
Have We Traded Away the Opportunity for Innovative Health Care Reform? The Implications of the NAFTA for Medicare

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The integrity of medicare depends on governments having flexibility to respond to the changing dynamics of the health care system. This article concludes that the *North American Free Trade Agreement* ("NAFTA") has potential to place constraints on the ability of Canadian federal and provincial governments to regulate freely.

The health care system is a mix of public and private interests. At its core, "medically necessary" hospital and "medically required" physician services are fully publicly financed, but often privately delivered. However, private financing is funding an increasing number of important goods and services such as drug therapy. Various proposals have been made for the reform of the health care system, including national insurance programs for prescription drugs and home care, and this article assesses some of these proposals in light of the NAFTA.

Canada has made reservations to the NAFTA to protect medicare but these reservations fail to recognize the public/private nature of the health care system, resulting in uncertainty as to what services are protected from application of some of the NAFTA's key provisions. The expropriation provision presents particular concerns for reform, as the reservations provide no protection from its application. Further, the dispute settlement process allows disputes to be heard away from the light of public scrutiny.

Canada should work towards a political solution to these concerns. In all relevant contexts, both the federal and provincial governments should clarify that their intention with regard to health care is to act for a "public purpose". The authors also emphasize the importance of international trade negotiators working with Health Canada officials to ensure appropriate treatment of health care in international trade negotiations.

L'intégrité de l'assurance-maladie dépend de la flexibilité qu'ont les gouvernements à réagir aux dynamiques changeantes du système de soins de santé. Cet article conclut que l'*Accord de libre-échange nord-américain* («ALÉNA») peut imposer des limites aux habilités des gouvernements fédéral et provincial à gouverner librement.

Le système de soins de santé est un mélange d'intérêts publics et privés. Au cœur de ce système, les fonds publics financent les services «médicalement nécessaires», alors que le secteur privé offre ces services. Les fonds privés financent un nombre croissant de biens et de services importants tels que la pharmacothérapie. Des programmes nationaux d'assurance pour les médicaments de prescription et les soins de santé à la maison figurent parmi les exemples des nombreuses propositions faites en vue de la réforme du système de soins de santé; cet article se penche sur quelques unes de ces propositions à la lumière de l'ALÉNA.

Les réserves énoncées à l'ALÉNA par le Canada afin de protéger l'assurance-maladie n'ont pas su reconnaître la nature publique et privée du système de soins de santé. Ainsi, l'incertitude règne quant à savoir quels services sont protégés. La disposition relative à l'expropriation soulève des inquiétudes précises quant à la réforme, car les réserves émises n'assurent aucune protection contre l'application de la réforme. De plus, la procédure pour les règlements de différends permet que les différends soient entendus hors de la portée d'un examen minutieux du public.

Le Canada devrait trouver une solution politique à ces problèmes. Les gouvernements fédéral et provincial devraient énoncer clairement leur intention d'agir dans l'intérêt du public dans le secteur de soins de santé. Les auteurs soulignent également l'importance de la collaboration entre les négociateurs du commerce international et les fonctionnaires de Santé Canada afin d'assurer le traitement adéquat de soins de santé dans le négociation des accords de commerce international.

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Revue de droit de McGill 2002

To be cited as: (2002) 47 McGill L.J. 747

Mode de référence : (2002) 47 R.D. McGill 747

Introduction

I. Canada's Health Care System

- A. *Medicare*
- B. *The Mix of Public and Private Interests in Canadian Health Care*
- C. *The Shifting Public and Private Mix: Recent Changes to Our Health Care System*
- D. *The Potential for Export of Health Care Services*
- E. *Proposals for the Reform of Medicare*

II. The NAFTA and Canadian Health Care Reform

- A. *The Relevant Provisions*
 - 1. National Treatment and Most-Favoured-Nation Treatment
 - 2. Expropriation
 - 3. Dispute Settlement
 - 4. Reservations
- B. *The NAFTA's Effect on Proposals for Reform*
 - 1. National Pharmacare and/or Home Care Programs
 - 2. Managed Competition Reform
 - 3. Internal Market Reform: Contracting Out to Competing Providers
 - 4. Primary Care Reform

Conclusion

Introduction

Canada's publicly funded health care system ("medicare") is the country's most cherished social program. It has been described as "iconic",¹ "'embedded' in Canadians' perceptions of their political culture,"² "a unifying force, a national obsession, and, not least, one of the few features that allows Canadians to differentiate themselves from their neighbours to the south."³ Despite its hallowed status, tensions within medicare are becoming increasingly obvious; the system is now frequently described as being in crisis.⁴ Being a system upon which all Canadians must rely, at least for "medically necessary" hospital and "medically required" physician services⁵ (for which there are few private options), the trials and tribulations of medicare are never far from the media spotlight and bedevil politicians of all political stripes.

The health care system is shaped by changing economic, political, and social circumstances. One of the most powerful economic and political forces of the past decade is globalization, encompassing the liberalization of international trade and investment. International trade agreements negotiated during the 1990s have trade and investment liberalization as their primary goals and have altered the context within which medicare must operate. The *North American Free Trade Agreement*⁶ ("NAFTA") aims to create a free trade area between the territories of Canada, the United States, and Mexico and is arguably the most important international trade agreement to date in terms of possible implications for medicare. The Canadian government's stated reasons for entering into the NAFTA include:

- Canada needs improved and more secure access to world markets to exploit our economic strengths.

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¹ B. Rae, "Is the Canadian Public Really Ready for Health Reform?" (paper presented at the Health Law and Policy Seminar Series, Faculty of Law, University of Toronto, 15 February 2001) [unpublished].

² A. Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton: Princeton University Press, 1998) at 173.

³ C.D. Naylor, "Health Care in Canada: Incrementalism under Fiscal Duress" (1999) 18:3 Health Affairs 9 at 24.

⁴ See e.g. P. Barnett, A. Coyne, C. Flood, D. Gratzner, P. O'Reilly, panelists, & M. Enright, moderator, "Medicare: Crisis, What Crisis?" *CBC This Morning* (broadcast 2 October 2000).

⁵ See *infra* note 14 and accompanying text.

⁶ *North American Free Trade Agreement between the Government of Canada, the Government of Mexico and the Government of the United States*, 17 December 1992, Can. T.S. 1994 No. 2, 32 I.L.M. 289 & 605 (entered into force 1 January 1994).

- More open access to foreign markets under fair-trade rules will help the Canadian economy become even more competitive. This will eventually pay off in more and better jobs in Canada, better deals for our consumers, and increased national wealth to help us support and improve our social programs.⁷

There are two sharply contrasting perspectives on the implications of the NAFTA for medicare. Critics argue that, rather than helping the government support and improve medicare, the NAFTA will force Canada to open up medicare to entry by foreign (particularly U.S.) service providers and commercial insurers.⁸ It is feared that such an opening of the health care market will inevitably result in the erosion of medicare and a slide into a U.S.-style system of health care driven by for-profit insurers and providers. By contrast, the federal government has given a number of assurances that the NAFTA protects the health care sector and therefore poses no threat to the integrity and sustainability of medicare.⁹

We assess which, if either, of these two contrasting perspectives is correct and closely examine Canada's obligations under the NAFTA in order to determine what constraints it might impose on various proposals for the reform of medicare. While we

⁷ Canada, Department of External Affairs and International Trade, *The NAFTA Manual: Focus on Issues: Canada and the North American Free Trade Agreement (NAFTA): Information Papers for Briefing Book/Media Kit and Public Info* (Ottawa: Department of External Affairs and International Trade, 1992), online: QL (NAFT).

⁸ See e.g. Gottlieb & Pearson, "International Trade Standards and the Regulatory Power of Governments at the end of the 20th Century—with Special Emphasis on Public Health Standards and the Canadian Public Health System" (October 1999), online: Canada Health Coalition <<http://www.healthcoalition.ca/gottlieb.html>> (date accessed: 1 November 2002); Canadian Federation of Nurses Unions, "Privatization of Health Care Position Statement" (February 1998), online: Canadian Federation of Nurses Unions <<http://www.nursesunions.ca/ps/privatization.shtml>> (date accessed: 1 November 2002); J. Nelson, "Dr. Rockefeller Will See You Now: NAFTA's Bitter Pill for Health Care Systems" *Z Magazine* 8:5 (May 1995) 25, online: *Z Magazine* <<http://zena.secureforum.com/Znet/zmag/allarticles1.cfm>> (date accessed: 1 November 2002).

⁹ See e.g. Canada, Department of Foreign Affairs and International Trade, Press Release 55, "Canada's Health Care System Protected under the NAFTA" (2 April 1996), online: DFAIT <<http://webapps.dfaite-maeci.gc.ca/minpub>> (date accessed: 1 November 2002). See also Canada, Standing Committee on Foreign Affairs and International Trade, *Evidence*, 36th Parl., 2nd Sess., Meeting No. 57 (14 June 2000) at 1540 (Hon. P.S. Pettigrew), online: <<http://www.parl.gc.ca/InfoComDoc/36/2/FAIT/Meetings/Evidence/faitev57-e.htm>> (date accessed: 1 November 2002) where the minister says, "As I have stated before, public health and education are not on the table in any international trade negotiations. My government will maintain our right and ability to set and maintain the principles of our public health and education. It is that simple. Those who wish to pick away at issues, to find threats in every trade agreement to our values and our social system, are simply wrong."

conclude that the NAFTA will not lead medicare to be privatized “United States-style”, the federal government’s assurances regarding the security of medicare paint an overly simplistic picture. The NAFTA provides some protection for medicare, yet still poses a number of roadblocks to reforms needed to modernize medicare, such as expanding health insurance coverage to prescription drugs and home care. In the absence of these reforms, and as the focus of health care moves away from physicians and hospitals towards, for example, drug therapy, medicare will slowly but surely be privatized.

In Part I we examine Canada’s health care system, its underlying values, and how it has changed in recent years. In so doing, we demonstrate the shifting mix of private and public interests that forms its basis. We then present the specific proposals for the reform of medicare that will be dealt with in this article. In Part II we turn to examine the NAFTA provisions that are of the most relevance to Canada’s health care system, paying special attention to Canada’s reservation under NAFTA Annex II and to the article 1110 expropriation provision, which applies regardless of reservations. We then go on to examine the impact of these provisions on various proposals for reform, and draw some conclusions as to what can be expected in the future regarding the impact of the NAFTA on medicare and what can be done to ensure Canada’s best interests.

I. Canada’s Health Care System

A. Medicare

A high level of government intervention characterizes Canada’s health care system. This is partly justified on the grounds that health care is subject to a number of market failures,¹⁰ but primarily government intervention is justified to ensure a distributive goal of access for all to important health services. Medicare is founded on the belief that most hospital and physician services should be distributed so that all Canadians have access to them according to medical need, and not according to their ability to pay. Medicare is distinguishable from other social programs where eligibility for benefits usually depends on some criterion of financial need (*i.e.* some form of income testing occurs). It also sharply contrasts with most other sectors of the Canadian economy where services are allocated according to the capacity to pay (*e.g.* someone with more money can buy more or higher quality goods and services, such

¹⁰ For discussion on market failure in health care systems, see C.M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000) c. 2 [hereinafter Flood, *International Health Care Reform*].

as cars, houses, or investment services), as people cannot generally buy more or higher-quality hospital or physician services within Canada.¹¹

The Constitution of Canada has been interpreted as giving the provinces exclusive jurisdiction over the insurance and supply of health goods and services.¹² The federal government, however, uses its spending powers to maintain some national standards, particularly with regard to access to services. The present vehicle used to achieve national access standards is the *Canada Health Act, 1984* ("CHA").¹³ The CHA protects and gives primacy to "medically necessary" hospital services and "medically required" physician services,¹⁴ and establishes the following five criteria that the provinces must comply with in order to obtain federal funding for such services: comprehensiveness,¹⁵ accessibility,¹⁶ universality,¹⁷ portability,¹⁸ and public administration.¹⁹ The CHA effectively prevents the development of a two-tier system through a

¹¹ See C.M. Flood, M. Stabile & C.H. Tuohy, "The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care" (2002) 12 *Health Matrix* 297; C.M. Flood & T. Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 *Canadian Medical Association Journal* 825.

¹² *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, ss. 92(7), 92(13), 92(16), reprinted in R.S.C. 1985, App. II, No. 5. See *Schneider v. R.*, [1982] 2 S.C.R. 112 at 137, 139 D.L.R. (3d) 417, where Dickson J. states: "This view that the general jurisdiction over health matters is provincial ... has prevailed and is not seriously questioned." See also *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. 624 at para. 24, 151 D.L.R. (4th) 577, La Forest J. [hereinafter *Eldridge*].

¹³ R.S.C. 1985, c. C-6.

¹⁴ *Ibid.*, s. 2. The terms "medically necessary" and "medically required" are not defined in the CHA. The provinces have discretion to decide which services are "medically necessary" as well as which ones are "medically required". This has an important bearing on what services are covered by provincial health insurance plans.

¹⁵ *Ibid.*, s. 9. Provincial plans are required to insure all insured health services delivered by medical practitioners, dentists, and hospitals.

¹⁶ *Ibid.*, s. 12(1). Insured health services are to be provided on uniform terms and conditions in a manner that does not impede reasonable access to those services by insured persons.

¹⁷ *Ibid.*, s. 10. Provincial plans must entitle all provincial residents to insured health services on uniform terms and conditions.

¹⁸ *Ibid.*, s. 11. Provinces must insure all residents within three months of arrival in the province. They must also cover the cost of services for insured persons temporarily absent from the province.

¹⁹ *Ibid.*, s. 8(1). Provincial insurance plans must be administered and operated on a non-profit basis by a public authority. For further discussion of the five criteria listed in the CHA, see C.M. Flood, "The Structure and Dynamics of Canada's Health Care System" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 5 at 18-24.

requirement that the federal government claw back from the provinces any amounts that patients pay in the form of user charges²⁰ and extra-billing.²¹

The *CHA*'s protection of hospital and physician services, however, no longer reflects the reality of the range of goods and services that are viewed as medically important.²² Goods and services not covered by the *CHA* include drugs used outside of hospitals, home care, and alternative and complementary therapies.²³ Indeed, the recent shift of health care out of hospitals and into the home, along with other important changes such as technological advancements and increased reliance on drug therapy, means that large portions of health care now lie outside the protection of the *CHA*. Most of the calls for the reform of medicare that we will examine in this article are in reaction to this shift. Matters are further complicated by the presence of the NAFTA and its potentially negative impact on health care reform. An analysis of the relevant NAFTA provisions therefore becomes important to an assessment of whether medicare can survive recent changes to the health care system given today's context of trade liberalization. In the next section we begin by describing the private and public mix that forms the basis of the health care system. Describing this mix provides us with a framework within which to understand recent changes to the system, and its nature becomes especially relevant when we later assess the potential impact of the NAFTA on health care reform.

B. The Mix of Public and Private Interests in Canadian Health Care

Canadians are often surprised to find out that over thirty percent of total expenditure on health comes from private sources (private insurance and out-of-pocket payments).²⁴ They are even more surprised to find out that prescription drugs used outside of hospitals are not protected by the *CHA* and that, as a consequence, over sixty-six percent of spending on these drugs comes from private sources.²⁵ Private financing also plays a very large role in respect of dental services, vision care, home care, as

²⁰ *CHA, ibid.*, s. 19. A "user charge" is any charge imposed by a province for an insured health service that is not payable, directly or indirectly, by the provincial health care insurance plan (*ibid.*, s. 2).

²¹ *Ibid.*, s. 18. "Extra-billing" means any charge to patients for insured services that is above the amount covered by the health care insurance plan of a province. *Ibid.*, s. 2.

²² The definitions date back to the inception of medicare in the 1950s. See *Hospital Insurance and Diagnostic Services Act*, S.C. 1957, c. 28; *Medical Care Act*, S.C. 1966, c. 64. These acts were simultaneously replaced by the *CHA, ibid.*, in 1984.

²³ See Sections I.B. and I.C. below. We return to this issue again in the context of the need for the reform of the *CHA* and the potential impact of the NAFTA in that regard.

²⁴ OECD, *OECD Health Data 2000: A Comparative Analysis of 29 Countries* (Paris: OECD, 2000).

²⁵ See Canadian Institute for Health Information, *Drug Expenditures in Canada 1985-2000* (Ottawa: Canadian Institute for Health Information, 2001) at 8.

well as complementary and alternative drugs and therapies (e.g. services provided by chiropractors, homeopaths, and naturopaths, as well as the purchase of herbal and vitamin supplements).²⁶

It is important to distinguish the financing of health care services from their delivery. The method of financing has important ramifications in terms of access to services, since private financing, all other things being equal, means that access is based on willingness and capacity to pay and not on the basis of relative need. By contrast, the means of delivery (e.g. for-profit clinics) does not affect access so long as services are publicly funded. Thus, while the privatization of finance clearly raises access and equity concerns, the privatization of delivery does not necessarily raise the same concerns—although there may in some cases be concerns about the quality of care delivered by for-profit as opposed to non-profit providers.²⁷

While popularly described as a single-payer, public system, Canada's health care system is in fact characterized by a wide range of public/private relationships (see Table 1). At the core of the system, "medically necessary" hospital and "medically required" physician services are fully publicly funded. Looking at the *delivery* side, however, and contrary to popular understanding, very few publicly funded services are actually delivered by public (government-owned) hospitals or other public entities. In fact, publicly funded services are for the most part delivered by private non-profit organizations (such as hospitals)²⁸ or private for-profit professionals (such as physi-

²⁶ See Canadian Institute for Health Information, *Health Care in Canada 2000: Annual Report* (Ottawa: Canadian Institute for Health Information, 2000) at 19, 38, online: Canadian Institute for Health Information <<http://secure.cihi.ca/cihiweb/products/Healthreport2000.pdf>> (date accessed: 1 November 2002) [hereinafter CIHI, 2000 *Annual Report*]. The Canadian Institute for Health Information ("CIHI") notes that the amount spent on alternative drugs and therapies is not known but that studies in other countries suggest it may be significant. See e.g. M. Lau, "Acupuncture Petition Seeks Health Coverage" *Calgary Herald* (18 December 2000) B1. The article reports how Calgary acupuncture practitioners launched a petition to persuade the province to include their services in medicare coverage, and suggests that many people will be unable to continue acupuncture treatment because of financial constraints.

²⁷ For a recent study demonstrating poor outcomes in U.S. for-profit hospitals, see P.J. Devereaux *et al.*, "A Systemic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-For-Profit Hospitals" (2002) 166 *Canadian Medical Association Journal* 1399.

²⁸ Although hospitals are private institutions, provincial governments play a large role in their regulation and funding, and as a result it is often difficult to differentiate them from government-owned hospitals. See A. Blomqvist, "Conclusion: Themes in Health Care Reform" in A. Blomqvist & D.M. Brown, eds., *Limits to Care: Reforming Canada's Health System in an Age of Restraint* (Toronto: C.D. Howe Institute, 1994) 399 at 416.

cians).²⁹ Outside the core of full public funding for all there are some goods and services that are only publicly insured (in full or in part) for some groups. For example, most provinces provide coverage for prescription drugs for those aged over sixty-five and those on welfare, albeit subject to a range of different user charges. With regard to delivery, there is again a wide and varied range of providers with, for example, drugs being supplied by for-profit private corporations. Most provinces also publicly fund a limited range of home care services for those whose family members cannot provide the care they need in the home. These services are delivered by a mix of private for-profit providers (*e.g.* home care services in Ontario), non-profit providers, and government employees.³⁰ Outside the realm of public funding of any sort are health care services that are fully privately financed and delivered by either for-profit or non-profit private entities (*e.g.* cosmetic surgery, dental services, laser eye surgery, and in vitro fertilization services).

TABLE 1: FINANCING AND DELIVERY OF HEALTH CARE SERVICES IN CANADA

Financing	Delivery	Example of Health Care Services
Public	Public	Public health departments
	Private (non-profit)	Hospitals
	Private (for-profit professional groups)	Physicians
	Private (for-profit firms)	Home care in Ontario; some private facilities in Alberta
	Private (non-profit)	Charitable organizations, <i>e.g.</i> the Victorian Order of Nurses
Private	Private (for-profit professional groups)	Dentists; physicians providing services not covered by the CHA
	Private (for-profit firms)	Long-term care facilities; laser eye surgery clinics

²⁹ Private physicians are for-profit providers to the extent that they are entitled to the revenues of their practice; they are expected, however, to offer and recommend services that are in their patients' best interests. See R.G. Evans *et al.*, *Private Highway, One-Way Street: The Decline and Fall of Canadian Medicare?* (Vancouver: University of British Columbia, Centre for Health Services and Policy Research, 2000), online: Centre for Health Services and Policy Research <<http://www.chspr.ubc.ca/hpru/pdf/20003D.PDF>> (date accessed: 1 November 2002).

³⁰ See *e.g.* Canadian Home Care Association, "Nova Scotia Fact Sheet—Final Version", online: Canadian Home Care Association <<http://www.cdnhomecare.on.ca/doc/FactSheets/NSFACTS.pdf>> (date accessed: 1 November 2002). Some home care services in Nova Scotia are delivered by the Department of Health's employees. Twenty-five percent of nursing-home care staff are directly employed.

C. The Shifting Public and Private Mix: Recent Changes to Our Health Care System

Canada's health care system is a dynamic mix of public and private interests, and the growing variety of public/private arrangements possible (such as contracting out, exclusive contracts, licensing, and joint ventures) makes it difficult to distinguish what is public from what is private.³¹ In addition, medicare has undergone significant changes in recent years due to factors such as fiscal constraints on the federal and provincial governments,³² changing medical practices, development of new technologies, changing demographics, and changing expectations and demands.

Provincial governments have delisted or deinsured some health services from time to time due to fiscal constraints. That is, they have decided that certain health services previously considered "medically necessary" or "medically required" are no longer to be categorized as such and thus do not qualify for public funding. Fiscal constraints have also made provincial governments reluctant to cover new technologies.³³ For example, public funding for breast cancer testing was halted recently in British Columbia due to a complaint by Myriad Genetic Laboratories. Myriad argued that domestic providers of certain predictive tests were in breach of Myriad's patent to the BRCA1 and BRCA2 gene sequences—sequences identified by the tests—and that provincial governments must therefore purchase those tests from Myriad or its licensees. The Ontario government has said that it will fight Myriad's claim and continue to provide predictive testing. Reportedly, the Ontario government pays \$800 per test

³¹ For example, in considering whether the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 applies to a hospital's actions, the Supreme Court of Canada found that "the *Charter* applies to private entities in so far as they act in furtherance of a specific governmental program or policy. In these circumstances, while it is a private actor that actually implements the program, it is government that retains responsibility for it." *Eldridge*, *supra* note 12 at para. 42.

³² The proportion of provincial health expenditures provided as a direct cash transfer from the federal government fell from 50 percent at the inception of medicare to 30.6 percent in 1980. It fell again to 21.5 percent in 1996 and to much lower levels in wealthier provinces. Naylor, *supra* note 3 at 12. If one considers tax point transfers, however, the financial burden on the provinces is less than the reduced cash support suggests. The CIHI reports that in 1995 the federal share of health care spending (including tax point transfers) was 33 percent. CIHI, *2000 Annual Report*, *supra* note 26 at 18.

³³ See e.g. B.C. Cancer Agency, "Policy Change: Hereditary Breast/Ovarian Cancer Genes (BRCA1 and BRCA2)" (2002), online: B.C. Cancer Agency <<http://www.bccancer.bc.ca/PPI/PreventionandScreening/HereditaryCancerScreening/HereditaryCancerProgram2.htm>> (date accessed: 1 November 2002).

from domestic providers, whereas the same test done by Myriad or its licensees would cost \$3850.³⁴

Over the last five years, more than 275 hospitals in Canada have been either closed, merged, or converted to other types of care facilities.³⁵ The proportion of total health care spending on hospitals declined from 44.7 percent in 1975 to an estimated 31.8 percent in 2000.³⁶ This decline has been due not only to fiscal constraints in the public sector but also to the increased use of drug therapy, gene therapy, new forms of medical equipment and aids, as well as new forms of health care delivery such as home care and telehealth. Because services not provided in hospitals or by physicians fall outside the protections of the *CHA*, the result of these changes has been an increased reliance within the system on private financing. This process of shifting care out of hospitals and into homes is described as “passive privatization”.³⁷

In order to help cover the costs of private care many Canadians hold private insurance. As of December 2000, 22 million people had some form of private health insurance³⁸ to provide coverage for a range of services, including dental expenses, semi-

³⁴ Ontario, Ministry of Health and Long-Term Care, “Myriad Gene Patent Issue” (Speech by Hon. T. Clement, 19 September 2001), online: Ontario Ministry of Health and Long-Term Care <http://www.gov.on.ca/health/english/news/speech/sp_091901_tc.html> (date accessed: 1 November 2002); C. Perkel, “Ontario Defies U.S. Gene Company over Cancer Test, Arguing Health Care at Risk” *Canadian Press Wire Service* (19 September 2001), online: QL (CPN).

³⁵ Canadian Institute for Health Information, *Health Care in Canada 2001* (Ottawa: Canadian Institute for Health Information, 2001) at 27, online: Canadian Institute for Health Information <<http://secure.cihi.ca/cihiweb/products/Hlthrpt2001.pdf>> (date accessed: 1 November 2002) [hereinafter *CIHI, 2001 Annual Report*].

³⁶ *Ibid.* at 75.

³⁷ Tuohy, Flood, and Stabile note that the process of passive privatization is largely responsible for the decrease in the public share of total health expenditure in Canada. C.H. Tuohy, C.M. Flood & M. Stabile, “How Does Private Finance Affect Public Health-Care Systems? Marshalling the Evidence from OECD Nations” (2000) 67:9 *Ontario Medical Review* 14.

³⁸ Canadian Life and Health Insurance Association, “Facts and Figures: Canada and Out of the Country”, online: Canadian Life and Health Insurance Association <<http://www.clhia.ca/e4.htm>> (date accessed: 1 November 2002). The proportion of Canadians with private insurance has doubled since 1971, while the proportion of expenditures covered by private insurance has tripled. See Tuohy, Flood & Stabile, *ibid.* at 39. A study undertaken by the CIHI found that in 1998/1999 Canadians with a high income and education level were far more likely to have some form of private insurance than those with a low income and education level. For example, the percentage of Canadians with private insurance for prescription drugs ranged from 58 percent for those Canadians in the lowest income bracket to 87 percent for those in the highest income bracket. Similarly, 71 percent of Canadians with less than high school education had some insurance for prescription drugs, while 80 percent of those with university education had such insurance. See CIHI, *2000 Annual Report*, *supra* note 26 at 21.

private or private hospital rooms, prescription drugs (to the extent that they are not publicly funded), special duty nursing, paramedical services, ambulance services, crutches and other appliances, wheelchair rental, vision care, acupuncture, chiroprody, and home care (again, to the extent that it is not publicly funded).³⁹

Two increasingly important areas of health care that are not fully publicly funded pursuant to the *CHA* are home care⁴⁰ and drug therapy. Home care has been defined 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."⁴¹ While home care is not covered as a "medically necessary" hospital or "medically required" physician service under the *CHA*, each province and territory has some kind of publicly funded home care program. The provision of home care varies significantly from province to province, however, resulting in significant disparities in access and entitlements across the country.⁴²

As home care is not covered by the *CHA*, there is nothing to prevent the development of a two-tier system where those people with sufficient resources can buy more services or services of a higher quality in the private sector. People look to privately financed home care for a variety of reasons: they may not be eligible for publicly funded services; they may require additional services beyond those covered by the public system; they may wish to purchase services perceived as being of a higher quality than those provided in the public system; or they may not wish to submit to official home care assessments.⁴³ Home care purchased in the private sector may be paid

³⁹ Insurance plans that cover these services are described as "extended health coverage" or "supplementary health coverage" plans. For example, Liberty Health's extended health care plan includes coverage for services provided by chiropractors, chiropodists, osteopaths, naturopaths, podiatrists, massage therapists, acupuncturists, psychologists, and physiotherapists; prosthetic appliances; and durable medical equipment. Where any of these services are financed by public plans, payment will only be made once the government plan maximum has been reached. Online: Liberty Health <<http://www.coverme.com>> (date accessed: 1 November 2002).

⁴⁰ It is projected that by 2026, home care expenditures will have grown by 80 percent. P. Coyte & P. McKeever, "Home Care in Canada: Passing the Buck" (2001) 33:2 *Canadian Journal of Nursing Research* 11 at 19.

⁴¹ Health Canada, *Report on Home Care* (Ottawa: Federal-Provincial-Territorial Working Group on Home Care, 1990) at 2. Home care services include medical services as well as community and social services such as social work and homemaking.

⁴² Between 1997 and 1998, home care expenditure, as a percentage of total public health spending, ranged from as low as 1.95 percent, 2.3 percent, and 3 percent in Prince Edward Island, Quebec, and Alberta, respectively, to as high as 5.1 percent in Ontario and Newfoundland. See Coyte & McKeever, *supra* note 40 at 18.

⁴³ See generally Health Canada, "Home Care in Canada 1999: An Overview", online: Health Canada <<http://www.hc-sc.gc.ca/homecare/english/profil.html>> (date accessed: 1 November 2002).

for by either out-of-pocket payments or private insurance. Recent media reports have highlighted the growing and unmet demand for home care services.⁴⁴ A 1999 Price-waterhouseCoopers poll found that eleven percent of recently discharged people who needed help at home did not receive it and that the average out-of-pocket expense was \$407 a week when home care services had to be purchased.⁴⁵ It is not surprising, then, given the increasing demand for and the fragmentation of funding for home care across the country, that a number of calls have been made for the implementation of a national publicly funded home care program.

Drug therapy is a growing component of every stage of health care: primary, emergency, acute, outpatient, home, long-term, and self-care.⁴⁶ While recognized as an important aspect of health care, drug therapy is only treated as a “medically necessary” service under the *CHA* when provided in hospitals. All provinces therefore cover the drug costs of in-patient care,⁴⁷ but coverage for drugs used outside hospitals varies across the provinces. Most provinces provide prescription drugs for seniors and welfare recipients, albeit subject to a range of different user charges. A number of provinces (British Columbia, Saskatchewan, Manitoba, and Quebec) provide some coverage to all residents, but with substantial user charges in the form of copayments or deductibles.⁴⁸

[hereinafter Health Canada, “An Overview”]. It seems that such a “two-tier” system is already developing. See e.g. Liberty Health’s “Home Care PLUS” insurance plan, *supra* note 39, which focuses exclusively on home care and provides coverage for a number of services, including nursing care, home health aid, physical therapy, occupational therapy, speech therapy, social workers and clinical psychologists, ambulation and exercise, personal care, and home management services.

⁴⁴ *The Toronto Star*, for example, reported that community care access centres in Ontario were struggling with inadequate budgets and were under intense pressure to meet the needs of an aging population. It also reported some people having to pay thousands of dollars for private care. R. Daly, “Home Sweet Profit” *The Toronto Star* (22 March 1998) F1, F7. See also G. Smith, “Cuthacks Kill Diploma Dream” *The Globe and Mail* (11 July 2001) A17.

⁴⁵ A. Picard, “Home Health Care: Only If You Can Afford It” *The Globe and Mail* (6 December 1999) A1. In addition, one-third of caregivers reported that their charges were receiving inadequate assistance because of government-imposed caps on hours of care and insufficient family resources to purchase supplemental care privately.

⁴⁶ Institute for Research on Public Policy, Task Force on Health Policy, *Recommendations to First Ministers* (Montreal: Institute for Research on Public Policy, 2000) at 35, online: Institute for Research on Public Policy <<http://www.irpp.org/newsroom/archive/2000/0907pape.pdf>> (date accessed: 1 November 2002).

⁴⁷ The federal government covers full costs for status Indians, military personnel, penitentiary inmates, and veterans.

⁴⁸ The National Forum on Health reported that deductible amounts in the above-mentioned provinces are set at such a level that relatively few residents will actually receive any reimbursement. National Forum on Health, “Directions for a Pharmaceutical Policy in Canada”, (Joint Report by the

The reduction of in-hospital care, where drugs are free to patients, has led to an increase in out-of-pocket drug costs for many patients. Many Canadians must rely on their own financial resources or private insurance to cover the cost of prescription drugs. In 2001, sixty-one percent of retail drug sales were paid for by private sources.⁴⁹ A recent study found that ten percent of the Canadian population has no drug insurance at all, and another ten percent is underinsured, meaning that they are reimbursed less than thirty-five cents on the dollar.⁵⁰ As we will discuss, a number of proposals have been put forward to ensure coverage for prescription drugs for all Canadians. Before examining these reform options, however, we will briefly address export initiatives on the part of the federal government and other bodies that have the potential to alter the public/private mix of the health care sector fundamentally.

D. The Potential for Export of Health Care Services

Recently, the government has become aware of opportunities for Canadian health care goods and services providers to expand into foreign markets. Any moves to capitalize on such opportunities may have NAFTA implications. Although not strictly a proposal for reform, the potential for export of health care goods and services, when considered in relation to the NAFTA, raises concerns regarding the potential *inadvertent* reform of domestic health care policy.

To date, the health sector has contributed in a very minor way to the development of world trade. The level of international trade in health services is gradually increasing, however, largely as a result of two factors.⁵¹ First, regulatory regimes in a number

Striking a Balance and Evidence Based Decision-Making Working Groups) in Public Works and Government Services Canada, *Canada Health Action: Building on the Legacy*, vol. 2 (Ottawa: National Forum on Health, 1997) at 3, online: National Forum on Health <<http://www.nfh.hc-sc.gc.ca/publicat/finvol2/pharm/back.htm>> (date accessed: 1 November 2002) [hereinafter National Forum on Health, "Directions"]. Further, a study in Quebec found that the introduction of cost-sharing for essential and non-essential drugs among elderly persons and welfare recipients resulted in reduced use of essential drugs. Higher rates of serious adverse events and emergency visits were associated with these reductions. R. Tamblyn *et al.*, "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons" (2001) 285 *Journal of the American Medical Association* 421.

⁴⁹ Canadian Institute for Health Information, *Health Care in Canada 2002* (Ottawa: Canadian Institute for Health Information, 2002) at 85, online: Canadian Institute for Health Information <<http://secure.cihi.ca/cihiweb/products/HR2002eng.pdf>> (date accessed: 1 November 2002).

⁵⁰ A. Picard, "Six Million Lack Proper Drug Plan, Study Finds" *The Globe and Mail* (14 March 2001) A1. The study in question was commissioned by the federal government.

⁵¹ WTO, *Health and Social Services—Background Note by the Secretariat* (1998), WTO Doc. S/C/W/50 at para. 3, online: WTO <www.wto.org/english/tratop_e/serv_e/w50.doc> (date accessed: 1 November 2002).

of countries have moved towards a stronger market approach, with health sectors in various countries being opened to increased private for-profit involvement, both domestic and foreign. Second, technical changes such as more efficient transport and communication technologies have enhanced the mobility of both health professionals and patients and have enabled services to be delivered in new ways (e.g. telehealth). These technologies are increasingly enabling a range of health care services to be traded between countries and continents.⁵²

Business interests are increasingly recognizing the possible opportunities and profits to be made in exporting health care goods and services.⁵³ In particular, it has been suggested that U.S. private for-profit health care corporations are looking to expand into foreign markets.⁵⁴ While there is concern about infiltration by for-profit U.S. and other foreign providers into Canada's health care system, it has also been recognized that Canadian health care providers stand to benefit from trade liberalization through participation in other countries' health sectors. The Standing Committee on Foreign Affairs and International Trade reports, for example, that a number of people believe major opportunities exist for Canada's telehealth industry to expand into foreign markets.⁵⁵ Health Canada works with Industry Canada and the Department of Foreign Affairs and International Trade in order to assist Canadian exporters of health care products and services.⁵⁶ In particular, the International Business and Development

⁵² For example, "U.S. suppliers provide commercial telemedicine services to customers in several Arab Gulf countries; and Jordan has established telemedicine links with the Mayo Clinics in the United States." *Ibid.* at para. 19.

⁵³ A recent international conference on the private health care sector sought to understand the dynamics of the provision and financing of health care around the world and to promote the ability of the private sector to improve health care outcomes. Severyn Group, "2000 Summit Proceedings Report" in Academy for International Health Studies, *5th Annual International Summit on the Private Health Sector* (3-6 December 2000), CD-ROM: *5th Annual International Summit on the Private Health Sector—Summit Proceedings 2000* (Davis, Cal.: Academy for International Health Studies, 2001).

⁵⁴ See D.R. Luther, "Health Care Services: Strong Fundamentals and Innovations Foreshadow Growth in U.S. Exports and Foreign Direct Investment," *Industry, Trade, and Technology Review* (June 1999: Publication 3206) 19, online: United States International Trade Commission <<http://www.usitc.gov/ittr.htm>> (date accessed: 1 November 2002).

⁵⁵ Public Works and Government Services Canada, *Canada and the Future of the World Trade Organization: Report of the Standing Committee on Foreign Affairs and International Trade* (Ottawa: Standing Committee on Foreign Affairs and International Trade, 1999) at 6-1.

⁵⁶ See Health Canada International Business and Development Division, online: Health Canada <http://www.hc-sc.gc.ca/datapcb/iad/ibd_aboutus-e.htm> (date accessed: 1 November 2002). See also Trade Team Canada Health Industries, online: Industry Canada <<http://strategis.ic.gc.ca/SSG/ht01172e.html>> (date accessed: 1 November 2002).

Division plays a supportive role in promoting trade for Canada's health industry as a member of the Trade Team Canada Sector Health Industries.

A sector that will benefit from increased access to foreign markets is the Canadian health insurance industry. In addition to their dominant presence in the Canadian market,⁵⁷ Canada's life and health insurance companies have a significant presence in foreign markets.⁵⁸ In 2001, the Canadian Life and Health Insurance Association reported that Canadian-controlled life and health insurance companies operate branches and subsidiaries in over twenty countries.⁵⁹ These companies collect significantly more premiums abroad than foreign-owned companies collect in Canada.⁶⁰ Ninety-two percent of private health insurance in Canada was sold by life insurance companies, with the remainder sold by property and casualty companies.⁶¹

Benefits from trade do not flow only one way, however, and the *quid pro quo* for gaining increased opportunities for Canada's exports abroad is that Canada must be prepared to grant reciprocal treatment to foreign interests under international trade agreements. With respect to the NAFTA, this means that Canada will likely find it politically difficult to argue for access to a particular area of the U.S. health sector, while at the same time trying to protect that area of its own health sector from U.S. interests. Thus, the benefits of liberalization in trade have to be set off against the impact of allowing foreign entities (insurers and providers) entry into Canada's health care market. There is a potential tension between these different aims of government, namely, increasing opportunities for health service exports while maintaining a comprehensive publicly funded health care system.

⁵⁷ Of 140 insurance companies active in the private health insurance field in Canada, 93 are Canadian incorporated, 37 are from the U.S., and 10 are from the U.K., Europe, or elsewhere. Canadian Life and Health Insurance Association, *Canadian Life and Health Insurance Facts—2001 Edition* (Toronto: Canadian Life and Health Insurance Association, 2001) at 25, online: Canadian Life and Health Insurance Association <<http://www.clhia.ca/download/F&F2001Ed.pdf>> (date accessed: 1 November 2002) [hereinafter CLHIA, *Facts 2001*]. Canadian-controlled firms have about 71 percent of the Canadian life and health insurance market (*ibid.*).

⁵⁸ Canada, Department of Finance, *Canada's Life and Health Insurers*, online: Department of Finance <http://www.fin.gc.ca/toce/2001/health_e.html> (date accessed: 1 November 2002) [hereinafter Department of Finance, *Canada's Insurers*]. Canada's life and health insurers derive a significant portion of their premiums (55%) from foreign operations. CLHIA, *Facts 2001*, *ibid.* at 5. Income from foreign premiums increased from \$11.4 billion in 1990 to \$49.1 billion in 2000. CLHIA, *Facts 2001*, *ibid.* at 26.

⁵⁹ CLHIA, *Facts 2001*, *ibid.* at 26. The U.S. provides the largest market for Canadian life and health insurers, followed by the U.K. and Europe, then Asia.

⁶⁰ *Ibid.*

⁶¹ *Ibid.* at 25.

With respect to health insurance, there is sometimes a tendency to treat the entire financial services sector as a unit during international trade negotiations. For example, in a recent consultation paper regarding financial services negotiations in the World Trade Organization, Finance Canada discussed the need for further liberalization of financial services.⁶² While not specifically referring to the health insurance industry, the paper notes that the health and life insurance industry forms part of the financial sector. This highlights the importance of effective communication and co-ordination between government departments. Policies that are appropriate for financial institutions such as banks may be completely inappropriate in the health insurance market given the distributive objectives underpinning medicare. Finance Canada and other government departments need to be aware of the implications for the health sector of seeking improved access for financial service suppliers to the U.S. and Mexican markets, even where such access will be beneficial to private Canadian exporters, and must therefore seek appropriately worded exemptions.

E. Proposals for the Reform of Medicare

There are a number of reform proposals that seek to maintain the core value of Canada's health care system (ensuring access to care on the basis of need) but that also look to improve the equity or efficiency of the system. Key reform proposals include: the introduction of national pharmacare and home care programs; efforts to expand access to privately financed services like prescription drugs through regulation of private insurers ("managed competition" reform such as that implemented by Quebec with respect to prescription drugs); and moves to promote increased efficiency in the publicly funded sector through contracting out to competing providers (whether for-profit or non-profit) and through devolving budgets to groups of family physicians and nurses to purchase a range of care on behalf of patients enrolled with them.

In February 1997 the National Forum on Health recommended that "home care ... be considered an integral part of publicly funded health services."⁶³ It also made recommendations with respect to prescription drugs, suggesting that the way to improve appropriate access to and utilization of drugs, as well as to control the growth of drug expenditures, is to ensure that medically necessary prescription drugs be made avail-

⁶² Canada, Department of Finance, *Consultation Paper for the World Trade Organization Negotiations on Financial Services* (Ottawa: Department of Finance, 2000), online: Department of Finance <http://www.fin.gc.ca/gats/wto2000_e.pdf> (date accessed: 1 November 2002). This paper also notes that changing technologies will increase the ability of financial institutions to service foreign markets from abroad without having to establish a commercial presence in a given market.

⁶³ National Forum on Health, *Canada Health Action: Building on the Legacy*, vol. 1 (Ottawa: National Forum on Health, 1997) at 21 [hereinafter National Forum on Health, *Canada Health Action*].

able to all Canadian residents, without deductibles or copayments.⁶⁴ The forum concluded that the best way to accomplish this goal would be by means of a publicly financed and regulated system administered by the provinces.⁶⁵ In its 2000 *Recommendations to First Ministers*, the Institute for Research on Public Policy's Task Force on Health Policy also recommended increased federal financial support to ensure equitable access to pharmaceuticals.⁶⁶ The Liberal government promised in its 1997 Red Book to put in place national pharmacare and home care programs.⁶⁷ In 1998, Health Minister Allan Rock identified continuing care/home care as a priority area for federal, provincial, and territorial action.⁶⁸ In 1999, the federal Speech from the Throne promised reform in respect of home care and pharmacare.⁶⁹

Despite these various calls for and promises of reform, Canadians have yet to see medicare expand to include prescription drugs and home care. This impasse likely speaks to the continued concern over ensuring the sustainability of the status quo, let alone expanding public funding into new areas. It also speaks to the difficulties of warming up the frigid relations between the federal and provincial governments, as the latter are wary of federal promises of new programs when there remains the possibility of federal funding reductions in the future.

One possible means of funding a national pharmacare or home care program that would not involve large expenditures of general taxation revenues is through the in-

⁶⁴ National Forum on Health, "Directions", *supra* note 48.

⁶⁵ *Ibid.*

⁶⁶ *Supra* note 46 at 38. The task force concluded, however, that moving to a solely federal drug plan may prove too radical for the current state of federal-provincial relations. It put forward as a second option the development of national standards to be accepted by each provincial drug plan with the objective of ensuring that all Canadians are covered.

⁶⁷ Liberal Party of Canada, *Securing Our Future Together: Preparing Canada for the Twenty-First Century, The Liberal Plan—1997* (Ottawa: Liberal Party of Canada, 1997) at 74-75, online: Liberal Party of Canada <<http://206.191.18.18/pdf/97platform.pdf>> (date accessed: 1 November 2002).

⁶⁸ See "Speaking Notes for Allan Rock, Minister of Health" (Speech delivered at the National Home Care Conference, Halifax, 9 March 1998), online: Health Canada <<http://www.hc-sc.gc.ca/english/media/speeches/minister1998.htm>> (date accessed: 1 November 2002); "Speaking Notes for Alan Nymark, Associate Deputy Minister" (Speech delivered at A Federal Perspective on Health Care Reform: Pulse '98, Toronto, 11 May 1998), online: Health Canada <<http://www.hc-sc.gc.ca/english/media/speeches/pulse98e.htm>> (date accessed: 1 November 2002); *Report on the National Roundtable on Home and Community Care* (10 February 1998), online: Health Canada <http://www.hc-sc.gc.ca/english/care/home_round/roundtbl.htm> (date accessed: 1 November 2002).

⁶⁹ Governor General, "Building a Higher Quality of Life for All Canadians: Speech from the Throne to Open the Second Session of the Thirty-Sixth Parliament of Canada" (12 October 1999), online: Government of Canada Privy Council Office <http://www.pco-bcp.gc.ca/default.asp?Page=Publications&Language=E&doc=throne99/throne1999_e.htm> (date accessed: 1 November 2002).

roduction of a social insurance scheme and managed competition reform. Such a system would be financed by both employer and employee contributions fixed at a certain percentage of salaries with government revenues having to cover only the unemployed or elderly. Such a system would thus be progressively financed (albeit not through taxation revenue) and would “ensure universal coverage of citizens for a core range of health services on the basis of need as opposed to ... willingness or ability to pay.”⁷⁰

The managed competition model involves requiring private insurers to compete within a government-regulated system for the business of customers who bring with them a risk-adjusted share of funding. Competition occurs between insurers on the basis of price and quality rather than risk avoidance. A managed competition system involves a sponsor (e.g. a government-appointed body) pooling money received from employer/employee contributions and from general taxation revenues. The sponsor then pays, on behalf of individuals, a risk-adjusted share of the pooled funding to that individual’s chosen insurer.⁷¹ Managed competition reform is a relatively complicated model, and an important feature of it from the perspective of the NAFTA is that it requires sophisticated government regulation.

Let us shift here from reform initiatives geared towards expanding public *coverage*, and turn to look at reforms aimed at the *delivery* of health care services. An initiative that is currently being experimented with in Ontario and in a very limited way in Alberta is that of the government contracting out the supply of publicly funded services to competing public and private providers (non-profit or for-profit). This is sometimes described as internal market reform. For example, Alberta’s *Health Care Protection Act*⁷² allows regional health authorities to contract with private for-profit facilities for the provision of some publicly insured health care services. In Ontario, home care is partly publicly funded and provided through community care access centres that must contract out service delivery to competing private for-profit and non-profit providers.⁷³ Some proposals for reform, following on from reform undertaken in countries like the United

⁷⁰ C.M. Flood, “Accountability of Health Service Purchasers: Comparing Internal Markets and Managed Competition Reform Models” (1998) 20 Dal. L.J. 470 at 478.

⁷¹ *Ibid.* at 478-79.

⁷² R.S.A. 2000, c. H-1.

⁷³ See Canadian Home Care Association, “Ontario Fact Sheet Draft—Edited Version”, online: Canadian Home Care Association <<http://www.cdnhomocare.on.ca/doc/FactSheets/ONFACTSHEET.pdf>> (date accessed: 1 November 2002). Ontario is moving towards an open competitive model for home care service delivery through a Request for Proposal process.

Kingdom, New Zealand, and Sweden, have advocated expanding the use of contracting out hospital and medical services to competing providers.⁷⁴

All major reviews of medicare have concluded that primary care must be reformed and that the current system of solo, fee-for-service practice results in a variety of systemic problems.⁷⁵ Some reform proposals have suggested devolving budgets to groups of family doctors and nurses to purchase a range of care on behalf of the patients enrolled with them.⁷⁶ This reform follows similar initiatives in the U.K. with what is known as "GP Budget-holding",⁷⁷ and the goal is to give doctors an incentive to be somewhat sensitive to the cost of the various services and goods that they supply, prescribe, and recommend. Such reform would not constitute privatization, since

⁷⁴ See e.g. Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role*, vol. 4 (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2001) at 64-68, online: Senate of Canada <<http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-E/SOCI-E/rep-e/repintsep01-e.htm>> (date accessed: 1 November 2002).

⁷⁵ See e.g. National Forum on Health, *Canada Health Action*, *supra* note 63 at 23; D. Mirkin, R. Parke & R. Grignon, *Proposed Inter-professional Primary Health Care Groups (PCGs) Costing Models*, Technical Costing Report prepared for the Health Services Restructuring Commission's Primary Health Care Strategy (Toronto: Ontario Health Services Restructuring Commission, 1999), online: Health Services Restructuring Commission <http://192.75.156.24/pccr/Costing_Report.doc> (date accessed: 1 November 2002); Saskatchewan Commission on Medicare, "Caring for Medicare: Sustaining a Quality System" (April 2001) at 9-19, online: Saskatchewan Health Information Network <http://www.shin.sk.ca/Fyke_report/commission_on_medicare-bw.pdf> (date accessed: 1 November 2002); Quebec, Ministry of Health and Social Services, *Emerging Solutions: Report and Recommendations* (Quebec City: Commission of the Study of Health and Social Services, 2001), online: Commission d'étude sur les services de santé et les services sociaux <<http://www.cessss.gouv.qc.ca/pdf/en/01-109-01a.pdf>> (date accessed: 1 November 2002); Premier's Advisory Council on Health for Alberta, "A Framework for Reform: Report of the Premier's Advisory Council on Health", online: Government of Alberta <http://www.gov.ab.ca/home/health_first/documents/PACH_report.pdf> (date accessed: 1 November 2002).

⁷⁶ See e.g. Institute for Research on Public Policy, Task Force on Health Policy, *supra* note 46 at 21: "We would hope to see, for example, experimentation in primary care by way of further devolution of budgetary responsibility to groups of family doctors and community nurses ..." Jérôme-Forget and Forget also make a proposal involving managed care principles. The basis of their recommendation is a capitation formula, where physicians' budgets are based on the number of patients who sign up. Physicians, in turn, purchase services from hospitals on a fee-for-service basis. They argue that this system would introduce greater accountability since physicians will have to meet individual patient demand in the provision of information and in the delivery of health care. M. Jérôme-Forget & C.E. Forget, *Who is the Master?: A Blueprint for Canadian Health Care Reform* (Montreal: Institute for Research on Public Policy, 1998) at 93-109.

⁷⁷ For discussion on reform in the U.K., see Flood, *International Health Care Reform*, *supra* note 10 at 95-103.

provincial governments would continue to fund and govern the system for the benefit of all citizens. The choices made (*e.g.* with respect to treatment, hospitalization, or out-patient care), however, would be rooted in an accountable relationship between doctors and patients and would rely on some degree of competition among providers.⁷⁸

These reform proposals, although obviously influenced by a desire to import some private sector style of incentives, are nonetheless aimed at improving efficiency within the publicly funded system. Such reform proposals (which may involve a greater role for private *delivery*) can be sharply distinguished from proposals that advocate increased private *financing* as a means of reducing the burden on the publicly funded system. Recently, at a national level, the possibility has been raised of allowing more private financing of the system in the form of user charges or by allowing a two-tier system where people can hold private insurance and buy higher quality services or more timely treatment in the private sector.⁷⁹

Whatever the outcome of current reform proposals, it is clear that ongoing changes in the health care system and the possibility of reform make it impossible to draw any hard and fast conclusions about how public/private boundaries will be drawn in the future. As we discuss below, the significance of this in the context of the NAFTA lies largely in the apparent failure on the part of the NAFTA's negotiators to appreciate the dynamic and changing nature of the health care system. We begin in Section II.A with a discussion of the relevant NAFTA provisions. Then, in Section II.B we consider the NAFTA's potential impact on reform proposals and whether the NAFTA will have unintended or unwanted consequences as a result of reform.

II. The NAFTA and Canadian Health Care Reform

A. The Relevant Provisions

The NAFTA aims to establish a free trade area between the territories of the U.S., Canada, and Mexico. Its objectives, as listed in article 102, are: to eliminate barriers to trade in, and facilitate the cross-border movement of, goods and services among the U.S., Canada, and Mexico; to promote conditions of fair competition in the free trade area; to increase investment opportunities in these countries; to provide adequate and effective protection of intellectual property rights in each country; to create effective

⁷⁸ Jérôme-Forget & Forget, *supra* note 76 at 145.

⁷⁹ See *e.g.* Canada, Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 74.

procedures for the implementation and application of the NAFTA, its joint administration, and the resolution of disputes; and to establish a framework for further trilateral, regional, and multilateral co-operation so as to expand and enhance the benefits of the NAFTA.⁸⁰ The NAFTA requires that these objectives be looked at whenever the agreement's other provisions are interpreted,⁸¹ and it is therefore relevant to note that their overriding theme is trade liberalization.

While the parties to the NAFTA are the federal governments of Canada, the U.S., and Mexico, these governments are obligated to "ensure that all necessary measures" are taken in order to give effect to the agreement's provisions, including their observance by state, provincial, and local governments.⁸²

The NAFTA's scope extends to all economic sectors, including the health sector, unless there are exceptions or the parties have made reservations for particular sectors (or parts thereof) that they wish to exempt from some of the NAFTA's liberalizing provisions. The agreement is divided into chapters that deal with various aspects of trade. The chapters of the most relevance to the provision of services within Canada's health care system are chapters 11 (investment),⁸³ 12 (services), and 14 (financial services).⁸⁴ In accordance with the NAFTA's objectives, the provisions contained in these chapters impose a number of constraints on the regulatory measures a government can take. We discuss below the key provisions that have relevance to the health care sector, namely, national treatment, most-favoured-nation treatment, expropriation, and dispute settlement. We then examine Canada's reservations.⁸⁵

⁸⁰ *Supra* note 6, art. 102.

⁸¹ *Ibid.*, art. 102(2).

⁸² *Ibid.*, art. 105.

⁸³ The term "investment" is defined broadly to include assets owned or controlled, directly or indirectly, actually or contingently, by an investor; it also includes enterprises, equity security, and certain debt security (*i.e.* contractual rights, economic interests, intellectual property rights, and licenses). *Ibid.*, art. 1139. An investor is defined as "a Party or state enterprise thereof, or a national or an enterprise of such Party" (*ibid.*). The definition applies to U.S. and Mexican investors of Canadian incorporated private health care service providers and insurers. It also applies to U.S. and Mexican organizations that make loans to or have a stake in Canadian incorporated service providers and insurers.

⁸⁴ Chapter 14 (financial services) is applicable to the extent that it covers commercial health insurers.

⁸⁵ There are other provisions that may have an impact on health care, but they are not discussed here as being less central to this article's focus: arts. 1104, 1204 (standard of treatment), art. 1106(1)(c) (performance requirements), art. 1205 (local presence and rights of establishment), and art. 1210 (licensing of providers). See NAFTA, *supra* note 6.

1. National Treatment and Most-Favoured-Nation Treatment

The key trade liberalizing provision in the NAFTA is the national treatment rule, which applies in respect of investors (article 1102), service providers (article 1202), and financial service providers (article 1405). It requires that Canada treat relevant entities from the U.S. and Mexico no less favourably than it treats its own entities in like circumstances. In other words, U.S. and Mexican entities must be given the same rights and opportunities as Canadian entities in like circumstances. With respect to measures taken by a Canadian province, the national treatment rule requires that a province accord entities from the U.S. or Mexico treatment no less favourable than the most favourable treatment accorded by that province, in like circumstances, to Canadian entities.⁸⁶

The national treatment rule could be violated if a province established investment rights only for Canadian individuals and companies. For example, if a provincial government required the contracting out of publicly funded surgical services but only to Canadian-owned private facilities, this would put U.S. and Mexican service providers and investors at a disadvantage relative to their Canadian counterparts. Similarly, provincial regulations prohibiting the cross-border delivery of services (e.g. diagnostic services) could violate the national treatment principle, as the result would be that U.S. and Mexican laboratories would be treated less favourably than Canadian laboratories.⁸⁷

Government measures that *prima facie* do not discriminate in their treatment of domestic and imported products or services might nonetheless be found in violation of the national treatment rule.⁸⁸ This is because measures might make the same demands of foreign and domestic entities, but effectively put the foreign entities at a competitive disadvantage by placing a more onerous burden on them. For example, in a trade dispute concerning the import, distribution, and sale of beer by Canadian pro-

⁸⁶ *Ibid.*, arts. 1102(3) (investment), 1202(2) (services) and 1405(4)(a) (financial services).

⁸⁷ See B. Appleton, "International Agreements and National Health Plans: NAFTA" in D. Drache & T. Sullivan, eds., *Market Limits in Health Reform: Public Success Private Failure* (New York: Routledge, 1999) 87 at 89.

⁸⁸ See e.g. *United States—Section 337 of the Tariff Act of 1930 (Complaint by the European Economic Community)* (1989), GATT Doc. L/6439, 36th Supp. B.I.S.D. (1990) 345 at paras. 5.11, 5.13, online: WTO <http://www.wto.org/english/tratop_e/dispu_e/gt47ds_e.htm> (date accessed: 1 November 2002); *European Communities—Regime for the Importation, Sale and Distribution of Bananas (Complaint by Ecuador et al.)* (1997), WTO Doc. WT/DS27/AB/R at para. 234 (Appellate Body Report), online: WTO <http://www.wto.org/english/tratop_e/dispu_e/distabase_e.htm> (date accessed: 1 November 2002).

vincial marketing agencies,⁸⁹ the U.S. complained, among other things, that minimum prices maintained for imported and domestic beer in British Columbia, New Brunswick, Newfoundland, and Ontario were inconsistent with the national treatment principle contained in article III.4 of the *General Agreement on Tariffs and Trade*.⁹⁰ Canada argued that the minimum prices were consistent with the provision because they applied equally to both imported and domestic beer. The panel found for the U.S., holding that applying minimum prices equally to imported and domestic beer did not necessarily accord equal conditions of competition, as the U.S. suppliers were effectively prevented from competing on the basis of price. There was discrimination to the extent that U.S. beer was brewed more efficiently and was more competitively priced. The maintenance of a minimum price for imported products at the level at which the directly competing, higher-priced domestic product was supplied was inconsistent with the national treatment principle because the minimum prices were fixed in relation to the prices at which the domestic beer was sold.

The NAFTA requires Canada to provide to NAFTA investors (article 1103), service providers (article 1203), and financial service providers (article 1406) from the U.S. and Mexico treatment no less favourable than it accords, in like circumstances, to investors, service providers, and financial service providers from any other country (including, but not limited to, the U.S. or Mexico).⁹¹ This rule is not as far-reaching as the national treatment rule, as it only comes into play once access has already been granted to foreign entities. It would have to be considered, for example, if access were to be granted to Swiss-owned surgical facilities or diagnostic providers. In that case, the same opportunities would have to be opened to surgical facilities and diagnostic providers from both the U.S. and Mexico.

2. Expropriation

The most controversial aspect of the NAFTA, and arguably of the most concern with respect to the health care system, is the article 1110 expropriation provision. It has been argued that this provision will make it difficult for governments to retreat

⁸⁹ *Canada—Import, Distribution and Sale of Certain Alcoholic Drinks by Provincial Marketing Agencies (Complaint by the United States)* (1992), B.I.S.D. 39S/27 at para. 6.1 (Panel Report), online: WTO <http://www.wto.org/english/tratop_e/dispu_e/gt47ds_e.htm> (date accessed: 1 November 2002).

⁹⁰ 30 October 1947, 58 U.N.T.S. 187, Can. T.S. 1947 No. 27 (entered into force 1 January 1948) [hereinafter GATT]. The GATT has an almost identically worded national treatment provision to that of the NAFTA. Decisions concerning disputes under it are therefore relevant.

⁹¹ *Supra* note 6.

from policies of economic liberalization or privatization.⁹² Article 1110(1) of the NAFTA reads:

No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment ("expropriation"), except:

- (a) for a public purpose;
- (b) on a non-discriminatory basis;
- (c) in accordance with due process of law and Article 1105(1); and
- (d) on payment of compensation ...⁹³

Compensation is required to be equivalent to the fair market value of the expropriated investment immediately before the expropriation took place.⁹⁴ The requirement for payment of compensation is the condition that has provoked the most concern among critics of the NAFTA. In particular, it has been argued that article 1110 has the effect of rendering prohibitive the cost of re-establishing in the public domain those elements of the health system opened to private foreign investors.⁹⁵ That is, if a government wanted to fund or provide health care services in an area that was currently privately financed or open to private providers, such action could be considered a measure tantamount to expropriation by depriving investors present in the market of their current or potential business, thus opening up the possibility of a claim for compensation.

The Canadian government has called for a clarifying statement regarding article 1110 on the grounds that "the NAFTA parties never intended the expropriation and compensation provisions of NAFTA Chapter Eleven to limit the legitimate rights of governments to regulate."⁹⁶ Canada has argued that the NAFTA should not "give in-

⁹² Appleton, *supra* note 87 at 100; S. Shrybman, *A Legal Opinion Concerning NAFTA Investment and Services Disciplines and Bill 11: Proposals by Alberta to Privatize the Delivery of Certain Insured Health Care Services* (Ottawa: Library of Parliament, 2000). The following analysis of the expropriation provision and of Canada's Annex II reservation is based to some extent on the approach offered by Shrybman.

⁹³ *Supra* note 6, art. 1110(1).

⁹⁴ *Ibid.*, art. 1110(2). Examples of criteria used to determine fair market value are going concern value and asset value (including declared tax value of tangible property).

⁹⁵ Appleton, *supra* note 87; Shrybman, *supra* note 92.

⁹⁶ "Issues Paper on Expropriation" attached to J. Gero, "Canadian Memo on Investor-State Provisions", Memorandum from the Director General of Trade Policy Bureau II at the Department of Foreign Affairs and International Trade to Eduardo Solis Sanchez and Jon Huenemann, 13 November 1998, reprinted in N. Sherif, "Canadian Memo Identifies Options for Changing NAFTA Investment Rules" (1999) 17:6 *Inside U.S. Trade* 1 at 20.

vestors the right to seek compensation for wealth deprivation caused by acts or measures [that] are non-discriminatory and within the normal exercise of a State's regulatory prerogative."⁹⁷

No such statement has been issued to date. The meaning of the term "expropriation", however, was considered by the arbitral tribunal in a claim brought against the Canadian government by S.D. Myers Inc.⁹⁸ In that case, the tribunal drew a distinction between expropriation and regulation, in that expropriation tends to involve the deprivation of property rights, whereas regulation generally involves a lesser interference.⁹⁹ On this basis the tribunal declared it unlikely that regulatory conduct would be the subject of a successful complaint under article 1110, although they did not rule out the possibility. Indeed, the tribunal accepted "that in legal theory, rights other than property rights may be 'expropriated' and that international law makes it appropriate for tribunals to examine the purpose and effect of governmental measures."¹⁰⁰ One tribunal member, Dr. Bryan Schwartz, opined that the phrase "tantamount to expropriation" in article 1110 requires a tribunal to "take a hard look at whether government conduct amounts *in substance* to an expropriation. ... The real purpose and real impact of a measure must be considered, not merely the official explanations offered by government or the technical wrapping in which the measure is cloaked."¹⁰¹ In addition, it has been argued by one of the NAFTA's negotiators that while a measure that diminishes the value of an investment but does not necessarily transfer ownership to a third party may be scrutinized under the expropriation provision, a "generally applicable non-discriminatory measure, which merely has the effect of lessening the economic fortunes of a particular enterprise such that the enterprise could not repay a debt, would not be treated as an expropriation."¹⁰²

In sum, explicit legislation forcing established U.S. or Mexican entities out of Canadian health care markets would trigger a requirement for expropriation compensation. Other kinds of legislation and regulations that impact on (but do not explicitly preclude) foreign participation may or may not be used as the basis for a successful

⁹⁷ *Ibid.*

⁹⁸ *S.D. Myers Inc. v. Government of Canada* (2000), NAFTA/UNCITRAL Arbitration, Partial Award, at paras. 279-88, online: DFAIT <http://www.dfait-maeci.gc.ca/tna-nac/myersvcnadapartialaward_final_13-11-00.pdf> (date accessed: 1 November 2002).

⁹⁹ *Ibid.* at paras. 281-82.

¹⁰⁰ *Ibid.* at para. 281.

¹⁰¹ *S.D. Myers Inc. v. Government of Canada* (2000), NAFTA/UNCITRAL Arbitration, Separate Opinion (Dr. B. Schwartz), at para. 217, online: DFAIT <<http://www.dfait-maeci.gc.ca/tna-nac/Swartz.pdf>> (date accessed: 1 November 2002).

¹⁰² D.M. Price, "NAFTA Chapter 11 Investor-State Dispute Settlement: Frankenstein or Safety Valve?" (2000) 26 (Supp.) Can.-U.S. L.J. 1 at 4.

expropriation claim. The only certainty is that it will depend on how the particular arbitration panel views the scope and substance of the regulation or legislation in question.

3. Dispute Settlement

The rights and obligations in the NAFTA are only as effective as the mechanisms by which they can be enforced. While governments can intercede on behalf of their nationals in respect of chapters 12 (services) and 14 (financial services),¹⁰³ foreign investors have a right under chapter 11 (investment) to invoke international dispute resolution processes themselves to enforce their rights under that chapter. The ability of a private party to bring a claim directly against a foreign government is a recent innovation in international trade policy. Prior to implementation of the NAFTA and other recent bilateral investment treaties,¹⁰⁴ private parties did not have standing to take up a cause of action against sovereign states. Rather, the government of the country of which the private actor was a national had to agree to take the case on its behalf. The dispute resolution mechanism in NAFTA chapter 11, however, eliminates the need for a state to intercede on behalf of its national in respect of investments.

Investment disputes are decided by international arbitration panels pursuant to articles 1115 to 1133. Panels consist of three arbitrators, one appointed by each of the disputing parties, and the third (the presiding arbitrator) appointed by agreement of the disputing parties.¹⁰⁵ If a party fails to appoint an arbitrator, or the parties cannot agree on a presiding arbitrator, selection is by the secretary-general of ICSID.¹⁰⁶ The secretary-general makes appointments from a roster of presiding arbitrators established pursuant to article 1124(4). The panels operate under international law,¹⁰⁷ according to procedures established for resolving international commercial disputes.¹⁰⁸

¹⁰³ Disputes under chapters 12 and 14 are dealt with pursuant to chapter 20, which provides for an initial consultation phase (art. 2006), followed, if necessary, by arbitration. Arbitration panels established pursuant to chapter 20 are comprised of members selected by the disputing parties from a roster that is maintained pursuant to article 2009. The chair of the panel is chosen by agreement between the parties. If agreement cannot be reached, a disputing party chosen by lot shall select as chair an individual who is not a citizen of that party. See NAFTA, *supra* note 6.

¹⁰⁴ The U.S. has signed a large number of bilateral investment treaties with other countries. These treaties seek to protect U.S. investment interests abroad and often contain an investor-state dispute mechanism similar to that found in chapter 11 of the NAFTA.

¹⁰⁵ NAFTA, *supra* note 6, art. 1123.

¹⁰⁶ *Ibid.*, art. 1124.

¹⁰⁷ *Ibid.*, art. 1131, which provides that disputes shall be decided in accordance with the NAFTA and applicable principles of international law.

¹⁰⁸ *Ibid.*, art. 1120, which stipulates that “a disputing investor may submit the claim to arbitration under:

Such international disputes tend to be closed and secretive, since, for example, rule 15(1) of the ICSID Arbitration Rules provides that "deliberations shall take place in private and remain secret."¹⁰⁹ This means that there is little opportunity for public scrutiny or participation in the dispute settlement process.¹¹⁰ In July 2001 the NAFTA Free Trade Commission issued an interpretive statement clarifying that "nothing in the NAFTA imposes a general duty of confidentiality" and that, subject to limited exceptions including limitations on disclosure imposed by the specific arbitral rules being used, documents associated with NAFTA arbitrations must be made available to the public.¹¹¹ One commentator has noted, however, that this may provide an incentive for parties to use the UNCITRAL Model Law rather than the ICSID Additional Facility Rules, because the former provide for confidentiality of party submissions.¹¹² It is also worth noting that the chapter 11 dispute settlement process does not make any allowance for direct intervention of other interested parties or any guarantee that amicus submissions of such parties will be accepted.¹¹³

The NAFTA investment dispute resolution process allows the possibility of decisions being made concerning Canada's health care system behind closed doors. Decisions under NAFTA chapter 11 may be made by arbitrators who have little familiarity with Canadian law or health policy objectives and little understanding of the very different set of values that underlie the Canadian health care system relative to the U.S. health care system. Panel decisions must be made by a majority. Ganguly notes that

(a) the ICSID Convention, provided that both the disputing Party and the Party of the investor are parties to the Convention;

(b) the Additional Facility Rules of ICSID, provided that either the disputing Party or the Party of the investor, but not both, is a party to the ICSID Convention; or

(c) the UNCITRAL Arbitration Rules."

¹⁰⁹ ICSID, *Rules of Procedure for Arbitration Proceedings*, online: ICSID Basic Documents <<http://www.worldbank.org/icsid/basicdoc/63.htm>> (date accessed: 1 November 2002). See also ICSID, *Rules Governing the Additional Facility for the Administration of Proceedings by the Secretariat of the International Centre for Settlement of Investment Disputes (Additional Facility Rules)*, Schedule C, art. 24(1), online: ICSID Additional Facility <<http://www.worldbank.org/icsid/facility/facility-en.htm>> (date accessed: 1 November 2002).

¹¹⁰ See J.C. Beauvais, "Regulatory Expropriations under NAFTA: Emerging Principles and Linger-ing Doubts" (2002) 10 N.Y.U. Env't L.J. 245 at 263.

¹¹¹ *Ibid.* Beauvais refers to NAFTA Free Trade Commission, "Notes of Interpretation of Certain Chapter 11 Provisions" (31 July 2001), online: DFAIT <<http://www.dfait-maeci.gc.ca/tna-nac/NAFTA-Interpr-e.asp>> (date accessed: 1 November 2002).

¹¹² T. Weiler, "Trade Ministers Say the Darndest Things" (August 2001), online: NAFTALAW.ORG <<http://www.naftalaw.org>> (date accessed: 1 November 2002).

¹¹³ This is unlike the general dispute settlement provisions in chapter 20, which do allow for third party participation. See NAFTA, *supra* note 6, art. 2013.

this opens up the possibility of the “neutral” member (the presiding arbitrator) being pressured to agree with one or the other of the appointed members.¹¹⁴ The danger in this process is that there may not be that many available arbitrators with a knowledge of health issues, and it is possible that Canada would have to accede to the appointment of a presiding arbitrator who has little or no knowledge of its health care sector and who would tend to sympathize with the arbitrator chosen by the investor.¹¹⁵

Ganguly argues that a number of aspects of the chapter 11 dispute mechanism process are particularly advantageous to investors: the arbitral process is binding, and decisions are enforceable with no right of judicial review or appeal; arbitral panels are not required to follow the decisions of previous panels, resulting in uncertainty whenever a dispute is heard; there are strict standards of confidentiality; the costs of litigation in the courts of the host country or the investor are removed; and the ability to bypass domestic courts of the foreign government enables the investor to avoid potentially unfavourable domestic laws of the host country and judiciaries sympathetic to their government.¹¹⁶ He also notes that there are no checks or balances as to the use of the NAFTA investor-state dispute mechanisms and that the need to evaluate the merits of investors’ claims makes it impossible to dismiss claims readily.¹¹⁷ These are all valid concerns should U.S. investors seek to challenge government regulations in the health care sector, as public interests are so clearly at stake.

4. Reservations¹¹⁸

The parties to the NAFTA were permitted to make reservations in order to protect specified sectors from the full force of the agreement’s provisions with respect to investment,¹¹⁹ services,¹²⁰ and financial services.¹²¹ Reservations do not, however, extend

¹¹⁴ S. Ganguly, “The Investor-State Dispute Mechanism (ISDM) and a Sovereign’s Power to Protect Public Health” (1999) 38 Colum. J. Transnat’l L. 113 at 124.

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.* at 122.

¹¹⁷ *Ibid.* at 115.

¹¹⁸ Besides reservations, the NAFTA contains a variety of exceptions that will not be discussed in any detail in this article. As a brief example, we note that the national treatment and most-favoured-nation treatment provisions do not apply to “procurement by a Party or state enterprise”. NAFTA, *supra* note 6, arts. 1108(7), 1201(2)(c). This arguably means that where health care services are purchased by the federal or provincial governments for their direct use, they will not be subject to the stated provisions. The effect of this exemption is narrow as very few, if any, health care services are provided directly for the use of either the federal or provincial governments. Also exempted are subsidies and grants provided by Canada or a state enterprise (*ibid.*, arts. 1108(7), 1201(2)(d)).

¹¹⁹ *Ibid.*, art. 1108.

¹²⁰ *Ibid.*, art. 1206.

to all of the NAFTA's obligations. In terms of the most important provisions for a discussion of health care reform, reservations extend to the national treatment and most-favoured-nation treatment provisions, but not to the article 1110 expropriation provision. The failure of reservations to extend to the expropriation provision is of crucial importance to our analysis. Canada has entered two types of reservations, which are set out in Annexes I, II, and VII of the NAFTA.

The Annex I (investment and services) and Annex VII (financial services) reservations permit a government to maintain any specific non-conforming measures that it chooses to list. These measures may be amended in the future but must not be amended so as to "decrease the conformity" of the measure with the NAFTA's provisions. There were difficulties determining the full extent of provincial and state non-conforming measures at the date of entry into force of the NAFTA, and as a solution the parties agreed to grandfather *all* such measures.¹²² Accordingly, Canada is not in breach of the NAFTA by virtue of any non-conforming provincial measure that existed prior to 1 January 1994 and is still in place. While Annex I and Annex VII are important, Annex II contains the more important reservation in terms of health care, as it has relevance for future changes in the health care system.

Canada's Annex II reservation allows the government to "adopt or maintain" measures that would otherwise violate the NAFTA where those measures are for the purpose set out in the reservation. The reservation reads:

Canada reserves the right to adopt or maintain any measure with respect to the provision of public law enforcement and correction services, and the following services *to the extent that they are social services established or maintained for a public purpose*: income security or insurance, social security or insurance, social welfare, public education, public training, *health* and child care.¹²³

This reservation protects the health care sector from the full application of the NAFTA only to the extent that the services in question are "social services established or maintained for a public purpose." Annex II is not specific as to what is meant by either "social services" or "public purpose", and there has been controversy over how the reservation ought to be interpreted. Unfortunately, the NAFTA does not define ei-

¹²¹ *Ibid.*, arts. 1409(2), 1409(4). Where a party sets out a reservation to arts. 1102, 1103, 1202, or 1203 in their schedule to Annex I, II, III, or IV, it is deemed also to be a reservation to arts. 1405 (national treatment) and 1406 (most-favoured-nation treatment).

¹²² Exchange of letters between Canada, the U.S., and Mexico (29 March 1996), cited in A. de Mestral, "The North American Free Trade Agreement: A Comparative Analysis" (1998) 275 *Rec. des Cours* 219. See also Canada, Department of Foreign Affairs and International Trade, *supra* note 9.

¹²³ NAFTA, *supra* note 6, Annex II [emphasis added]. The U.S. and Mexico have entered identical reservations.

ther of these phrases. Canada and the U.S. have suggested very different interpretations of the reservation, neither of which has been tested before a dispute settlement tribunal.

The Canadian government has suggested a broad interpretation of the Annex II reservation that emphasizes “government intent” as a crucial factor in determining whether a service is provided for a “public purpose”.¹²⁴ This interpretation recognizes that a government may explicitly indicate that it is acting in order to provide a service “for a public purpose”, while in other cases it can be inferred from the circumstances.¹²⁵ In the case of health care services, the act of providing public funding (e.g. government funded health insurance plans) is an important factor in showing the government’s intent to provide services “for a public purpose”. If the government did not intend to benefit the public, presumably it would not have chosen to fund the services from general taxation revenues, thus ensuring access to care on the basis of need rather than ability to pay.

The United States Trade Representative has expressed a contrary view. Indeed, he issued a narrow interpretation of the “social services” reservation, which states that

[t]he reservation in Annex II (II-U-5) is intended to cover services which are similar to those provided by a government, such as child care or drug treatment programs. *If those services are supplied by a private firm, on a profit or not-for-profit basis, Chapter Eleven and Chapter Twelve apply.*¹²⁶

It would be extremely problematic for Canada if this interpretation were to prevail, as virtually all health care services, whether publicly or privately funded, are supplied by private firms or other private entities, either on a for-profit or non-profit basis—even hospitals in Canada are private organizations, albeit heavily regulated. The United States Trade Representative has also expressed the view that chapters 11 and 12 apply once “[a] state allows private providers to offer similar services on a commercial basis.”¹²⁷ Following this line of reasoning, if any part of a sector is operated on a commercial basis, then the government-operated part of that sector is subject to the full force of the NAFTA.

Clearly the Canadian and United States governments’ views on Annex II conflict. Which interpretation should prevail? A starting point is the *Vienna Convention on the*

¹²⁴ B. Schwartz, “NAFTA Reservations in the Areas of Health Care” (1997) 5 Health L.J. 99 at 107-09.

¹²⁵ *Ibid.*

¹²⁶ “Draft USTR Guidelines for U.S. States’ NAFTA Service Reservations: Guidelines for NAFTA Non-Conforming State Measures” *Inside NAFTA* 2:24 (29 November 1995) 18.

¹²⁷ *Ibid.*

Law of Treaties,¹²⁸ which provides that the primary method of interpreting a treaty should be the "ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose."¹²⁹ What is a "social service that is maintained or provided for a public purpose"?¹³⁰ Neither "social service" nor "public purpose" are defined in the NAFTA. The *Oxford English Dictionary* defines "social service" as "a service supplied for the benefit of the community, esp. any of those provided by the central or local government, such as education, medical treatment, social welfare, etc."¹³¹ The term "public purpose" in international law is discussed in *Amoco International Finance Corporation v. Government of the Islamic Republic of Iran*.¹³² The tribunal in that case dealt with expropriations by the state, which are only justified when undertaken for a "public purpose". According to the tribunal, the precise definition of "public purpose" has been neither agreed upon nor suggested in international law. Further, "as a result of the modern acceptance of the right to nationalize, [the] term is broadly interpreted and ... States, in practice, are granted extensive discretion."¹³³

It is arguable that most health care services are social services provided for a public purpose, at least to the extent that they are publicly funded. In our view, the suggested definition of "social service for a public purpose" is satisfied where the government funds services for the benefit of all those who require them on the basis that everyone ought to have access to such care. The meaning of "public purpose" is arguably wide enough to include services that the government wishes to fund for the public benefit. Thus, in our view, the Canadian interpretation of Annex II should prevail.

We discussed above the increased use of contracting out the delivery of fully publicly funded services to competing private for-profit companies. Do services delivered in this manner qualify as social services established or maintained for a public purpose? In our opinion they do. The Canadian government funds certain health services because it believes it is in the public interest that everyone have access to

¹²⁸ 23 May 1969, 1155 U.N.T.S. 331 (entered into force 27 January 1980). Though this convention has not been ratified by the United States, it has become part of customary international law. See *Fisheries Jurisdiction Case (United Kingdom v. Iceland)*, (Jurisdiction of the Court), [1973] I.C.J. Rep. 3 at 18; *Case Concerning the Gabčíkovo-Nagymaros Project (Hungary v. Slovakia)*, [1997] I.C.J. Rep. 7 at 38.

¹²⁹ *Ibid.*, art. 31(1).

¹³⁰ Canadian officials have suggested that the phrase was left deliberately vague in order to allow the term to be interpreted in a broad manner. See Schwartz, *supra* note 124 at 110.

¹³¹ *Oxford English Dictionary*, 2d ed., s.v. "social service".

¹³² (1987) 15 Iran-U.S. C.T.R. 189, 27 I.L.M. 1314 [hereinafter *Amoco*], quoted in Ganguly, *supra* note 114 at 136.

¹³³ *Amoco*, *ibid.* at 233.

necessary services, regardless of their ability to pay. The act of contracting out delivery to private for-profit companies is a means by which the government hopes to deliver services more efficiently—it does not change the fundamental nature of such services as social services for a public purpose, nor does it change the government's intent that such services be available to everyone. It is difficult to rationalize the United States Trade Representative's view that services lose their characterization as social services for a public purpose simply by virtue of being provided by for-profit providers and companies on a commercial basis. Rather, the question seems to us to be whether or not the services are publicly *funded*, as public funding is an indication of what services the government has decided ought to be made available for the benefit of the general public.

A factor bolstering the U.S. interpretation is that the NAFTA's objectives are to be used to assist in interpreting its text.¹³⁴ The overriding tenor of promoting trade liberalization supports a narrow interpretation of Annex II. Even if we accepted an argument that the exception in Annex II be construed strictly, we believe the Canadian interpretation should prevail. In publicly funding services, particularly for all citizens, a government clearly establishes a system for a "public purpose", even if within that system the services are actually delivered by private entities. In addition, that there was such a high level of private delivery within Canada's health care system at the time the reservation was entered into should be taken into account in interpreting the reservation. To argue that Canada intended all privately delivered health care services to be excluded from the reservation's protection would render the reservation virtually meaningless from a Canadian perspective.

It is worthwhile to look at the method of interpretation of exceptions to other international trade agreements used by dispute panels. The World Trade Organization's Appellate Body said the task of interpreting the chapeau of article XX of the GATT was

essentially the delicate one of locating and marking out a line of equilibrium between the right of a Member to invoke an exception under Article XX and the rights of the other Members under varying substantive provisions ... of the GATT 1994, so that neither of the competing rights will cancel out the other and thereby distort and nullify or impair the balance of rights and obligations constructed by the Members themselves in that Agreement. The location of the line of equilibrium ... is not fixed and unchanging; the line moves as the kind

¹³⁴ NAFTA, *supra* note 6, art. 102(2).

and the shape of the measures at stake vary and as the facts making up specific cases differ.¹³⁵

In the context of Annex II, this approach would involve balancing Canada's right to protect its health care sector with the U.S. and Mexico's rights to seek entry into Canada's market under the NAFTA's substantive provisions. In order to protect the health care sector, a trade-off needs to be made between the benefits of trade and the values of Canada's health care system. The extent to which a particular tribunal is willing to give primacy to the health care system or to be fully cognizant of the redistributive values that underlie it remains to be seen.

Any conclusion on the meaning of Annex II must be tentative given that it has not yet been the subject of interpretation pursuant to the NAFTA dispute settlement process. In our opinion, the U.S. interpretation of the exemption should *not* prevail. Such an approach would subject all publicly funded services delivered by the private sector, whether by for-profit or non-profit entities, to the full extent of the NAFTA's provisions. The corollary of this of course is that where services are privately financed, and access thereto is allocated according to the capacity and willingness to pay, there is no public purpose element. We argue, however, that some services, even though not financed by general taxation revenues, are provided for a public purpose if they are provided by charitable non-profit organizations and made available to anyone according to need without requiring payment. Charitable organizations operating in this way provide services for a public purpose without the objective of commercial gain, and on that basis should be excluded from the full extent of the NAFTA's application.

One of the biggest difficulties in assessing the implications of the Annex II reservation with any certainty is the dynamic nature of the health care system. Goods and services are shifting across the boundaries as the public/private mix of funding changes. For example, as home care has become a more important component of care, so the degree of public funding has increased significantly. This makes it difficult to assess the likely application of the reservation at any point in the future. We reiterate that regardless of the interpretation of the reservation, it does not provide any protection from the article 1110 expropriation provision.

¹³⁵ *United States—Import Prohibition of Certain Shrimp and Shrimp Products (Complaint by India, Malaysia, Pakistan, Thailand)* (1998), WTO Doc. WT/DS58/AB/R at para. 159 (Appellate Body Report), online: WTO <http://www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1996> (date accessed: 1 November 2002).

B. The NAFTA's Effect on Proposals for Reform

1. National Pharmacare and/or Home Care Programs

As we noted in Part I, two important areas of health care that are not covered by the *CHA* are drugs used outside hospitals and home care. Many Canadians rely on private insurance to cover the cost of these services. Does Canada's Annex II reservation for "social services established or maintained for a public purpose" protect the private health insurance market from the NAFTA's provisions? To the extent that provinces do provide public coverage for drugs and home care, in our opinion this sector of the market falls within the reservation. To the extent that drugs and home care are privately financed, however, their provision, or that of private insurance services to cover them, cannot be viewed as "social services established or maintained for a public purpose." As noted, the national treatment principle applies unless services are covered by an exemption or are included within the scope of the reservation. This means that on an objective interpretation, in respect of private insurance for drugs and home care, the NAFTA requires Canadian governments to provide market access to private U.S. and Mexican insurers on the same basis as domestic Canadian insurers. The U.S. interpretation of Annex II, on the other hand, would find that the reservation does not even apply to publicly funded provincial insurance plans covering drugs and home care because the state is allowing private providers to offer similar services on a commercial basis.

The article 1110 expropriation provision applies regardless of the interpretation of Annex II, and it has the potential to entrench the investment rights of foreign health insurers by allowing them to claim compensation if a Canadian government nationalizes or expropriates their investment or takes a measure tantamount to nationalization or expropriation. The possible impact of article 1110 in this regard can be explained by considering a hypothetical case in which a U.S. insurance company, Peace of Mind, Inc., enters the Canadian market to provide insurance for extended health care services including prescription drugs and home care. Within five years, Peace of Mind, Inc. has a significant share of this market. The Canadian government, as part of a health care reform package, decides to expand the coverage of medicare to include universal coverage of medically necessary prescription drugs and home care services. The *CHA* is amended to provide protection for these services and prohibit extra billing and user charges in respect of them. The provinces, not wanting to lose federal transfers pursuant to the *CHA*, take steps to introduce legislation prohibiting the purchase of private insurance to cover the cost of drugs and home care. Peace of Mind, Inc. finds it has lost access to a large market, and delivers a notice of intent to submit a

claim to arbitration to seek compensation for the indirect expropriation of its investment. Canada now potentially faces a large bill for implementing health care reforms.

How realistic is this scenario? In 2000, the private health insurance industry in Canada consisted of 140 active firms.¹³⁶ Of these, 93 were Canadian incorporated firms, 37 were American, and 10 were European (including British).¹³⁷ Despite the implementation of the NAFTA in 1994, the market share of total industry premiums (life and health insurance) held by foreign insurance companies fell slightly over the last decade, from 32 percent in 1990 to 29 percent in 2000.¹³⁸ Clearly, costly compensation claims by US insurance companies are a real possibility.

It is relatively expensive and time-consuming to bring an expropriation claim, and it is arguably unlikely that a foreign insurer will bring a claim unless it stands to sustain losses that are substantial enough to exceed the cost of bringing a claim. Thus, the theoretical risk that arises from article 1110 may not always translate into a realistic threat. Yet the mere threat of article 1110 claims may discourage both the federal and provincial governments from extending medicare's coverage where they believe that to do so might result in costly claims for compensation. Existing fiscal constraints already present an impediment to the extension of medicare, and the threat of article 1110 claims only serves as yet another disincentive to act. At worst, such claims may render reform economically unfeasible.

2. Managed Competition Reform

An alternative to a single-payer publicly funded insurance program for prescription drugs and home care is to implement managed competition reform. A form of

¹³⁶ CLHIA, *Facts 2001*, *supra* note 57 at 25. Over ninety percent of these firms were for-profit life and health insurance companies. Department of Finance, *Canada's Insurers*, *supra* note 58. Non-profit groups such as the Blue Cross are also active in the market. See online: Blue Cross <<http://www.bluecross.ca/medianews.html>> (date accessed: 1 November 2002).

¹³⁷ CLHIA, *Facts 2001*, *ibid.* at 25.

¹³⁸ *Ibid.* When the NAFTA was signed in 1994, it was predicted by some that as the health insurance market in the U.S. was saturated, U.S. insurers would look to expand into the Canadian market. P.V. Rosenau *et al.*, "Anticipating the Impact of NAFTA on Health and Health Policy" (1995) 21 Canadian-American Public Policy 1 at 26-27. The Health Insurance Association of America noted in 1994 that opportunities for U.S. companies in foreign markets were likely to grow, since public sector insurance is "pinched by rising costs" in many industrialized countries with the consequent effect of benefits being curtailed and national systems privatized. B. Gradison, "US Health Insurers Can Export Their Skills" (1994) 95:3 *Best's Review* 44, cited in Rosenau *et al.* (*ibid.* at 27). While Canada has not seen an influx of U.S. private insurers, this does not rule out the possibility of a claim by a U.S. insurance company should their business be adversely affected by Canadian health care reforms.

managed competition reform has been implemented in Quebec, where all residents are covered by a basic insurance plan covering prescription drugs.¹³⁹ A managed competition model requires significant government regulation, for example, to prevent insurers from charging people different premiums depending on their risk factors, and to control the level of copayments and deductibles. Regulations may also dictate what goods or services the insurers must cover. The Quebec legislation, for example, stipulates that for the purposes of the basic plan, membership of a group insurance or an employee benefit plan may not be determined on the basis of the age, sex, or state of health of plan members,¹⁴⁰ while insurers transacting group insurance and all administrators of employee benefit plans must pool the risks arising from the basic plan coverage they provide.¹⁴¹

Would the provision of services by private insurers in a managed competition system be exempt from the national treatment principle pursuant to the Annex II reservation as being services maintained “for a public purpose”? If not, the national treatment principle would require market access to be given to U.S. insurers. Governments implementing managed competition reform would need to be wary of regulations that might have a disparate effect on the ability of U.S. health insurers to compete for customers. For example, one could envisage an argument by U.S. health insurers that the fixing of maximum premiums has a disparate effect on them—it affects their ability to compete on the quality of the plan offered because customers cannot trade-off higher prices against higher quality. The U.S. would almost certainly argue that insurance services under a managed competition model are not provided for a public purpose due to the presence of competing private insurers. In our opinion, however, despite the presence of private insurers, the objective of providing universal coverage, the requirement of a sophisticated governance model, the requirement of risk-pooling, and the requirement that the scheme be progressively funded makes it clear that services in a managed competition model are provided for a public purpose. Thus, the national treatment rule should not apply and there should be no impediment to any regulation the government wanted to introduce.

Regardless of the interpretation given to the Annex II reservation, the article 1110 expropriation provision presents a potential problem on two fronts. First, if U.S. in-

¹³⁹ See *An Act Respecting Prescription Drug Insurance*, R.S.Q. c. A-29.01. The basic plan is administered by the government. Private insurers also play a part by insuring those people who belong to group plans or private sector employee benefit plans. Legislation requires that people who are part of such plans be covered, at a minimum, for the same benefits as those offered by the basic plan (*ibid.*, s. 38).

¹⁴⁰ *Ibid.*, s. 41.

¹⁴¹ *Ibid.*, s. 43.

surers are already present in the market at the outset of such reform (and it is likely they would be given that a number of U.S. insurers currently operate in Canada), the government would face a potential financial obstacle if it wished to exclude them from the new model. Second, if any U.S. insurers only enter the market after managed competition reform, the government might face compensation claims if later it wished to retreat from managed competition reform to a single-payer insurance system.

3. Internal Market Reform: Contracting Out to Competing Providers

An internal market model involves public funding of services that are provided by private for-profit or non-profit organizations who tender for contracts on a competitive basis with government-appointed bodies such as regional health authorities. The NAFTA presents no obvious constraints to implementation of internal market reform. The article 1110 expropriation provision, however, may result in consequences that were not foreseen as part of the reform model.

As we argued above, it is correct to interpret Canada's Annex II reservation as covering all publicly funded services, and as a consequence these services should not be subject to the NAFTA's national treatment rule. On the other hand, the U.S. interpretation of Annex II implies that even publicly funded services are not covered by the reservation if they are privately delivered; thus, the NAFTA should apply. If the U.S. interpretation were to prevail and the national treatment rule found to be applicable, Canadian provincial governments would be required to ensure that U.S. and Mexican providers have the right to be considered on an equal basis for contracts to deliver publicly funded services.

Regardless of the application of the Annex II reservation, unintended consequences also could flow from the article 1110 expropriation provision if provinces allow foreign entities to enter their markets. For example, contracts might be awarded to foreign entities if they are able to provide services more cost effectively. As discussed above, the potential effect of article 1110 is that where a government allows foreign private entities to operate in a market, it may be forced to pay compensation if it later wishes to remove or restrict their right to operate in that market. Thus, while on our interpretation a government will not be hampered in implementing internal market reform, it may find that doing so commits it to a course of action that would be costly to reverse at a later date. In this regard, the fact that a number of similar reforms in other jurisdictions like the U.K., New Zealand, and Sweden have been significantly modified, if not reversed, speaks to the need to allow governments to experiment with different reform initiatives without fear of having to pay compensation.

Consider the hypothetical case of a successful new form of gene therapy that is developed to treat cancer. The Ontario government wishes to fund the therapy, yet there are high capital expenses involved in setting up facilities to provide it. Therefore,

it is more feasible to contract out the delivery of such services so that they can be made accessible to all people on the basis of need. There are a number of private enterprises in Canada capable of delivering the services, but U.S. corporations are able to offer a more competitive cost structure. Notices to tender are published and contracts are awarded to a U.S. corporation that will operate facilities in Toronto, Ottawa, and Windsor. The U.S. corporation performs satisfactorily and the Ontario government renews its contracts for a number of years. Eight years later, however, the government finds that the cost of contracting out has become prohibitive due to factors including exchange rate fluctuations, contract negotiation costs, quality regulation, and monitoring. Given that the cost of providing the therapy has now dropped, the government decides to provide the services out of public hospitals. Accordingly, it gives the U.S. corporation notice that it will not be re-tendering for contracts when the current contract expires. When it learns that the Ontario government proposes to have publicly funded hospitals provide the services, the U.S. company brings an article 1110 claim based on the expropriation of its profitable business interests in Ontario. The Ontario government is faced with the possibility that the corporation will be successful in its argument that it has suffered a deprivation of its ownership rights and that it will be required to pay a large sum in compensation.

4. Primary Care Reform

Unless foreign providers have entered Canada's primary care market, the NAFTA is not likely to prevent governments from undertaking primary care reform to devolve budgetary responsibility to groups of physicians and nurses. To date, primary care services have been provided by physicians, nurses, and other domestic providers with little foreign presence in the market. It is possible, however, that if primary care reform led to the presence of a competitive internal market with a focus on health networks with devolved budgets, Canada's primary health care sector would appear more attractive to foreign for-profit health organizations such as U.S. health management organizations ("HMOs") or physician practice management groups ("PPMs"). Within the U.S. health care system, the number of for-profit HMOs increased dramatically between 1980 and the late 1990s.¹⁴² On the heels of this growth has been the emergence of PPMs. PPMs are for-profit organizations that link physician groups in multiple markets and provide physicians with capital and resources through investment from private sources including venture capitalists, bond underwriters, private inves-

¹⁴² S. Srinivasan, L. Levitt & J. Lundy, "Wall Street's Love Affair with Health Care" (1998) 17:4 *Health Affairs* 126 at 126.

tors, and public equity markets.¹⁴³ Such commercial activity south of the border raises the spectre of for-profit organizations seeking to expand into Canada's market should the opportunity arise. The opportunity is only required to be given to U.S. providers, however, if primary care services are not covered by the Annex II reservation and are therefore subject to the NAFTA's national treatment rule.

In our opinion, Canada's Annex II reservation covers primary care services, even in the scenario of a competitive internal market. Once again, provided that services are fully publicly funded, they are "social services" provided for a "public purpose". If the reservation is found not to apply, U.S. for-profit organizations would have to be treated as favourably as Canadian physician groups and be given access to Canadian primary care markets. The expropriation provisions could then make it potentially expensive for the government to turn back the clock and remove U.S. providers from the market. As discussed earlier in this section, even though Canada's Annex II reservation protects publicly funded services, the expropriation provisions will still apply, meaning that if a U.S. or Mexican provider is allowed to enter the Canadian primary care market (regardless of whether they are entitled to such entry under the NAFTA), they will have the right to claim compensation if that right is later taken away by a Canadian government.

Conclusion

In the introduction to this article we noted that there are two contrasting perspectives on the implications of the NAFTA for medicare. Critics fear a slide into a U.S.-style health care system, while the federal government has given assurances that the NAFTA poses no threat to medicare. We conclude that neither of these perspectives is completely correct, since each presents a black and white picture of the situation. In fact, as this article has shown, things are much more complex than such a binary opposition would suggest. Our view is that the NAFTA does present concerns for the sustainability and enhancement of medicare. In particular, the operation of both the national treatment and expropriation rules casts doubt on the ability of governments to enact a number of advocated reforms. Even where reforms can be undertaken, the NAFTA may have unintended or unwanted consequences where such reforms in-

¹⁴³ PPMs provide either the full spectrum of professional services, or focus on a single specialty, disease category, or type of facility. They subcontract on a fee-for-service, episode-of-illness, or capitated basis with HMOs, health plans, hospitals, integrated delivery systems, multispecialty medical groups, and self-insured employers. J.C. Robinson, "Financial Capital and Intellectual Capital in Physician Practice Management" (1998) 17:4 *Health Affairs* 53 at 53-55.

crease the participation of the private sector within medicare. Such reforms may prove both costly and difficult to reverse because of the article 1110 expropriation rule.

The NAFTA is unlikely, however, to cause a total slide into a U.S.-style health care system. The Annex I reservation allows the continuation of NAFTA-inconsistent provincial measures that were in place at the time of the agreement's implementation. Annex I, however, does not allow new or more NAFTA-inconsistent measures. Accordingly, from the perspective of future health care reforms, it is Annex II that is more important, as it allows the parties to enact measures in specified sectors that are inconsistent with some of the NAFTA's provisions, including the national treatment rule. Unfortunately, the Annex II reservation fails to provide clear and certain protection for Canada's health care system, although we believe that it should be interpreted so as to cover all services that are publicly funded, whether delivered by private (for-profit or non-profit) or public entities. It should also cover social insurance schemes where contributions are collected on a progressive basis from employer and employee contributions. It may also extend to privately funded services delivered by private, non-profit entities, if it can be said that the services are being supplied for a public purpose (this may be the case with some charitable organizations). It is important to keep in mind, however, that the Annex II reservation provides no protection from the operation of the expropriation rule.

Our interpretation of Annex II is much more generous than that of the U.S. Even with our interpretation, however, there are still significant concerns, given that the reservation will not apply to the privately financed sector, a sector that is growing significantly and that covers a large component of important services, including prescription drugs used outside hospitals and home care. As we discussed, these services are increasingly important and are not covered by the *CHA*. The national treatment principle will apply to these areas and will require Canada to provide access to U.S. and Mexican providers, investors, and insurers in respect of these services, unless provincial measures in place before 1994 expressly prohibit the entry of foreign investors or providers.

The NAFTA's negotiators do not appear to have appreciated either the complex range of public/private relationships within Canada's health care system or the changing dynamics of the system when they agreed to the wording of the Annex II reservation. Changing technologies and changing health care needs not only make it difficult to draw a line between public and private in the health care sector today, but also make it impossible to draw any firm conclusions about how public/private boundaries will be drawn in the future. For example, services that are only considered experimental today, such as genetic testing, may be widely accepted as an important medical service in five years, and the government will want people to have universal access to them accordingly. By then, however, the market may be saturated with foreign private providers and insurers who will not give up their market share without seeking compensation.

The NAFTA's investor dispute settlement process is of significant concern, as it allows foreign private investors to bring claims against the Canadian government and—at least from an investor's point of view—provides for an effective and binding enforcement process. The investor dispute settlement process gives private investors the opportunity to have their claims heard in secret by arbitral tribunals that are not bound by precedent, and whose members may have little or no knowledge of the values underlying Canada's health care system and the complexities that surround it.¹⁴⁴ This process opens up the possibility that areas of Canada's health policy will be determined in the future by foreign commercial interests through the NAFTA investor dispute settlement process.¹⁴⁵ The government needs at least to ensure that if a claim is brought that concerns the health sector, those arbitration rules with the least protection for confidentiality of party submissions are chosen and where possible, the selected arbitrators have some knowledge of the Canadian health care system.

In terms of reform options, an area of key concern is the potential obstacle posed by the expropriation provision to the extension of medicare to prescription drugs and home care. National pharmacare and home care programs, although long promised, have yet to appear. In an era of ongoing fiscal constraints, there are already significant financial impediments facing the government in this regard and the possibility of U.S. insurers bringing an article 1110 claim will be yet another deterrent to the implementation of such reform.

Canadian governments are beginning to experiment with contracting out publicly funded services to competing private organizations. There are salutary lessons from other jurisdictions, however, as experiences with contracting out initiatives in countries like the U.K., New Zealand, and Sweden have been very mixed. Significant aspects of the reforms in these countries have been subsequently modified or even revoked. Canadian provinces will want the freedom to be able to experiment with new public/private initiatives if first attempts are not successful. Article 1110 may mean, however, that provinces find themselves compelled to pay compensation to U.S. or Mexican investors if they later wish to remove or restrict the right of those investors to operate in the Canadian market. Thus, while a government will not be hampered in

¹⁴⁴ Ganguly, *supra* note 114.

¹⁴⁵ In this respect, NAFTA investment claims are in stark contrast, for example, to decisions made in the European Court of Justice. That court operates under conditions of openness and transparency. *Protocol on the Statute of the Court of Justice of the European Community*, 17 April 1957. See in particular Article 28 (hearing shall be public) and Article 37 (right to intervene for member states, institutions, other persons with an interest in the result of the case). Online: ECJ <<http://europa.eu.int/cj/en/txts/acting/statut.htm#>> (date accessed: 1 November 2002).

increasing the use of contracting out services, it may find that doing so commits it to a course of action that would be costly to reverse at a later date.

Another possible reform is “managed competition”, where competing private insurers are heavily regulated to ensure universal coverage (as is the case with Quebec’s prescription drug plan). If Canada’s Annex II reservation is not interpreted to cover a managed competition model, then the NAFTA’s national treatment rule will apply and may adversely restrict a government’s ability to regulate private insurers. Regulation is critical to managed competition reform, and any restrictions would be potentially problematic to the successful introduction of a managed competition model. Regardless of the interpretation given to the Annex II reservation, the NAFTA could result in unintended consequences flowing from the article 1110 expropriation provision. As with the increased use of contracting out, the government could face difficulties if at a later date it wished to retreat from managed competition reform to a single-payer insurance system.

Primary care reform proposals—with the idea of creating a competitive internal market that focuses on health networks with devolved budgets—may render Canada’s primary health care sector more attractive to foreign for-profit health organizations such as American HMOs or PPMs. Once again, the expropriation provision would apply, making policy reversal difficult if U.S. or Mexican providers were allowed to enter the Canadian market.

The challenge facing the Canadian government is to maximize the NAFTA’s potential benefits while minimizing its potential negative impact on the health care sector. Canada may be able to benefit from the export of health care services and technology, but international trade benefits do not only flow one way. Thus, if Canada wishes to argue for increased access to U.S. or Mexican markets, it will be unable to claim the protection of the Annex II reservation for the same services in its own market. Finance Canada, Industry Canada, and the Department of Foreign Affairs and International Trade should be cautious and consider the possible implications for medicare as they seek to support Canadian exporters of insurance services, health services, and technology in gaining access to U.S. and Mexican markets.

An important first step in responding to the problems we have raised is for Canada to negotiate with the U.S. towards an interpretation of the Annex II reservation that gives the greatest protection to Canada’s health care system. In the interim, it is crucial that all future measures concerning the health care sector, whether they be at the legislative level (*e.g.* implementing new legislation to contract out services to private providers) or at the operative level (*e.g.* a decision by a regional authority in Alberta to contract out the delivery of a particular service to a U.S. organization), be made in light of the possible NAFTA consequences. This will require informed communication between various government departments, including Industry Canada, Health Canada, and the Department of Foreign Affairs and International Trade. It is

also important that governments make explicit in any legislation or regulations their intent that publicly funded health care services be considered social services established or maintained for a public purpose. The clearer the government's intention in this regard, the more likely it is that a tribunal decision will find the sector concerned to be covered by the Annex II reservation and therefore exempt at least from the national treatment rule.
