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SUMMARY REPORT

GLOBALIZATION AND HEALTH

PUTTING HEALTH FIRST

Canadian Health Care Reform, Trade Treaties and Foreign Policy

by

Canadian Centre for Policy Alternatives

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Principal Investigator, Author

Bruce Campbell
Executive Director, Canadian Centre for Policy Alternatives, Ottawa

Authors:

Chantal Blouin
Researcher, North-South Institute, Ottawa

John Foster
Principal researcher – civil society, North-South Institute, Ottawa

Ron Labonte
Director, Saskatchewan Population Health Evaluation and Research Unit, Regina

Joel Lexchin
MD and Associate professor, School of Health Policy and Management, York University

Matthew Sanger
Research associate, Canadian Centre for Policy Alternatives, Ottawa

Steven Shrybman
Partner, Sack, Goldblatt and Mitchell, Ottawa

Scott Sinclair
Senior research fellow, Canadian Centre for Policy Alternatives, Ottawa

Advisors

- Paul Leduc Browne, Senior research fellow, Canadian Centre for Policy Alternatives, Ottawa
- Marcy Cohen, Senior Research and Policy Co-ordinator, Hospital Employees Union, Vancouver
- Bob Evans, Professor, Department of Economics and Centre for Health Services Research and Policy (University of British Columbia)
- Colleen Fuller, Research associate, Canadian Centre for Policy Alternatives, Ottawa
- Gordon Guyatt, Professor, Departments of Clinical Epidemiology and Biostatistics, and Medicine, McMaster University, Hamilton
- Andrew Jackson, Research Director, Canadian Council on Social Development, Ottawa
- Stan Marshall, Senior Research Officer, Canadian Union of Public Employees, Ottawa
- Aleck Ostry, Assistant Professor, Department of Health Care and Epidemiology and Centre for Health Services Research and Policy (University of British Columbia)
- Jerry Spiegel, Assistant Professor, Institute of Health Promotion Research and Liu Centre for the Study of Global Issues, Vancouver
- David Zakus, Director, Centre for International Health, Faculty of Medicine, University of Toronto
- Christina Zarowsky, Senior Scientific Advisor, Health Program and Partnership Branch, International Development Research Centre, Ottawa

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Summary

The Issue: Trade treaties' coverage of health care

Is Canada's health care system beyond the reach of the North American Free Trade Agreement (NAFTA) and the World Trade Organization (WTO)? Or do these treaties make effective health care reform impossible? This report concludes that the short answer to these questions is: Neither.

Contrary to repeated assurances, international trade treaties such as the NAFTA and the General Agreement on Trade in Services (GATS) do indeed cover important aspects of Canada's public health care system. These treaties extend far beyond traditional trade matters, and the safeguards they contain for health are of uncertain, or limited, value. Indeed, if Medicare did not already exist today, Canada's current trade obligations would almost certainly make its creation far more difficult, if not impossible.

The principles underlying these international trade treaties are at odds with the principles upon which Canada's health care system is based. The treaties promote the freer flow of goods, services, and investments—thereby facilitating international business by constraining and re-directing the regulatory ability of governments. These commercial priorities conflict with the fundamental public purpose of Canadian Medicare: the provision of health care to all, on the basis of need rather than the ability to pay. If unattended to, this clash of principles could result in ratchet-like constraints on Canada's current health care system and could undermine its future reform.

Rejuvenating Canada's heath care system requires a level of principled commitment similar to that exhibited when Medicare was created. In reforming the nation's health care system governments cannot safely ignore trade constraints. Changes to Canada's trade policy and treaty obligations will be needed to secure Medicare for the future, but governments should not be deterred by the uncertainties and threats that trade treaties pose. Fortunately, Canadian governments still have within their power the ability to implement democratically decided health care reform and strengthen the health policy flexibility that will be needed in the future. In fact, the prospects for meaningful, successful and durable health care reform—in spite of existing trade treaties and ongoing negotiations—are favourable. There may be no better time than now to grasp the opportunity to put the health of Canadians first.

The Constraints: Key trade provisions affecting health care policy

Both the NAFTA and the GATS are very broad, covering important aspects of Canada's health care system. The NAFTA is a "top-down" agreement, covering all measures and sectors that governments have not explicitly excluded. The GATS covers all types of actions taken by governments that "affect" trade in health services, and all the ways in which these services are supplied, including electronically. Certain GATS provisions are "top-down", applying generally, while the most forceful are "bottom-up", applying only

to those sectors, such as health insurance, that the Canadian government has specifically agreed to cover.

Both treaties contain provisions to exempt health services, but in neither case can these be relied upon to fully protect the Canadian health care system from the treaties' force. Indeed, there is no protection against certain important NAFTA provisions. Moreover, where safeguards do apply to a health service, increasing the commercial or competitive element in the financing or delivery of that service narrows the scope of those safeguards and, consequently, increases the exposure of the health service to trade law restrictions.

In these treaties, the following provisions warrant particular attention:

- Expropriation and compensation: This NAFTA investment protection provision, which can be invoked directly by investors through investor-state dispute settlement, has been interpreted expansively and could be used by investors to demand compensation for measures that expand Medicare coverage or restrict private for-profit provision of health care services. None of Canada's safeguards for health care protect against such expropriation claims.
- Non-discrimination provisions: *National treatment* requires that governments give foreigners the best treatment given to like Canadian goods, investments or services. *Most-favoured-nation (MFN) treatment* requires that governments extend the best treatment given to *any* foreign goods, investments or services to *all* like foreign goods, investments or services. Where they apply, these provisions could be used to challenge policies that overtly favour local, community-based health providers, or formally non-discriminatory policies that favour not-for-profit providers, if these adversely affect the competitive opportunities of foreign investors or service providers.
- Minimum standard of treatment: Seemingly innocuous, this NAFTA provision requiring investors to receive "fair and equitable treatment and full protection and security" has been interpreted in unexpected ways. In effect, it provides foreign investors an exclusive right of administrative review that is directly enforceable through an international commercial arbitration process. Health-related administrative measures are not protected from this provision and thus are exposed to possible challenge.
- Restrictions on domestic regulation: Negotiations are currently underway on the GATS to develop "any necessary disciplines" to ensure that licensing, certification, technical standards and certain other domestic regulation of services and service providers is "not more burdensome than necessary." If such "disciplines" were agreed to, they could provide WTO panels the ability to second-guess domestic regulators about the optimal or most efficient way of regulating health services.

There are other provisions that have the potential to affect the health care system. These include:

- Performance requirements: These provisions could prevent governments from placing or enforcing certain obligations on investors to purchase locally, use local services, or transfer technology in order to achieve local economic development, environmental or social policy benefits.
- Quantitative restrictions: Though Canada has not made GATS commitments in market access for health, if it ever did so, many cost-saving health care policies could be threatened, including, for example, limits on: the number of doctors; certain types of expensive diagnostic equipment; or the value of services that are reimbursed under public health plans.
- Provisions affecting monopolies and state enterprises: The GATS and NAFTA restrictions on monopolies and exclusive service suppliers raise concerns about whether an expansion of compulsory public health insurance might attract claims for compensation from foreign insurers.
- Procurement rules: Since neither the NAFTA procurement chapter nor the WTO agreement on government procurement currently apply to procurement of health and social services, or to local or provincial purchasing, the impact of these rules is now minimal. However, negotiations continue to expand the reach of these procurement agreements.
- Intellectual property rights: Both NAFTA and the WTO provide extensive protection for intellectual property, including drug patents. Both agreements require a minimum term of 20 years of monopoly patent protection, although they permit compulsory licensing under certain conditions. Drug prices are one of the key drivers of rising health care costs in Canada and many observers point to onerous intellectual property protection under international treaties as a key factor restricting the availability of cheaper generic drugs.

The Effects: Implications of trade treaties for health care policies

Increasing commercialization of hospital and clinical services

The trend towards increasing commercialization in health care—through private financing, market-based models for allocating funding, and for-profit delivery of services—raises particularly troubling trade policy issues. Such commercialization threatens to set in motion a self-reinforcing dynamic—a vicious circle—that could undermine the foundations of Canada's Medicare system. Commercialization weakens the protective effect of trade treaty safeguards for health at the same time that it facilitates the entry of foreign investors and service providers into newly created markets in health services. The greater the presence of foreign investors and service providers, the greater the possibility of trade disputes if governments take actions that limit or reverse foreign penetration. Thus, once foreign investors and service providers become involved in Canada's health care system—and the more involved they become—the more difficult and costly it will be to limit or reverse the trend towards commercialization in general.

Keeping commercialization of health services to a minimum—and taking prompt action to contain or reverse commercialization wherever it already exists—would have the beneficial effect of reducing the overall risk of future trade treaty challenges.

Health insurance

Private health insurers have substantial commercial interests that could be affected by health reforms, and international investors could be expected to seek trade remedies if this business were diminished. Canada has entered health insurance in its schedule of National Treatment and Market Access commitments in the GATS. While the federal government's grounds for asserting that *existing* public health insurance is excluded are uncertain, NAFTA and GATS rules indisputably apply to *new* government measures affecting foreign private health insurers. Consequently, extending Medicare to prescription drugs or home care services could trigger trade challenges from foreign private insurers (or their home governments) whose commercial opportunities are adversely affected. Such a claim would not preclude Canada from extending Medicare, but could make it more expensive to do so. The most likely grounds for such trade challenges appear to be the NAFTA provisions on expropriation and compensation and GATS monopolies rules.

Home care

There is currently wide variation in existing home care programs, with private providers having a considerable stake in public spending. There are a number of proposals for *increasing public funding* of home care services. These include developing:

- a cost-sharing program, effectively extending Medicare;
- a social insurance fund, financed from mandatory contributions from income;
- tax incentives, including increasing existing tax deductions and credits, or creating individual tax-sheltered savings plans.

Since certain of these options could adversely affect the operation of foreign-owned private insurers, policy makers need to anticipate the possibility, however unlikely, of trade treaty challenges. They should also be alert to the fact that trade treaty provisions could make some reforms more difficult to reverse.

There are also a number of options for *regulating the delivery* of home care services, through: direct public provision; competitive tendering; partnership with non-profit providers; and self-managed care. In each case, practical considerations suggest that trade provisions are unlikely to significantly constrain reforms to the regulation of home care service delivery, but could make some changes more difficult to reverse.

Pharmacare

There are a number of ways to extend publicly financed insurance for drugs. The extension of public insurance coverage involves the risk of compensation challenges brought by affected foreign private insurers. Other possible financing options—mixed

public/private insurance coverage and fully private insurance coverage—while unlikely to provoke similar compensation claims, could prove difficult to reverse.

One of the key challenges for a Pharmacare programme is providing the means for controlling drug costs. Of these, *compulsory licensing* is still feasible under international trade rules, contrary to recent federal government statements. *Tendering for generic drugs* entails uncertain risks, largely because it is not clear whether this would be deemed to constitute procurement. *Controlling prices through reference based pricing and cross-therapeutic listing* is unlikely to pose a significant risk of trade challenge or foreign investor claim. In short, the WTO and NAFTA intellectual property provisions allow more scope for compulsory licensing than is generally recognized, and Canadian governments have considerable ability to control drug costs without running afoul of trade rules.

The Approach: Avoiding the chill, turning down the heat

Finding principled, durable approaches to health care reform

As part of a principled approach to health care reform, Canadian governments should acknowledge, rather than deny, that there is a risk of trade challenges. It is recommended that they should then proceed with much-needed health reform, asserting and defending their right to do so. More specifically, the Government of Canada should make explicit, and vigorously support, the public interest objectives of health care reforms. In order to limit potential liabilities for trade challenges and compensation, the government should also:

- strongly assert its view that exercising its right to regulate in health policy does not constitute an expropriation requiring compensation under Canadian or international law;
- make known that it intends to vigorously defend its right to regulate in health policy; and
- signal its future policy directions as early as possible.

The government should also fashion its reforms so as to derive maximum benefit from those limited safeguards that exist in NAFTA and the GATS. It can do so by introducing measures that minimize the role of private financing and for-profit service delivery, and that thus correspond to a narrow conception of public services. In general, health reforms are least likely to be restricted by trade rules if they:

- extend universal access to services on the basis of need, rather than ability to pay;
- establish clear public purpose objectives and regulations;
- finance services out of public revenue;
- favour direct subsidies or grants over contracted services; and
- where services are contracted, adopt standard government procurement procedures.

Above all, Canadian governments should not succumb to a "regulatory chill" in health policy induced by trade policy restrictions and uncertainty. To do so would mean

unacceptably acceding to the ratchet-like imposition of trade rules that will, by degrees, constrain and distort current and future health care policy. In effect, it would involve abandoning many promising policy options that could prove effective in meeting the critical health needs of Canadian citizens, in favour of options that privilege much narrower, commercial interests.

But avoiding the "chill" is only part of a broad Canadian approach that is needed for enduring health policy reform.

Changing Canada's trade policy

Canadian governments should also act to reduce the excessive "heat" that Canada's current approach to trade treaties inflicts on the nation's health care system. To ease existing conflicts between its health and trade policies, and to prevent the future distortion of key health care priorities, the federal government needs to change its trade policy—it needs to turn down the heat.

The first principle of Canadian trade policy with regard to health objectives in these negotiations should be to *do no harm*. Canada is actively engaged in negotiations to create a Free Trade Area of the Americas (FTAA), some regional free trade agreements, and in the WTO Doha Round, which includes many health-related matters including services, investment, and intellectual property. Canada should adopt a precautionary approach in these negotiations to prevent further exposure of our health care system to increased pressure and possible challenge. In short, it should negotiate trade rules that are less intrusive to public health care systems. As part of this approach, wherever conflicts between health and trade policy emerge, Canada should not rely exclusively on country-specific exceptions for health, which have significant shortcomings and should only be regarded as stopgap measures. Instead, Canada should pursue generally agreed exceptions or safeguards—permanent features of treaties that are far more likely to endure over time. Canadians deserve permanent protections for health care that are embedded in the very foundation of its international trade and investment agreements.

One effective reform to Canadian trade policy-making would be to open up the negotiating process to full public scrutiny and participation from health professionals, advocates and the general public. Trade negotiators, whose primary mandate is to expand export markets, cannot reasonably be expected to be fully cognizant of the intricacies of the Canadian health care system nor should they be entrusted with the task of safeguarding health policy. The federal government should propose adoption of the United Nations treaty-making process in which negotiating sessions are open and all documents are public.

Canada should make other changes to its trade policy and negotiating processes. Among other things, Canada should:

- urgently pursue a binding interpretation of NAFTA's investment chapter to ensure that the meaning of "expropriation" is narrowed to be consistent with Canadian

law. It should also pursue a narrow meaning of the term in the proposed FTAA and any other future agreement.
- withdraw its support for investor-state dispute settlement procedures that allow investors to directly challenge public policy measures.
- withdraw its 1994 GATS commitment covering health insurance.
- refrain from making any further GATS commitments directly covering health services.
- conduct a health impact assessment of the GATS request-offer process.
- Apply a "horizontal," across-the-board limitation to protect its flexibility over health policy in all its future GATS negotiating offers.
- make public all GATS requests Canada makes of other countries, requests other countries make of Canada, and the offers Canada makes for further GATS commitments.

Strengthening coherence in health, trade and foreign policy

Attaining coherence in Canada's domestic health policy, its approach to trade treaties, and its foreign policy would help preserve the integrity of the Canadian health care system. It would also help strengthen international health accords, thereby offsetting the preponderant influence of trade treaties and dispelling the shadow they cast over public health initiatives in Canada and around the world.

This coherence should be founded on a commitment to *health as a human right*, which is internationally recognized in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural rights. The same universalistic values that are recognized in these treaties, and which are embedded in Canada's health care system, should serve as the basis for the nation's trade and foreign policy.

There are a number of practical steps Canada can take to promote the realization of health as a human right internationally. For example, Canada should:
- recognize the primacy of international human rights law over other areas of international law, including trade and investment treaties;
- ensure that Canadian foreign policy initiatives, including our participation in international trade negotiations, do not constrain health policies of other nations or impede their ability to respond to changing health needs;
- strengthen Canadian support for the major international human rights bodies.

In addition, Canada should:
- support provisions in the proposed Framework Convention on Tobacco Control to ensure that tobacco control measures supersede trade rules wherever there is a conflict. Canada should also end public support for the export of tobacco products and end the participation of tobacco companies in Team Canada trade missions abroad.
- follow the example of the UK National Health Service and commit that it will not actively recruit health professionals from developing countries.

- propose an international accord to affirm the right of governments to maintain distinctive national health policies, modeled on the approach developed for a New International Accord on Cultural Diversity.
- promote the formation of a group of "like minded" nations committed to maintaining national health care systems that are founded on universalistic principles and strong public interest regulation.

The Challenge: Putting health first

This report is based on the conviction that the actions of Canadians, in particular our collective actions through our elected governments, should—*and can*—influence events so as to improve the health and well-being of Canadians and of citizens around the world. In an era of increasing global economic integration, what is important, as Canadian economist Gerald Helleiner has stated, are the "terms on which countries and their governments … interact with the new global economy."

In our view, Canada's domestic and international actions should be based on the universalistic principle that health is a human right. Putting this principle in practice should be one of the "terms" of Canada's global interactions. This is indeed a significant challenge, one that requires clarity of vision and a consistency of approach—coherence—in the nation's domestic and international activities.

This report has focused on a lack of coherence in Canada's approach to health care on the one hand, and trade and foreign policy on the other, that commands an urgent remedy. If the underlying conflicts between Canadians' health care priorities and the commercial interests promoted in the most recent trade treaties are not addressed, the nation's health care system will come under increasing strain and the options for reform will be seriously diminished. Fortunately, as this report emphasizes, there are many practical ways in which greater coherence between health and trade policy can be achieved.

There is a marked need for coherence in a different, equally important sense. Medicare's creation required governments to take decisive, principled action—often despite intense opposition and powerful commercial interests—to serve the broader public interest. Today, Canadian health care reform demands the same decisive, principled action to meet Canadians' key priorities—despite the powerful commercializing bent of trade treaties—by putting health first.

1. Introduction

Is Canada's health care system beyond the reach of the North American Free Trade Agreement (NAFTA) and the World Trade Organization (WTO) agreements? Or do these treaties make effective health care reform impossible?

The short answer to these questions is: Neither.

Contrary to repeated assurances, trade treaties do indeed cover important aspects of Canada's health care system, and could, if unattended to, undermine its reform. But, on the other hand, Canada still enjoys considerable policy flexibility. By adopting a judicious, principled approach to health and trade policy, Canadian governments can both implement democratically decided health care reform and strengthen the health policy flexibility that will be needed in the future.

This report provides guidance on implementing health care reform despite current, and looming, trade treaty constraints. Above all, this report underscores the importance of governments not succumbing to the "chill" of trade treaty constraints but proceeding to devise and implement reform with a determination to put our health policy priorities first.

Many Canadians have been led to believe that the nation's health care system is beyond the reach of NAFTA and the WTO. It is increasingly evident that this view is not tenable. As this report will explain, important aspects of our health care system are already covered by a new generation of broad international treaties that extend far beyond traditional trade matters. These treaties do not fully shield our health care system from their force, and the safeguards that do exist are of uncertain, or limited, value.

Trade treaties and our health care system do not merely intersect, however; they rest on principles that are, at root, incompatible. International trade treaties are designed primarily to facilitate international business by constraining and re-directing the regulatory ability of governments—promoting the uninterrupted flow of goods, services, and investments. Within this context—even though some core health services are often excluded from certain treaty rules—health care is seen as just another service sector that is, or eventually will be, available for commercial exploitation.

These commercial principles are at odds with the fundamental public purpose of Medicare: the provision of health care to all, on the basis of need rather than the ability to pay. Durable health care reform requires acknowledging this underlying clash of principles and firmly establishing that Canadians' democratically expressed values regarding health care take precedence over commercial and trading interests.

To create Medicare, governments had to act decisively in the public interest despite powerful opposition. Our governments, first in Saskatchewan and then nationally, built the foundations of Medicare after almost two decades of public debate among divergent interests. They determined that the collective benefit of a public health insurance system—pooling the risk of all Canadians and guaranteeing access to hospital and

medical services on the basis of need—outweighs the commercial losses to private health insurers who were displaced by the introduction of Medicare. In the 36 years that followed, federal legislation extended public insurance to cover physicians' services as well as hospital care, our health care system has expanded enormously, and an intricate relationship between public and private sectors has evolved. This system, which was implemented despite sometimes bitter opposition by private insurers and powerful elements of the medical profession, has become not only Canada's most valued social program, but also a crucial feature of Canadian identity.

If Medicare did not already exist today, the full force of Canada's current international trade and investment obligations would now almost certainly make creating it far more difficult, if not impossible. The prospect of compensating well-entrenched foreign commercial interests for lost investment opportunities would probably be enough to tip the balance in favour of Medicare's foes.

Today, rejuvenating Canada's health care system, and allowing for its future enhancement, demand the same strength of principled commitment that prevailed in building Medicare. Frankly acknowledging the risks posed by international trade treaties is the first step to ensuring that they do not hinder health care reform and to averting adverse impacts on Canada's health care system.

There are many reasons to be optimistic. While it may be fashionable in some circles to paint a bleak picture of the future of Canada's public health care system, the Medicare system, while under strain, remains strong. The evolution of a closely regulated, mixed system over the past 36 years has contained the presence of foreign commercial interests that might take advantage of trade treaty rights to challenge government actions affecting their commercial interests. Successive Canadian governments have also secured safeguards in international trade and investment agreements that, despite their shortcomings, mean that free trade rules do not apply fully to the health care sector. Finally, Medicare remains Canada's most cherished social program and commands powerful public support that any Canadian government ignores only at its political peril.

Nevertheless, Medicare cannot be taken for granted. It is a dynamic system that must change with the times and the needs and desires of Canadians. Although organized and regulated for an overriding public purpose, it includes substantial elements of private not-for-profit and private for-profit delivery and financing. Some of these commercial interests in our large and complex health care system are foreign and, if unchecked, their growth could be rapid. Once established in our health care system, their presence becomes, under treaty provisions, very difficult to scale back or reverse. Medicare's consistency with Canada's still rapidly expanding international trade and investment treaty commitments cannot simply be assumed.

It is clear that Canadian governments that are committed to pursuing new public policy initiatives must now consider how to fashion reforms to reduce the risk of trade challenge. They also need to consider how to modify Canada's trade commitments both

to reduce existing trade treaty constraints, and avoid new constraints, on health policy. It is on these critical challenges that this report focuses.

Perspective and approach of the report

An underlying premise of this report is that health care services are best provided and allocated on the basis of societal values rather than market mechanisms. There is a large literature in health economics that demonstrates why the supply and demand of health care services does not operate well on market principles (Drache and Sullivan 1999a; 1999b; Evans 1999). Equally important, Canada's system of Medicare is rooted in an ethical commitment to providing health care to all on the basis of need.

In support of this commitment, successive provincial and federal governments have established and maintained mechanisms for providing health care on a non-market basis. Most notably, our publicly funded health care services generally conform to the five conditions set out in the *Canada Health Act – public administration* of health insurance; *comprehensive coverage* of all medically necessary health services; *universal coverage* of all Canadians on uniform terms and conditions; *portabality* of coverage between provinces and territories; and *accessibility* to services on uniform terms and conditions, without impeding access through any form of private charges (Sullivan and Baranek 2002).

The publicly enshrined, universalistic values that are the foundation of our Medicare system are also reflected in international human rights law. The right to health is recognized in the Universal Declaration of Human Rights (article 25), the International Covenant on Economic Social and Cultural Rights (article 12), and several other international covenants to which Canada is a party.[1] The internationally recognized right to health, like our Medicare system, sits uneasily with the market principles that are the foundation of international trade law. Although some experts maintain that international human rights law has formal precedence (e.g. Howse and Matua 2000), trade law is in practice more effectively enforced because violations are subject to commercial sanction (Dommen 2002).

In our view, there is a glaring imbalance in international law. While the commercial interests of investors and traders are effectively enforced through trade sanctions, the enforcement of the multilateral legal regimes that express fundamental human values such as the right to health relies largely on moral suasion. This is true not only for international human rights law, but also for the body of international law developed over the past 150 years to address transborder threats to public health (Fidler 2001).

As well as impeding international health collaboration, this imbalance also distorts our domestic priorities. The value of Canada's cross-border trade and investment in health

[1] The obligations of national governments to realize the right to health are spelled out in some detail by the responsible United Nations body, which regularly reviews the performance of Canada and other parties to these covenants (UNCESCR 2000).

services is dwarfed by services that are financed publicly and provided on a non-commercial basis within the publicly regulated health care system.[2] Yet these commercial interests exercise a disproportionate influence over Canadian trade policy.[3] Health-related trade and foreign policy should be developed through processes that better reflect the interests of the Canadian citizens and public and not-for-profit providers that use, pay for and provide the overwhelming share of our health care services.

As the forces of globalization increase health interdependence, it becomes increasingly important to redress the imbalance in international law and strengthen international mechanisms for realizing the right to health and protecting public health. As commerce grows, migration flows increase; international travel is easier and more frequent; health-damaging substances such as tobacco are more widely distributed and marketed; infectious diseases proliferate internationally and global environmental health challenges become more pressing. International threats to health, such as the growing AIDS-HIV pandemic, have a profound impact on global security. In sum, the health of Canadians is increasingly intertwined with the health of other peoples. As our earlier research report for the Commission argues, it is in the enlightened self-interest of Canadians to strengthen the capacity of the global community to protect and promote public health (Blouin, Foster and Labonte 2002).

These observations highlight the need for greater coherence of Canadian trade and foreign policies with our domestic health policy. While the focus of this report is on the implications of Canada's trade treaty commitments for health care reform, improving policy coherence should not be seen only as a matter of shielding domestic Canadian health policy from internationally-imposed constraints. It also requires strengthening the international institutions and legal frameworks that complement and enhance our domestic capacity to regulate health services in the public interest.

Underlying the analysis of this report is the conviction that the actions of Canadians, in particular our collective action through governments, can influence the direction of globalization to improve our own health and well-being and to improve the health and well being of others.

In the following sections, this report:

- Reviews the key provisions of Canada's international trade and investment agreements and the degree of protection that safeguards in these agreements afford to our health care system;

[2] Indeed, cross-border exports of Canadian health *services*, which were valued at $188 million in 1997, amounted to a mere 0.4% of output in the health sector. The value of cross-border *investment* by Canadian firms, while more—about $1.4 billion in the US—still represents less than 2% of the domestic health sector (Chen 2002).

[3] This is most evident in the composition of the Sectoral Advisory Group on International Trade (SAGIT) that is responsible for advising Canada's Minister of International Trade on health and trade issues. The membership of the Medical and Health Care Products and Services SAGIT consists almost entirely of senior business executives from health care and drug companies.

- Explores the risks of trade challenges, and the likely efficacy of exemptions and exclusions intended to safeguard Canada's health care system, in the event of such challenges;
- Suggests ways to shape domestic reforms to achieve health policy objectives while reducing the risk of successful trade challenges; and
- Proposes changes to Canada's international trade agreements and its negotiating objectives to protect more effectively the full range of health care programs and policies.

Finally, this report

- Suggests ways to achieve greater policy coherence by ensuring that Canada's foreign economic policies reflect the values of our health care system and complement our international health policy initiatives.

Part I: Key Trade Provisions Affecting Health Care Policy

2. Summary of key provisions

From a health care policy perspective, Canada's most significant trade and investment agreements are the NAFTA -- particularly its investment, services, monopolies, and intellectual property chapters -- and the WTO agreements, particularly the General Agreement on Trade in Services (GATS) and the Agreement on Trade-Related Intellectual Property Rights (TRIPS).[4]

The basic rules of these agreements are similar, but their precise scope and application can vary significantly. Interpretation is not always straightforward; applying the rules to a specific set of policy facts can be difficult. As usual, the devil is in the details. Domestic policy-makers must be aware of all the key obligations and how they overlap, diverge and interact (Sinclair 2000; Sinclair and Grieshaber-Otto 2002).

International trade lawyer Jon Johnson provides a useful guiding principle for sorting out the variable policy implications of the parallel NAFTA and WTO regimes: "The practical result for lawmakers is that laws must conform to the more stringent of the two sets of parallel but somewhat differing norms" (Johnson 1998). This brief summary employs Johnson's principle by focusing on the most stringent provisions affecting Canadian health care policy in the respective agreements.[5]

Scope and coverage

The NAFTA is extraordinarily broad. It is a "top-down" agreement, covering all measures and sectors that governments have not explicitly excluded. Canada negotiated a sectoral reservation (or country-specific exception) that excludes Canadian health care to the extent that it is "a social service for a public purpose" from certain, but not all, provisions of NAFTA's investment and services chapters (NAFTA Annex II-C-9). A separate reservation (in NAFTA Annex I) exempts all non-conforming provincial and local government measures that existed on January 1, 1994. These non-conforming measures can only be amended to make them more NAFTA-consistent. Once removed, or made less non-conforming, they cannot later be restored.

The GATS is also very broad. It covers all types of actions taken by governments that "affect" trade in health services, and all the ways in which these services are supplied, including electronically. Certain GATS provisions -- the most important of which is the

[4] Other treaties, including the World Trade Organization treaties on Technical Barriers to Trade (TBT) and Sanitary and Phytosanitary (SPS) measures, and numerous bilateral investment treaties (BITs), may also be relevant, but are generally beyond the scope of this report.
[5] Our research report (Sanger, Shrybman and Lexchin, 2002) prepared for the Commission includes a more detailed analysis of these provisions and related case law.

Most-Favoured Nation rule -- are top-down and apply generally. But, in contrast to NAFTA, the most forceful provisions of the GATS are "bottom-up," applying only to those sectors that governments specifically agree to cover. Canada has not made specific commitments covering "health services" as classified by the GATS. It has, however, made commitments to cover important health-related areas including, most remarkably, health insurance (Sanger 2001).

The GATS excludes services provided in the "exercise of governmental authority" that are defined as services provided *neither* on a commercial *nor* a competitive basis (GATS Article I:3). Because Canadian health care is a mixed system with significant private financing and delivery of services, this exclusion cannot be relied upon to fully protect the Canadian health care system from GATS rules.

Both NAFTA and the GATS contain general exceptions (NAFTA Article 2101 and GATS Article XIV) that allow governments to argue that otherwise inconsistent measures are necessary to achieve legitimate objectives, including protection of human health. These general exceptions have, however, been interpreted quite restrictively by trade dispute panels. NAFTA's general exception does not apply to the NAFTA investment chapter.

In view of their importance, these safeguards are considered in more detail in section 3 below.

Expropriation and compensation

NAFTA 1110 provides that governments can expropriate foreign-owned investments only for a public purpose *and* if they provide compensation. The NAFTA's investment protection provisions can be invoked directly by investors through investor-state dispute settlement. Neither of Canada's reservations regarding health care protects against expropriation claims under Article 1110. The existing WTO agreements contain no comparable investment protection provisions.

Whether a particular measure is an expropriation, and the amount of compensation due to investors, are matters of interpretation determined by a NAFTA arbitral panel. Investors have successfully argued that non-discriminatory regulations that significantly diminish the value of their investments are tantamount to expropriation.[6] Thus, in sharp contrast to Canadian law, *which does not regard a measure such as a legitimate land rezoning to be expropriation*,[7] NAFTA panels have ruled that non-discriminatory government regulation can be expropriatory. This expansive interpretation of

[6] In the words of the Metalclad panel, "expropriation under NAFTA includes not only open, deliberate and acknowledged takings of property … but also covert or incidental interference with the use of property which has the effect of depriving the owner, in whole or in significant part, of the use or reasonably-to-be-expected economic benefit of property even if not necessarily to the obvious benefit of the host state." *Metalclad*, para. 103.

[7] For a review of the relevant case law and Canadian legal principles regarding land use and expropriation see Lindgren and Clark (1994).

expropriation, which departs sharply from Canadian legal principles regarding expropriation, opens the door to NAFTA claims that measures to expand Medicare coverage or to restrict private for-profit provision of heath care services amount to expropriation and that compensation must be paid to U.S. or Mexican investors that are adversely affected (Sanger, Shrybman and Lexchin 2002).

Non-discrimination provisions

Non-discrimination on the basis of nationality is a core principle of international trade agreements, but it has only recently been extended to investment and services matters. The *most-favoured-nation (MFN) treatment* rule requires that governments extend the best treatment given to *any* foreign goods, investments, or services to *all* like foreign goods, investments, or services. The *national treatment* rule requires that governments give foreigners the best treatment given to like Canadian goods, investments, or services. Even measures that are formally non-discriminatory can violate these rules if they, in fact, adversely affect the equality of competitive opportunities of foreign investors. The application of MFN and national treatment to investment and services, matters once considered exclusive domestic policy prerogatives, raises concerns for the Canadian health care system.

The GATS MFN obligation (GATS Article II) applies fully to Canadian health care services. The NAFTA investment chapter's MFN obligation (Article 1103) applies fully to health-related investment measures, except for those measures in effect as of January 1, 1994, which are shielded by the Annex I reservation. Their combined effect means that the best treatment given to any single foreign investor or service provider in the health care sector must be extended immediately and unconditionally to all other *like* foreign investors and service providers in the health care sector.

Canada shielded those health policy measures existing on January 1, 1994 from the national treatment rules in both NAFTA's investment and services chapter (NAFTA Articles 1102 and 1202). Canada also reserved the right to adopt or maintain health care measures that would otherwise violate national treatment, but only to the extent that they apply to health services that are "social services established or maintained for a public purpose."

The GATS national treatment rule (Article XVII) only applies to services that governments expressly agree to list. Canada has not listed most health services under the GATS, although it has covered health insurance. For scheduled services, the GATS national treatment obligation is more stringent because, unlike NAFTA's national treatment rules, it applies to subsidies.

The Canadian health care system includes many policies that favour, directly or indirectly, locally based service providers. Such policies arguably disadvantage foreign service providers or investors (Sanger, Shrybman and Lexchin 2002). Policies that favour not-for-profit providers, even though formally non-discriminatory, might also be

construed as **de facto** national treatment violations where not-for-profit providers are predominantly Canadian and commercial providers are predominantly foreign.

Performance requirements

Performance requirements are government measures that oblige investors to meet certain conditions: for example, to purchase locally, transfer technology or to achieve other local economic development, environmental or social policy benefits. The NAFTA investment chapter prohibits governments from imposing or enforcing certain types of requirements "in connection with the establishment, acquisition, expansion, management, conduct or operation of an investment" (NAFTA Article 1106). Remarkably, Article 1106 applies not only to US and Mexican investments, but to foreign investments of any nationality and Canadian investors as well (Sanger, Shrybman and Lexchin 2002).[8]

The NAFTA Annex II-C-9 reservation does not exempt performance requirements in the health care sector. Provincial and local government performance requirements that existed on January 1, 1994 are exempted under Annex I. But new measures in the health care sector (i.e. any adopted after January 1, 1994) are exposed to challenge as potential violations of NAFTA Article 1106.

From a health policy standpoint, probably the most significant performance requirement prohibition is against requirements "to purchase, use or accord a preference to goods produced *or services provided* from persons in its territory" (emphasis added). Hence, new measures requiring investors in the health care sector, whether domestic or foreign, to purchase, use or prefer goods or services within Canada would breach NAFTA Article 1106 (Johnson 2002).

Minimum standard of treatment

The NAFTA investment chapter (Article 1105) requires host governments to treat foreign investors "in accordance with international law, including fair and equitable treatment and full protection and security." This seemingly innocuous obligation has been interpreted in rather unexpected ways by NAFTA investor-state tribunals. Tribunals have examined the administrative behaviour of governments towards investors and, in several instances, ruled that government officials have acted arbitrarily, in an untimely manner, or without sufficient transparency (Sanger, Shrybman and Lexchin 2002).

[8] While the GATS does not explicitly prohibit performance requirements, its national treatment principle implicitly prevents governments from applying local content, sourcing and other performance requirements to foreign service providers in covered sectors.

In some instances, damages have been awarded for the breach of Article 1105.[9]

The NAFTA minimum standards of treatment rule has, in effect, created an exclusive right of administrative review for foreign investors that is directly enforceable through an international commercial arbitration process. This rule is not subject to any reservations. All administrative measures, including health-related measures, are therefore exposed to potential challenge.

Quantitative restrictions

GATS Article XVI, Market Access, prohibits governments from restricting on either a regional or national basis: the number of service suppliers or operations; the value of service transactions; the number of persons that may be employed in a sector; and the types of legal entities through which suppliers may supply a service. This article prohibits such measures even if they are non-discriminatory (Sanger, Shrybman and Lexchin 2002).

Article XVI only applies to scheduled sectors. Canada has not committed most health services under the GATS. If it ever did so, a number of common health care policies would be at odds with GATS Article XVI. Regional quotas on, for example, the number of doctors, services per doctor, certain types of expensive diagnostic equipment, or on the total value of services that will be reimbursed under public plans are commonly used, or proposed, as measures to control health care costs (Luff 2002). Furthermore, provincial and local governments sometimes restrict subsidies or contracts for the private delivery of certain health services to legally constituted non-profit providers.

Domestic regulation

Ongoing negotiations under GATS Article VI.4 aim to develop "any necessary disciplines" to ensure that licensing and certification, technical standards and certain other domestic regulation of services and service providers are, among other things, "not more burdensome than necessary to ensure the quality of the service." Pending the outcome of the negotiations under Article VI.4, GATS article VI.5 provisionally applies certain restrictions to measures in scheduled sectors. GATS Article VI is explicitly intended to restrict non-discriminatory regulation.

[9] Furthermore, in the Metalclad case the investor argued successfully that the minimum standards of treatment provisions entitled the investor to a standard of treatment expressed not in NAFTA chapter 11, but in a separate part of the NAFTA. Subsequently, other investors have used this opening to argue that other provisions in NAFTA, and even in the WTO agreements, can be indirectly enforced through NAFTA chapter 11. In July 2001, the NAFTA Commission, comprised of the three trade ministers, adopted an interpretation, based on a traditional customary international law interpretation of minimum international standards. This interpretative note should restrict investors to enforcing only NAFTA chapter 11 through the investor-state process. It remains to be seen how arbitral panels will implement this note.

This article raises concerns that, in the event of a challenge, WTO panels will be positioned to second-guess domestic regulators regarding the optimal or most efficient way to regulate services. David Luff provides several examples of the types of health care measures that could be considered "more burdensome than necessary." These include: obliging health care providers to accept all patients rather than providing them with incentives to do so; restricting fees for service to ensure health care services are affordable rather than increasing social security payments to enable patients to afford the fee that is charged; cancelling licenses of doctors or health facilities for non-compliance with licensing conditions rather than using fines or publicizing lists of wrong-doers; or requiring hospitals or physicians to operate on a non-profit basis rather than controlling how they operate on a for-profit basis.[10]

The health care system is complex and highly regulated. Given the non-commercial values that underlie regulation in this sector, oversight by an international organization committed to expanding commercial opportunities for foreign providers could be particularly problematic (Pollock and Price 2002).

Monopolies and state enterprises

The GATS (Article VIII) and NAFTA (Chapter 15) restrictions on monopolies and exclusive service suppliers are broadly similar. Both agreements prohibit monopolies from abusing their monopoly position when competing in sectors outside their monopoly. Under the GATS, monopolies must be listed as country-specific exceptions in committed sectors or eliminated. Under both agreements, a government wishing to designate a new monopoly in a covered sector may be required to provide compensation. In the case of NAFTA, monetary compensation is due where the creation of a monopoly is found to have expropriated a foreign investment. Under the GATS, a government must negotiate trade concessions to compensate foreign service providers for their lost market access, or face retaliation from the provider's home governments. [11] As already noted, Canada has listed health insurance under the GATS.

As discussed more fully later in this report, these monopoly provisions raise concerns that expanding public health insurance might attract claims for compensation from foreign insurers under either or both of these agreements (Sanger, Shrybman and Lexchin 2002).

[10] David Luff, "Regulation of Health Services and International Trade Law," paper prepared for the OECD-World Bank Services Experts Meeting, OECD, Paris, March 4-5, 2002. paras. 148 ff.

[11] NAFTA's monopoly rules apply only to federal monopolies (NAFTA Article 1505), while the GATS applies to both federal and provincial monopolies. The NAFTA's expropriation and compensation provisions, however, apply to provincial as well as federal measures.

Procurement

The NAFTA and the WTO Agreement on Government Procurement (AGP) are broadly similar. Both agreements set out detailed tendering procedures that must be followed in all government procurements over specified monetary thresholds. Both also prohibit local preferences, local sourcing and offsets (e.g. local content, technology transfer or local economic development requirements) for covered public purchases.

Neither the NAFTA procurement chapter nor AGP currently apply to procurement of health and social services. Moreover, neither NAFTA nor the AGP apply to local or provincial purchasing. Because of these exclusions, the current impact of these procurement rules on the Canadian health care system is minimal.

Intellectual property rights

Both NAFTA chapter 17 and the WTO Agreement on TRIPS provide extensive protection for intellectual property, including patents on pharmaceutical products and processes. Both agreements require a minimum term of 20 years of monopoly patent protection from the date of filing a patent application (TRIPS Article 33 and NAFTA Article 1709(12)). Both agreements permit compulsory licensing regimes, although with certain conditions. A compulsory license allows another manufacturer, upon payment of royalties to the patent holder, to produce generic copies of a patented drug.

Drug prices are one of the key drivers of rising health care costs in Canada (Sanger, Shrybman and Lexchin 2002). Some provincial insurance plans have taken steps to ensure greater use of cheaper generic drugs. But many observers have pointed to the onerous system of intellectual property protection under international agreements as a key factor restricting the availability of cheaper generic drugs.

3. Safeguards for health

The Government of Canada and most independent trade policy analysts agree on a basic point: that there is a fundamental incompatibility between Canadian health care policies and the full application of free trade treaties. By establishing a public sector health insurance monopoly, and by regulating who can provide health care services and on what terms, the *Canada Health Act* and the Medicare system cut against the grain of trade and investment liberalization.

To manage this tension, the Canadian government has negotiated safeguards for health care in its various trade and investment agreements. In all recent and current trade negotiations, Canada's stated objectives include ensuring its ability to maintain existing health measures and to adopt new health measures.

What is at issue is the efficacy of these safeguards. They consist of various exclusions, exceptions and reservations to the application of NAFTA and WTO trade rules, some of which apply generally to all nations while others are specific to Canada. To a considerable degree, the viability of our existing health care system and our capacity to introduce health reforms depend upon the integrity and broad application of these safeguards.

It is clear that these safeguards do not *completely* exclude the Canadian health care system. Key terms are undefined, or defined and qualified in ways that raise questions about the scope of protection they afford for health care measures. Furthermore, there are gaps in the web of protection. By how far the safeguards fall short of the "ironclad" exemptions pledged to Canadians remains a topic of sometimes lively debate (Sanger, Shrybman and Lexchin 2002).

Most of this debate has focused on the crucial NAFTA reservations, although the GATS governmental authority exclusion is also under growing scrutiny. NAFTA Annex II-C-9 allows Canadian governments to adopt or maintain otherwise-inconsistent health care measures but only to the extent that they apply to health services that are "social services established or maintained for a public purpose."As discussed more fully in our second research report, these key terms are undefined and untested, leaving a significant interpretive issue that may be decided only by a dispute settlement panel.

There is a wide range of expert opinion. A succession of critical legal opinions by Schwartz (1996), Gottlieb and Pearson (1999), Appleton and Associates (2000) and Shrybman (2000) raise concerns that this crucial reservation is inadequate and may be interpreted narrowly, exposing health care measures that disadvantage foreign private interests to successful challenge. In the view of Steven Shrybman, "it is hard to be confident about the prospects of persuading a trade panel or arbitral tribunal of the need to give Annex II a broad and liberal reading…" (Shrybman 2000).

International trade lawyer Jon Johnson (2002) maintains that NAFTA Annex II-C-9 is sufficiently broad to cover the public component of the health care system in each province, which he equates with insured health services under the *Canada Health Act*.[12] In Johnson's view, however, the NAFTA safeguard cannot confidently be relied upon to shield home care and other services that are primarily publicly funded but are not 'insured services' under the *Canada Health Act*.

Epps and Flood (2001) take a somewhat more expansive view of the reservation and assert that a publicly funded health service that is privately delivered -- whether by a non-profit or for-profit provider -- should nevertheless meet the "public purpose" criterion of NAFTA Annex II-C-9 (Epps and Flood 2001).

Even among legal experts then, the meaning of Canada's crucial NAFTA reservation for health is "contentious and uncertain" (Sanger, Shrybman and Lexchin 2002). Most

[12] Providers of these services are compensated by the provincial health insurance monopoly at rates set in provincial fee schedules and cannot contract with patients for the price of the service. (Johnson 2002, 4, 20)

worryingly, however, the U.S. and Canadian governments have expressed dramatically conflicting views regarding the scope of the NAFTA reservation.

In 1995 John Weekes, then Canada's NAFTA coordinator, assured Canadian provincial governments that the key term "for a public purpose" was purposely left undefined to allow for the broadest possible interpretation of Annex II-C-9.[13] But in guidelines drafted concurrently for U.S. state governments, the United States Trade Representative (USTR) took a far narrower view, asserting that, under the identically worded U.S. reservation, if social services "similar to those provided by a government … are supplied by a private firm, on a profit or not-for-profit basis, [the NAFTA] Chapter Eleven and Chapter Twelve apply" (USTR 1995).

These conflicting views are serious cause for concern. It is far from clear that, in the breach, the NAFTA reservation would provide the degree of protection for health measures that the Canadian federal government attributes to it. Yet, Canadian officials persist in their view that the scope of the reservation is broad, even self-defining.

Government of Canada officials suggest[14] that because all three NAFTA parties have reservations with identical wording, no NAFTA member has an interest in interpreting its scope narrowly.[15] This view, however, overlooks the very substantial differences between the Canadian and US health care systems and interests. What Canada views as a narrow interpretation could be perfectly acceptable to the US with its far more commercially oriented system. And, given the history of hardball in Canada-US trade disputes, it appears naive to expect that the US would support an interpretation of this annex that would sacrifice the export interests of its own powerful commercial health care industry to Canadian sensibilities about Medicare.

There are strong parallels between the debate on NAFTA Annex II and the growing debate on the exercise of governmental authority exclusion in the GATS.[16] Prominent proponents such as WTO director-General Michael Moore have publicly asserted that the "GATS explicitly excludes services supplied by government" (Moore 2001). But independent analysts have pointed out that the legal text excludes services "supplied in the exercise of governmental authority" only if they are provided neither on a commercial nor a competitive basis and that the interpretation of this provision is unlikely to be broad (British Columbia 2001; Krajewski 2001).

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[13] This view was expressed in correspondence between Weekes and the Ontario Deputy Minister of Health, reproduced in *Inside NAFTA*, November 29, 1995, cited in Epps and Flood, p 25, n6.

[14] Roundtable discussion with external experts, organized by CCPA consortium on globalization and health, Ottawa, April 26, 2002.

[15] NAFTA Article 1132 stipulates that if, in a NAFTA investor-state dispute, a government asserts as a defence that an impugned measure falls within the scope of a reservation, then the tribunal must refer that matter to the NAFTA Commission (the three NAFTA ministers or their designates) for an interpretation. If the Commission, which operates by consensus, agrees then their interpretation binds the investor-state tribunal. If the Commission fails to reach consensus or to submit an interpretation within 60 days, then the tribunal decides the issue.

[16] See Sanger, Shrybman, and Lexchin, 2002, 2.5 for a more detailed discussion of the GATS governmental authority exclusion.

In fact, the USTR NAFTA guidelines referred to previously follow the logic of the GATS exclusion rather closely. This is not that surprising, since the GATS and the NAFTA investment and services chapters were negotiated concurrently by some of the same US and Canadian government negotiators.

One of the main shortcomings of both these key exceptions can be stated as a general principle: the greater the commercial or competitive element in the financing or delivery of a health service, the narrower the scope of the NAFTA and GATS safeguards and, consequently, the greater the exposure to international trade law restrictions.

A further point on which there is no disagreement among legal experts, is that the NAFTA reservations apply only against certain provisions of the NAFTA investment and services chapters. Most critically, the NAFTA reservations provide no protection at all against investor claims that health care measures are tantamount to expropriation under NAFTA Article 1110. In our view, this is one of the most likely -- and among the most dangerous -- arguments that could be mounted by a U.S. investor against Canadian health policy initiatives such as the expansion of public health insurance to cover new services.

Part II: Implications of Trade Treaties for Health Care Policy

Having described some of the most important provisions contained in NAFTA, the GATS and TRIPS, this report now turns to the critical issue of what implications those provisions hold for health care policy in Canada. Four specific areas are considered, as follows:

- the commercialization of hospital and clinical services,
- health insurance,
- home care, and
- pharmacare.

In each case, the context for possible health care reform -- often including commercial interests involved -- is described. Then, the potential application of key trade treaty provisions to the area in question is considered, and an assessment of the degree of risk of various types of trade challenges is provided. Finally, the report offers suggestions for approaches that could reduce the threat or consequences of such challenges without unduly compromising either the principles underlying Canada's current health care system, or the kinds of health care reforms which may be anticipated in the future.

4. Commercialization of hospital and clinical services

Much of the discussion in this report considers the implications of Canada's international trade obligations for reforms to expand the Medicare system, particularly in the areas of home care and pharmacare. It is also important, however, to discuss the potential impact of international trade rules on current initiatives to commercialize and privatize certain health care services and infrastructure.

Current Developments

Several provinces have introduced incremental reforms that commercialize aspects of health care. These include increased private financing of services, market-based models for allocating funding, and more for-profit delivery of services.

Despite recent increases in public health spending, private spending on health care continues to grow. Indeed, between 1996 and 2000, spending on health care by Canadian households increased by over 15%. Most of this private spending paid for health insurance premiums, drugs, and dental services (CIHI 2002).[17] In fact, private spending on health care services and products in Canada is much higher than in many Organization

[17] The public share of total spending on health care increased to about 73% in 2001, after dipping below 70% in the late 1990s (CIHI 2002, 29-31).

for Economic Cooperation and Development (OECD) jurisdictions, and almost twice as high as in Britain (CHA 2001).

Experts estimate that most of the increase in private health spending is due to *passive privatization* – governments withdrawing funding from services that were previously publicly financed (Sullivan and Baranek 2002). Examples of passive privatization include:

- de-insuring services previously covered by provincial health insurance plans, as has occurred in most provinces;
- increased private spending on drugs by patients released early from hospital, where drugs are publicly provided;
- spending on private duty nurses to attend frail patients in hospital, where nursing shortages limit the attention staff can provide; and
- shifting acute care patients out of hospital to the home, where family members often pay for services they cannot provide themselves and are unable to receive from public home care programs.

Another activity that drives up private spending is the sale of so-called "add-ons" or enhanced services that provinces do not include on public insurance plans. Most hospitals have always offered private-pay options such as semi-private rooms, televisions and other similar services. But the growth of private surgical clinics in a number of provinces is enabling physicians to profit by selling enhanced service packages that critics note are designed to decrease the pain and discomfort of surgical procedures. Studies suggest that in Alberta, a pioneer in the private clinic business, companies charge for add-ons that may improve surgical outcomes and support quicker access to surgery (Armstrong 2000).[18]

Like increased private spending on health services, private financing of health care infrastructure has also increased. The Ontario and British Columbia governments are proceeding with public-private partnerships (P3s) to fund new hospital construction. Under a P3 arrangement, private companies will finance and construct the new facilities, leasing them back to the government or regional health authority, which thereafter pays for services over the life of the contract (usually 25-35 years) out of annual operating budgets rather than capital expenditures. These arrangements usually involve contracts to provide non-clinical services in the facility.

Recent reforms have also introduced market-based methods of allocating public funding. Outside of Ontario, regional health authorities are responsible for most distribution of public monies to purchase health services. In many cases, they have

[18] This practice was entrenched after a May 1996 agreement between the federal and Alberta governments based on 12 principles. One, referred to as "Principle 11", states that "The same physician can practice in both the public and private systems if he/she is offering insured services which are fully paid for by the public system and non-insured services which are paid for privately". This allows the same physician to charge public insurers for basic surgical procedures and private payers or patients for "add-ons" (Health Canada and Alberta Health 1996; see also Plain, 2000)

introduced competitive tendering models for purchases of laboratory services, which are provided primarily by for-profit companies. In Ontario, the Community Care Access Centres are required to allocate funding for home care through a competitive tendering process in which for-profit and non-profit providers compete. Critics argue that this model has led to higher costs, overly complex administration, and the fragmentation of service delivery (Armstrong 2001).

Until recently, for-profit hospitals (of which there are very few in the Canadian system) and clinics have been limited to operating entirely outside the Medicare system or to providing uninsured services. Extending public funding to for-profit facilities creates the potential for a rapid commercialization of health care. Alberta is an active proponent of this approach. It is permitting the growth of private surgical facilities in the province and has passed legislation to permit such facilities to provide a wider range of insured medical services. The Calgary-based Health Resources Group recently announced that it intends to file the first application for a license under this legislation. The Ontario government has followed suit with a recent announcement that it will support the establishment of new Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) equipment in for-profit and private not-for-profit clinics. This is expected to attract numerous investors to establish commercial MRI and CT facilities, which have previously been limited to serving only those who can pay the full cost of a scan (Ontario 2002).

Recent studies shed some light on the impact of commercialization on the quality of health services. Comparative studies of American hospitals show that mortality rates were 2% higher in the for-profit hospitals sampled, even though non-profit hospitals treated patients with more acute conditions (Devereaux et al. 2002). A study of publicly-funded, for-profit long term care facilities in Ontario found that they had higher costs and lower levels of nursing time per resident than was the case in other jurisdictions (Ontario Health Coalition 2002).

Trade policy issues and implications

The recent increase in various forms of commercialization in the Canadian health care system, especially in hospital and clinical services in certain provinces, raises particularly troubling regulatory and trade policy issues. This increasing commercialization *reduces the protection afforded to Canadian health care-related measures by the safeguards in trade agreements.* This, is turn, may significantly reduce the policy and regulatory flexibility of governments to respond to future and evolving health care services needs in Canada.

For example, for-profit provision of hospital and clinical services undermines the effectiveness of the NAFTA safeguards that shield *existing* health services. As previously discussed, the NAFTA Annex I general reservation permits subnational governments to maintain existing measures that do not conform to certain NAFTA obligations. Once a service, such as a diagnostic lab service or cataract operation, has

been commercialized, the NAFTA Annex I protection for existing, non-conforming measures related to that service -- including those that currently preclude such for-profit delivery-- is lost forever. The general reservation in Annex I only permits changes that increase the conformity of provincial measures with NAFTA rules. Such increased commercialization thereby reduces the number and types of existing health measures that remain protected from the full force of the treaty.

Commercialization also reduces the scope of protection provided for *future* government measures. It does so by shifting the character of hospital and medical services along the spectrum from "public purpose" to "private purpose", within the meaning of NAFTA Annex II-C-9. As previously discussed in part I of this paper and our research report, the U.S. government has asserted an extremely narrow interpretation of the Annex II safeguard (Sanger, Shrybman and Lexchin 2002). At a minimum, authorizing for-profit hospital and medical service firms to provide insured services increases the likelihood of trade disputes in which the effectiveness of this NAFTA safeguard would be tested. Powerful American health corporations seeking access to the Canadian health care market could exert considerable pressure on the U.S. government to mount trade challenges to any Canadian measures that disadvantage them. If a narrow interpretation were to prevail in such a dispute, the effect would be significant: new measures with respect to hospital and clinical services in which there is private for-profit or not-for-profit delivery would then be fully subject to NAFTA's provisions.

Extending the application of NAFTA provisions, as a result of weakened safeguards, would increase the incentive and the ability of American for-profit health corporations to expand in Canada. The United States has the most commercialized health care system in the developed world and, arguably, an enormous "comparative advantage" in providing for-profit health care. If certain provincial governments continue to turn increasingly to private health care providers, it is highly likely that this will draw in U.S. capital, management expertise and, sooner or later, direct providers. Their increased presence in Canada increases potential liabilities for NAFTA-imposed compensation, should their investments be adversely affected by future health care reforms.

These U.S. investors and service providers would gain rights under certain of Canada's international trade treaty commitments -- rights that are not enjoyed by Canadian investors or service providers. Subsequently, if future governments take steps to reverse commercialization, for example, by shifting services back into the not-for-profit or public sector, then affected U.S. investors could be expected to argue that such measures are a form of expropriation. The increased risk of future compensation claims, with mounting liabilities, would thus make it more difficult to reverse commercialization, even when governments set out to do so in a completely non-discriminatory manner, treating Canadian and American firms alike.

On the other hand, given the negligible demand in Canada for fully private hospital and medical services, controlling access to public revenue streams is the key to continuing to limit the role of commercial providers of these services. Because NAFTA exempts subsidies, grants, and procurement from national treatment (NAFTA Article

1108.7), Canadian governments employing such measures can still favour not-for-profit and/or domestic providers over for-profit or foreign companies. This provides significant policy flexibility, even in the event that a narrow interpretation of NAFTA safeguards prevails.

Significantly, however, the NAFTA national treatment exemption cannot be considered in isolation from other trade treaty obligations. Commercialization of health care also weakens the protection provided by the GATS exclusion for "services supplied in the exercise of governmental authority," which only excludes governmental services supplied neither on a commercial nor a competitive basis (Sanger, Shrybman and Lexchin 2002). In contrast to NAFTA, the GATS does not exempt subsidies from national treatment or MFN. While the GATS national treatment rules do not apply to most Canadian medical services, hospital and medical services are covered under the generally applicable GATS Most-Favoured-Nation provision. This raises the possibility that American health corporations, which benefit from a NAFTA National Treatment right to establish in Canada, could invoke a GATS MFN right to as much subsidization as received by any other foreign provider. Furthermore, if any future Canadian government decided to list medical services under the GATS, foreign providers would be legally entitled to the same subsidies as Canadian providers. Any future attempts to retract these advantages gained under the GATS could then be subject to NAFTA compensation claims.

The situation is further complicated by the workings of Canadian federalism. The recent experiments in commercialization of certain hospital and clinical services are occurring mainly within a few provinces, while both the authority to negotiate trade treaties and overall responsibility for ensuring the integrity of the health care system through the *Canada Health Act* rest with the federal government.

Later, in part III, this report recommends changes to federal trade policy to better safeguard Canada's health care system. Federal leadership is also required to prevent such safeguards and the Canadian health care system from being undermined by incremental commercialization. While Ottawa does not have the constitutional authority to determine *how* provincial health care services are delivered, it can uphold the fundamental principle that publicly insured health services be available to all "on the basis of need", which is incompatible with the commercialization of the Canadian health care system.

One specific concern that arises is whether market-oriented policies in one province could set a benchmark for national treatment that other provinces would be required to follow. For example, could Alberta's legislation allowing private, for-profit clinics to receive public funding to deliver certain insured medical services lead to demands from foreign investors for similar treatment in other provinces? In his paper prepared for the Commission, Jon Johnson correctly points out that the NAFTA standard for national treatment with respect to provincial measures is the best treatment given by *that*

province.[19] So, simply because one province commercializes some aspect of health services, other provinces are not required under NAFTA's national treatment rule to follow suit.

But Steven Shrybman, in a legal opinion examining the NAFTA implications of proposals by Alberta to privatize the delivery of certain insured health care services, takes the national treatment issue a step further by considering the impact on federal measures to regulate health care, including the *Canada Health Act* (Shrybman 2000). The standard of national treatment applied to *federal government measures* is the best treatment provided to a good, service or investor, anywhere in Canada. By not intervening to curtail privatization in one province, the federal government may be establishing a national treatment benchmark, jeopardizing its ability to intervene later to prevent similar privatizations that occur anywhere in Canada. Indeed, a NAFTA investor that was adversely affected by federal intervention, could be expected to argue that it is "in like circumstances" to private investors supplying health services elsewhere in Canada and that the federal government's intervention was inconsistent with its *lack* of intervention in Alberta, thus violating its NAFTA national treatment obligations. As Shrybman (2000) argues, federal inaction to prevent privatization in one province not only weakens the efficacy of Canada's NAFTA reservations, it "would leave Canada open to foreign investor claims asserting their right to National Treatment … founded on Canada's support, tacit or otherwise, for Alberta's privatization experiment".

These scenarios illustrate the challenges posed by the complicated interaction between Canada's international trade law obligations and our health care system. While many of the concerns that have been raised in this context are necessarily tentative, it seems indisputable that the commercialization of medical and health services increases the risk of trade challenges and foreign investor claims; the greater the extent of privatization, the greater the risk of such undesirable outcomes. If the policy, program and regulatory prerogatives of Canadian governments in the area of health care are to be preserved, then the prudent course would be to reconsider current commercialization initiatives, or even to reverse those that have already occurred.

In sum, increased commercialization of core hospital and clinical services threatens to set in motion a self-reinforcing dynamic — a vicious circle — that could threaten the foundations of our Medicare system. Commercialization weakens the protective effect of trade treaty safeguards. Trade obligations then facilitate the entry of foreign investors and service providers into the newly created markets in health services. And the greater the presence of these foreign investors and service providers, the greater the possibility of trade complaints or investor claims if governments subsequently take steps that limit or diminish foreign penetration — whether directly or, by reversing commercialization, incidentally. Thus, once foreign investors and service providers become involved in Canada's health care system — and the more involved they become — the more difficult and costly it will be to limit or reverse the trend towards commercialization in general.

[19] "When Articles 1102(1) and (2) are read together with Article 1102 (3) it is clear that the comparison of the treatments accorded to US vis-à-vis domestic insures is the treatment by "that province," and not the treatment accorded by some other province." (Johnson 2002, 17)

Fortunately, commercialization of hospital and clinical services in Canada is not widespread. The market for private, for-profit hospital and clinical services is relatively small, and foreign investment and participation in that market smaller still. Accordingly, the current risk of trade challenges or foreign investor claims is correspondingly small. However, Canadians and their governments must be cognizant that with each step towards privatization involving foreign investment, that risk will grow.

At some point, the increased involvement of foreign commercial interests in our health care system will undermine Canada's ability to defend its health care policies, programs and laws as deserving exempt status from some of the more onerous obligations Canada has undertaken in international trade agreements. If a parallel private system and two-tier health care system is permitted to evolve, Canada's capacity to justify its departure from market imperatives to support a universal, comprehensive, accessible, portable and publicly funded Medicare system would become much more difficult. Without changes to the applicable trade treaty rules, the longer that creeping commercialization and privatization is allowed to proceed unchallenged, the more difficult it will become to intervene to reverse it. In effect, under Canada's trade treaty commitments, health care commercialization has become a one-way street.

5. Health insurance and financial services rules

The *Canada Health Act* lies at the heart of Canada's Medicare system. Its principles govern the operation of provincial public health insurance plans and restrict private insurance coverage of health services. This legislation, together with complementary provincial legislation and regulations, determines how health risks are pooled in Canada and how most health services are financed. Our ability to maintain and modify these essential features of Medicare is therefore the primary policy tool regulating access, quality and cost controls in Canada's health care system.

Although it is clearly vitally significant to health care, health insurance is not considered part of the health services sector for the purposes of trade agreements. Health insurance is categorized, along with other forms of insurance, as a financial service. As such, it is subject to special NAFTA and GATS rules and safeguards concerning financial services.

These rules are relevant for health reforms that could adversely affect the commercial operations of private insurers that are wholly or partly foreign-owned. A significant expansion of Medicare would shrink the private health insurance market for drugs, home care or other services that become "insured services" under the *Canada Health Act*. Mixed public/private approaches to financing these services would require complex regulatory measures that could also affect the operations of private health insurers. International investors in private health insurance providers could, therefore, seek compensation or other remedies through an international trade action.

This section assesses the risk that extending Medicare to services currently covered by private health insurers might precipitate a trade challenge based on the NAFTA or GATS financial services rules. It first assesses the commercial interests at stake by summarizing the extent of private health insurance in Canada and the value of international investment in the sector. After briefly describing how the financial services rules apply to health insurance, it then discusses the risk that extending Medicare to cover home care or prescription drugs could provoke a trade challenge.

Commercial interests

The risk of a trade challenge depends, in the first instance, on the existence of a commercial interest by foreign investors or traders. International trade cases are costly, often lengthy and, when they involve matters of important public policy, politically controversial. Such a course of action is most likely when substantial commercial interests are at stake.

Industry surveys estimate that private health insurers covered $8.6 billion in health spending in 2000 (CLHIA 2001).[20] With the addition of health benefits provided by property and casualty insurers, private health insurance paid for about 10% of total health spending and about one-third of total private health spending in that year (CIHI 2001a).[21]

Based on industry data for 1999, Finance Canada estimates (Finance Canada 2001):

- 22 million Canadians held private insurance for extended health benefits (typically covering prescription drugs, private/semi-private hospital accommodation, special duty nurses, para-medical services, ambulance services, vision care and a variety of other costs).
- 15 million Canadians hold private insurance for dental care; and
- 8 million hold private disability insurance that replaces income lost due to illness or injury.

Private insurance coverage of home care is thought to be modest, although there is great potential for growth.[22]

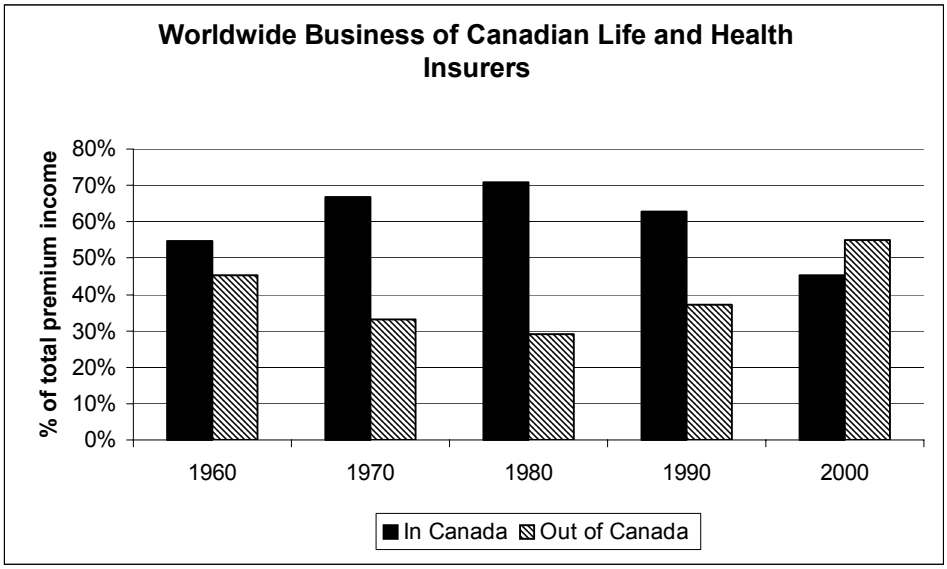
At the end of 2000, there were 140 private health insurance firms active in Canada. Of these, 93 were Canadian-owned, 37 were American-owned and 10 were European-owned. These firms sold 92% of private health insurance provided in Canada. The

[20] Property and casualty insurers also provide some health benefits (they collected 8% of private health insurance premiums in 2000).
[21] CIHI forecast total health spending in 2000 at $95 billion and private health spending at $27.5 billion.
[22] Coyte (2000) estimates private spending on home care was $0.7 billion in 2000-2001. After out-of-pocket payments by individuals and direct payments by employer health plans, the share covered by private insurers is likely to be modest. "Based on the current uses and costs of home care, we can expect a 78.4 percent total increase in home care expenditures between 1999 and 2026 due to (…) demographic changes. How this will be paid for (i.e. publicly or privately) is an important reform decision that remains to be made." (Sullivan and Baranek 2002, 76-77.)

remainder was provided by some 49 property and casualty insurance firms (CLHIA 2001).

Available evidence suggests that international investors control between 10% and 30% of the market for private health insurance. The Canadian Life and Health Insurance Association (CLHIA) estimates that about 10% of supplementary health benefits are written by foreign owned companies. (Lexchin meeting with CLHIA). Finance Canada, on the other hand, reports that the market share of the life and health insurance sector held by foreign insurers was 29% in 2000 (Finance Canada 2001).[23]

The international operations of Canadian-controlled life and health insurers account for a large and growing share of their total revenue. In recent years their foreign operations have grown and diversified beyond their long-established markets in the U.S. and the United Kingdom. Finance Canada reports that over a dozen Canadian insurers now operate branches and subsidiaries in over 20 countries (Finance Canada 2001). In 2000, foreign operations accounted for 55% of total premium income of Canadian insurers, up from 37% in 1990 (CLHIA 2001). By this measure, Canadian private insurers are more global than their counterparts in any other G-7 country.



(source: Canadian Life and Health Insurance Association 2001)

In summary, private health insurers have substantial commercial interests that could be affected by health reforms. More than a third of private insurers are foreign-controlled, and best estimates suggest that these firms receive between $860 million and $2.5 billion in private health premiums from Canadians. International investors could be expected to seek trade remedies if this business was diminished by health reforms. At the same time,

[23] The life and health insurance industry has consolidated in recent years, due in part to deregulation of financial markets and to legislation allowing mutual insurers to convert to stock companies. Finance Canada reports that consolidation has been accompanied by sales of foreign-owned operations to Canadian-owned companies.

Canadian private insurers are very active in international markets and can be expected to support further trade liberalisation to increase their access to these markets.

Coverage and safeguards in financial services rules

Both NAFTA and the GATS have special provisions that modify how their rules on investment and trade in services apply to financial services, including health insurance.

The NAFTA chapter on Financial Services (chapter 14) specifies how National Treatment, MFN and other rules are to apply to financial services. It also incorporates certain rules from the Investment (chapter 11) and Services (chapter 12) chapters. Most importantly, it incorporates the Chapter 11 provision on expropriation and compensation (article 1110) and provides for disputes under this provision to be resolved through the NAFTA investor-state mechanism. The Financial Services chapter incorporates all country-specific reservations to National Treatment and MFN in investment and services, and also adds reservations specific to financial services.

Canada entered health insurance, along with other financial services, in its original schedule of National Treatment and Market Access commitments in the GATS. Canada's commitments are subject to the GATS Financial Services Agreement of 1997 that modifies the "governmental authority" exclusion and elaborates a set of stronger market-opening commitments, including stronger restrictions on financial services monopolies (Thompson 2000; Finance Canada 1997).

Canada's commitments in health insurance are bound, meaning they apply to future as well as existing measures. Canada entered no explicit limitations on these GATS commitments to shield measures affecting public health insurance. Instead, as discussed further below, Canada is relying on its interpretation of the modified "governmental authority" exclusion to shield public health insurance from GATS obligations.

Application to Medicare

Public health insurance is among the most clearly public features of the health care system: it is financed entirely by public funds and is an exclusive government monopoly that provides universal coverage to all Canadians. Even so, because Canada has entered no explicit exclusion for Medicare in either NAFTA or the GATS, Medicare's protection from the financial services rules rests on definitional interpretations of key provisions and terms in the two agreements.

Canadian government officials maintain that Medicare is a "statutory system of social security," -- a category of activity outside the scope of the financial services rules as defined by Article 1(b) of the GATS *Annex on Financial Services* and NAFTA Article 1401.3. They argue that Medicare does not involve underwriting services, and is

therefore neither an insurance program nor a financial service and is therefore not covered by the NAFTA and GATS financial services rules.[24]

Both these grounds for excluding existing Medicare services are a matter of interpretation and, in the event of a trade challenge, would ultimately be decided by an international trade tribunal. In short, while the NAFTA and GATS rules arguably do not apply to measures affecting *existing* public health insurance, the legal arguments that Canada relies upon to shield Medicare are surprisingly subtle and untested.

Application to reforms to extend Medicare

By contrast, the NAFTA and GATS rules on financial services do indisputably apply to government measures affecting foreign private health insurers. There is therefore a significant risk that these rules could be invoked to challenge health reforms, including extensions to Medicare, adversely affecting the commercial opportunities of private insurers.

The market for private insurance coverage of prescription drugs and home care services would be diminished by extending public health insurance to these services, whether or not provincial legislation expressly prohibits private coverage of an expanded range of "insured services" under the *Canada Health Act* (Johnson 2002). Because Canada's NAFTA and GATS commitments are bound, they apply to future government measures affecting commercial insurance coverage of these health services.

NAFTA expropriation and compensation (Article 1110)

An extension of Medicare could trigger a compensation claim through the NAFTA investor-state process. An American investor could charge that the loss of its private health insurance market constitutes an expropriation under NAFTA article 1110, and that it is entitled to compensation at fair market value. A successful claim would not prevent Canada from extending Medicare, but would make it more expensive to do so.

Were a government required to pay such compensation to American investors, it would certainly face political pressure to also provide equivalent compensation to Canadian-owned insurers -- although it would not be legally required to do so. Given the larger market share held by domestic insurers, this could multiply the total compensation costs several times over.

Unfortunately, the NAFTA reservation for social services (Annex II-C-9) does not provide any protection against the application of Article 1110 and there are no relevant reservations entered in the NAFTA financial services schedule (Annex VII).

[24] This explanation was presented at a meeting of the CCPA Trade and Investment Research Project with Government of Canada officials, June 27, 2001.

Domestic law in both Canada and the United States recognizes that non-discriminatory government measures taken in the public interest may adversely affect private property rights, but should nevertheless not be treated as compensable takings. Canadian law is even stronger in this regard, deferring to governments' right to regulate or legislate in the public interest even if this adversely affects private commercial interests. Compensation is generally reserved for cases of classic expropriation, where governments acquire property without the consent of the owner, such as the taking of land to build a highway.

The right to regulate or legislate in the public interest is also recognized in international law as the "police power.". Although it is not explicitly recognized in the NAFTA investment chapter, there is a strong argument that the "police power" should circumscribe NAFTA investor rights: "under the traditional international law concept of the exercise of police powers, when a state acted in a non-discriminatory manner to protect public goods such as its environment, the health of its people or other public welfare interests, such actions were understood to fall outside the scope of what was meant by 'expropriation.' … Such acts were simply not covered by the concept of expropriation, were not a taking of property, and no compensation was payable as a matter of international law (Mann and von Moltke 2002)."

Nevertheless, the NAFTA concept of expropriation is not clearly defined and some investors are interpreting its provisions aggressively. Alarmingly, in a growing number of cases, investors have challenged a non-discriminatory regulatory measures as expropriatory.[25] Some of these cases are yet to be decided. But in at least one case, a tribunal held that the decision to withhold a license for a hazardous waste facility and the subsequent creation of an ecological preserve including the proposed site amounted to an expropriation requiring compensation. Even in certain cases where compensation claims have been rejected, the legal reasoning behind the tribunals' decisions is troubling and opens the door to future claims that non-discriminatory actions that substantially interfere with commercial interests are expropriatory.[26] Consequently, Canada cannot confidently expect that future panel decisions will conform to the meaning of expropriation under domestic law or even under conventional international law.

There is therefore a significant risk that a tribunal could uphold a claim that extending public health insurance constitutes an expropriation under NAFTA Article 1110, requiring Canada to compensate American investors adversely affected by an extension of Medicare.

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[25] S.D. Myers, Inc. v. Government of Canada
Metalclad Corporation v. United Mexican States
Pope & Talbot v. Canada
Ethyl Corp. v. Canada
Crompton Inc. v. Canada
Methanex v. United States
Most of the publicly available documentation related to these cases,including awards, can be found at http://www.naftaclaims and at http://www.dfait-maeci.gc.ca/tna-nac/NAFTA-e.asp.

[26] For example, the Pope and Talbot tribunal held that the company's access to the US market was a property right protected under Article 1110. The Pope and Talbot case is further discussed in Sanger, Shrybman and Lexchin, section 3.

GATS monopolies (Article VIII)

The GATS provisions most relevant to an extension of Medicare are its rules concerning monopolies that, unlike the NAFTA rules on monopolies, apply to provincial government monopolies. GATS Article VIII.4 requires Canada to negotiate compensation with other WTO member countries whose service providers are affected by the granting of monopoly rights in a service sector covered by Canada's specific commitments – such as an extension of Medicare to health services currently covered by private health insurers. Compensation would be in trade concessions, not monetary benefits.[27]
In this context, Canada's arguments for excluding existing Medicare services from the scope of the GATS are irrelevant. At issue is the application of article VIII.4 to measures affecting private health insurance services, which Canada has clearly covered in its specific GATS commitments.

There is no evident basis for arguing that an extension of Medicare would be shielded from the GATS requirement to negotiate compensation. Canada entered no relevant limitations to its commitments in health insurance. Its commitments are bound, and as previously mentioned, apply to future government measures.

If Canada could not reach a deal on compensation with other WTO members, then it could face trade sanctions. Given the substantial commercial interests at stake, there is a practical risk of a GATS monopolies challenge to an extension of Medicare.

Assessing the risks

In our view, a compensation claim brought through the NAFTA investor-state mechanism entails the greatest risk to unimpeded health policy reform. As previously mentioned, a successful claim would not prevent Canadian governments from extending Medicare, but would make it more expensive to do so – perhaps by hundreds of millions of dollars. Canada could eliminate this risk by eliminating the offending provisions of NAFTA and appears to have made certain efforts to do so. For the time being, however, federal and provincial governments can manage the political context of health reform firstly to deter investor-state expropriation cases and secondly to minimize the potential compensation costs of such a claim should one be initiated. This approach is considered in more detail below.

6. Home Care

Home care programs combine a diverse range of services, financed and delivered in a variety of ways across Canada. Reforms to extend publicly financed access to home care

[27] The Understanding on Commitments in Financial Services further requires Canada to list all existing monopoly rights in its financial services schedule and "endeavour to eliminate them or reduce their scope."

services are likely to accommodate the considerable variation that exists within and between provinces within a framework of national standards or principles.

This section first highlights the main constituent services of home care programs and the variation in existing funding and delivery modes. It then assesses the extent of commercial interest that might be adversely affected by reforms to home care, and the significance of external trade and international investment in the sector. Finally, it discusses how trade rules could impede reforms: focusing first on measures for extending public financing of home care and second on measures for regulating delivery of home care services.

Existing home care programs

Health Canada describes home care as: "An array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying or substituting for long term care or acute care alternatives" (Health Canada 1999). Home care programs combine the services of health professionals -- including registered nurses, physiotherapists, occupational therapists and dieticians -- and services of non-professional staff who provide personal care -- such as dressing, toileting and bathing -- and home support -- such as cooking, cleaning and shopping.

According to one authoritative estimate, total home care spending in Canada was $3.4 billion in the 2000-2001 fiscal year. Of this amount, about $0.7 billion (20%) comes from private sources and the remaining $2.7 billion (80%) from public sources (Coyte 2000). Public spending on home care increased at an annual rate of 9% during the 1990s, when total public spending on health averaged annual increases of 2.2%. Public spending varies widely -- from around $90 per capita in New Brunswick, Newfoundland and Labrador, Ontario and Manitoba, to about half that amount in Prince Edward Island and Quebec. This variation reflects many factors, including different mixes of public and private funding for home care services (Sullivan and Baranek 2002).

There is also considerable variation in how publicly funded home care is delivered. Four main modes are relevant for the purposes of a trade analysis:

- Direct provision of services by public employees -- e.g. most home care services in Saskatchewan and the services of nurses and other health professionals in Quebec.
- Competitive tendering for services provided by private agencies including both for-profit and not-for-profit home care providers -- e.g. most home care services in Ontario, and home support services in Alberta.
- Partnership between government and non-profit providers of home care -- e.g. home support services in Quebec.
- Self-managed care -- at least seven provinces offer eligible disabled adults a cash transfer or service vouchers allowing them to directly employ and supervise their own care providers.

Given the wide variation in existing home care programs, federal reforms are unlikely to apply a single model to all provinces. Reforms are more likely to establish national principles or standards for home care services that provinces can achieve through a variety of modes of delivery in order to qualify for increased federal funding.

Commercial interests

Private providers, both non-profit and for-profit, have a considerable stake in public spending on home care. A national survey estimates that about 93% of the 663 private home care agencies in Canada received some public funding and about 50% receive all their funding from public sources (MacAdam 2000). Based on an examination of confidential financial data, Peter Coyte found that 80% of the revenue of three national home care providers was from public sources. This was true for the for-profit operations (Comcare and We Care) as well as for the non-profit provider (Victorian Order of Nurses) (Coyte 2000).

Although reliable trade data is not available for home care services, it is evident that cross-border investment is more significant than cross-border trade. Large American-based commercial home care providers operating in Canada include Caremark. Other Canadian-based companies -- including Extendicare and Dynacare -- are partially owned or financed by international investors. (Other large Canadian-based companies, such as Comcare and We Care, are majority Canadian owned.) (Armstrong 2001)

Cross-border trade in home care services has become practically feasible with the application of telecommunications and information technologies. Telehealth applications in home care -- such as replacing some home visits with remote surveillance and monitoring -- have been seen as both a source of significant cost savings and a promising area of export growth. A recent survey of the Canadian telehealth industry, however, found no Canadian exporters of home care services (Picot and Cradduck 2000). There are no available data on imports, i.e. home care services provided to Canadian residences remotely, from outside Canada. Nevertheless, Trade Team Canada reports identify telehealth, particularly home care applications, as a priority sector with the "potential for dramatic growth both in Canada and international markets." (Industry Canada 2000; DFAIT 1999). An expansion of telehealth applications in home care would require addressing a host of regulatory issues, including recognition of professional qualifications; legal liability and malpractice; insurance coverage; and privacy and confidentiality (Sanger 2001; Vellinga 2001).

The significance of public revenue for commercial providers suggests that an international investor adversely affected by home care reform could initiate a trade dispute. A dispute is most likely to arise through the NAFTA investor-state procedure, to which the major American investors have direct access. A government-to-government dispute under NAFTA or GATS is less likely, given the relatively modest revenue involved in terms of national economic interest. This risk could grow, however, if health care reforms increase the potential commercial value of the home care sector and if the

projected growth in telehealth leads to increased interest in market access for cross-border supply of home care services.

Coverage and safeguards

The key NAFTA and GATS safeguards are unlikely to shield most home care services from Canada's trade commitments.Narrowly interpreted, the NAFTA reservation for future social services measures (Annex II-C-9) would provide little if any protection to provincial home care programs, as commercial providers are active even in provinces where publicly financed services are provided exclusively by public employees. A broader interpretation could provide some measure of protection for provincial home care programs. Provincial and territorial programs in place before January 1, 1994 are shielded from the key NAFTA services and investment rules, but these cannot be modified with impunity to make them less NAFTA-consistent.

Most home care services are unlikely to be shielded by the GATS exclusion for "services supplied in the exercise of governmental authority", as they typically involve commercial provision and competition between providers. MFN and other GATS general obligations, applicable universally, would therefore apply to government measures affecting home care. Canada did not enter any exceptions to its MFN obligations that would shield home care services.

The GATS National Treatment and Market Access rules do not apply to professional home care services such as nursing, physiotherapy, nutritionists and occupational therapy. These services are grouped in the WTO classification for "Services provided by midwives, nurses, physiotherapists and para-medical personnel", [28] that Canada regards as part of our health system and has pledged to keep out of our GATS commitments.

Canada has, however, made GATS commitments in certain services -- including "building cleaning" [29] and "food preparation" [30] -- components of home support services. A foreign-owned provider of these services could therefore invoke the National Treatment and Market Access rules to challenge a government measure it considered prejudicial to its commercial interests, as an investor established in Canada.
In summary, NAFTA coverage of home care is more stringent because the most forceful rules, including National Treatment and expropriation and compensation, apply except where specifically exempted. How the NAFTA annex II-C-9 reservation is interpreted would determine the extent to which home care reforms are constrained by these NAFTA rules. The GATS National Treatment and Market Access rules may apply to certain home support services, including cleaning and food preparation services. The GATS rules are more stringent in these services, but are unlikely to pose an obstacle to health

[28] WTO Secretariat, *Services Sectoral Classification List* (MTN.GNS/W/120, 10 July 1991).
[29] Code 87403 in ibid; Code 85330 in CPC v.1
[30] Code 64230 in ibid. The updated CPC v.1, which is not yet used in GATS schedules, classifies catering services more appropriately under distribution services. Its description of catering services includes "meals on wheels" programs and "food preparation and supply services provided by caterers to private households, on the premises or elsewhere" (Code 63230).

care reform because home support services are not currently of significant commercial interest to international services exporters and investors.

Financing home care

Major reform proposals have identified a range of options for increasing public funding of home care services:

- A cost-sharing program financed out of general revenue of federal, provincial and territorial governments. This would effectively extend Medicare, either by including home care in insured services under the *Canada Health Act* or through a separate federal-provincial-territorial agreement (e.g. the Social Union Framework Agreement) specifying conditions for federal funding (Sullivan and Baranek 2002).
- A social insurance fund, as proposed by the Clair Commission, would be financed from mandatory contributions from income (possibly through a payroll deduction), but would be kept separate from general revenue and would be capitalized so that sufficient funds accumulate to pay for contributors' future long term care needs (Clair 2000).
- Tax incentives to stimulate increased private spending on home care could include increases to a number of existing tax deductions and credits, and the creation of individual tax-sheltered savings plans which, like RRSPs, would allow Canadians to deduct contributions to pay for their future long term care needs (Senate of Canada 2001).

Each of these options could, to varying degrees, affect the operations of foreign-owned private insurers. The NAFTA and GATS financial services rules, discussed in the previous section on health insurance, are therefore relevant.

There is a risk that extending Medicare through a cost-sharing program would precipitate a NAFTA compensation claim by an American-owned insurer that has effectively been excluded from providing private coverage of home care services. The extent of this risk is proportionate to the value of private insurance coverage of home care, which the available information suggests is modest. Some observers indicate that uninsured benefit plans (in which employers directly reimburse the cost of health benefits rather than purchase insurance coverage) may pay for a more significant share of private home care expenses (CCPA consortium roundtable). These employers would likely welcome the extension of Medicare to home care services, reducing the cost of their benefit programs.

A social insurance fund could be implemented various ways. The Clair Commission report suggests that a single fund could be administered on a non-profit basis by an independent institution, such as the board of the Canada Pension Plan, Quebec Pension Plan or a financial institution. This would effectively displace coverage by private insurers and employer benefit plans, at least for the services covered by a universal basic

plan, raising the possibility of a NAFTA compensation claim as previously discussed in the section on extending Medicare.

Others have suggested that a social insurance fund could resemble some European systems by including payroll-funded group insurance plans, providing coverage for a prescribed set of home care services (Sullivan and Baranek 2002). This would require close regulation to ensure that different plans provide coverage for a common prescribed set of home care services, charge standard premiums, provide benefits according to the same eligibility criteria and that services meet expected levels of quality. This level of regulation would pool risk more broadly than is possible in separate group plans and would effectively make insurers into quasi-public entities for the provision of home care coverage.

In developing this approach, policy makers would need to anticipate the possibility of NAFTA compensation claims and National Treatment challenges. If participation in the plan was restricted to Canadian-owned insurers, American-owned insurers established in Canada could charge that their exclusion from the plan constitutes an expropriation and that, contrary to NAFTA article 1110.1, the expropriation was discriminatory. Canadian-owned insurers eligible to participate in the fund would very likely benefit from the greatly expanded business and could be expected to support the initiative.

Restricting the fund to non-profits could also precipitate a compensation claim by American-owned insurers. In this case, the measure would be formally non-discriminatory. Given the market dominance of Canadian commercial insurers, who would be similarly affected, it would be difficult for U.S. insurers to sustain a charge of de facto discrimination

If American-owned insurers were permitted to participate in the fund, there is a possibility that they could charge that the regulation of premiums, eligibility criteria and other factors have a discriminatory effect. They could maintain, for instance, that these measures prevent them from competing with other insurers on the basis of the quality of services offered (Epps and Flood 2001). If Canada could demonstrate to a trade tribunal that the social insurance fund is a social service established for a public purpose, as described in Annex II-C-9, its regulation of participating insurers would be shielded from the National Treatment rule.

Tax incentives including a tax-sheltered savings plan are unlikely to have an adverse effect on private insurers, whether domestic or foreign, and may in fact benefit them. Consequently, there is little cause for concern that foreign insurers would seek recourse under trade and investment agreements.

Regulating delivery of home care services

Given the wide variation in how home care programs are currently delivered, reforms are likely to accommodate a range of different delivery modes that would allow for variation

among provinces and territories and for differences in how services are provided for different groups of users within a single jurisdiction.

Direct public provision

Reform of home care could involve direct public provision of services in at least some jurisdictions. This could have the effect of displacing commercial home care providers currently offering those services. American-owned providers who are adversely affected could initiate a compensation claim under NAFTA article 1110.

Under Canadian law, Canada would be on very strong grounds in arguing that there is no expropriation and no requirement to compensate. Where commercially provided services are displaced by direct public provision, the government would be assuming an obligation to provide those services. There would be no taking of commercial providers' property for the benefit of government. Moreover, it is unlikely that this measure would render a commercial provider worthless, as the American-owned home care corporations offer a wide range of services that would be only partially affected by a decision that public employees in some jurisdictions will directly provide certain services.

In the unlikely event that an American-owned provider were forced out of business, Canada has a favourable domestic legal precedent stemming from a Manitoba government decision in 1984 to replace a contracted home care service with direct public provision. The contractor, Home Orderly Services, sought compensation but was denied in a judgement by the Manitoba Court of Appeal, which reasoned that,

> *Surely, after having provided the major portion of the income between 1969 and 1984, the government is not faced now with having to purchase as a going concern or having to substantially compensate what it has itself caused to be created by having hired the services of the plaintiff corporation.* (Home Orderly Services et al. 1986; 1987)

The fact that even large commercial home care providers are largely reliant on public funding establishes a valid parallel with this case.

A NAFTA tribunal, however, would not be obliged to follow, or even consider, Canadian domestic legal precedent. NAFTA tribunals have given expansive readings to the meaning of expropriation. So even though Canada would have strong arguments that such measures were not compensable expropriation under Canadian (or traditional international law), it is not possible to predict confidently that Canada would prevail in a NAFTA dispute.

Competitive tendering

There are no apparent trade constraints to the implementation of competitive tendering for publicly financed home care services. Provincial and local government procurement is not covered under either NAFTA or GATS. Competitive tendering can, however, take a variety of forms, not all of which would be defined as procurement under international

trade rules. In such instances, policy makers would need to anticipate potential NAFTA National Treatment challenges if they intended to limit eligible contractors to Canadian providers. A competitive tendering model may also encourage an influx of American-owned companies, possibly raising the potential compensation costs of a subsequent reversal of policy in this area.

A generous interpretation of Canada's social services reservation could permit governments to differentiate between Canadian and foreign-owned providers (Epps and Flood 2001). A more narrow interpretation would require that American providers be treated equally in the tendering process. As well as preventing formal discrimination, the obligation of non-discriminatory treatment could extend to conditions that have a discriminatory effect against American providers. This requirement could, for instance, impede the ability of governments to set eligibility conditions for contractors, such as certification or licensing by Canadian regulators, or an established record of providing home care services in Canada. It could also make it more difficult to regulate confidentiality and privacy by, for instance, preventing the cross-border transmission of personal health information and administrative records.

Providing home care services through competitive tendering could also commit governments to a course of action that would be difficult to reverse at a later stage. American-owned firms would likely be attracted to Canada in greater numbers if increased funding for home care were allocated by competitive tendering. Once established in Canada, these firms could claim compensation if they were adversely affected by a subsequent decision to publicly provide home care services, depriving them of a significant proportion of their business. Consequently, the potential compensation costs of a future change in policy would be increased.

Partnership with non-profit providers

For-profit providers could be adversely affected if home care reforms in some jurisdictions include closer partnership arrangements between government and non-profits. Such partnerships could involve exclusive service arrangements with designated non-profits; public support for developing infrastructure and organisational capacity of non-profits; and long-term contractual arrangements. Commercial operators would be harmed where they are supplanted by non-profits benefiting from these measures, and could seek recourse through the NAFTA expropriation provision, or the National Treatment and Market Access provisions of NAFTA or GATS.

An expropriation claim in this case would be weakened if, as is likely, commercial providers remained free to provide any home care service on a purely private basis to individuals who are ineligible for publicly financed services. They may lose a substantial portion of their business, but would retain their property and the ability to provide home care services. As in the case of direct public provision, an expropriation claim could also be defended on the grounds that there is no taking of property for the benefit of government. Consequently, Canada would be on firm ground were it to face such a claim.

A National Treatment challenge under NAFTA could concern measures related to any home care service, while a GATS National Treatment challenge would be restricted to measures affecting services committed by Canada, such as food preparation and building cleaning services. In either case, a successful challenge would have to demonstrate that a measure has a discriminatory effect.

Like the GATS National Treatment provisions, the GATS Market Access provisions currently also apply only to food preparation, building cleaning and possibly other home support services. Most significant in this context are the prohibitions against limitations on the number of service providers and against restrictions on the kind of legal entity permitted to provide a service. By establishing a network of designated home support providers, partnerships of the kind developed in Quebec may effectively limit the number of service providers and exclude for-profit providers from the market. The demand for commercial home support services, paid entirely out-of-pocket, might be effectively eliminated by the availability of publicly funded services provided by non-profits. While this could provide the legal basis for a market access challenge, it is unlikely that another national government would consider the commercial value at stake sufficient to initiate a challenge.

Self-managed care

Existing self-managed care programs provide service vouchers or cash with which individuals directly employ and supervise care providers. These benefits are therefore a form of subsidy, as are existing federal and provincial tax incentives for home care expenses. Increased and new tax measures, such as a tax-sheltered savings plan, would also constitute a subsidy.

Because NAFTA rules do not apply to subsidies, only the GATS National Treatment provision is relevant in this case. It could impede conditions placed on the use of these benefits if they adversely affect non-Canadian providers, but only insofar as they affect food preparation, building cleaning or other services already committed by Canada. As these services require the physical presence of the provider, the only plausible cases would involve a condition that discriminates between Canadian- and foreign-owned providers established in Canada. While conceivable, it is unlikely that any such measures would have enough commercial impact to precipitate a GATS trade challenge.

Assessing the risks

Practical considerations weigh against the likelihood of trade provisions posing significant constraints on reforms related to the financing and delivery of home care services.

Reforms may well include measures that have a discriminatory effect, for which there may be a legal basis for a NAFTA or GATS complaint. The value of the commercial

interests at stake, however, are not likely to be significant enough to lead to a government-to-government trade challenge.

A NAFTA compensation case is more likely as it could be initiated directly by an American investor. While Canada would have strong grounds to defend home care reforms from such a challenge, the outcome of a case is unpredictable. This suggests that policy makers should anticipate possible compensation claims and take steps to minimize the potential compensation costs. In addition to the political management strategies mentioned in the health insurance section, governments should proceed quickly with reforms in areas where there is rapid commercialization. This would limit the number of affected American investors and therefore avoid the risk of greater compensation costs that may result from reforms implemented later.

7. Pharmacare

This section discusses the risk of trade rules impeding reforms to extend publicly financed insurance for drugs. It briefly describes the current extent of publicly financed drug coverage then discusses various proposals for expanding coverage. Possible trade impediments are considered in relation to the regulation of private insurers and measures to control drug costs.

Drug coverage in Canada

Interest in expanding public coverage of drug costs is driven by both equity and cost considerations.

Recent studies have found that about 90% of Canadians have some form of public or private insurance coverage for drug expenses. There is great variation, however, among different provincial plans, and between employer-based group plans and public plans. These differences include, among other things, disparities in the products covered and the level of reimbursement provided. Consequently, affordable access to pharmaceutical drugs is far from universal in Canada (Willison, Grootendorst and Hurley 1998).

Canada ranks near the bottom of OECD countries in every measure of public spending on pharmaceuticals. Only the United States consistently ranked below Canada (Jacobzone 2000).

A Pharmacare program would also help to control escalating drug costs, now the second largest component of health care spending after hospitals. These costs are driven by the increased volume of drugs per capita and the entry of new drugs. Studies by Green Shield show that annual price increases for newly patented medications far exceed that for unpatented medications. A national Pharmacare plan would provide the federal government or a coalition of provincial governments with the opportunity to utilize

monopsony buying power to purchase these newer more expensive patented drugs at larger discounts than are currently available.

As drug costs escalate, an increased share of this expense is being borne out of private payments. In 1999, total annual spending on prescribed drugs was $9.3 billion, a $5.6 billion increase over 1988. Over 60% of this increased amount was in higher private sector spending. Cutbacks in provincial/territorial spending relative to the private sector resulted in an overall decline in the publicly funded share of total spending from 45.1% to 41.4% (CIHI 2001b).

Options for expanding drug coverage

In recent years a number of reports have proposed options for increasing drug coverage (Palmer D'Angelo Consulting Inc 1997; Blomqvist 2001). In addition, Quebec undertook a study of options before establishing a mixed public/private regime for universal drug coverage in that province (Quebec 1996).

There are a large number of models for providing universal coverage, but the main distinguishing features are:

- The method of financing: fully public; mixed public/private insurance (similar to the Quebec model); or fully private insurance.

- Coverage: first dollar coverage where all eligible expenses are compensated; or cost-sharing, a portion of expenses being paid by individuals out-of-pocket (e.g. co-payments, coinsurance, deductibles).

- Administration: through existing provincial drug programs, private plans, a new federal program, or the tax system. In practice a national Pharmacare initiative may involve a combination of these delivery options.

None of these options are mutually exclusive. For instance, a plan that is fully financed from public sources could require some out-of-pocket payments by individuals. A publicly financed plan could be administered by private insurers. Private insurers could provide a basic mandatory level of universal insurance on terms that are publicly regulated, as is the case in Quebec.

In models integrating private sources of financing and private providers, there is a need for sophisticated regulation to advance public objectives, including: improving access to medically necessary drugs; pooling risks across groups of different risk status; financing care in a progressive manner; applying systematic approaches to improving prescribing; integrating incentives across health services; and controlling drug costs (Morgan 1998).

Reforms that rely on private financing and participation of private providers would benefit less from Canada's existing safeguards for health care in NAFTA and the GATS. Consequently, it is particularly important to anticipate potential constraints on the ability of governments to fund and regulate Pharmacare. Any possible Pharmacare regime would require complex regulation, the trade implications of which cannot be confidently predicted without a detailed examination of specific measures. The following sections discuss some illustrative examples of possible impediments to options for Pharmacare reform.

Financing of Pharmacare

A previous section discusses the risk of a compensation case brought by private sector insurers affected by an extension of public insurance coverage. The other possible financing options - mixed public/private insurance coverage and fully private insurance coverage -- would expand the market for private insurance coverage and are unlikely to provoke a compensation claim by insurers.

Both of these regimes could, however, commit governments to a course of action that would be difficult to reverse at a later stage. The value of drug coverage provided by established insurers, both domestic and American-owned, would increase -- thereby raising the potential compensation costs if Canadian governments subsequently decided to provide drug coverage from fully public sources. Also, new American-owned insurers may be attracted to an expanded market for private drug coverage. Once established in Canada, these firms could claim compensation if they were adversely affected by a change in policy. Consequently, both a mixed and fully private insurance regime could make it more difficult for governments to subsequently change the method of financing.

Regulating access to drug coverage

Public regulation is needed in a mixed or private insurance regime to ensure that all citizens have equal access to drug coverage. The Quebec legislation prevents private group insurers offering the basic drug insurance plan from determining eligibility for coverage on the basis of sex, age, state of health or other risk factors. Furthermore, Quebec requires that all private group insurers and employee benefit plans must pool the risks arising from the basic plan coverage they provide (Epps and Flood 2001).

These and other forms of regulation could have differential effects for domestic and American-owned companies. For instance, a U.S. based company could maintain that the conditions on basic plan coverage restrict its ability to benefit from its economies of scale and therefore offer full drug benefit coverage (above the basic plan) at more competitive prices. A national treatment challenge on this basis would need to establish that such regulation of private insurers was not shielded by the NAFTA annex II-C-9 reservation. The divergent interpretations given to this reservation make it difficult to predict confidently what a trade tribunal would find.

Regulating costs of drug coverage

One of the most significant challenges for a Pharmacare program is the cost of providing drugs. There are numerous ways to control drugs costs (these are discussed in more detail in Lexchin 1999).

Compulsory licensing

Until the promulgation of Bill C-91 almost ten years ago, compulsory licensing of pharmaceutical products was a cornerstone of Canadian health care policy. Generic drugs provided consumers with early access to many essential medicines at lower costs, and allowed governments to more readily fund programs to subsidize the cost of providing drugs to the elderly and the poor. It is clear that compulsory licensing may provide an effective mechanism for reducing the cost of pharmaceutical products and the consequent costs of a Pharmacare program.

The question is whether the re-establishment of a generic drug licensing system could be accomplished in a manner consistent with Canada's international obligations concerning the protection of intellectual property. We believe the answer to this question is yes.

Recent federal government statements have apparently misapprehended the nature of WTO disciplines concerning the issuance of licenses to produce generic drugs.[31] Indeed a detailed code is set out by the intellectual property provisions of both NAFTA and the WTO establishing the terms and conditions under which such licenses may be granted. Neither intellectual property regime specifically identifies the reasons that might be used to justify compulsory licensing. TRIPS Article 31 does mention national emergencies, other circumstances of extreme urgency and anti-competitive practices -- but only as grounds for waiving the normal requirements for compulsory licensing, such as the need to first try for a voluntary licence.[32] It is also noteworthy that the United States has established compulsory licensing regimes in several areas of patent protection.[33]

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[31] During parliamentary hearings into the effects of Bill C-91 in the mid 1990s, the then Minister of Health expressed the view that it would be impossible for Canada to revive the compulsory licensing regime that had been abandoned by Bill C-91 without offending Canada's obligations under the intellectual property regimes of the both the WTO and NAFTA. While the Minister acknowledged the existence of provisions that explicitly provided for licensing patented products *without the authorization of the right holder*, he indicated that this right was "available only in very exceptional circumstances" and then only to "cure cases of abuse."

[32] Precisely this characterization is offered by the WTO Secretariat in an explanation posted to its web site: http://www.wto.org/english/tratop_e/trips_e/factsheet_pharm02_e.htm

[33] "Although U.S. patent law does not provide for compulsory licenses, compulsory licenses are allowed under special legislation and under the antitrust law. The United States is probably the country with the richest experience in the granting of compulsory licenses to remedy anti-competitive practices and for governmental use, including national security. More than one hundred such licenses have been granted, both for present and future patents. Licensees have generally been required to pay a reasonable royalty, determined on the basis of the "willing-buyer, willing-seller" formulation, but in some cases the compulsory licenses have been conferred royalty free. In some cases, moreover, the patentee was required to make the results of its research readily available to other industry members, or to transfer the know-how." (Correa 2000)

Moreover greater certainty as to the scope and application of these provisions was provided at the WTO Ministerial Conference convened in Doha, Qatar that explicitly confirmed that, "*Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted"* (WTO 2001).

It is clear that there is considerable scope for the use compulsory licenses, and the use of such measures has the potential to provide an effective, and trade compliant, mechanism for reducing the cost of medicines and any Pharmacare program the government may wish to establish.[34]

In our view, the issuance of compulsory licenses would not expose Canada to a claim for compensation under NAFTA investment rules where such licenses are issued in accordance with TRIPS and NAFTA requirements that *adequate* compensation be paid in accordance with the *circumstances of each case, taking into account the economic value of the authorization*.[35] In Canada, the customary norm for such royalty payments was 4%. Moreover, disputes concerning the quantum of compensation to be paid are subject to judicial review by the Party's domestic courts. Because the intellectual property regime explicitly provides for the licensing of drugs without the consent of the patent holder and sets out the criteria by which compensation is to be provided, and disputes resolved - there is a strong argument that it displaces any opportunity for a patent holder to seek recourse under NAFTA investment rules. NAFTA chapter 11 (investment) explicitly provides that in the case of conflict with other NAFTA disciplines (including the intellectual property protections in chapter 17) the latter provisions prevail.[36]

Tendering for generic drugs

Tendering for generics on a competitive basis can produce substantial savings. The Ontario Provincial Auditor has estimated that if Ontario followed the Saskatchewan practice of tendering for certain generic drugs that it could save approximately $54 million annually (Ontario 2001).

To the extent that tendering schemes can be established as procurement regimes, considerable scope would be permitted for establishing and structuring such a price control measure. As noted, the AGP and NAFTA procurement rules apply only to procurement by federal government entities, therefore provincial drug tendering can be designed with little regard to the potential for conflict with Canada's international trade obligations. Direct procurement by Health Canada would be covered, but a new national entity created to jointly purchase drugs on behalf of all jurisdictions would not be covered

[34] It should be noted, however, that Canada has supported a narrow interpretation of the Doha declaration, and that continuing debate in the WTO TRIPS council will likely influence the outcome of any future trade dispute in which Canada may be implicated. In the FTAA negotiations the United States is seeking intellectual property protection provisions that are more stringent than existing TRIPS provisions. If agreed by Canada and other nations, these 'TRIPS-plus' provisions could be more restrictive of compulsory licensing and other cost containment measures.
[35] NAFTA Article 1709:10(h) and TRIPS Article 31(h).
[36] Article 1112:1

unless it was expressly entered into Canada's schedules to the AGP and NAFTA procurement provisions.

A risk of trade impediments arises because there is no certainty that a WTO or NAFTA tribunal would find that a public tendering regime for drugs is a form of government procurement. Surprisingly, no positive definition of procurement is provided in either the AGP or NAFTA agreements. Canada has entered its own definition of procurement in its annexes to the AGP. "Procurement in terms of Canadian coverage is defined as contractual transactions to acquire property or services for the direct benefit or use *of the government*."(emphasis added)[37] A narrow interpretation of this definition (broadly consistent with other definitions employed in NAFTA and WTO agreements) would not include drugs purchased by a government entity for provision to the public. In this case, a public tendering regime might be subject to the non-discrimination and other rules of the General Agreement on Tariffs and Trade (GATT).

Price controls: reference based pricing and cross-therapeutic listing

Governments can use their regulatory power to negotiate price controls with pharmaceutical manufacturers. For instance, governments can place conditions on the listing of drugs that are eligible for coverage by publicly financed insurance plans.

Reference based pricing involves establishing categories of therapeutically equivalent drugs and reimbursing patients or pharmacists for the lowest or the average cost of drugs in the category. A recent report evaluating the effect of price controls in British Columbia, concludes that Pharmacare expenditures on nitrate drugs prescribed to senior citizens declined by $14.9 million during the first three and a half years where reimbursement for these drugs was based on reference prices (Grootendorst et al. 2001).

Another approach is cross-therapeutic listing, used effectively in New Zealand (New Zealand 2001). Under this system, a provincial government would agree to list one drug on its formulary in return for the company dropping its price on a second drug. The company gains subsidized market access for the first drug and the government saves money on the other drug.

If established in a manner that accords drug imports national treatment, these and other forms of price controls should not engender a significant risk of trade challenge or foreign investor claim.[38]

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[37] AGP Appendix 1, Canada: General Notes (WT/Let/330) 1 March 2000.

[38] It is worth noting, however, that PhRMA, the American pharmaceutical lobby group has repeatedly urged the United States Trade Representative to retaliate against the modest price control measures of Canada's Patented Medicines Price Review Board (Elliot 2001). Also, reference based pricing and cross-therapeutic listing have drawn the attention of the USTR in a recent report on New Zealand government barriers to U.S. exports. It reports that the U.S. pharmaceutical industry considers these forms of price control to be discriminatory, and argues that the crown corporation responsible for administering the national drug plan should be subject to the New Zealand competition laws. No formal trade challenge has been issued, and New Zealand representatives maintain that their practices are fully consistent with all trade obligations (USTR 2000, New Zealand, pp.4-5).

Assessing the risks

Full public financing could displace private insurers that currently cover drug expenses that are brought into a Pharmacare program. Canada's best protection against a NAFTA compensation case would be to manage the political context, as discussed in section 3. There seems to be little risk of a NAFTA compensation case following introduction of mixed or privately-financed insurance regime, but such an approach could restrict future policy options by expanding the market for American insurers and consequently raising potential compensation costs if commercial insurers were later displaced.

Mixed and private insurance regimes require complex regulation to ensure access to drug coverage. Regulators would need to be careful that these regulations are not found to be discriminatory, otherwise they could be vulnerable to a trade challenge. This risk should be of practical concern to policy makers, given the significance of drug coverage as a component of private insurance plans.

Canadian governments have considerable scope for controlling drug costs without running afoul of trade commitments. The WTO and NAFTA intellectual property provisions allow more scope for compulsory licensing than is generally recognized. Cost savings through competitive tendering and bulk buying are largely shielded from the WTO and NAFTA procurement rules. Price controls, such as reference-based pricing and cross-therapeutic listing, are unlikely to violate non-discrimination provisions.

Part III: Options for Maintaining and Enhancing Flexibility in Health Care Policy

This section proposes directions for federal government policy: first to reduce the risk that health reforms will run afoul of trade rules; secondly to modify Canada's trade policies and practices to better ensure policy flexibility in health; and thirdly to better address global health challenges by strengthening coherence between our health and foreign policies.

8. Managing uncertainty surrounding trade constraints: guiding principles for health care reform

Canada's international trade commitments and their application to health policy need to be considered in order to fashion health reforms in a manner that will minimize the risk that these commitments will obstruct public policy objectives.

As is evident from the previous discussions of health insurance, home care, Pharmacare, and commercialization of health care services, the full extent of the constraints imposed by trade commitments is uncertain. This is because of the novel and largely untested character of NAFTA and WTO trade rules concerning investment, services, government procurement and intellectual property rights. Uncertainty is exacerbated by the ambiguity of key NAFTA and GATS safeguards that are subject to divergent interpretations by trade panelists and by Canada, the U.S. and other important trading partners.

While this degree of uncertainty is decidedly unhelpful, it is nevertheless possible to proceed with health reforms while problems with Canada's trade commitments remain unresolved. Indeed, exercising our capacity to modify and enhance domestic health policies, and being prepared to defend our right to do so, can only help to minimize the degree to which this capacity is impinged by our international trade commitments.

Without meaning to minimize other important trade constraints, it is our considered view that the most important risk to health reform is the potential for American-owned corporations to claim compensation under NAFTA article 1110 for commercial operations that are adversely affected by measures to extend public financing or delivery of health services. Article 1110 is not subject to Canada's safeguard for social services, nor the safeguard for existing provincial measures. Investors can pursue compensation directly through the NAFTA chapter 11 investor-state mechanism that lacks the political checks and balances built into the conventional state-to-state dispute resolution process. The jurisprudence in NAFTA compensation cases is inconsistent at best; some NAFTA chapter 11 panels have interpreted expropriation more expansively than the established norms of international and domestic Canadian and U.S. law. A successful compensation claim would not prevent health reforms but would make them far more expensive and this potential consequently may deter governments from proceeding.

While federal and provincial governments cannot eliminate this risk, they can manage the political context of health reform to deter investor-state expropriation cases and to minimize the potential compensation costs of a successful claim. Instead of denying that such a risk exists, governments should assert their right to proceed with health reform in the face of an acknowledged risk and make clear that they intend to defend this right.

In our view, a good offense is the best defense against a trade challenge to extending Medicare. Instead of denying the risks, Canada should assert its right to proceed with health reform and make clear that it intends to defend this right. It can do this by spelling out the public interest objectives of reform measures and stipulate that health care services conforming to the requirements of the *Canada Health Act*, or any new legislation, constitute a public service immune to any claim (domestic or foreign) for damage or restriction to commercial business. [39] In particular, it can make publicly known in Canada and internationally that the Canadian government does not regard extending Medicare to be an expropriation and will resist any claims for compensation.

This assertive posture would ensure that Canada's public policy position is well known by investors and by the American government. It would show Canadians that the federal government intends to back up its reassurances that health care policy is not constrained by our trade commitments. In this context, a NAFTA compensation claim would be seen as inflammatory to Canadian public opinion and potentially destabilizing for the NAFTA regime.

As well as serving a direct warning to investors that any compensation claim will be hard fought, this approach would give American political leaders and trade officials concerned with the integrity of NAFTA an interest in deterring American investors from initiating a claim against a health reform measure. It would also help to strengthen Canada's position in achieving stronger safeguards for health in subsequent rounds of trade negotiations.

Canada could also reduce its potential compensation costs by asserting its approach as early as possible in the process of health reform. Strong private sector growth is projected for home care services and drug costs are among the fastest growing component of health care spending. Early notification that governments intend to extend public health insurance would deter an expansion of private insurance coverage of these or other services. Given increasing commercialization and the potential for increased foreign investment in the Canadian health insurance sector, acting sooner is prudent and reduces potential liabilities. Such an approach could also help to deter another WTO member country from seeking trade compensation under the GATS monopolies provision.

The preamble of the GATS affirms the right of WTO members to regulate services in order to meet national policy objectives -- a provision frequently cited by the

[39] This follows a suggestion by Tom Kent, who as Policy Secretary to Prime Minister Lester Pearson, and a senior deputy-minister, was one of the principal architects of Medicare.

Governments of Canada and other WTO members, although it has little legal force. By setting out the public interest objectives of extending Medicare, and asserting Canada's right to pursue these objectives, the federal government would cause other governments to carefully consider the implications for all Members of a GATS challenge and the implications this could have on Members' ability to regulate in this critical area of public interest.

Recommendations:

- **The public interest objectives of all health reforms should be made explicit and vigorously supported.**

- **At every opportunity the Government of Canada should make known its view that exercising the right to regulate in health policy is not a compensable taking under international law and that it intends to defend this right.**

- **To reduce potential compensation costs, governments should signal future policy directions as early as possible in the process of health reform. This would deter increased foreign commercial investment in services that may be subject to health reforms, thereby limiting liabilities for compensation.**

The risk of other trade impediments appears to be more limited but, as previously noted, also requires careful consideration in health reforms. There is an inherent tension between, on the one hand, the public policy objectives of regulating access and quality and containing costs in health services and, on the other hand, the principles of non-discrimination and open market access as they are applied in modern trade agreements.

As highlighted above, in general, the risk of encountering obstacles to public policy initiatives mounts with the degree of private financing and commercial delivery of health services. Medicare has contained commercialization to the periphery of our health care system, and established a regulatory framework in which private providers of hospital and medical services operate within clearly defined parameters. To the degree that governments permit services at the centre of our health care system to be privately financed and provided by for-profit companies, public policy regarding these services will become more constrained by Canada's international trade commitments.

A crucial issue, which warrants emphasis, is the scope and effectiveness of safeguards that shield government measures from the National Treatment and Market Access provisions of NAFTA and the GATS. It is clear that these safeguards do not completely exclude Canada's health care system; and there is a wide range of expert opinion regarding the flexibility they provide to governments to introduce reforms that would otherwise be inconsistent with Canada's trade commitments. Most worrying is the gap between Canadian and American interpretations of the crucial NAFTA reservation for "social services established or maintained for a public purpose." Policy makers should

expect that the United States government will assert its more narrow interpretation, corresponding to the more commercially oriented American health care system and which favours American health corporations with a strong commercial interest in entering the Canadian market.

Recommendation:

- **Health reforms can be fashioned to make the most benefit of existing safeguards in NAFTA and the GATS by introducing measures most closely corresponding to a narrow conception of public services. This means minimizing the role of private financing and for-profit service delivery. In general, health reforms are least likely to be restricted by trade rules if they:**
  - **Extend universal access to services on the basis of need, rather than ability to pay or other criteria;**
  - **Establish clear public purpose objectives and regulations;**
  - **Finance services out of public revenue;**
  - **Favour direct subsidies or grants over contracted services; and**
  - **Where services are contracted, adopt standard government procurement procedures.**

These kinds of measures are most likely to be shielded from the various NAFTA and GATS provisions. They consequently preserve government flexibility to modify policies whereas market oriented reforms are more likely to trigger trade obligations that could restrict public policy flexibility.

9. Reducing uncertainty: options for Canadian trade policy

This report has highlighted a number of existing and potential conflicts between Canada's health and trade policies. While domestic health care policy-makers can take certain steps to reduce the risk that our domestic health care reforms will run afoul of international trade rules, this is an unsatisfactory situation. Canadian health care policies should be guided by health care objectives and should be not be distorted by concern over possible trade challenges.

Steps must therefore also be taken to reduce the possibility of trade challenges to health policy at their source -- in Canada's foreign trade policy and its trade and investment agreements themselves. While Canada's existing safeguards provide important protection for health care, there are serious gaps in this patchwork quilt of exceptions and exclusions. Canada's international trade policy and negotiating objectives need to change to reduce the sources of conflict between trade and investment treaty obligations and Medicare. The status quo poses serious and unacceptable risks to Canada's health care system and especially to its future policy flexibility.

As previously noted, there are certain trade policy reforms that Canada can take on its own that would strengthen protection for health care. But structural changes to international treaties can only be made with the support of other parties to these agreements. Consequently, federal trade officials must also work to build support for creating fully effective safeguards for health care in all its international trade and investment agreements and to make the case to other governments that health policy must take priority over commercial treaties in the event of an inconsistency.

Trade policy changes

The first principle of Canadian trade policy with regard to health objectives should be to do no harm. International trade and investment agreements are dynamic; they are continually revised. Most have built-in negotiating agendas and are subject to periodic negotiations aimed at broadening and deepening the agreements. Canada is also participating in negotiations to create a Free Trade Area of the Americas (FTAA) and in some regional free trade agreements (for example, with four Central American countries). Canada is also an active participant in the WTO Doha Round which includes negotiations on many health-related matters including services, investment, and intellectual property. Canada's objectives in these negotiations should reflect a precautionary approach to prevent further exposure of our health care system to pressure and possible challenge (Copeland 2002; Curtis and Ciuriak 2002). Certain changes to our existing agreements are also required if Canada's health care policies – especially their future flexibility – is to be fully safeguarded.

NAFTA, the FTAA and bilateral trade and investment treaties

As we have seen, the NAFTA investment chapter and investor-state process pose the most serious risks to the Canadian health regulation and particularly to Medicare's future policy flexibility. Accordingly, Canada should make limiting the meaning of expropriation under NAFTA Chapter 11 an urgent priority. The NAFTA (Article 1131) allows the three parties to make binding interpretations of NAFTA investment chapter provisions. The protection against expropriation afforded to foreign investors and service providers should be narrowed to that afforded under Canadian domestic law to domestic investors.

Canada should also pursue a narrow meaning of expropriation in the FTAA and any other future agreements. It should withdraw its support for investor-state dispute settlement procedures that allow investors to directly challenge public policy measures. Canada should also review and revise its bilateral investment treaties (Foreign Investment Protection Agreements) to be consistent with these objectives.

The GATS and WTO negotiations on services

For obvious reasons related to their subject-matter, the WTO negotiations on services are centrally important to Canadian health care policies and programs. Canada's 1994 decision to list health insurance under the GATS is particularly problematic. Canada should withdraw this commitment by invoking GATS Article XXI that permits countries to withdraw any commitment in their schedule at any time after three years from which the commitment entered into force.

The Canadian government has stated repeatedly that it will not make any further GATS commitments directly covering health services. It is critically important that this position be rigorously maintained. Canada should also carefully assess every request it receives and especially any subsequent Canadian offers in any sector to ensure that there are no adverse consequences for the Canadian health system. This health impact assessment of the request-offer process should include public participation and dialogue. This will require that GATS requests received by Canada, and the GATS offers Canada makes to other countries, be publicly available.

Canada should apply horizontal limitations protecting its flexibility over health policy to all its future GATS offers. The GATS includes built-in negotiations on subsidies and government procurement. Both sets of negotiations have potential implications for Canadian health care and other social policies. Canada should take a precautionary approach to ensure that there are no adverse health policy impacts.

GATS negotiations to develop "disciplines" on domestic regulation under Article VI.4 of the GATS are a very serious concern. Non-discriminatory regulation, especially complex, ever-changing, and socially indispensable sectors such as health care, should not be restricted by commercial trade and investment treaties. Canada should shield the health care system from any such restrictions agreed at the WTO.

Securing permanent and effective safeguards

Since the Canada-U.S. Free Trade Agreement (FTA) in the mid-1980s, Canada has been one of the leading proponents globally of trade and investment treaties that are universal in coverage and range beyond traditional border trade issues to include new rules on investment, services, standards-setting and intellectual property protection.

Recognising the potential conflict of these new types of agreements with Canadian health care, Canadian negotiators have relied on country-specific exceptions to limit the impact of trade and investment agreements on the Canadian health care system. These country-specific exceptions or reservations are intended to create a safe haven for Canadian health care, while allowing Canada to aggressively support strong "state-of the-art" trade and investment agreements.

Another, arguably more secure, approach to safeguarding health systems in Canada and around the world would be to address the conflict at its source, by changing the rules to be less intrusive and/or writing more effective exceptions for health care systems into the basic architecture of the treaties themselves.

Country-specific reservations have significant shortcomings. First, they can be removed unilaterally by any future Canadian federal government. Once removed, they can not be reinstated and are eliminated forever. While there is currently a strong multi-partisan consensus that Canadian health care should be insulated from trade rules, it can't be assumed that this will endure indefinitely. Debate over health policy is lively and sometimes fractious. There are strongly differing perspectives: particularly on the role of private and for-profit financing and provision. A single federal government devoted to a private market approach could unilaterally reduce or even eliminate reservations under NAFTA and Canada's other trade agreements. Future governments would then find their hands tied.

By contrast, generally agreed exceptions or safeguards are permanent features of a treaty that can only be changed with the agreement of all parties. They are far more likely to endure over time. Canadians deserve permanent protections for health care that are embedded in the very foundation of its international trade and investment agreements. Such exceptions could only be changed with the consent of all parties to an agreement and are therefore far more likely to survive the ideological ebbs and flow of domestic politics.

Canadian trade officials should be directed to pursue a self-defining exemption for health policies in all its international trade and investment agreements. There are at least two models for such an exception in Canada's existing treaties. The strongest are the national security exceptions that occur in NAFTA (Article 2102), the GATT (Article XXI) and the GATS (Article XIVbis). These exceptions ensure that any measure a government itself considers essential to its national security interests is excluded from the treaty.

A second type of self-defining exception is that for prudential measures related to financial services regulation, such as occurs in NAFTA Article 1410 and the GATS Annex on Financial Services. Again, measures deemed by a government itself to be essential to regulate or to ensure the integrity and stability of its financial system are excluded. An intermediate step that is sometimes employed is to set up an independent panel of financial services experts whose role is confined to determining whether the measure at issue is a bona fide financial services measure. If so, then the exception can be invoked. While this exception is not so strong as the national security model, a broad exception for prudential regulation of health would represent considerable progress.

The current pastiche of country-specific exceptions should be regarded as a second-best solution, as stopgap measures until more permanent protection can be secured. They must be strongly defended, but Canadian trade policy-makers should be mandated to

secure more effective and permanent protection by changing these agreements themselves.

Reforming the trade policy-making and negotiating processes

One of the most highly effective reforms to Canadian trade policy-making would be to open up the negotiating process to greater participation and full public scrutiny. Trade negotiators, whose primary mandate is to expand export markets, cannot reasonably be expected to be fully cognizant of the intricacies of the Canadian health care system nor should they be entrusted with the task of safeguarding health policy. This can better be achieved by opening up the trade policy making and negotiating processes to health professionals, advocates, and the general public.

Canada's trade and investment treaties are negotiated by the federal government, while most of its health care system is administered by the provinces. More direct involvement of provincial health officials, along with Health Canada officials, in trade negotiations would ensure that those with hands-on experience of the intricacies of the operation and regulation of health care are at the table to spot potential problems.

Currently, the main private sector consultative bodies used by the federal government are heavily dominated by commercial interests. For example, the Medical and Health Care Products and Services Sectoral Advisory Group on International Trade (SAGIT) is composed almost entirely of senior business executives from Canada's commercial health interests. Representation on the SAGIT should be restructured to fully reflect the reality of the health care sector and its major players, including hospitals, health practitioners, users and public interest advocates.

It is inappropriate that a body so influential in formulating Canada's negotiating position is dominated by businesses whose export interests are negligible in relation to the importance of the domestic health care sector. There are no representatives from hospitals, medical associations, nurses' organizations, trade unions, consumer organizations, health regions or academic health researchers. Participation on the SAGIT should be broadened to include all major sectors involved in Canadian health care system as well as public interest advocates. If there had been greater input from Canadian health professionals, hospital administrators, trade unions, and independent health policy experts into Canada's GATS offers during the Uruguay round, it is quite likely that Canada could have avoided its regrettable decision to list health insurance under the GATS.

Recommendations:

- **Canada should urgently pursue a binding interpretation of NAFTA's investment chapter to ensure that the meaning of expropriation is narrowed to be consistent with Canadian law.**

- **Canada should pursue a narrow meaning of expropriation in the proposed FTAA and any other future agreements.**

- **Canada should withdraw its support for investor-state dispute settlement procedures that allow investors to directly challenge public policy measures.**

- **Canada should withdraw its 1994 GATS commitment covering health insurance by invoking GATS Article XXI.**

- **The Canadian government should not make any further GATS commitments directly covering health services.**

- **There should be a health impact assessment of the GATS request-offer process that should include public participation and dialogue.**

- **GATS requests received by Canada and its GATS offers should be made public.**

- **Canada should shield the health care system from any GATS restrictions on non-discriminatory domestic regulation agreed at the WTO.**

- **Canada should apply horizontal limitations protecting its flexibility over health policy to all its future GATS offers.**

- **Canadian trade officials should be directed to pursue a self-defining exemption for health policies in all its international trade and investment agreements.**

- **The federal government should more directly involve Health Canada and provincial health officials in international trade negotiations to ensure that experienced health care administrators and regulators are involved at the earliest opportunity.**

- **Canada should work to open up the trade negotiations process to enable health care consumers, advocates, researchers and the public to be informed and voice their views to government. The federal government should propose adoption of the UN treaty making process in which negotiating sessions are open and all documents are public.**

- **As a first step, the federal government should make public all its proposals and all requests for Canadian commitments in the WTO, FTAA and other trade negotiations.**

- **The composition of the federal government SAGIT for Medical and Health Care Products and Services should be restructured to fully reflect the reality of the health care sector and its major players,**

including hospitals, health practitioners, users and public interest advocates.

10. Strengthening coherence in health, trade and foreign policy

Greater coherence of trade and foreign policies with Canadian health policies and the values that underpin our Medicare system would strengthen both our domestic policy flexibility and our capacity to respond to new global health challenges.

Maintaining domestic policy flexibility is not only a matter of shielding Canadian health measures from internationally-imposed constraints, but also requires collaborative international action to address conditions affecting the health of Canadians together with the health of other peoples. In this way, international institutions and legal frameworks can complement and enhance our domestic capacity to regulate health services in the public interest. In turn, these multilateral health institutions may themselves need to be shielded from the potentially distorting influence of commercial trade treaties.

Globalization makes the health of Canadians increasingly interdependent with the health of other nations' peoples. Increased global commerce brings with it new threats to health through greater exposure to new or newly resistant diseases and regional insecurities brought on by heightening disease inequalities. Conflicts in poor countries not only produce disease; they often are caused by, or exacerbated by, disease. These conflicts heighten global security risk. Some of the diseases that grow in human scale also grow in treatment resistance, and can be less than a day's plane trip away from Canada (Blouin, Foster and Labonte 2002).

In a review of globalization and public health issues, senior World Health Organization (WHO) staff note that the "growing number of international health initiatives reflect a widespread awareness of the need for domestic action to be complemented by cross-sector and cross-border action" (Drager and Beaglehole 2001; see also Chanda 2000; Cornia 2001; Dollar 2001; Lipson 2001; Woodward et al. 2001). It is time for Canada to establish a concerted, coherent approach to health in our domestic, trade and foreign policies.

A coherent approach to health requires, most fundamentally, a clearly established framework of values to guide specific initiatives and policy choices. Also important are measures to improve accountability and strengthen collaboration across sectors and between governments, both domestically and internationally. These governance initiatives can help Canada to respond coherently to an ever changing international environment and evolving domestic interests. The following sections recommend steps the federal government can take to strengthen policy coherence by:

- founding Canada's approach to health on a commitment to health as a human right;

- strengthening governance in the development of health policy, both domestically and internationally; and
- asserting Canadian health values in our participation in international health initiatives.

Health as a human right

Canadian foreign policy in health should be founded on a commitment to health as a human right. The right to health is recognized in the *Universal Declaration of Human Rights* and the *International Covenant on Economic, Social and Cultural Rights*, as well as a number of other international and regional human rights covenants. In these treaties the global community recognizes the same universalistic values as are embedded in Canada's health care system. Thus, our domestic commitment to equity in, and access to, health care, can be projected abroad by championing health as a human right.

Recommendation:

Canada can take a number of practical steps to promote the realization of health as a human right internationally:

- **Support the capacity of other nations to respect, protect and fulfill the right to health by, among other things, ensuring that Canadian foreign policy initiatives -- including our participation in international trade negotiations --do not constrain health policies of other nations nor impede the ability of other governments to respond to changing health needs and conditions.**

- **Strengthen Canadian support for the major international human rights bodies – the UN Commission on Human Rights and the UN Committee on Economic, Social and Cultural Rights. As well as providing increased financial support for these bodies, Canada should:**
  - **contribute to the work of the Special Rapporteur, who has recently been mandated to prepare recommendations to the *Commission* on measures to promote and protect the right to health; and**
  - **support measures to better implement findings of the *Committee* and the development of a protocol permitting individual citizens to report violations of the *International Covenant on Economic, Social and Cultural Rights*.**

- **Recognize the primacy of international human rights law over other areas of international law, including international trade and investments treaties. Canada should work with other nations to develop an effective legal mechanism for reconciling conflicts between human rights and other internationally recognized obligations.**

- **Include government officials with expertise in international human rights law in developing Canada's trade negotiations objectives, with a mandate to ensure coherence with our human rights commitments.**

Governance in health policy

Improved governance is needed to help Canada respond coherently to new health challenges and a continually evolving international context (Drache and Ostry 2002). Governance measures include improving accountability in the policy development process and strengthening coordination between researchers, practitioners and policy makers in different fields, both domestically and internationally.

Canada's ability to maintain our domestic health policy flexibility can be enhanced by collaborating with other nations with common interests. One approach, which has been effective in other sectors, is to form a group of "like-minded" nations which work in concert at the international level. By sharing information and developing common positions in international trade negotiations and other fora, a "like-minded" group of nations committed to achieving "Health for All" could enhance the ability of its member nations to maintain national health care systems founded on universalistic principles and strong public interest regulation.

One specific objective of such a group could be to promote an international legal accord that recognizes the diversity of national health systems and affirms the right of national governments to maintain distinctive health policies. Canada, France and other nations support the development of a 'New International Instrument on Cultural Diversity', which has strong support from cultural producers (Bernier and Ruiz Fabri 2002). A similar international health accord would seek to maintain the national policy flexibility needed to achieve "Health for All." It would, at a minimum, recognize a range of health-related measures that should be shielded from international trade commitments. A more ambitious approach would be to develop a framework convention which (like the Convention on Biological Diversity) establishes a set of shared principles and is the basis for binding protocols in specific areas of health.

Recommendations:

- **Canada should promote the formation of a group of "like minded" nations committed to maintaining national health care systems founded on universalistic principles and strong public interest regulation.**

- **Canada should propose an international accord to affirm the right of governments to maintain distinctive national health policies, modelled on**

the approach developed for a New International Accord on Cultural Diversity.

Key international health initiatives

Guided by its commitment to health as a human right, Canada should continue to strengthen the international legal and institutional basis for collaboration on specific health issues. This report can only touch on some of the key initiatives which enhance our capacity to protect Canadians from communicable disease and exposure to dangerous products, while also improving the health of other peoples.

International Health Regulations. Canada and other members of the WHO have commitments under the International Health Regulations to monitor and report outbreaks of certain designated diseases (cholera, yellow fever and plague). National governments can be required to impose temporary trade restrictions and other measures to control the spread of a disease outbreak.

Since 1995, WHO members have been negotiating revisions to the International Health Regulations, the only legally-binding international health convention currently in existence, to strengthen enforcement, reduce disincentives to compliance and address the growing significance of new and re-emergent communicable diseases.

Revised regulations would enhance the ability of Canadian governments to protect public health by, among other things, reducing the risk that measures to control pathogens are challenged as an unwarranted restriction on trade. Proposed revisions would update the Regulations' definition of what constitutes an urgent international health risk (Fidler 2001). Also important is the need for mechanisms to strengthen the public health surveillance capacity of developing countries (Aginam 2002).

Recommendations:

- **Canada should give priority to renewing the International Health Regulations and urge other nations to support a strengthened international accord, complemented by measures to support improved public health surveillance in developing countries.**

- **Revisions should, among other things, affirm the competence of the World Health Organization in determining legitimate international health risks involved in trade disputes**.

Framework Convention on Tobacco Control (FCTC). Also under negotiation at the WHO, the FCTC is intended to circumscribe the global spread of tobacco and tobacco products. It is hoped that a set of common principles and objectives will be adopted by the World Health Assembly by May 2003. These will provide the framework for the negotiation of legally binding protocols with specific obligations in areas such as pricing,

taxation, advertisement/sponsorship, packaging, protection of children and adolescents and product regulation.

A key issue in these negotiations is the potential for conflict between trade rules and tobacco control measures. There is strong support for provisions that would ensure that measures to control tobacco are not impeded by trade obligations (Callard, Collishaw and Swenarchuk 2001). These provisions would help to reduce the risk of trade challenges, such as the threat of compensation claims that tobacco manufacturers have made in an effort to stall Canadian legislation on cigarette packaging.

Recommendations:

- **Canada should support provisions in the FCTC to ensure that tobacco control measures supersede trade rules where there is a conflict.**

- **Canada should end public support for the export of tobacco products, including ending the participation of tobacco companies in Team Canada trade missions.**

Migration of health workers. International collaboration is also needed to address inequities created by international recruitment of medical workers. The health systems of many poor nations are undermined by the movement of expensively trained doctors and nurses to wealthy northern countries, including Canada. One estimate puts the annual loss to southern countries at $500 million in education costs alone.

A collaborative international approach would establish a basis for providing compensation for these costs, recognize measures source countries can take to retain health personnel, and contribute to strengthening national health systems. These provisions would counterbalance provisions in the GATS that seek to remove restrictions on the cross-border movement of individual service providers. An international accord of this kind may restrict the ability of Canadian health authorities to respond to immediate needs by recruiting staff from abroad. It would, however, help to plan longer-term human resource strategies by establishing a more stable and predictable basis for international migration of health workers.

Recommendations:

- **Canadian governments and health authorities at all levels should follow the UK National Health Service and commit that they will not actively recruit health professionals from developing countries.**

- **Canada should promote collaborative efforts to address inequities created by the migration of health workers by:**
- **reimbursing developing countries for their training cost investments in emigrating professionals;**

- **ensuring better domestic health human resource management by developed countries; and**
- **increasing financial aid to public health systems in developing countries.**

Financing international action against communicable diseases. As a concrete action to support health as a right for all, the Canadian government can take greater international leadership by committing itself strongly to the intervention strategies and donor requirements identified by the extensively researched Commission on Macroeconomics and Health (WHO 2001). As the health of Canadians is increasingly linked to the health of citizens of other nations, Canada already recognises the importance of global health and invests resources in the provision of such public goods. However, to reflect our values of equity and access, greater investments are needed. Canada will also need to urge other donor countries to collaborate in this endeavour, given its relatively small economic weight. To attain the health targets of the Millennium Development Goals and to mobilize the resources to achieve them, strong political leadership will be required in Canada and abroad.

Canada currently funds initiatives to control the spread of communicable disease, including:

- *Global Fund to Fight AIDS, Tuberculosis and Malaria*. Canada invests considerable effort and funding to combat the spread of AIDS worldwide, especially in sub-Saharan Africa where HIV/AIDS infection is at pandemic levels. Canada has pledged US$ 100 million to the Global Fund established at the 2001 UN General Assembly Special Session on HIV/AIDS, where the Canadian delegation included NGO as well as government representatives.
- *Global Alliance for Vaccines and Immunization (GAVI)*. GAVI is a public-private partnership formed to combat preventable childhood diseases through immunization in the least developed countries. Three million children die annually of diseases that could be prevented by existing vaccines. Canada has committed $10 million over 3 years to the $US 1 billion global fund for providing vaccines and immunization equipment in least developed countries, where mortality from preventable childhood disease is highest.

Recommendations:

- **Canada should increase its contributions to the Global Fund and GAVI to help meet the target of a $US 1.5 billion annual increase recommended by the WHO Commission on Macroeconomics and Health.**

- **Canada should contribute to a separate "Global Health Research Fund" recommended by the WHO Commission on Macroeconomics and Health. With a target annual budget of $US 1.5 billion, the Fund would help to offset the 10/90 research gap in**

which 90% of health research is directed to health problems affecting the wealthiest 10% of the world's population.

- **Canadian government agencies, including Health Canada, the Canadian International Development Agency (CIDA), the International Development Research Centre (IDRC) and the Canadian Institutes for Health Research (CIHR), should deepen their collaboration in support of research on health issues affecting the majority world population.**

11. The Challenge: Putting health first

This report is based on the conviction that the actions of Canadians, in particular our collective actions through our elected governments, should—*and can*—influence events so as to improve the health and well-being of Canadians and of citizens around the world. In an era of increasing global economic integration, what is important, as Canadian economist Gerald Helleiner has argued, are the "terms on which countries and their governments … interact with the new global economy" (Helleiner 2000).
In our view, Canada's domestic and international actions should be based on the universalistic principle that health is a human right. Putting this principle in practice should be one of the "terms" of Canada's global interactions. This is indeed a significant challenge, one that requires clarity of vision and a consistency of approach—coherence—in the nation's domestic and international activities.

This report has focused on a lack of coherence in Canada's approach to health care on the one hand, and trade and foreign policy on the other, that commands an urgent remedy. If the underlying conflicts between Canadians' health care priorities and the commercial interests promoted in the most recent trade treaties are not addressed, the nation's health care system will come under increasing strain and the options for reform will be seriously diminished.

Fortunately, as this report emphasizes, there are many practical ways in which greater coherence between health and trade policy can be achieved. Governments should begin by acknowledging, rather than denying, that health care reform entails some risk of trade challenges. They should then fashion health reforms so as to derive maximum benefit from those limited safeguards that exist in trade treaties; this generally means minimizing the role of private financing and for-profit health care delivery. As this report suggests, fundamental changes to Canada's trade policy and commitments are also needed. Canadian governments at all levels should protect against trade-induced "regulatory chill" and instead should work assiduously to ensure that Canada's trade and foreign policy conform much more closely to Canadians' vital health care needs and hopes for the future—rather than the other way around.

There is a marked need for coherence in a different, equally important sense. Medicare's creation required governments to take decisive, principled action—often

despite intense opposition and powerful commercial interests—to serve the broader public interest. Today, Canadian health care reform demands the same decisive, principled action to meet Canadians' key priorities—despite the powerful commercializing bent of trade treaties—by putting health first.

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