group, sex, Canada, provinces, annual average, 2001," *Labour Force Historical Review 2002.*

down from 73% in 1976. As a result, women today make up 46% of the employed work force – the highest percentage ever, up from 37% in 1976 (Figure 20).[91]

Figure 20. Percentage of men and women employed, and women as percentage of total employment, Canada, 1976 – 2001



Source: Statistics Canada, *Women in Canada: Work Chapter Updates,* Table 1, Employment

Even though Atlantic Canada has lower employment rates for both men and women than the rest of Canada, the female *share* of jobs has increased even more rapidly in this region than elsewhere. In fact, the gap between male and female employment is narrower here than in any other part of the country.

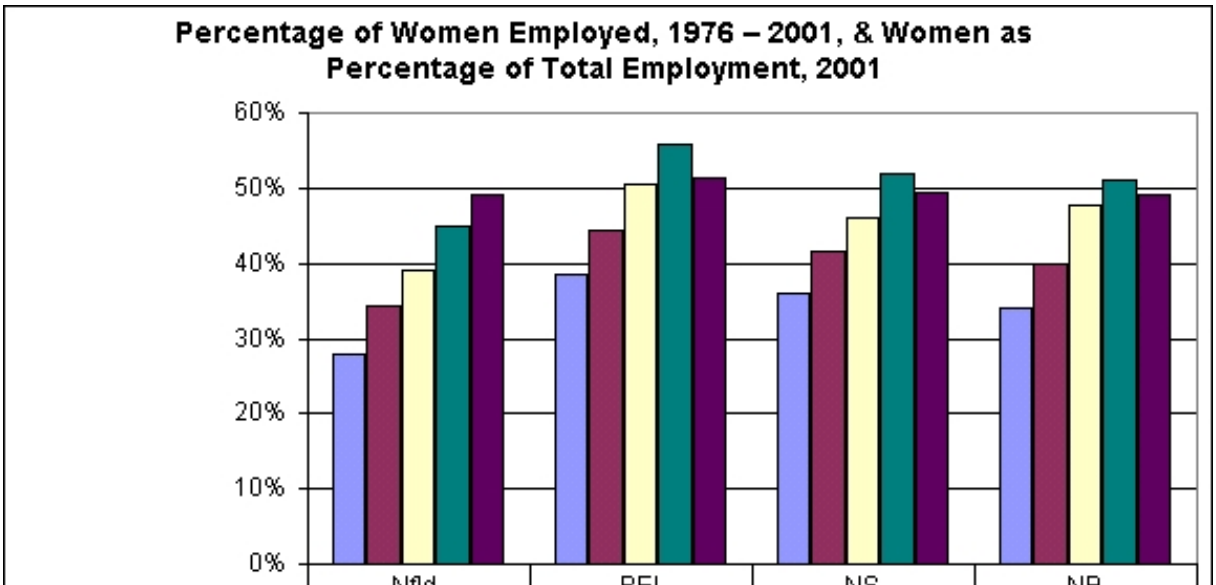
The percentage of women with jobs in Newfoundland increased from 27.9% in 1976 to 45% in 2001; in PEI from 38.5% to 55.7%; in Nova Scotia from 35.9% to 51.8%; and in New Brunswick from 34.1% to 51.2%, while the percentage of men with jobs has fallen in all four provinces. Thus in 2001, women in Newfoundland, Nova Scotia, and New Brunswick made up more than 49% of all paid workers, compared to 46% in the rest of Canada, while PEI was the only province in the country that actually had more women working for pay than men (Figure 21).

[91] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 4 and 10, Tables 1 and 2; Statistics Canada, *Labour Force Historical Review 2002.*

However, the nation-wide increase in female employment is not spread evenly among all age groups and educational levels. Women aged 25-54 have increased their employment rate the fastest – by more than half in the last 25 years. By 2001, 75.3% of Canadian women aged 25-44 had a job, compared to less than 50% in 1976; and 72.2% of women aged 45-54 had a job, up from 45.6% twenty-five years earlier. In 1976, women aged 25-54 were only about half as likely to be employed as men. Today they are 87% as likely to be employed. Male and female youth aged 15-24 are equally likely to be working today, with just over 56% of each employed in 2001, compared to 52% of young women and 60% of young men in 1976.[92]

Women with a university degree are more than twice as likely to have a job as women who have not completed high school, and they are 95% as likely as men to be employed. In 2001, 75.4% of female university graduates had a job, compared to 79.3% of male graduates. By contrast, women with less than a grade 9 education are less than half as likely to be employed as their male counterparts – 13.6% of women compared to 29.4% of men.[93]

Figure 21. Percentage of women employed, 1976 – 2001, and women as percentage of total employment, 2001, Atlantic provinces, (%).



	Nfld.	PEI	NS	NB
1976	27.9%	38.5%	35.9%	34.1%
1985	34.4%	44.4%	41.7%	39.8%
1995	39.2%	50.4%	46.1%	47.6%
2001	45.0%	55.7%	51.8%	51.2%
% of total employment	49.2%	51.3%	49.4%	49.1%

Sources: Statistics Canada, Women in Canada: Work Chapter Updates; Statistics Canada, Labour Force Historical Review 2002

[92] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 5 and 11, Table 4.
[93] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 5 and 11, Table 3.

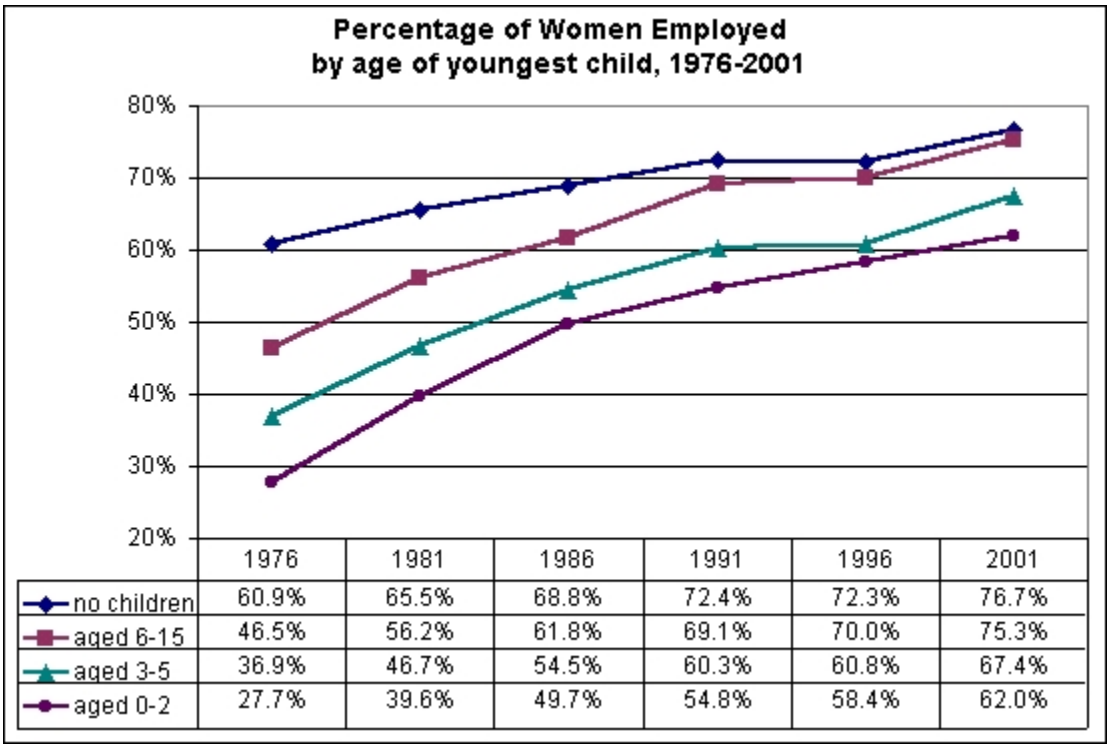
Women without children have always been more likely to work for pay than women with children. In 1976, for example, 61% of Canadian women without children under 16 had jobs, compared to 39% of those with children, and 28% of those with infants under 3. But, since that time, women with children have sharply increased their rate of employment, with particularly dramatic increases for women with infants. Women whose youngest children are aged 6-15 are now almost as likely to work for pay (75.3%) as women without children (76.7%). And women with children under 6 have more than doubled their employment rate, from 31.5% in 1976 to 64.2% in 2001.[94]

Since 1976:

- women without children have increased their employment rate by 26%;
- women with a youngest child aged 6-15 have increased their employment rate by 62%;
- women with a youngest child 3-5 have increased their employment rate by 83%; and
- women with a youngest child aged 0-2 have increased their employment rate by 124%

(Figure 22).

Figure 22. Percentage of women employed, by age of youngest child, Canada, 1976-2001



	1976	1981	1986	1991	1996	2001
no children	60.9%	65.5%	68.8%	72.4%	72.3%	76.7%
aged 6-15	46.5%	56.2%	61.8%	69.1%	70.0%	75.3%
aged 3-5	36.9%	46.7%	54.5%	60.3%	60.8%	67.4%
aged 0-2	27.7%	39.6%	49.7%	54.8%	58.4%	62.0%

Source: Statistics Canada, Women in Canada: Work Chapter Updates

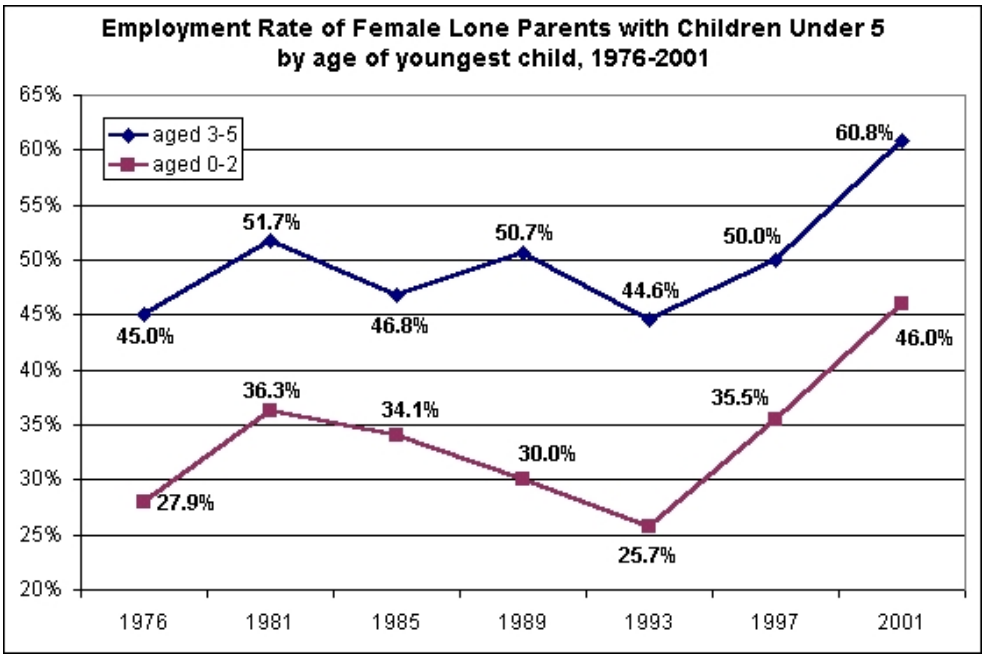
The staggering increase in employment for women with very young children has major implications for policy, child-rearing, and family finances that have not been adequately studied or debated in Canada.

[94] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 6 and 12, Table 5

- What are the impacts of this dramatic social shift on children and on families?
- Is the increase in female employment driven primarily by financial necessity, by career goals, or by equity considerations?
- What new workplace arrangements are necessary to accommodate the dual needs of job and household?
- Why has the gender division of labour within the household not changed as rapidly as the gender division of labour in the market economy? Statistics Canada time use surveys show that women still perform nearly two-thirds of the household work.
- What new national and provincial child-care policies are now needed?
- Are families paying more to work more? Between 1986 and 1997, for example, the inflation rate in Nova Scotia was 48% for child care, 44% for restaurant food, and only 26% for wages.[95] In other words, families are becoming more dependent on eating out and paid child-care, but the cost of these services is rising at a more rapid rate than their incomes.

By contrast with the trends outlined above, the employment rate of single mothers with young children remained fairly stable until 1993, dipping somewhat during the recessions of the early 1980s and early 1990s. After 1993, employment increased very sharply, jumping by nearly 80% in just eight years for single mothers with infants (Figure 23).[96]

Figure 23. Employment rate of female lone parents with children under 5, by age of youngest child, 1976-2001 (%)



Source: Statistics Canada, Women in Canada: Work Chapter Updates

[95] Statistics Canada, *The Consumer Price Index,* catalogue no. 62-001-XPB; Statistics Canada, CANSIM database 7466 and 1453; Statistics Canada, Average Weekly Wages, Nova Scotia: Industrial Composite.
[96] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 6 and 13, Table 6.

Changes in the business cycle and in social policy appear to have had a much stronger effect on the employment patterns of single mothers with young children than on their married counterparts. It is likely that the sole child-rearing responsibilities of single mothers force many into insecure, temporary, part-time jobs that are the first to be cut during an economic downturn. In 1993 major cuts to federal social transfers and to provincial social assistance programs contributed to a sharp increase in the poverty rates of single mothers and their children, pushing many single mothers into the market economy.

3.2 Types of employment and job security

Type of employment and occupation, as well as length of time in a job, can have a major effect on job security, income level, and financial security, or it may reflect personal choice. For example, part-time work tends to fetch lower rates of pay, but may be chosen for reasons of child care and family responsibilities, schooling, illness, or personal preference. On the other hand, those who work part-time because they cannot find full-time work are classified as "involuntary" or "underemployed" part-time workers.

Involuntary part-time work, most temporary work, marginal self-employment, non-unionized work, short job tenure, and incidence and duration of unemployment are all markers of job insecurity, which in turn may have adverse impacts on health. Indicators of job security and stability will be examined briefly here from a gender and regional perspective where possible.

3.2.1 Degree and type of part-time and temporary work

About 27% of all employed women work ***part-time***, or less than 30 hours a week, compared to 10% of men. Since the late 1970s, about 70% of all part-time workers have been women. When asked why they work part-time, more than one in five Canadian women give child care or other family responsibilities as the primary reason. Only 2.3% of men give this reason. One quarter of Canadian women work part-time because they cannot find full-time employment. This is a sharp drop from 1997, when 35.3% of female part-time workers were involuntary part-timers. All four Atlantic provinces have a higher rate of ***involuntary part-time*** work among women than the Canadian average. In Newfoundland, more than half of the women working part-time are doing so primarily because they cannot find full-time work. This is twice the Canadian rate (Figure 24).[97]

Temporary jobs include ***seasonal work, term or contract jobs, casual jobs, and on-call work***. These jobs generally provide little security, rarely carry benefits, and tend to be low-paying. For example, only 20% of temporary jobs provide pension plans, paid sick leave, or supplementary health benefits, and only 29% provide paid vacation leave. By comparison, 55% of permanent jobs provide pension plans, 62% paid sick leave, 64% provide supplementary health benefits,

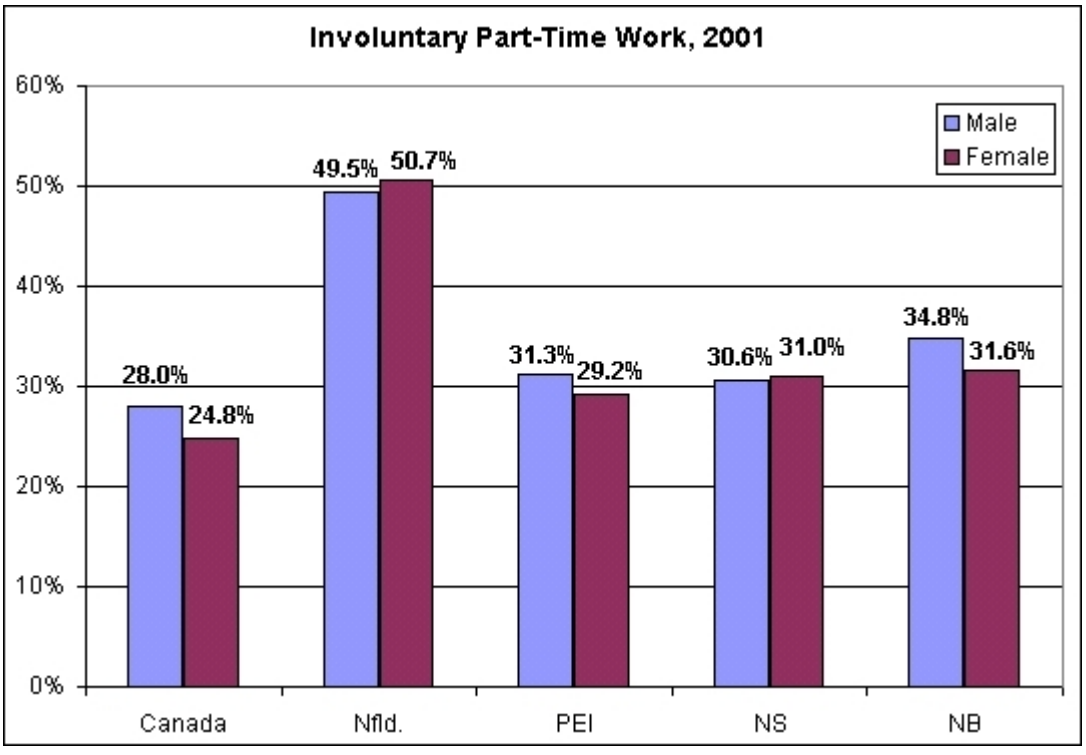
[97] Statistics Canada, *Labour Force Historical Review 2002.*

and 78% provide vacation pay.[98] Temporary jobs also provide few, if any, promotion and career advancement opportunities. Contingent and temporary workers are frequently the first laid off in times of economic downturn or reduced demand. Both men and women in Atlantic Canada have higher rates of temporary employment than in the rest of Canada (Figure 25).

Though male and female rates of temporary work are not very different, men and women tend to have different types of temporary work, and the nature of that work differs according to key industries. More men do seasonal work, and more women have term contracts and casual jobs.[99]

The high rate of temporary work in PEI is partly explained by the importance of the agriculture and tourism industries in that province. Thus, 41% of all male agriculture jobs on the Island are seasonal, and more than one-third of all accommodation and food service jobs are seasonal. Among women, 37% of all seasonal workers are employed in these two industries – 26% in the accommodation and food service industries, and another 11% in agriculture. Counting all forms of temporary work, 16% of female temporary employment in PEI is in the accommodation and food service industries.[100]

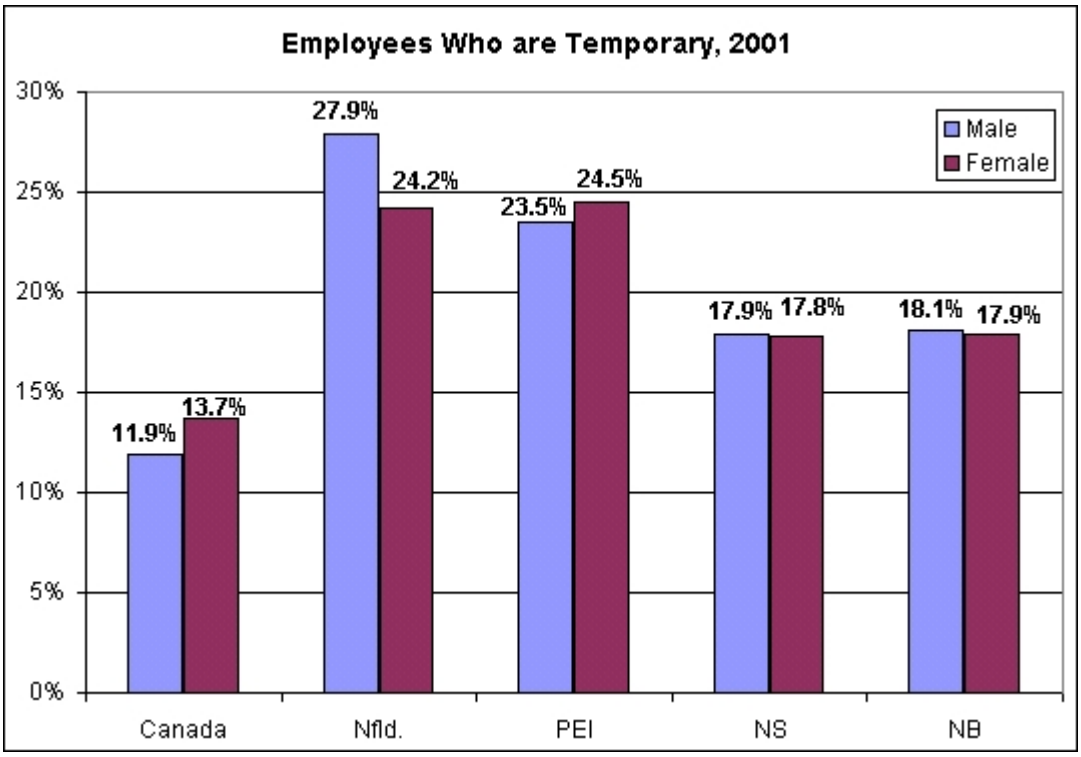
Figure 24. Involuntary part-time work, Canada and Atlantic provinces, 2001 (%)



Source: Statistics Canada, Labour Force Historical Review 2002.

[98] Grenon, Lee, and Barbara Chun, "Non-permanent paid work," *Perspectives on Labour and Income*, Statistics Canada, catalogue no. 75-001-XPE, Autumn, 1997, pages 21-31.
[99] Statistics Canada, *Labour Force Historical Review 2002.*
[100] Statistics Canada, *Labour Force Historical Review 2002.*

Figure 25. Percentage of employees who are temporary, Canada and Atlantic provinces, 2001 (%)



Source: Statistics Canada, Labour Force Historical Review 2002.

3.2.2 Self-employment

Increasing numbers of Canadian women are ***self-employed*** – 11.2% of all those with jobs in 2001 compared to 8.6% in 1976. By comparison, 18.8% of male earners were self-employed in 2001, up from 14.3% in 1976. Women have gradually increased their share of self-employment in Canada from 26% in 1976 to 31% in 1990 to 34% in 2001.[101]

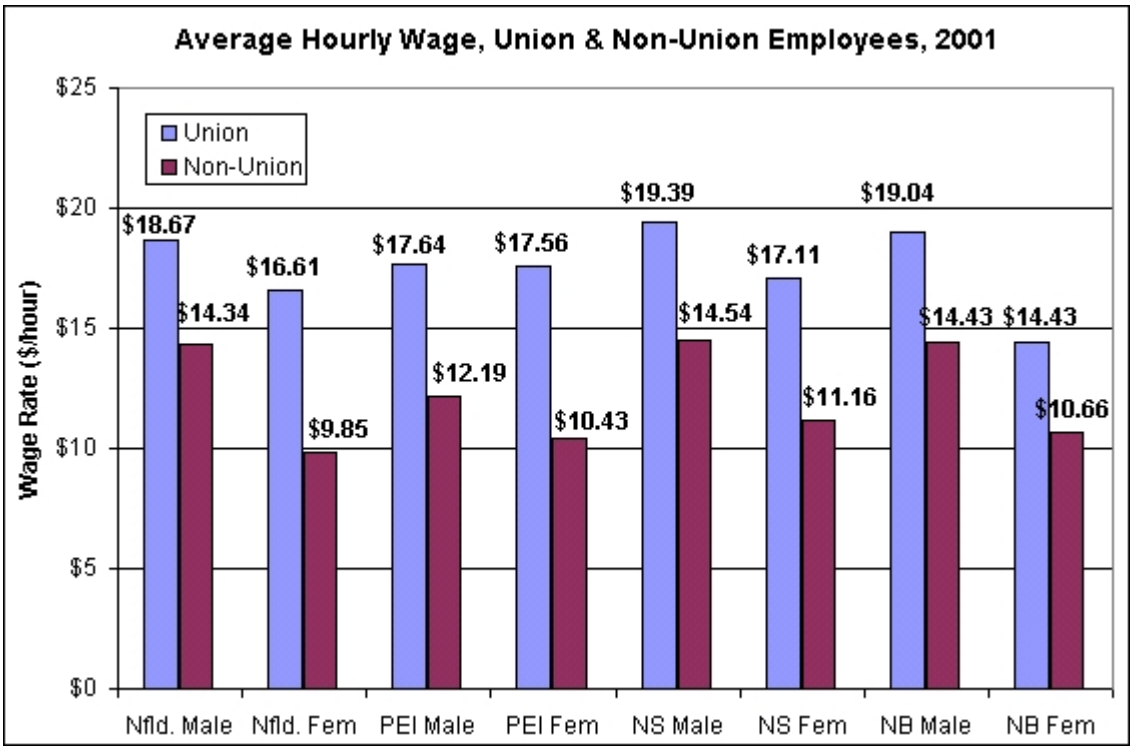
There is considerable controversy over the causes of the marked increase in self-employment in Canada. Some have argued that more people are being pushed into marginal self-employment because they cannot find paid employment, and that it is primarily a stop-gap measure until they find paid work. Others argue that it reflects a greater entrepreneurial spirit, with more people attracted to being their own boss, having greater independence, and setting their own, flexible work schedules.[102] It is possible that self-employment allows some women to balance their paid and unpaid work responsibilities more successfully than paid jobs with fixed work hours. This summary overview does not delve into this issue.

[101] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 7 and 16, Table 10.
[102] Lin, Zhengxi, Janice Yates, and Garnett Picot, "Rising self-employment in the midst of high unemployment: An empirical analysis of recent developments in Canada," Statistics Canada, catalogue no. 11F0019-MPE, no. 133, March, 1999.

3.2.3 Union coverage

Another marker of job and financial security is ***union coverage***. Union jobs tend to be higher paying, to carry benefits, and to provide protections against arbitrary layoff. Wage differentials between union and non-union jobs can be substantial, particularly for women, and union coverage provides some protection against gender-based labour market discrimination. The gender wage gap among unionized employees is much smaller than among non-unionized employees, with unionized women earning 87 cents to the male dollar compared to 77 cents for non-unionized women (Figure 26).[103]

Figure 26. Average hourly wage, union and non-union employees, Atlantic provinces, 2001 ($)



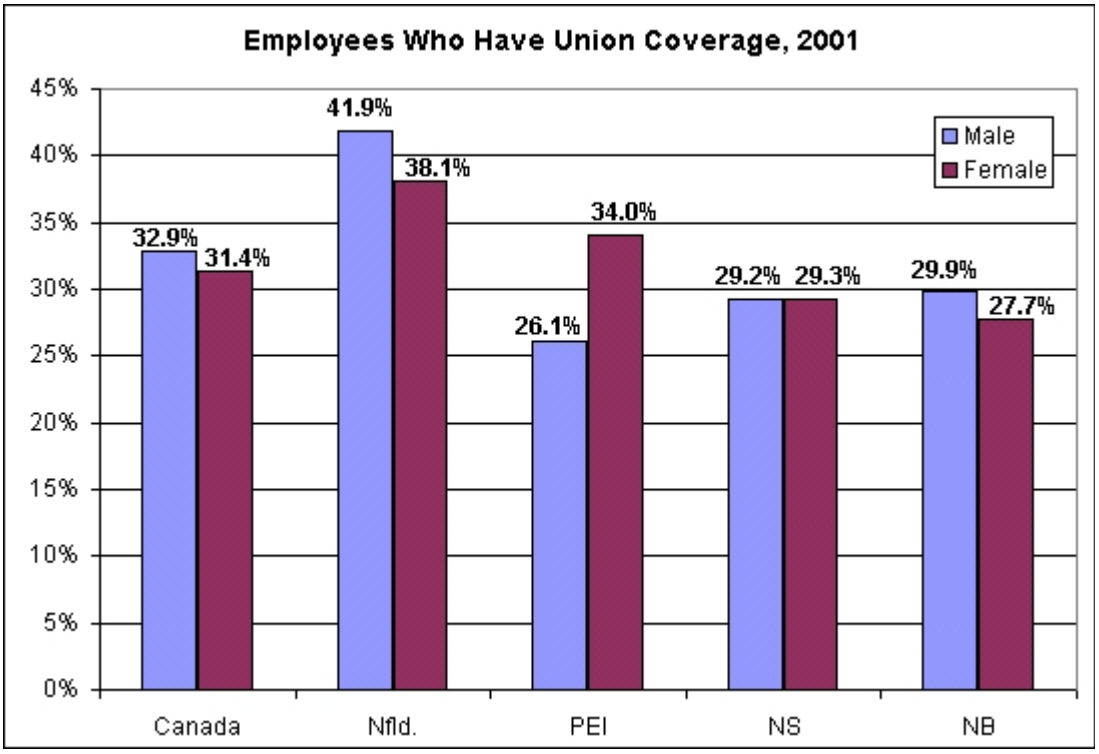
Source: Statistics Canada, Labour Force Historical Review 2002

Female union coverage has gradually increased to relative parity with male coverage in the Atlantic region. While Newfoundland and New Brunswick still have slightly higher rates of union coverage for men, Prince Edward Island has a higher rate of female union coverage, and parity between male and female union wages. This may help explain the fact that that PEI has a smaller gender wage gap than any other province.

[103] Drolet, Marie, *The Persistent Gap: New Evidence on the Canadian Gender Wage Gap,* Statistics Canada, catalogue no 11F0019-MPE, no. 157, January, 2001, page 10; Statistics Canada, *Labour Force Historical Review 2002*.

The overall proportion of Newfoundland employees with union coverage is significantly higher than the Canadian average. Interestingly, Newfoundland has high rates of union coverage, temporary work, and involuntary part-time work, indicating a relatively polarized work force, with security and decent wages for some and high levels of insecurity for others (Figure 27).[104]

Figure 27. Percentage of all employees who have union coverage, Atlantic provinces, 2001



Source: Statistics Canada, Labour Force Historical Review 2002

3.2.4 Changes in occupational and professional status

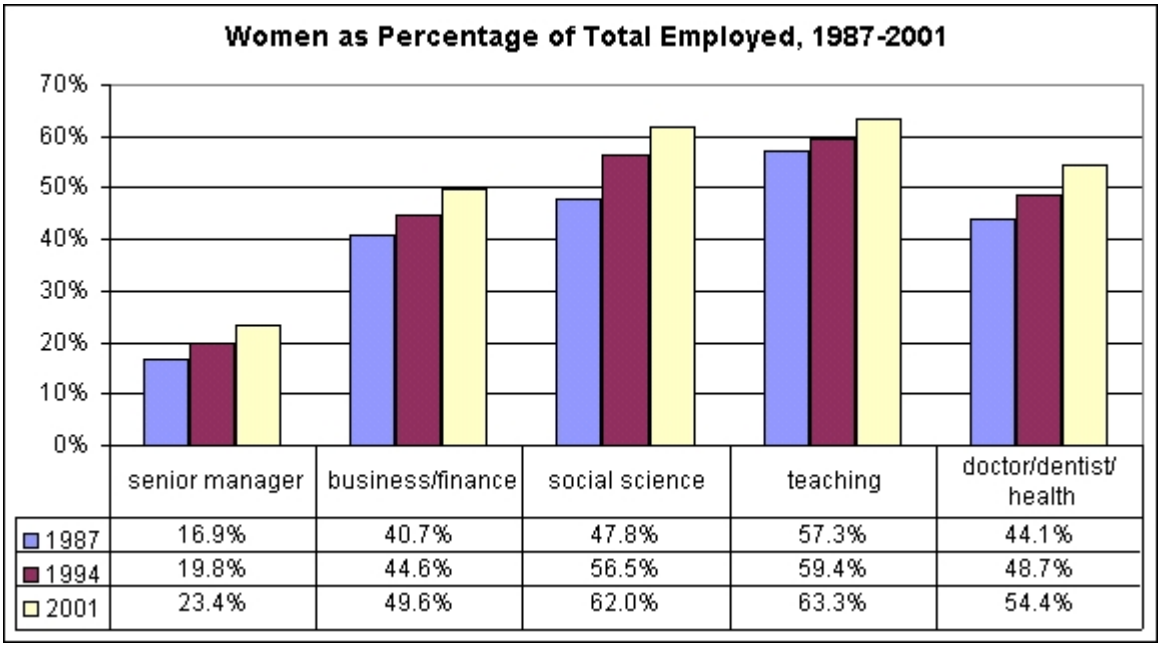
Changing occupational status may also affect income and security. In 2001, 70% of all employed women in Canada were working in occupations where women have traditionally been concentrated. Women account for 87% of nurses and health-related therapists, 63% of teachers, and 58% of sales and service personnel. In 2001, 25% percent of all employed women worked in clerical and administrative jobs, down from 30% in 1987, although women still constitute 76% of these workers. By contrast, only 30% of all employed men work in these occupations.

The most important gains for women have been in the higher paying professional and managerial fields. Women made up half of all business and financial professionals in 2001, up from 41% in 1987; 54% of all doctors and dentists, up from 44%; 62% of social scientists, up from 48%; and

[104] Statistics Canada, *Labour Force Historical Review 2002.*

35% of all managers, up from 23% in 1987. Among female managers, 35% were lower level managers, up from 31% in 1987, and 23% were senior managers, up from 17% (Figure 28).[105]

Figure 28. Women as percentage of total employed, selected occupations, 1987-2001 (%)



	senior manager	business/finance	social science	teaching	doctor/dentist/ health
1987	16.9%	40.7%	47.8%	57.3%	44.1%
1994	19.8%	44.6%	56.5%	59.4%	48.7%
2001	23.4%	49.6%	62.0%	63.3%	54.4%

Source: Statistics Canada, Women in Canada: Work Chapter Updates.

These significant occupational shifts are directly related to the rapid educational gains made by women in relation to men, which were described in more detail in GPI *Atlantic*'s 2000 statistical profile of women's health. In Canada as a whole, the percentage of women in the labour force with a university degree increased by 7.7% a year between 1976 and 1998, compared to just 4.2% for men. By 1998, a larger share of women aged 25-34 held degrees than men.[106]

The movement of women to higher paid occupations and fields of study has increased women's earnings much more rapidly than those of men. Between 1986 and 1995, women's annual earnings rose by 10.6%, while those of men fell by 1%. In 1967, the annual earnings of women working full-time, full-year were only 58.4% of male earnings. By 1997, they were 72.5% of male earnings. The wage gap has narrowed most for male and female university graduates. In fact, the higher the educational level, the smaller the gap. For doctoral graduates, the male-female wage gap has completely disappeared.[107]

[105] Statistics Canada, *Women in Canada: Work Chapter Updates,* catalogue no. 89F0133-XIE, April 2002, pages 7-8, and Table 11, page 17.
[106] Heisz, Andrew, A. Jackson, and G. Picot, *Winners and Losers in the Labour Market of the 1990s,* Statistics Canada, catalogue no. 11FOO19, no. 184, March, 2002, page 13.
[107] Heisz et al. (2002), op. cit., pages 14-17.

While this trend is certainly a sign of genuine progress and growing equity, it is tempered by detailed Statistics Canada analyses of the gender wage gap, which have tried to determine why women's hourly wages overall have remained at 80% of the male hourly wage over time despite these clear educational gains. After controlling for hours worked, educational attainment, work experience, job tenure, industry, occupation, supervisory role, and a wide range of other employment characteristics and socio-demographic factors, Statistics Canada analysts have concluded that "roughly one half to three quarters of the gender wage gap cannot be explained."[108]

3.2.5 Job tenure

Job tenure – length of time in a job – is another potential mark of job security. Longer average job tenure indicates a greater prevalence of steady long-term employment that allows workers to build up job skills, increase their wages, and advance their careers, contributing in turn to both stability and financial security. A reduction in average job tenure, on the other hand, could signal an increase in short-term contingent work that exposes workers to more spells of unemployment, increases the need for mid-career job training, and makes it more difficult to accumulate a pension, thereby undermining stability and security.

Due to more recent entry to the labour market, women's average job tenure is still about 17% less than that of men, but the gap is closing fast. As recently as 1987, average female job tenure was 31% shorter than that of men. Women have steadily increased their average job tenure in recent years, with Newfoundland women showing the sharpest gain in the country (Figure 29).[109]

The averages, however, mask important changes over time. Even positive trends may conceal an increase in job insecurity for many. For example, Statistics Canada found a 24% drop in jobs lasting between 6 months and 5 years, and a corresponding 17% increase in jobs lasting less than 6 months between 1981 and 1994. But there was no change in the 14% of jobs that lasted more than five years or in the 6% of jobs lasting more than 20 years. Thus a relatively flat average, skewed upwards by strong stability at the top, concealed a growing polarization of jobs characterized by an increase in short-term jobs and a decline in medium-term jobs. Statistics Canada concluded that between 1981 and 1994:

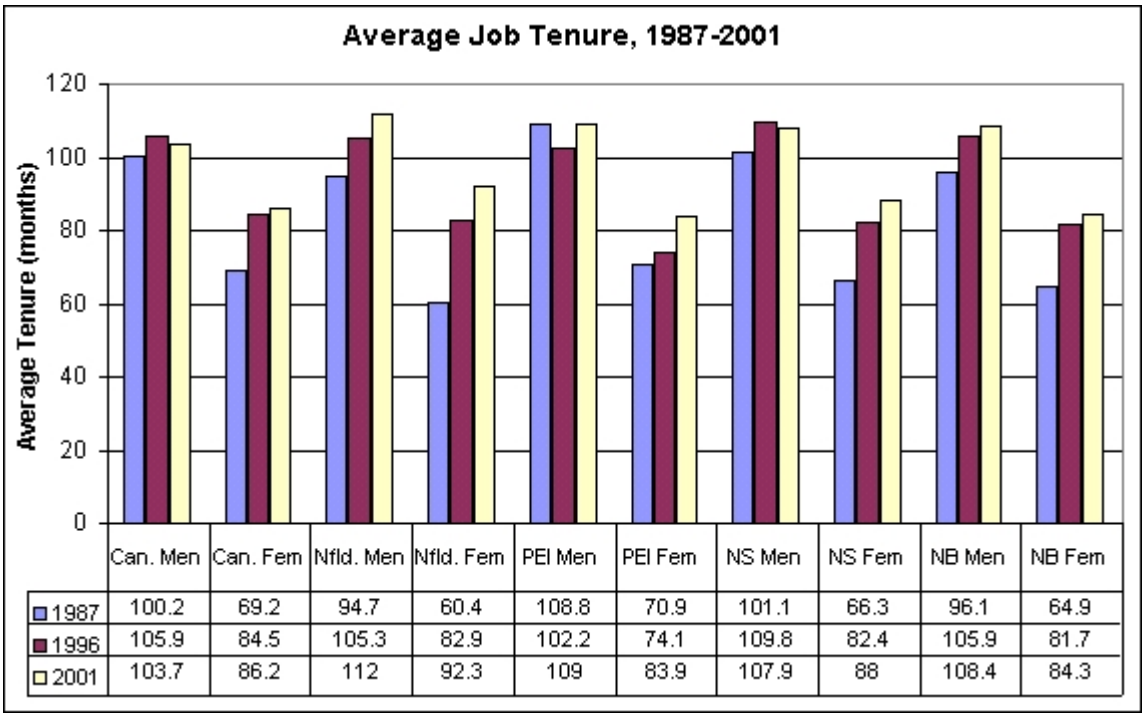
> *"Workers with more than one year of job security are enjoying increasing stability while at the same time the ranks of stable job holders [are] becoming more difficult to join."*[110]

Average job tenure figures may also conceal significant shifts among different demographic and socio-economic groups. The same Statistics Canada analysis found that those with some post-secondary education had jobs that lasted almost twice as long on average as those with less

[108] Drolet, Marie, *The Persistent Gap: New Evidence on the Canadian Gender Wage Gap,* Statistics Canada, catalogue no 11F0019-MPE, no. 157, January, 2001, page 9.
[109] Statistics Canada, *Labour Force Historical Review 2002.*
[110] Heisz, Andrew, *Changes in Job Tenure and Job Stability in Canada,* Statistics Canada, catalogue no. 11F0019-MPE, no. 95, November, 1996, pages 6-7.

education. It noted that the shift to very short-term jobs lasting less than 6 months hit women, workers over 55, and Atlantic Canadians the hardest. Paradoxically, if a woman made it to six months, then she had a better chance of her job lasting longer than five years than did a man. Thus, there was also a growing polarization of jobs among women.[111]

Figure 29. Average job tenure, (months), Canada and Atlantic provinces, 1987-2001



	Can. Men	Can. Fem	Nfld. Men	Nfld. Fem	PEI Men	PEI Fem	NS Men	NS Fem	NB Men	NB Fem
1987	100.2	69.2	94.7	60.4	108.8	70.9	101.1	66.3	96.1	64.9
1996	105.9	84.5	105.3	82.9	102.2	74.1	109.8	82.4	105.9	81.7
2001	103.7	86.2	112	92.3	109	83.9	107.9	88	108.4	84.3

Source: Statistics Canada, Labour Force Historical Review 2002

Those trends shifted markedly in the 1990s, with women sharply increasing their job stability. Between the late 1980s and the late 1990s, job stability for all employees grew markedly, with the average length of paid jobs increasing by 36%.[112] A Statistics Canada study, released October 16, 2002, summarized the latest job tenure trends:

> *"In 2001 80% of employees remained with the same employer at least one more year, compared with 76% in 1980 and 74% in 1989…. Job stability was higher among men than women in the 1980s, but the gap between them had all but closed by 2001. In 1980, about 78% of men held their jobs for at least one more year, compared with 74% of women. By 2001, the proportion for men increased slightly to 80%, and the proportion for women rose substantially to 79%.*
>
> *"Men and women with a university degree had greater job stability than their counterparts with a high school education or less. In 2001, 85% of men with a university degree held their jobs for one more year, compared with 77% of men*

[111] Heisz, op. cit., pages 10-16.
[112] Statistics Canada, *The Daily,* April 4, 2001.

> *with a high school education or less. Similarly, 85% of women with a university education held their jobs for at least one additional year, compared with 76% of women with a high school education or less."*[113]

Following the increase in short-term jobs observed between 1981 and 1994, there has been a marked decline in short-term jobs since that time. In 1980, 53% of jobs ended within a year after they started. That proportion increased to 58% in 1989, and had dropped to 47% by 2001. There has been a similar decline in very short-term jobs. In 1999, just 38% of jobs lasted less than six months, down from 48% in 1996 and 55% in 1991. Interestingly, Statistics Canada did not interpret the increase in job stability as entirely good news. The agency pointed out that the 1990s saw slower growth and more sluggish hiring than the 1980s, so that workers were less likely to quit their jobs during this period.[114]

3.2.6 Implications for gender analysis

The complexity of interpreting the job tenure data noted here is a warning against simplistic reliance on averages or on any one indicator taken in isolation. Even simple male-female distinctions can be deceptive, and do not constitute an adequate gender analysis, which must account, among other things, for distinctions among sub-groups of women. For example, the employment and job tenure data reveal entirely different results for women with university degrees and for those with less than a high school education.

Similarly, we noted in the previous chapter that the "good news" of a significant decline in the poverty rates of single mothers is tempered by deeper inquiry. That analysis reveals that 88% of single mothers without jobs still live below the low-income cut-off line, an increase from 10 years earlier, and that the massive shift to paid work among single mothers was occasioned largely by major cuts to social transfers and social assistance payments in the mid-1990s. We have also questioned the potential impacts on children of the dramatic increase in employment of mothers of infants aged 0-2, when not accompanied by provision of quality, subsidized child-care. And we have noted the increase in time stress on women, when employment gains are not accompanied by an equally dramatic shift in the gender division of labour in the household.

In sum, a proper gender analysis must include a "diversity" approach that examines the differential impacts of social and economic trends on sub-groups of women, particularly those who are disadvantaged or have distinct vulnerabilities. It must also transcend reliance on single indicators and instead encompass a deeper understanding of the complex interactions among diverse determinants of health. These are essential prerequisites for any conclusions and recommendations that are designed to lead towards effective policy interventions that can improve women's health.

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[113] Statistics Canada, The Daily, October 16, 2002. For the full report, see Heisz, Andrew, *Evolution of job stability in Canada: Trends and comparisons to US results*, Statistics Canada, catalogue 11F0019-MIE, no.162, October 16, 2002. See also Picot, G, Andrew Heisz, and Alice Nakamura, *Job Tenure, Worker Mobility, and the Youth Labour Market in the 1990s,* Statistics Canada, catalogue 11F0019-MIE, no. 155, March, 2001.

[114] Statistics Canada, *The Daily,* October 16, 2002.

3.2.7 Unemployment

Losing a job can be the ultimate form of job and income insecurity. As noted earlier, evidence points to serious physical and mental health impacts related to unemployment.

Definitions of unemployment change comparative male-female rates

Definitions of unemployment vary. The official Statistics Canada definition is as follows:

Unemployed persons are those who, during reference week:

a) were on temporary layoff during reference week with an expectation of recall and were available for work, or

b) were without work, had actively looked for work in the past four weeks, and were available for work, or

c) had a new job to start within four weeks of reference week, and were available for work.

The unemployed, in short, are defined by their availability for paid work, and their active search for paid work. The unemployment rate is therefore expressed as a percentage of the labour force, which includes all those working for pay and actively looking for work.

However, Statistics Canada has recognized that this definition does not distinguish between those unemployed for long periods and those experiencing very short spells of unemployment between jobs. The former is likely a better indicator of job and financial insecurity than the latter. The official definition also excludes many people who want jobs, but have become so discouraged that they have given up looking for work. It also excludes estimates of underemployment, including the extra hours that involuntary part-time workers would work if they could find full-time employment. To provide this information, Statistics Canada has recently developed "supplementary measures of unemployment" that expand the official definition.

Statistics Canada's supplementary unemployment rates provide measures of:

1) long-term unemployment – the proportion of the labour force unemployed for more than one year;
2) the proportion of the labour force unemployed for more than three months;
3) what Canadian unemployment rates would look like if the stricter U.S. definition of unemployment were used;
4) "discouraged searchers" – people not looking for work because they believe no jobs are available (this rate is particularly high in Newfoundland and in areas like Cape Breton);
5) people who are not officially included in the labour force because they are waiting to start a new job. This includes a) those not looking for work because they are awaiting replies from prospective employers; b) those not looking because they were waiting to be recalled to a former job; and c) people with jobs lined up to start in more than 4 weeks.
6) involuntary part-timers, or those who are "underemployed" and want to be working longer hours. These are people who would be working full-time if full-time work were available. Statistics Canada expresses this measure in terms of full-time job equivalents, to reflect the quantity of hours lost to underemployment.

Categories (1) and (2) above are smaller than the official unemployment rate, because they only count people who are in the labour force and actively looking for work, and are already included in the official unemployment statistics. Category (3) is also smaller than the official Canadian rate, because the U.S. definition of unemployment is even stricter than the Canadian one. Categories (4) and (5) include people not working for pay, but excluded from the official unemployment counts because they are not officially recognized as being in the labour force. Category (6), by contrast, counts some people who are normally counted as employed – involuntary part-timers – but who are actually underemployed. Only those hours lost to unemployment, expressed as full-time job equivalents, are included in these supplementary unemployment calculations.[115]

Any gender-based analysis of Atlantic Canada employment patterns must include these supplementary measures, firstly because this region has higher than average rates of long-term unemployment, discouraged workers, and involuntary part-timers. Secondly, women have a much higher rate of part-time work than men, and so the absolute *number* of female involuntary part-timers is also much larger than for men, even though the male and female *rates* of involuntary part-time work are comparable. A high rate of female underemployment added to the official unemployment statistics will therefore swell the official statistics much more than a similar rate of underemployment for men. For example, adding female underemployment statistics to the official Canadian unemployment statistics for 2001 swells the female unemployment rate by 3.3 percentage points compared to only 1.3 percentage points for men (Figures 30 and 31).[116] This example demonstrates the care that must be taken in any gender-based analysis.

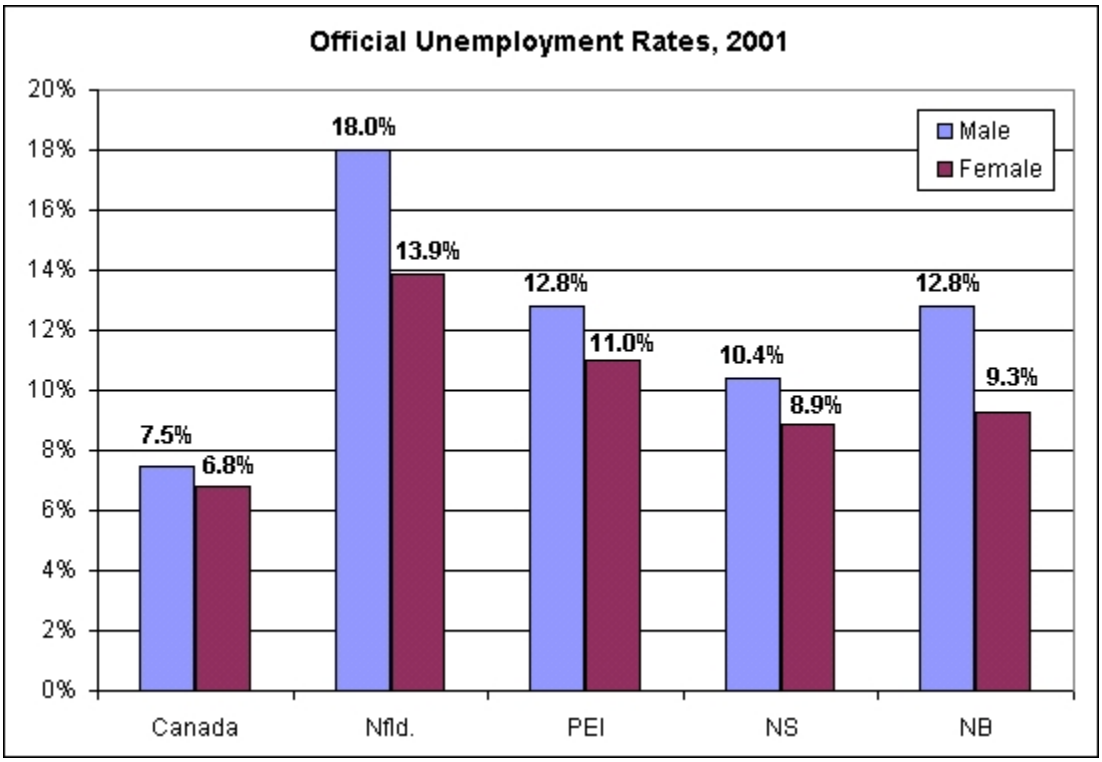
Finally, Statistics Canada provides a comprehensive measure of unemployment that adds categories (4), (5), and (6) above to the official statistics, and thus includes discouraged searchers, those waiting to start work, and the underemployed portion of involuntary part time work. (As noted, the long-term unemployed in categories (1) and (2) are already part of the official unemployment statistics.) This comprehensive measure would have raised the official unemployment statistics for Canada in 2001 from 7.5% to 9.7% for men, and from 6.8% to 10.5% for women. Even in Newfoundland and New Brunswick, where the comprehensive unemployment rate remains higher for men, the supplementary measures narrow the male-female gap (Figure 31).

Standard reporting mechanisms, based on official statistics, therefore note a lower female than male unemployment rate for Canada, whereas Statistics Canada's comprehensive measures, which are much more rarely applied, show the opposite. For example, most of the Statistics Canada sources used extensively in this report, including those specifically analyzing women's work, use only the official unemployment statistics and make no mention of the agency's supplementary measures. Heisz et al. (2002) conclude that "while unemployment was higher for women than men in the 1980s, by 1998-2000 this was reversed." Similarly, the Work Chapter Update to Statistics Canada's Women in Canada report notes that "unemployment rates are

[115] Statistics Canada, "Supplementary measures of unemployment," *Labour Force Update,* catalogue no 71-005-XPB, volume 3, no. 3, summer, 1999.
[116] Statistics Canada, "Supplementary unemployment rates by age groups, sex, Canada, provinces, annual averages," *Labour Force Historical Review 2002.*

currently slightly lower among women than men." [117] Again, the more comprehensive measures produce the opposite conclusion.

Figure 30. Official unemployment rates, Canada and Atlantic provinces, 2001 (%)



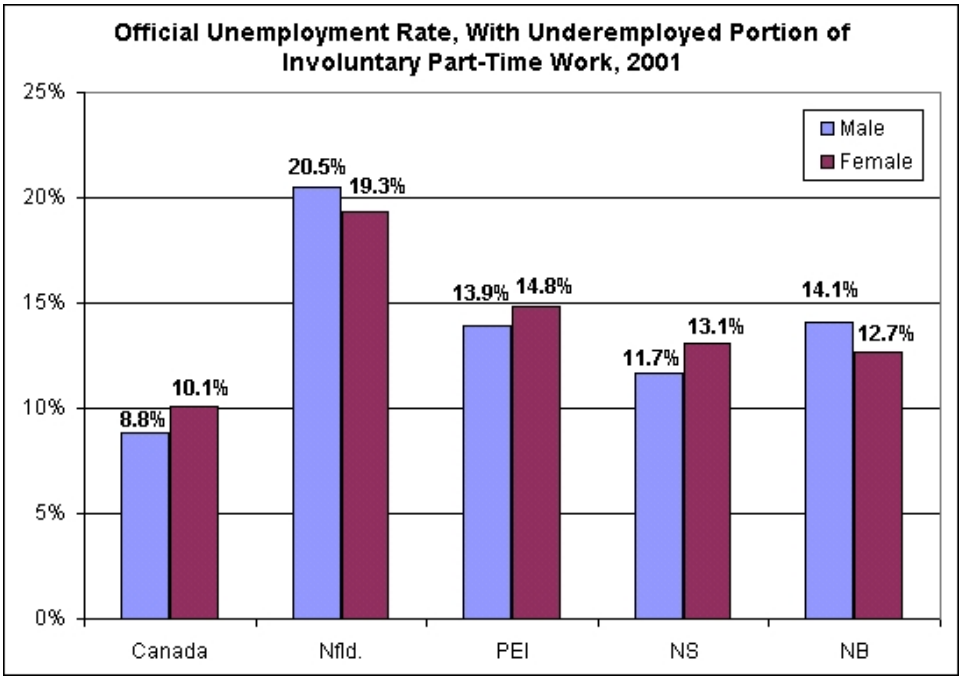
Source: Statistics Canada, Labour Force Historical Review 2002

Other measures of unemployment seek to demonstrate the causes and dynamics of unemployment. For example, "structural unemployment" occurs when workers are unable to fill available jobs because they lack the skills, do not live where jobs are available, or are unwilling to work at the wage rate offered in the market. Structural unemployment is assessed by comparing the type, location, and salary of job vacancies with the characteristics of those seeking work. A Statistics Canada analysis concluded that "although during the 1980s the outward shift in the relationship between the Help-Wanted Index and the unemployment rate raised concerns that structural unemployment was an increasing problem in Canada, that shift has been reversed in the 1990s."[118] This study cannot examine these deeper analytical issues, but does provide measures of both the official and supplementary unemployment rates for the Atlantic provinces.

[117] Heisz, Andrew, A. Jackson, and G. Picot, *Winners and Losers in the Labour Market of the 1990s,* Statistics Canada, catalogue no. 11FOO19, no. 184, March, 2002, page 17; and Statistics Canada's *Women in Canada: Work Chapter Update,* page 8.

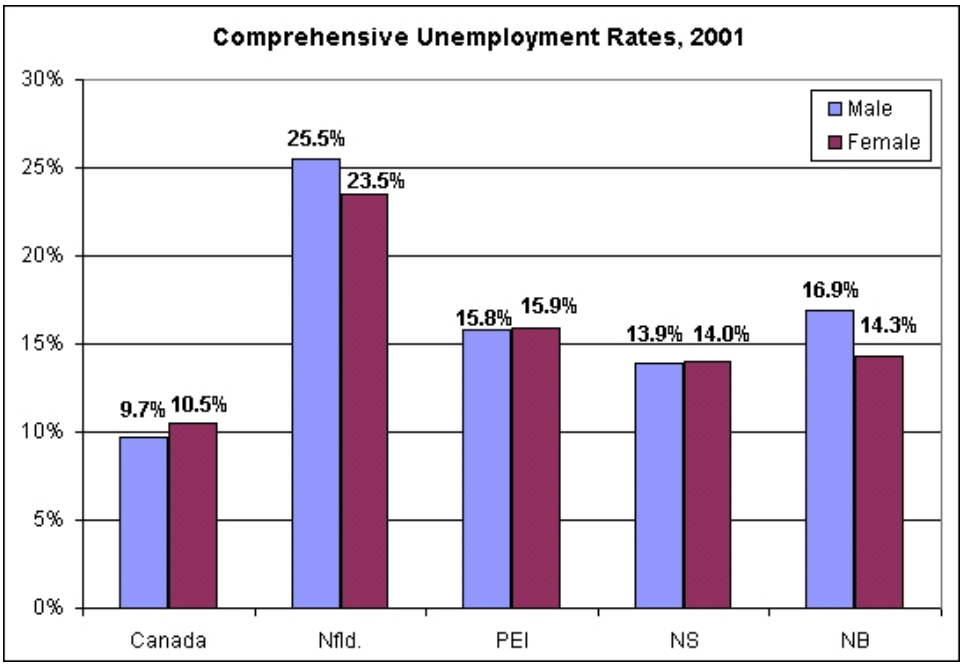
[118] Lin, Zhengxi, and Lars Osberg, "How much of Canada's unemployment is structural?", Statistics Canada, catalogue no. 11F0019 – MPE, no. 145, October 16, 2000.

Figure 31. Official unemployment rate with underemployed portion of involuntary part-time work added, Canada and Atlantic provinces, 2001 (%)



Source: Statistics Canada, Labour Force Historical Review 2002

Figure 32. Comprehensive unemployment rates, Canada and Atlantic provinces, 2001 (%)

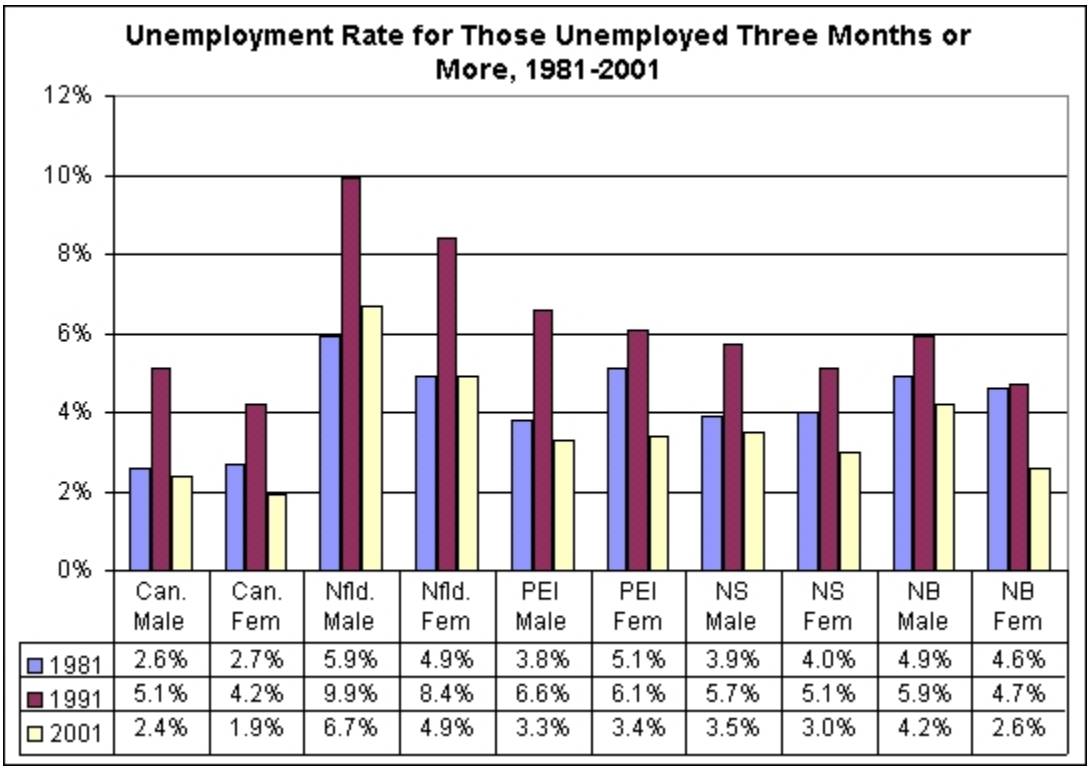


Source: Statistics Canada, *Labour Force Historical Review 2002*

Note: (Comprehensive rates include discouraged searchers, those waiting to start work, and full-time job equivalent estimates of the underemployed portion of involuntary part-time work).

Those who have been looking for paid work and unable to find it for three months or more are likely to experience much greater job and income insecurity than those unemployed for shorter periods. Long-term unemployment rates have dropped sharply in recent years for both men and women throughout Canada, but they still remain higher in the Atlantic provinces than in other regions.

Figure 33. Unemployment rate for those unemployed three months or more, Canada and Atlantic provinces, 1981 - 2001 (%)



	Can. Male	Can. Fem	Nfld. Male	Nfld. Fem	PEI Male	PEI Fem	NS Male	NS Fem	NB Male	NB Fem
1981	2.6%	2.7%	5.9%	4.9%	3.8%	5.1%	3.9%	4.0%	4.9%	4.6%
1991	5.1%	4.2%	9.9%	8.4%	6.6%	6.1%	5.7%	5.1%	5.9%	4.7%
2001	2.4%	1.9%	6.7%	4.9%	3.3%	3.4%	3.5%	3.0%	4.2%	2.6%

Source: Statistics Canada, Labour Force Historical Review 2002.

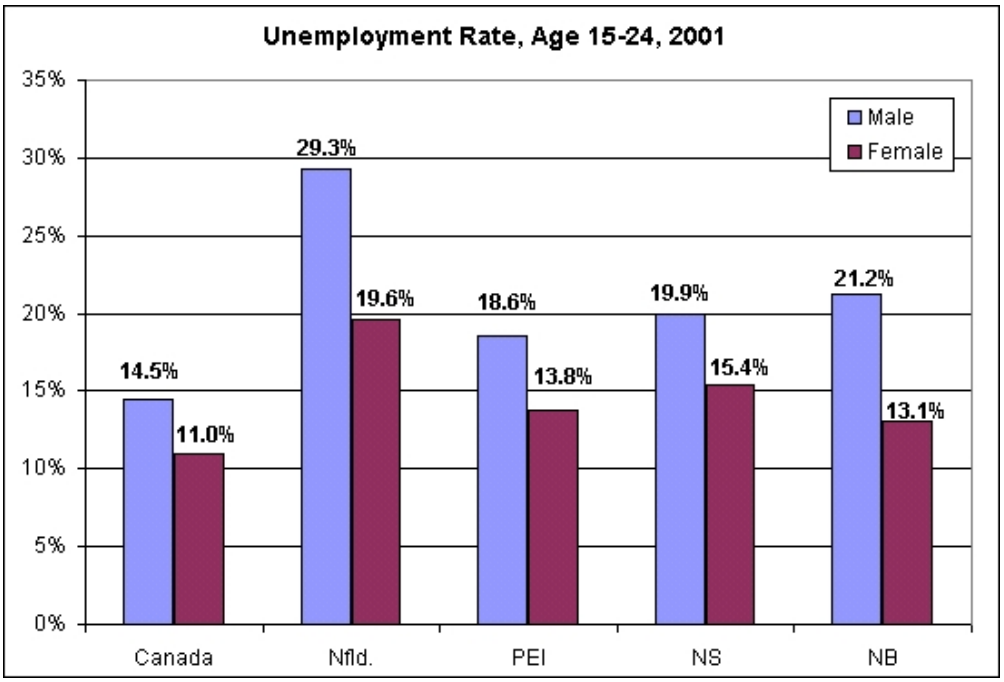
As noted above, official unemployment rates in Canada were generally higher for women than men in the 1980s, and lower in the 1990s. For workers aged 25-54, male unemployment rates dropped marginally from 6.6% to 6.5% from the late 1980s to the late 1990s, while for women, they dropped sharply from 7.9% to 6.3%. Interestingly there has also been a convergence between men and women on the duration of unemployment. For unemployed men, the average duration of unemployment dropped marginally from 4.6 weeks to 4.5 weeks between the mid-1980s and the mid-1990s, while for women the duration of unemployment rose from an average 3.8 weeks to 4.3 weeks. One Statistics Canada analysis admits frankly that "little is known regarding these relative shifts in earnings, employment and unemployment, and this remains one area requiring further research."[119]

[119] Heisz, Andrew, A. Jackson, and G. Picot, *Winners and Losers in the Labour Market of the 1990s,* Statistics Canada, catalogue no. 11FOO19, no. 184, March, 2002, page 17; and Statistics Canada's *Women in Canada: Work Chapter Update,* pages 8-9, and Table 12, page 18.

All these averages conceal significant differences among women by age, region, and other characteristics. To illustrate the importance of assessing information for different sub-groups of women, we shall briefly review the evidence on unemployment by age, education, and region.

Unemployment rates for youth aged 15-24 are more than twice as high as for older workers, and they are about one-third higher for young men than for young women (Figure 34). Indeed, the male-female gap among young people explains nearly the entire disparity between *overall* male-female unemployment rates. Women over the age of 25 were about as likely to be unemployed as men.

Figure 34. Unemployment rate, age 15-24, Canada and Atlantic provinces, 2001 (%)

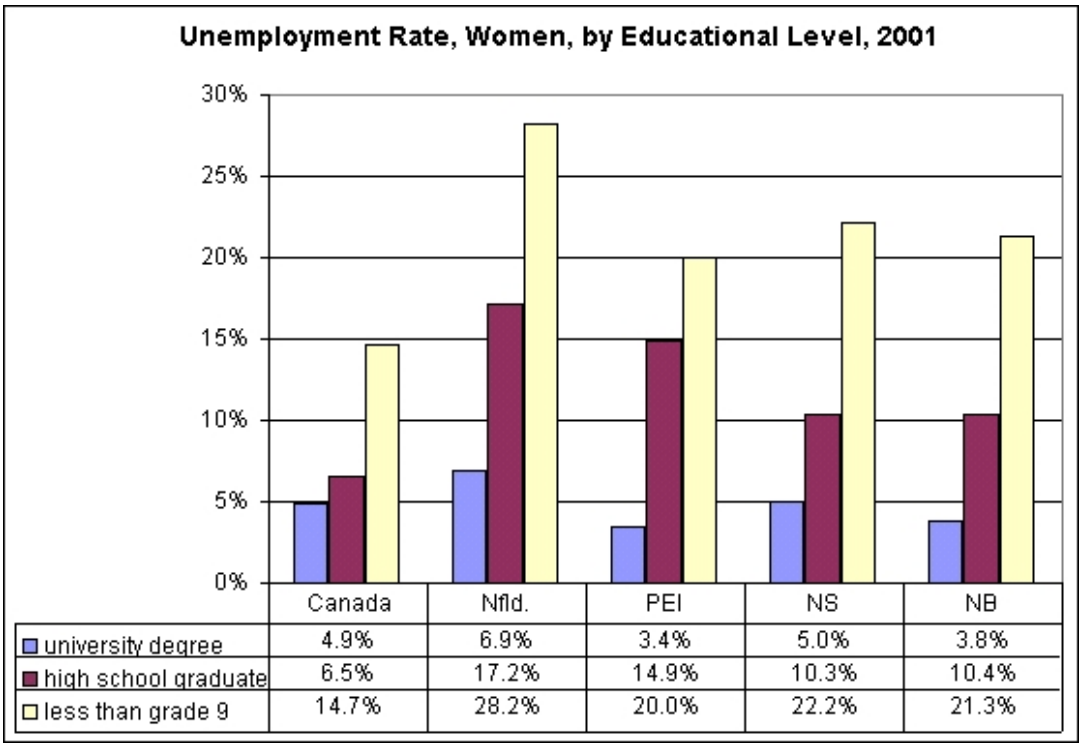


Source: Statistics Canada, Labour Force Historical Review 2002.

Women with higher education were far less likely to be unemployed than high school graduates or those with less than a Grade 9 education (Figure 35). And those who live in Cape Breton, or on Newfoundland's south coast and Burin Peninsula, the Campbellton-Miramichi region of New Brunswick, or in many other rural regions in Atlantic Canada are far more likely to be unemployed than those living in Halifax, St. John's, Moncton, and Fredericton (Figure 36).[120] In short, our male-female provincial averages conceal wide disparities among women within the four Atlantic provinces. Indeed the overall male-female gaps are far less wide than gaps based on age, education, and region.

[120] Statistics Canada, *Labour Force Historical Review 2002.*

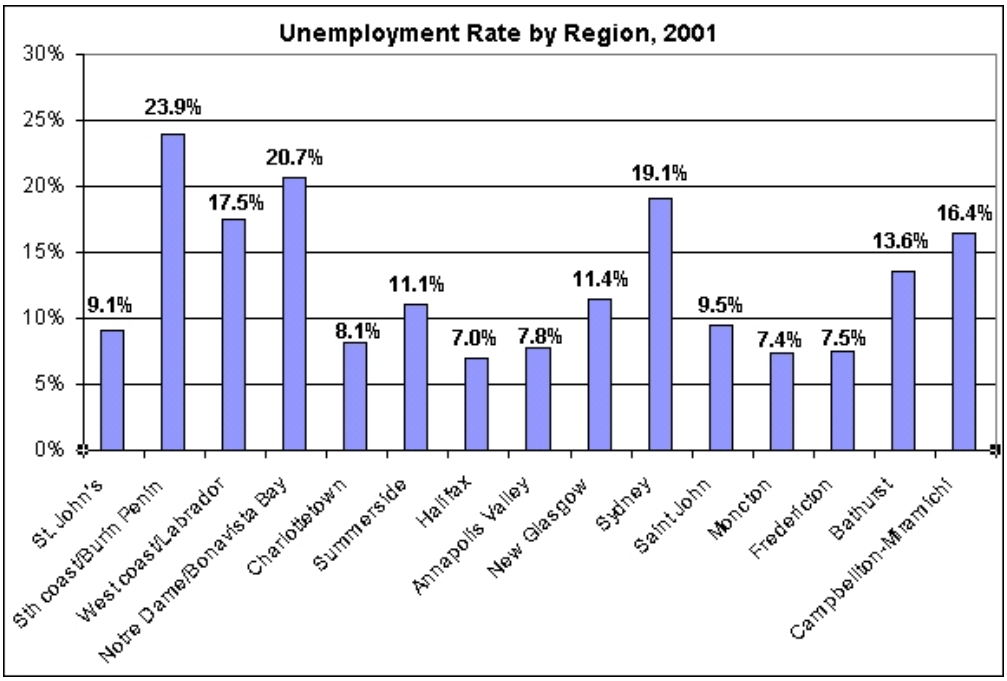
Figure 35. Unemployment, women, by educational level, Canada and Atlantic provinces, 2001 (%)



	Canada	Nfld.	PEI	NS	NB
university degree	4.9%	6.9%	3.4%	5.0%	3.8%
high school graduate	6.5%	17.2%	14.9%	10.3%	10.4%
less than grade 9	14.7%	28.2%	20.0%	22.2%	21.3%

Source: Statistics Canada, Labour Force Historical Review 2002

Figure 36. Unemployment rate by region, Atlantic provinces, 2001



Sources: Statistics Canada, *CANSIM II* database, Table 282-0053; Statistics Canada, *Labour Force Survey 2001;* Statistics Canada, *Labour Force Historical Review 2002.*

4. Balancing paid and unpaid work

The last quarter century has seen dramatic changes in women's labour market participation, some of which are briefly outlined in this chapter. As Statistics Canada analyses have acknowledged, we do not have a good understanding of the reasons for many of the shifts in women's employment and unemployment or of the persistent gender wage gap.[121] We have even less understanding of the social implications of these rapidly changing patterns, or of their implications for women's health.

One of the biggest knowledge gaps is in understanding the impacts of these labour market changes on women's *total* work burden. We do know that women have significantly higher time stress levels than men, that time stress has been growing, and that stress has adverse effects on health. We also know that the gender division of labour within the household has not changed nearly as markedly as the gender division of labour in the market economy.

We know further that policy has not kept pace with the rapid changes in women's employment patterns. For example, a coherent national child care policy has not emerged to deal with the remarkable growth in employment rates for women of infants and very young children. Nor have most workplace arrangements satisfactorily accommodated the growing need to balance job and household responsibilities.

While GPI *Atlantic* reports in the past five years have pointed to the need to account for, value, and track women's unpaid household work, and its relationship to paid employment, far more dedicated research is required to explore and understand these issues in greater depth. That exploration is not possible in this report. However, no discussion of women's work would be complete without a brief overview of trends in women's unpaid work. This discussion is essential in order that the employment trends described above not be seen in isolation, and so that potential health impacts can be assessed in the context of women's *total* work load.

The 2000 statistical profile of women's health in Atlantic Canada indicated that by 1998 Canadian women had more than doubled their rate of paid work since 1961, but still did 62% of the household work. This had fallen slightly from 65% in 1992, and from 68% in 1986 where it had remained almost unchanged since 1961.[122] In other words, there has been a modest change in the gender division of labour in the household, but it has not matched the increased hours that women put in for pay in the market economy, so women have experienced an absolute loss of free time. The 2000 statistical profile did not break down the unpaid household work burden further, and the following analysis is the first attempt to do so for the four Atlantic provinces.

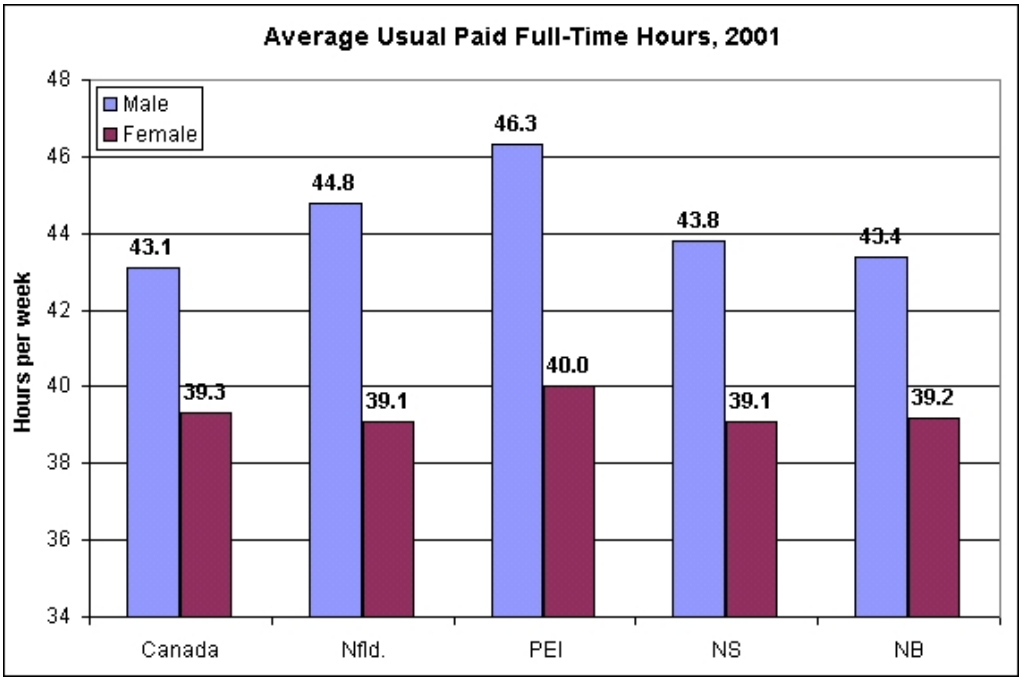
The data that follow come from the time use survey in Statistics Canada's 1998 General Social Survey. These are the most recent data on unpaid household work available in Canada, and the next data will not become available till the end of 2005, when results from the 2004 General

[121] Heisz, Andrew, A. Jackson, and G. Picot, *Winners and Losers in the Labour Market of the 1990s,* Statistics Canada, catalogue no. 11FOO19, no. 184, March, 2002; Drolet, Marie, *The Persistent Gap: New Evidence on the Canadian Gender Wage Gap,* Statistics Canada, catalogue no 11F0019-MPE, no. 157, January, 2001.
[122] Colman, Ronald (2000), *Women's Health in Atlantic Canada,* Atlantic Centre of Excellence for Women's Health and GPI Atlantic, Halifax, page 26.

Social Survey are released. It is a mark of how low on the policy agenda of governments the issue of unpaid work remains that unpaid work trends are only tracked once every six years, while economic growth statistics and paid employment trends are carefully monitored on a monthly basis. It is highly unlikely that women's total work burden and its impact on women's health will enter the policy mainstream or be sufficiently explored, debated, or understood until it is measured and tracked more frequently.

Canadian women who work full-time at a paid job put in an average of 39.3 hours a week at their paid jobs, about four hours less than most men. Atlantic Canada rates are similar, though PEI and Newfoundland men work longer hours than the Canadian average (Figure 37). When all jobs, full and part-time are counted, men put in an average of 6.7 hours more per week in paid work time than women (40.4 hours compared to 33.7 hours). [123]

Figure 37. Average usual paid hours, full-time employed men and women, Canada and Atlantic provinces, 2001, hours per week.



Source: Statistics Canada, Labour Force Historical Review 2002.

But this does not tell the whole story. Canadian women put in an average of 28.4 additional hours of unpaid household work per week, 11.6 hours more than Canadian men, who put in an average of 16.8 additional hours of unpaid work each week.

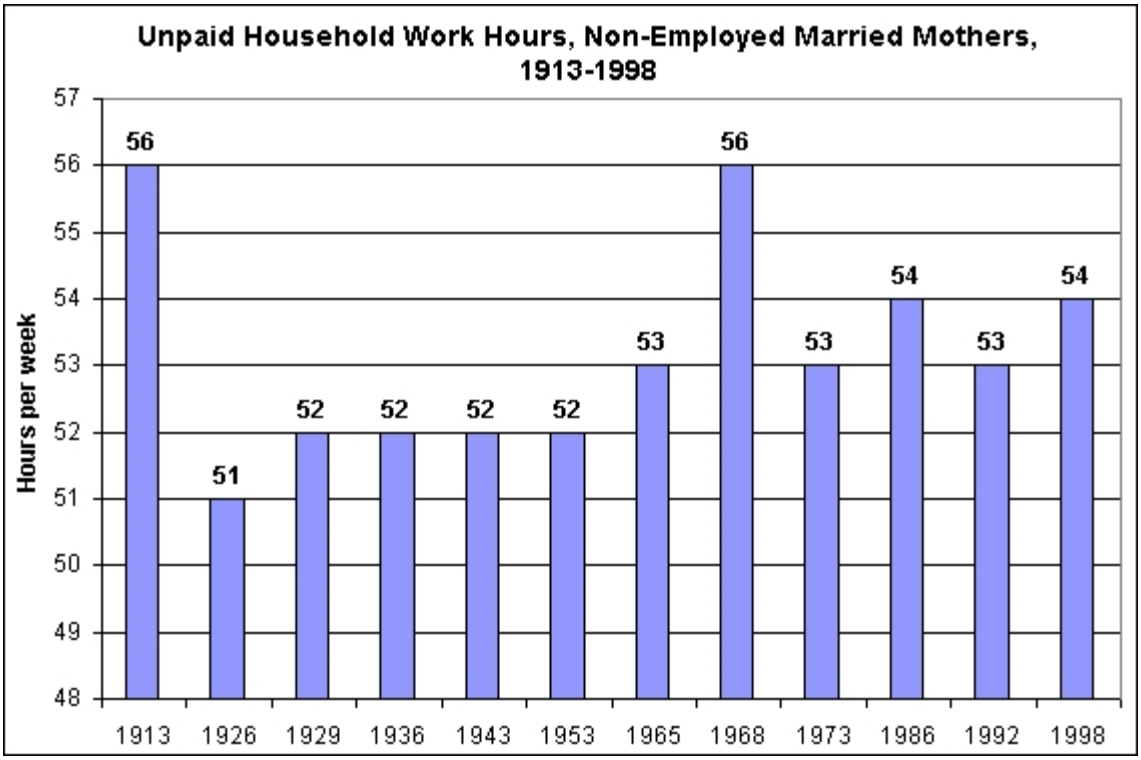
These averages conceal major differences among different groups of women. Full-time working mothers put in an average 74-hour work week when paid and unpaid work are both counted, and full-time working single mothers average 75 hours a week. By contrast, parents working part-

[123] Statistics Canada, *Labour Force Historical Review 2002.*

time put in about 10 fewer hours a week in total work time, and have correspondingly more free time and personal time.[124]

Interestingly, historical studies have found that, when children and labour force status are taken into account, there has been no fundamental change in housework hours in the last 100 years, despite the introduction of a wide range of so-called "labour-saving" devices. The constancy of household work hours over time is illustrated both by the unpaid work hours of non-employed married mothers, for whom data are available going back to the early part of the century (Figure 38), and by the fact that overall unpaid housework hours have hardly changed across Canada in 30 years.[125] The trend toward smaller families living in larger dwellings may mean that fewer household members carry a growing burden of cleaning and maintenance.[126]

Figure 38. Unpaid household work hours, non-employed married mothers, 1913-1998, based on U.S. and Canadian studies, (hours per week).



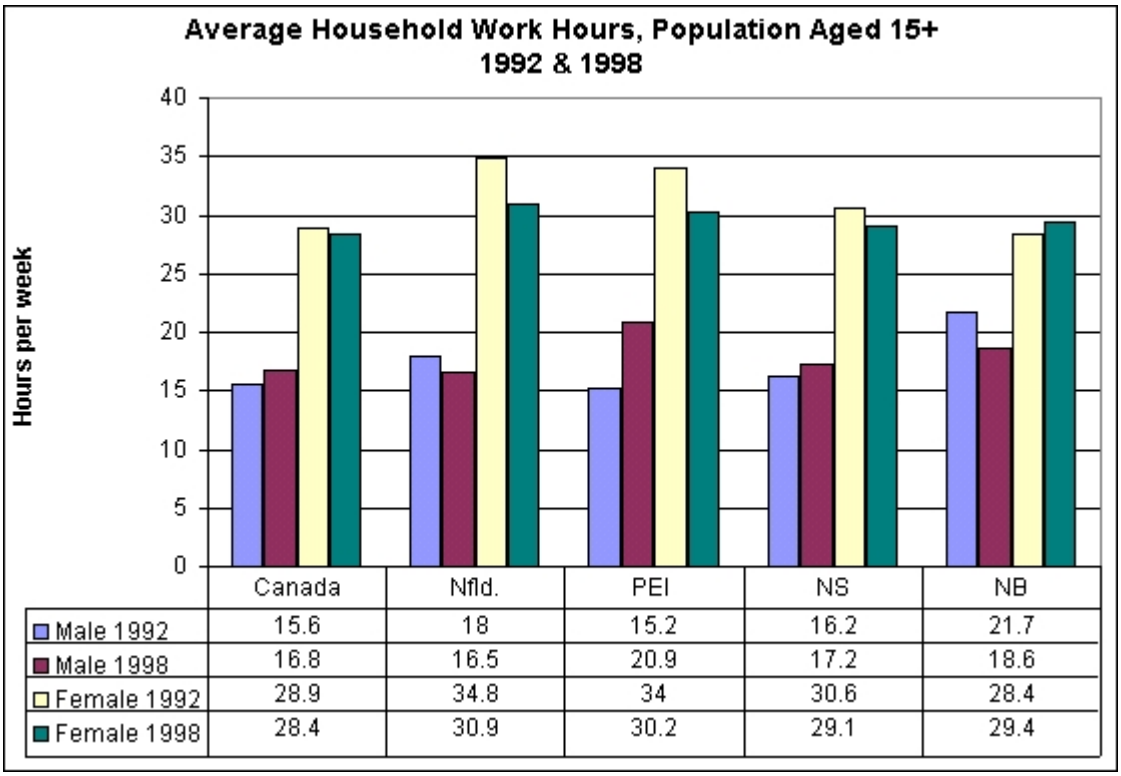
Sources: Statistics Canada, *General Social Surveys;* historical sources are listed in Colman (1998), *The Economic Value of Unpaid Housework and Child Care,* footnote 128, page 76.

[124] Statistics Canada, *Overview of the Time Use of Canadians in 1998,* catalogue no. 12F0080-XIE, Ottawa, November, 1999, Table 1, page 5, and Table 3, page 14.
[125] Sources of historical information are listed in Colman, Ronald, *The Economic Value of Unpaid Housework and Child Care,* GPI *Atlantic*, Halifax, 1998, page 76, footnote 128, and in Schor, Juliet, *The Overworked American: The Unexpected Decline of Leisure,* New York, Basic Books, 1991, pages 87 and 200. 1986, 1992 and 1998 data are from Statistics Canada's General Social Surveys. See also Colman (1998) op. cit., Figure 4.3, page 50.
[126] Colman, Ronald, *The Economic Value of Unpaid Housework and Child Care,* GPI *Atlantic*, Halifax, 1998, pages 83-87, especially Table 6.1, and Figures 6.4 - 6.7.

The Figure above refers only to the unpaid household work of non-employed married mothers. For all Canadians, 15 and older, average unpaid household work hours remained fairly stable, increasing slightly between 1992 and 1998 by 1.2 hours a week for men, and decreasing marginally by half an hour a week for women. Across the country, the gender division of labour in households narrowed slightly between 1992 and 1998. In 1992, Canadian women did about 65% of the unpaid household work and child care. In 1998, they did 63% of the household work (Table 2; Figures 39 and 40).[127]

The most dramatic change was in Prince Edward Island, where women reduced their housework hours by 11%, but men increased their hours by 38%. PEI men now put in more household work time than men in any other province. As a result, PEI now has the narrowest male-female gap in the country, with PEI women doing 59% of the unpaid household work, down from 69% in 1992. It was noted earlier that PEI also has the narrowest gender wage gap in the market economy. Alberta has the widest gender gap in Canada in the division of household work, with women in that province contributing 65% of the unpaid housework and child care (Figure 40).

Figure 39. Average household work hours, Canada and Atlantic provinces, population aged 15 and over, 1992 and 1998



	Canada	Nfld.	PEI	NS	NB
Male 1992	15.6	18	15.2	16.2	21.7
Male 1998	16.8	16.5	20.9	17.2	18.6
Female 1992	28.9	34.8	34	30.6	28.4
Female 1998	28.4	30.9	30.2	29.1	29.4

Sources: Statistics Canada, *General Social Surveys,* 1992 and 1998

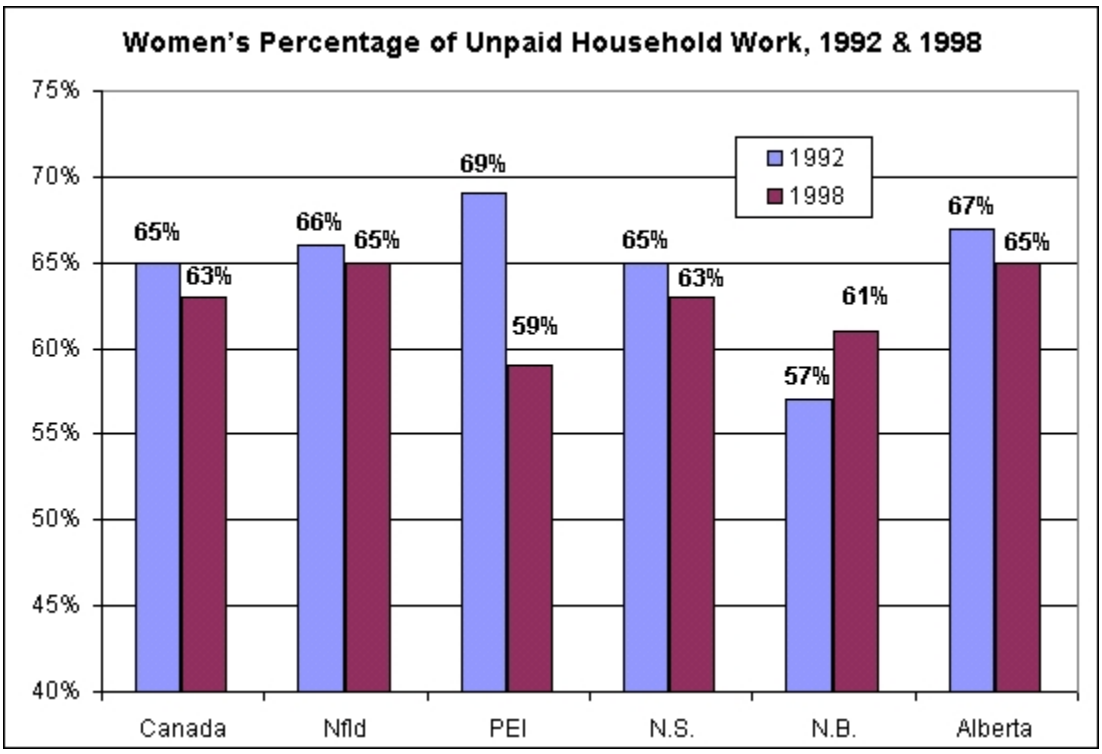
[127] Statistics Canada, *General Social Survey: Overview of the Time Use of Canadians,* November, 1999, Table 1: Canada, regions and provinces, special tabulations run for GPI *Atlantic*; Statistics Canada, *Initial Data Release from the 1992 General Social Survey on Time Use,* catalogue no. 11-612, #30, Table 1.

Table 2. Paid, unpaid, and total work hours, population 15 and over, Canada and Atlantic provinces, 1992 and 1998, (hours), and female percentage of these hours (%).

		Canada		Atl.	Nfld		PEI		Nova Scotia		N.B.	
		1992	1998	1998	1992	1998	1992	1998	1992	1998	1992	1998
Paid + unpd work hrs	All	50.2	50.6	49.2	47.5	46.7	50.3	52.4	49.4	48.5	49.4	51.6
	Male	49.8	50.9	48.4	46.3	44.0	49.5	52.0	51.3	47.0	49.8	52.5
	Fem	50.4	50.5	50.3	48.5	49.1	51.1	52.5	47.5	50.1	49.0	50.8
	Cum	100	109	107	94.8	102	101	110	98.3	104	98.8	113
	F %	50.3	50	51.1	51.2	52.9	50.8	50.4	48.3	51.7	49.6	49.5
Total paid work hrs	All	25.0	25.6	22.3	17.6	19.6	23.1	24.5	22.4	21.9	21.0	24.5
	Male	31.5	31.7	27.3	25.3	23.7	31.7	28.2	31.0	26.4	24.7	30.8
	Fem	18.7	19.5	17.6	10.2	15.5	14.9	21.0	14.1	17.6	17.4	18.4
	Cum	50.2	51.2	44.9	35.5	39.2	46.6	49.2	45.1	44	42.1	49.2
	F %	37.3	38	39.2	28.7	39.5	32	42.7	31.3	40	41.3	37.4
Vol. work F + I	All	2.7	2.5	3.3	3.4	3.3	2.3	2.8	3.4	3.5	3.3	3.0
	Male	2.7	2.3	3.4	3.2	3.9	2.5	2.7	4.1	3.5	3.3	3.0
	Fem	2.8	2.6	3.0	3.7	2.8	2.2	3.0	2.8	3.4	3.3	2.9
	Cum	5.5	4.9	6.4	6.9	6.7	4.7	5.7	6.9	6.9	6.6	5.9
	F %	50.9	53	46.9	53.6	41.8	46.8	52.6	40.6	49.3	50	49.2
Total h'hld work hrs	All	22.4	22.8	23.8	26.4	23.7	24.9	25.7	23.6	23.2	25.1	24.0
	Male	15.6	16.8	17.5	18	16.5	15.2	20.9	16.2	17.2	21.7	18.6
	Fem	28.9	28.4	29.6	34.8	30.9	32.9	30.2	30.6	29.1	28.4	29.4
	Cum	44.5	45.2	47.2	52.8	47.4	49.2	51.1	46.8	46.2	50.1	48.0
	F %	64.9	62.8	62.7	65.9	65.3	69.1	59.1	65.4	62.9	56.7	61.3
cook & wash up	All	5.5	5.4	5.1	8.1	6.1	7.5	4.9	6.7	4.7	6.8	5.7
	Male	2.6	3.2	2.9	3.7	3.3	3.0	3.0	3.4	2.3	4.1	3.3
	Fem	8.2	7.6	7.5	12.4	8.9	11.8	6.7	9.8	7.0	9.5	7.1
	Cum	10.8	10.8	10.4	16.1	12.2	14.8	9.7	13.2	9.3	13.6	10.4
	F %	75.9	70.4	72.1	77	73	79.7	69.1	74.2	75.3	69.9	68.3
clean & do laun-dry	All	4.6	4.8	6.0	5.4	6.8	5.6	6.0	4.7	5.7	4.1	5.7
	Male	1.5	2.2	2.8	1.3	2.6	1.3	2.8	1.2	2.9	1.2	2.7
	Fem	7.6	7.2	9.1	9.2	11	9.7	9.0	7.9	8.4	6.9	8.5
	Cum	9.1	9.4	11.9	10.5	13.6	11.0	11.8	9.1	11.3	8.1	11.2
	F %	83.5	76.6	76.5	87.6	80.9	88.2	76.3	86.8	70.8	85.2	75.9
shop	All	5.3	5.6	5.0	4.7	3.6	4.4	5.5	4.4	5.4	4.9	5.7
	Male	4.3	4.8	4.4	3.7	2.7	3.4	4.2	3.3	4.9	4.3	5.3
	Fem	6.2	6.3	5.6	5.5	4.4	5.4	6.9	5.4	5.7	5.5	6.1
	Cum	10.5	11.1	10.0	9.2	7.1	8.8	11.1	8.7	10.6	9.8	11.4
	F %	59	56.8	56	59.8	62	61.4	62.2	62.1	53.8	56.1	53.5

Notes: Total work hours excludes education. Cum = cumulative total of male and female hours. Vol. F + I denotes volunteer work offered through organizations (formal) and directly to individuals (informal). Paid work includes commuting time, lunch breaks, unpaid work for farm and business, and time spent looking for work. Source: Statistics Canada, *General Social Surveys* 1992 and 1998.

Figure 40. Women's percentage of unpaid household work, Canada and Atlantic provinces, 1992 and 1998 (%)



Source: Statistics Canada, *General Social Surveys,* 1992 and 1998.

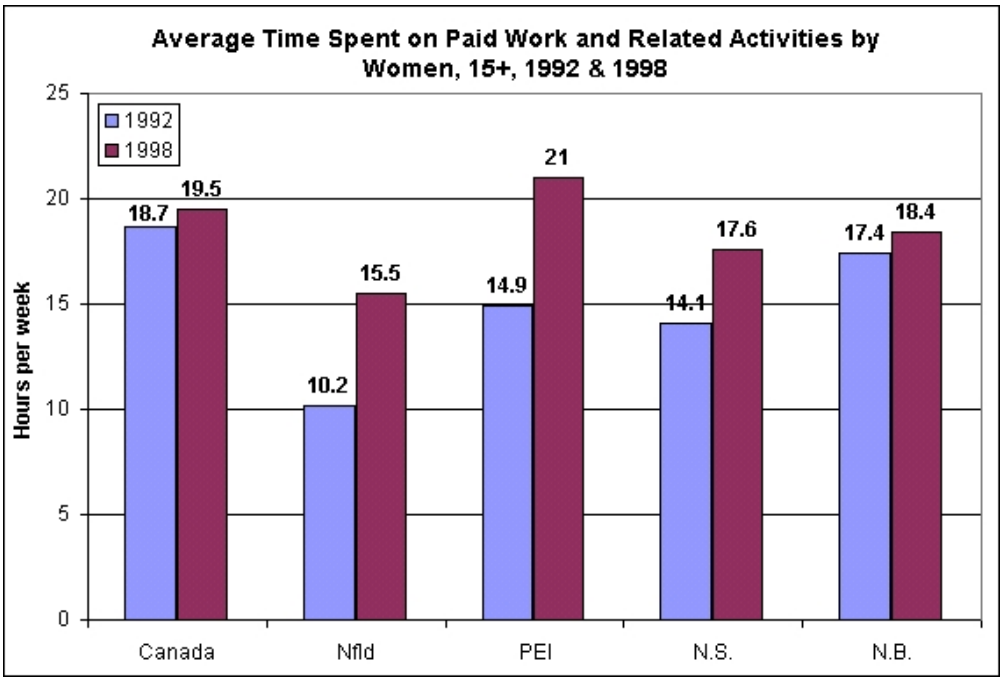
It should be noted that Statistics Canada's time use data from the General Social Surveys are averaged over the entire population 15 and older, and are not therefore comparable to data from the Labour Force Survey or other sources. In other words, paid work hours are averaged over the entire adult population, *including* those who are not employed. Volunteer hours are averaged over the entire population, *including* those who do not volunteer, and so on.

Separate and more detailed analyses are therefore required to assess different patterns for employed and unemployed adults, for those with and without children, single and married, young and old, in school and retired. These breakdowns are not publicly available for the Atlantic provinces, but could be obtained through access to Statistics Canada's micro-data files or in special custom tabulations ordered through Statistics Canada, subject to adequate survey sample size for the Atlantic provinces. That more detailed analysis has not been attempted for this report, but is highly recommended for future updates of this important material.

Table 2 above demonstrates some interesting patterns over time. In all four Atlantic provinces women have sharply increased their paid work hours (Figure 41). Although there has been a modest decline in women's household work hours in the Atlantic region as a whole, this has not fully compensated for the increase in paid work hours, and women have therefore seen their total work hours increase. Not surprisingly, Statistics Canada reports that rates of time stress increased

sharply across Canada for both men and women between 1992 and 1998. Women in 1998 registered rates of time stress that were more than 30% higher than those of men.[128]

Figure 41. Average time spent on paid work and related activities by women, aged 15 and over, Canada and Atlantic provinces, 1992 and 1998



Source: Statistics Canada, *General Social Surveys* 1992 and 1998.

4.1 Impacts on free time and personal time

The changing work patterns illustrated above have affected the free time available to women and men in the four Atlantic provinces for socializing, reading, sports, movies and other relaxation, as well as for personal care like sleep and meals. These changes again have health impacts, although they are not yet well documented and understood. What is known is that adequate sleep is necessary for good health, that stress is influenced by time available for relaxation, and that stress, in turn, can trigger a variety of ailments and has been documented as the most costly health risk factor.[129]

When free time and personal care time are added, women lost personal time in all four Atlantic provinces between 1992 and 1998. In 1992, women in all four Atlantic provinces still had more free time than women in other parts of Canada. By 1998 rates of free time and personal care time for women in the Atlantic region were at or below the Canadian level. In some cases, as in Nova Scotia, the changes in work patterns have manifested in reduced free time. In the other three

[128] Statistics Canada, *Overview of the Time Use of Canadians in 1998,* General Social Survey, catalogue no. 12 F0080-XIE, N ovember, 1999, and Statistics Canada, *The Daily,* November 9, 1999.
[129] On the health costs of stress, see for example, Geotzel, Ron (ed), "The Financial Impact of Health Promotion," *American Journal of Health Promotion* 15 (5), May / June, 2001.

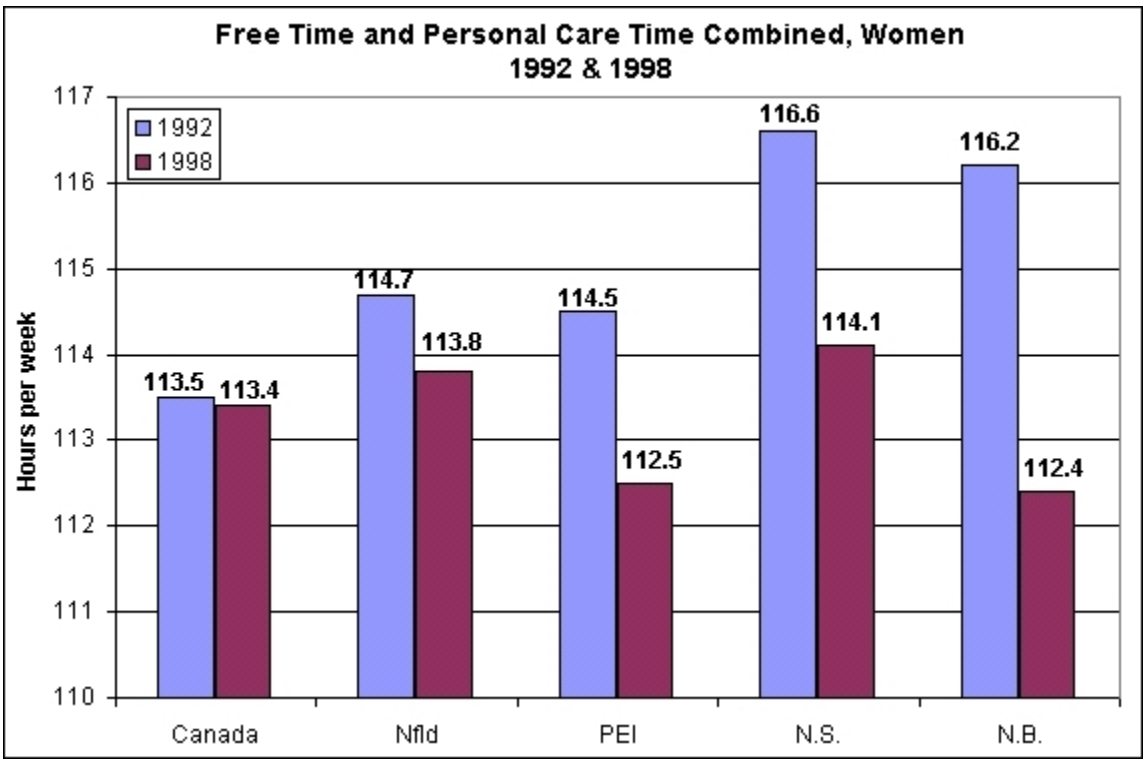
Atlantic provinces, they have reduced women's sleep and personal care time. In PEI, where men have sharply increased their share of unpaid household work, the extra work hours have also reduced free time for men (Table 3 and Figure 42).[130]

Table 3. Free time and personal care (including sleep), Canada and Atlantic provinces, 1992 and 1998 (hours per week)

		Canada		Atl	Nfld		PEI		Nova Scotia		N.B.	
		1992	1998	1998	1992	1998	1992	1998	1992	1998	1992	1998
Free time	All	40.0	40.4	42.2	41.8	44.8	42.5	41.4	43.3	43.3	39.9	39.3
	Male	42.0	41.9	45.3	44.2	49.6	46.3	43.9	43.4	45.9	41.7	41.5
	Fem	38.2	39.0	39.4	39.6	40.1	38.9	39.0	43.2	40.8	38.4	37.1
Pers. care	All	73.6	73.0	72.3	73.7	70.9	71.9	71.4	71.3	72.5	75.0	72.5
	Male	72.0	71.6	70.5	72.2	70.4	68.0	69.3	69.1	71.6	72.2	69.5
	Fem	75.3	74.4	74.0	75.1	73.7	75.6	73.5	73.4	73.3	77.8	75.3

Source: Statistics Canada, *General Social Surveys* 1992 and 1998.

Figure 42. Free time and personal care time combined, women in Canada and four Atlantic provinces, 1992 and 1998 (hours per week).



Source: Statistics Canada, *General Social Surveys* 1992 and 1998

[130] Statistics Canada, *General Social Survey: Overview of the Time Use of Canadians,* November, 1999, Table 1: Canada, regions and provinces, special tabulations run for GPI *Atlantic*; Statistics Canada, *Initial Data Release from the 1992 General Social Survey on Time Use,* catalogue no. 11-612, #30, Table 1.

While the changes may not seem dramatic in terms of absolute hours, it must be noted that these losses have occurred in a very short period of time. The consistency of the pattern across all four provinces may indicate a longer-term trend that could have serious consequences if current rates of personal time loss and increased time stress continue unabated. If free time is a core element of the quality of life of which Atlantic Canadians are justly proud, then the recent changes in women's time patterns in this region may signify the depreciation of a valuable regional asset.

In 1985, across the country, women registered lower levels of chronic stress than men, by more than 10% in the Atlantic provinces, and 6% nation-wide. Ten years later, female stress levels across Canada were 20% above male levels. Just as significantly, the regional gap appears to be closing, with Nova Scotia and New Brunswick gradually moving towards national levels of stress.[131]

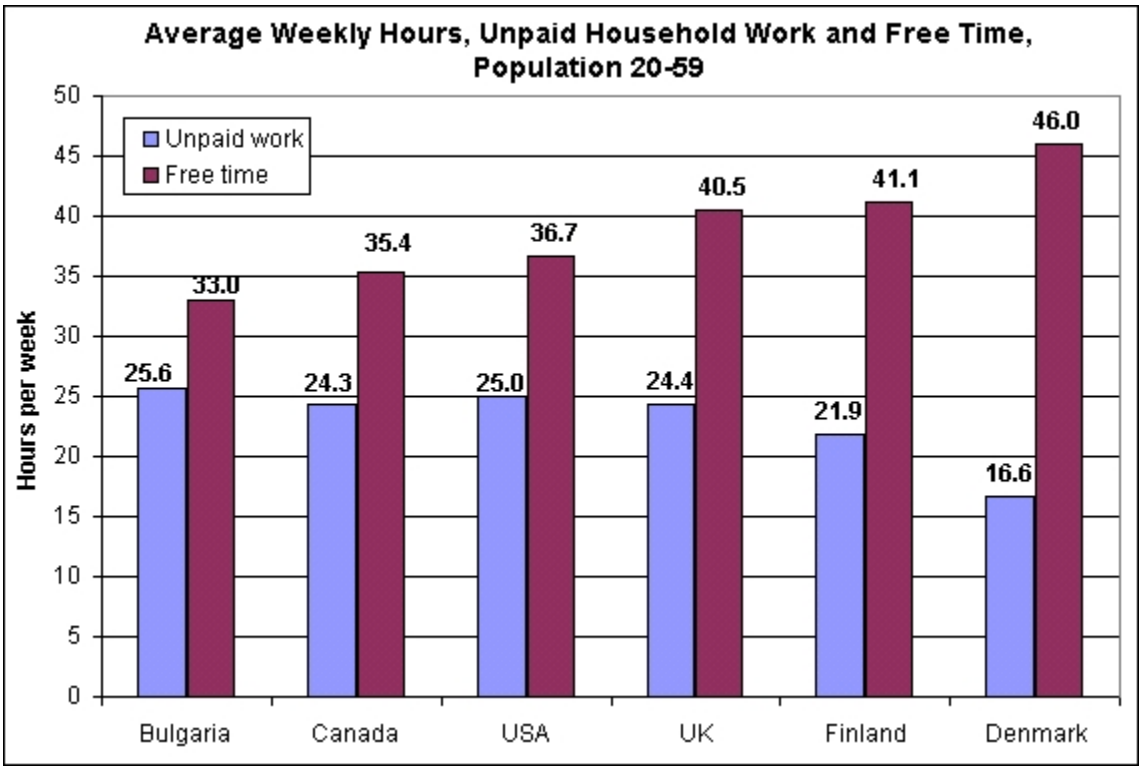
The recent 2000/01 Canadian Community Health Survey shows women in Nova Scotia and New Brunswick with stress levels still 12% and 15% respectively below those of their counterparts in the rest of Canada. As in all previous surveys, Newfoundland and PEI still register the lowest stress levels in the country.[132] But the time use data above indicate more dramatic time losses for women in Atlantic Canada than for women in the rest of the country, and a gradual convergence with national levels of free time and personal time. If adequate free time and personal care time are essential elements of relaxation and a buffer against stress, these present work and social trends may well be precursors of a gradual convergence of stress levels.

Instead, the time may be ripe for Atlantic Canada to learn from European countries that have sought to increase free time and quality of life by reducing work hours. International time use studies, for example, show that people have 11 hours more free time per week in Denmark than in Canada. This is due not only to shorter paid work hours and longer vacations, but to shorter unpaid work hours. Danes spend seven and a half hours less per week on housework than Canadians (Figure 43).[133]

The results may be partly a function of the propensity for smaller living spaces that require less cleaning time. Denmark, for example, has been a world leader in creating more efficient "co-housing" units that have smaller individual residences and shared facilities that can reduce the burden of domestic chores. These models cannot be explored in detail in this brief overview, but they are clearly worthy of careful study for their potential to reverse the trends toward overwork and stress indicated in this chapter.

[131] Statistics Canada, *Health Statistics, 1999,* CD-ROM, Table 00060139.IVT: "Levels of Stress," and Health Canada, *Statistical Report on the Health of Canadians,* Ottawa, 1999.
[132] Statistics Canada, "Life stress, by sex, household population aged 18 and over, Canada, provinces, territories, health regions and peer groups, 2000/01," available at: http://www.statcan.ca/english/freepub/82-221-XIE/00502/tables/html/2336.htm.
[133] Source: Harvey, Andrew, "Canadian Time Use in a Cross-National Perspective," *Statistics in Transition,* volume 2, no. 4, November, 1995, page 603.

Figure 43. Average weekly hours, unpaid household work and free time, population aged 20-59, selected countries (hours).



Note: Definitions of unpaid work have been adjusted for comparability.

Source: Harvey, Andrew, "Canadian Time Use in a Cross-National Perspective," *Statistics in Transition* 1995.

4.2 Changes in types of household work

Beyond the broad workload and stress issues, people's time use reveals important information about the nature of the gender division of labour within the household. In fact, the overall numbers for unpaid household work conceal some significant shifts among different types of household work. Women still do about three-quarters of the cooking, cleaning, and laundry, but their share of these tasks declined somewhat in the 1990s. Across Canada, women's share of cooking and washing up declined from 75.9% in 1992 to 70.4% in 1998; and their share of housekeeping dropped from 83.5% in 1992 to 76.6% in 1998. Women's share of repair and maintenance work has grown somewhat during the same period, though men still did 79% of it in 1998, down slightly from 83% in 1992.[134]

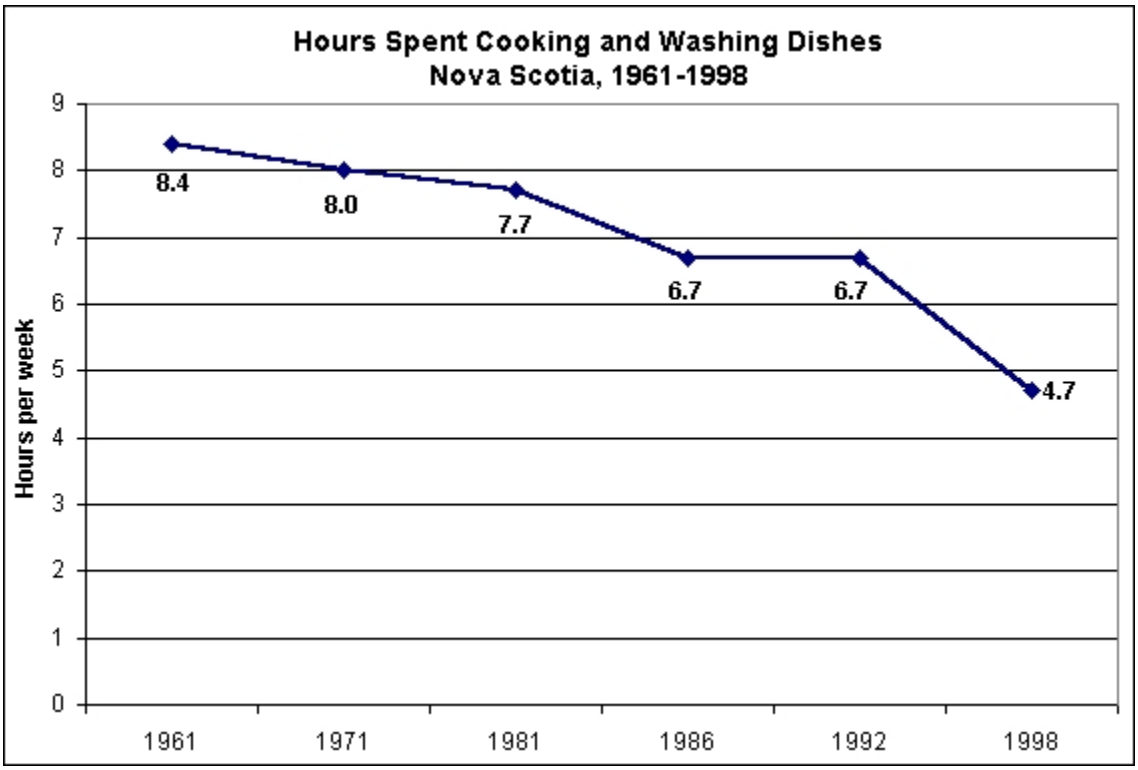
But these gender shifts must also be seen against the background of changing patterns of household work. Atlantic Canadians are spending less time cooking meals at home and more

[134] Statistics Canada, *General Social Survey: Overview of the Time Use of Canadians,* November, 1999, Table 1: Canada, regions and provinces, special tabulations run for GPI Atlantic; Statistics Canada, *Initial Data Release from the 1992 General Social Survey on Time Use,* catalogue no. 11-612, #30, Table 1.

time shopping and cleaning. Maritimers spent about five and a half hours a week shopping in 1998, about an hour more than in 1992. Newfoundlanders, on the other hand, spent less time shopping than any other Canadians – about two fewer hours a week. Atlantic Canadians also spend more than one hour longer per week cleaning house and doing laundry than they did in 1992.

At the same time, Atlantic Canadians are now spending a lot less time cooking their own meals, and they are spending an increasing share of their household budgets eating out.[135] In 1992, Atlantic Canadians spent about 30% more time cooking and washing dishes than other Canadians. By 1998, they were spending about the same time each week cooking and washing up as other Canadians. This represented a drop of 25% in Newfoundland, 35% in PEI, 30% in Nova Scotia, and 16% in New Brunswick. In fact, the decline in cooking time has been steady and continuous for 40 years, as the increase in dual-earner families has left less time to prepare meals at home (Figure 44).

Figure 44. Hours per week spent cooking and washing dishes, Nova Scotia, 1961-1998



Source: Statistics Canada, General Social Surveys, Statistics Canada, Households' Unpaid Work; Colman, Economic Value of Unpaid Housework and Child Care.

[135] Statistics Canada, *Family Food Expenditure in Canada,* catalogue no. 62-554, and *Family Expenditure in Canada,* catalogue no. 62-555. See Colman (1998) op. cit., Figure 4.7, page 55; and Colman, Ronald (2000), *The Cost of Obesity in Nova Scotia,* GPI *Atlantic*, Halifax, and (2001), *The Cost of Obesity in New Brunswick,* Figure 15.

4.3 Impacts of changing work patterns on health

These trends have impacts on health. For example, it is likely that healthy diets have suffered in the transition from home cooking to greater reliance on prepared fast food, and that this trend has contributed to a sharp increase in obesity in the Atlantic provinces. All four Atlantic provinces saw sharp increases in obesity (BMI > 30) between 1994/95 and 2000/01 – from 18% to 21% of the population aged 20-64 in Newfoundland; from 16% to 19% in PEI; from 16% to 21% in Nova Scotia; and from 19% to 21% in New Brunswick.[136]

A Harvard University study of 16,000 children released in 2000 found that the more frequently families ate together, the more fruits and vegetables and the less fried foods were consumed. Children who had regular family meals also had a far higher intake of important nutrients such as calcium, fibre, folate, iron, and vitamins B and E, and had healthier diets at other times of day as well, compared to children who rarely ate family meals.[137]

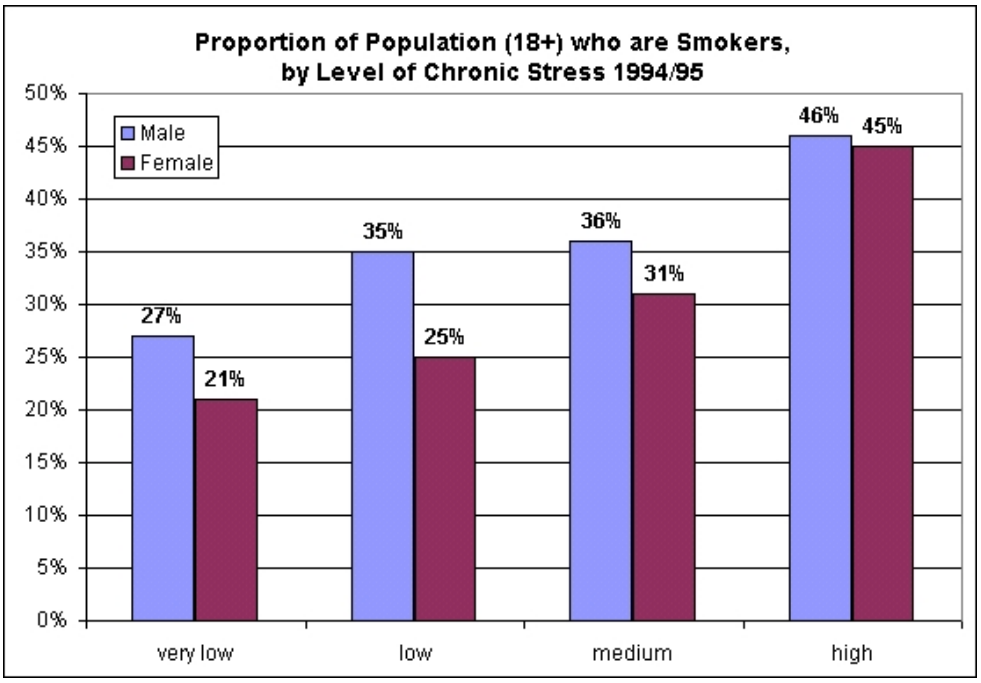
Columbia University professor, Dr. Michael Rosenbaum, commented on the study results: "In terms of teaching your children good habits, the dinner table is great…. There is a tremendous amount of data to show that healthy habits learned early persist into adulthood."[138] In short, the trend away from home cooking and family meals towards fast food and eating out, revealed by Statistics Canada's time use and family expenditure surveys, may have negative health impacts into adulthood.

This very brief overview cannot do justice to the analysis required to assess the impact of changing work roles and gender divisions of labour both in the market economy and in the household on women's health. But even these few remarks indicate that an understanding of changes in health status over time cannot be sought simply in individual lifestyle choices. Those choices are themselves clearly dependent on deeper social changes.

There are many other examples, beyond the nutrition issue raised above, of health behaviours that depend on deeper social trends. An analysis of 1994/95 National Population Health Survey results, for example, found that smoking rates are directly linked to stress. Among men, 46% of those who experienced high levels of chronic stress were smokers, compared to just 27% for men with a very low level of stress. The relationship was even more pronounced for women, whose smoking rates ranged from 21% among those with a very low stress level to 45% for those with high stress (Figure 45).[139]

[136] Statistics Canada, *Canadian Community Health Survey 2000/01,* "Counts and rates by body mass index (international standard)," reported in Statistics Canada, *The Daily,* May 8, 2002.
[137] Randi Hutter Epstein, "Linking Children's Health to Family Meals: Study shows families who eat together have better eating habits," *The New York Times,* reprinted in *The Chronicle-Herald,* Halifax, 29 March, 2000.
[138] Idem.
[139] Statistics Canada, *National Population Health Survey Overview, 1994-95,* catalogue no. 82-567, pages 10-11; and see Colman, Ronald, *The Cost of Tobacco in Nova Scotia,* GPI *Atlantic*, Halifax, November 2000, chapter on "Smoking and Stress", pages 6-8.

Figure 45. Proportion of population (18+) who are smokers, by level of chronic stress and sex, Canada, 1994/95 (%).



To date, research on these underlying social trends has focussed far more extensively on links between lifestyle behaviours, income, and education than on work hours, and policy links have also been better established.

For example, analysts have noted that "health promotion strategies focused purely at individual health behaviours are yielding limited success."[140] Evidence indicates that those who are marginalized do not attend smoking cessation and nutrition classes, do aerobics, join gymnasiums, or shop for healthy foods. A comprehensive $1.5 million 5-year cardiovascular disease prevention and lifestyle intervention program in St. Henri, a Montreal neighbourhood where 45% of families live below the poverty line, attracted only 2% participation. The only significant result, compared to a control group, was that more people had their blood cholesterol levels measured.[141] The researchers concluded:

> *"…unless or until basic living needs are ensured, persons living in low-income circumstances will be unlikely or unable to view CVD [cardio-vascular disease] prevention as a priority."*[142]

[140] Lyons, Renee, and Lynn Langille, *Healthy Lifestyle: Strengthening the effectiveness of lifestyle approaches to improve health,* Atlantic Health Promotion Research Centre, Dalhousie University, prepared for Health Canada, Population and Public Health Branch, April, 2000, page 7

[141] Raphael, Dennis, *Inequality is Bad for our Hearts,* York University, 2001: "Inequality is bad for our hearts: why low income and social exclusion are major causes of heart disease in Canada" can now be read and downloaded from http://depts.washington.edu/eqhlth/paperA15.html; and see "Having Healthy Heart is Often a Question of Income," *The Toronto Star,* 9 November, 2001, page F02.

[142] Cited in Lyons and Langille, op. cit., page 22.

Because lifestyle interventions have been most successful in changing the behaviour of those with higher levels of education and income, and least effective for disadvantaged populations who have fewer options and less control over their lives, they have had the unintended effect of deepening health inequalities between socioeconomic levels.[143]

More effective interventions to alleviate the negative impacts of poverty on health range from social programs directed towards low-income individuals to wider-ranging social reforms. One example of an effective program that alleviates some effects of poverty is the WIC Special Supplemental Nutrition Program in the U.S., which provides seven million low-income women, infants, and children with food, nutrition information and health services. Every dollar spent on the program saves $3 in health costs within the same year.[144]

Supplemental feeding assistance for children from low-income households that are unable to provide adequate nutritious food, can improve health and social outcomes. School lunch and breakfast programs have been shown to relieve hunger and lead to improved nutritional status, enhanced cognitive functioning, improved behaviour, and increased social support for children with inadequate dietary intake at home.[145]

Low income Canadians are more likely to be overweight and to have poorer diets than those with higher incomes, which may be due, in part, to cheaper pricing of poor-nutrient fast foods compared to higher quality healthy foods. For example, 40% of low-income Canadians believe that low-fat products are expensive, and 27% believe that grain products are expensive, compared to 32% and 8% respectively of those with high incomes (Figure 46).[146]

However, the disparity here may be related to education, strategy, and policy as much as to income. One study found that simple substitution of healthy alternatives for equivalent foods in the "average" diet, increased food costs by 11-14%, which can help explain why low-income earners have poorer diets. However, *restructuring* the diet to include more cereals, whole grains, fruits, and vegetables (rather than simply *substituting* healthier equivalents such as leaner meat), reduced food costs per megajoule of energy. The researchers concluded that healthful eating is not necessarily more expensive and that restructuring the diet is more cost effective than substitution.[147]

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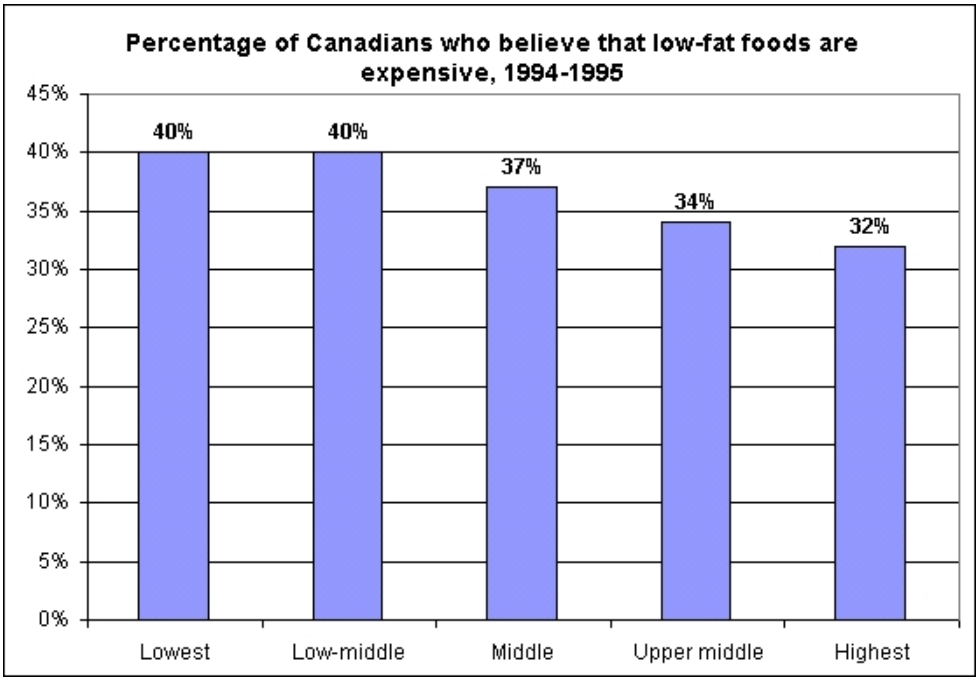
[143] Ibid., pages 23-25.
[144] Buescher, Paul, et al., "Prenatal WIC Participation Can Reduce Low Birth Weight and Newborn Medical Costs: A Cost-Benefit Analysis of WIC Participation in North Carolina," *Supplement of the Journal of the American Dietetic Association,* 93 (2): 163-166, February, 1993; Canadian Nutrition Institute, October 11, 1991, page 2; Matsumoto, Masao, "The WIC Program Meets A Special Need," *Food Review* 15 (1): 40-42, 1992; Goldberg, Jeanne, and Jean Mayer, "The White House Conference on Food, Nutrition and Health Twenty Years Later: Where Are We Now?", *Journal of Nutrition Education,* Viewpoint, 1990: 47-50; all cited in Province of British Columbia (1996), op. cit., pages 2-4.
[145] McIntyre et al., "School-Based Feeding Programs: A Summary of the Literature," *A Special Report of the Canadian School Boards Association,* July, 1992, cited in Province of British Columbia (1996) op. cit., page 6,
[146] Health Canada, *Statistical Report on the Health of Canadians,* Ottawa, September, 1999, page 267.
[147] McAllister, Marian et al., "Financial Costs of Healthful Eating: A Comparison of Three Different Approaches," *Journal of Nutritional Education* 25 (3): 131-139, May-June, 1994, cited in Province of British Columbia (1996), op. cit., page 12.

Figure 46. Percentage of Canadians who believe that low-fat foods are expensive, 1994-1995



Source: Statistics Canada, *National Population Health Survey,* 1994-95

In the longer term, health researchers have pointed to the need for wider social reforms that increase the income of the poor, prevent material deprivation, and address social exclusion and powerlessness. Recommendations include increasing the minimum wage, ensuring pay equity, providing a guaranteed minimum income, increasing welfare payments, improving access to education and training, protecting minority rights through legislation, building housing cooperatives, and funding daycare programs. According to one Toronto physician:

> *"These are reasonable solutions that are within our grasp as a society concerned about creating a healthier future for all its citizens. Preventing heart disease is possible, if we resist doing the familiar and insist on doing the political."*[148]

The same attention that is increasingly paid to the links between income, lifestyle, and health must also be paid to the links between work hours, shifting gender divisions of labour, and health outcomes. While a seminal Statistics Canada study has now definitively linked longer work hours with increased rates of smoking, overweight, physical inactivity, and depression among women, researchers have not yet explored the relationship between *total* workload (paid and unpaid) and health.[149] In fact, we earlier noted two Statistics Canada analyses that have acknowledged that even gender shifts in paid employment patterns, unemployment trends, and gender wage gaps are not well understood and cannot be fully explained. The knowledge gap is even wider when unpaid work issues are added to the equation.

[148] "Having Healthy Heart is Often a Question of Income," *The Toronto Star,* 9 November, 2001, page F02.
[149] Shields, Margot, "Long Working Hours and Health," Statistics Canada, *Health Reports* 11 (2), Autumn, 1999, pages 33-48.

When those relationships between work and health are better understood, there may be greater incentive to seek solutions to health problems in more profound social changes than in individual lifestyle shifts alone. For example, European models of longer vacations and shorter work hours may hold greater promise from a population health perspective than the U.S. model of longer work hours that Canada is currently emulating.

The Netherlands, for example, drastically reduced its unemployment rate and increased labour productivity by making part time work more attractive and thereby reducing and redistributing work hours. Legislation in the Netherlands ensures part-time workers equal hourly pay, pro-rated benefits, and equal opportunity for career advancement, and the country, not surprisingly, now has the highest rate of part-time work among OECD countries. Its rate of involuntary part-time work is minimal – 6%, less than one-fifth the Atlantic Canada rate.[150]

The social trends observed in this chapter and the last indicate that the time is right to study the potential for such models to improve health in general and women's health in particular, and to assess their applicability to Atlantic Canada. If successful here, they may function as pilot projects for the country as a whole.

[150] For an excellent account of shorter work time initiatives in Europe, see Hayden, Anders, *Sharing the Work, Sparing the Planet: Work Time, Consumption, and Ecology,* Between the Lines, Toronto, 1999. For Danish figures and comparative free time estimates among nations, see Harvey, Andrew, "Canadian Time Use in a Cross-National Perspective," *Statistics in Transition,* November, 1995, volume 2, no. 4, pages 595-610, especially Table 3, page 603. For comparative annual work hours, see International Labour Organization, *Key Indicators of the Labour Market,* September, 1999, available at http://www.ilo.org/public/enlgish/60empfor/polemp/kilm/kilm.htm. See also European Industrial Relations Observatory, Netherlands, 1999, "Political compromise on proposed part-time work legislation," available at http://www.eiro.eurofound.ie/1999/10/inbrief/NL9910170N.html.

5. Social Supports

5.1 Volunteering and Health

Social networks may play as important a role in protecting health, buffering against disease, and aiding recovery from illness as behavioural and lifestyle choices such as quitting smoking, losing weight, and exercising.[151] Newfoundlanders have lower incomes and higher rates of unemployment than the rest of Canada, as well as high levels of behavioural risk factors, all of which are conventionally associated with health problems. Yet they consistently record the highest rates of self-reported excellent and very good health, the highest rates of psychological wellbeing, the lowest stress and depression rates, and the lowest rates of several chronic ailments in the country. It has been suggested that strong communities and social networks may help explain this anomaly.[152]

According to Health Canada, social support networks extend from close family and friends to the broader community, and are "reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others."[153] Health Canada uses volunteerism as a key indicator of a "supportive social environment" that can enhance health.[154]

"Formal" voluntary activity describes work for charitable, non-profit, and community organizations. "Informal" voluntary work is assistance given directly to individuals, not through any organization, such as shopping, cleaning and doing yard work for a disabled, sick, or elderly neighbour. Given Atlantic Canada's disproportionately large rural population (more than double the Canadian rate), informal voluntary work is particularly important in this region, since many charities and formal service organizations do not have a presence in rural communities.

The 2000 statistical profile on women's health in Atlantic Canada noted that residents of all four Atlantic provinces have the highest volunteer participation rates in the country when both formal and informal voluntary work are counted. They also put in considerably more hours of voluntary work per week than other Canadians, 43% higher than the national average in Nova Scotia, and 33% higher in Newfoundland. Using 1997 and 1998 data, the 2000 report also noted a nation-wide decline in both formal and informal voluntary work, with Canadians giving 8.7% fewer hours per capita in 1998 than in 1992. Nova Scotians and Prince Edward Islanders were the only ones to buck that national trend. Although both provinces saw a decline in formal voluntary work, like the rest of the country, they saw a sharp increase in informal voluntary work, leading to a net gain in volunteer hours per capita. [155]

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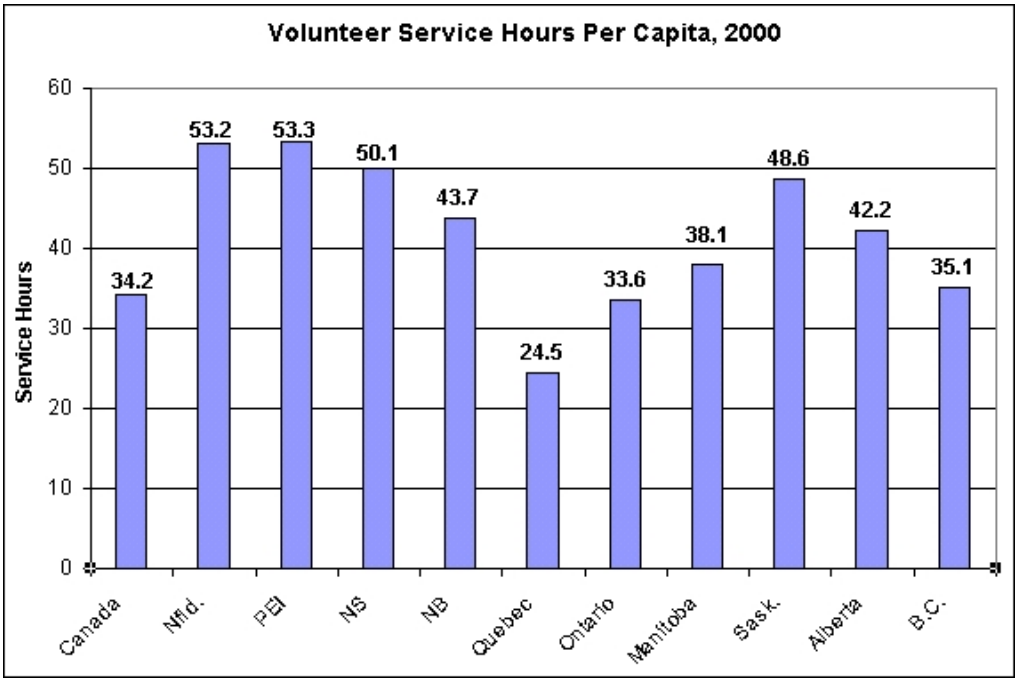
[151] See for example: Mustard, J.F., & Frank, J. (1991).The Determinants of Health. (CIAR Publication No. 5) Canadian Institute for Advanced Research, Toronto.
[152] Colman, Ronald (2000), *Women's Health in Atlantic Canada,* Atlantic Centre of Excellence for Women's Health and GPI *Atlantic*, Halifax, February, 2000, pages 10-11, and 40.
[153] Health Canada (1999), *Toward a Healthy Future: Second Report on the Health of Canadians,* Ottawa, page 60.
[154] Health Canada (1999), op. cit., pages 60-62.
[155] Colman, Ronald (1998, with updates in 1999 and 2000), *The Economic Value of Civic and Voluntary Work in Nova Scotia,* GPI *Atlantic*, Halifax; and see Colman (2000), *Women's Health in Atlantic Canada,* pages 42-46.

5.1.1 Trends in Volunteer Work 1997 – 2000

New information on formal voluntary work trends was released in August, 2001, allowing us to update the earlier results reported in the 2000 women's health report, which are based on surveys conducted in 1987 and 1997. In 2000, Statistics Canada conducted a similar National Survey of Giving, Volunteering, and Participating that assessed trends in formal voluntary work to "determine whether the care that Canadians demonstrate for one another, their communities and their environment is growing, remaining stable, or on the wane."[156] Statistics Canada's next assessment of trends in combined formal and informal voluntary work will be the 2004 General Social Survey, for which results should become available at the end of 2005.

The 2000 survey results indicate that more women than men volunteer, both in Canada as a whole and in the Atlantic provinces in particular. The four Atlantic provinces have higher than average rates of formal voluntary work (Figure 47).

Figure 47. Volunteer service hours per capita, 2000 (total volunteer hours divided by population)



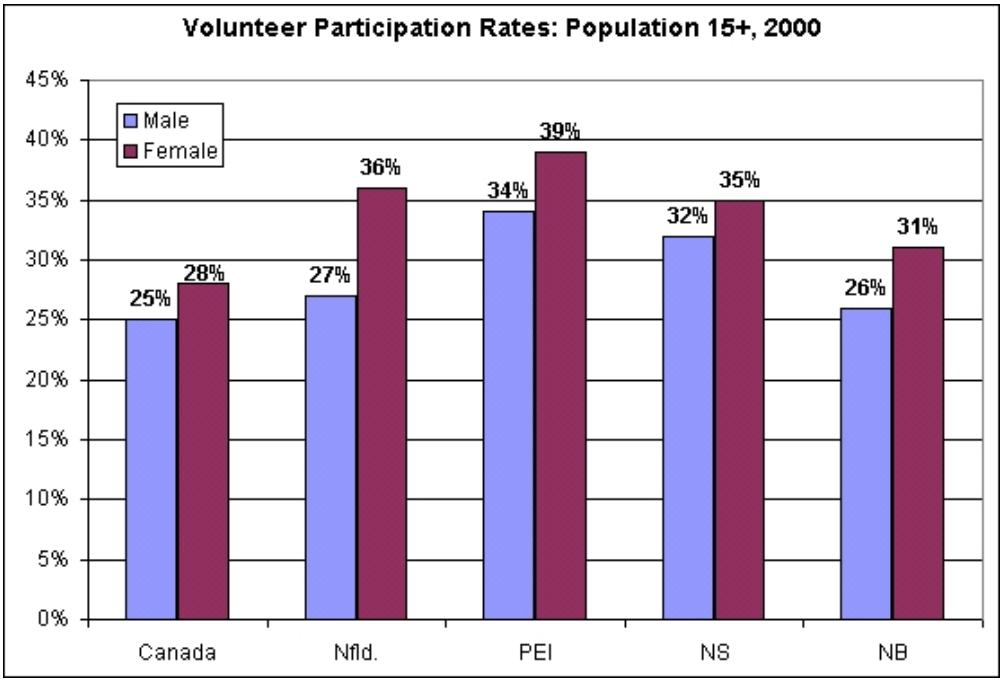
Source: Statistics Canada, Caring Canadians, Involved Canadians 2001

The results also show a continuing sharp decline in formal voluntary work throughout Canada. Nationwide, 12.8% fewer Canadians volunteered in 2000 than in 1997, and the volunteer participation rate dropped from 31% to 27% of Canadians. There were parallel declines among

[156] Hall, Michael, Larry McKeown, and Karen Roberts, *Caring Canadians, Involved Canadians: Highlights from the 2000 National Survey of Giving, Volunteering and Participating,* Statistics Canada, catalogue, no. 71-542-XPE, Ottawa, August, 2001, page 5.

both men and women. Despite a 2.5% growth in population, there were 960,000 fewer Canadian volunteers in 2000 than there were in 1997. However, the dedicated remaining volunteers picked up some of the slack in order to protect the services their organizations offer, and increased their own volunteer hours by 8.7%. Thus the total number of hours volunteered in Canada declined by 5% in just three years (Figure 48).[157]

Figure 48. Volunteer Participation Rates: Population 15+, Canada and Atlantic Provinces, 2000 (%) (formal volunteer organizations)



Source: Statistics Canada, Caring Canadians, Involved Canadians 2001

However these total volunteer numbers underestimate the impact of this decline in volunteerism on those Canadians who benefit most from voluntary activity, such as the elderly, disabled, sick, homeless, youth in need, abused women and children, and other vulnerable groups. From the perspective of the beneficiaries of voluntary work, the most accurate measure of progress is volunteer service hours offered per capita, taking into account changes in population rather than just the absolute number and hours of volunteers. From that perspective, volunteer hours per capita declined by 6.3% between 1997 and 2000. In other words, on a per capita basis, Canadians received 6.3% fewer volunteer services in 2000 than they did in 1997 (Table 4).[158]

[157] Hall et al. (2001), op. cit, pp. 11 ff.

[158] Statistics Canada does not provide this calculation, even though it is probably the most accurate measure of the actual impact of the voluntary sector on Canadians, and the key variable in assessing the potential health impacts of volunteerism. Thus GPI *Atlantic* simply derives volunteer service hours per capita by dividing the total annual volunteer hours (from Hall et al. above) by the total population of Canada and of each province. This takes into account population changes over time.

Table 4. Fewer volunteers putting in longer hours leads to net loss of volunteer services in Canada, increase in Atlantic Canada (formal volunteer organizations 1987-2000)

	Numbers of volunteers (thousands)				Total annual volunteer hours (thousands)		
	1987	1997	2000	% change 1997-2000	1987	1997	2000
Canada	5,337	7,472	6,513	-12.3%	1,017,548	1,108,924	1,053,200
Nfld	110	150	138	-8.0%	22,600	20,494	28,600
PEI	32	38	40	+5.2%	4,669	4,869	7,400
N.S.	218	283	253	-10.7%	40,901	40,029	47,200
N.B.	162	208	174	-16.3%	34,097	34,121	33,000
Quebec	1,005	1,313	1,135	-13.6%	206,911	196,974	180,500
Ontario	1,870	2,890	2,378	-17.7%	352,923	421,596	393,500
Manitoba	303	344	312	-9.3%	48,748	44,763	43,700
Sask.	276	361	323	-10.5%	50,497	48,311	49,700
Alberta	701	878	913	+4.0%	121,035	128,323	127,000
B.C.	661	1,005	845	-15.9%	135,166	169,443	142,600
	Average annual hours per volunteer				Volunteer service hours per capita (total population)		
	1987	1997	2000	% change 1997-2000	1987	1997	2000
Canada	191	149	162.0	+8.7%	38.3	36.5	34.2
Nfld	206	137	207.2	+51.2%	39.2	36.7	53.2
PEI	148	127	185.0	+45.7%	36.2	35.5	53.3
N.S.	188	141	186.6	+32.3%	45.6	42.3	50.1
N.B.	211	164	189.7	+15.7%	46.6	44.8	43.7
Quebec	206	150	159.0	+6.0%	30.4	26.5	24.5
Ontario	189	146	165.5	+13.4%	36.4	36.8	33.6
Manitoba	161	130	140.1	+7.8%	44.2	39.2	38.1
Sask.	183	134	153.9	+14.9%	49.2	47.3	48.6
Alberta	172	146	139.1	-4.7%	49.5	44.9	42.2
B.C.	205	169	168.8	-0.1%	44.1	43.0	35.1

Notes: (1) Figures for absolute volunteer numbers and annual volunteer hours do not account for population increases. (2) Hall et al. provide rounded numbers only for total volunteer hours.

Sources: Statistics Canada, *Caring Canadians, Involved Canadians,* catalogue no. 71-542-XPE, 1998; Doreen Duchesne, Statistics Canada, *Giving Freely: Volunteers in Canada,* catalogue no. 71-535, no. 4, 1989; Hall, Michael, Larry McKeown, and Karen Roberts, *Caring Canadians, Involved Canadians: Highlights from the 2000 National Survey of Giving, Volunteering and Participating,* Statistics Canada, catalogue, no. 71-542-XPE; Ross, David, *Economic Dimensions of Volunteer Work in Canada,* Department of the Secretary of State of Canada, January, 1990, page 11; Colman, Ronald, *The Economic Value of Civic and Voluntary Work in Nova Scotia,* GPI Atlantic, Halifax, July, 1998; Statistics Canada, *Quarterly Demographic Statistics, July – September, 1997,* catalogue no. 91-002-XPB; Statistics Canada, *Provincial Economic Accounts, Annual Estimates, 1996,* catalogue no. 13-213-PPB, population, page 167; Statistics Canada, *CANSIM II* database, table 051-0001.

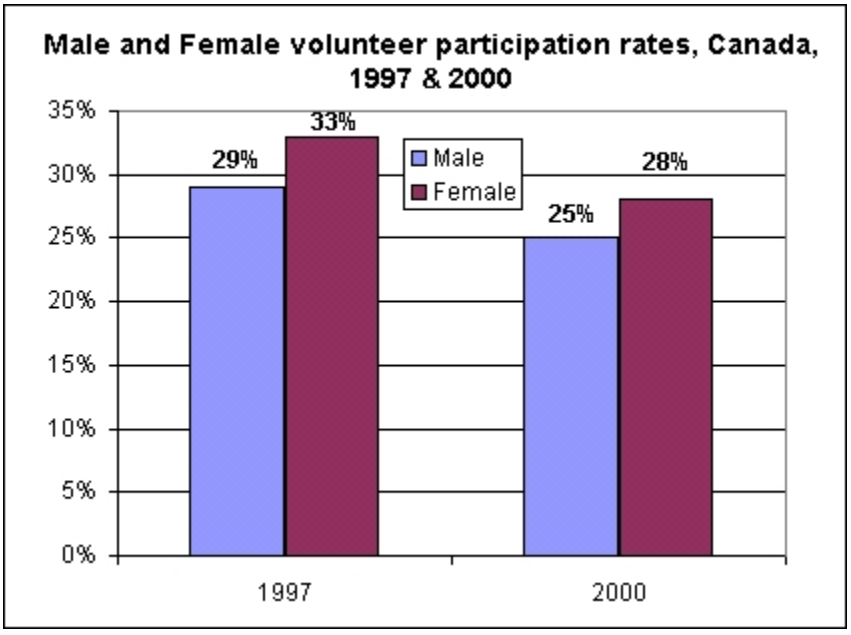
The latest trends indicate a dangerous situation. While Atlantic Canadians can be justly proud of the remarkable strength of the voluntary sector in this region, and of the tremendous contribution that volunteers make to our wellbeing, standard of living, and quality of life, we must recognize that a growing responsibility and burden rests on ever fewer shoulders. A smaller number of dedicated volunteers is being spread increasingly thin, and the danger of volunteer burnout is real.

On the whole, Atlantic Canadians bucked that national trend in 2000, and they did so dramatically. Only four provinces in Canada *increased* their per capita formal volunteer service hours between 1997 and 2000 – Newfoundland (by 45%), Prince Edward Island (by 50%), Nova Scotia (by 18%), and Saskatchewan (by 3%). But this is not particularly cause for celebration. In all these provinces, except for PEI, the increase was entirely achieved by fewer volunteers putting in longer hours. Only PEI saw a modest increase in the number of volunteers, with 2,000 more Islanders volunteering in 2000 than in 1997. Newfoundland and Labrador had 12,000 fewer volunteers in 2000 than in 1997; Nova Scotia had 30,000 fewer; and New Brunswick had 34,000 fewer, the second largest percentage drop in the country after Ontario in number of volunteers. In total, Atlantic Canada had 74,000 fewer volunteers in 2000 than it did in 1997.

To compensate for this decline, volunteers in all four Atlantic provinces increased their contributions more dramatically, as measured by hours per volunteer, than volunteers in any other province. The remaining Atlantic volunteers worked 51% more hours in Newfoundland, 46% more in PEI, 32% more in Nova Scotia, and 16% more in New Brunswick.

Atlantic Canadian volunteers now work longer hours than volunteers in any other province. Newfoundland volunteers put in the longest hours of any volunteers in Canada, 28% higher than the national average, with New Brunswick volunteers ranking second (17% higher), Nova Scotian volunteers third (15% higher), and Prince Edward Islanders fourth (14% higher). Unfortunately, the longer hours of New Brunswick volunteers were not able to compensate for the 16.3% decline in the *number* of volunteers in that province, leading to a net 2.6% loss in volunteer hours per capita, when population change is taken into account. Nevertheless, New Brunswick still ranks fifth in the country in total volunteer service hours contributed per capita, after PEI, Newfoundland, Nova Scotia and Saskatchewan (Figure 49).

Figure 49. Male and Female volunteer participation rates, Canada, 1997 and 2000



Source: Statistics Canada, Caring Canadians, Involved Canadians 2001

As Statistics Canada notes:

> *"Such reliance on a small minority of the population to provide the bulk of volunteer time and charitable donations may be a source of vulnerability for charitable and non-profit organizations and the people they serve. Any decline in number among this small core group of contributors could have dramatic repercussions."*[159]

5.1.2 Economic Value of Voluntary Work Losses: 1987 - 2000

The 1997-2000 trend continues the decline in formal voluntary service hours received by Canadians that was first observed between 1987 and 1997. Thus, the accelerating 6.3% decline between 1997 and 2000 builds on an earlier 4.7% decline between 1987 and 1997. Cumulatively since 1987, and taking Canada's population increase into account, volunteer service hours per capita have dropped by 10.7% nationwide. Every province in the country, with the exception of Newfoundland, PEI, and Nova Scotia, shared in that decline. Since 1987, Newfoundland increased its volunteer hours per capita by 36%, PEI by 47%, and Nova Scotia by 10%. New Brunswickers, on the other hand, received 6.2% fewer volunteer service hours in 2000 than they did in 1987, in conformity with the national trend towards declining volunteer service hours.

If volunteer work had continued to be offered through community-based organizations at the same rate as in 1987, Canadians would have received the benefits of 126 million more hours of voluntary services than they actually did. What this means in practical and human terms is that the sick, elderly, and disabled are no longer receiving the same level of volunteer health supports as before. The poor are receiving fewer volunteer social services; and victims of crime and abuse are receiving less support and counselling than they used to. It is harder to find volunteers to staff telephone help lines, to organize church events, to coach sports, and direct theatre, arts and other cultural events in children's after school and weekend programs. And it is getting harder to fundraise for charities and for hospital telethons, and to find volunteers to serve on the boards of community organizations.

Across Canada, volunteers are trying to compensate for these losses by putting in longer hours, but only in Newfoundland, PEI, Nova Scotia, and Saskatchewan have these extra hours succeeded in maintaining, and even increasing, the level of voluntary services. In the rest of Canada, there are simply fewer volunteer services than there used to be, with corresponding impacts on the health and quality of life of Canadians, and on the strength of Canada's civil society and communities.

The nationwide loss of voluntary services has economic as well as human implications. A decline in voluntary work of this magnitude can either produce an absolute loss in services, with a corresponding decline in standard of living and quality of life, *or* the lost voluntary services can be replaced for pay. "Replacement cost" valuations assess the value of the lost volunteer hours by imputing a market value to the work that volunteers do. At Statistics Canada's estimated replacement cost rate for volunteer work of $16 an hour, the decline in formal

[159] Hall et al. (2001), op. cit., page 9.

volunteer services cost Canada more than $2 billion in lost services in 2000.[160] Because voluntary work is not valued or measured in the conventional economic accounts, this $2 billion loss does not show up in the GDP or in any other market statistics, and is presented here for the first time.

When formal and informal voluntary work are both considered, volunteers contribute the equivalent of $53 billion worth of services to the Canadian economy; including $2 billion in Nova Scotia, $1.5 billion in New Brunswick, $1.3 billion in Newfoundland; and $300 million in PEI. This massive contribution is not counted in our economic growth statistics, and therefore remains invisible in our conventional measures of progress.

Indeed this invisibility is undoubtedly the primary reason why most policy makers are unaware of the decline in voluntary work, and why the unfolding crisis in the voluntary sector has never been debated in any legislature in the country. A 10.7% decline in the gross domestic product would be called a depression and would constitute a national emergency. Yet a decline of this magnitude in unpaid voluntary work does not register on the policy radar screen. This anomaly demonstrates how powerful indicators are in determining the policy agenda of governments, and is the primary reason why the Genuine Progress Index does include the value of voluntary work as one of its core measures of progress. If voluntary work is indeed a mark of community strength and quality of life, and a vital determinant of population health, as Health Canada has stated, then urgent action is clearly needed to support and strengthen the voluntary sector and to reverse the troubling trends of the last 15 years.

5.1.3 Predicting the Decline

Are the trends of the last few years unexpected? If voluntary work is not tracked as part of Canada's core measures of wellbeing and progress, as is currently the situation, then the decline in volunteer services will not be predicted, and will only manifest later in a gradual, subtle, and unexplained deterioration in the health and quality of life of Canadians. If, on the other hand, voluntary work is carefully monitored in a core set of measures of progress, as in the Genuine Progress Index, then the trends of recent years are not at all surprising, and were, indeed, entirely predictable.

For example, a July 1998 GPI *Atlantic* report noted that university graduates have the highest rate of participation in formal volunteer work of any educational group. In Canada as a whole, 46% of university graduates volunteered for some non-profit organization, compared to 35% of those with a post-secondary certificate or diploma, 24% of those with only a high school education, and only 13% of those with less than a high school education. Statistics Canada

[160] Monetary values are derived using Statistics Canada's replacement cost (specialist) imputation for volunteer work, in Statistics Canada, *Households' Unpaid Work: Measurement and Valuation,* catalogue no. 13-603E, no. 3, Table A4, page 71, adjusted to 2000 dollars. For monetary valuation methodology, see Colman, Ronald (1998), *The Economic Value of Civic and Voluntary Work in Nova Scotia,* GPI *Atlantic*, Halifax, July, 1998, sections 5.2, pages 17-20; 7.2, pages 34-36; and 7.3, page 37. Since university graduates have a disproportionately high rate of contribution to volunteer organizations, the opportunity cost method of valuation is likely to yield a considerably higher value than the replacement cost method used here. The $2 billion figure given here can therefore be regarded as a conservative estimate.

analyses of results from the 1987 National Survey on Volunteer Activity state conclusively that "the tendency to volunteering rises with the level of education."[161] GPI *Atlantic*'s own analysis of the data found that "level of education had a much greater effect on the rate of participation in formal volunteer work through organizations than it did on informal voluntary work."[162]

The same 1998 GPI report noted the propensity of highly educated Canadians to work increasingly long hours in their paid jobs. This occurred partly as a result of corporate and government "downsizing" in the 1990s, which led employers to retain their most highly skilled and educated employees, and to expect those remaining employees to maintain or increase levels of output. The GPI report cited a 1997 Statistics Canada study, which found that "the propensity to work overtime rises with an employee's educational attainment."[163] That study found 27% of university graduates working overtime, compared to 17% of those with some postsecondary education, 18% of those with a high school education, and just 9% of those with less than a high school education.

In short, the same highly educated group that contributed a disproportionately large share of voluntary work was found, in the late 1990s, to be working ever-longer hours in the market economy. Three years before results from the 2000 national volunteer survey were released, the 1998 GPI report therefore warned:

> *"Since hours are finite, there is a strong possibility that voluntary hours have decreased in proportion to the increase in work hours for the highly educated. It must be emphasized that there is currently no firm evidence of this…. But the circumstantial evidence for a link between longer work hours and a potential time squeeze that may threaten the economic and social contribution of volunteer organizations is strong….*
>
> *"From the perspective of the GPI, this example illustrates the critical importance of tracking trends in unpaid work. An increase in overtime hours in the market economy will show up as economic growth and as an increase in the GDP. At the same time, a potential cost or consequent loss of economic and social value in the volunteer sector remains invisible in the accounts….*
>
> *"The GPI view is that it is more prudent to track such potential problems in a more comprehensive system of accounting that includes the value of civic and voluntary work. This, in turn, can function as an early warning system to enable policy makers to arrest such a potential decline in volunteer work in its early*

[161] Duchesne, Doreen, *Giving Freely: Volunteers in Canada,* Statistics Canada, Labour Analytic Report no. 4, catalogue no. 71-535, #4, Ottawa, August, 1989; also Webber, Maryanne, Statistics Canada, Labour and Household Surveys Division, *Volunteers in Sports and Recreation,* presentation to the 16th annual conference and general meeting of the Recreation Association of Nova Scotia, November 16-19, 1989; Catano, Janis Wood, *Volunteers in Nova Scotia: A Profile of Volunteers based on the 1987 National Survey on Volunteer Activity,* Profile no. 28, Voluntary Action Directorate, Multiculturalism and Citizenship Canada, Department of the Secretary of State, Ottawa, 1989.

[162] Colman, Ronald (1998), *The Economic Value of Civic and Voluntary Work in Nova Scotia,* GPI *Atlantic*, Halifax, July, 1998, pages 23-24.

[163] Statistics Canada, *Perspectives on Labour and Income,* Winter, 1997, catalogue no. 75-001-XPE; see especially pages 5, 6, 13, 14, and 27.

stages, and before it manifests in social problems that may produce additional costs."[164]

Results from the 2000 national volunteer survey confirm these earlier GPI predictions, and are also in line with the "greying" of the Canadian population. According to Statistics Canada:

"Although volunteer rates have declined since 1997 for each education group, the greatest decline was among those with a university education (from 48% to 39%)."

Nor surprisingly, the 35-44 age group experienced the sharpest drop in volunteer rates. Among the volunteers who remain, also not surprisingly, Statistics Canada reported:

"Compared with 1997, the greatest increases in average number of hours volunteered occurred among those with less than high school education."[165]

By age group, older volunteers experienced the sharpest increase in average hours volunteered, with a 21-hour increase in average hours among 55-64 year olds, and a 67-hour increase among those 65 and older.

This changing composition of the volunteer work force, which partly parallels the aging of the Canadian population, in turn has implications for the skill sets available to community and non-profit organizations, and for the kind of voluntary services they can deliver effectively. Volunteers on the whole are older and less educated. Prime-aged, highly educated volunteers are becoming scarcer.

According to the 1998 GPI report, the "strength of the data on the connecting variables" between volunteer work and market work by educational level constituted "warning signals that the economic and social contributions of voluntary work cannot be taken for granted."[166] The 1998 GPI report pointed to similar dangers to the voluntary sector arising from increasing rates of time stress among women, who constitute the majority of volunteers. And this present analysis points to future dangers to the voluntary sector arising from volunteer burnout and from the increased workload that now rests on fewer volunteer shoulders.

Interestingly, the trends in voluntary work since 1987 show how the growing time crunch on Canadians, confirmed by Statistics Canada's time stress surveys,[167] manifests differently in distinct phases. More Canadians volunteered in 1997 than in 1987, both in absolute numbers and

[164] Colman (1998), op. cit., pages 22 and 25.
[165] Hall et al. (2001), op. cit., page 33.
[166] Colman (1998), op. cit., page 27.
[167] Statistics Canada's 1992 and 1998 General Social Surveys asked an identical 10-question time-stress survey. Respondents classified as "extremely time stressed" by Statistics Canada are those who gave affirmative answers to seven out of the ten questions, such as "Do you consider yourself a workaholic?", "Do you worry that you don't spend enough time with your family and friends?", and "Do you feel that you're constantly under stress trying to accomplish more than you can handle?" Results revealed significantly larger percentages of Canadians being extremely time stressed in 1998 than in 1992. 1992 results are from Judith Frederick, Statistics Canada, *As time Goes By…Time Use of Canadians,* General Social Survey, catalogue no. 89-544E, pages 15-16. 1998 results are from Statistics Canada, *The Daily,* November 9, 1999, catalogue no. 11-001E, pages 2-4; and Statistics Canada, General Social Survey, Cycle 12, 1998, Housing, Family and Social Statistics Division, special tabulation.

on a per capita basis. But Canadians were also busier and more time stressed, and so they contributed 22% fewer hours on a per volunteer basis than 10 years earlier. That trade-off, as we saw, led to a net 4.7% decline in volunteer service hours per capita, when population increases were taken into account.

The 1997-2000 trend marks a second phase in the time crunch, in which those who are most time stressed, such as highly educated, working age people putting in longer overtime hours, simply drop out. During this second phase, the composition of the volunteer work force also changes, with fewer remaining volunteers – older, less educated, and less time-stressed – putting in longer volunteer hours. If the numbers alone are examined, without reference to these social and demographic changes, it might be argued that there is no problem, since average annual hours per volunteer in 2000 are still 15% less than they were in 1987, despite the sharp increase in hours since 1997. But in the context of growing time stress rates, an aging population, a markedly changed volunteer work force, and declining volunteer numbers, a return to 1987 conditions is not an option. The key challenges for the next phase are to prevent burn-out among the volunteers themselves, and to reduce workplace pressures and overwork, in order to coax educated and middle-aged Canadians back into the voluntary sector.

5.1.4 Overcoming Fragility and Strengthening the Voluntary Sector

The purpose of these remarks is not simply to say *"I told you so!"* Rather it is to indicate the policy relevance of the GPI, and its utility in pointing to preventive measures that can avoid later costs. An accurate and comprehensive set of indicators has the capacity to predict social trends more successfully than current measures of progress based on a narrow range of market statistics. While Atlantic Canadians can justly celebrate the comparative strength of the voluntary sector in this region, and the dedication and generosity of the tireless and dedicated volunteers in their midst, they also cannot take this contribution for granted.

In total, Atlantic Canada now has 74,000 fewer volunteers than it did in 1997. The remaining volunteers in all four Atlantic provinces are now working longer hours than ever, between 16% and 51% more than they did in 1997. These volunteers are putting in 28% more hours than the national average in Newfoundland and 15% more hours in the Maritimes. Voluntary work is being spread more thinly in the population among an ever smaller number of volunteers who, almost miraculously, have managed to buck the national trend and to *increase* the level of voluntary services provided to Atlantic Canadians by 17%, as measured by volunteer service hours per capita. During this same period, voluntary services nationwide declined by 6.3%. By this measure, Atlantic Canada has the highest rate of volunteer service of any region in the country. But this remarkable contribution rests on a narrower and more fragile base than ever.

Recognizing the treasure that exists in this region, both in human and economic terms, the four Atlantic region governments are well placed to take the lead in strengthening and supporting a voluntary sector that makes such a vital contribution to community and population health. They can consider and analyze these trends carefully, take the dangers and warning signals as seriously as they would a comparable decline in economic activity, and address and tackle the root causes as assiduously and creatively as they would work to remedy and reverse an economic

downturn. To prevent potential adverse impacts on community and population health, and to avoid serious long-term costs, the four governments can work with volunteer and community-based organizations to ensure they have sufficient resources, staff, and support to do their work effectively. In the long run, such policies will be highly cost-effective.

6. Family Violence

GPI Atlantic's 2000 statistical profile of women's health in Atlantic Canada, prepared for the Atlantic Centre of Excellence for Women's Health, noted that families can be a key pillar of social support that protect health, buffer against social problems and illness, and aid recovery. Indeed, Health Canada has recognized social supports, including families, as one the twelve key determinants of health:

> *"Families and friends provide needed emotional support in times of stress, and help provide the basic prerequisites of health such as food, housing and clothing…. Indeed, some experts in the field believe that the health effect of social relationships may be as important as established risk factors such as smoking and high blood pressure."*[168]

Because of the importance of social support networks to health, we have devoted an entire chapter in this report to the strength of the voluntary sector in Atlantic Canada. In this chapter, however, we look at the other side of the coin, and explore the possibility that family may undermine rather than strengthen social supports, and thereby adversely impact health outcomes. In the 2000 GPI report, after noting the low divorce rates in Newfoundland, PEI, and New Brunswick compared to the national average, we noted:

> *"In some cases family is not a safe place. Family violence can have a devastating effect on the health and wellbeing of women and children in both the short and long term, and divorce can be a healthy alternative to spousal abuse."*[169]

In sum, what can and should be a key pillar of social support, protecting and enhancing health, may well turn into its opposite, and seriously undermine health.

That report was unable to explore this important issue in more detail. However new evidence from Statistics Canada's 1999 General Social Survey has since been published in three separate statistical profiles of *Family Violence in Canada,* released in July 2000, June 2001, and June 2002.[170] Unfortunately, only very limited regional and provincial data are available in these reports, and we have therefore supplemented them here with data from the Uniform Crime Reporting (UCR) surveys.

In addition, we refer to Atlantic region results from Statistics Canada's 1999-2000 Transition Home Survey, which is conducted on a biennial basis as part of the federal Family Violence Initiative. That survey is sent to 508 shelters in Canada, including 50 in the four Atlantic provinces, which provide residential services for women victims of abuse and their children. Aside from collecting information on admissions and residential services in the previous 12 months, the survey also provides a one-day snapshot of those being served on a specific date.[171]

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[168] Health Canada, *Toward a Healthy Future: Second Report on the Health of Canadians,* Ottawa, 1999, page 60.
[169] Colman, Ronald (2000), *Women's Health in Atlantic Canada: A Statistical Profile,* GPI Atlantic and Atlantic Centre of Excellence for Women's Health, Halifax, February, 2000, page 41.
[170] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000, Family Violence in Canada: A Statistical Profile 2001, Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE.
[171] For information about the survey, see Statistics Canada, http://stcwww.statcan.ca/english/sdds/3328.htm.

Reference is also made in this chapter to selected results from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), released by Health Canada in 2001.[172] Those results are also reported in the 2001 Statistics Canada profile of family violence in Canada. Finally, we refer to historical information on sexual assault rates in the four Atlantic provinces, from the UCR surveys, compiled by Joan Campbell for Health Canada's Health Promotion and Programs Branch, Atlantic Region, and updated in this chapter with data from Statistics Canada's *Crime Statistics in Canada 2001.*[173]

Despite the limited provincial data they provide, the three Statistics Canada family violence profiles do give important details on the magnitude of the problem, on various types of family violence including spousal abuse, child abuse and neglect, and violence against elderly family members. They also report on the nature and severity of injuries, on the incidence of reporting of crime, on the characteristics of both victims and perpetrators, and on socio-economic and demographic risk factors.

This brief chapter cannot begin to do justice to these critical issues, which are of vital importance to women's health and wellbeing, and the reader is therefore referred to the three Statistics Canada reports for more information. In this chapter, we shall simply provide some basic statistics on rates of spousal violence from these reports, along with the very limited provincial information available for the Atlantic region.

6.1 Family violence in the larger context

It must first be acknowledged that family violence is only one aspect of the broader issue of violence in general, and of violence against women and children in particular. Yet it occupies a remarkably large portion of that violence. For example:

- Spousal violence accounts for 18% of all violence reported to police. Women accounted for 85% of reported spousal abuse – more than six times the rate for men. Nearly one-third of all reported female victims of violence in Canada were attacked by a spouse.[174]

- If non-reported offences are added, the incidence of spousal abuse is much higher, as women report only 37% of attacks by their husbands and partners.[175] When non-reported cases are added, the 1999 General Social Survey found that an estimated 220,000 Canadian women

[172] Trocme, Nico, and David Wolfe, *Child Maltreatment in Canada: Selected Results from the Canadian Incidence Study of Reported Child Abuse and Neglect,* Health Canada, Ottawa, 2001.
[173] Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Canada, Health Promotion and Programs Branch, Atlantic Regional Office, April, 1999, section 2.6.
[174] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, pages 1 and 6. Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000, page 21. Police-reported statistics in this publication represent a subset of 166 police agencies, which represent 53% of the national volume of reported crime.
[175] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000, page 21.

(3% of all women with a spouse or ex-spouse) were victims of spousal violence in the previous 12 months.[176]

- In 2001, family violence accounted for 43% of all homicides in Canada. Women accounted for 29% of all murder victims, and 52% of these were killed by someone with whom they had an intimate relationship at one time, either through marriage or dating.[177] Victims of spousal homicide accounted for 17% of all victims of solved homicides in Canada.[178]

- Only one-quarter of reported sexual abuse of children and youth under 20 is perpetrated by strangers, with the vast majority of incidents attributable to family, friends, and acquaintances, though youths are twice as likely to be victimized by strangers as children under 12.[179]

- For children 15 and younger, 16% of sexual abuse is attributable to fathers and step-fathers, 5% to mothers and step-mothers, and 44% to other relatives. Parents are responsible for more than 90% of substantiated cases of physical abuse of children, with non-relatives responsible for only 4%.[180]

In other words, the violence that occurs within families constitutes a very large proportion of all violence directed against women and children. But it is still only part of the problem, albeit a major part. The magnitude and dimensions of sexual violence, for example, are staggering:

- Sexual violence actually affects the majority of Canadian women at some point in their lives, with one study estimating that 51% of all Canadian women had experienced at least one instance of sexual violence since the age of 16.
- A national survey on child sexual abuse found that half of adult women and nearly one-third of adult men had been sexually abused as children.
- In Nova Scotia, one-third of youth aged 14-24 reported having sexual experience forced on them.[181]
- The Canadian Incidence Study of Reported Child Abuse and Neglect found that 69% of victims of sexual abuse, aged 15 and younger, were girls.[182]

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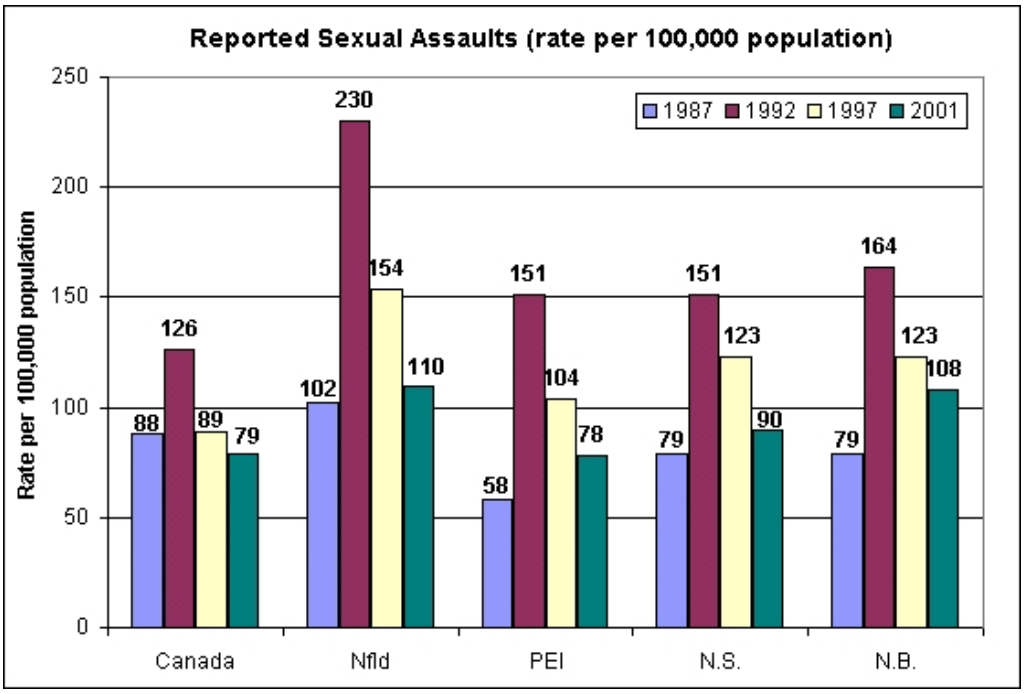
[176] Idem.
[177] Statistics Canada, "Homicides," *The Daily,* 25 September, 2002; and Statistics Canada, "Victims and persons accused of homicide, by age and sex," *CANSIM II* database, table 253-0003.
[178] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 9.
[179] Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Canada, Health Promotion and Programs Branch, Atlantic Regional Office, April, 1999, section 2.6.
[180] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2001*, catalogue no. 85-224-XIE, June, 2001, page 8, particularly Figure 1.6. Biological fathers are responsible for 46% of cases physical abuse; biological mothers for 43%; step-parents and other relatives for 21%; and non-relatives for 4%. Totals exceed 100% due to multiple responses – for example, cases where a child was assaulted by more than one relative.
[181] Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Canada, Health Promotion and Programs Branch, Atlantic Regional Office, April, 1999, section 2.6.
[182] Trocme, Nico, and David Wolfe, *Child Maltreatment in Canada: Selected Results from the Canadian Incidence Study of Reported Child Abuse and Neglect,* Health Canada, Ottawa, 2001, page 24.

- Among cases of sexual assault reported to police, 64% involved children under 12 (28%) and youth aged 12-19 (36%).
- According to Statistics Canada's General Social Survey, only 10% of all sexual assaults are reported. Extrapolating from reported cases, one study estimated that 21,000 children and youth in Atlantic Canada may have been subjected to some form of sexual violence in 1997.[183]

Assaults reported to police, while only a fraction of the total, likely represent the most serious cases. Fifteen years ago, according to police records, the Maritime provinces had lower rates of reported sexual assault than the rest of Canada. Since that time, however, the Atlantic region has regularly recorded significantly higher rates of sexual assault than the rest of Canada, with particularly high rates in Newfoundland. In recent years, the incidence of reported sexual assault has dropped throughout the country, though all four Atlantic provinces still record rates higher than 15 years ago (chart).[184] It is not clear to what extent the changes over time and by region reflect differences in reporting rates.

Figure 50. Reported sexual assaults, Canada and Atlantic provinces, 1987-2001, rate per 100,000 population



Sources: Canadian Centre for Justice Statistics, Crime Statistics in Canada 2001; Campbell, Joan, Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces, 1999.

[183] Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Canada, Health Promotion and Programs Branch, Atlantic Regional Office, April, 1999, section 2.6.
[184] Savoie, Josee, "Crime Statistics in Canada 2001," *Juristat,* Canadian Centre for Justice Statistics, Statistics Canada, volume 22, no. 6, catalogue no. 85-002, Table 3, page 16; Campbell, Joan, *Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces,* Health Canada, Health Promotion and Programs Branch, Atlantic Regional Office, April, 1999, section 2.6.

6.2 Spousal Violence

The 1999 General Social Survey found that 8% of Canadian women who were married or living in a common-law relationship, experienced some type of violence by a partner during the previous five years. In the Atlantic region, the reported numbers ranged from a low of 4% of women in Newfoundland, to 8% in Nova Scotia, 9% in New Brunswick, and 12% in PEI, although these numbers must be treated with caution due to a small sample size and high margin of error.[185]

Interestingly, the numbers were almost as high for Canadian men (7%) as for women (8%). But these broad averages conceal the fact that spousal violence against women was much more severe than spousal violence against men. Women were three times more likely than men to be injured as a result of spousal violence. Fully 38% of female victims feared their lives were in danger because of the violence, compared to just 7% of men. Women were also more likely to experience depression, anxiety, and sleep problems as a result of the violence. Women were also more likely than men to report repeated violence by their partners – 65% of those assaulted were victimized more than once, and 26% more than 10 times in the previous five years.[186]

One-third of female victims of spousal violence had to take time off as a result of the assault (three times as high a rate as male victims), and 15% required medical attention (five times the rate for men). Fully 11% were hospitalized as a result of the violence, compared to just 2% of male victims.[187]

Despite the very high rate of spousal violence (8% for women), it is actually one-third lower than the rate reported in 1993 (12%). The difference may be related with the recession and higher unemployment rates that prevailed in the early 1990s, as chronic unemployment of a male partner is a documented risk factor and predictor of wife assault.[188] Another significant trend is that women reported only half the incidence of violence from their current spouse in 1999 (4%) compared to 1993 (8%), but significantly higher rates of violence from a former partner – 28% of women in 1999, compared to 15% in 1993.[189]

Between 1993 and 1999 there was also a decline in the severity and frequency of assaults, and in the number of assaults resulting in injury (down from 47% to 40%) or requiring medical

[185] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000. The rates for all four Atlantic provinces have a high coefficient of variation (16.6% to 33.3%). See Table A4, page 51.
[186] Ibid., page 5
[187] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 1.
[188] Weir, Erica, "Wife Assault in Canada," *Canadian Medical Association Journal* 2000; 163 (3): 328.
[189] It should be noted that different survey methods were used in the 1999 survey than in the 1993 survey to derive the proportion of assaults from former partners. The 1999 survey only asked those women who had been in contact with a previous partner about violence from a former partner, and the percentage (28%) is therefore expressed as a proportion only of that more limited survey sample, whereas the 1993 survey asked the question to all women with previous partners. Had the 1993 survey method been used, the relevant rate of violence from former partners would have been 22%, not 28%, still substantially higher than the 1993 rate of 15%. See Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000, Table A5, page 51.

attention (down from 21% to 15%).[190] Nevertheless, this rate of serious assault remains remarkably high.

Another significant change over time is a marked increase in the number of spousal assaults reported to police. The number of incidents reported to police increased by 13% between 1995 and 1999. The reporting rate actually declined by 5% between 1995 and 1997, and then increased by 19% between 1997 and 1999.[191] According to the 1999 General Social Survey, 37% of female victims of spousal violence in the previous five years reported the incidents to police, compared to 29% recorded in the 1993 survey. Of incidents reported to police, 84% of female victims saw charges laid by the police.[192]

Clearly reporting to police is still hampered by the secrecy that still surrounds domestic violence, by the frequent economic dependency of the victim on the perpetrator, by the fear of repercussions, and by lack of knowledge. However, Statistics Canada notes that the increase in reporting to police may be due in part to:

> *"…a reduction in the social stigma of being a victim of spousal violence and seeking help, increased public awareness, improved training of police- and court-related victim support services, and, consequently, increased public confidence in the ability of the criminal justice system to deal effectively with spousal violence cases."*[193]

In addition, all Canadian jurisdictions have now adopted mandatory charge and prosecution policies for spousal violence that require police to charge in cases of spousal violence when there are reasonable grounds to do so, and the Crown to prosecute when there is a reasonable likelihood of conviction.[194] Despite these changes, a 2001-2002 public opinion survey found that nearly two-thirds of Canadians believe that the court system is unresponsive toward family violence, and 44% believe the police treat cases of family violence too lightly.[195]

Canadian rates of spousal violence are comparable to U.S. and British estimates. In Canada, 3% of women reported physical assault by their current or former partners in the previous year, compared to 1.5% of U.S. women, and 4.2% of British women.

The U.S. National Violence Against Women Survey in 1995-96 found that 25% of women had been assaulted by their current or former spouse in their lifetimes, including 1.5% of women in the previous 12 months. Of those assaulted, 41% were injured, 11% required medical attention,

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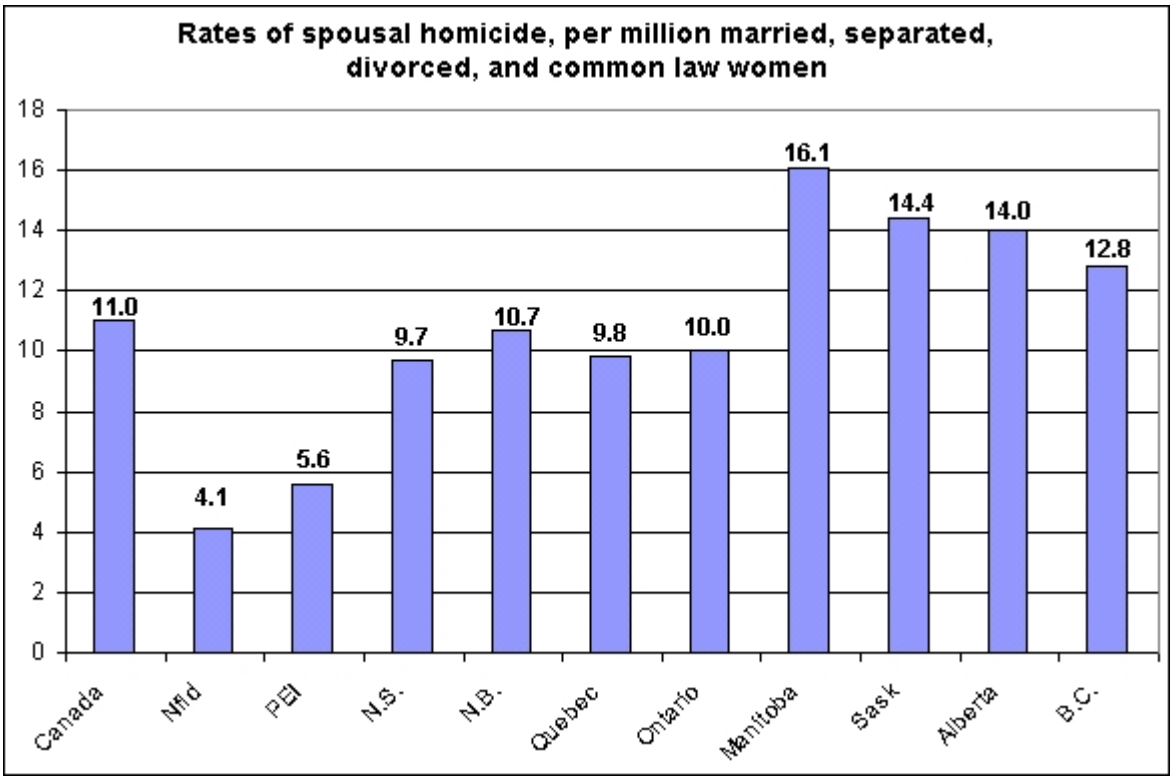
[190] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000, Table 2.5, page 14 (1999 rates), and Table A9, page 53 (1993 rates).
[191] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, July, 2000.
[192] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, pages 7 and 8.
[193] Cited in: Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 9. See also page 2.
[194] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 13.
[195] EKOS Research Associates poll, cited in Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002,* catalogue no. 85-224-XIE, June, 2002, page 17.

9% were hospitalized, 18% lost time from work, and 27% required counselling. In Britain, 23% of women reported being physically assaulted by their current or former partner at some point in their lives, including 4.2% of women during the previous year. When frightening threats were added, these rates went up to 26% and 6% respectively. Half the British victims reported having been assaulted three or more times.[196]

Clearly the most serious form of spousal violence is homicide. Canadian women are more than three times as likely to be victims of spousal homicide as men, with more than two-thirds of cases involving a prior history of domestic violence. For both homicides and spousal assault in general, young, separated women are at much greater risk than older, married women.

The rate of spousal homicide for both women and men has declined sharply since the mid-1970s. Women in 2000 were 62% less likely to be killed by their partners than in 1974, with a decline from 16.5 victims per million couples to 6.3. Spousal homicide rates are also considerably lower in the four Atlantic provinces than in the west, with Newfoundland registering the lowest rate in the country (Figure 51).[197]

Figure 51. Rates of spousal homicide, Canada, 1974-2000, rate per million married, separated, divorced, and common law women



Source: Statistics Canada, Family Violence in Canada: A Statistical Portrait 2002.

[196] Ibid.
[197] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 11.

There appears to be a strong relationship between the declining rates of spousal violence and the social and economic changes described in earlier chapters of this report. Statistics Canada cites studies that have noted:

> *"Increasing gender equality over the past several decades, including rising income levels and labour force participation rates among women, are linked to both delayed marriage and improvements in women's economic status. These factors may have helped expand women's alternatives to either entering or remaining in a violent relationship….*
>
> *"As the proportion of young people getting married has declined, exposure to violence in the highest-risk age groups may be reduced. Furthermore, the increase in the age of first marriage may reflect greater selectivity among would-be spouses."*[198]

While the Statistics Canada survey did not address the causes of family violence, an EKOS public opinion survey found that Canadians were most likely to identify stress in the family, including money problems and unemployment, as the key factor (54%). Alcohol and drugs were identified by one third of respondents, and a history of violence or learned behaviour in childhood was identified by 23%.[199]

6.3 Transition homes

The most frequently used social service by female victims of domestic violence is a counsellor or psychologist (28%), and 11% use transition homes. Statistics Canada's 1999-2000 Transition Home Survey reported nearly 100,000 annual admissions to transition homes throughout Canada, including more than 57,000 women and nearly 40,000 of their children. This has increased from 78,000 in 1991-1992.

Eighty per cent of abused women in transition homes were seeking shelter from an abusive spouse or ex-spouse, and more than two-thirds were escaping physical abuse. Others were fleeing threats, harassment, sexual assault, and psychological or financial abuse.[200]

The 1999-2000 survey reported 1,246 admissions of women and dependent children in Newfoundland, 251 in PEI, 8,436 in Nova Scotia, and 1,878 in New Brunswick.[201] Profiles of transition homes in the four Atlantic provinces, and characteristics of women and children who use them, are available on Statistics Canada's web site.[202]

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[198] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2002*, catalogue no. 85-224-XIE, June, 2002, page 12.
[199] Cited in Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, June, 2002, page 17.
[200] Statistics Canada, Canadian Centre for Justice Statistics, *Family Violence in Canada: A Statistical Profile 2000*, catalogue no. 85-224-XIE, June, 2002, page 18.
[201] Statistics Canada, *Transition Home Survey 1999-2000,* Canadian Centre for Justice Statistics.
[202] Statistics Canada, http://www.statcan.ca/english/freepub/85-404-MIE/free.htm.

7. Access to Health Care Services

Access to Health Care Services: Key Messages

1. Women use more health care services than men, and are thus disproportionately affected by barriers to access.
2. Atlantic Canadians have greater difficulties accessing care than most other Canadians.
3. These barriers appear to result primarily from lack of availability of key health care services in rural areas, rather than from longer waiting times.
4. Atlantic Canadians are generally highly satisfied with the quality of the health care services they receive.

Access to good health care is a key determinant of health. Studies have found that access to a regular family physician, for example, can improve overall health status.[203] Yet Canadians are increasingly facing difficulties accessing health care services. According to Statistics Canada, one in eight Canadians reported having unmet health care needs in 2000/01, up from one in 24 in 1994/95, with long waits and unavailability of services the most frequently cited complaints.[204]

The Romanow Commission recently acknowledged that: "Providing timely access to quality health care services is a serious challenge in every province and territory…. Canadians' first concern is with access, and that issue must be dealt with on a priority basis."[205] As one of its key recommendations, the Commission emphasized the need for access to primary care and health information 24 hours a day, seven days a week.[206]

Statistics Canada has acknowledged that, up to this point, existing Canadian data on health care utilization have not provided a complete picture of access to health services. They have not informed about the experiences of those accessing care, they provided only limited information on potential barriers to care, and there was no comprehensive information on waiting times for health care services.[207]

To fill these vital information gaps, Statistics Canada conducted its first Health Services Access Survey in November-December 2001, with a national sample size of 14,210 respondents. Key results were released in June, 2002. Although Statistics Canada did not publicly release these

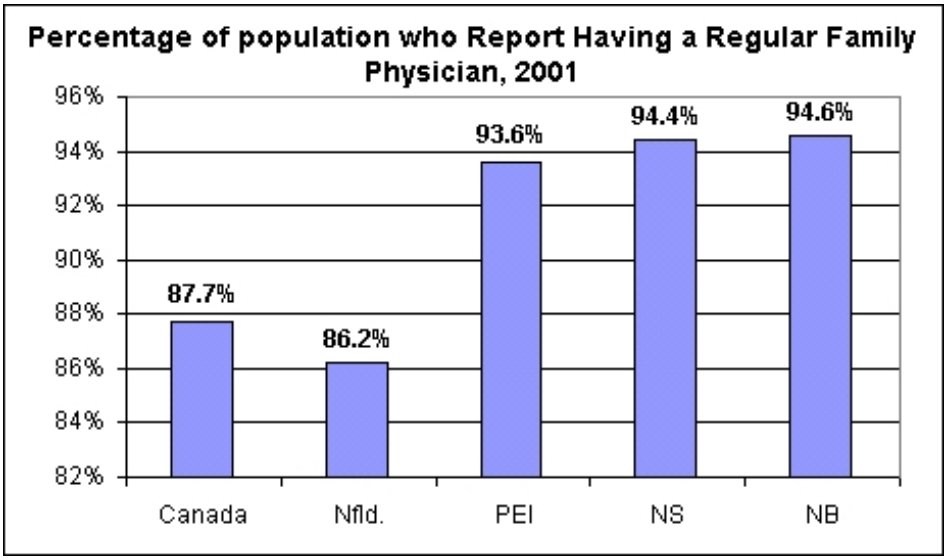
[203] Shi, L. and B. Starfield, "The effect of primary care physician supply and income inequality on mortality among blacks and whites in US metropolitan areas," *American Journal of Public Health* 2001; 91 (8): 1246-1250, cited in Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, pages, 8, 22.
[204] Sanmartin, Claudia, et al., "Changes in unmet health care needs," *Health Reports* 13 (3), March, 2002, Statistics Canada, catalogue no. 82-003, pages 15-21.
[205] Romanow, Roy, *Building on Values: The Future of Health Care in Canada, Final Report,* Commission on the Future of Health Care in Canada, November, 2002, pages 137-138.
[206] Ibid., chapter 5.
[207] Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, pages 6-8.

results by gender, they are included here both because of the distinct profile of the Atlantic provinces, and because women have higher rates of health care utilization and are therefore disproportionately affected by difficulties accessing these services.

Maritimers are more likely to have a regular family physician than other Canadians, with New Brunswick and Nova Scotia registering the highest rates in the country (Figure 52). Among those who did *not* have a regular physician however, Atlantic Canadians were much more likely than other Canadians to cite lack of physician availability as the key reason (Figure 53). In other provinces, Canadians were much more likely to give their main reason for not having a regular family physician as not having contacted one.

Aside from having a regular family physician, Atlantic Canadians generally reported more difficulties accessing primary health care services than other Canadians. Prince Edward Islanders, Newfoundlanders, and Nova Scotians reported the highest rates of difficulty accessing care in the country, after Manitobans. New Brunswickers had more difficulties accessing health services than the national average, but experienced the fewest barriers in the Atlantic region (Figure 54).[208] Reported barriers to care included problems getting an appointment, waiting too long for care, and getting inadequate information.

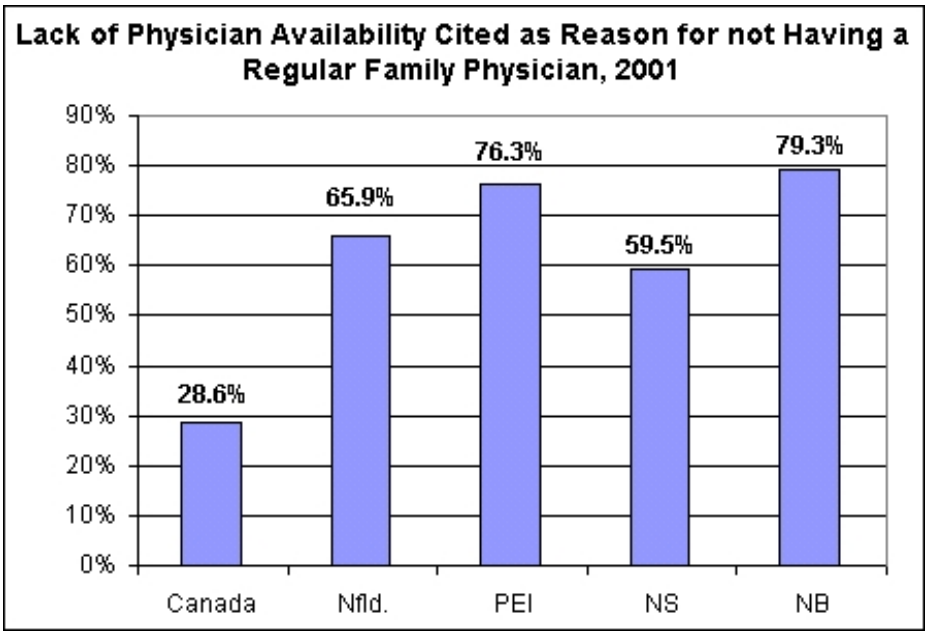
Figure 52. Percentage of population who report having a regular family physician, 2001



Source: Statistics Canada, Access to Health Care Services in Canada 2001

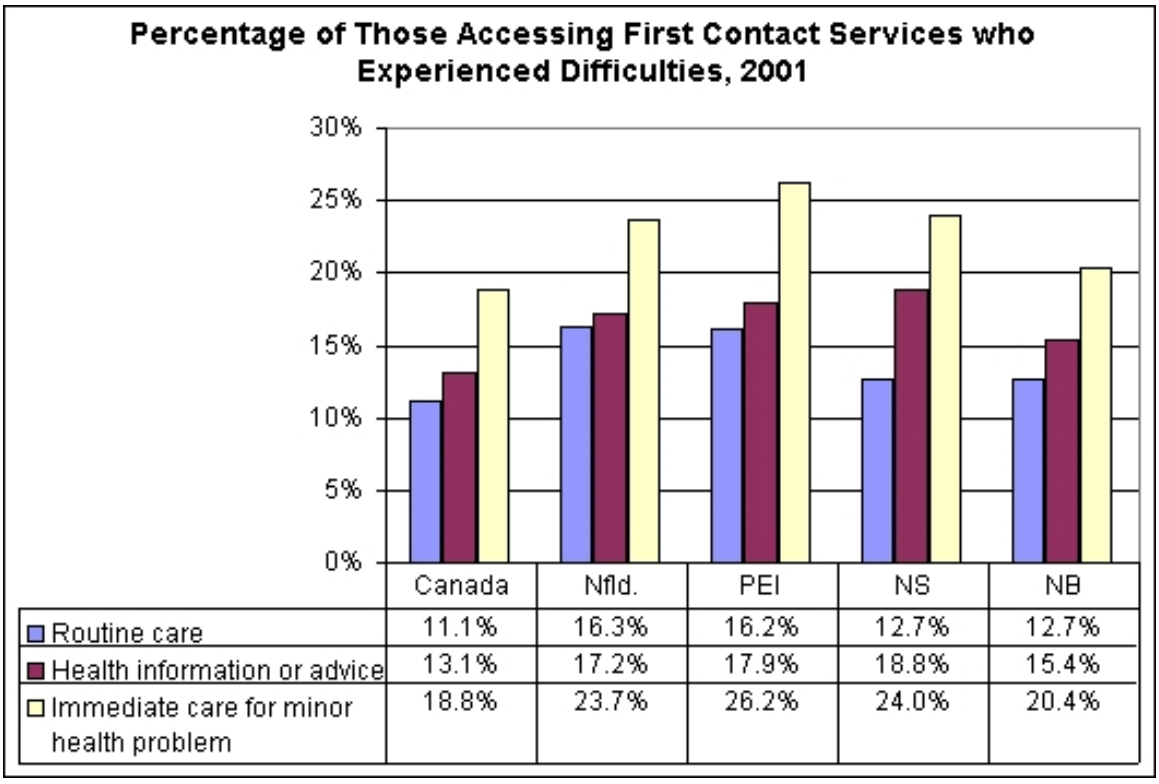
[208] Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, Table A-2, page 24. Statistics Canada's *CANSIM II* database, Tables 105-3027, 3028, and 3029, report the barriers by time of day (regular office hours, evening, and night) from the same source (the Health Services Access Survey, 2001, but give lower rates, apparently calculated as a percentage of *all* respondents rather than as a percentage of those accessing care as in the Figure provided here.

Figure 53. Lack of physician availability cited as reason for not having a regular family physician (as % of those who did not have a regular family physician), 2001



Source: Statistics Canada, Access to Health Care Services in Canada 2001

Figure 54. Percentage of those accessing first contact services who experienced difficulties, 2001



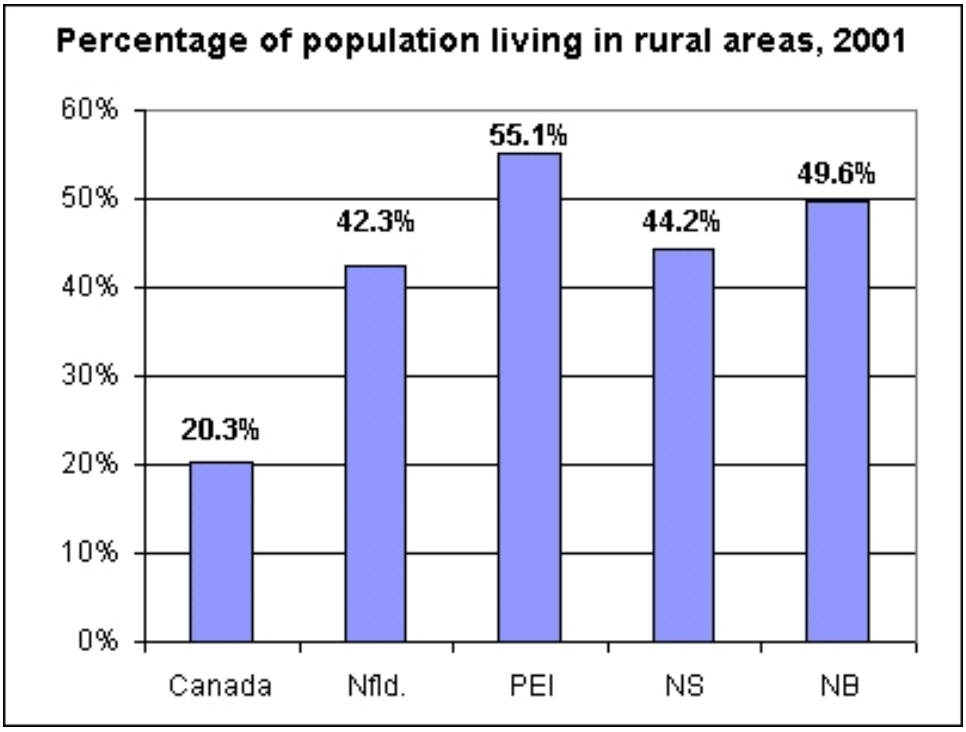
	Canada	Nfld.	PEI	NS	NB
Routine care	11.1%	16.3%	16.2%	12.7%	12.7%
Health information or advice	13.1%	17.2%	17.9%	18.8%	15.4%
Immediate care for minor health problem	18.8%	23.7%	26.2%	24.0%	20.4%

Source: Statistics Canada, Access to Health Care Services in Canada 2001

Interestingly, Atlantic Canadians generally did not experience longer median waiting times for *specialist* visits, non-emergency surgery, and diagnostic tests than other Canadians, with one exception. Nova Scotians reported median waiting times for non-emergency surgery of six weeks, 40% longer than the 4.3 week Canadian median. Prince Edward Islanders experienced median waiting times of three weeks, 30% less than the Canadian median, and all other waiting times were comparable to the national median.

Together with the evidence on physician availability above, this appears to indicate that the barriers to health care access experienced by Atlantic Canadians have more to do with lack of available services than with long waiting times. That in turn is likely a function of the fact that the four Atlantic provinces have higher rates of rural residency than any other province in the country (Figure 55).[209]

Figure 55. Percentage of population living in rural areas, 2001



Source: Statistics Canada, 2001 Census

As the Romanow Commission recognized:

> *"Canadians in rural communities often have difficulty accessing primary health care and keeping health care providers in their communities, let alone accessing diagnostic services and other more advanced treatments…. People in rural communities also have the added burden of paying for the high costs of travel in*

[209] Statistics Canada, 2001 Census, cited in Romanow, Roy, *Building on Values: The Future of Health Care in Canada, Final Report,* Commission on the Future of Health Care in Canada, November, 2002, page 160.

order to access the care they need. This often means days and weeks away from family and social support as well as the added cost of accommodation and meals….

"Problems in access to health services quite often stem from serious shortages in health care providers in rural communities…. In 1993, there was less than one physician per 1,000 people in rural and small town areas, compared to two or more physicians per 1,000 people in larger urban centres."[210]

To remedy these difficulties, the Romanow Commission recommended a Rural and Remote Access Fund to attract and retain health care providers, to provide rural experiences as part of the education and training of physicians and nurses, to expand telehealth approaches, and generally "to support innovative ways of delivering health care services to smaller communities."[211] Implementation of these recommendations may help overcome some of the barriers to health service access noted above and improve access for the high proportion of Atlantic Canadians living in rural areas.

For reasons that are unclear and require further investigation, difficulties and barriers to access translated into unmet health care needs for a higher proportion of Newfoundlanders and Prince Edward Islanders than Nova Scotians and New Brunswickers. Respondents to Statistics Canada's Health Services Access Survey were asked whether there was a time in the past 12 months when they needed health care services and did not receive them. In response to that question, residents of Prince Edward Island and Newfoundland and Labrador reported the country's highest rates of unmet needs for health care services, Nova Scotians had a lower than average rate of unmet needs, and New Brunswickers had the lowest rate in the country (Figure 56).[212]

When those who didn't get the health care services they needed were asked why this occurred, respondents cited lengthy waits for care, and the unavailability of the service either when needed or in their area.[213] Many Canadians reported worry, anxiety, stress, pain, and diminished health status while waiting for care, and more than one-quarter of those who waited for specialized services said their waiting time was "unacceptable." Statistics Canada concluded: "Long waits were clearly not acceptable to Canadians, particularly when they experienced adverse affects (sic) such as worry and anxiety or pain while waiting for care."[214]

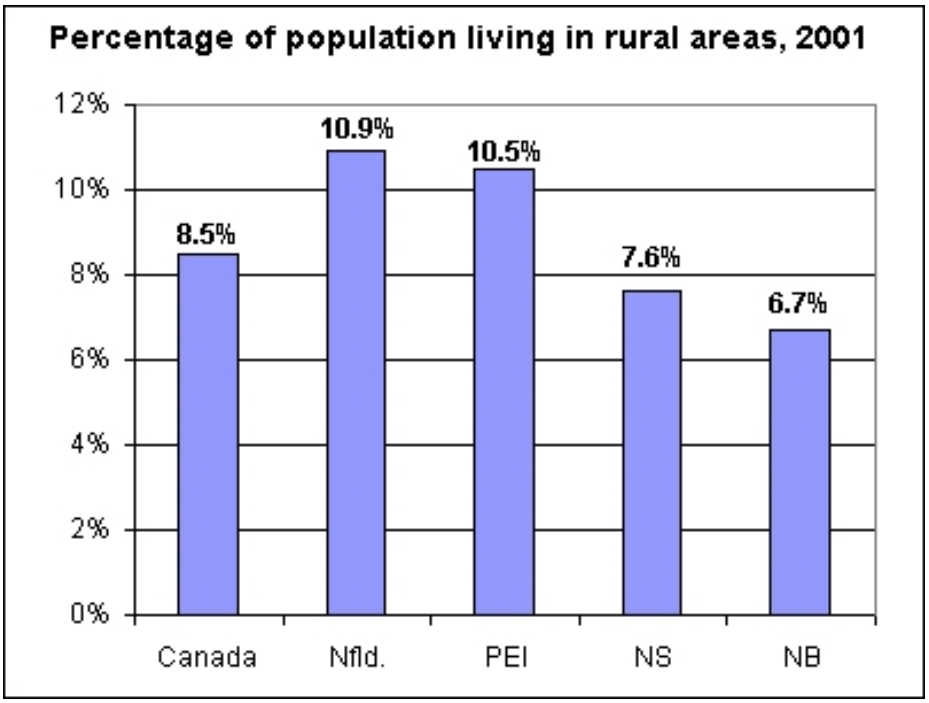
While access to health services is recognized by Health Canada as a key health determinant, we can only speculate here whether the gap between health care needs and availability of services helps to explain actual health outcomes in the Atlantic provinces. For example, Newfoundland and Labrador has the country's lowest incidence of new cancers – 20% below the national

[210] Romanow, op. cit., page 162.
[211] Romanow, op. cit., Recommendations 30-33, pages 166 and 168.
[212] It should be noted that due to limited sample size, confidence intervals are frequently sufficiently large to prevent attribution of statistical significance to these rankings. See Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, Table 8, page 15.
[213] Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, pages 15-16.
[214] Ibid., page 21.

average, but some of the highest rates of cancer mortality – 12% above the national average. Whether this unusual gap is due to lack of timely diagnosis and treatment or to other factors requires further research. The Romanow Commission report provides a possible clue:

> *"In fact, some would say that there is an 'inverse care law' in operation. People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres."*[215]

Figure 56. Percentage of population reporting unmet health care needs, 2001



Source: Statistics Canada, Access to Health Care Services in Canada 2001

Despite greater barriers to access, Atlantic Canadians are generally more satisfied with health care services than most other Canadians. According to the Canadian Community Health Survey 2000/01, residents of PEI and Newfoundland have the highest rates of satisfaction in the country with the quality of the health care services they receive. Atlantic Canadians also generally express high levels of satisfaction with the quality of hospital, physician, and community-based health care in particular.

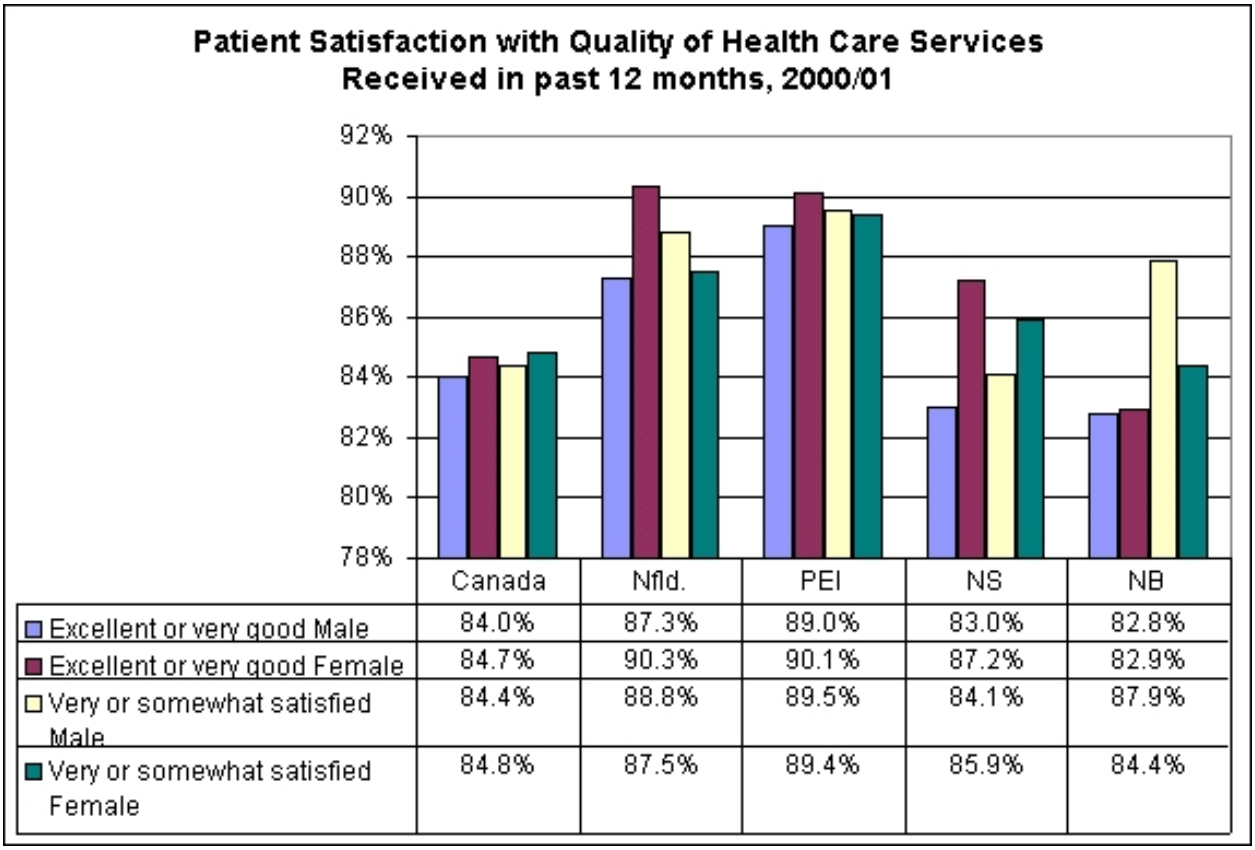
Women in Newfoundland, PEI, and Nova Scotia are more likely than men to rate their health services as excellent or very good. Remarkably, every female survey respondent in Newfoundland was satisfied with the community-based health care she received, and almost all (99.4%) rated that community care as excellent or very good – by far the highest levels of

[215] Romanow, op. cit., page 162.

satisfaction in the country (Table 5 and Figure 56). By contrast, fewer than three-quarters of women in Ontario rated their community-based health services as excellent or very good.[216]

In sum, health care services in Atlantic Canada are often harder to access, but, once they receive the services, most Atlantic Canadians are highly satisfied with the care they do access. Residents of Manitoba, Alberta and Ontario generally had the lowest rates of satisfaction in the country, indicating that barriers to access are not necessarily related to satisfaction with key health services.

Figure 57. Patient satisfaction with quality of health care services received in past 12 months, 2000/01



	Canada	Nfld.	PEI	NS	NB
Excellent or very good Male	84.0%	87.3%	89.0%	83.0%	82.8%
Excellent or very good Female	84.7%	90.3%	90.1%	87.2%	82.9%
Very or somewhat satisfied Male	84.4%	88.8%	89.5%	84.1%	87.9%
Very or somewhat satisfied Female	84.8%	87.5%	89.4%	85.9%	84.4%

Source: Statistics Canada, Canadian Community Health Survey, CANSIM II database.

[216] Statistics Canada, *CANSIM II* Database, Tables 105-0080, 0081, 0082, and 0083, using data from the Canadian Community Health Survey (CCHS) 2000/01. Interestingly, a parallel question in the 2001 Health Services Access Survey (HSAS) on the quality of family physician care reported by those with a regular family physician yields different results. 53% rated that family physician care as excellent compared to 51.4% of Nova Scotians, 51.2% of New Brunswickers, 48.5% of Newfoundlanders, and 48.2% of Prince Edward Islanders. Sanmartin, Claudia, et al., *Access to Health Care Services in Canada 2001,* Statistics Canada, catalogue no. 82-575-XIE, Ottawa, June, 2002, Table 3, page 11. The CCHS data are used here because the sample size is many times larger than that of the HSAS, (and the confidence intervals are correspondingly smaller for the Atlantic provinces). The CCHS data thus likely yield more accurate results for the "satisfaction" indicator.

Table 5. Patient satisfaction with most recent hospital care, with physician care in the past 12 months, and with most recent community-based health care received in the past 12 months, (%), 2000/01

	Patient satisfaction with:											
	Hospital care – most recent experience				Physician care – past 12 months				Community-based health care – past 12 mths			
	Excellent or very good		Satisfied		Excellent or very good		Satisfied		Excellent or very good		Satisfied	
	male	fem	male	fem	male	fem	male	fem	male	fem	male	fem
Can	79.8	80.5	79.7	79.3	88.7	90.5	90.8	90.9	76.3	78.8	80.1	82.8
Nfld	82.5	91.4	82.2	84.0	94.4	92.9	94.4	94.6	94.5	99.4	91.1	100
PEI	86.7	85.3	83.8	86.5	95.6	91.8	95.0	94.0	85.0	76.4	98.2	91.1
NS	85.3	81.8	80.2	80.8	90.9	91.8	91.7	90.4	81.6	85.0	92.0	89.5
NB	73.5	82.1	81.3	84.6	94.3	90.4	93.2	91.6	96.1	91.3	90.3	96.1

Note 1: The "satisfied" category combines "very" and "somewhat" satisfied.

Note 2: The question on community based health care asked respondents to evaluate their "most recent" experience in the past 12 months.

Source: Statistics Canada, Canadian Community Health Survey, CANSIM II database.