



CENTRE FOR
HEALTH SERVICES AND POLICY
RESEARCH

Trading Away Health?
Globalization and Health Policy

Report from the
14th Annual Health Policy Conference of the
Centre for Health Services and Policy Research
November 9, 2001

Edited by:
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Karen Cardiff

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Trading Away Health? Globalization and Health Policy

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Abbreviations

| | |
|---|-------|
| Acquired Immune Deficiency | AIDS |
| European Union | EU |
| Free Trade Agreement | FTA |
| General Agreement on Tariffs and Trade | GATT |
| General Agreement on Trade in Services | GATS |
| Human Immune Deficiency Virus | HIV |
| Multi-national Corporations | MNCs |
| North American Free Trade Agreement | NAFTA |
| Sanitary and Phyto-sanitary Agreement | SPS |
| Technical Barriers to Trade Agreement | TBT |
| Trade Related Intellectual Property Agreement | TRIPS |
| United Kingdom | UK |
| United States of America | USA |
| World Health Organization | WHO |
| World Trade Organization | WTO |

Foreword

Highly public and highly conflicted conferences organized around negotiations to encourage free trade have dominated the press for the past two years. The WTO negotiating round that never quite got off the ground in Seattle in the year 2000 and this year's Free Trade of the America's conference in Quebec City woke North Americans up to the importance of free trade agreements and the extent of passionate disagreement about their advisability, depth, and scope.

While anti-globalization activists and non-governmental organizations representing a broad and diverse group of stakeholders have brought these concerns into the public eye, much of the discussion has been on general issues as well as the media circus which surrounds these events.

Most members of the public understand at this point that developing nations are concerned that they may be left out in the cold as the developed world hammers out bi-lateral and multi-lateral trade agreements. Many developed nations have been asked to open up their economies but in turn are not obtaining coveted access for their goods and raw materials in markets of developed nations. Another common theme that has emerged in the media is that these agreements will cause a "race to the bottom" as trade agreements de-regulate markets and labour and environmental standards are eroded.

In all this talk there has been virtually no mention of the healthcare. However, the new trade regime which has emerged on the international stage over the past decade may have long term and important consequences for the future shape of healthcare systems, particularly, systems such as ours in Canada with a large component that is publicly financed. This conference, has drawn together several health and legal policy experts to explore the question of current and potential future impacts on healthcare in Canada and health policy, more broadly, arising from these agreements.

Globalization: What is it? Where does it come from?

Aleck Ostry

The new round of WTO negotiations, postponed by riots in Seattle in 2000, opens in a small Persian Gulf State tomorrow. Hundreds of negotiators from nations all over the world are gathering to further develop the international trading regime that will increasingly affect our lives.

To fully understand what globalization is and where it is likely to lead it is necessary to discuss its history which is fairly lengthy because the first era of globalization began in the late 19th century. Exploring this era may provide insights to the present globalization. The history of the Post-second World War evolution of the international trading regime is a rich one and is similarly insightful. As most of you know GATT was developed in 1946 and culminated in the formation of the WTO in 1995. The replacement of the old GATT-based international trading regime by the WTO was a revolution that deserves historical explanation.

Before launching into this discussion it is necessary to define what most people seem to mean when they use the word “globalization”. The term does not appear in the literature until the mid-1980s. Although, since then, it has meant (and continues to mean) different things to different people there are probably some general areas of agreement about globalization.

Most people would agree that globalization involves a profound and worldwide shift in economic, geographic, cultural and social relations. And, it is usually discussed in terms of its economic dimensions which involve increasing national economic integration, often in novel ways and with greater complexity and inter-penetration than in the past. A main feature of this economic globalization is the development of a single global market for money and credit. Other features include the proliferation of highly integrated and deregulated markets for goods and an evolving deregulated, and increasingly global market for the trade in services.

At the cultural level, Giddens discusses “the intensification of worldwide social relations, such that local happenings are shaped by events occurring many miles away and vice versa”. Many sociologists talk about an emerging reflexive global consciousness; of course, this is currently dominated by the English language, particularly through the Internet and what one might call Anglo-American values. Geographers are concerned with the effects of technology and in particular the ways in which digital communications technology compresses time and space, effectively shrinking the world so that people have a completely different conception of space and time than in the past. Sociologists describe the growth of strategic global cities, such as Bangalore, Singapore, San Francisco, and New York. It’s in these cities where the infrastructure of the new global economy is concentrated.

In general, most would agree that globalization is currently driven by the marriage of digital technology and deregulated financial and other markets. Many also speak of the unique nature of globalization; of how it will lead to “progress” and economic efficiency (which is, of course, what many really mean by progress), and of its inevitability. WTO documents focus on the economic efficiency that globalization and market deregulation will bring and how this will produce wealth that will “trickle down” even to the poorest members of society.

These are, generally speaking, the central and generally agreed upon views on the nature of the current globalization. But, do these capture what is really going on? One way to find out is to look at past globalizations in history and compare and contrast these to the current situation. The first era of globalization began in the last quarter of the 19th century. Britain moved from an economic policy of mercantilism to one of free trade in 1850. As in America today, the British did this when they were in a powerful economic position. In the 1850s Britain was technologically, by far, the most advanced nation on earth and also had the largest concentrations of capital (obtained from its colonies mainly). Free trade made sense for the British because of their dominant economic and technological position.

By the mid-19th century, the technological fruits of the British industrial revolution had diffused to many other rapidly developing nations. The era between 1850 and 1913 witnessed the most rapid accumulation of wealth the world had ever seen to that point. The value of capital and goods traded between the nations of Northern Europe was larger, measured as a proportion of GDP, than is transferred today between developed nations. This was a time of expansion of technology and financial and global markets. As well, economic historians have shown that the globalization of the late 19th century was associated with increasing income inequality within the major nations of Northern Europe a phenomenon noted since the 1980s particularly in nations, like the UK and the USA, with the most highly de-regulated economies.

While these are obvious similarities between the past and the present eras of globalization there are also major differences. For example, today, the world has truly de-regulated financial markets so that the speed with which capital moves cannot be compared with the first era of globalization. And, even within the current globalization, the speed with which capital travels is startling. For example in 1973, daily trade in money amounted to about \$20 billion. Today this daily trade is up over a trillion dollars!

Another major difference is in the role of large corporations. In the 19th century only a few large international companies such as the British East India Company, the Hudson's Bay Company, and the Dutch East India Company existed. Today international trade is dominated by thousands of large multi-national corporations (MNCs). Approximately 40% of the trade in goods and 60% of trade in services involves intra-firm, that is, within corporation transactions.

This poses a problem for the nation-state because intra-corporate trade renders trade less visible, less controllable, and therefore less accountable to the state. These new MNCs are huge. For example, WalMart, which is the 12th largest corporation in the world, is also the 42nd largest economy. It's around the size of Poland. As well as their size and internal control, they have a privileged place at the international-trade negotiating table. The rise of the MNC is a feature present in the current globalization but missing from the first era of globalization.

The geography of the late 19th century globalization is different from today's as it was concentrated on the nations of northern Europe. Today's globalized economy revolves around three large regional economies located in Western Europe, East Asia based in Japan (and China increasingly) and in North America. Trade between and within this triad amounts to about 70% of world trade. Developing nations are largely excluded from this trade. This is triadization not

globalization, as economic activity is largely concentrated within and between these three regions.

This is a very important point to make in relation to Canada, because to use the word “globalization” is missing what’s really going on. For example, prior to NAFTA, 70% of our trade was with the USA. Since 1989 and the first bilateral trade agreement (FTA), our trade with the USA has increased to 87%. Globalization for Canada is a misnomer. A more accurate term is Americanization, as our increased involvement in NAFTA has reduced our trading connections with nations in other parts of the world. Finally, and unlike in the 19th century, we have new institutions with enhanced supra-national authority over trade. I will now speak briefly about the post-war evolution of these institutions.

The first era of globalization ended in World War I, and was followed by growing protectionism in the 1920s and in the depression later in the 1930s. The present era of globalization really began following World War II, and can be divided into two separate periods: 1) the era between 1945 and 1986 when the Uruguay round of world trade negotiations was initiated and, 2) the post-Uruguay round of negotiations.

In 1947 at meetings in Havana, the international community attempted to establish an international trade organization to reduce tariffs on goods in order to promote increased trade and move away from the disastrous protectionism of the 1930s. Instead of an international trade organization, a general framework agreement was reached called the GATT. This was a broad negotiating framework for reaching international trade agreements. It had minimal powers of enforcement. At the end of World War II, the average tariffs on goods in Japan, Europe and the USA were about 40%. By the mid-80s, and the beginning of the Uruguay round of negotiations, these were reduced to about 5%. The GATT had done what it was supposed to do.

It is important to understand that a major shift took place during the Uruguay round of the GATT negotiations. GATT had been an ongoing series of negotiations. In 1986 the Uruguay round began and ended in 1994. The result of this round was the formation of the WTO in 1995. After this, there was a six-year hiatus until the next round was attempted in Seattle in 2000. Due to public protest in conjunction with increasing resistance from developing nations, the Seattle meetings failed. The new round is starting tomorrow, on November 10th in Doha, Qatar.

It is essential to look at the period between 1986 and the present in some detail to appreciate the revolution in international trading relationships that occurred in this time. The trade negotiations between 1945 and 1986 were focused on the trade in goods. This Uruguay round was different because nations turned their focus from trade in goods to the trade in services. The fruit of these negotiations was the formation of the WTO which, although structured around the GATT (with its “goods” focus) also consists of several major agreements such as the GATS and the TRIPS which are concerned largely with trade in services.

Why did the world’s chief trading nations shift from a focus on trading in goods to trade in services? There are three reasons. First, trade in services currently represents about 20% of all international trade. But trade in services is by far the fastest growing segment of international trade. Second, trade in services represents the largest potential for growth in trade because, in

developed nations, approximately 80% of the economy is service-based. Modern economies do produce goods, but they are mainly organized to produce services. Third, trade in services is more possible now because services are now commodifiable and therefore trade worthy in ways they have never been before.

For example, on a trip to Fredericton recently, the airport taxi driver told me that the city houses a call center where every reservation call to a North American Delta Hotel is directed. Electronic transmission of these calls across the American/Canadian border is an international trade in a service. Cheap and reasonably well-educated Canadian labour processes these calls in Canada and spits the reservations data back across the American border to relevant hotels. Such service transactions would have been unthinkable even 20 years ago. These transactions are possible now because of new communications and data processing technology and de-regulation in this sector.

Trade in services opens up new trade opportunities, especially for nations on the technological leading edge. That is why the big push for the new agreements during the Uruguay round, came from the USA. In particular, the American entertainment, software and biopharmaceutical companies had the most to gain. Lobbyists from these industries had a place at the negotiating table. The TRIPS and GATS agreements were pushed into existence largely over the objections of developing nations, who were promised that if they accepted these agreements they would obtain greater access for their textiles and agricultural products to markets in developed nations.

It is necessary to understand what the key barriers are to an increase in international trade in services. They are not tariffs. They are the so-called "hidden barriers" – domestic rules and regulations, such as licensing agreements, limitations on foreign investment, the movement of electronic data across borders, the movement of skilled people across borders and so on. GATS specifically targets domestic regulations so it opens up a country's internal domestic policies for change and deregulation.

The GATS also commits nations to an ongoing series of negotiations. It puts pressure on nations to offer up sectors of their service economy to the "Full Monty" GATS, which is intensive market deregulation. Once a service sector is open to this Full Monty treatment, GATS has enforcement provisions, not present in the old GATT trading regime, to levy fines and sanctions even if a nation wants to retreat to pre-liberalization conditions or impose non-GATS compatible rules within the sector.

The new international regime has the means to punish and control what happens within the domestic sector of other nations. Let me give you an example, which is not directly connected to GATS and trade in services, but that might be instructive. At present we have an ongoing dispute with the American government on softwood lumber tariffs--an old regime kind of dispute involving trade in goods. The American government alleges that we subsidize the price of raw logs making it easier for our sawmills to make a profit. The American government, backed by American lumber manufacturers, says that our current domestic pricing system is an unfair trade subsidy to our lumber manufacturers. In spite of several international trade rulings in Canada's favour, the American government has engaged in bullying trade tactics with the purpose of altering our domestic log-pricing regime. This dispute involves lumber today but could be healthcare tomorrow.

Earlier when I asked if you were aware that the Canadian government had agreed to open up our health insurance sector for negotiation under the GATS most of you replied in the negative. And, earlier when I asked if you were aware of what healthcare issues may be under negotiation today as the latest round of negotiations begins none of you knew. It is very interesting that in this room of health policy experts nobody seems to know what has gone on and what is currently going on in these negotiations which are likely to have a major impact on healthcare in this country.

It is no wonder as these negotiations have not been widely publicized. Nor do we really know from what set of principles, or from what intellectual framework, and with what mandates, this team is negotiating on our behalf. I'm going to ask Dr. Robert Evans to tell us more about our trade negotiators as a way of deepening this introduction to globalization and to link it to the issue of health.

Ideology, religion, and the WTO

Robert G. Evans

It is appropriate to begin this talk with the last question posed by Aleck Ostry: “Who are the trade bureaucrats?” Who are the people negotiating all-encompassing international trade agreements on our behalf? And perhaps more importantly, at least for this talk, “What is in their minds? How do their minds work?” It is important to understand that most of the bureaucrats behind trade organizations have a conventional training in economics. This is not comforting because there are aspects of conventional economic theory that are fundamentally flawed. And bad theory kills, or at least causes serious problems for a lot of people.

Paul Starr opens his magisterial survey, The Social Transformation of American Medicine: “The dream of reason did not take power into account.” He was talking about the rational ideal, the rational dream of the functioning of a medical system. I think this characterization applies equally well to economics. In fact, it probably applies even better to economics than it does to medicine. There is a strong theme in economic theory of the dream of rationality, a dream with its roots in the 18th century.

Economists collectively, like the deists of the 18th century, have always been fascinated with the notion of complex self-regulatory systems. The deists saw the universe like a gigantic clock, with God as the Divine Clockmaker who set it all going and now sits to one side and contemplates the automatic functioning of the process. Furthermore, as Voltaire’s Pangloss never tired of pointing out, this clockwork system -- having been created by God -- is the best possible system that could be created. Do not monkey with it. Leave it alone, because this is the best that could happen in the best of all possible worlds. If it were not the best of all possibilities a benign and omnipotent God would not have created it. So the self-regulating system is self-balancing, self-equilibrating and yields, for humans, the best outcomes possible. That sounds very much like the story told by the significant proportion of economists who claim that decentralized voluntary exchange in free markets -- a self-regulating, self-equilibrating system -- is the best way in which you can possibly organize economic activity. Any state intervention will make things worse because by definition you cannot make things better. This sort of theoretical framework now dominates a number of the economic schools.

It is interesting that the economists depart from the deists in one respect: the optimality of the self-regulating process stops at the borders of the state. The deists went farther: they said the universe, as a whole, is operating as well as possible. The economists who look at the world through Panglossian spectacles, say that the world is working as well as it can, so long as governments do not do anything. As soon as governments do something, whatever they do is wrong. It is outside the system of decentralized voluntary exchange and therefore a threat to the whole process.

Why do I bring this up? Because I think there are two different things driving this trade liberalization process in the broadest sense. One is pecuniary self-interest. In the first presentation the role of the biopharmaceutical and entertainment industries in pushing for trade liberalization has already been touched upon. They’re doing it for the same reason they do everything else: to enhance shareholder value. Shareholder value is a polite term for profit. The corporate people

pushing trade liberalization are doing this because they expect to make money. That's their job and their legal responsibility to their shareholders – but not, of course, to you and me, or to any broader public interest. Pure private economic interests are a major driver of the trade liberalization process.

However, trade bureaucrats, both those at the national and at the WTO level, are not motivated by pure economic self-interest in the same way that corporations are. Trade bureaucrats tend not to own pharmaceutical companies. They do, of course, have an interest in making sure that the skills that they have paid to acquire are utilized. If they know a lot about private markets, because that is how they were trained, then obviously they want to find applications – markets -- for that knowledge and the associated intellectual skills. But trade bureaucrats are motivated as much or more by the religion they acquire during their training.

Because they are so tightly and religiously held, it is important to understand the source and nature of the principles motivating the bureaucrats who produce the documents from the WTO. What an extraordinary set of principles this is! These bureaucrats are seeking to establish supra-national institutions that are in no way politically accountable to the citizens of the countries party to the agreements. The principles embodied in the new trade agreements are something we have not seen since the days of the medieval papacy. Modern trade bureaucrats are economic Jesuits who, for the greater glory of the market, are attempting to establish a structure in which the rules of the trade agreements will override those made by nations -- just as the popes claimed to rule kings of the earth in medieval times. The popes who styled themselves *servi servorum dei*, servants of the servants of God, regarded themselves in fact as rulers of the rulers. The trade agreements are modeled on this premise of medieval governance. WTO documents say, in so many words, that disciplines will be applied to regulate the internal political structures of countries. They say quite explicitly that GATS will involve much more extensive intervention in the domestic arrangements of different countries. The fact that the citizens of a country may not want such an intervention is simply irrelevant. Countries will be disciplined and forced into line. This is an extraordinary claim.

How will these new popes enforce their will? I began this talk quoting from Paul Starr, “the dream of reason did not take power into account”. To apply this to the papacy, I think of Joseph Stalin's insightful query at the beginning of the Second World War: “The Pope? How many divisions has he got?” Well, the medieval popes actually had some divisions, because they controlled the Papal States in the center of Italy, but they did not have very many. Mostly, their force was legitimation of force applied by other people. In other words, declare an individual ruler to be anathema, lay his lands under an interdict, and then it becomes a holy duty for everyone else to attack him. That is what sanctions are; sanctions applied by the WTO are a license, indeed a duty, for other countries to attack the offending country, essentially to launch a more or less limited form of economic warfare. Unlike the medieval papacy, the WTO does not try to promote direct physical assaults but the process still involves inflicting as much pain as is necessary to achieve compliance.

The problem, of course, is that when trying to sanction a very powerful country it may be difficult to encourage other, particularly less powerful, nations to attack it. (The popes had this problem with the Holy Roman Emperors — well known for being neither Holy nor Roman nor an

Empire.) For example, under the WTO agreement, Canada could attempt to impose sanctions against the Americans for their behaviour on softwood lumber. The point is that the WTO arrangements do not get rid of power; they merely create a separate framework in which power is enforced on those who are not very strong, and negotiated among those who are. It is becoming increasingly evident that the USA may choose whether or not to abide by WTO decisions; the European Union has some degree of flexibility, and the rest of us must do what we are told. Power is at the core of the process; the dream of reason is just a dream.

But the medieval popes did, claim that their motivation was not temporal power. Their concern was the salvation of souls from hell, to eternal life, and what objective could possibly be more important? What is the ideological basis for the claims of these new popes? They claim to offer improved economic welfare for all, and their theology is economic theory. Imagine that we are in the world hypothesized in most economic theory. It is a world of essential equals in power. No one controls the marketplace or influences prices. All are equal in subjection to the prices determined within the market. These are important assumptions made in economic theory and form part of the intellectual baggage of the people designing international trade agreements. These bureaucrats genuinely believe, as the Jesuits did, that they are promoting the greater good. In the case of the Jesuits, it was the greater glory of God, but in the case of trade bureaucrats, it is the greater good of mankind.

A middle-level bureaucrat from the WTO came to a symposium here at UBC last September. He was a decent, well-meaning, intelligent individual, hiding nothing. He was open about the fact that the WTO hoped for a world in which governments had two functions: (1) to define, maintain, and enforce the terms of contracts so as to provide the underpinnings for private voluntary exchange; and, (2) to manage the transition to this new world of the minimal state by dealing with the political and economic problems created in the short run. He appeared quite sincere in his belief that this was going to be a much better world for everyone. His argument was that the trade in goods had done wonderful things to enhance prosperity and human well-being over the last fifty years, and therefore free trade in services will be equally or even more beneficial. And we are certain of this because economic theory tells us so.

I want to address the flaws in the assertion that if free trade in goods worked it is going to work in services as well, and then follow this up by addressing basic flaws in economic theory itself. One would have thought that those making the arguments that if trade works in goods, it must work in services, would be sensitive to two things. First, what goes on in public service sectors like education, health, and government services more generally, is typically not taught in the standard economics training programs. Although they make up a large part of modern economies, these sectors are largely terra incognita for the conventionally trained economist. Far too many economists assume that organizational structures that yield satisfactory results – more or less – in the currently private sectors must of necessity also have application to public services. But this assumption is rooted, not in knowledge of comparative sectoral characteristics, but in simple ignorance. They don't know any better.

Second, if they were aware that they did not know what they were talking about, they might at least have reflected upon the fact that in practice governments in the developed world have obviously chosen not to place these services in the (invisible?) hands of the marketplace. We have

mixed economies. We have the private sector handling a lot of the production of shoes, ships, sealing wax, wheat, and steel, and we have the public sector taking major responsibility for the central service sectors such as health care and education. If this is true, how can one be so confident that the people who govern all (more or less) developed democracies have got it wrong, and that things will work better if these sectors were opened to the private market? It is an arrogance born of ignorance – and of religious conviction.

One hears arguments like “State planning failed east of the Berlin Wall. Capitalism has achieved brilliantly west of the Wall”. Very true, but it is also true that no successful capitalist country has turned the major public service sectors over to the market. So, the generalization that if it works here it has to work there is fundamentally baseless. Accordingly, and because I am a professional economist, I will aim my principal fire at the theoretical argument.

Without going into the details it is clear that the simplistic economic models generally available to trade economists will tend to show that a country cannot be worse off from trade. Furthermore, these models show that if a country produces more of the thing that it is good at producing and trades it on the world market for other commodities, it will obtain an even bigger gain from trade. But “countries” do not, cannot, gain or lose anything at all. Only people can do that. So when “a country” is asserted to gain or lose, does that mean that everyone in it gains or loses the same amount, or in the same proportion? In fact, that is precisely what the conventional theoretical framework does assume, and that is of course nonsense. Some gain, others lose, and the differences can be large.

The conventional theory models the circumstances of a hypothetical “representative agent” that stands for all the residents of the country. The problem with developing policy based on these representative agent models is that they hide the distributional effects. It is very difficult to model distributional effects analytically. Consequently, they are ignored by simplifying assumptions that imply that they are not important. In other words, the analytic structure of economics forces distributional considerations under the rug and enables people to pretend they are not there. Using economic theory, allows people to talk about gains from trade as if they applied to everybody. They don't.

If pushed hard on this point, most economists would fall back on an argument that freer trade makes it possible for every citizen to be better off. The gainers could compensate the losers, and still be better off themselves. If the losers are not in fact compensated – and they never are – then that is an internal matter. But it is profoundly dishonest to advocate a policy on the basis that it is good for everyone, when one knows full well that it is not, and will not be. The economic advocate is in reality making an implicit judgement that the interests of the winners from his/her proposed policy are in some sense more important than those of losers. But that is a political choice, not a “scientific” conclusion, and no one elected economists to make such choices.

Furthermore, even the claim that gainers could compensate losers rests on the assumption of trade among equals, in which no country or group of countries has power to manipulate the world market. Alternatively, countries can if they choose simply withdraw from international trade entirely. Neither of these is true, so that in the real world countries that open themselves up to the global market cannot go back, and are open to exploitation by more powerful trading partners.

Collectively, the citizens of a country may not gain from trade even in the sense that losers could be compensated. That comforting result emerges only from the simplest and most naïve view of the process.

Apart from these critical issues of the distribution of gains and losses from trade, there is a fundamental assumption of consumer theory called the axiom of non-satiation. This means that goods (and services) are good, and more of both is always better. Higher levels of consumption always lead to increased well-being. This may work reasonably well for boots, clothing, and food - although even with these this axiom may not apply simply. (One must assume that higher quality items are “more” of a commodity than lower quality items – not unreasonable in general but leading into a minefield of perception versus reality – a wilderness of mirrors.) But it is definitely not true -- simply false – if applied to health care. More is not necessarily better and may in fact be much worse. Consider the overuse of antibiotics, for example, that is harmful for both the patient and for the wider community. More generally, when Canada established universal public health insurance, expenditure on health care flattened out. In the US, where public health insurance was partially instituted expenditure escalated rapidly. From the perspective of standard economic theory, what happened in Canada was an economic disaster, because the output of health services is much higher in the USA than in Canada. In fact, even that is not true. The payments for health services are higher in the USA than they are in Canada but the output is not much different. The American prices are higher. But standard theory would teach that the “quality” of care must therefore be higher in the USA. Otherwise it would not cost more. Under the standard assumptions of consumer theory, the Americans are much better off because they get more dollars’ worth of health care. Now, they may not be getting any healthier, in fact they’re less healthy than Canadians, and they may not actually be getting much more in the way of services, they’re just paying higher prices, but the economic framework says that if they’re paying higher prices, then the commodities must be more valuable. Very specifically, if a new drug comes on the market, substituting for a previously used drug but at ten times the price, and if it is used, then it must be ten times as much drug. Whether or not it has any greater benefits in terms of therapeutic outcome is irrelevant to the economic model. If it sells, it must be worth more.

This can be seen in relation to drug advertising. For example, if billions of dollars are spent on direct-to-consumer advertising, and if this results in greater drug use, even if these drugs don’t do people any good in terms of improved health, the economic theory forces the conclusion that there has been a gain in prosperity and well-being. These trade agreements are being conducted in that mental framework. The model values the services or the goods by the amount that is paid for them, and that too is part of the mental furniture of a trade bureaucrat.

Trade agreements are resulting in the creation of a supra-national structure that has, at its ideological heart, a rather middle to low-brow understanding of economics. Furthermore this structure has been created by and is governed by people who are working with outdated and naïve economic models built on profoundly erroneous assumptions. Under such circumstances, we shouldn’t be surprised if trouble is brewing.

International trade agreements

Steven Shrybman

In the opening plenary, Ostry and Evans provided an historical and ideological perspective on globalization. The purpose of my talk is to provide a legal perspective on globalization as reflected in the development of international trade law. I will describe how the new generation of international trade agreements have intruded into areas of domestic policy and law never before subject to international rules. What formerly were exclusively matters of local or national concern, are now the subject of binding international trade disciplines. Finally, I will recommend what can be done to respond to these new challenges.

In the preceding talk, Ostry outlined the evolution of international trade policy from 1947 and the formation of GATT, through the Uruguay Round of negotiations, which began in 1986 and culminated with the establishment of the WTO in 1995. The transformation of international trade law that occurred during this period can truly be described as revolutionary.

Whereas the GATT had been entirely concerned with the trade in goods across international borders, the Agreements of the WTO concern virtually all spheres of both international and domestic commerce including services, intellectual property rights, technical regulation, subsidies, procurement, and investment.

A following example serves to illustrate how international trade and services disciplines come into play even in the local context. The case concerns a plan by the Greater Vancouver Regional District (GVRD) to enter into a public-private partnership in which a private company would design, build and operate a large water filtration plant in the region. The Canadian Union of Public Employees (CUPE) retained our firm to assess the proposal in light of Canada's obligations under the investment and services provisions of NAFTA and the WTO.

We pointed out that by entering into the contract it proposed with one of the trans-national corporations that were lining up to tender on the project, the GVRD would also enter into a relationship that would be subject to the investment provisions of NAFTA and GATS under the WTO. This prompted the GVRD to retain legal counsel to review the concerns we had raised. While their legal opinion has not been made public, the GVRD subsequently abandoned its privatisation plan citing trade concerns as a prominent reason for having done so.

This example shows that a privatisation project that formerly would have been a local transaction governed by Canadian contract law, may now be a matter subject to complex international trade, services and investment rules. When conflicts arise between Canadian law, whether statutory or common-law in origin, and international trade rules - the latter prevails. Moreover, what is true for a water filtration plant in Vancouver, is true for a private hospital in Alberta, or a privatised diagnostic services in Quebec.

The most remarkable feature of these new international trade, investment and services regimes, is that these 'trade' rules are truly enforceable. Under the WTO, decisions of the Appellate Body (the regime's penultimate trade dispute body) are automatically enforceable within ninety days of having been rendered, unless every member of the WTO Council agrees to block implementation.

Let me give you an example. The first trade dispute to be resolved by the WTO was a challenge to the *US Clean Air Act* regulations. The purpose of those regulations was to require both domestic and foreign gasoline manufacturers to remove contaminants from gasoline products in order to improve air quality in the USA. Some foreign producers balked at having to make substantial investments to upgrade their refineries in order to improve air quality in American cities. They challenged the *US Clean Air Act* regulations as a hidden trade barrier.

The WTO dispute resolution panel agreed with their complaint, and the Americans appealed. The Appellate Body also ruled against the USA, concluding that its air quality regulations were not in compliance with WTO rules. The Americans would either have to abandon its regulations, or be liable for sanctions in the order of \$150 million. This entire dispute from beginning to end lasted eleven months, which as most will know, is astonishingly quick for the resolution of any legal dispute.

The case illustrates the enormous reach and power of WTO disciplines when made effective by its new enforcement procedures. But as powerful as the WTO's enforcement regime may be, it is at risk of being eclipsed by an international dispute resolution mechanism that is even more coercive. I am referring the investor-State dispute procedures of international investment agreements, such as the one included in Chapter Eleven of NAFTA.

Under these procedures, countless foreign investors have been accorded a unilateral right to claim damages against a nation state where the latter fails to live up to its obligations under an international trade or investment treaty. By according foreign investors the right to enforce an international treaty to which they are not parties, and under which they have no obligations, these dispute procedures represent a dramatic departure from the norms of international law. Moreover, foreign investor claims under NAFTA are resolved by tribunals that operate entirely outside the context of Canadian judicial norms and Canadian legal institutions.

We have now seen these dispute procedures invoked on several occasions to challenge public health, resource conservation, environmental protection and other government laws and regulations. Moreover, while there have now been several formal claims brought against Canada, just the threat of investor-State litigation has exerted a deep chill over the development of policy and regulatory initiatives that are unpopular with MNCs doing business in Canada. Take for example, federal proposals tabled in 1995, for legislation that would require cigarettes to be sold in plain packaging.

The RJR Reynolds Tobacco Company didn't much care for this idea and retained Carla Hills, a former senior American trade official, to prepare a legal opinion that was subsequently tabled with the parliamentary committee considering the plain packaging proposal. That opinion concluded, that if the federal government were to proceed with its initiative, it would be expropriating the company's good will and infringing its trademark rights. It further concluded that these property rights were subject to absolute protection under NAFTA, and that Canada would be liable under the treaty to pay the company full market value for the property it would be taking. Damages would likely be in the hundreds of millions of dollars if Canada actually went forward with its proposed public health initiative. It did not.

No agreement is more effective than the enforcement mechanism available to ensure compliance. Thus, because they engender no meaningful sanctions, international human rights, environmental treaties and labour standards are rarely observed. Conversely, the enforcement regimes of the WTO and NAFTA create a very powerful incentive for governments at all levels to comply with the international trade obligations that Canada has undertaken.

It is also significant that the international trade commitments that Canada has made have profound domestic constitutional implications as well. Thus in addition to having transformed the landscape of international law, WTO and NAFTA have had a similar impact on Canada's constitutional arrangements. Under our constitution, international trade is a matter of exclusive federal jurisdiction and the federal government is free to negotiate trade agreements that speak to both its obligations and those of provincial and local governments as well. Accordingly it can, and routinely does, undertake commitments concerning matters that fall entirely within the sphere of provincial constitutional competence, such as the delivery of health care services.

Thus, what the federal government could never achieve through formal constitutional reform in Canada, it is free to accomplish unilaterally in the course of negotiating international trade agreements. The wrinkle is that the provinces don't have to go along. In other words, as a matter of formal constitutional law, local and provincial governments are free to ignore the international trade commitments that Canada has made in areas of their constitutional competence.

However, even though Canada may not be able to ensure compliance by the provinces, it nevertheless remains bound by its international commitments, including those that may only be accomplished by provincial governments, and may be punished for not meeting them. Moreover, the trade sanctions that may result from non-compliance, will often be assessed against exports that are vital to the economies of provincial governments. Take softwood lumber for example.

Furthermore, trade sanctions are likely to be targeted very strategically. For example, when Canada did not move quickly enough to implement a ruling by the WTO against it in a case involving cultural policy (the split-run magazine case), the U.S. threatened to impose vastly inflated trade sanctions (\$300 million) against Canadian steel products and other exports. It is not a coincidence that steel workers are a major presence in the riding of the federal minister responsible for Canadian cultural policy.

Because this type of cross-retaliation is permitted under WTO and NAFTA rules, it is common for trade sanctions to be targeted where they will be most keenly felt – adding considerably to the coercive impact of these international regimes. Thus while provinces and municipalities are, as a matter of formal constitutional law, free to ignore the commitments that Canada has made under the WTO and NAFTA, as a practical matter, they have little option but to comply with them.

The effect of these international developments has been to bring about a fundamental transformation of Canada's constitutional landscape. Thus, matters of provincial competence, such as the delivery of health care services, must now be consistent with Canada's international trade obligations, unless the province is willing to brave the consequences of retaliatory trade sanctions, and foreign investor claims. While the latter may be brought only against the federal government, it is unrealistic to imagine that a provincial government would emerge unscathed

should a tribunal award substantial damages against Canada because of actions taken by the province.

Unfortunately, while the public policy and legal dimensions of Canada's international trade policies were being dramatically expanded in the years leading to the conclusion of NAFTA and WTO negotiations, the domestic framework for informing those negotiations remained as narrow as it had been when trade agreements were only about trade in goods. The predictable results of this domestic policy failure, are international trade regimes that reflect a myopic preoccupation with the commercial interests of the corporate community, to the virtual exclusion of all other societal interests or goals, including those relating to social, environmental, and cultural concerns.

I believe in the adage that one should not put off to deceit, what can be attributed to incompetence. In my view, it is quite apparent that the trade officials that had carriage of Canada's international trade negotiations, often did not understand the broader social and legal implications of their endeavours. Recent remarks by Renato Ruggiero, the first director of the WTO, lend support to this assessment.

Speaking at a European conference concerning trade in services, Ruggiero commented on the implications of the GATS. He said:

The GATS provides guarantees over a much wider field of regulations and law than the GATT. The right of establishment and the obligations to treat foreign service providers fairly and objectively in all relevant areas of domestic regulation, extend the reach of the agreement into areas never before recognized as trade policy. I suspect that neither governments nor industries have yet appreciated the full scope of these guarantees or the full value of existing commitments.

In other words the ranking official at the WTO is acknowledging that the public policy and legal implications of agreements such as the GATS, were not, and still are not, fully understood by the governments that are now bound by them. I think that Ruggiero might have gone even further with these candid remarks had the subject been NAFTA's investment rules, rather than the GATS, because of the amenability of the former to private enforcement.

Finally, I would like to talk about the current state of play of some of the issues that I have touched upon. There is now a growing and vigorous debate taking place both nationally and internationally about the implications of the international trade commitments on competing public policy objectives such as public health care and environmental protection. In many ways this debate has been spurred by trade disputes that have exposed the far-reaching impacts of these regimes.

In Canada, cultural policies, the Autopact, technology development funding, supply management regimes for agricultural products, and drug patent laws have all come under attack for being non-compliant with WTO disciplines. As noted, several investor-state claims have challenged environmental and public health measures, the way in which public services are delivered, and even the administration of other trade agreements.

Trade and investment tribunals have consistently given trade rules liberal reading, extending their application to policies and laws that one might have reasonably assumed to be beyond their reach. Thus the GATS has been successfully invoked to challenge preferential tariffs on goods under the Autopact, and a convention between European countries and their former colonies. The countries against which these claims were made seemed genuinely surprised that measures concerning international trade in goods, now also have to meet the requirements of the GATS.

Where does this assessment leave us? First, with an understanding that there is great need to improve the trade literacy of public officials, and others in society, who must bring to the sphere of international trade negotiations, a much broader perspective than is offered when trade policy is simply left to a handful of bureaucrats resident in the trade ministries of provincial and federal governments. It is crucial that Canada's trade agenda reflect a much more balanced policy approach than has hitherto been the case.

Second, prudence should dictate that we acquire a much better sense of the true extent of the commitments we have already taken on board, before venturing forth to expand those obligations. Unfortunately as Canada pursues negotiations in both the global and hemispheric contexts, there is little evidence of this restraint.

Third, there may be a need to reconsider some of the commitments that Canada has already made. Commitments of insurance services under the GATS, which may seriously erode our capacity to maintain or extend the Medicare system, are a likely candidate. The same is true for the qualified and ambiguous reservations that Canada is relying upon to shield its health care policies from the full brunt of NAFTA investment and services disciplines.

Fourth, we must proceed very cautiously with domestic reform, lest we lose the protection of trade safeguards that apply to non-conforming measures that were in place when these trade agreements were established. Under NAFTA, reform is one-way street in favour of liberalization.

It is clear that Canadian health care policy and policy reform now must be vetted against Canada's obligations under international trade agreements. In many ways those obligations entrench market-oriented policies that cut directly against the grain in a public health care system that has rejected the market as a sufficient mechanism to determine the allocation of health care services. Given the new importance of international trade law, there is obvious need to rethink international trade policy so that it does not overwhelm Canada's social policy agenda, particularly in those areas, like health care, that have very little to do with international trade at all.

Trade agreements and tobacco control: how global and regional trade agreements may stand in the way of reducing tobacco use

Neil Collishaw and Cynthia Callard

Physicians for a Smoke-Free Canada is a small organization that works in coalition with groups that work on tobacco and public health issues. You may wonder what motivated physicians to become interested in tobacco, public health, and international trade issues? Our catalyst was the 1994 opinion expressed by Carla Hills, the former American trade representative, that if the Canadian government were to proceed with legislation to enforce plain packaging for cigarettes, “it would cost them millions and millions in compensation.” This was a wake-up call for our organization: it made us realize we had to become better informed about broad trade issues because they were going to have an impact on domestic public health.

We realized too, that the groups resisting globalization were diverse but they were arrayed, in the case of tobacco, against corporate organizations with a very focused agenda. This required a response within the anti-globalization movement that brought to bear physicians’ concerns about tobacco and public health in a similarly focused and organized manner. That is why we as members of *Physicians for a Smoke-Free Canada* are at this conference speaking to you about the links between tobacco, public health, and international trade.

Tobacco companies want to provide cigarettes that are cheap, widely available, and attractively packaged. It is in their economic interest to increase the public’s consumption of their products. Trade liberalization helps companies increase tobacco consumption which is obviously in total opposition to the public health agenda for tobacco.

In order to understand the likely impact of liberalized trade in tobacco products on public health, it is necessary to discuss the impact of tobacco on health. Over the past 100 years, the tobacco epidemic has gone through several stages in developed nations. The first stage of the tobacco epidemic consists of an increasing prevalence of smoking among males. An increase in female smoking rates follows twenty years later, although these don’t equal peak male smoking rates. Each of these increases in smoking rates, first for men and then for women, is inevitably followed, after a lag of thirty to forty years, by an increase in mortality. The range of smoking-caused diseases responsible for this increased mortality includes respiratory diseases, cancers, and coronary heart disease.

In Canada, we are currently at the fourth and last stage of the tobacco epidemic with declining male mortality from tobacco-related causes and increasing female mortality due to the effects of increased smoking rates which began some thirty years ago among women. Other nations are at different phases of this epidemic. For example, Russia currently has extremely high rates of smoking among men and increasing rates among women. The peak impact on mortality rates for both men and women will be experienced about twenty or thirty years from now. These expected tobacco-related mortality increases will push their overall mortality rates even higher. Russia is in the third stage of the epidemic.

Another example is Malaysia, which is at an earlier stage in the epidemic compared to Russia and Canada. Smoking rates among Malaysian men are very high, but they still remain quite low among women. For a tobacco manufacturer, this low rate of smoking among women (about 3.5 percent in Malaysia) is simply a marketing opportunity, especially given that this is not yet viewed as a public health problem in that country. Malaysia is in the second stage of the epidemic. Finally, there are many nations in Africa at an even earlier stage in the epidemic than nations such as Malaysia. This is because smoking rates are very low among both men and women in Africa. The point is that the tobacco epidemic has distinct patterns in developing, partly developed, and extremely under-developed nations.

We estimate a current total of one million tobacco-related deaths split 50/50 between the nations of the developed and under-developed world. This burden of mortality will soon shift dramatically towards less-developed nations. By 2020 we expect about six million deaths in developing countries, compared to 2.5 million in developed countries. By that year, deaths caused by tobacco will likely exceed the combined number of maternal deaths and mortality due to AIDS, tuberculosis, car accidents and suicide. The burden of tobacco-related disease and mortality will be disproportionately borne by poor people living in poor nations.

This looming shift in the epidemic is driven largely by the new dynamics of international trade. As developed nations move more aggressively against tobacco companies, they have begun to look more seriously for markets in the developing world.

There are a small number of large companies that are driving this epidemic? The Chinese have a state-run tobacco monopoly, which, because of its huge population and high smoking rates, has made it the single largest company in the world. The Chinese tobacco monopoly accounts for one-third of all worldwide cigarette sales, but these are almost all domestic sales. The international companies such as Phillip Morris, British American Tobacco (BAT), and Reemasma, while not as large as the Chinese state monopoly, are the primary international traders in tobacco. Phillip Morris is the biggest of these; one in six cigarettes sold around the world is a Phillip Morris product. Marlboro, which is not sold in Canada, is not only the world's largest selling cigarette, it is the world's largest selling packaged good.

What has all this got to do with trade agreements? The GATS, SPS, TBT, and TRIPS agreements are the ones that are most salient in relation to the tobacco trade.

The TBT agreement sets rules under which regulations can be made, which may have an impact on trade. Any government seeking to develop new regulations must show that they are necessary and that they do not constitute a technical barrier to trade. Similarly any regulations developed by government in the arena of food safety falls under the SPS agreement. New regulations must be necessary, science based, and transparent so they cannot be a disguised trade restriction. And most importantly, harmonization of regulations developed under these two agreements is encouraged. This means that it is difficult for a nation to elevate its standards above those of the rest of the world.

The GATS agreement will have profound effects on the international trade in tobacco because, although tobacco is a good, there are many services associated with it including extensive

retailing, advertising, packaging and research. Thus, as Steven Shrybman mentioned in his reference to the Canada/USA Autopact, these “trade in services” agreements have been and will be used to liberalize trade in goods.

Finally, the TRIPS agreement is concerned with all intellectual property rights, including trademark rights. If you want to take the Marlboro man’s name and face off a racing car, you are affecting a trademark right. If you want to have plain packaging of cigarettes, you are affecting a trademark right. The TRIPS Agreement has not been tested thoroughly in these areas, partly because the measures that would test them have not been taken in many places as this agreement has exerted a marked chilling effect.

One of the most telling stories in regard to TRIPS took place in Guatemala. It has been long established that breast-feeding, certainly in a non-AIDS context, is a healthier way to feed babies than with infant formula. And Guatemala, which was moving ahead with WHO-suggested policies, was trying to discourage the use of infant formula. Due to high illiteracy rates in Guatemala, Gerber, the main manufacturer of infant formula in the country, put pictures of healthy, beautiful babies on their infant formula to promote its sale. To counter this campaign, the Guatemalan government passed a law stating that the company could not use these pictures in their infant formula advertisements.

In response, Gerber wrote letters to the government threatening a WTO trade appeal. The basis of the trade action was to be the TRIPS. Gerber stated that the pictures of healthy babies used in their advertisements were a trademark, and that if the Guatemalan government removed it they would face trade sanctions. With these threats, the Guatemalan government backed down. This demonstrates the importance of trademark rights for corporations and the vulnerability, particularly for third world and impoverished governments to corporate threats.

In spite of these agreements there has been some successful resistance. Before these agreements were established, in the 1980s, the tobacco industry decided they were going to use their client state, the USA, to pry open markets in Southeast Asia such as, Japan, South Korea, Taiwan and Thailand. Three countries quickly capitulated and opened their markets to American cigarettes. The Thais however, resisted, and as a result, under the GATT, had a trade sanction imposed on them by the USA. The dispute eventually went to a GATT panel, which ruled that Thailand could not ban American cigarettes. The panel decided however, that Thailand could apply rules to domestic and imported products alike, such as a ban on advertising.

Thailand complied with the ruling and opened their market to American cigarettes but they promptly instituted a ban on all forms of tobacco advertising, including advertising of imported cigarettes. While tobacco use has increased, because Thailand now has comprehensive tobacco control policies in place the country is doing a little better than the other three countries that were pried open by the Americans.

Since the formation of the WTO a number of measures have been undertaken by the EU, Japan and the USA to continue pressuring Thailand to further liberalize its tobacco markets. Over the last ten years we have counted twenty-two instances of harassment of the Thai government by the EU, the USA, or Japan as they tried to pry open the Thai market further. Specifically they wanted

to force the Thai government to rescind their tobacco policies. So far, they've had no success. Thailand has stood up to the challenge.

A global response to this problem is in development. The Framework Convention on Tobacco Control is a treaty that is currently being negotiated through at the WHO. This agreement has the potential to deliver the comprehensive tobacco control measures that are needed in an international context. It can also deal with the trans-boundary elements that include unfair trade challenges, cross-boundary advertising, and deliberate smuggling by the companies to undermine tax policies. The framework agreement also gives developing countries the tools they need to put tobacco control into place.

The impetus for this agreement was the GATT challenge in Thailand when the Marlboro Man walked unhindered through the Thai border. The WHO took up the challenge to develop this treaty, quietly at first and then more vocally. Negotiations started in earnest just over a year ago and they are continuing. By 2003 the treaty should be finalized.

One of the key challenges of this treaty will be to work out what to do about WTO agreements. In a recent session seventy-five nations agreed that, if we are going to pass a tobacco treaty, we must ensure that health rules the day. This is an important principle agreed to by governments, and is now enshrined in the emerging treaty. All of these nations have agreed that health trumps trade. Only three countries balked, 1) Russia; their stance was difficult to understand, 2) the USA said, "we are talking business here, the WTO has to rule" and, 3) Canada which said, "we should give this more study."

One hundred and fifty civil society organizations like *Physicians for a Smoke-Free Canada* are working within the Framework Convention Alliance to mobilize support for this treaty. That is one of the reasons I am here today. We want to pass a global tobacco treaty that makes it clear that trade agreements do not determine health policy.

TRIPS, Traps and drugs: trade agreements and the pharmaceutical industry

Joel Lexchin

This presentation outlines the effects of international trade agreements on pharmaceutical and drug policy, mostly in Canada but also internationally. Specifically, I will discuss the effects of these agreements on: (1) prescription prices, (2) overall drug expenditures, (3) our ability to institute a national Pharmacare plan, (4) the economic impact on the pharmaceutical industry in Canada and, (5) how the agreements may affect our relations with developing countries.

In order to understand the impact of free trade agreements on pharmaceuticals, it is necessary to begin with a short lesson on drug price controls in Canada. The primary way in which drug prices were controlled in this country was through compulsory licensing. Compulsory licensing agreements allowed generic drugs to enter the Canadian market relatively soon (usually within five to seven years) after the introduction of its brand name equivalent. The presence of generic drugs leads to increased competition and savings estimated at between 25 to 50% on the price of a prescription.

Between 1969 and 1987, compulsory licensing had major effects on our ability to control pharmaceutical costs. For example, in 1983 Canada spent \$1.5 billion on pharmaceuticals. If compulsory licensing had not been in place, an extra \$211 million (14%) would have been spent on drugs in that year. Two factors were responsible for the substantial savings despite the fact that compulsory licensing did not affect large segments of the market. First, as previously stated, the generic drugs were much cheaper, and second, in response to compulsory licensing, the brand name companies kept prices lower than they otherwise would have been.

Although the brand name pharmaceutical industry was doing well in Canada in the early 1980s, it was never particularly happy about compulsory licensing. Successful compulsory licensing in Canada was seen, by these companies, as a bad example. If Canada could enact this kind of legislation affecting the brand name companies so could other countries with even bigger markets. In particular, drug manufacturers were concerned about markets like India and Brazil—developing countries with large enough middle classes to make their overall markets even larger than Canada's.

For a number of reasons such as, the election of the Conservatives in the early 1980s, the growing power of the pharmaceutical industry in the USA and worldwide, and domestic politics in relation to Quebec (many multinational companies have their Canadian operations based in Montreal) and, most importantly, in relation to this talk, the pressures created on government by free trade agreements, Canada began a process of limiting and then finally abolishing compulsory licensing.

Passage of the Free Trade Agreement between Canada and the USA in 1987, led to the introduction and passage in parliament of Bill C-22, which placed the first limitations on compulsory licensing in Canada. The Free Trade Agreement was soon followed by NAFTA, which in combination with the WTO agreement on TRIPS, led to Bill C-91 that abolished compulsory licensing completely.

The introduction of free trade agreements during the 1980s and 1990s resulted in the staged abolition of compulsory licensing. In order to compensate for limiting and later abolition of compulsory licensing, the Patented Medicine Prices Review Board (PMPRB) was created to keep drug prices from becoming excessive. The PMPRB sets limits on the introductory price of a new patented drug and, limits the rate of price increases of existing patented medications. The board cannot however, influence substitution (i.e. the replacement of one drug by another) so the price of a prescription can still increase despite the presence of the PMPRB. This limitation is illustrated by looking at what has happened to the price of a prescription for various classes of drugs. For unpatented drugs—largely generics, with some other drugs that have gone off patent—the price starts low and since 1992 has risen at a rate of 4% per year. The price per prescription for newer, patented drugs has risen at a rate of 21% per year since 1992. This is due to a substitution of newer, more expensive drugs for older, less costly, but usually not any less effective ones. This trend in the dramatic rise of the price of a prescription is increasing as patented medicines have taken more market share. For example, in 1995, 44 percent of drug costs in Canada were for patented drugs; in 2000, this had risen to 63 percent.

While prescription prices have increased since the introduction of free trade agreements and the role back in compulsory licensing, what about overall drug expenditures? The abolition of compulsory licensing means that generics come on the market later in the lifecycle of the brand name product than in the past so that effective competition with patented drugs is limited. When the generic equivalents came on the market five years after introduction of the brand name drug, the sales for that particular brand name drug were still relatively large, so that the corresponding savings, due to earlier competition between generic and brand name product, were also large. With the abolition of compulsory licensing, a brand name product has a monopoly for about 13 years. (The patent life is 20 years but it takes about 6-8 years to move the drug through the regulatory approval process.) At 13 years, sales of the brand name drug are much smaller, reducing the ability to save money through the introduction of generics.

It's interesting to look at changes in drug expenditures since compulsory licensing was abolished. From 1975 to 1987, an era when compulsory licensing was in place in Canada, drugs accounted for between 8.9 and 10.1% of health care spending. Drug expenditures grew from 10.1 % of health care spending in 1987 to 12.5% in 1996, and still higher to over 15% today. Thus, both overall drug expenditures and per capita spending on prescription drugs have escalated. This is thanks to the establishment of free trade agreements and the associated passage of legislation to abolish compulsory licensing.

While trade agreements have had a large and adverse impact on our ability to control drug and prescription prices, do these agreements have the potential to make an impact on the implementation of drug policy in Canada, and in particular, the development of a comprehensive Pharmacare program? The answer would seem to be yes. First, both under Chapter 11 provisions in NAFTA and under the GATS, (because Canada has committed our health insurance industry to full exposure under the latter agreement) any adverse impact that a national Pharmacare plan may have on private drug health insurance plans would probably require compensation. Thus, any potential savings that could result from a Pharmacare plan would be in jeopardy because of potential costs of compensation that are written into these agreements.

Specifically, under the provisions of NAFTA's Chapter 11, private foreign owned insurance companies could sue the government if it abolished the right of companies like Liberty Health to sell private drug insurance to Canadians. Furthermore, future government measures affecting government health insurance have to be GATS-consistent. It is possible that an extension of Medicare to include Pharmacare would be considered a GATS-inconsistent extension of a public health monopoly.

If this sort of constraint means that Pharmacare will not be implemented in Canada, then the economic difficulties imposed by the abolition of compulsory licensing will be further compounded. This further increase in drug expenditures will occur because under Pharmacare, administrative costs in running drug benefits programmes would decrease. Private drug insurance programmes cost about 8% in administrative costs, whereas large provincial programmes like the one currently in place in Ontario cost about 2% to administer. The difference in administration costs afforded by the introduction of a national Pharmacare plan would save about \$100 million a year. As well, if Canada had a national Pharmacare plan, it could exercise monopsony buying power to reduce drug prices. In the early 1990s, in Australia, where a national drug insurance programme exists, drug prices were about 30% below the OECD average. Canada's drug prices were about 30% above the OECD average. Through a Pharmacare program, Canada could dramatically lower drug costs.

Besides the impact of free trade agreements on drug costs and our ability to implement broader drug policies such as Pharmacare, these agreements have direct and adverse economic consequences for Canada's overall balance of trade. Canada's trade balance in pharmaceuticals went from a deficit of about \$2 billion in 1996, up to a current deficit of about \$4.5 billion. The change in import penetration (the percent of the market made up by imports) by pharmaceuticals in the Canadian market is even more dramatic. Between 1983 and 1987, the import penetration was between 18% and 20%—going up by about half a percent a year. Between 1994 and 2000, since the institution of free trade agreements, it has been going up at a rate over 6% per year. The free trade agreements, by limiting compulsory licensing, have handicapped our generic drug industry and that in turn limits our ability to manufacture our own products. Canada is becoming a modern drawer of water and hewer of wood in the pharmaceutical industry as we are increasingly an assembly line importing active ingredients for pharmaceuticals and putting these together with fillers, coloring agents, and stabilizers while the real knowledge, research and development is done elsewhere.

While spending by drug companies on research and development increased after Bill C-22 was passed in 1987, expenditures as a percent of total sales peaked in 1997, and are now on their way down. Interestingly, nobody has examined how valuable this new research and development is. About two-thirds of the new research has been in clinical trials—the value of which is not known. Are these trials just a comparison of one “me too” drug against another “me too” drug? Are they advancing medical knowledge? The level of basic research done in Canada is about 15 to 18 percent of the R & D dollar. How valuable is that? Nobody knows.

Coming up to the present, disputes based on international trade agreements have placed Canada under continuing attack. For example, the EU lodged a complaint at the WTO about Canadian Bolar provisions. Under these provisions, before patents expired, generic companies were

allowed to produce their own version of a drug in order to conduct bioequivalency tests that are necessary to get onto the market, and they could also manufacture and stockpile the drugs so that they could begin marketing as soon as the patent expired. These stockpiling provisions were recently ruled illegal by the WTO as a result of the EU complaint. This ruling will mean a delay in the entry of generic drugs by three to six months. In a separate complaint, the USA recently alleged that, under NAFTA, patents were supposed to be extended to 20 years. Canada did extend its patents, but did not do so retroactively for drugs approved prior to October 1989. Pursuant to the complaint by the USA, patents for about 30 drugs had to be retroactively extended. That change will lead to an additional \$40 million in drug costs in Canada.

Recently Canada has been placed on the American “Special 301” Priority Watch list. This provision of the trade law is a mechanism that the government uses to pressure countries to modify their trade-related practices. Canada has been placed on this list because of its ostensible failure to provide adequate protection for the information that the brand name companies generate to demonstrate to Health Canada that a drug is safe and effective and should be licensed. The charge is that lax protection of this information in Canada allows generic companies to use it, essentially for free, so that they don’t have to do the same testing again.

While the concerns related to the free trade agreements that I have been discussing up until now have been mainly about Canada’s domestic situation there are ramifications resulting from Canada’s stance on free trade agreements for our relations with developing countries. Canada has acceded to conventions on human rights that have been interpreted by the United Nations Committee on Economic, Social and Cultural Rights, to say that parties should ensure that the right to health is given due attention in international agreements. Canada is not, to its shame, living up to its commitments because the government is not speaking out about the effects that free trade agreements such as TRIPS are having in the developing world. For example, consider the prices of drugs for HIV/AIDS treatment. In sub-Saharan African countries, the prices of drugs to treat HIV/AIDS are about the same as they are in the USA. The cost of a single dose of some of these medicines represents the entire annual drug budget in many of these countries. In the face of this situation, in June 2001, Canada, along with the Americans backed away from a European initiative to give poor countries better access to inexpensive AIDS drugs. A spokesman for Pierre Pettigrew, Minister for International Trade, justified the Canadian position with the claim that “the TRIPS agreement at this time provides sufficient flexibility in the AIDS crisis.” At the Doha WTO Ministerial Conference, which starts tomorrow, Canada will be backing a paper put forward by the U.S. and Switzerland that implicitly rejected a call by the developing countries for a Ministerial Declaration on TRIPS and public health. Such a declaration would allow these countries to interpret TRIPS in a flexible enough manner to allow the use of cheap generic medications, such as ones produced in India, to treat HIV/AIDS. These generic medications drop the price of triple therapy for HIV/AIDS from approximately \$10,000 per person per year to about \$500. (The final agreement at Doha was a compromise between the positions put forward by the developing countries and the U.S./Swiss position.)

Before ending, I’d like to outline what the future in international trade agreements may hold for Canada, particularly under the Free Trade Area for the Americas agreement. One of the provisions being proposed in a draft version of this agreement is “patent term restoration”. Patent term restoration means that, in addition to the 20 years that companies already have for drug

patents, they would get more time to make up for the time the drug spends in the regulatory approval process. Consequently, generics would take even longer to get on the market and there would be even less savings from them. Draft proposals in this proposed agreement also raise concerns about the issue of data protection. If data protection is extended, entry will be more costly for generics, and longer delays in their appearance will result.

In conclusion, the negative domestic economic consequences of international trade agreements have included increases in the price of prescriptions and overall drug costs, diminished prospects for a universal Pharmacare plan, and an increasing trade imbalance. Canada is also abandoning the developing world to predatory drug pricing policies embodied in the latest TRIPS agreement. What does all this mean? This is what I would term an example of the Golden Rule. The Golden Rule is: “those who have the gold make the rules”. In this case, the pharmaceutical industry has the gold. The pharmaceutical industry was largely responsible for the inclusion of intellectual property rights in the Uruguay round of trade talks that led to the adoption of agreements such as TRIPS. They pushed this issue very heavily then, and they are still doing so now, both in Canada and internationally.

Europe and North America: a clash of cultures?

Martin McKee

In the talk that follows mine, Professor Flood will be looking at the implications of membership in NAFTA for health reform. I want to look in more detail at another major trading bloc, the EU. In particular, I want to reflect on the challenges ahead, specifically in the context of negotiations within that very different forum, the WTO.

Why bring a European perspective to this discussion on globalization and health? First, there is a danger that the American worldview will, through the new international trading regime, become increasingly dominant in our globalizing world. The European experience here may be important as a kind of counter-weight to this process and, for Canada, may have some interesting lessons because Canada is both next door to the USA but also has elements, in its social policy that are quite familiar in many nations in Western Europe.

As well it's extremely important to understand cultural expectations and beliefs about healthcare in Europe. The EU has, at its heart, a fundamental contradiction. On the one hand, recent treaties state explicitly that health care is a responsibility for Member States. Cultural expectations are such in Europe that healthcare is not regarded as a commodity to be traded across borders, regardless of the social consequences. On the other hand, as health systems involve interactions with people, such as staff or patients, goods such as pharmaceuticals and medical devices and services such as health care funders and providers, all of whose freedom to move across borders is guaranteed by the same treaty, it is increasingly apparent that many of the activities embodied in "healthcare" are subject to European law and in particular to European competition law.

The European Court of Justice has always upheld the social nature of health care, but recent rulings, in particular on the free movement of patients, are seen by some people as eroding this view. The Court's role is interesting, as the EU requires it to interpret the law in a way that promotes the fundamental goal of an ever-closer union within Europe.

The court rulings have been especially important in countries such as the UK. Here they sought to contain costs by limiting supply, leading to waiting lists, for which the National Health Service is very famous. It is now clear that patients who face what is now defined as "unreasonable delay" can insist on the right to obtain treatment elsewhere in the EU.

At the same time, market-based reforms providing greater autonomy for providers, are acting as a stimulus to take advantage of these new opportunities. We now see French and German hospitals with excess capacity openly marketing their services to the British health authorities. In fact, the British government, recognizing the long legacy of under investment in the British Health Service, and now struggling to redress it through increased funding, actually welcomes these moves, at least as a short-term strategy. However, when linked with some of the emerging initiatives in the insurance market, there are growing concerns that competition law could compromise some aspects of the social nature of European health systems.

There is an increasing recognition of the potential threats to these systems from outside national borders. The recent judgments on the free movement of patients have acted as a wake-up call for

many European governments. In the past, most governments saw health care as being sheltered from the provisions of the treaty and from the internal market. Now this shelter is no longer considered to be as secure as they first thought.

Here, I think it is important to reflect on some fundamental differences between the EU and other trading blocs, in particular, NAFTA. While the mechanisms may be imperfect, the EU is explicitly under democratic control. Policies are developed by the commission, who are essentially Europe's civil servants. They must be agreed upon by the relevant ministers of the Member States although as you know, this may not be a great safeguard because your ministers also have to agree to things within NAFTA. Much more importantly, we have the European Parliament, with 625 directly elected independent Members from each of the member states. They demonstrated their independence on one memorable occasion, which led to the resignation of the entire European Commission. It is this democratic oversight that makes it possible for health and social protection policies to balance the excesses of the market.

It is safe to say that Canada and Western Europe share the same set of values that have given rise to the welfare state. These values are quite distinct from those in the USA. They will obviously fluctuate from time to time, such as with electoral cycles, but they appear over the long term to be relatively stable. While some politicians occasionally advocate radical reforms, it is notable that no European country has dismantled its health care system in the way that Pinochet did in Chile, with disastrous consequences.

The USA clearly has an objective to open up health and education services to global competition to provide opportunities for its own domestic health care industry to expand abroad. After many years of rapidly rising profits, the outlook for the American health care industry is now becoming much less optimistic, and if it is to continue to grow at historic rates, it has to look for markets elsewhere. American healthcare corporations have successfully penetrated countries in Latin America but they have had virtually no success in Europe.

As well as being concerned about issues within Europe we are increasingly involved in the international trading regime through our relationships in the WTO. But, the WTO is a very different animal from the EU in many ways. We in Europe have already felt the consequences of participating in this process, as has Canada. Our concerns include being forced to accept hormone treated beef with the knowledge that the hormones used are potentially carcinogenic. This then requires an increase in the use of antibiotics in the animals concerned, which leads to resistance in humans. These are clear health effects. We have also been forced to change our import patterns of bananas. This has devastated the economies of small Caribbean islands that historically we have supported. Now subsistence farmers have little choice but to move into the far more lucrative cocaine trade.

However, we should not forget our experience with the European Court. Its rulings have had important implications for health care, even though the politicians did believe the system to be exempt from European law. Just as the Court is required to facilitate an ever-closer union in its judgments, so governments have committed, through the WTO, "to enter into successive rounds of negotiations... with a view to achieving a progressively higher level of liberalization". Even if

health care is thought to be excluded, or is formally excluded, there is absolutely no doubt whatsoever that it will be affected by the changes in all of the other services that feed into it.

It is perhaps the contrast between the EU and either NAFTA or the WTO that is the most informative. Few now would reject the idea that increased trade can bring long-term benefits, but what NAFTA and WTO consistently overlook, is that these benefits do not automatically flow equally to all. Indeed, the history of world trade is that the weakest suffer at the hands of the strong.

There is little doubt that adoption of the American health care model, or any variant of it, would be catastrophic for Europe and Canada. There would be virtually no popular or political support for such a course. But if the American health care industry is to spread into Europe, the only way it can do so profitably is by undermining solidarity. Put it simply, there is no money to be made in providing health care cover for people who are old, poor and sick. The only way of making money is by covering those people who are young, rich and well, and if their money leaves the system then the principle of solidarity disappears. We will also see the disappearance of subsidies and the transfers that we have always accepted in Europe and which we see as a fundamental part of the social model.

The problem that we may face is that while keeping our eyes on Europe, we have signed up to something in Doha that has undermined what we have achieved at home. Douglas Adams tells the story of how Arthur Dent, a resident of this planet Earth was told by travelers from a distant galaxy that the planet was about to be demolished to make way for an intergalactic freeway. He protested that he knew nothing about these plans He was told that he should have, because they had been clearly displayed on a neighbouring planet for the past million years. The recognition that a similar fate could affect us in Europe has finally dawned on us

The lessons of beef and bananas have meant that the WTO is now firmly on the European political agenda. The UK is, of course, a special case. As the putative fifty-first state, and with a Prime Minister who seems to seamlessly have mutated into the American Vice President while the real one is hidden from view, we have always occupied a strange transatlantic position. However, the position of our politicians has led to an active media debate, admittedly only among the readers of The Guardian newspaper, but it is slowly raising awareness of the dangers ahead.

Earlier this year there was some considerable concern when the European Competition Commissioner proposed including hospitals within the ambit of GATS. Since then, however, the European Court rulings have placed international influences on domestic health policy much more clearly on the political agenda. Health ministries that never previously thought that organizations such as WTO had anything to do with them are at last getting involved.

Although, in its internal documents the WTO does concede that there is a danger that considerations of trade and commerce outweigh those of equity and social policy, few doubt that the negotiations will be dominated by American commercial interests. One sign of hope is the emergence within Europe of a statement of explicit social policy that reflects long-held implicit values. This is the challenge of the European Court rulings. They are forcing European ministers to say what it is we actually believe in; to declare the principles of the European social model and

writing them down. Such an explicit statement makes it more difficult for the opponent if we are overruled in a WTO dispute tribunal. It provides a boundary, a line in the sand that determines what we can be coerced into.

In this process, it seems to me that Europe, Canada and the other industrialized nations apart from the USA have a particular responsibility. Unlike many of the middle-income countries, we do have functioning health systems based on solidarity. We are therefore especially vulnerable. If we want to preserve what we have built up over so many years, we will need to work together much more closely. It is imperative that those who represent us outside the health policy community, such as those in the trade policy community, are aware of the potential unintended consequences of their actions. We in Europe have much to learn from your experiences, given the much greater predatory attention that you receive from the USA. On the other hand, we should not lose sight of the wider agenda in Europe to show how concerns about international trade have to be balanced with social protection. We must demand to have a social dimension to an internal market within the trading bloc. Here arguably, those countries participating in NAFTA may have some lessons to learn from Europe, if only to say that there is an alternative. It may be difficult to change anything when you are forced to deal with something as large as the USA. I would like to leave the final word to my fellow Irishman, Edmund Burke, who noted that, “ All that is required for evil to succeed is for good people to remain silent.” I think that we are now getting these things on the agenda, raising these issues onto the political radar screen.

NAFTA: Have we traded away our capacity for innovative health reform?¹

Colleen Flood & Tracey Epps

There are two sharply contrasting views about NAFTA's impact on medicare. Critics are for the most part incredibly pessimistic about NAFTA. They worry that the end result of living under this trade regime will be the destruction of our healthcare system as it moves to a more private American model. At the same time, government spokespersons have continued to issue comforting statements that medicare is not on the negotiating table. What is the reality behind these contrasting views?

The purpose of this talk is to outline the values underpinning the NAFTA agreement; to identify the key elements in NAFTA that may affect healthcare in Canada and to discuss more broadly how the NAFTA agreement may impinge on our future flexibility to craft health care reforms, such as national homecare and pharmacare programs.

Robert Evans described in some detail the values held by economists involved in international trade negotiations. The fundamental purpose of international trade agreements is to reduce barriers to trade. The underlying assumption is that the unhindered and invisible hand of the free market will result in the best allocation of scarce resources, and improved economic growth and welfare. In the free market, as we know, goods are allocated on the basis of purchasing power and there is no concern with equity. This is the key critique of an economics approach, that it is only concerned about maximizing the total pie, not with the distribution of the pie. This contrasts sharply with the goals of the health care sector, where the free market gives way to high levels of government intervention, in order to achieve redistributive goals.

The core value underpinning medicare is that, at least for medically necessary hospital services and medically required physician services, Canadians should have access to services on the basis of need and not on their ability to pay. This is, of course, in sharp contrast with our American neighbours.

There are a number of provisions in NAFTA that concern health care. The two most important are 1) the "national treatment" provision and, 2) the "expropriation" provision. The national treatment provision is the cornerstone of the NAFTA. It requires that Canada treat investors, goods and service providers (including financial service providers) from the USA and Mexico no less favourably than it treats its own domestic investors, goods and service providers in "like" circumstances.

This means, for example, that if a Canadian private surgical facility was allowed to provide services in British Columbia, then an American company would also have the right to provide the same kind of services in British Columbia. The implications of national treatment are that any moves toward health care privatization in Canada, have the potential to open up this formerly protected arena to American and Mexican providers and investors.

¹ This presentation was based upon a larger paper by Tracey Epps and Colleen M. Flood, forthcoming in the McGill Law Journal.

The expropriation provision in Chapter 11 of NAFTA, which Steven Shrybman mentioned, allows American and Mexican corporations to claim compensation from the Canadian government if it nationalizes or expropriates their investment, or takes an action tantamount to nationalization or expropriation. The expropriation provision thus empowers foreign corporations in new and unprecedented ways by allowing them to bring claims directly against foreign governments without having to persuade their own government to bring a claim on their behalf. NAFTA critics are particularly concerned with the potential effect of these corporate rights on any future progressive reforms to Canada's health care system (such as expansion of public health insurance programs to cover all drugs and homecare). There are serious economic consequences that could result from having to compensate foreign corporations, who claim losses by, for example, any expansion of the public health insurance system into an arena in which they would otherwise have maintained a market share.

The primary protections from NAFTA's impact on medicare lie in the reservations contained in the annexes. Annexes I and VII protect provincial measures pertaining to health care that were in place on January 1, 1994 when NAFTA was signed. However, in terms of the future of the health care system, Annex II is of importance. Annex II contains a broad reservation to the application of a number of NAFTA's provisions, including the national treatment provision. However, it does not provide any protection from the expropriation provision which applies regardless of any exceptions or reservations. The Annex II reservation provides that Canada may adopt or maintain any measure with respect to health to the extent that it is a social service "established or maintained for a public purpose". For example, this means that if hospital services are determined to be services supplied for a public purpose, the national treatment rule will not apply and Canada will not have to give access to American hospital chains. This obviously means that the applicability of the reservation contained in Annex II, depends entirely on the interpretation of supplying a service "for a public purpose".

Unfortunately, there is a complete lack of clarity on how the phrase "for a public purpose" will be interpreted in the event of a dispute. The American Trade Representative has indicated that they will argue that the Annex II reservation only applies where services are both entirely government financed and publicly delivered. This is a narrow interpretation and if applied rigidly could place Canada's healthcare system at risk. The delivery of health care services in Canada has a mixture of public and private providers, and currently a number of healthcare reforms (e.g., Alberta's recent Health Care Protection Act) are gradually increasing the role of the private sector in Canadian healthcare, on both the financing and delivery sides. The more the system is privatised, the less likely is Canada's claim that all services are provided for a public purpose, and therefore exempt from provisions including the national treatment provision.

In our opinion, the NAFTA's negotiators overlooked the complex web of public/private relationships in Canada's health sector, and the dynamic nature of the system when they agreed to the text of Annex II. The myriad of public and private relationships do not fit easily into the wording of the reservation, which assumes that the line between the public and private realms can be crisply drawn. As private financing and delivery of healthcare increases in Canada, there are a wider range of services which are clearly not "for a public purpose" and to which the Annex II reservation does not apply. If private insurers and providers penetrate the public system for drugs, genetic testing and other important new technologies, we may be constrained in health policy

reform options because of the combination of national treatment and expropriation provisions and the non-applicability of the reservation in Annex II.

It is important therefore, to examine some of the options for healthcare reform. One reform proposal is to introduce a national pharmacare and home care programme. Approximately 40 out of some 149 insurers currently operating in Canada are American-based. The Canadian government could face a compensation claim if it implemented a national publicly funded pharmacare or home care programme, which would take away the market share of these American private insurers.

A second area of reform is the increased presence of private delivery of publicly funded services. Canadian governments are beginning to experiment with contracting out of publicly funded services to competing private organizations (e.g., home care in Ontario). To the extent that American or Mexican private providers are allowed to provide these services, the expropriation provision may force provinces to pay compensation to foreign investors if they later wish to remove or restrict those investors' rights to operate in the Canadian market. This is a serious concern, as Canadian provinces will want the freedom to be able to experiment with public/private initiatives.

A third reform option involves a means of funding a national pharmacare or home care programme without large expenditures of general taxation revenue through a managed competition model. Such a system would be financed by both employer and employee contributions fixed at a certain percentage of salaries with government revenues only having to cover the unemployed or elderly. The model involves requiring private insurers to compete for the business of customers who bring with them a risk-adjusted share of funding, within a government regulated system. Managed competition reform is a relatively complicated model and an important feature from the perspective of NAFTA is that it requires sophisticated government regulation. If it were found that insurance services provided in a managed competition model are not provided for a "public purpose" pursuant to the Annex II reservation, then the national treatment provision would apply and may restrict the government's ability to regulate.

In conclusion, the values underpinning the health care system are very different from those underpinning NAFTA. We believe that the NAFTA's negotiators displayed a lack of understanding about the myriad of public/private relationships in the health care system, and the changing dynamics of the health care system. The Annex II reservation arguably does not protect any aspect of the health care system that has been opened to private financing. And more importantly, the expropriation provision may impede the government's ability to extend medicare's coverage, or at least discourage the government from doing so because of the threat of compensation claims. It might also impede the government's ability to reverse policies that give foreign providers greater access to the health sector in areas such as contracting out the delivery of publicly-funded services and restrict the government's ability to regulate to achieve reform

In these negotiations, Finance Canada and Industry Canada must have long conversations with Health Canada regarding the impact NAFTA will have on the health sector. It is important that any future reform initiatives reflect the requirements of the NAFTA. For example, if a province was experimenting with some kind of contracting out provision as an initiative for a public purpose, then it must use the language of NAFTA. This will not immunize Canada from disputes, but, would go a long way to help.

A price to pay: Canadian trade policy, the GATS, and the future of health care

Matthew Sanger

I'm going to talk to you today about health insurance both in global and Canadian terms and about the way free trade agreements affect, in particular, public health insurance in this country.

First, it is necessary to understand that the size of the global insurance market is huge. For example, the global market for all forms of insurance, including life insurance, was worth \$2.3 trillion in 1990. Japan and the USA account for more than 50% of this market. The domestic Canadian insurance market is the eighth largest in the world. Although 85% of the world's population lives in the developing world, these nations account for less than ten percent of the insurance market.

Developing nations have small commercial insurance sectors, very little export capacity, but they are the fastest growing markets. In the 1990s, insurance premiums in developing nations grew by nine percent, which is double the rate in the industrialized world. For instance, China had a 35% annual growth rate in insurance premiums through the 1980s and 90s. This means that insurers from the North, who have the export capacity, want access to those markets.

Because the insurance industry is so concentrated in the North most of the benefits of liberalization will be skewed in favour of wealthy countries. As well, the insurance industry has obtained a special place at the GATS negotiations. The large European and American insurers were leading members of the industry lobby which played a decisive role in the GATS agreements during the Uruguay round. According to David Hartridge, the Director of Trade in Services at the WTO, lobbyists from the insurance industry provided the kind of political momentum that pushed the GATS negotiations through difficulties that almost blocked a final agreement in 1994. And, the influence of this industry was such that when the GATS was concluded in 1994, the section on financial services was left open and the negotiations allowed to continue until 1997 because the American insurance industry was not happy with the level of liberalization committed to by developing countries. Large insurance corporations have been key architects of the GATS agreement, which has so richly rewarded them.

While this provides a broad sketch of the relationship between the entire insurance industry and the new international trade regime, what is the situation in relation to health insurance in Canada?

I will go over some of the same ground that Colleen Flood just covered, but with reference to GATS rather than NAFTA and then I want to end by talking about what we as citizens and as health advocates can do. I have focused on health insurance, first because it is fundamental to health systems; it affects not only the level of services that are provided but the composition of those services, who provides them, and the way that they are provided. Second, Canada and many other countries have committed our health insurance system to the full impact of GATS rules.

Over the past two decades the private health insurance industry in Canada has grown enormously, particularly in the share of premiums that it earns from sources outside of Canada. In the year 2000, fifty five percent of premiums earned by Canadian insurance companies came from offshore sources. Most of these sources were in the USA and the UK, the traditional markets for Canadian companies,

but Latin America and Asia are growing areas of business. Also, during this period Canadian life and health insurers have taken part in a worldwide trend towards consolidation in the industry. This has been facilitated by deregulation of financial markets, which has removed limits on foreign ownership leading to the boom in mergers and acquisitions that occurred during the 1990s. This means that the large nationally based companies have increasingly become part of giant global companies.

It is also important to understand that, in the GATS negotiation process, health insurance is defined as a Financial Service. Health insurance does not come under the category of Health Related Services in the GATS. Our negotiators committed our financial services to the most forceful GATS provisions. Our negotiators did not commit our Health Related Services in the GATS.

As well, Canada has not entered any limitations in its commitment for health insurance, which might explicitly exclude medicare or public hospital insurance. In Canada, to this point, very little attention has been given to assessing the implications of these rules for our health services. This is a problem because we are committed to further ongoing GATS negotiations.

The WHO has recently, in its commission on macroeconomics and health, conducted studies on the privatization of health insurance, particularly in developing countries. They have shown that the introduction of private insurance fosters a structure of incentives that tend to pull resources away from preventive and public health services and into acute care. This could work against national health objectives. On the basis of these studies, WHO has concluded that it could be harmful for developing countries to make full binding commitments in the health insurance subsector until effective domestic regulatory frameworks and enforcement mechanisms are in place. However, many of these nations have already made these commitments.

Shifting back to Canada, we have also seen a major growth, over the past two decades in our private health insurance sector in part because not all health services are covered by medicare. Private health insurance coverage has generally expanded to fill the gaps created by cuts to medicare and under-or non-coverage. For example, seven million Canadians have dental coverage and the growth in the dental insurance business in this country has been from about two billion dollars in 1980 to about ten billion in 2000.

There are two big questions that remain for our negotiators. First, does Canada's commitment in health insurance include public health insurance and, second is medicare protected by the GATS exclusion for services provided in the "exercise of governmental authority"? As in the case of NAFTA reservations, discussed previously by Colleen Flood, whether or not public health insurance is included in the definition of health insurance in Canada's commitment depends on the definition of the phrase "the exercise of governmental authority".

As well, as already mentioned, health insurance is classified, along with all insurance, under the Financial Services section of GATS. The Financial Services section has its own exclusion for systems of statutory social security. In discussions with our trade negotiators we were told that this was the exclusion, within GATS, that protected our public health insurance system. While this is what we were told by Canada's negotiators, it is not clear that a trade tribunal would agree with this conclusion.

The real point here, as emphasized in the presentation by Flood and Epps on NAFTA, is that both these potential exclusions are an alarmingly tenuous basis for safeguarding medicare from Canada's commitments in the GATS.

DISCUSSION

Globalization is not new nor is it inevitable. It is characterized by truly globalized capital markets in which approximately 1 trillion dollars a day circulate linking national economies in new and complex ways. The global economy has seen the rise of the multi-national corporation and increasing control of international trade within these vertically structured organizations. These developments have intensified trade within and between three large trading blocks located in North America, Europe, and East Asia and increasingly excluded less developed nations located, in particular, in Western and South Asia, Africa, and South America.

A triad of developed nations dominates world trade and the term triadization may be more accurate than globalization as the latter term implies a world with more equal global economic integration. From the Canadian perspective globalization is a glaring misnomer as enhanced free trade has clearly Americanized rather than globalized Canadian economic relations.

In terms of its potential impact on healthcare, economic globalization has been facilitated by the new international trading regime embodied both in bi-lateral agreements such as NAFTA and in the series of “trade-in-services” agreements administered by the WTO. The new trade regime embodied in these international agreements differs from the post-war international trade regime which was framed around the GATT agreement.

The shift from a GATT to a WTO-based regime, which occurred during the period 1986 to 1994, marked a revolution in international trading relationships for three reasons. First, the new regime has historically unique power to impose sanctions on states which do not comply with trade rules. Second, the focus of this regime is increasingly on the trade in services rather than the trade in goods. Third, in a “trade-in-goods” era the main barriers to trade were tariffs. However, now, in a “trade-in-services” era the main barriers to trade are domestic policies which govern the rules of service sector operation within nations. This means that the new trade regime increasingly targets domestic policy under the guise of implementing free trade.

Canada has a binding commitment, under current international law, to participate in ongoing WTO negotiations to liberalize trade. These negotiations have been conducted with little input from other levels of government. As well, ordinary citizens and health policy makers seem to have little knowledge about the negotiations, their objectives and ideological and intellectual background, and the potential impacts of any agreements on health policy.

It is therefore imperative for ordinary Canadians to better understand the ideological and intellectual framework which informs our trade negotiators. These negotiators operate from four main assumptions. First, that increased and liberalized international trade will improve the economic welfare for everyone due to “trickle-down” effects. Second, that we are in a world of essential equals in power in which no one controls the marketplace or influences prices. According to this, obviously naïve theoretical assumption, all nations are equal in the market place. Third a hypothetical “representative agent” stands for all the residents of a nation, a simplifying assumption that precludes consideration of any within-nation distribution effects. This latter assumption implies that when “a country” gains or loses, from international trade all citizens gain or loses the same amount or proportion.

Finally, the fundamental assumption of consumer theory called the axiom of non-satiation means that higher consumption of goods and services always leads to increased well-being. This assumption may work for goods but it is false if applied to services such as health care. More healthcare is not necessarily better and may be much worse. Under the standard assumption of the axiom of non-satiation, Americans are better off than Canadians because they get more dollars' worth of health care. They may not be getting any healthier, in fact they're less healthy than Canadians, and they may not get much more in the way of services, they're just paying higher prices, but the economic framework says that if they're paying higher prices, then the commodities must be more valuable.

Governments in the developed world do not leave healthcare to the private marketplace. While the private sector handles the production of goods the public sector takes major responsibility for health care and education in all nations in the developed world. Even in the USA 50 percent of healthcare expenditures fall within a public financing model.

Thus, the intellectual and ideological framework used by our trade negotiators is particularly inadequate in theorizing trade in a public good such as healthcare. However, it is this naïve framework which they bring to the table when negotiating international trade agreements which will impact Canadian health policy. Our health sector could be opened up to American and Mexican influence under NAFTA and, it could be de-regulated for other nations under a number of agreements administered by the WTO including the GATS, TRIPS, TBT, and SPS agreements.

We will consider NAFTA first. There are a number of sections under the NAFTA which could, in the future, affect health policy. Of particular concern are the Chapter 11 provisions which allow American and Mexican corporations to claim compensation from the Canadian government if it expropriates their investment, or takes an action tantamount to nationalization or expropriation. The expropriation provision empowers foreign corporations in new and unprecedented ways by allowing them to bring claims directly against foreign governments without having to persuade their own government to bring a claim on their behalf. With this provision under NAFTA, corporations are given the same status as nation states. NAFTA critics are particularly concerned with the potential effect of these enhanced corporate rights on any future progressive reforms to Canada's health care system (such as expansion of public health insurance programs to cover drugs and homecare). There are serious economic consequences that could result from having to compensate foreign corporations, who claim losses by, for example, any expansion of the public health insurance system into an arena in which they would otherwise have maintained a market share.

Besides Chapter 11 NAFTA has a "national treatment" provision which requires Canada to treat investors from the USA and Mexico no less favourably than it treats its own domestic investors, goods and service providers in "like" circumstances. This could mean, for example, that if a Canadian private surgical facility was allowed to provide services in British Columbia, then an American company would also automatically have the right to provide the same kind of services in British Columbia. The implications of national treatment are that any moves toward health care privatization in Canada, have the potential to open up this formerly protected arena to American and Mexican providers and investors. A provision for "national treatment" is also embodied in

the GATS agreement. Any sector committed by the Canadian government under GATS will therefore ensure that all nations (not just the USA and Mexico) will be accorded this right.

These bilateral and international agreements may have far-reaching constitutional implications for Canada. Under international law the federal government has responsibility for negotiating international trade agreements. And, the federal government, in its negotiations will often undertake commitments concerning matters that fall within provincial constitutional jurisdiction, such as the delivery of health care services.

Cross-sectoral retaliation is allowed under WTO and NAFTA rules so that if Canada were to incur sanctions from another nation involving, for example trade in steel products, these could be targeted against completely unrelated sectors including healthcare and education. The point is that federal government commitments made in the new trading regime have constitutional and jurisdictional implications for other levels of government which have, as in the case of the general public, to this point, been relatively oblivious to their implications.

The influence of NAFTA has been felt for some time in relation to the Canadian pharmaceutical industry. Prior to the 1980s Canada had a large generic (i.e. non-brand name) pharmaceutical sector that produced drugs which were equivalent to many popular brand name products but at much lower prices. The existence of Canada's generic pharmaceutical industry helped keep costs of drugs in check contributing to the sustainability of the public healthcare system.

However, in the 1980s the federal government, under pressure from the brand name, usually American pharmaceutical companies enacted legislation to control generic manufactures. This process of de-regulation of the pharmaceutical industry in Canada was given impetus by the passage of the NAFTA and its predecessor, the FTA. De-regulation, under the impact of these free trade agreements has led to increased drug consumption and a growth in drug expenditures from 10.1% of health care spending in 1987 to over 15% today.

As well as the impact of these agreements on de-regulation and drug consumption, they also have an adverse impact on our ability to implement future drug policy in Canada, particularly, the development of a comprehensive Pharmacare program. Both under Chapter 11 provisions in NAFTA and under the GATS any adverse impact that a national Pharmacare plan may have on private drug health insurance plans would likely require compensation. Thus, any potential savings that could result from a Pharmacare plan could be in jeopardy because of the potential costs of compensation that are written into these agreements.

While free trade agreements between Canada and the US have been affecting the Canadian generic drug industry for decades, provisions within NAFTA and recent developments under GATS may create new pressures on our public health insurance system.

In the last round of GATS negotiations Canadian negotiators committed our Financial Services sector to the most forceful GATS provisions. Because health insurance, both public and private, lies within this financial services sector, this means that we have committed our health insurance system to GATS oversight. The Canadian government has not committed our Health Related Services to the GATS which includes the delivery of healthcare services such as long term care,

homecare, and hospital services. It is fairly well known that Canada has not committed our Health Related Services to GATS and because people quite naturally assume that our public health insurance system is included within this category most Canadians are unaware that our health insurance industry has been committed to GATS oversight.

This begs two large questions. First, does Canada's commitment in health insurance include public health insurance? And, second, if it does are there reservations within the NAFTA and GATS agreements that might specifically exclude the public component of our health insurance system?

The primary protections from NAFTA's impact on public health insurance lie in the reservations contained in Annex II of the agreement. The Annex II reservation provides that Canada may adopt or maintain any measure with respect to health to the extent that it is a social service "established or maintained for a public purpose". A similar situation pertains in relation to GATS. Under this agreement a reservation provides that Canada may exclude any measure with respect to health to the extent that it is used in "the exercise of governmental authority". Thus the extent to which our public health insurance system is protected under NAFTA and GATS depends on legal interpretation of the meaning of these two phrases.

In terms of the NAFTA reservation, there is a complete lack of clarity on how the phrase "for a public purpose" will be interpreted in the event of a dispute. The application of the GATS exclusion for services provided in the "exercise of governmental authority" is, likewise, unknown. The point is that these potential exclusions are an alarmingly tenuous basis for safeguarding public health insurance from NAFTA and from Canada's commitments in the GATS. It's important to note that even if public health insurance was protected by these exceptions, they would not extend to insurance coverage for services that are currently provided by private providers so that, at this point our private health insurance industry is open to full oversight under NAFTA and GATS.

While the concerns related to the free trade agreements discussed up until now have been mainly about Canada's domestic situation there are ramifications resulting from Canada's stance on free trade agreements for our relations with developing countries. For example, at present, through the TRIPS agreement, poor countries are unable to produce or buy generic versions of expensive drug cocktails necessary to treat AIDS.

In the current round of negotiations, Canada is supporting a proposal advanced by the U.S. and Switzerland that rejects a call by the developing countries for a Ministerial Declaration on TRIPS and public health which would allow these countries to interpret TRIPS in a flexible enough manner to obtain cheap generic medications to treat HIV/AIDS.

As well there are issues for health insurance in developing nations. The WHO has recently, in its commission on macroeconomics and health, conducted studies on the privatization of health insurance in developing countries. They have shown that the introduction of private insurance creates incentives that pull resources away from preventive and public health services and into acute care. This could work against national health objectives. On the basis of these studies, WHO has concluded that it could be harmful for developing countries to make full and binding

commitments in the health insurance subsector until effective domestic regulatory framework and enforcement mechanisms are in place. However, many of these nations have already made these commitments.

Finally a very important impact of these agreements in the realm of international public health arises in relation to the proliferation of tobacco products. Organizations such as Physicians for a Smoke Free Canada have estimated that currently there are one million tobacco-related deaths annually split 50/50 between the nations of the developed and the under-developed world. But, by 2020 there will be approximately six million deaths in developing countries, compared to 2.5 million in developed countries as the burden of tobacco-related mortality will be disproportionately borne by poor people living in poor nations. The looming shift in this epidemic is driven by the new dynamics of international trade in conjunction with tighter regulations against tobacco within developed nations as tobacco companies, companies look more seriously for markets in the developing world.

The GATS agreement will have profound effects on the international trade in tobacco because, although tobacco is a good, there are many services associated with it including extensive retailing, advertising, packaging and research. And, the TRIPS agreement is concerned with all intellectual property rights, including trademark rights. Removing the Marlboro man's name and face from the side of a racing car affects a trademark right. Passing laws insisting on plain packaging of cigarettes affects a trademark right.

This conference has demonstrated that the general public, as well as health experts and provincial and municipal levels of government are largely ignorant of the trade negotiations underway and the impact these might have on domestic policies such as healthcare policy. Given the lack of knowledge and democratic input into trade negotiations up to now and the lack of balance in our trade negotiating positions are there other models that we can look to for guidance and direction?

In Europe free trade has evolved in a much different environment than in Canada. One of the fundamental differences between the EU and other trading blocs, in particular, NAFTA is that the EU is explicitly under democratic control as citizens across Europe directly elect 625 members to the European Parliament. It is this democratic oversight that makes it possible for health and social protection policies to balance the excesses of the market within the European trading bloc.

Canada and Western Europe share the same set of values that have given rise to the welfare state. As in Canada, most European nations have well functioning health systems based on social solidarity. Canadian and European healthcare systems are therefore especially vulnerable to free trade. It is imperative that those who represent us outside the health policy community, such as those in the trade policy community, are aware of the potential unintended consequences of their actions.

Europe has much to learn from Canada given the much greater predatory attention that Canada receives from the USA. On the other hand, the European model may have relevance for Canada. The example of the European parliament as a counterweight to the brute force of the de-regulated market might work on this side of the Atlantic. It will be important in North America to must demand a social dimension to an internal market within the trading bloc. While it may be difficult for North America to move to such a model it is important that at least now these issues of globalization are on the public's political radar screen.

Recommendations emerging from this conference

1. To improve the trade literacy of public officials at all levels of government and to involve ordinary citizens as well as health policy experts in advising these officials.
2. To improve understanding of the meaning of current commitments made under NAFTA and the WTO and reconsider some of these commitments such as the one for health insurance.
3. To proceed with domestic reform of Canada's healthcare system with the full reach of these agreements in mind.
4. Ensure in the international arena that Canada takes a stance in relation to health policy issues related, in particular to tobacco control and control of the HIV/AIDS epidemic, that puts the health of ordinary people ahead of national trade advantages.
5. To continue to educate Canadians about the implications of Canada's international trade agreements for Canadian health policy.

About the authors

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Martin McKee obtained a degree in medicine from Queens University, Belfast in 1979 and, after working for several years in internal medicine in Belfast moved to the London School of Hygiene and Tropical Medicine in 1985. Martin McKee is professor of European public health and manages a large research programme on health and health care involving many countries in Europe, as well as methodological work in health services research. He is co-director of the School's European Center on Health of Societies in Transition, and one of the research directors of the European Observatory on Health Care Systems and editor in chief of the European Journal of Public Health. Martin McKee holds an honorary doctorate from the Medical university of Debrecen, Hungary and is an Honorary Member of the Romanian Academy of Medical Sciences.

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Matthew Sanger is an independent trade and social policy analyst, working with a wide range of government and popular sector organizations. His previous work over the past decade includes published studies of the health and social policy implications of the MAI, NAFTA, FTA and the European Social Charter. He is a research associate of the Canadian Center for Policy Alternatives. Matthew Sanger's most recent publication is "Reckless Abandon: Canada, the GATS and the Future of Health Care."

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