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The CETA and Health Care Reservations
A briefing note for the Canadian Health Coalition

By Scott Sinclair

Overview

There is a clear incompatibility between Canadian health care policies and the increasing scope of international trade and investment treaties. Canada's public health insurance system and the regulations around who can provide health care services and on what terms (including the Canada Health Act) cut against the grain of such treaties, which, in contrast to Medicare, tend to place the ability to make profits before the needs of citizens.

Consequently, successive Canadian governments have negotiated exemptions for health care in Canada's trade and investment agreements. These exemptions, while flawed, are vital in ensuring Canadian governments' ability to maintain existing health measures and to adopt new health measures that might otherwise be challenged under international trade and investment treaties.

The Comprehensive Economic and Trade Agreement (CETA) currently being negotiated by Canada and the European Union threatens to erode Canada's existing protections for health care. There is an urgent need to raise awareness of this threat and to build support for a broad exemption that would fully shield the Canadian health care system.

Background

Within the NAFTA, Canada negotiated two important "reservations", or country-specific exceptions, that shield government measures in the health sector from certain of the NAFTA's investment and services obligations.

The NAFTA Annex II reservation for health care[1] protects not only *existing* non-conforming measures, but also allows Canadian governments to take *new* measures that would otherwise be NAFTA-inconsistent. The Annex II-C-9 reservation, however, stipulates that any such measures must be related to health to the extent that it is "a social service established or maintained for a public purpose." These undefined terms were subject to sharply differing interpretations by the U.S. and Canadian governments,[2] creating uncertainty about the scope of protection provided by the Annex II reservation.

Partly to address this uncertainty, Canada negotiated a second reservation. Annex I (agreed in 1996) is a general reservation that permits each of the three NAFTA parties to maintain all non-conforming provincial and state government measures that existed when NAFTA came into force on January 1, 1994. The Annex I reservation[3] excludes "existing, non-conforming measures," although they can only be amended to make them more NAFTA-consistent. If a measure is eliminated or amended it cannot be restored. This reservation provides significant additional protection for the health sector by

providing blanket protection for regulatory measures in place prior to 1994.

There are, however, serious flaws in both the NAFTA safeguards. Most importantly, the NAFTA's broad provisions against "expropriation" without compensation apply with full force to all sectors, including health care. This means that expanding Medicare to cover new sectors in which foreign commercial interests are active could result in claims from U.S. investors seeking compensation for lost market share. Increasing the commercial or competitive element in the financing or delivery of a health service also narrows the scope of the safeguards, increasing exposure to trade and investment treaty challenges.

The CETA negotiations

Both Canada and the European Commission (EC) have stated their intention to exclude health services from the CETA. However, one of the EC's highest priorities in the CETA negotiations is to expand coverage of provincial and local government measures. Accordingly, the EC has demanded that Canada abandon the NAFTA Annex I general reservation. Canada has reportedly agreed, which means provincial governments will be required to negotiate exemptions for specific non-conforming measures in the health sector or to rely exclusively on the Annex II reservation.

As Canada's experience in the NAFTA reservations process in the mid-1990s demonstrated, it is very difficult to identify specific non-conforming measures, particularly in complex sectors such as health care. There is inherent uncertainty about the scope of the treaty provisions, which foreign investors and arbitral panels can interpret in unexpected ways. Certain provincial governments may not take a precautionary approach to protecting specific measures in the health sector because they are less concerned about the risks of increasing the private, for-profit aspects of Canadian health care system. In addition, abandoning the Annex I general reservation in the CETA would also extend to U.S. investors and service providers because of NAFTA's most-favoured nation provisions.[4]

The CETA will also include commitments covering private health insurance, which is a critical element of the Canadian health care system. While Canada's existing public health insurance system would probably be protected, if future Canadian governments expand Medicare to new services (such as pharmacare or home care) they could face compensation claims from European investors under the investment protection provisions of the CETA.

To address this concern, in 2002 the Romanow Commission on the Future of Health Care recommended that Canada negotiate a new, more effective exemption for health care in all future trade and investment agreements. Certain European member governments, EC health officials and civil society public health advocates would likely support such a broad exemption for health care in the CETA.

Recommendation

In order to provide maximum protection for health care and to safeguard its ability to expand coverage of public health insurance, Canada should negotiate a new exemption (modeled on the cultural exemption in recent Canadian bilaterals[5]). This exemption would stipulate that nothing in the CETA shall be construed to apply to measures adopted or maintained by a party with respect to health care or public health insurance.

Notes

1. The NAFTA Annex II reservation applies against the national treatment (1102, 1202), the services chapter's most-favoured nation treatment (1203), local presence (1205) and senior management and board of directors (1107) articles.

2. For a discussion of the differing views of Canadian and U.S. governments during the NAFTA sub-national reservations exercise, see *Putting Health First*: *Canadian Health Care Reform in a Globalizing World*, (Canadian Centre for Policy Alternatives, 2004), endnote 1, pp. 13–15 and *Inside NAFTA*, November 29, 1995.

3. The Annex I reservation applies against the NAFTA national treatment (1102, 1202), most-favoured nation treatment (1103, 1203), local presence (1205), performance requirements (1106) and senior management and board of directors (1107) articles.

4. NAFTA's most-favoured nation rule (Article 1103 in NAFTA's investment chapter) requires that the best treatment given to any foreign investor must also be extended to investors from other NAFTA parties. The NAFTA Annex II-C-9 reservation does not apply against Article 1103.

5. The cultural exemption in the Canada-U.S. FTA, which was carried over under the NAFTA, contains a retaliation clause which authorises the U.S. to take counter-measures if Canada invokes the cultural exemption. The cultural exemptions in more recent bilaterals do not include any retaliation clauses.