ABSTRACT

In Canada, coverage for ambulatory prescription drug expenditures is provided to some groups by provincial drug plans through a provincial formulary. Little is known about the drugs provincial formularies give access to. We report the variation in availability of new drug molecules (NDM) across provincial formularies.

We identified 108 NDM approved in Canada between 1991 and 1998. From each drug plan bulletin or formulary, we abstracted names of NDM listed as per 15 January 1999. We compared the level of listing across provinces using kappa coefficients.

In the Quebec, BC, Manitoba and Saskatchewan formularies, more than 70% of the NDM were listed. In four provinces, this proportion was lower than 50%. In general, the agreement between formularies was poor.

There is a wide variation across provinces in terms of NDM listed in the formularies. This variation reflects inter-provincial differences in the way drugs are selected for coverage.

ABRÉGÉ

Au Canada, les programmes provinciaux d'assurance-médicaments permettent aux citoyens admissibles d'obtenir sur ordonnance les médicaments dont le nom figure sur la liste provinciale. On en sait très peu sur le contenu de ces listes. Notre étude visait à répertorier les écarts entre les listes provinciales quant aux nouvelles molécules (NM).

Entre 1991 et 1998, 108 NM ont été approuvées au Canada. Nous avons extrait le nom des NM figurant sur les listes provinciales le 15 janvier 1999, puis évalué la concordance entre les listes à l'aide de coefficients Kappa.

Au Québec, en Colombie-Britannique, au Manitoba et en Saskatchewan, plus de 70 % des NM figuraient sur les listes. Dans quatre autres provinces, cette proportion n'atteignait pas 50 %. En général, la concordance entre les listes était faible.

Les listes varient beaucoup d'une province à l'autre, ce qui traduit les différences inter-provinciales dans la façon de sélectionner les médicaments remboursables.

Inter-Provincial Variation in Government Drug Formularies

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Pharmaceuticals play an important role in health care. When used appropriately, prescription drugs can efficiently treat or prevent many illnesses.¹ They can replace more invasive treatment modalities² or reduce the use of expensive health resources.^{3,4} Technological advances in pharmacotherapy have shortened the length of stay in hospitals and, therefore, have contributed to the substitution of ambulatory care for inpatient care.⁵ As a result, there are increasing concerns about appropriate access to and use of outpatient prescription drugs.⁵

In Canada, ambulatory prescription drug expenditures are generally paid through private insurance or directly out-of-pocket by patients, but coverage of such expenditures is also provided to some groups by provincial drug benefit plans. Drugs that are eligible for reimbursement are included in a list called the provincial formulary. In most provinces, there also are "special programs" outside of the provincial formulary through which some high-cost drugs are provided as a benefit to certain patient groups (e.g., AIDS/HIV or cystic fibrosis). Out of a Canadian population of 28.8 million, 3.2 million seniors, 3.2 million people with low incomes, and 1.5 million others depend on provincial drug benefit programs for drug coverage.⁶

Most health policy reports on prescription drug coverage have focused on eligi-

bility for enrolment and cost-sharing issues.⁷⁻⁹ To our knowledge, the issues of which drugs are reimbursed and the differences between provinces in reimbursement policies have not been specifically examined.

We examined the variation in listing of new drug molecules across Canadian provincial formularies. We also assessed to what extent provinces limit access to new drugs through administrative formulary processes.

METHODS

We identified new drugs approved in Canada that received a notice of compliance (NOC) between 1 January 1991 and 31 December 1998 using the information published by the Therapeutic Products Program, Health Canada, on the Government of Canada web site. Only new drug molecules receiving a first NOC were considered. We excluded generic copies and products that were granted a new NOC due to change in product ownership, approved indications, route of administration, or manufacturing processes. We also excluded over-the-counter products, vaccines, and products that would normally be used inside a hospital because these three groups of products are not normally considered for reimbursement through provincial drug plans. Drugs not launched in Canada or withdrawn from the market were also excluded. We classified drugs according to their therapeutic class using the Anatomical, Therapeutic and Chemical classification.¹⁰

We examined the formulary status of the new drugs in each of the ten provinces. From each drug plan formulary issued since 1 January 1992, we abstracted names of new drugs listed and their reimbursement status as per 15 January 1999. We

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TABLE I
New Drugs Launched in Canada Between 1 January 1991 and
31 December 1998 by Therapeutic Class (N=148)

Therapeutic Class*	Drug	Date of Notice of Compliance Day/Month/Year	Therapeutic Class*	Drug	Date of Notice of Compliance Day/Month/Year
Alimentary tract and metabolism	Acarbose	15/11/95	Antineoplastic and immunomodulating agent	Valacyclovir	05/01/96
	Betaine anhydrous	30/07/98		Zalcitabine	07/07/92
	Dolasetron mesylate	21/05/97		Anastrozole	01/08/96
	Insulin lispro	08/10/96		Bicalutamide	02/11/95
	Lansoprazole	12/05/95		Capecitabine	31/08/98
	Levocarnitine	19/01/95		Estramustine phosphate disodium	09/07/92
	Olsalazine sodium	21/09/92		Glatiramer acetate	04/09/97
	Ondansetron	06/05/91		Interferon beta 1-A†	05/02/98
	Pantoprazole	23/09/96		Letrozole	21/05/97
	Pinaverium bromide	28/10/93		Mylcphenolate	15/11/95
Blood and blood forming organs	Ranitidine bismuth citrate	23/07/97	Musculo-skeletal system	Nilutamide	20/12/91
	Ursodiol	12/02/91		Tacrolimus	06/12/95
Cardiovascular system	Clopidogrel bisulfate	07/10/98		Tretinoin	22/12/94
	Amiodarone HCL	21/06/93		Alendronate sodium	18/12/95
	Amlodipine	26/06/92		Clodronate disodium	11/05/92
	Atorvastatin	19/02/97		Diclofenac sodium / Misoprostol	15/01/93
	Benazepril HCL	14/06/93		Etidronate Disodium	13/08/92
	Bezafibrate	28/03/94		Etidronate/Calcium carbonate	19/07/95
	Carvedilol	30/09/96		Etodolac	22/12/94
	Cerivastatin Sodium	18/02/98		Ketorolac tromethamine	18/03/91
	Cilazapril	22/03/93		Nabumetone	18/03/94
	Doxazosin mesylate	16/12/91	Nervous system	Tenoxicam	27/06/91
	Felodipine	24/12/91		Butorphanol	07/07/94
	Fluvastatin	21/12/93		Clobazam	18/06/92
	Irbesartan	01/06/98		Clozapine	20/03/91
	Lisinopril/Hydrochlorothiazide	07/10/92		Dihydroergotamine mesylate	04/10/96
	Losartan potassium	28/09/95		Donepezil HCL†	12/08/97
	Losartan potassium / Hydrochlorothiazide	15/11/96		Gabapentin	07/04/94
	Midodrine HCL	27/06/91		Lamotrigine	21/11/94
	Nimodipine	27/02/95		Naratriptan (Hydrochloride)	28/04/98
	Pentosan polysulfate sodium	26/04/93		Nefazodone HCL	27/04/94
	Perindopril erbumine	21/09/94		Olanzapine	28/10/96
Dermatologicals	Ramipril	08/10/93		Paroxetine HCL	04/05/93
	Torsemide	27/09/94		Pergolide mesylate	27/06/91
	Trandolapril	11/06/97		Pilocarpine HCL	08/01/97
	Valsartan	03/11/97		Pramipexole dihydrochloride monohydrate	29/01/98
	Adapalene	24/06/97		Praziquantel	07/03/97
	Calcipotriol	27/10/92		Quetiapine fumarate	02/12/97
	Econazole Nitrate	19/11/91		Risperidone†	23/04/93
	Halobetasol propionate	22/01/93		Ropinirole Hydrochloride	19/08/97
	Isotretinoin	03/05/91		Sertraline HCL	30/01/92
	Podofilox†	23/10/91		Sumatriptan†	20/01/92
Genito-urinary system and sex hormones	Terbinafine HCL†	04/05/93		Tazorotene	25/02/97
	Cyproterone Acetate/ Ethinyl Estradiol	17/09/97		Tetrabenazine	29/12/95
	Desogestrel / Ethinyl estradiol	13/07/93		Tolcapone	08/10/97
	Estradiol	02/06/95		Tolterodine L-tartrate	20/11/98
	Estradiol 17B / Norethindrone	22/06/94		Venlafaxine HCL	18/07/94
	Finasteride†	23/10/92		Vigabatrin†	14/01/94
	Levonorgestrel	15/12/93		Zolmitriptan	24/08/98
	Levonorgestrel / Ethinyl estradiol	03/12/97		Zopiclone	23/12/96
	Progesterone	15/05/95		Zuclopenthixol dihydrochloride	24/04/95
	Tamsulosin HCL	01/06/98	Antiparasitic products, insecticides and repellents	Atovaquone	25/11/92
Systemic hormonal preparations excluding sex hormones	Terconazole	14/05/91		Atovaquone / Proguanil HCL	22/06/98
	Nafarelin acetate	18/03/91		Halofantrine	29/03/95
General anti-infectives for systemic use	Prednisolone sodium	04/02/97	Respiratory system	Mefloquine HCL	22/01/93
	Cefprozil	31/03/95		Dornase alfa	30/12/93
	Clarithromycin	08/05/92		Fluticasone dipropionate	07/09/93
	Delavirdine mesylate	22/07/98	Sensory organs	Fluticasone propionate	31/07/95
	Didanosine	08/10/91		Formoterol fumarate	06/03/97
	Famciclovir	31/07/95		Levocabastine HCL	09/02/93
	Ganciclovir	10/10/95		Montelukast sodium	17/06/98
	Grepafloxacin HCL	09/04/98		Salmeterol xinafoate	25/10/94
	Indinavir sulfate†	13/09/96		Zafirlukast	21/10/97
	Itraconazole	17/08/93		Apraclonidine HCL†	25/03/92
	Lamivudine	08/12/95		Betaxolol	08/10/92
	Levofloxacin	14/11/97		Brinzolamide	23/10/98
	Nelfinavir mesylate	11/08/98	Various	Dorzolamide HCL	25/04/96
	Nevirapine	04/09/98		Emedastine digumate	16/02/98
	Ofloxacin	28/06/91		Latanoprost	16/06/97
	Rifabutin†	23/03/93		Levodopa / Dipivefrin HCL	02/02/96
	Rifampin/Isoniazid/ Pyrazinamide	12/01/95		Lodoxamine tromethamine	27/06/91
	Ritonavir†	14/08/96		Mometasone furoate monohydrate	22/07/98
	Saquinavir†	22/03/96		Olapatidine HCL	16/09/97
				Remexolone	17/01/96
				Naltrexone HCL	23/03/95

* ATC classification (ref. 10) † Breakthrough drugs

defined the reimbursement status of each new drug as listed without restriction, listed with restriction, or non-listed. Drugs listed with restriction are those for which the province has applied administrative or clinical criteria that must be met before approval to reimburse the drug is granted.

In New Brunswick (NB), Newfoundland (NF), Nova Scotia (NS), Saskatchewan (SK), and Prince Edward Island (PEI), drugs are listed according to categories of beneficiaries. In the former four provinces, reimbursed drugs were considered listed without restriction if they were available as such for both seniors and welfare recipients. In PEI, we considered listed without restriction to be drugs reimbursed as such to seniors. We considered all other drugs admitted to these formularies as listed with restriction.

ANALYSIS

We conducted analyses in two steps. First, we performed a descriptive analysis to characterize drugs listed in each provincial formulary in regard to their reimbursement status. Next, we compared the level of listing across provinces using kappa coefficients. These coefficients provide a measure of agreement between two provin-

cial formularies, corrected for chance. In the context of this study, kappa coefficients are a quantitative measure of how similar reimbursement status is across provincial formularies regarding new drug entities. According to Fleiss,¹¹ a kappa value greater than 0.75 is generally considered to represent excellent agreement, values between 0.40 and 0.75 represent fair to good agreement, whereas kappa values below 0.40 represent poor agreement beyond chance. Statistical analyses were performed using the SAS software package version 6.12.¹²

RESULTS

We identified a total of 148 products that met our eligibility criteria for new drugs launched in Canada between the beginning of 1991 and the end of 1998. Names and therapeutic classes of these drugs are listed in Table I.

In Figure 1, we show the proportion of new drugs listed without or with restriction in each provincial drug formulary. In the Quebec (QC), British Columbia (BC), Manitoba (MB) and Saskatchewan (SK) formularies, more than 70% of the new drugs were listed. The QC formulary contains the highest proportion of drugs (83.1%) followed by BC, SK, MB, NS and

Alberta (AB). NB, NF, Ontario (ON) and PEI listed less than 50% of the new drugs. The province with the highest proportion of drugs listed without restriction was Quebec, followed by Manitoba, Alberta and Saskatchewan. Ontario and PEI were the provinces reimbursing the lowest proportions of drugs without restriction. In PEI, NS, BC and ON, over 50% of new drugs listed in the provincial formulary had their reimbursement tied to restrictive criteria.

In Table II, we present the proportion of new drugs listed in each province by therapeutic class. If we consider therapeutic classes with 20 drugs or more – namely nervous system, cardiovascular system, and anti-infective for systemic use – there was a wide variation in the proportion of new drugs listed for reimbursement in provincial formularies. For the nervous system, the listing of new drugs ranged from a low of 34.5% in ON to a high of 86.2% in QC. For the cardiovascular system, the listing ranged from a low of 34.8% in PEI to a high of 95.7% in BC, MB, QC and SK. Lastly, the proportion of new anti-infective drugs listed ranged from a low of 15% in PEI to a high of 90% in QC.

The level of inter-provincial agreement in the listing of new drugs is presented in Table III. Kappa coefficients range from a low of 0.12 to a high of 0.63. The majority of coefficients are below 0.40, indicating that the level of inter-provincial agreement in the listing of new drugs in provincial formularies is low. Of the 18 new drugs that were listed in all provincial formularies (Table IV), all received a NOC in or before 1996 while, of the 10 new drugs that were not listed in any province, all but 1 received a NOC in 1997 or later.

DISCUSSION

Two important findings emerge from this study. First, in the period we studied, there was a wide variation across provinces in terms of new drugs that are listed in the formularies. Second, the extent to which the reimbursement of new drugs is restricted through administrative procedures also varied across provincial formularies.

There was very little inter-provincial agreement with respect to the listing status of new drugs. With the exception of the

TABLE II

Proportion of New Drugs Launched in Canada Between 1991 and 1998 That Were Listed in Each Provincial Formulary as per January 15, 1999, According to Their Therapeutic Class

Therapeutic Class*	Province									
	Alberta	British Columbia	Manitoba	New Brunswick	Newfoundland	Nova Scotia	Ontario	Prince Edward Island	Quebec	Saskatchewan
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
N (N=29)	72.4	79.3	79.3	48.3	37.9	72.4	34.5	37.9	86.2	79.3
C (N=23)	78.3	95.7	95.7	43.5	52.2	82.6	73.9	34.8	95.7	95.7
J (N=20)	40.0	70.0	80.0	40.0	30.0	35.0	55.5	15.0	90.0	85.0
A (N=12)	66.7	83.3	66.7	50.0	16.7	66.7	50.0	41.7	83.3	66.7
L (N=11)	0.0	63.6	45.5	45.5	27.3	45.5	45.5	27.3	90.9	36.4
S (N=11)	36.4	54.5	63.6	36.4	36.4	36.4	36.4	18.2	54.5	63.6
G (N=10)	70.0	80.0	60.0	30.0	40.0	60.0	50.0	20.0	70.0	90.0
M (N=9)	88.9	100.0	88.9	66.7	55.6	88.9	44.4	22.2	88.9	66.7
R (N=8)	50.0	87.5	62.5	37.5	37.5	50.0	37.5	37.5	75.0	62.5
D (N=7)	57.1	71.4	57.1	42.9	57.1	57.2	28.6	28.6	71.4	71.4
P (N=4)	0.0	50.0	25.0	0.0	0.0	0.0	0.0	0.0	75.0	0.0
H (N=2)	50.0	100.0	100.0	100.0	50.0	50.0	50.0	50.0	100.0	100.0
B (N=1)	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
V (N=1)	0.0	100.0	0.0	100.0	0.0	100.0	0.0	0.0	100.0	0.0
Average %	56.1	79.1	72.3	43.9	37.2	59.5	45.9	28.4	83.1	73.0

* A : Alimentary tract and metabolism, B : Blood and blood forming organs, C : Cardiovascular system, D : Dermatologicals, G : Genito-urinary system and sex hormones, H : Systemic hormonal preparations, excl. sex hormones, J : General anti-infectives for systemic use, L : Antineoplastic and immunomodulating agents, M : Musculo-skeletal system, N : Nervous system, P : Antiparasitic products, insecticides and repellents, R : Respiratory system, S : Sensory organs, V : Various.

TABLE III

Inter-provincial Agreement (Kappa Coefficients) in the Formulary Listing of New Drugs Launched in Canada Between 1 January 1991 and 31 December 1998, as per 15 January 1999

Provincial Formulary	Alberta	British Columbia	Manitoba	New Brunswick	Newfoundland	Nova Scotia	Ontario	Prince Edward Island	Quebec	Saskatchewan
Alberta	—	0.45	0.43	0.31	0.37	0.63	0.45	0.32	0.27	0.41
British Columbia	—	—	0.42	0.29	0.20	0.41	0.21	0.15	0.34	0.43
Manitoba	—	—	—	0.28	0.27	0.45	0.39	0.20	0.31	0.44
New Brunswick	—	—	—	—	0.33	0.27	0.30	0.30	0.23	0.30
Newfoundland	—	—	—	—	—	0.34	0.27	0.32	0.12	0.17
Nova Scotia	—	—	—	—	—	—	0.41	0.30	0.31	0.23
Ontario	—	—	—	—	—	—	—	0.41	0.30	0.32
Prince Edward Island	—	—	—	—	—	—	—	—	0.15	0.21
Quebec	—	—	—	—	—	—	—	—	—	0.44
Saskatchewan	—	—	—	—	—	—	—	—	—	—

comparison between AB and NS, the agreement is no better than fair. In at least four situations, the agreement is very poor.

One would expect a good level of agreement among provinces listing a similar proportion of new drugs. Nevertheless, agreement does not appear to be related to the proportion of products listed. For instance, there is only fair agreement between the two provinces listing the highest number of new drugs – QC and BC – or between the two provinces listing the lowest number, namely NF and PEI.

The lack of inter-provincial agreement in the listing of new drugs probably reflects a combination of therapeutic considerations and budget constraints. For the purpose of controlling costs or promoting cost-effective prescribing, provinces may choose not to list a new drug even if its

efficacy has been well established. Some provinces require or encourage manufacturers to provide cost-effectiveness data with their submission prior to inclusion in the formulary. It is not clear how formulary committees use this information and the relative weight given to clinical and pharmacoeconomic data in the decision-making process.

Inter-provincial variation in the listing of new drugs could also be explained by differences in populations covered. For example, Quebec has a universal prescription drug plan covering all ages with very few additional special programs. On the other hand, Alberta provides public coverage for cancer treatment through a provincial Cancer Board. This might explain why, of the 11 new antineoplastic drugs considered in this study, none were listed

in the Alberta formulary while 10 were included in Quebec. In fact, all of these 11 drugs were available in Alberta, through the Alberta Cancer Board. The proportion of new drugs reimbursed in Alberta would therefore be higher had we considered listed, antineoplastic drugs made available through the Cancer Board. Other categories where this may arise include: anti-infectives, immunosuppressants and central nervous system drugs.

Variation in listing of new drug molecules across Canadian provinces might also be explained by differences in the level of cost-sharing required by each provincial plan. Willison et al.¹³ have compared inter-provincial variation in out-of-pocket expenditures for the same prescription drugs for seniors receiving Guaranteed Income Supplement. Across patient groups, they

TABLE IV
News Drugs Launched in Canada Between 1 January 1991 and 31 December 1998 by Therapeutic Class
According to Whether They Were Listed in All Provincial Formularies or in None as per 15 January 1999

Drugs Listed in All Provinces (N=18)			Drugs Listed in None of the Provinces (N=10)		
Year of Notice of Compliance	Name	Therapeutic Class*	Year of Notice of Compliance	Name	Therapeutic Class*
1991	Ofloxacin	J	1996	Rimexolone	S
1992	Sertraline HCL	N	1997	Olapatadine HCL	S
1993	Fluvastatin	C	1997	Cyproterone acetate / ethinyl estradiol	G
1993	Paroxetine HCL	N	1997	Adapalene	D
1993	Ramipril	C	1998	Capecitabine	L
1993	Risperidone	N	1998	Brinzolamide	S
1995	Fluticasone propionate	R	1998	Emedastine difumarate	S
1992	Etidronate disodium	M	1998	Grepafloxacin HCL	J
1991	Econazole nitrate	D	1998	Tolderodine L-tartrate	N
1992	Calcipotriol	D	1998	Montelukast sodium	R
1993	Amiodarone HCL	C			
1992	Betaxolol	S			
1993	Benazepril HCL	C			
1993	Cilazapril	C			
1993	Desogestrel / ethinyl estradiol	G			
1995	Etidronate / calcium carbonate	M			
1996	Dorzolamide HCL	S			
1996	Olanzapine	N			

* C : Cardiovascular system, D : Dermatologicals, G : Genito-urinary system and sex hormones, J : General anti-infectives for systemic use, L : Antineoplastic and immunomodulating agents, M : Musculo-skeletal system, N : Nervous system, R : Respiratory system, S : Sensory organs.

observed as much as a 10-fold variation between Ontario and Saskatchewan, Ontario being the province asking the least from its seniors (around \$40) and Saskatchewan the most (around \$450).

We did not observe a geographical trend in the listing of new drugs. For example, the two central provinces differed widely from each other. Quebec was the province with the largest range of new drugs listed. Of the 148 new drugs approved for sale between 1991 and 1998, 83% were listed in Quebec. Quebec is also the province that listed the highest proportion of drugs without restriction. On the other hand, only 46% of the new drugs launched between 1991 and 1998 were listed in the Ontario drug formulary and more than half of these were listed with restriction.

Variation between Quebec and Ontario could be explained by differences in overall provincial government policy. The high proportion of new drugs reimbursed in Quebec may reflect an industrial policy to encourage innovation through support of the local research-based pharmaceutical industry. Conversely, the focus of policy in Ontario since the early 1990s appears to have been cost control.¹⁴

Our study has several limitations. First, we included in the analysis drugs that were issued a NOC in 1998. For some of these drugs, the period of time between the date

of NOC and 15 January 1999 was relatively short. Therefore, this period of time may not have been sufficient on one hand for the manufacturers to present a submission to drug plans and, on the other hand, for provincial drug plans to assess the submission and take a decision. It is indeed not a surprise that, of the 10 new drugs that were listed in none of the provinces, 6 were launched in 1998 (Table IV). The proportion of new drugs listed may therefore have been higher had drugs that were issued their NOC in 1998 been excluded. However, the starting point was the same for all provinces and thus our assessment of the variation across provinces remains valid.

Second, and very important, we have focused this study on drugs that were listed in the provincial drug formularies. In most provinces, this does not include all of the drugs that are paid for by the public sector. Indeed, a comprehensive assessment of the inter-provincial variation in access to new drugs should include those drugs made economically accessible through special programs. Therefore, our results should be interpreted as indicative of this variation in accessibility rather than definitive.

Recent reports have described the variation across provincial prescription drug plans in terms of eligibility for coverage¹³ and cost-sharing modalities.^{7,13} Canadians

may have assumed that residents of all provinces who were enrolled in public drug plans have a similar access to prescription drugs. Our study shows that this is not the case. Some provinces give access to a high proportion of new drugs through their formularies, others do not. But, even more surprising, there is a wide variation in new drugs available across provinces that exhibit the same level of listing. This variation reflects inter-provincial differences in the way drugs are selected for coverage.

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The Politics of Women's Health: Exploring Agency and Autonomy

The Feminist Health Care Ethics Research Network: Susan Sherwin, Coordinator, Françoise Baylis, Marilynne Bell, Maria De Koninck, Jocelyn Downie, Abby Lippman, Margaret Lock, Wendy Mitchinson, Kathryn Pauly Morgan, Janet Mosher, Barbara Parish. Philadelphia, PA: Temple University Press, 1998; 321pp., \$39.90

This book resulted from a four-year collaboration among Canadian researchers committed to a feminist analysis of health care ethics. Consequently, it has both great depth and breadth, with issues taken up in several chapters from various perspectives. The “f” word (as it was described at a recent consultation of health researchers) is front and centre, and one of the achievements of this book is making the epistemological and theoretical positions clear to a potentially wide audience. Each chapter stands alone; however, the whole book is a rich source of critical analysis of the organization of Canadian health care and the values that inform practice, both historically and currently. In the introduction, Sherwin notes that “feminist health care ethics does not only change the way we handle traditional bioethical problems; it also changes the agenda of the discipline by making visible a whole range of new ethical problems.” (p. 10) Those who want to hone their skills for understanding what needs to be done to obtain justice and equity in Canadian health care will be pleased with its content. This should include anyone working in public health, particularly health promotion practitioners.

The introduction describes the work of the research network and introduces the two major themes of the book: autonomy and agency as related and important concepts; and the dominance of an individualistic model that ignores social conditions in both therapeutic and health-promoting interventions. Another theme that runs throughout the book is a caution against essentializing or assuming that any group or population – women, men, nurses, doctors, or feminists, for example – is homogenous. Each subsequent chapter is outlined in chapter 1 so that linkages are immediately apparent. Chapter 2 discusses problems with notions of autonomy, agency and informed consent and offers a relational model for ethical analysis in health. Subsequent chapters address meanings of health; the tendency to seek genetic explanations for a variety of phenomena; women in relationship with physicians; the requirement that women participate in decision-making around technology transfer; assumptions about female aging; medicine's response to wife abuse; and research ethics.

This book is a valuable resource for learning and teaching about gender analysis, and more broadly about the use of critical thinking and critical analysis in general. It is well referenced and has an extensive index. While it deals with issues globally, the Canadian roots and understanding of our health system are extremely refreshing and valuable. The current classification is Health Care/Women's Studies/Bioethics, and to these I would add Health Promotion/Masculinities. The book offers no simple solutions, but it makes substantial progress in proposing a framework for seeking solutions to some of the health problems facing both women and men today.

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