The New International Trade Regime: Problems for Publicly Funded Healthcare in Canada?

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Since the early 1970s and the demise of the Bretton-Woods agreement, economies have increasingly moved towards globalization as markets internationalize and deregulate a process that has been facilitated by the World Trade Organization (WTO), with new and historically unprecedented powers to enforce trade rules.¹

Why should the process of globalization, in general, and the rise to prominence of the WTO in particular, interest health researchers and policy makers? First, because, "owing to the health consequences, good and bad, of the sanctioning of monopoly pricing of new drugs and medical products – and because of its influence over international trade in medical supplies, insurance, and health services – the World Trade Organization is likely to emerge as one of the most important international players in health."^{2, pg.193}

Second, as well as the direct impact of the WTO on the trade in medical products, globalization may also impact health by creating a "regulatory deficit", wherein national institutions are rendered less effective by the internationalization of markets.³ A key to understanding the regulatory deficit attendant on the internationalization of markets lies both in an appreciation of the indirect pressures brought to bear on the nation state by deregulated international markets as well as the direct powers of coercion the WTO can now apply to nations to open markets.

This paper discusses the potential for the WTO, through its influence on the trade

in health and ancillary services, to directly impact publicly funded healthcare delivery systems.

Recent changes in the international trading regime

Most nations are bound by the rules of the General Agreement on Tariff and Trade (GATT), established in 1946 and superseded by the World Trade Organization (WTO) in 1995. The scope of the WTO is much larger than it was under GATT. In the past, trade agreements have largely involved trade in goods such as raw/natural products, manufactured products, and commodities. Today, international agreements have been extended to include trade in intellectual property and services (the fastest growing trade sector among developed nations).

The major impacts on healthcare services in developed nations will likely arise through WTO regulations governing the trade in services.

Potential for trade-in-services regime to impact healthcare delivery

The Trade-Related Intellectual Property Rights (TRIPs) agreement requires all WTO members to adopt US-style patent laws. Over the past several years, the Canadian government, under threat of patent law changes initially introduced via the Free Trade Agreement (FTA) between Canada and the United States, moved to expand patent protection for brand name drug companies at the expense of Canadian generic drug companies that had been supplying the Canadian market with low-cost generic drugs.⁴ Although Canada had cracked down on its own generic drug companies, the TRIPs agreement was used to force the Canadian government to

extend drug patent protection to multinationals to the full 20 years required under US patent law.⁵

The implications for healthcare systems are potentially serious because enhanced patent protection, by allowing drug companies to protect themselves from competition for a longer time, will reduce the availability of cheap drugs. This is a major problem because drugs are the single fastest-growing component of healthcare budgets.

Another important agreement, the General Agreement on Trade in Services (GATS), covers not just cross-border trade, but every possible means of supplying a service. At present, nations have the right to keep sectors of their service economy outside the scope of GATS. However, while Canada has taken the position that its health and education services will not be included in GATS, both the European Union and the United States are in the process of volunteering these sectors for full inclusion under GATS.

Within the United States, diverse stakeholders are trying to force health and education sectors in other nations into full inclusion under GATS. For example, the Coalition of Service Industries is "calling for a major foreign ownership to be allowed for all health facilities. We believe we can make much progress in the negotiations to allow the opportunity for US businesses to expand into foreign health care markets. Historically, health care services in many foreign countries have largely been the responsibility of the public sector. The public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries."⁶ These views are promoted by the US trade delegation at WTO which

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recently stated that "the US is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, and assisted living arrangements."⁷, pg.665

Such views are also promoted by important American health organizations. The Institute of Medicine in its recent report, *America's Vital Interest in Global Health*,⁸ says that the direct interests of the American people will be served when the United States promotes world health and implies that the process of increased trade in health services will both enhance world health and promote American strategic interests. These kinds of statements in conjunction with recent moves by both the EU and the United States to apply GATS to their own healthcare services, will create external pressure on the Canadian government to do likewise.

Recent moves by the Alberta government – both through contracting out of services to private providers and through the introduction and promotion of Bill C-11 – could also be the trigger for WTO intervention in the Canadian health services delivery market. GATS Article 1.3 states that "the hospital sector in many countries... is made up of government-owned and privately-owned entities which

both operate on a commercial basis, charging the patient or his insurance for the treatment provided." Furthermore, "wherever there is a mixture of public and private funding, such as user charge or private insurance, or there are subsidies for non-public infrastructure, such as *public/private partnerships or competitive contracting for services*, the service sector should be open to foreign competition."⁹

CONCLUSION

The WTO is emerging as an important player in the trade in health and ancillary services. This is of particular concern for nations like Canada with publicly funded healthcare systems. There are two main areas for potential concern. First, over the past 15 years, as drugs have become the fastest-growing component of healthcare costs, the power of provincial governments to control these costs has been eroded due to restrictive trade and patent rules initially introduced through the FTA agreement and consolidated under the WTO.

Second, the WTO, as well as representatives of the American healthcare industry, have targeted publicly funded healthcare systems – such as Canada's – as a potential market for increased trade in healthcare services. Moves to privatize components of

Canada's public system – such as Bill C-11 recently passed in Alberta – provide the WTO with an opening to mount a trade challenge which could allow the entry of the American healthcare industry into Canada.

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Le nouvel ordre commercial international : menace pour le système de soins de santé public du Canada ?

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Depuis le début des années 70, et l'effondrement des accords de Bretton-Woods, les économies s'orientent de plus en plus vers la mondialisation à mesure que les marchés s'internationalisent et se dérèglementent, une tendance favorisée par l'Organisation mondiale du Commerce (OMC), grâce à ses moyens nouveaux et sans précédent his-

torique pour faire appliquer les règles du commerce.¹ En quoi est-ce que la mondialisation en général, et l'influence de plus en plus importante de l'OMC en particulier, peuvent intéresser les chercheurs en santé et les décideurs politiques ? Premièrement, « parce qu'en raison des bonnes et des mauvaises conséquences sur la santé des prix de monopole fixés aux nouveaux médicaments et produits médicaux, et à cause de son influence sur le commerce international des fournitures médicales, des assurances, et des services de santé, il est probable que l'Organisation mondiale du Commerce va devenir l'un des plus importants acteurs

internationaux en matière de santé. »², p. 193
[traduction]

Deuxièmement, en plus des répercussions directes de l'OMC sur le commerce des produits médicaux, la mondialisation risque aussi d'influencer la santé en créant un « vide réglementaire », autrement dit l'internationalisation des marchés aboutit à affaiblir l'efficacité des institutions nationales.³ Pour comprendre le vide réglementaire causé par l'internationalisation des marchés, il est essentiel de bien comprendre les pressions indirectes que les marchés déréglementés font peser sur les
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on this research endeavour, both through the Canadian Legislator Study^{4,14} and other efforts.¹⁶ Other studies have found that a policy maker's policy preference may change, depending on how an issue is framed.^{17,18} However, even high levels of support do not necessarily translate into policy, and a better understanding in the public health community of the political barriers and facilitators that underpin public policy decisions is imperative.

ACKNOWLEDGEMENTS

Support for the research reported was provided by a grant from the National Health Research and Development Program of Health Canada. Statistical advice was provided by Dr. Shelley Bull, Senior Research Scientist, Samuel Lunenfeld Research Institute, Mount Sinai Hospital, Toronto.

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Received: March 24, 2000

Accepted: October 16, 2000

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États ainsi que les pouvoirs de coercition directs auxquels l'OMC peut recourir pour obliger les pays à ouvrir leur marché.

Cet article traite des répercussions potentielles directes de l'OMC sur les systèmes de prestation de soins de santé financés publiquement, en raison de son influence sur le commerce dans le secteur de la santé et de ses services auxiliaires.

Changements récents à l'ordre commercial international

La plupart des pays sont tenus de respecter les règles de l'Accord général sur les tarifs et le commerce (GATT en anglais), mis sur pied en 1946 et remplacé par l'Organisation mondiale du Commerce (OMC) en 1995. Le champ d'application de l'OMC dépasse de loin celui du GATT. Autrefois, les accords commerciaux portaient surtout sur le commerce de marchandises comme les produits naturels et les matières premières, les produits transformés et les denrées. Aujourd'hui, les accords

internationaux englobent le commerce des services et de la propriété intellectuelle (le secteur qui connaît la croissance la plus rapide dans les pays développés).

Il est probable que les plus importantes répercussions sur les services de santé des pays développés découleront des règlements sur le commerce des services adoptés par l'OMC.

Répercussions potentielles du commerce des services sur la prestation des soins de santé

L'Accord sur les aspects des droits de propriété intellectuelle qui touchent au commerce (les ADPIC) exige de tous les pays membres de l'OMC qu'ils adoptent une législation sur les brevets analogue à celle des États-Unis. Au cours des dernières années, sous la menace de changements à la législation sur les brevets introduits dans le cadre de l'Accord sur le libre-échange (ALÉ) entre le Canada et les États-Unis, le gouvernement canadien a commencé à étendre la protection des brevets aux entreprises fabricant des médicaments sous mar-

que déposée, aux dépens des entreprises canadiennes produisant des médicaments génériques qui avaient jusque-là approvisionné le marché canadien en médicaments à faible coût.⁴ Alors que le Canada était déjà intervenu sévèrement à l'encontre des fabricants de médicaments génériques, l'Accord sur les ADPIC a été utilisé pour le forcer à accorder aux multinationales une protection des brevets d'une durée de 20 ans comme le stipule la législation américaine à cet égard.⁵

Pour les systèmes de soins de santé, cette situation pourrait se révéler grave car une plus grande protection des brevets, en permettant aux entreprises pharmaceutiques de se protéger de la concurrence sur une plus longue durée, diminuera la disponibilité de médicaments meilleur marché. C'est un problème très grave car dans les budgets des soins de santé, les médicaments constituent la part qui augmente le plus rapidement.

L'autre accord important, l'Accord général sur le commerce des services ... voir Éditorial, à la page 23

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Received: January 4, 2000

Accepted: July 24, 2000

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(AGCS), ne couvre pas seulement le commerce transfrontalier mais aussi toutes les méthodes possibles de prestation de services. Ainsi, à l'heure actuelle, les pays ont le droit d'exclure certains secteurs de leur économie de l'AGCS. Toutefois, alors que le Canada a choisi de ne pas inclure ses services de santé et d'éducation dans l'AGCS, tant l'Europe que les États-Unis ont opté pour leur inclusion totale.

Aux États-Unis, divers groupes tentent d'obtenir l'inclusion totale des secteurs de la santé et de l'éducation des autres pays dans l'AGCS. Ainsi, la *Coalition of Service Industries* « demande que des intérêts étrangers puissent être propriétaires de toutes les infrastructures sanitaires. Nous pensons que nous pouvons faire avancer les négociations pour permettre aux entreprises américaines de pénétrer les marchés étrangers du secteur de la santé. Traditionnellement, dans de nombreux pays, la responsabilité des services de santé a toujours été entre les mains du secteur public. En raison de cette situation, les prestataires de soins de santé du secteur

privé des États-Unis ont des difficultés à commercialiser leurs services dans ces pays. » C'est d'ailleurs l'opinion avancée par la délégation américaine à l'OMC qui a récemment déclaré que « les États-Unis estiment qu'il existe des possibilités de commerce dans toute la gamme des infrastructures sanitaires et sociales, y compris les hôpitaux, les installations de soins ambulatoires, les cliniques, les centres de soins, et l'aide au logement. »⁷, p. 665

Cette façon de voir les choses est également reprise par d'importants organismes américains de la santé. Ainsi, l'*Institute of Medicine* dans un rapport récent, *America's Vital Interest in Global Health*,⁸ déclare qu'il est dans l'intérêt direct des Américains que les États-Unis fassent la promotion de la santé mondiale, et prétend que l'augmentation des échanges commerciaux dans le secteur des services de santé permettra à la fois d'améliorer la santé du monde entier et de favoriser les intérêts stratégiques américains. De telles déclarations associées aux évolutions récentes tant en Europe qu'aux États-Unis visant à appliquer l'AGCS à leurs propres services de soins de santé ne

manqueront pas d'exercer des pressions externes sur le gouvernement canadien pour qu'il emboîte le pas.

Les récentes décisions prises par le gouvernement albertain – tant au niveau de la soustraction des services à des prestataires indépendants que l'introduction et la promotion du *Bill C-11* – pourraient aussi avoir pour effet de déclencher une intervention de la part de l'OMC dans le marché canadien de prestation des services de santé. L'article 1.3 de l'AGCS stipule que « dans de nombreux pays le secteur hospitalier regroupe des entités publiques et privées qui sont exploitées commercialement, facturant des frais aux malades ou à leurs assurances pour les traitements fournis. » [Traduction] En outre, « dans tous les régimes de financement mixte, comme ceux qui imposent un ticket modérateur ou le recours à une assurance privée, ou lorsque les infrastructures non publiques sont subventionnées, comme c'est le cas pour les partenariats public/privé ou encore les services soumis à appel d'offres, le secteur des services devrait accepter la concurrence étrangère. »⁹ [Traduction]

...voir Éditorial, à la page 28

high-risk heavy drinkers to prefer a relaxation of alcohol controls was more striking than ever. The difference between these heavy drinkers and other types of drinker was significant at $p < 0.01$ for all items except lowering the legal drinking age (no significant differences) and warning labels (no significant difference between heavy and some-risk drinkers). Not surprisingly, the largest differences occurred between heavy drinkers and non-drinkers. For example, the odds that a heavy drinker would prefer a decrease in alcohol taxes were 7.2 times greater than the odds for a non-drinker.

Nevertheless even compared to social and some-risk drinkers, heavy drinkers stood out for their much more frequent expression of desire for a relaxation of alcohol controls. For instance, the odds that a heavy drinker would want an increase in beer and liquor store hours were 7.4 times greater than the odds for social drinkers; and the odds that a heavy drinker would want alcohol to be sold in corner stores were almost double (1.8 times) those of some-risk drinkers. These results strongly imply that it is the high-risk heavy drinker who is most likely to be pleased by policies that reduce alcohol controls.

DISCUSSION

Overall the data support the conclusions that: 1) favourable opinions on any given policy often coincide with what could be supposed to be the least personally inconvenient option; 2) women, older persons, non-drinkers and moderate drinkers support the status quo and also support greater restrictions on alcohol availability, along with warning labels; and 3) men, younger

persons, and heavy drinkers support the status quo and also greater availability of alcohol, along with warning labels.

This profile of the opinion of Ontario citizens would seem to constitute an indicator of a possible mandate for the government, at the very least, to maintain and enforce those restrictions on alcohol availability already in place. The seven policy items under discussion are not suitable for capturing subtleties in public opinion (which would require open-ended items analyzed by means of qualitative methods). Nor are they comprehensive (e.g., they do not include the huge policy-related issue of drinking and driving). Nevertheless, just a glance down the "Total" column of Table I reveals such robust levels of support for certain directions in policy that it is hard not to be impressed.

There appears to be little danger of public outcry against warning labels should they ever be introduced. And yet a number of attempts both at national and provincial levels have failed to make them a legal requirement. This failure in spite of public support highlights the complexity of alcohol policy generation, which is not merely a response to public opinion, but also to political climate, historical aspects, industry influence and cultural assessment, so to speak, of costs and benefits. Interestingly, the governments of the Northwest Territories and the Yukon do require warning labels to be attached to alcoholic beverage containers at the point of sale.¹⁴

According to our data, any move on the part of the Ontario government towards policies tending to increase physical, economic and especially demographic availability of alcohol would be contrary to the wishes of the majority.

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Received: January 4, 2000

Accepted: June 28, 2000

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CONCLUSION

L'OMC apparaît de plus en plus comme un acteur important dans le commerce des soins de santé et de ses services auxiliaires. Cette tendance est particulièrement inquiétante pour des pays, comme le Canada, qui ont des systèmes de soins de santé financés par les pouvoirs publics. À ce titre, il existe deux grands domaines qui pourraient poser problème.

Premièrement, au cours des 15 dernières années, à mesure que les médicaments occupent une part de plus en plus importante et sans cesse croissante des coûts des soins de santé, les pouvoirs de contrôle exercés par les autorités provinciales diminuaient en raison des pratiques commerciales restrictives et des règlements sur les brevets adoptés au départ dans le cadre de l'Accord de libre-échange avec les États-Unis et repris et intégrés dans le cadre de l'OMC. Deuxièmement, l'OMC ainsi d'ailleurs que les représentants du secteur des

soins de santé américain ont ciblé les systèmes de soins de santé financés par les fonds publics – comme celui du Canada – comme marché potentiel de multiplication des échanges commerciaux en matière de soins de santé. Les tentatives visant à privatiser certains pans du système de soins de santé public – par exemple le *Bill C-11* que vient d'adopter l'Alberta – donnent à l'OMC une ouverture pour justifier un panel commercial qui pourrait décider d'autoriser l'entrée du secteur des soins de santé américain au Canada.