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Public Healthcare and the Limits to a Canadian-Style Inclusive Trade Agenda

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Louise Dalingwater

01. Introduction

1 In response to the anti-globalization backlash, Canada has been developing a Progressive Trade Agenda (PTA) or what has more recently been referred to as "an inclusive approach" to trade (Government of Canada, 2020). This agenda, which is similar to many inclusive or sustainable trade projects developed by multinational fora (the WTO, the World Bank...) and the European Commission, aims to respond to the rejection of globalization, which has primarily been criticized on the grounds that the gains from ever freer trade have not been shared evenly. Moreover, such a progressive agenda also seeks to alleviate the detrimental effects on the environment and health. Trade policy-making has thus been aimed at reflecting such an inclusive stance. In Britain, there has also been some support for the development of a Canadian-style progressive trade policy agenda post-Brexit (Department for International Trade, 2018).

2 One of the key tenets of Canada's inclusive approach to trade is the safeguarding of the rights of national governments to regulate in the area of public services, including health services. The government underlines, for example, that the Canada-EU Comprehensive Economic and Trade Agreement (CETA) "protects the ability of Canada to regulate and legislate to achieve legitimate public policy objectives in public health" (Government of Canada, 2020). In a consultation report for the UK's post-Brexit trade deals, the UK Government stated that it "is committed to maintaining our high standards for consumers, workers, and the environment, and to protecting our public

services, in any future trade agreements that we conclude." (Department for International Trade, 2018). However, the extent to which such an agenda protects public healthcare provision is far from certain.

3 The policy space for national governments in the area of health has been firmly established in free trade agreements and clauses included in both multinational and new generation trade deals to exclude public health services from the trade liberalization process. This does not necessarily mean that healthcare services are protected, essentially because the changing nature of modern economies has resulted in a blurring of public and private activities. Yet trade policy-makers fail to take into account such complexities when setting provisions to protect public healthcare in trade deals. Official discourse, provisions in FTAs, and more generally trade policy may aim at excluding public health services in line with the progressive trade agenda, but the practice of trade tends to provide scope for inclusion and thus the furthering of international trade and investment in this sensitive sector.

4 It would seem appropriate at present, faced with the Covid-19 pandemic, to consider the impacts of healthcare marketization from an international perspective and to revisit the literature on the inherent dangers of furthering healthcare trade and investment. The Covid-19 pandemic has highlighted the weaknesses of many public healthcare systems and the need for greater investment. In countries in which healthcare is highly dependent on the private sector, such as the USA, the pandemic has shown the limits to this mode of supply. The US system has been exposed as dysfunctional, lacking the protective gear, and highly unequal, with poorer hospitals facing bankruptcy (Hook and Kuchler, 2020). Yet some observers have promoted the further development of the private supply of healthcare services through international trade. They lend support to the furthering of cross-border healthcare supply to fight the pandemic (see Gillson and Muramatsu, 2020).

5 The purpose of this article is to compare the cases of the UK and Canada concerning the furthering of trade and investment in health services and to consider the impact on publicly administered healthcare systems. This paper draws on theoretical and empirical insights from both health policy research and international political science to analyze the potential effects of further trade openness on public healthcare provision in two countries facing similar challenges. This article is the first to compare the cases of the UK and Canada for health services trade challenges. These two countries are good points of comparison because they both have healthcare systems free at the point of use, but are becoming increasingly reliant on private sector income from international suppliers, which has the potential to disrupt the public provision of healthcare.

6 The paper draws on IPE structuralist literature because it is, in essence, supporting a basic structuralist tenet that more trade leads to structural change in the periphery and in this case the reconfiguration of the health market. It will review some of the major concerns raised in the literature for public healthcare : lock-in liberalization through ratchet and negative listing, transparency and anti-trust clauses, and the potential for IPR clauses and ISDS mechanisms to result in escalating prices for the medication in both Canada and Britain. However, it goes further than this literature and uses other desk research to extensively examine the furthering of trade and investment in private health services and the extent to which this can impact the delivery of public healthcare services.

7 Several academic papers have already considered the constraints that commitments in FTAs place on the ability to deliver public health services (De ville and Siles Brugges, 2015 ; Maier de Kruiff *et al.*, 2016). However, there are fewer papers that analyze the broader reconfiguration of the market for healthcare that this implies. Nor indeed have many papers looked at the "shadow processes" beyond FTAs that are underway in Canada and the UK to free up trade and international investment in healthcare services. Public and private stakeholders are engaging in the furthering of trade and investment in health services thanks to the liberalization of public services. As a result, there would appear to be significant risks to the equitable supply of high-quality healthcare services.

8 This paper thus starts by considering the role of the market in public services. It then describes the liberalization process which has enabled the furthering of trade and investment in public health services and the locking in of liberalization as a result of trade deals. It points to the particularly harmful effects this can have, for example by resulting in unaffordable essential medicines for populations. It shows that, beyond the locking-in process, state support for expanding the private health market means that the market for public health services is still at risk even if carve-outs for public services are included in progressive Canadian-style FTAs.

02. Market mechanisms and public services

9 Whether it be in health, education, transport, or the like, "public" has become a highly contested notion. In practice, the division between public and private is debatable when we consider service delivery and service outputs. The traditional concept of public in neo-classical literature is defined, according to Samuelson (1954), as services or goods that are non-rivalrous and non-excludable. Non-rivalrous because they can be consumed by an unlimited number of people without depletion and non-excludable because they are available to all. However, nowadays most services or goods only partially conform to this model. Liberal theory creates a dualism between the state and the market. Yet the two are not necessarily exclusive of one another. Markets can be set up, managed, owned by governments or state agencies for profit. Public and private goods can be seen to be inter-dependent. As Teixiera *et al.* (2004) underline, our understanding of public and private becomes blurred as more stakeholders, such as semi-public organizations, independent agencies, regulatory bodies, or public-private networks are involved in the provision of public services.

10 Financial considerations have also meant the principle of margin, i.e. the cost or benefit incurred with changing allocations of resources is sometimes applied to public services, even if such analysis raises many difficulties. For example, in the health sector, public health systems may take into consideration the extra cost incurred by producing one unit of production and if the marginal cost rises above the average cost, health policymakers will decide whether it is worthwhile providing such services. Efficiency also comes into play in current health systems. The mantra of governments over the last decades has indeed been to make the best use of scarce resources to deliver health to the population.

11 Concerning this process, there has been what some have called a deification of the market (Cox, 2016). This absolute faith in the market has come from the way that economics is taught today as a simple demand and supply dynamic (Watson, 2018).

Markets are thus given divine qualities and presented as the mechanism by which efficient resource allocation will come about. As Leys (2001) points out, in all areas of public policy, politics have become market-driven, although the role of the market seems stronger in some economies than others.

12 Studies of capitalist economies have identified two opposing types of capitalist economies : "co-ordinated market economies (CMEs)" and "liberal market economies (LMEs)" (Hall and Soskice, 2001). CMEs are led by non-market institutions, they tend to coordinate with labor unions to bargain wages at the industrial or national level and inter-firm relations are important. LMEs on the other hand tend to turn to market institutions. Both Canada and Britain have been described as LME economies, which has meant maximum exposure to market forces (Leys, 2001). Hall and Soskice argue that in Anglo-Saxon economies where business coordination was less well organized than in CMEs, governments were forced to implement deregulation measures to remain internationally competitive. Added to this, the introduction of New Public Management (NPM) techniques in both Canada and the UK has also led to the blurring of the boundaries between the public and private spheres. There was a significant will on the part of the British government from the 1980s onwards to promote global capital mobility and to expose the economy to global market forces, even in areas such as public services where conventional market systems are often considered to be unsuitable. Leys (2001) argues that the British government under Margaret Thatcher decided to play a leading role in the construction of a global economy. The result has been a significant increase in the privatization of key government sectors and the marketization and commodification of other areas such as health and education. Canada has also privatized large segments of the public sector, developed public-private partnerships, and commercialized water, electricity, transport, and security. In Manitoba, there are increasing calls to privatize the health system and more and more funds are being invested in private schooling in British Columbia. Renewable energy is managed by the private sector in Ontario (McDonald, 2016). However, as structuralists such as Prebisch identified as early as the 1940s, market forces alone are unable to correct the asymmetries they reproduce in the area of international trade and development (Prebisch, 1946).

03. Literature Review of risks to the international liberalization of health service supply

13 The incompatibility between priorities regarding trade and investment and health policy has been largely documented. There is significant literature that supports the thesis that gains in income, goods, and services from trade have had a net negative impact on social welfare and population health because of the unevenness of gains (Andrews and Chaifetz, 2013 ; Blouin et al. 2009 ; Labonté, 2004 ; Labonté *et al.* 2009., Shaffer *et al.*, 2005 ; Smith *et al.* 2009 ; Stiglitz, 2006 ; Stiglitz, 2009).

14 Overall, quantitative analysis and several health impact assessments have illustrated that trade and investment agreements may result in unequal access to health services and increased public bads (Labonté R, Schram A, Ruckert A., 2016 ; Hirono K *et al.* 2016 ; Baker P *et al.* 2016 ; Weiss M., 2015 ; Smith R.D., 2012 ; Schram A *et al.*, 2015 ; Schram A *et al.*, 2013 ; Thow and Gleeson 2017.). This is a result of provisions that may limit access to medicines (Baker 2016 ; Gleeson *et al.* 2013 ; Thow and Gleeson 2017), constrain policy

space for health, and limit the scope that governments have to pursue public health goals (Thow *et al.*, 2015 ; Thow *et al.* 2014 ; Koisuvalo, 2014). A point that a number of these studies make is that the threats to public health systems tend to be greater for those countries that have significantly liberalized their public services.

15 Moreover, case studies of other countries have shown that an internationalized profit-oriented health system tends to distort the domestic market for healthcare. The US market is a case in point where highly specialized and profitable healthcare has been developed. The market has developed a wide range of exportable specialist medical techniques, devices, and highly qualified and specialized personnel, but the national health system remains one of the most inefficient and costly in the developed world (OECD 2019). Sasha Issenberg (2016, p. 70) shows how the same problem has emerged in Israel, which has become a haven for medical tourists. The latter enjoy medical treatment far superior to that received by the average Israeli. For less developed countries the risk is even greater. In West Africa, one of the causes of the disastrous Ebola crisis was the state of domestic hospitals. Since many local elites went for treatment abroad and opted out of local hospitals, the latter became underfunded and dysfunctional.

16 In addition, Lunt *et al.* (2011) have explored the negative externalities of furthering trade and investment in health services on home country health systems. Indeed, many distortive effects may arise. Qualified staff may concentrate their attention on health export services that have better pay and facilities, which diminishes services and facilities in the home country and can perpetuate inequalities. In the case of the UK, there is a possibility that the best consultants move to the South and London to engage in expanding lucrative international private health services. In Canada, if physicians can sustain enough income from profitable medical tourism, they may well switch to providing private healthcare. Indeed, much of the increase in trade and investment in health services is medical tourism. There is no agreed definition for medical tourism. Some authors make a distinction between medical tourism (travel for wellness, cosmetic, or other non-essential procedures) and medical travel (travel for essential procedures) (Ruggeri *et al.*, 2015). In the remainder of this paper, references to medical tourism will refer to foreign patients' visits to hospitals or health clinics for treatment for both essential and non-essential treatment.

17 Yet, the recent Covid-19 pandemic has also given new impetus for trade in health services. Gillson and Muramatsu (2020) argue that the pandemic has underlined the weaknesses of national health systems but at the same time highlighted the need for further development of cross border e-health services like telemedicine. Equally, they support the cross-border supply of health professionals to alleviate capacity constraints on domestic health systems. Yet, any move towards freeing up trade in health systems must bear in mind the risks of the development of a two-tier system, particularly within universal healthcare systems such as those which exist in Canada and Britain.

04. The Canadian public healthcare system and the blurring of the public and private

18 Canada has a universal system or so-called Saskatchewan single-payer model, which provides healthcare services that are considered to be medically necessary to the

population. So most hospital interventions are free at the point of use except for some operations (mainly cosmetic), which are not considered necessary. The Canadian system of health delivery is decentralized and, while overall the Medicare system protects the population, there are increasing gaps in cover because of the narrow scope of health services included in universal health coverage (Health Systems in Transition, 2013). Approximately 70 % of health expenditure is covered by this system in Canada (Health Systems in Transition, 2013).

19 Most primary healthcare services are delivered by private health providers. In the majority of provinces, a large number of consultants have joined professional corporations to increase revenue (Health Systems in Transition, 2013). Support services to private and acute care also tend to be provided by private operators, for example, ambulance services, food, and supplies. Dentistry care, opticians, psychology, and rehabilitation are mainly provided by the private sector. While traditionally hospitals were private, non-profit making institutions, the introduction of universal hospital coverage in 1984 under the Canada Health Act means that hospitals now rely almost entirely on public funding. Hospitals are mainly owned and operated by the Regional Health Authorities (RHAs). These RHAs are not responsible for collecting taxes, but receive funds which they redistribute from the ministries of health. RHAs are also responsible for delivering services.

20 However, in the 1990s, government cutbacks led to a reduction in the number of public sector healthcare workers and encouraged the growth in private sector activity. Indeed, since the 2000s, there has been substantial growth in private sector activity. Glauser (2011) is concerned by what she describes as a "swelling number of private clinics", which suggests that there is an increasing move towards private healthcare provision in Canada. The move towards a private system has been described by Cory Verbauwhede, a lawyer working for Médécins Québécois pour le Régime Public, as privatization by stealth. There are no official figures on the number of private clinics at the national level, but estimates have suggested that there are 300 private clinics in Quebec, 66 in British Columbia, and 60 in Alberta (Glauser, 2011). While many of these clinics provide cosmetic services, some are developing into mini hospitals to provide key surgery such as cataract, knee, and hip surgery (Glauser, 2011). However, one of the reasons why the growth has not been more significant is the prohibition under the Canada Health Act for physicians to bill Medicare systems and simultaneously provide services and charge patients for private clinic services. This has led many doctors to continue to work in the public system because of their inability to sustain enough income from working entirely in the private system.

21 However, evidence suggests as early as 2008 that 90 private clinics were violating the prohibition of public consultants working in the private sector (Glauser, 2011). Moreover, it has been suggested that regulators are turning a blind eye to illegal practices because the public system is underfunded which means that desperate patients are looking elsewhere to receive care more quickly. An investigation into such malpractice found that approximately 63 % of doctors working at the private clinics were also working in the public domain (Tomlinson, 2017). With the expansion of private health services and overseas income, there could well be more incentives for physicians to increase private healthcare work. Funding cuts in the public domain has meant a decline in capital equipment and better technology in the private sector. The private sector is also able to sell comprehensive packages of health, including those

sold in the public domain (hospital services) and preventative healthcare. There is thus scope to expand the private sector, but the risk is not quite the same as that of the UK because of the prohibitions of the Canada Health Act. The lifting of such prohibitions in Britain has meant the public health system in this country is perhaps even more vulnerable to the development of private healthcare.

05. Liberalizing public healthcare services in Britain

22 Britain like Canada uses a so-called "single-payer" model – whereby healthcare is free at the point of use, paid for out of taxation, and health workers are employees of the government. Britain has a national health system that provides universal or near-universal coverage of healthcare for several keys and costly health services : consultations with doctors and specialists, tests and examinations, and surgical and therapeutic procedures. Public expenditure covers 80 % of all healthcare costs here (OECD, 2019). However, dental care and pharmaceutical drugs are often excluded from coverage (OECD, 2019).

23 The vast project of liberalization in the 1980s led to a greater public-private mix in the National Health Service (NHS) and notably the introduction of market mechanisms such as public-private partnerships. The creation in 1991 of an internal market within the National Health Service in Britain furthered this tendency.

24 With the implementation of the internal market, the basis of funding altered. Hospitals became financially independent corporations and were responsible for making an income to survive. While the creation of an internal market allowed the entry of a certain number of private providers, there were caps on services contracted out to the private sector. However, the involvement of the private sector was also increased from 1997 onwards under the New Labour government. Compulsive Competitive Tendering was replaced by Public-Private Partnerships (PPPs) to outsource services to the private sector. The Prime Minister’s Delivery Unit was specifically set up to manage and enforce performance management, performance indicators, and Public Service Agreements (PSAs). Figures suggest that outsourcing health sources to private companies were greater under New Labour than during the previous Conservative governments.

25 The Health and Social Care Act of 2012 also significantly extended the scope for participation from the private sector. This Act lifted the cap that had existed until then on the amount that NHS hospital trusts and other providers could commission out to the private sector. It also removed the cap on the amount of private activity NHS consultants could engage in. Figures reported in 2014 after a Freedom of Information request made by former shadow minister, Gareth Thomas, showed that hospitals increased private income by 40 % after the lifting of the cap under the Health and Social Care Act (Watt, 2014).

26 In March 2018, another survey of the state of privatization of healthcare in Britain was carried out by the Centre for Health and the Public Interest (CHPI). It found that the total income that the NHS had generated from private patients had increased by 16 % over the four years since the enactment of the Health and Social Care Act of 2012. The main concern about privatization that emerged from the survey was that 1 % of the NHS’s 131,000 beds were occupied or put aside for private patients. This may appear small ; however, the number of NHS beds is constantly falling and total occupancy rates

are at dangerous levels (95 % or more in winter months), which represents a significant loss for the treatment of NHS-funded patients (Ewbank *et al*., 2017). Moreover, there is a disproportionate skew of private patients in NHS hospitals in London (60 % of all private income) (CHPI, 2018). London is largely where the most affluent people live and also a favorite destination for international patients. Enlarging the role of the market in healthcare in the international sphere is certainly a way in which some centrally-based NHS hospital trusts can increase private earnings. A freedom of information request conducted in July 2018 by the present author found that some trusts earned as much as 45 % of their income from private international patients. More than 16 trusts were also engaging in outward foreign investment (mainly setting up health infrastructures abroad).

06. Increasing the role of the market through trade and investment agreements

27 Indeed, in recent times, international trade and investment have been a channel through which the role of the market has been extended in public services, increasing commodification in the latter (Raza, 2016). The European Union has played a significant role in this drive towards liberalization of public services with the creation of an internal market and sectoral directives with the aim of freeing up trade and enhancing competition within the European Union (Keune *et al*., 2008). This has led to a blurring of notions of public and private and has raised questions as to what extent the state has a role in providing public services. Governance of public services may thus be left to other stakeholders on a national or, increasingly, on an international scale.

28 This process has also been supported by international agreements and notably the General Agreement on Tariffs and Trade (GATT), General Agreement on Trade in Services (GATS), and the creation of the WTO. After a series of Uruguay rounds of multilateral trade negotiations in 1994, the GATT became subsumed into the World Trade Organisation (WTO), with a view to further consolidating trade rules and principles (WTO, 2013). The main goals of the WTO since its inception have been implementing free trade by reducing tariffs and customs duties, enhancing transparency, stable investment, stable trading environments, and non-discrimination via the most-favored nation rule and national treatment rules (which prohibit the application of discriminatory trading rules between trading partners). The WTO rules have enabled tariffs to be cut significantly and consequently increased flows of goods and services (WTO, 2013 ; Friel *et al*., 2015). Since its creation, 24 multilateral trade agreements have thus been created, binding countries on a number of issues. The most significant agreements have been the General Agreement on Trade in Services (GATS), Trade-Related Aspects of Intellectual Property Rights (TRIPS), Technical Barriers to Trade (TBT), Sanitary and Phytosanitary (SPS) Agreement, the Agreement on Agriculture, and a dispute settlement system (WTO, 2014 ; Friel *et al*., 2015). There has also been a significant increase in Foreign Direct Investment (FDI) calling for agreements to protect investors from political risks (protection against discrimination, protection against expropriation without compensation, protection from unfair and unreasonable treatment, and a guarantee of free movement of capital). This has led to the signing of Bilateral Investment Treatments (BITs) or International Investment

Agreements (IIAs). Free Trade Agreements also include specific provisions relating to investment (Friel *et al*., 2015).

29 However, there does seem to be an inherent desire in countries worldwide to protect the policy space in the area of healthcare policy formulation and this may explain why efforts have been made to protect and thus exclude healthcare from trade and investment deals. Fewer than 50 of the WTO's members have made commitments in one of the four health services sub-sectors (WTO, 2020a). Health is the sector in which there are the fewest overall commitments. Moreover, European and Canadian interest groups have campaigned against furthering trade and investment in health services through inclusion in trade deals ever since 2000 during the GATS negotiations. From 2002 to 2003 the Directorate General (DG) Trade did refine the GATS position by excluding public services from negotiations. DG Trade press releases from 2003 onwards have underlined that "public services" "are fully safeguarded" and that no commitments have been made in health or education. Exclusion of public health services has also been at the heart of more recent trade and investment deals. In the resolution on Trade in Services Agreement (TiSA), the European Commission promises to introduce a "gold standard" clause to exclude public services from the scope of trade agreements irrespective of how they are supplied. CETA also has a public sector carve-out, which exempts "services supplied in the exercise of governmental authority" from the application of the chapter on trade in services, and certain elements of the investment chapter (European Commission, 2020).

30 Nevertheless, civil society and researchers are still raising concerns about regulatory loopholes. Indeed, one of the key issues was the irreversible nature of the privatization of public services due to the inclusion of a negative listing and a ratchet clause. Under the negative listing, trade agreements apply to all areas, unless they are explicitly exempted in the agreement. A negative listing means only exceptions will be listed with no further exceptions after the deal is signed, which could have a significant impact if public services are not included (Maier de Kruijff *et al.*, 2016). The negative listing was a key innovation of the CETA agreement, for example. A "ratchet clause" has been included in the CETA agreement and is planned for TiSA, which means that if a country decides to liberalize the market for a public service then that level of market liberalization must be maintained and cannot be reversed, i.e. services cannot be brought back into the domain of the state. Maier de Kruijff *et al.* (2016) underline the essential threat to democratic governance that this implies. A government that is democratically elected in a country may cease to make decisions to the extent to which a public service is provided to its citizens.

31 Investor protection has also been an issue raised by academics and civil society. The fear is that the Investor-State Dispute Settlement (ISDS) could enable companies investing in a specific country to bypass national jurisdiction and challenge a national government via undemocratic tribunals. The underlying aim of including ISDS is to provide a neutral international arbitration procedure to resolve conflicts. Many trade and investment agreements contain forms of ISDS. However, this may also be a way in which investors can sue governments or gain the upper hand and constrain governments' ability to regulate, especially in sensitive areas such as health services (Maier de Kruijff *et al.*, 2016).

32 The European Public Health Alliance (EPHA) notes for example that while Article 8.9 of CETA reaffirms the right for national governments to regulate in the area of public

health, the government would still have to compensate international companies if their investment rights are infringed. For example, under the North American Free Trade Agreement (NAFTA), Canada was sued 35 times and often in cases regarding public health. In 1997, Ethyl Corp challenged a Canadian ban on the gasoline additive because of its negative effects as a neurotoxin (EPHA, 2016). Canada settled and paid 13 million dollars in damages. In the *Eli Lilly* case in 2013, Canada's attempt to invalidate a US patent was challenged before an arbitral tribunal (UNCTAD, 2013). All claims which the US pharmaceutical company asserted against Canada were dismissed. Nevertheless, the arbitral proceedings of this case set future standards for litigation of patents governed by international investment law. During these proceedings, the arbitral tribunal make it clear that state courts should follow the provisions of Chapter 11 of the NAFTA agreement. Canada could therefore well have been held liable for the conduct of its courts if it had ruled that they had not complied with the standards of treatment established under NAFTA (Musmann, 2017).

33 The other major concern for Canada, which could also represent a threat for Britain post-Brexit, is the risk that Intellectual Property Rights (IPR) provisions in trade agreements may result in higher prescription costs. IPR were strengthened under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, negotiated in 1995 under the auspices of the WTO. This agreement provided for a minimum term of 20 years of protection for patents on pharmaceutical products. Given the risk of escalating prices of medication, the TRIPS did include safeguards to reduce the negative impact on access to medicines. There was thus an extension of the TRIPS to include the Declaration on the TRIPS Agreement and Public Health. This Declaration granted member countries the right to take action to protect public health and promote access to medicines.

34 Canada has the third highest drug costs in the Organisation of Economic Co-operation and Development (OECD) (Government of Canada, 2019). As Michael McBane underlines, "access to essential medicine and access to generics are key elements in a sustainable public health-care system. Canadians don't want this traded away" (McBane, 2012). A large number of Canadians cannot afford prescribed medication. Research carried out by the Angus Reid Institute and Mindset Social Innovation Foundation found that more than one in five (23 %) of Canadians have either chosen not to buy medication, skipped doses, or split pills because of the unaffordable price of medication (Angus Reid, 2015). A poll carried out in 2019 by the Heart & Stroke Foundation and the Canadian Federation of Nurses Union (CFNU) confirmed these findings, reporting that nearly one in four (24 %) of Canadian households had taken the decision not to fill or renew a prescription or take all prescribed drugs because of the high cost (Heart and Stroke Foundation, 2019). Medicine is not paid for by Medicare, apart from in hospital, and therefore represents out-of-pocket costs for some Canadians because the Canada Healthcare Act does not cover all prescription drugs.

35 In the UK, British citizens do not have to pay for the full costs of prescriptions, and medication for some chronic conditions is entirely covered by the NHS. However, access to drugs is still problematic. Faced with the spiraling costs of new drugs on the market, the NHS has been reported to reject a third of all new cancer drugs, which has meant that cancer patients are unable to access more effective treatment in Britain. It may be no coincidence that Britain has consistently scored poorly on cancer recovery

outcomes (OECD, 2019). The NHS also practices a price cap, which prevents access to new drugs (mainly those protected by IPR) (Thaysen, 2017).

36 The conclusion of FTAs such as CETA or CPTPP has led to the development of greater IPR protection, which can pose significant risks of escalating medication prices. This is a cause for concern given that access to medication is already somewhat compromised in Canada and the UK. All member countries of CPTPP must provide a grace period of one year before a patent filing date, during which time public disclosure by the inventor or their assignee has to be disregarded to determine whether the invention is new. Besides, for the period that marketing approval is being secured for a new product, the applicant may be required to submit undisclosed tests or other data concerning the safety and efficacy of such a product. The CPTPP thus obliges countries to protect such tests or data for at least 10 years from the date of marketing approval of the product. Such provisions could lead to off-patent medicines having exclusive rights and again prevent the market entry of generic versions because the companies supplying these generic versions are unable to replicate such costly and time-consuming tests to obtain marketing approval. There would therefore seem to be great risks for both Canada and the UK if it joins the CPTPP post Brexit.

37 Moreover, Lexchin and Gagnon (2014) estimated that CETA's provisions would increase Canadian drug costs by between 6.2 % and 12.9 % from 2023. This is essentially because patients would have to meet two price hikes : the rising drug costs and the subsequent increase in federal taxes. The authors also contend that with increased drug costs, provincial governments will be forced either to restrict publicly available drugs, transfer costs to patients, or cover the costs by reducing expenditure in other areas of healthcare provision.

07. Extension of the private health sector and the creation of a two-tier healthcare system

38 Yet beyond the impact of the potential for free trade agreements to lock in liberalization and result in uneven access to essential medicines, the furthering of trade and investment in services thanks to FTAs could more generally result in a two-tier healthcare market. Many of the provisions of trade agreements that claim to "exclude to protect" actually mask submerged or shadow institutional processes. Even the existing agreement of the GATS leaves enough scope for nations with a high penetration of the market in public health services, such as Canada and the UK, to extend trade and development in health services. The marketization of health services has enabled the expansion and commercialization of healthcare according to Mode 3 of the WTO Trade in services framework. The GATS distinguishes between four modes of supplying services : cross-border trade, consumption abroad, commercial presence, and presence of natural persons. Mode 3 involves the establishment of a foreign service provider in a host country. This form of supply can thus generate additional foreign direct investment, help upgrade healthcare infrastructure, create jobs, and transfer know-how and medical expertise (WTO, 2020b). Mode 2 of the WTO framework, which is the consumption of services abroad, has also grown thanks to the increasing openness of the public sector with the marketization of public services in general and further liberalization since 2012 with the Health and Social Care Act. The GATS agreement was perhaps the first step to providing a common framework for health

services : including provisions on health insurance, hospital services, telemedicine, etc. (WTO, 2013). However, it has also been highly criticized for not taking into account the specific nature of health policy in different countries and for transferring governance of public health systems away from national governments (Friel *et al.,* 2015). The move towards inclusiveness of health services in international trade can be seen as furthering the exchange of health services at the expense of public provision. The privatization of public healthcare is thus underway with the possibility of welcoming foreign patients, even if this does not yet amount to a significant share of healthcare services in the UK and Canada. There has also been increasing involvement in outward foreign direct investment.

08. How health and institutional actors further international liberalization

39 Significant protest from civil society groups about including public services in the trade deals has meant that states have made commitments to protect public healthcare services from the liberalization process in recent FTAs. However, this has not stemmed the commercialization of healthcare abroad with somewhat "submerged" or "shadow" processes underway. The statements about protecting healthcare in trade and investment deals are perhaps not telling the full story or quite simply ignoring the multilevel dynamics at play in the internationalization of health services beyond trade policymaking.

40 The British government would seem to be intent on furthering trade and investment in the NHS abroad and indeed the marketing of health services to try and reduce the burden of public healthcare provision. This is evident from the support for recent outward foreign direct investment in which hospital trusts are encouraged to engage. Only the provision of public NHS services is protected in these trade deals, but there is still plenty of scope to develop a private market within the NHS as the latter has begun to develop a two-tier system.

41 A key player in the furthering of trade and investment in healthcare, since 2012 and the introduction of the Health and Social Care Act, has been Healthcare UK. Healthcare UK is a joint initiative of the Department of Health (DH), UK Trade and Investment (UKTI), and NHS England. Until 2017, Healthcare UK was nevertheless presented as a separate entity with a website disassociated from the government department. However, the organization has now been fully integrated onto the government's website.

42 Both private healthcare providers and the NHS have thus been involved in healthcare agreements, mainly in countries that are looking to improve the domestic supply. Since its creation, the organization has made over £ 5bn worth of deals. The key markets are identified as China with 18 deals, followed by Brazil (11), Saudi Arabia (9), the UAE (7), and India (4). This mainly involved setting up healthcare infrastructure services but also clinical services, digital health, and education and training. The providers are private enterprises but also public sector organizations : NHS Trusts, Department of Health arm's-length bodies and academic institutions, working closely with Healthcare UK. The organization argues that such exchange can strengthen global health by sharing key infrastructures and healthcare in emerging economies and bringing

revenue back to the UK, which could be spent on public healthcare (Healthcare UK, 2017).

43 Healthcare UK's principal aim is to increase the UK's share of the growing global healthcare market. They act as "the bridge between international demand for healthcare services, systems and infrastructure and the rich pool of UK know-how and capability in these fields" (Healthcare UK, 2017). They are principally engaged in promoting the UK healthcare sector in overseas markets through seminars, conferences, and the setting up of business deals. They promote the UK's "thriving commercial healthcare industry and the world-renowned academic sector". They also act as an advisory body to NHS institutions and other organizations on political, commercial, and cultural issues to facilitate market access. They promote five key areas : healthcare infrastructure services, clinical services, digital health, education and training, and health systems development.

44 Healthcare UK promotes the furthering of trade and investment, even within the public health domain, stating that the NHS has been furthering trade in health services ever since the 1970s with the Department of Health's "Exporting the NHS". Such a document was published in response to requests made to best-performing NHS organizations, such as St Thomas' Hospital, to invest in healthcare in Middle Eastern countries. Healthcare UK claims that the benefits can accrue back to the British healthcare system, securing over £ 5bn for the UK economy, with £ 235m reinvested back into the NHS and other public-sector bodies. They admit that the profits may be centralized in London with major London trusts and foundations winning most of the work abroad (Kings College Hospital, Moorfields, Guy's & St Thomas' and Great Ormond Street Hospital). However, a few regional players have also been successful (such as Mersey Care and Alder Hey Children's Hospital in Liverpool, Leeds Teaching Hospital, and Northumbria Healthcare) (Healthcare UK, 2016).

45 Healthcare UK argues that there is scope for expanding outward direct investment and inward investment (receiving foreign patients in these establishments by creating private units) because international demand for better and more efficient healthcare is continually growing with the rise in elderly populations and long-term and chronic illnesses. The organization claims that inward investment will enable it to share best practices of an equitable health system with emerging nations. In their preamble to a report entitled "Enhancing the NHS through International Engagement" (Healthcare UK, 2016), the organization argues that such ventures also enable NHS professionals to learn thanks to the challenges of delivering healthcare in different markets. They contend such experiences can provide developmental opportunities for UK staff who can learn new skills and gain transferable experiences as well as enhancing the global reputation of the NHS.

46 Healthcare UK also argues that it identifies and manages the risks of international ventures and offers advice to NHS trusts engaging in such transactions. It claims to ensure that the quality of NHS services provided to the British public is not compromised by sharing NHS expertise abroad. However, the series of risks identified in the organization's manual are mainly concerned with marketing the NHS as a brand name and externalization risks, but it does not deal with the reconfiguration of the public health system implied by extending trade and investment in public health services. Healthcare UK does urge trusts to ensure that they are "effectively able to balance workforce requirements for clinical and managerial delivery outside of the

NHS with day-to-day requirements for core clinical delivery for the NHS" (Healthcare UK, 2016, p. 32). But from a micro-perspective, it seems rather ambitious to expect individual organizations (hospital trusts and the like) to be able to estimate the wider risks involved in furthering trade and investment in NHS services.

47 While the Canada Act prevents public consultants from engaging in private sector activities, the crowding out of the public sector by the private is also a risk in Canada and could be increased by the furthering of trade and investment within PTAs. Collaborations, for example between Manitoba's extensive private health services and Asia, is a case in point. The Manitoba Wellness Institutes at Seven Oaks General Hospital entered into a joint venture with the China Hospital Association in 2011. It was seen as an opening for other public health facilities in Canada to engage in overseas ventures. Like Britain, Canada is looking to increase the number of wealthy foreigners who come to their country for medical treatment. For example, the University Health Network (UHN) treated 621 foreign patients between 2011 and 2015 and raised revenue of around $ 30 million (UHN, 2014). Colleen Flood, a professor in Health Law and Policy at the University of Ottawa argues that the practice of increasing trade in healthcare can weaken the quality of Medicare for Canadians. The same fear that has been underlined in the UK case is that even if there is some reinvestment into the public sector, beds may be reserved for medical tourists rather than Canadians relying on the public system. She suggests that if Canada's medical tourism is extended, it could indeed "eat into the public health system" and lead to more doctors moving into private practice because of the prospect of earning better money (Flood, 2015).

48 Many Canadians are also reported to be leaving the country for medical treatment abroad to avoid long waiting lists. According to an annual survey of physicians in 12 specialty areas, an estimated 63,459 Canadians received non-emergency medical treatment abroad in 2016 (Feixue and Labrie, 2017). Outward medical tourism can however be detrimental to the Canadian healthcare system too. A study published in the Canadian Journal of Surgery estimated that over $ 560,000 was spent putting right bariatric surgery in Canada between 2012 and 2013 when medical tourists came back home (Kim *et al.*, 2013). A similar investigation in Britain found that the mean cost to the NHS of putting right failed cosmetic tourism carried out abroad was £ 6,360 (Miyagi, Auberson, Patel and Malata, 2012).

49 While it has been argued that engaging in trade and investment in health services may mobilize additional funds for cash-starved public sectors, it is more likely to fragment the healthcare system and lead to disjointed information and practice because of the provision of a two-tier and competing system between those services provided by the public sector and those provided by the private sector (Allottey *et al.,* 2012, Missoni 2012). While health tourism may promote economic growth in the destination country, at the same time it can also give incentives for health workers to move from rural to urban settings. The rise in the number of private health facilities for foreign consumers will inevitably worsen national residents' access to health services and, in particular, those groups of the population that cannot afford private care. There is some evidence that this might already be the case. As Glauser (2011) underlines, an increase in medical tourism, which may be enhanced through further liberalization in trade deals, can be seen as representing a shift to for-profit private healthcare. She argues that creating a second-tier contravenes the principles of Medicare in Canada and exacerbates unequal access to healthcare. The author contends that if human resources (doctors, nurses,

and administrators) are focused on medical tourism, this will divert attention from the public healthcare system. Likewise, if Canadians seek care abroad, which is increasingly possible thanks to GATS and PTAs, healthcare providers in Canada may find it difficult to coordinate care.

50 The British NHS is facing the same problems, which could intensify as trade is freed up under these new trade deals. The NHS Code of Practice for Private Patients states that "provision of services for private patients should not prejudice the interests of NHS patients or disrupt NHS services", and "NHS commitments should take precedence over private work" (UK Department of Health ; 2004, p. 1). In practice, there have been some adverse effects observed. A Centre for Health and the Public Interest (CHPI) report notes that junior doctors, interviewed as part of the investigation into the privatization of the NHS, admitted that taking notes on private patients tended to take up a lot of time. This left less time to deal with NHS patients (CHPI, 2018). Senior consultants seemed to be spending more time with private patients and encouraged their teams to do so to sustain a private income. The overall conclusion was that so long as the number of private patients remains low, it should not put pressure on public patients. However, with the future threat of NHS funding per patient falling and a possible increase in international private patients thanks to the liberalization of trade through PTAs, different levels of treatment may well emerge. The other risk is that currently there is no law stating that private patients have to wait as long as public patients for treatment. This could potentially mean that public patients wait longer for treatment. The increasing number of private patients seeking high-quality health services in NHS trusts, especially in London, may accentuate this problem.

09. Conclusion

51 Comprehensive trade and investment agreements have been seen as essential to advancing the globalization of healthcare. Such deals starting with the GATS and furthered by the recent comprehensive agreements such as CETA have already enabled the commodification of healthcare sectors around the world, but sufficient measures have not been taken to inform and involve locally affected populations and supra-national regional bodies of the dangers. Also, treaties and bilateral investment deals have also enabled the furthering of services trade and investment in health services.

52 Beyond the specific risks posed by ISDS, the extension of IPR in PTAs and other trade and investment deals, the crowding out of the public sector by the increasing scope for public sector consultants to work towards supplying healthcare to the international market should be taken seriously. This is, even more, the case gives the current pressures on public health systems owing to the Covid-19 crisis.

53 The key risks of furthering trade in health services, whether it be in the public or private domain, are a resulting two-tier health system, disincentives for practitioners to engage in the public sector, and, consequently, a move towards the private sector. The reconfiguration of the public health system in Britain and recent legislation to open up public health services to the private sector have made Britain even more vulnerable to such risks.

54 While public services may be excluded and thus protected in free trade agreements, the reality is that said services are still at risk because of current legislation which enables private and public health providers alike to further trade and investment largely

unheeded. Progressive trade deals that promise to protect healthcare from the furthering of trade and investment simply overshadow the issue that there are increasing incentives for public sector physicians to engage in international trade and investment and the state would seem to be prepared to support such processes because of the narrative of the superiority of the market. The British and Canadian public healthcare systems have progressively been developing into a complex mix of public and private services in recent years. Trade policy carve-outs do not therefore fully exclude the public good as intended.

55 The Global Healthcare Policy and Management Forum held in South Korea in October 2016 concluded that there are clear concerns about the extent to which the internationalization of healthcare or "medical tourism", furthered through free trade agreements, exacerbates health inequities. To date, no institution has established a valid method of qualitative and/or quantitative measures to evaluate these effects (Crooks *et al.*, 2017).

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ABSTRACTS

One of the key tenets of the Progressive Trade Policy agenda (PTA), set forth in the Canadian government's Report of the Standing Committee on International Trade on the Trans-Pacific Partnership, was the safeguarding of the national government's rights to regulate in the area of public services, including health services. However, the extent to which such an agenda protects public health care provision is far from certain. While the internationalization of health services has the potential to increase the supply of health services worldwide, a lack of global governance mechanisms to protect the health, and failure to take into account the risks to public health of the internationalization of health services may be highly detrimental to the health of trading nations. This paper draws on theoretical and empirical insights from both health policy research and international political science to analyze the potential effects of further trade openness on public healthcare provision in Canada and the UK.

L'un des principes clés du programme de politique commerciale progressiste (PTA), énoncé dans le rapport du gouvernement canadien du Comité permanent du commerce international sur le partenariat transpacifique, était la sauvegarde des droits du gouvernement national à légiférer dans le domaine des services publics, y compris les services de santé. Toutefois, qu'un tel programme puisse protéger les services de santé publique est loin d'être certain. Certes, l'internationalisation des services de santé peut accroître l'offre de services de santé dans le monde entier. Toutefois, l'absence de mécanismes de gouvernance mondiale pour protéger la santé et l'absence de prise en compte des risques pour la santé publique de l'internationalisation des services de santé peuvent être très préjudiciables à la santé des pays commerçants. Cet article s'appuie sur des données théoriques et empiriques issues de la recherche sur les politiques de santé et de la science politique internationale pour analyser les effets potentiels d'une plus grande ouverture commerciale sur la prestation des soins de santé publics au Canada et au Royaume-Uni.

INDEX

Mots-clés: Canada, Royaume-Uni, politique commerciale progressiste, services de santé
Keywords: Canada, UK, Progressive Trade Policy, healthcare services

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