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**A LEGAL OPINION CONCERNING  
NAFTA INVESTMENT AND SERVICES  
DISCIPLINES AND BILL 11: PROPOSALS  
BY ALBERTA TO PRIVATIZE THE  
DELIVERY OF CERTAIN INSURED  
HEALTH CARE SERVICES**

# - Legal Opinion -

## Concerning the Privatization of Insured Health Care Services and NAFTA

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## Introduction

You have asked for our opinion concerning present plans by the government of Alberta to contract with private for-profit health care companies for the delivery of insured surgical services. In particular you have asked for our views with respect to the potential impact of the services and investment provisions of the North American Free Trade Agreement (NAFTA) should Alberta proceed with present plans.

### Summary:

The following offers a summary of our opinion concerning these matters:

1. In many ways, the trade liberalization objectives of NAFTA are incompatible with policies that seek to exclude market forces in order to achieve other societal goals, such as the provision of universal and accessible publicly funded health care.
2. For example, the investment and services rules of NAFTA seek to contain the capacity of governments to regulate or otherwise intervene in these spheres of the economy. On the other hand, Canada's health care system depends upon a comprehensive framework of federal and provincial policy, law and funding arrangements that restrict the rights of private investors, and service providers in order to preserve a public health care system based on the five principles of Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility.
3. This conflict is also apparent when the provisions of Bill 11 are considered in the context Canada's obligations under NAFTA. For notwithstanding this Bill's orientation towards free-market private sector solutions, several of its provisions either ignore or breach NAFTA constraints.
4. The inherent and explicit contradictions between public health care and free trade explain why Canada needed to protect its health system from the full impact of trade disciplines. Ultimately the future viability of the Canada's public health care system depends upon the integrity and broad application of these safeguards.
5. However, in negotiating NAFTA Canada failed to insist upon a broad exclusion for health care, relying instead upon the more limited protection of certain "reservations" (listed under NAFTA Annexes I and II) and on exceptions for government procurement and funding.

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6. Furthermore, Canada's sectoral reservation for health care (Annex II C-9) is qualified and ambiguous because it only applies to health services "to the extent that they are social services established or maintained for a public purpose." Moreover, Annex II C-9 doesn't apply to several of NAFTA's most onerous provisions, such as those dealing with expropriation and compensation. This piecemeal and qualified approach creates real vulnerability to NAFTA challenges and investor claims.
7. Moreover, the privatization of insured health care services in Alberta would play directly to US arguments that would undermine the protection afforded by Canadian reservations. This is the case because the US has argued that, notwithstanding these reservations, "services supplied by a private firm, on a profit or not-for-profit basis" are entirely subject to NAFTA investment and services disciplines. Should this view prevail, a NAFTA dispute or arbitration panel would conclude that Canada's health care reservation had no application to those services Alberta now plans to contract out to private companies.
8. The impacts of Alberta's privatization initiative also have real potential to resonate beyond the province's borders. This will be particularly true if the federal government condones its experiment. It would then be open to foreign investors to insist on equally favorable treatment elsewhere in Canada under the national ambit of federal health care programs.
9. The risks that privatization poses to the integrity of Canada's public health system have been well documented by more than one federal health minister and many others. The influence of NAFTA's investment and services rules will significantly exacerbate the problems already associated with privatization in three ways:
  - The rights accorded foreign investors and service providers under NAFTA limit government policy and regulatory options to a degree that is not true vis-à-vis domestic investors and service providers under Canadian law. These constraints undermine Canada's capacity to preserve the essential features of its publicly funded health care system.
  - The same is true with respect to the proprietary interests of foreign investors, which are accorded much greater protection than is available to Canadians under our statutory or common law. These rights would make it virtually impossible for governments to retreat from privatization initiatives which gave rise to foreign investment.

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- Only foreign investors have recourse to the extraordinary and highly coercive enforcement machinery of NAFTA. We have already been able to observe the constraints on public policy that even the threat of investor-state claims can exert.

Each of these factors will, in our view, add significantly to the pressures that privatization initiatives will exert on the integrity of Canada's public health care system.

In our view therefore, Alberta's plans to privatize the delivery of surgical health care services threaten the integrity of Canada's public health care system in a manner that has far-reaching and adverse implications both for Alberta, and for the rest of Canada.

Furthermore, we also offer our responses to the following questions.

**1. Alberta's health care initiatives are likely to increase the participation of foreign investors and service providers in the delivery of surgical and other insured health services. Should this occur, would it be open to this or some future Alberta government to re-direct the provision of these health care services to Canadian not-for-profit providers should it decide to abandon its privatization initiatives?**

The reservation Canada has listed for the health sector (Annex II C-9) would theoretically allow a government to retreat from health care initiatives that result in the privatization of health care services. However no reservation has been taken from NAFTA's rules concerning expropriation, or investor-state claims. This is likely to make the cost of compensating foreign investors, who have established or expanded operations under any new regime prohibitively expensive.

It is not clear whether Alberta intends to limit the participation of foreign investors and service providers in any contracts regional health authorities may negotiate with private providers. Moreover, as a practical matter it would be difficult for it to do so once the door is open to greater private sector participation in the delivery of insured surgical services. Accordingly, the participation of foreign investors and service providers in the delivery of these health services is likely to increase under Alberta's proposed scheme. Under NAFTA investment disciplines, these inroads would almost certainly become permanent fixtures of the health care system.

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## **2. Would the implementation of Alberta's plans to allow greater private sector participation in delivering certain insured medical services undermine the integrity of either Annex I and/or II reservations?**

Bill 11 would not qualify as an "existing non-conforming measure," as defined by the reservation listed for provincial measures (Annex I), and therefore would not be entitled to the protection afforded by that reservation. Moreover, Canada's Annex II sectoral reservation for health is qualified in a manner that creates great uncertainty about its effectiveness and the extent of its application.

Furthermore, the US has expressed a view of the meaning of Annex II which casts into considerable doubt its application to those aspects of a health care system that involve the delivery of services by private companies on a commercial basis. Nor does Canada appear to be willing or able to resolve this uncertainty by agreement with the US. This leaves the meaning of Annex II to the vagaries of NAFTA dispute resolution processes including the prospect of foreign investor claims.

While the outcome of such a dispute is difficult to predict, it is clear that present Alberta proposals would lend significant support to the arguments already articulated by US trade officials – that Chapters 11 and 12 would fully apply *to services which are provided by a private firm, on a profit or not-for-profit basis.*

## **3. Is Bill 11 consistent with NAFTA investment and services disciplines?**

In the event that Chapter 11 and 12 rules apply fully to Alberta's proposals there is a significant risk that the province's experiment would quickly escape whatever bounds it may have intended. Without the protection of Annex I and II reservations the province would lose important regulatory authority necessary to preserve the public, not-for-profit character of its health care system.

In several instances, the application of NAFTA prohibitions to Alberta's health care initiatives is certain because no exception or reservation has been established to exclude application of these investment and services disciplines. In other instances the extent to which provincial policy and law is constrained by NAFTA requirements will depend upon the interpretation of Annex I and II reservations. Therefore, a consideration of the specific provisions of Bill 11 reveals two potential areas of conflict. Those that are certain to occur because Bill 11 is drafted in a manner that ignores the limits

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imposed by NAFTA investment and services disciplines, and those which may arise depending upon the views of trade dispute panels or arbitral tribunals called upon to determine these matters.

Examples of the former include:

- The imposition of terms and conditions on agreements between regional authorities and surgical facilities pursuant to Section 8 is left to the discretion of the Minister. But the Minister's authority is limited by the constraints of NAFTA Article 1106 which proscribes measures that would require the purchase of local goods or services, technology transfers, and certain service obligations.
- The prohibition against the transfer or sale of an approved agreement under Section 10 would offend the explicit prohibition against such measures set out in NAFTA Article 1109.
- Section 23 would insulate decisions by the Minister from appeal or judicial oversight. But while Bill 11 can limit the rights of domestic investors, public hospital boards, trade unions and health care consumers, it will have no bearing on the rights of foreign investors to invoke the powerful enforcement machinery of NAFTA's investment rules to challenge these same decisions.
- Sections 18 and 19 delineate the circumstances in which the Minister may withdraw or terminate a designation he or she may have granted to a surgical facility. Even when such action may be justified and for a public purpose, compensation to the extent of fair market value would still be payable pursuant to NAFTA Article 1110.

Examples of the latter include:

- Section 1 of Bill 11 bans the operation of private hospitals. Section 2 denies private surgical facilities the right to deliver major surgical services. Both measures clearly discriminate against foreign investors in favour of public hospitals, which according to NAFTA definitions would include hospitals run by governments, churches, social service agencies and community based organizations. These provisions of Bill 11 offend *National Treatment* obligations to provide the most favourable treatment to foreign investors.
- Sections 7 and 8 set out various preconditions to the operation of a surgical facility. These are substantially different and arguably

more onerous than the requirements for licensing public hospitals under Alberta's Hospital Act. Again a breach of *National Treatment* is apparent.

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To this assessment should be added one caveat. Without understating the consequences of undermining the integrity of Annex I and II reservations, the province would still retain some authority to allocate health care funding without having to comply with *National Treatment* and certain other NAFTA disciplines. The province would maintain these prerogatives because of certain exclusions for procurement, subsidies and grants written into NAFTA.

Accordingly, and while it may be very difficult to implement from a practical point of view, the provincial government would be entitled to refuse to contract with US providers for the delivery of insured health services. Ultimately however, this discussion is moot in light of Bill 11's silence on the subject of contracting out to US private providers.

**4. In the event that private sector health care service providers are accorded new business opportunities in Alberta, would foreign investors and service providers be entitled to claim similar treatment elsewhere in Canada?**

The federal government's capacity to defend public health care from the corrosive influence of international trade and investment obligations will be undermined if it does not intervene to prevent the further erosion of the not-for-profit, community based hospital system by the ever increasing participation of private for-profit service providers. Furthermore, should it accept Alberta's plans as being permissible within the federal framework, it would weaken its ability to defend Canada's health care system as falling under the protection of the Annex II C-9 reservation.

This would leave Canada open to foreign investor claims asserting their right to *National Treatment* – in this case public funding throughout Canada for the delivery of insured surgical services – founded on Canada's support, tacit or otherwise, for Alberta's privatization experiment. Federal responsibility for Canada's **national** health care system, and the Canada Health Act, might then become the lynchpins for extending the impacts of Alberta's initiative beyond its borders.

## Part I: The Facts

Bill 11, the Health Care Protection Act was introduced by the government of Alberta on Mar. 2, 2000. It represents the third attempt by the province to pass legislation that would provide a formal legal framework for privatizing the delivery of certain insured surgical services. The Bill represents a more sophisticated legislative expression of this intent than did Bill 37, its immediate antecedent, by advancing the cause of privatization under the banner of “health care protection.”

One might be forgiven therefore for concluding that Bill 11 was drafted with a view to obscuring its true purpose, which has little if anything to do with preserving the character of Alberta’s public health care system. Rather Bill 11 would transform that system by substantially increasing the scope for private for-profit hospitals to perform surgical services. As the Globe and Mail described it:

*Alberta will be the first province to entrench a large-scale private component in its public health care system<sup>1</sup>.*

The obfuscation of the Bill’s title is also carried to its text. For example, Section 1 of the Bill 11 provides *that no person shall operate a private hospital in Alberta*. But the very next section introduces the concept of “approved surgical facilities” which, with the exception of certain unspecified major procedures and emergency care, would be licensed to provide the full array of services typically performed in hospitals.

The Concise Oxford Dictionary defines “hospital” *as an institution providing medical and surgical treatment and nursing care for ill or injured people*. Certainly by this definition and common parlance “approved surgical facilities” would have to be considered hospitals.

Nothing in Bill 11 precludes the licensing of “approved surgical facilities” that are privately owned and operated for profit. Nor does the Bill establish any constraints on foreign investment in or ownership of such facilities.

However Bill 11 does introduce certain limits on the range of services that such facilities would be licensed to deliver. Section 2(2) provides that major surgical services, as defined by bylaws under the Medical Profession Act, only be provided by public hospitals. Section 29(m) defines “private hospital” to mean

*an acute care facility that*

- (i) provides emergency, diagnostic, surgical and medical services, and*
- (ii) admits patients for medically supervised stays exceeding 12 hours,*

*but does not include a public hospital.*

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<sup>1</sup> Friday, Mar. 3/00.

Section 5 explicitly allows these “non-hospital” surgical facilities to provide enhanced medical goods and services subject to certain consumer protection safeguards. Section 7 establishes three requirements for licensing such surgical facilities:

- accreditation by the College under the Medical Profession Act;
- an agreement with a health authority that the Minister has approved; and,
- designation by the Minister.

Section 10 imposes certain constraints on ownership transfers. Section 11 empowers the Minister to designate surgical facilities to perform specified surgical services, and to impose terms and conditions on those approvals.

Division 2 of the Bill sets out licensing requirements regarding the provision of uninsured in-patient, and day surgical services. Division 3 allows for the withdrawal and termination of designations. Part 3 deals with various general matters and includes: a privative clause to limit judicial oversight of decisions made by the Minister under the Act; and, a clause empowering the Cabinet to make regulations concerning various matters.

Part 4 establishes a Premier’s Advisory Council on Health and Part 5 sets out various definitions relevant to the Bill. Finally Part 6, includes various transitional provisions as well as amendments to the Alberta Health Care Insurance Act, the Hospital Act and the Medical Profession Act.<sup>2</sup>

While the Bill appears to have been crafted to address some the concerns that greeted its precedents, it is clear that it still represents a significant and unprecedented advance of the rights of private sector providers to participate in the delivery of insured health care services. Should the province succeed in this endeavour, it would, through regional health authorities, institutionalize private health care service delivery in a manner that has until now, eluded its promoters.

## **Qualifications**

Pursuant to your instructions, we have not considered the implications of Alberta’s proposals against the obligations set out in the General Agreement on Trade in Services (the GATS) to the World Trade Organization. Nor have we addressed issues regarding Canadian arrangements under the Agreement on Internal Trade. Finally we note that we offer no opinion about the compliance of Alberta’s plans with the requirements of the Canada Health Act.

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<sup>2</sup> Alberta’s proposals would also rely upon the significant groundwork already laid in provincial health care legislation to authorize, by regulation, the provision of insured health services by private hospitals (see s. 62 of the Hospitals Act).

## **Part II: Canadian Obligations under Chapters 11 and 12**

The advent of international agreements concerning investment and services is a relatively recent phenomenon. Prior to this modern era of comprehensive international trade agreements, Canada and other countries were free to fashion domestic social policies as they saw fit. The establishment of binding international obligations under NAFTA and the World Trade Organization has changed all that. Now governments must operate within the constraints imposed by these agreements on pain of retaliatory trade sanctions, or damage awards, should they ignore the limits imposed by these trade regimes on their sovereign authority.

Moreover, the fundamental free market objectives of trade liberalization that are expressed by NAFTA and the WTO are fundamentally incompatible with public policies that seek to exclude market forces in aid of serving other societal goals, such as the provision of universal and accessible public health care. The inherent contradictions between these respective agendas explain why Canada needed to take steps to protect its health care system from the full impact of trade disciplines. As we will discuss, the future viability of the Canadian system depends upon maintaining the integrity of those protections.

Before doing so, we begin by providing an overview of the most important provisions of NAFTA rules concerning investment and services for our present purposes.

### **NAFTA Investment and Services Rules**

The Investment and Services Chapters of NAFTA impose certain broad constraints upon the measures (law, regulation, procedure, requirement or practice) a country can adopt or implement. These include the following obligations:

#### **Article 1102: National Treatment**

1. Each Party shall accord to investors of another Party treatment no less favorable than that it accords, in like circumstances, to its own investors with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments.
2. ....
3. The treatment accorded by a Party under paragraphs 1 and 2 means, with respect to a state or province, treatment no less favorable than the most favorable treatment accorded, in like circumstances, by that state or province to investors, and to investments of investors, of the Party of which it forms a part.

In other words, Canada must extend the very best treatment it accords its own citizens and companies to US and Mexican investors on a non-discriminatory basis. Article 1202 establishes the same rule for foreign service providers. Therefore unless explicitly

excluded, *National Treatment* would require that foreign investors and service providers be given the same rights and opportunities that Canada makes available to domestic health care service providers and investors.

**Article 1106: Performance Requirements**

1. No Party may impose or enforce any of the following requirements, or enforce any commitment or undertaking, in connection with the establishment, acquisition, expansion, management, conduct or operation of an investment of an investor of a Party or of a non-Party in its territory:  
.....
  - (b) to achieve a given level or percentage of domestic content;
  - (c) to purchase, use or accord a preference to goods produced or services provided in its territory, or to purchase goods or services from persons in its territory;
  - .....

Article 1106 prohibits government regulation that would condition the right to conduct business with obligations to support the local economy.

**Article 1110: Expropriation and Compensation**

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

- (a) for a public purpose;
- (b) in a non-discriminatory basis;
- (c) in accordance with due process of law and Article 1105(1); and
- (d) on payment of compensation in accordance with paragraphs 2 through 6

Because of the far reaching implications of these provisions for the protection of publicly funded health care service delivery we will return to discuss them in further detail below.

**Article 1205: Local Presence**

No Party may require a service provider of another Party to establish or maintain a representative office or any form of enterprise, or to be resident, in its territory as a condition for the cross-border provision of a service.

Article 1107 imposes similar constraints with respect to the composition and nationalities of Senior Management and the Boards of Directors.

The dispute settlement provisions of Chapter 11 are also of critical importance and are discussed under a separate heading below.

## **Reservations**

No exception for health care is included among the general exceptions to NAFTA set out in Chapter 21. This contrasts with the approach taken for *National Security, Taxation and Cultural Industries* which are given broad exemption from the application of NAFTA rules. Rather, to protect health care policy and law from trade disciplines, Canada elected to list only certain health care services as reservations, and then only to some of the provisions of Chapters and 11 and 12.

The authority to do is set out by Articles 1108 for investment, which provides in part:

**Article 1108: Reservations and Exceptions**

1. Articles 1102, 1103, 1106 and 1107 do not apply to:
  - (a) any existing non-conforming measure that is maintained by
    - (i) a Party at the federal level, as set out in its Schedule to Annex I or III,
    - (ii) a state or province, for two years after the date of entry into force of this Agreement, and thereafter as set out by a Party in its Schedule to Annex I in accordance with paragraph 2, or
    - (iii) a local government;
  - (b) the continuation or prompt renewal of any non-conforming measure referred to in subparagraph (a); or
  - (c) an amendment to any non-conforming measure referred to in subparagraph (a) to the extent that the amendment does not decrease the conformity of the measure, as it existed immediately before the amendment, with Articles 1102, 1103, 1106 and 1107.
2. Each Party may set out in its Schedule to Annex I, within two years of the date of entry into force of this Agreement, any existing non-conforming measure maintained by a state or province, not including a local government.
3. Articles 1102, 1103, 1106 and 1107 do not apply to any measure that a Party adopts or maintains with respect to sectors, subsectors or activities, as set out in its Schedule to Annex II.
4. No Party may, under any measure adopted after the date of entry into force of this Agreement and covered by its Schedule to Annex II, require an investor of another Party, by reason of its nationality, to sell or otherwise dispose of an investment existing at the time the measure becomes effective.

Article 1206 establishes a similar regime with respect to services with reference to Articles 1202, 1203 and 1205 of that Chapter.

Thus pursuant to these provisions the ambit of permissible reservations is restricted to the following specific investment and services obligations:

- National Treatment (Investment and Services)
- Most Favoured-Nation Status (Investment and Services)

- Performance Requirements (Investment)
- Senior Management and Boards of Directors (Investment)
- Local Presence (Services)

Measures are defined broadly by Article 201 to include “law, regulation, procedure, requirement or practice.”

Both Articles 1206 and 1108 permit two different types of reservations: bound and unbound. The former -- Annex I reservations -- permit a government to maintain any specific non-conforming measures which it lists. While countries are permitted to amend such a measure at a future date they may “not decrease the conformity of this measure” with the constraints imposed by the listed provisions. In other words, governments are prevented from developing policy and legislation that would be more restrictive of the rights of foreign investors and service providers as established by these chapters of NAFTA.

Unbound reservations on the other hand provide much greater latitude for future policy and law reform. Thus governments are entitled to “adopt or maintain” measures that would otherwise violate the constraints imposed by NAFTA provisions. The preamble to Annex II provides:

... the reservations taken by that Party with respect to specific sectors, subsectors or activities for which it **may maintain existing, or adopt new or more restrictive, measures that do not conform with obligations** imposed by [the listed Articles] ...

This means that governments are entitled to pursue new initiatives that may be more restrictive of the rights of foreign service providers so long as they keep within the parameters of the public policy and legal domain described by the reservation.

Canada has taken advantage of the opportunity to list both Annex I and II reservations that are relevant to the present discussion.

Annex II C-9 provides, with respect to the Social Services Sector, the following:

Type of Reservation:

National Treatment (Articles 1102, 1202)  
 Most-Favored-Nation Treatment (Article 1203)  
 Local Presence (Article 1205)  
 Senior Management and Boards of Directors

(Article 1107)

Description:

Cross-Border Services and Investment

Canada reserves the right to adopt or maintain any measure with respect to the provision of public law enforcement and correctional services, and the

following **services to the extent that they are social services established or maintained for a public purpose:** income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care. [emphasis added]

It should be noted that Canada's sectoral reservation doesn't apply to Article 1106: *Performance Obligations*, notwithstanding the authority provided by Articles 1108 and 1206 for it to do so. Because of uncertainty about the adequacy of federal reservations to shelter all provincial measures, including those that pertain to health care, the following Annex I reservation was also listed pursuant to Articles 1108 and 1206 with respect to all sectors:

Type of Reservation:

National Treatment (Article 1102, 1202)  
Most-Favored-Nation Treatment (Article 1103, 1203)  
Local Presence (Article 1205)  
Performance Requirements (1106)  
Senior Management and Boards of Directors (1107)

Level of Government: Provincial

Measures: All existing non-conforming measures of all provinces and territories.

Phase-Out: None.

## **Reservations vs. Exceptions**

Canada's decision not to include health care among the general exceptions to NAFTA has significant implications for public policy and law in this domain. Quite apart from their more limited ambit, reservations have less weight and permanence than exceptions such as those concerning cultural industries (Article 2106) and national security interests (Article 2102). Without reviewing the international law on this point, there are key distinctions that should be noted between these two approaches.

1. Exceptions apply to all signatories to an agreement and are included in the treaty's text. For example, the broad and unqualified carve-out for *National Security* offers a good example. On the other hand, a reservation applies only to the country declaring it, and is usually found in an annex or supplementary document to the main text, as is the case for health under NAFTA.
2. Exceptions such as those set out in Chapter 21 are included as permanent features of the agreement, while reservations are often subject to agreement about *standstill* and *rollback*. Standstill precludes the development of law and policy that would be more restrictive of the rights established by the treaty, and the principle of rollback anticipates the gradual reduction of the protection afforded by particular reservations. An apt description of the combined effect of such rules

was offered in the commentary to a draft text for the Multilateral Agreement on Investment, which as we know, was patterned on NAFTA's investment rules:

*Rollback is the liberalisation process by which the reduction and eventual elimination of non-conforming measures to the MAI would take place. It is a dynamic element linked with standstill, which provides its starting point. Combined with standstill, it would produce a "ratchet effect," where any new liberalisation measures would be "locked in" so they could not be rescinded or nullified over time.*<sup>3</sup>

While there are significant differences with respect to the application and permanency of reservations and exceptions, both approaches share the common characteristic of being given narrow interpretation under international law. Thus where ambiguities exist concerning the effect or extent of a particular reservation, the interpretation that gives broadest application to the substantive provisions of the main text would, as a matter of legal interpretation, be preferred.<sup>4</sup>

In simpler terms, given a contest between the provisions of the main text, and the language of a country specific reservation, the former will be given broad and liberal interpretation while the latter will be construed narrowly.

## **Dispute Settlement**

The provisions of Section B of Chapter 11 provide foreign investors with the extraordinary right to invoke international dispute resolution processes to enforce their rights under the Chapter. Accordingly, under Articles 1121 and 1122 foreign investors of a NAFTA party have a virtually unqualified right to sue national governments for any alleged breach of the expansive and broadly-worded investor rights they are granted by this trade agreement. These disputes are then decided, not by our courts or judges, but by international arbitration panels [Article 1120] operating under the auspices of institutions such as the World Bank.<sup>5</sup>

Moreover, panels operate, not in accordance with domestic legal principles and procedures, but under international law and according to procedures established for resolving

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<sup>3</sup> DAF/MAI/NM(97)2, at p.154 para 1.

<sup>4</sup> See Shaw, *International Law* (4<sup>th</sup> ed.) pp. 641-649, See the *Belilos case before the European Court on Human Rights*, 39ICLQ, 1990, pp 18-2, and J. K. Koh, *Reservations to Multilateral Treaties*, Harvard International Law Journal, 1982, p71. Also see discussion infra under Question 2.

<sup>5</sup> For example, the International Center for the Settlement of Investment Disputes (ICSID) was established under the *Convention on the Settlement of Investment Disputes between States and Nationals of Other States* and is overseen by an Administrative Council and a Secretariat. The Administrative Council is chaired by the World Bank's President and consists of one representative of each State which has ratified the Convention.

international commercial disputes.<sup>6</sup> In many ways these procedures are antithetical to the principles of open, participatory and democratic decision-making that are the hallmarks of Canada's legal system. For example, Article 24 of the ICSID Arbitration Rules (Additional Facility) provides:

1. The deliberations of the Tribunal shall take place in private and remain secret.

Indeed the rules of international arbitration might even preclude the publication of an arbitration award but for the explicit authority to do so provided by Article 1137 and Annex 1137.4. Even in this case however, Canada is under no obligation to make an award public, and would be free to negotiate terms of settlement that bar publication.

It bears emphasis that investor-state enforcement represents a rather significant departure from the norms of international law in two key ways:

1. by providing corporations with the right to directly enforce an international treaty to which they are neither parties, nor under which, they have any obligations; and,
2. by extending international commercial arbitration to claims that have no foundation in contract, and which may only obliquely be considered commercial in character.

Thus, under Article 1122 Canada has unilaterally consented to international arbitration for claims arising under the Chapter notwithstanding the absence of any contractual relationship with the claimant. Nor do investors have any obligation to exhaust domestic remedies before resorting to international dispute resolution [Article 1121].

We should also note, that with the solitary exception of the Investment Canada Act<sup>8</sup>, Canada has taken no reservations from the application of these dispute resolution provisions.

We have taken some time to describe the enforcement procedures of Chapter 11 because an understanding of the risks that NAFTA poses to Canadian health care policy and programs must appreciate the character of the quasi-judicial processes that will be invoked to judge any challenge or claim that may be made to them. Simply put, in the event that Canada's NAFTA partners or their investors initiate disputes or claims concerning Canadian measures relating to health care, these will be resolved behind

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<sup>6</sup> These are the regimes established pursuant to the ICSID convention, and UNCITRAL Arbitration Rules, recourse to which is provided by Article 1120.

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<sup>8</sup> Annex 1138.2.

closed doors, without the benefit of interventions by parties other than the federal government and the disputing party, and by arbitrators chosen by the parties or appointed by international institutions and who need have no familiarity with Canadian law, or health policy.

## Interpretation (Uncharted terrain)

As one final preliminary matter, and following our discussion of investor-state litigation, we should point out the inherent difficulty of making confident predictions about the outcome of disputes or claims arising from the provisions of Chapters 11 and 12. There are several factors that compound the difficulty of this task.

1. Several key terms set out in these chapters are left undefined by NAFTA. Examples include “social services,” “public purpose,” “direct or indirect expropriation,” or “in like circumstances.”
2. Similarly there has been no formal interpretation of these same terms and phrases. The few precedents which exist for NAFTA’s investment and services rules, are themselves recent innovations in the area of international treaty law and have not yet been considered by trade dispute panels, arbitral tribunals or by the courts.
3. The principle of binding precedent (*stare decisis*) does not apply in the area of international commercial arbitration or trade adjudication. This means that dispute panels are not be bound by previous interpretations offered by other panels of arbitration tribunals. Articles 1131 and 1132 empower the NAFTA Commission to issue binding interpretations of contentious provisions to ensure some measure of consistency among panel and tribunals. But, this authority not been exercised to clarify the ambiguity that surrounds many key terms in these two NAFTA chapters.

## Part III: Discussion

### The plan of this decision

Much of our assessment of the potential consequences of Alberta's pending health care initiatives turns on our opinion about the likely effectiveness of Canada's sectoral reservation for health. This issue determines the extent to which Canadian health care programs will be protected from some of NAFTA's more onerous obligations.

However, some of the consequences that are likely to flow from the application of NAFTA disciplines in this context are far more certain than others. This is particularly true for those provisions of NAFTA from which no reservation has been made. Of these, by far the most important are Articles 1110: *Expropriation and Compensation*, and Part B of Chapter 11: *Settlement of Disputes between a Party and an Investor of Another Party*. In fact the impact of these provisions renders significant aspects of the debate about the breadth and application of NAFTA reservations, moot.

Because of the seriousness of the consequences that may follow from these NAFTA provisions, we begin with an assessment of the potential impact of these disciplines should Alberta proceed with current plans. We then consider a number of questions, the answers to which depend upon one's views about the effectiveness of Annex I and II reservations. We address these issues under three headings.

The first concerns the nature of Canadian reservations and the uncertainty that exists about their extent and application. While it may be difficult to estimate how a dispute or arbitral panel will interpret Canada's reservations, it is much easier to predict the consequences for Canadian health care systems should these reservations be given narrow interpretation. Accordingly the second and third questions we attempt to answer, concern the potential health care related consequences should Annex I and II reservations not apply: first, for the province of Alberta; and, then for the rest of Canada.

### 1. The New Permanence of Health Care Reform

**Alberta's health care initiatives are likely to increase the participation of foreign investors and service providers in the delivery of surgical and other insured medical services. If this occurs, would this or some future Alberta government be able to re-direct the provision of these health care services to not-for-profit public hospitals, should it decide to abandon this experiment?**

The evolutionary course of public policy and law will often take false turns. In most cases these errors are soon corrected by parliaments and legislatures which may either choose to retreat, or chart a new course forward. This is no more or less than the iterative dynamic of policy and law reform.

The modern era of international trade agreements has made these course corrections far more difficult to make. Nowhere is this more clear than with respect to the rights of foreign investors under NAFTA. Two provisions of Chapter 11 are key: Article 1102: *National Treatment* and Article 1110: *Expropriation*. The latter, as noted, is not reserved under either Annex I or II, and will, in our opinion, represent a very substantial impediment to any derogation of the investor rights that present Alberta proposals would create. In other words, should Alberta's experiment with private care proceed, it will be very difficult for this or any future Alberta government to interfere with the interests foreign investors are likely to acquire.

Because Canadian reservations may effectively shelter health care measures from the full application of *National Treatment* obligations, we will address the implications of this rule further below. For the moment we will concentrate on the impact of Article 1110 on future policy and legislative options should Alberta proceed with present proposals.

### **The Impact of Article 1110**

While the premise of Canada's Annex II reservation would allow governments to retreat from unsuccessful health care measures, this right is almost certain to prove more putative than real when those measures give rise to investments and investor interests under Chapter 11. This is true because in the case of measures which allow such private health care providers to establish or expand their investments in Canada, the cost of re-establishing those elements of the public system that may be lost to private investors would almost certainly be prohibitive.

We appreciate that the cost of compensating individuals and companies adversely affected by the establishment of public sector enterprises has always been an important consideration for governments contemplating such initiatives. However, under NAFTA the cost of compensating foreign investors in such cases is certain to be considerably higher and much less predictable than would otherwise be the case.

The Expropriation and Compensation provisions of Article 1110 will play a key role:

#### **Article 1110: Expropriation and Compensation**

1. No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment ("expropriation"), except:
  - (a) for a public purpose;
  - (b) on a non-discriminatory basis;
  - (c) in accordance with due process of law and Article 1105(1); and
  - (d) on payment of compensation in accordance with paragraphs 2 through 6.

2. Compensation shall be equivalent to the fair market value of the expropriated investment immediately before the expropriation took place ("date of expropriation"), and shall not reflect any change in value occurring because the intended expropriation had become known earlier. Valuation criteria shall include going concern value, asset value including declared tax value of tangible property, and other criteria, as appropriate, to determine fair market value.
3. Compensation shall be paid without delay and be fully realizable.

Pursuant to these provisions foreign investors are entitled to compensation in every case that a government measure may *indirectly expropriate* an investment, or be *tantamount to expropriation*. Neither term is defined, nor is the record of NAFTA negotiations revealing of the intent of the parties in qualifying the term "expropriation" in such a broad and open-ended manner.

Clearly however, these rules represent a fundamental departure from the legal rights available to both domestic and foreign investors alike under Canadian law – for unlike the United States, Canada has rejected the notion of entrenching private property rights in our constitution. This means that under Canadian law, parliaments and legislatures are free to determine whether, and the extent to which compensation will be paid when governments act in a manner which may reduce or limit the proprietary interests of individuals and corporations.<sup>9</sup>

### **A Fundamental Departure from Canadian Law**

When expropriation takes place pursuant to statutory authority that is silent on the subject of compensation, Canadian courts have on occasion read in an obligation to pay compensation when property is taken.<sup>10</sup> In other instances however, the public interest has been seen as over-riding a claim to compensation notwithstanding an adverse impact upon property values or business interests.<sup>11</sup>

In yet others, our courts have refused to recognize certain interests as being compensable. A case in point is the decision of the Manitoba Court of Appeal rejecting a claim for compensation by a private home care service provider because of a decision by the Manitoba government to deliver the service itself.<sup>12</sup> The impact of that decision effectively terminated the plaintiffs business. Nevertheless, the court held that because the plaintiffs entitlement existed only because of a decision by government to contract

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<sup>9</sup> Canadian courts have consistently recognized this prerogative, although they have been unwilling to imply, absent a clear requirement, that governments intended to take property without compensating the owner for it, see Manitoba Fisheries Ltd. Vs. The Queen, 533R.S.C. 1970, c.F-13; and The Queen (British Columbia) v. Tener, [1985] 1 S.C.R.

<sup>10</sup> Idem, see Manitoba Fisheries.

<sup>11</sup> See Soo Mill & Lumber Co. Ltd. V. City of Sault Ste. Marie [1975] 47 DLR [3<sup>rd</sup>] and Sanbay Development Ltd. V. City of London, [1984] 8 DLR [4<sup>th</sup>] 321.

<sup>12</sup> Home Orderly Services Ltd. V. Government of Manitoba, (1987), 43 D.L.R. (4<sup>th</sup>) 300 (Man. C.A.), leave to appeal refused (1988), 54 Man. R. (2d) 160 (S.C.C.).

out the services in the first place, it fell short of the proprietary interest needed to give rise to a claim for expropriation.

It is very unlikely in our view that this reasoning would be followed by an arbitral panel called upon to resolve a claim under Article 1110, because of the expansive way in which expropriation is defined. Moreover, by establishing this protection with respect to “investments,” NAFTA significantly expands the domain of compensable interests that Canadian courts have been willing to recognize.<sup>13</sup>

Another way in which the provisions of Article 1110 represent a fundamental departure from Canadian and the common law is by removing from Canadian governments their authority to determine whether to award compensation and how much to pay. Therefore where a public health care measure is considered to expropriate a foreign investment, pursuant to the requirements of Article 1110 (1), compensation is mandatory in every case, and is fixed by Article 1110(2) at “fair market value”. This effectively removes from Canadian governments their prerogative to weigh the public interest against the rights of private investors.

### **Fair Market Value**

But for this constraint, a government might decide to limit compensation to the monetary loss actually suffered by a private health care provider in consequence of a public health care measure. Under the “fair market value” provision of Article 1110, such a company would also be entitled to compensation for future business losses even where these far exceed the actual investment made in the enterprise. It is this provision that explains the enormous damages that foreign investors have sought in bringing investor-state suits – which are now routinely in the order of hundreds of millions of dollars<sup>14</sup>.

Alternatively a government might decide not to compensate a private health care provider, where the loss to the investor is only prospective or where the loss is simply in keeping with the normal business risks associated with establishing new ventures. Or, a government might conclude, as the federal government did in the case of victims of the Canadian blood system, to cap compensation at a certain level. None of these options are available under Article 1110 constraints.

Another point which should be made here concerns the application of international legal principles to NAFTA disputes. Article 1131 stipulates that a Tribunal convened pursuant to an investor-state claim *shall decide the issues in dispute in accordance with this Agreement, and applicable rules of international law*. There are several points at which international legal principles diverge significantly from those established under Canadian law. A pertinent example concerns the matter of expropriation, where international

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<sup>13</sup> Article 1139 defines investment to include inter alia, debt securities, loans, equity and intangible property.

<sup>14</sup> In the claim by Ethyl Corporation against the government of Canada, damages in excess of \$300 million were sought. In the case of Sun Belt Water Inc. the claim is ten billion dollars, and \$1 billion in damages is being sought by a Canadian company, Methanex, in a claim concerning environmental regulation in the US.

norms are likely to accord greater protection to property rights than would be the case under Canadian law.

### **Unpredictable and Potentially Unbounded Damage Awards**

A further disincentive to re-establishing public health care service delivery can be found in the unpredictable nature of investor-state dispute resolution. As noted, the absence of any requirement that arbitral panels follow the decisions of other tribunals on similar or identical points, greatly adds to the uncertainty that abounds in this domain. Moreover the absence of any formal right of appeal or judicial review, denies crucial judicial oversight that might ultimately impart some consistency to the approach adopted by such panels.<sup>15</sup> As it now stands, the failure of a claim before one panel, would not prevent a similar complaint from succeeding before another tribunal which might come to very different conclusions on the same matter.

One final dimension of the consequences that are likely to flow from NAFTA's expropriation rule should be noted: investor-state enforcement is only available to foreign investors. This distinct advantage may well create an incentive for Canadian companies to attract foreign investors or restructure their companies to claim these extraordinary rights as well.

Before leaving this issue, we should also mention the other provisions of Chapter 11 and 12 with respect to which no reservation has been taken. These include: *Minimum Standards of Treatment* [Article 1105]; *Performance Requirements* [Article 1106] (under Canada's sectoral reservation); and, *Licensing and Certification* [Article 1210]. Similarly, and as implied by the foregoing discussion, no reservation was permitted, nor taken, from investor-state dispute settlement. This means that all matters arising under Chapter 11, including the effect of a listed reservation, are vulnerable to challenge pursuant to these enforcement rules.

### **Might an Unsuccessful Tender Bid Give Rise to Claim Under Article 1110?**

One qualification should be added to this assessment. This concerns foreign investments which are established in consequence of government procurement and granting programs. These are specifically exempted from Chapter 12 and certain provisions of Chapter 11. However no exemption from the application of Article 1110 is made.

The allocation of contracts or funding by regional health authorities would clearly fall within the NAFTA definitions of procurement and grants.<sup>16</sup> This gives rise to the question: would an investor who was unsuccessful in bidding for contract tendered by a regional health authority have a claim to compensation under Article 1110?

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<sup>15</sup> We have noted elsewhere the unexercised opportunity the NAFTA Commission (the three NAFTA Parties) has to resolve matters of interpretation under Articles 1131 and 1132.

<sup>16</sup> See Articles 1108(7) and 1201(2).

We believe that it would not. The right to participate in a competitive bidding scheme to provide insured health care services would not, in our view, rise to the status of a compensable proprietary interest, notwithstanding the broad meaning of expropriation delineated by Article 1110. Were this to be otherwise, every foreign investor which bids successfully on a contract with a regional health authority would have a guaranteed right to succeed with future tender bids. The same would be true for any investments that were established in consequence of being awarded a contract pursuant to such a tendering process, should a subsequent tender fail to garner ongoing or new business.

However we believe that a different result would result in a situation where the right to bid on a tender is withdrawn by government because of a change of policy or law. For example, after having established a regime to tender insured health services to private providers, including US investors, the province decides that its experiment has been a failure. It then decides to abandon the project and reallocate the delivery of insured surgical services to not-for-profit hospitals.

In this case we believe that a foreign investor could claim under Article 1110, arguing that by taking away the right to compete for the delivery of health services, the province has effectively expropriated the investments it established in consequence of having that opportunity. Indeed this situation is analogous to a claim now proceeding under NAFTA's investment provisions, in which a US company is seeking approximately \$10 billion in damages because of a decision by the government of BC to reverse its policy on bulk water export licenses.<sup>17</sup>

It might still be argued that the exemptions for procurement under Chapter 10 and 12 should prevail, notwithstanding Article 1110. However, we believe that a dispute panel would be likely conclude that, a change or policy or law restricting the rights of foreign investors to bid for surgical care contracts, would fall outside the ambit of the actual procurement process itself, and therefore not be entitled to the exceptions set out in these Chapters.

**To summarize:**

The unbounded nature of Canada's reservation with respect to health services would theoretically allow a government to retreat from health care initiatives that result in the privatization of health care services. A government may conclude for various reasons, that its experiment with private sector delivery was unsuccessful, unpopular, too costly or all three.

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<sup>17</sup> This is a claim by Sun Belt Water Inc. arguing that it had been dealt with in a discriminatory manner by the BC government. But, while the case on its surface concerns certain issues arising from a civil action brought by the company against BC – at the heart of the matter lies the refusal of the province to allow bulk water exports.

But while a theoretical right to retrace its steps may exist, the unpredictable and potentially unbounded costs of compensating foreign investors, that have established or expanded operations under the failed regime, are likely to be prohibitive. This would effectively secure in perpetuity whatever terrain a private health care provider may have been successful in occupying once the opportunity to do so is presented. In other words, investments by US or Mexican providers under any privatization scheme are almost certain to become permanent fixtures of the Canadian health care system. Moreover for reasons we discuss elsewhere, once the door is open to such foreign private investment, it would be very difficult to shut.

The effect of these constraints then is to very substantially increase the risks of proceeding with any amendments to Canadian health care regimes that might give rise to additional foreign investment and consequent investor rights.

## **2. The Effectiveness of Canadian Reservations**

### **Would the implementation of Alberta's plans to allow greater private sector participation in delivering certain insured medical services undermine the integrity of either Annex I and/or II reservations?**

An assessment of the efficacy of Canada's reservations concerning the health sector is essential to estimating the potential consequences that may follow should Alberta proceed with present proposals. As described above, Canada has listed reservations to certain provisions of Chapters 11 and 12 which pertain to:

- National Treatment (Investment and Services)
- Most Favoured-Nation Status (Investment and Services)
- Performance Requirements (Investment)
- Senior Management and Boards of Directors (Investment)
- Local Presence (Services)

Even for those matters specifically reserved, the ambit of the protection afforded for non-conforming measures is limited by several factors, including: the inherent vulnerability of the reservations to erosion and narrow interpretation; and the qualified and ambiguous language that is used to describe the sectoral reservation for health services set out in Annex II C-9.

We have already discussed the general problems that attend the interpretation of reservations given the inherent biases of treaty interpretation. Here we consider the specific problems associated with estimating the effectiveness of Canada's Annex I and II reservations. We will begin with Annex II C-9, which is by far the more important of the two.

## Annex II C-9

The key elements of this reservation provide as follows:

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

Therefore, unlike the reservations listed for public law enforcement and correctional services, health services are reserved only to the extent that they can claim the status of “*social services established or maintained for a public purpose.*” Accordingly, to qualify, government measures with respect to health must satisfy a two-fold test: they must not only qualify as “social services,” but must also have been established or maintained for a “public purpose.” These terms are not defined in NAFTA nor have they been considered by any trade dispute or arbitral panel convened pursuant to its provisions.

### The Rules of Treaty Interpretation

The rules of international treaty interpretation offer general guidance about the approach that a panel or tribunal will adopt if called upon to interpret the meaning of this reservation.<sup>18</sup>

Article 31.1 of the Vienna Convention articulates the core obligation that a treaty is to be interpreted in good faith **in accordance with the ordinary meaning to be given to terms in their context and in the light of [the treaty’s] object and purpose.** [emphasis added]

As to the ordinary meaning of “social service”, The Oxford English Dictionary defines the term as:

*A service supplied for the benefit of the community, especially any of those provided by the central or local government, such as education, medical treatment, social welfare, etc.*

This definition raises the question of whether a service delivered by a private company on a for-profit basis would qualify as a social service. We will return to discuss this question further below.

The term “public purpose” isn’t defined in the Oxford Dictionary but it does appear in Article 1110 with reference to expropriation. In this context the term may be considered as having broad application. For example an American text on the subject of

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<sup>18</sup> *The Vienna Convention on the Law of Treaties 1969* (the Vienna Convention) which establishes the rules governing the application and interpretation of treaties. And see Shaw, *International Law*, p. 633 *et seq.*

expropriation under international law, comments that the “*concept of public purpose is broad and not subject to effective reexamination by other states.*”<sup>19</sup> But caution is needed to not take this view out of context. The interpretation of “public purpose” might understandably be more liberal in the context of expropriations law because of the requirement that compensation be paid even where the taking is for public purpose. A trade panel or tribunal might be more circumspect where the result would be to deny rights altogether.

Article 102 of NAFTA defines its objectives to include “*the elimination of barriers to trade ... in services, the (promotion) of conditions of fair competition, and the goal of increasingly substantially investment opportunities in the territories of the parties.*”

Article 102(2) further provides that:

The parties shall interpret and apply the provisions of this Agreement in the light of its objectives set out in paragraph 1 and in accordance with applicable rules of international law.

Unfortunately NAFTA makes no reference to the importance of preserving the integrity of the Parties’ social and cultural programs. Nor is there any other reference that would prove helpful in supporting an interpretation of Annex II that is otherwise inherently difficult to reconcile with the stated goals on NAFTA concerning services and investment.

### **The Tenor of Trade Jurisprudence**

It is also important to appreciate that the fora within which these matters would be resolved – international trade dispute or arbitration proceedings – are not conducive to the consideration of the diverse perspectives that Canadian courts routinely solicit when issues of broad public importance are being determined. The dispute resolution processes established by NAFTA exist to serve the essential objectives of trade and investment liberalization and have consistently failed to accommodate competing public policy objectives.

In the years since NAFTA was negotiated, we have been able to observe the norms of international trade dispute resolution when nations seek to rely upon carve-outs or exceptions to the trade disciplines their domestic measures may offend. Several of these cases have required NAFTA and WTO panels to parse the meaning of the exceptions set out in GATT Article XX concerning the measures “*necessary to protect health, animal or plant life of health, or relating to the conservation of natural resources.*”<sup>20</sup>

It is beyond the scope of this opinion to review this jurisprudence, however it is relevant to note the consistently narrow interpretation given these provisions by trade panels. In case after case, the impugned national measure has been found to fall outside of the parameters afforded by Article XX exceptions.<sup>21</sup> We believe these cases reveal a

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<sup>19</sup> Restatement of the Law: Foreign Relations Law in the United States.

<sup>20</sup> See the General Agreement on Tariffs and Trade (1947) Articles XX(b) and (g).

<sup>21</sup> The list casualties now includes US Clean Air Regulations and Marine Mammal Protection Laws; European standards concerning the importation of beef grown with hormones; and, Canadian fisheries regulations – see

significant bias to further trade liberalization objectives at the expense of other societal goals.

In our view a similar tendency can be observed in the trade jurisprudence to which Canada has been a party. Indeed the federal government's record in defending trade challenges directed at Canadian law and policy has been very poor. Casualties now include the Auto Pact, measures to regulate split-run magazines, aspects of Canada's supply management for dairy commodities, and the Technology Partnerships Fund. Of course it is possible to consider these cases as simply vindicating the effectiveness of international trade disciplines to confront unfair trading practices and policies. But a more considered assessment often reveals legitimate domestic policy goals in conflict, sometimes only tangentially, with those engendered by free trade agreements. When this occurs, in virtually every case, the former is expected to give way.

### **Canada's Arguments in Support of a Broad Reading for Annex II**

It isn't that Canada would not be able to muster substantial arguments to defend its health care system as representing a "social service for a public purpose". The extent of public funding support, the strength of the regulatory controls built into federal and provincial legislation, and the five principles of public health care that represent the cornerstones of federal health policy and the Canada Health Act, provide strong support for this contention.

Notwithstanding the merit of these arguments, it is hard to be confident about the prospects of persuading a trade panel or arbitral tribunal of the need to give Annex II a broad and liberal reading regardless of the impact on foreign investors and service providers. It is also clear that a panel or tribunal convened to address this issue will be confronted by some forceful arguments to the contrary. We turn to these next.

### **Canadian and US Views of the Sectoral Reservation for Health Differ Sharply**

Article 32 of the Vienna Convention states that:

where an interpretation under Article 31 leaves the meaning ambiguous or obscure, then recourse may be had to supplementary means of interpretation, including the preparatory work of the treaty and the circumstances of its conclusion.

We are aware of no letters that were exchanged between Canada, the US or Mexico with respect to the meaning of Annex II. However there was correspondence and debate between the Parties and their respective sub-national governments that exposes very different views about the meaning and ambit of this sectoral reservation.

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Cameron and Campbell, *Dispute Resolution in the WTO*, and Steven Shrybman, *The World Trade Organization: A Citizens Guide*.

Indeed significant differences can be found among the pronouncements offered on this subject by representatives of our own federal government. For example, responding to concerns articulated by Canadian provinces, Senior Deputy Minister and NAFTA co-ordinator, John Weekes, assured the provinces that Annex II C-9 would receive the broadest possible interpretation. Mr. Weekes also indicated that the term “public purpose was left indefinite to allow precisely for such broad interpretation.”<sup>22</sup>

But within a matter of weeks, Mr. Weekes successor had issued a qualification of that assessment advising the provinces that not all measures relating to the provision of health care would necessarily be covered by its Annex II reservation. Accordingly he advised the provinces to consider listing such measures under Annex I.<sup>23</sup>

If the differences between Canadian negotiators are troubling, they are modest by comparison with those that appear to separate the views of Canada and the US on this crucial subject. For example, consider the opinion expressed by the US Trade Representative in responding to the concerns of state governments regarding the need to protect social services at that level. Describing the meaning of an identical reservation to that set out by Annex II C-9, the USTR put it this way:

*The reservation in Annex II (II-U-5) is intended to cover services which are similar to those provided by a government, such as child care or drug treatment programs. **If those services are supplied by a private firm, on a profit or not-for-profit basis, Chapter Eleven and Chapter Twelve apply.** If a private firm provides those services on contract to the government, then it is considered government procurement.*<sup>24</sup> [emphasis added]

We will return to consider the issue of procurement under Question #3. For the time being, suffice it to say, that should the US view on this matter prevail the consequences for Canada’s health care system would be very problematic.

## **Canada’s Mixed Health Care System**

Canada’s health care system is a mixture of public and private sector service delivery. Most physicians providing insured medical services operate private for-profit businesses subject to certain regulatory controls, eg. licensing and extra billing. On the other hand, most hospitals in Canada delivering insured medical services are not-for-profit institutions, and many are operated by religious or charitable foundations. A number of private hospitals and clinics also exist in Canada providing services that fall both within and outside of the medicare funding umbrella.

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<sup>22</sup> As related in a letter by Ontario’s Deputy Minister of Health to her federal counterpart, dated Oct. 23, 1995. Exerpts from this correspondence are also reproduced in Inside NAFTA, Vol. 2, No. 24 – November 29, 1995.

<sup>23</sup> Idem.

<sup>24</sup> Correspondence from the USTR, Michael Kantor to the Attorney General for the State of Oregon, Mar. 1996.

Moreover the landscape of Canadian health care continues to evolve, but often in ways that are hardly conducive to maintaining a robust and durable public health care system. The Honourable Monique Begin, who is one of the architects of the present regime, recently described the gradual erosion of our health care system this way:

*Surreptitious de-listing or de-insurance of services by provincial governments; private clinics operating both in and out of provincial plans for “medically necessary services” (and their medical practitioners keeping hospital privileges and having it both ways); treating GPs or specialists directing their patients to private labs and clinics for regular procedures for the full out-of-pocket cost; hospitals charging partial costs for exams because these might not be “medically necessary” (wanting a MRI is not like choosing to have a hair colouring!) – these are all erosions of Medicare. People started losing all sense of their entitlements to health care<sup>25</sup>.*

The allegation implicit in this assessment is that Canada has been complicit in allowing the foundations of the health care system to be undermined. As part of the process, services that were once clearly part of the public system, have been excised from it. In other words, the map of the Canadian health care system is continually being redrawn. Arguably the same may be said of the boundaries of the Annex II reservation.

### **Would a NAFTA Dispute Panel Seek the Middle Ground?**

The fact that the sectoral reservation of health was qualified in the way it was, clearly indicates that the Parties considered some health services to fall outside the protection of the reservation. Indeed Canada conceded that this was true for health services in Canada in its discussions with provincial governments.<sup>26</sup> In a trade dispute or investor claim concerning the ambit of Annex II, a trade or arbitral panel would have to determine where the shifting boundaries of Canada’s health care system should be drawn.

The risk of proceeding as Alberta proposes is that its initiative significantly increases the risk that the map of Canadian health care will be redrawn to place acute surgical and overnight care services outside the ambit of the Annex II reservation.

### **Proceeding with Caution**

Whatever the current extent of erosion to the public health care landscape, it is important to recognize that Alberta’s proposals would be different in kind, not just degree, when compared with the incursions by private companies that have occurred to date. In this regard Alberta’s proposals would give formal statutory expression to a scheme that would establish a measure of private sector participation in the health care sector that would be

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<sup>25</sup> The Canadian Centre for Policy Alternatives: *The Future of Medicare: Recovering the Canada Health Act*, September 1999 ISBN: 0-88627-1487.

<sup>26</sup> *Supra* fn. 20.

unprecedented. According to the US view, this would then bring these services within the orbit of investment and services rules.

In our view, Alberta's proposed initiative to increase private sector participation in the delivery of insured health services significantly weakens its claim to the protection afforded by the Annex II C-9 reservation. Notwithstanding the Premier's assurances that he intends to protect the health care system, it is certainly not clear that his proposed measures would be viewed by a NAFTA dispute or arbitral panel, as measures relating to a "social service established or maintained for a public purpose."

## Federal Concerns

Indeed the federal Minister of Health appears to share this concern. In a letter to his provincial counterpart in Alberta, Mr. Rock expresses several concerns about the impact of increased private investment in providing surgical services, including the prospect of American firms seeking to establish hospitals in Alberta to take advantage of the new opportunities the province would be providing the private sector.<sup>27</sup> Mr. Rock states his concern this way:

*Some have suggested that permitting private hospitals in Alberta which would be paid for by the public purse would encourage American firms to seek to establish similar hospitals within your jurisdiction. Further, it has been suggested that attempting to keep out such enterprises, or refusing to send them patients, may run afoul of provisions of NAFTA. Have you considered a strategy to deal with this potential problem?*

Without the protection of Annex II for its measures, it would not be possible for Alberta to prohibit foreign investors from establishing and operating health care services in the province without offending the *National Treatment* obligations of both Chapters 11 and 12.<sup>28</sup>

While acceptance of the US view on the meaning of Annex II reservations is certainly not a foregone conclusion, it would be unwise in our view to underestimate the potential for such an outcome given the serious, and in many ways irredeemable, consequences of being confronted with a narrow interpretation of Annex II C-9. That result would significantly increase the exposure of Canada's health care system to NAFTA disciplines. Should that occur, Canada would find itself in the extremely problematic position of having to scramble to rescue its health care system in the face of rather severe external pressure. Whether this took the form of an arbitration award against the government for very substantial damages, or the threat retaliatory trade sanctions, hardly matters.

A recent and successful US challenge to Canadian cultural measures is illustrative of the risks that abound here. As we know, Canadian cultural programs were also to have been saved harmless from the disciplines of international trade rules. Indeed unlike health care, protection for culture was actually written into the text of NAFTA. While the US

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<sup>27</sup> Letter of Nov. 26, 1999 to the Honourable Halvar Jonson from the federal Minister of Health.

<sup>28</sup> This would not mean however, that the province would have to allow these investors and service providers to bid on contracts the regional health authorities may tender. See discussion infra under the heading procurement.

challenge to Canadian split run magazines proceeded under the auspices of the WTO, the \$300 million dollars in retaliatory trade sanctions the US threatened to unilaterally impose appeared to rely upon the very provisions of NAFTA that were intended to protect Canadian cultural diversity. It was in this heated context that Canada had to hastily overhaul its cultural programs in a manner that satisfied corporate interests based in the US.

In our view the fate of Canadian cultural programs, and other policies and programs that have fallen victim to international trade or investment challenges, are cautionary tales that should inform judgments about the nature of the risks that arise in consequence of Alberta's proposal.

In our opinion therefore, the risk that some approximation of the US view of Annex II will prevail, makes it imperative for Canada to limit the participation of private firms in the delivery of health care services if it is to maintain the integrity of this critical reservation. Alberta's plans to increase the participation of private firms in the provincial health care system would clearly offend this constraint.

## **Annex I**

This brings us to a consideration of Annex I reservations which shelter all provincial non-conforming measures in existence as of January 1, 1996. The ambit of protection afforded by this reservation is slightly broader than that of Annex II-C-9 because it applies to Article 1106 *Performance Requirements* as well.

The establishment of new health care legislation along the lines of Bill 11 would clearly represent a significant departure from Alberta's current health care regime. The question that arises then is whether these new rules would be considered as "not decreasing the conformity of"<sup>29</sup> Alberta's health care legislation with the requirements of Chapters 11 and 12. In our opinion they would not.

The status quo in Alberta provides no authority for regional health authorities to contract out the types of insured medical services that Bill 11 would authorize. Accordingly such reforms are likely to be seen as representing a significant departure from, rather than amendment to, provincial health care laws. Even should this not be the case, in our view the changes Alberta proposes to bring about would be seen as decreasing the conformity of provincial laws with NAFTA requirements.

Alberta proposes to create opportunities for private sector service providers and investors that did not exist at the time the Annex I reservation was listed. At that time, neither Canadian nor US and Mexican service providers and investors were entitled to contract with regional health authorities to deliver the types of services now being proposed. Should Alberta now seek to establish these rights only for Canadian individuals and companies, it would be putting US and Mexican service providers and investors at a

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<sup>29</sup> Article 1108(1)[c].

further disadvantage relative to their Canadian counterparts. In other words it would be reducing the conformity of its health care regime with the *National Treatment* requirements of both chapters.

For this reason, we believe that present proposals to transform Alberta's health care system, would fall outside the parameters of Annex I. Whether these reforms might taint the entire edifice of Alberta legislation on health care is an open question, but the application of Chapter 11 and 12 disciplines to some reincarnation of Bill 11 would not be in doubt unless these measures can be seen as falling under Annex II C-9 protection.

### **To Summarize:**

The integrity of Annex II C-9 is essential to the continued viability of Canada's public health care system. Without it, the rights of foreign investors and service providers under NAFTA, would overwhelm the capacity of Canadian governments to preserve the essential goals of our system. Unfortunately the sectoral reservation listed by Canada for health is qualified in a way that creates great uncertainty about its extent and effectiveness. Moreover the US interpretation of Annex II creates considerable doubt about its application to a health care system that involves the delivery of services by private companies. Nor does Canada appear to have been willing or able to resolve these differences by agreement with the US. This leaves the meaning of Annex II to the vagaries of NAFTA dispute resolution processes including the prospect of foreign investor claims.

While the outcome of such a dispute is difficult to predict, it is clear that present Alberta proposals would lend significant support to the arguments already articulated by US trade officials – that Chapters 11 and 12 would fully apply *to services which are provided by a private firm, on a profit or not-for-profit basis.*

Should some variation of the US view prevail, it is important to understand the impact Alberta's initiative would likely have on Canadian health care systems. We turn to these questions next. In order to prevent its reforms from resulting in the wholesale transformation of the provincial health care system to one dominated by private for-profit service providers, many of which would be US based, it is important for Canada to maintain the integrity of the Annex II sectoral reservation for health. The paradox here is that by proceeding in the manner it intends, Alberta will critically weaken the very safeguards needed to prevent its experiment from becoming a run-away reaction.

## **3. Privatizing Health Care in the Context of NAFTA**

### **Is Bill 11 consistent with NAFTA investment and services rules?**

We have already examined the likely impact of Bill 11 on the integrity of Annex I and II reservations. As noted, Bill 11 will, in our view, fall outside the protection afforded by

the province's Annex I reservation. The availability of Annex II C-9 safeguards is more difficult to predict, but there can be little doubt that Bill 11 will significantly weaken Canada's claim that its sectoral reservation for health be given broad reading. Whether this damage proves fatal or not, will only become apparent when a trade panel or arbitration tribunal rules on the matter.

It is important in our view therefore to assess the potential consequences for Alberta's health care system should Bill 11 proceed and NAFTA safeguards not be available to shelter these new measures from NAFTA disciplines. Moreover certain provision of Bill 11 either ignore or directly violate NAFTA rules from which no reservation is made.

### **Foreign Investors and Health Care Companies**

As we have noted, Bill 11 includes no constraint on the participation of foreign investors and service companies in the privatization scheme it would establish. We take it therefore, that US and Mexican companies and entrepreneurs will be welcome to bid for any contracts regional authorities might tender pursuant to the Bill. We also assume that foreign investors and service companies would be accorded non-discriminatory treatment with respect to accreditation by the College and designation by the Minister. Were this to be otherwise, a clear breach of *National Treatment* obligations would clearly occur.

Moreover, this would be the case even in the absence of an explicit statutory restriction on foreign ownership or participation. In other words, should the licensing decisions of the College or Minister reflect a bias in favour of domestic investors, Canada would be vulnerable to trade complaint or an investor state claim. This is the case, in our view, because "de facto" discrimination is sufficient to support such a challenge or claim notwithstanding the absence a "de jure" provision establishing a less favourable standard of treatment for foreign investors and health service providers.

### **The Ban on Private Hospitals**

While the ban on private hospitals set out in Section 2 represents little more than a semantic shell game, it nevertheless does raise a question about consistency with *National Treatment*. By explicitly discriminating against private hospitals, Section 2 represents a clear derogation from *National Treatment* by denying foreign investors and service providers the right to establish and operate health care facilities in Alberta. On its face, Alberta's prohibition is both discriminatory and prejudicial to the rights of foreign investors and service providers.

Like so much of this uncharted terrain, it is not clear however how a trade or arbitral panel would address a complaint concerning the denial of *National Treatment* in this context. The answer will depend upon whether such a panel is willing to consider the circumstances of public and private hospitals as being distinct for *National Treatment* purposes. According to this view, a licensing regime which treated all private hospitals alike, whether Canadian, US or Mexican, would arguably be consistent with NAFTA requirements, even where preferential treatment was accorded public hospitals.

However, no provision of Chapters 11 or 12 recognizes a distinction between public and private service providers. Therefore a panel or tribunal might just as readily conclude that for the purposes of *National Treatment*, Alberta must treat foreign investors at least as favorably as it does any domestic investor or service provider – including public hospitals. It will be relevant to this dispute that public hospitals, whether operated by the Crown, churches, service associations or community based organizations are considered domestic investors for the purposes of NAFTA investment and services rules.<sup>30</sup> In this case then, the ban on private hospitals would certainly offend *National Treatment* requirements and could only be sustained if Alberta is exempt from having to meet this standard.

### **Licensing Surgical Facilities**

Section 7 establishes certain preconditions to the operation of a surgical facility which include accreditation by the College, designation by the Minister and a contract to provide certain surgical services with a regional health authority. This once again invites comparison with the treatment accorded public hospitals. Indeed the very establishment of distinct regime for private investment, a priori, suggests discriminatory and less favourable treatment.<sup>31</sup> We have discussed the arguments that are likely to arise in this regard and can only underscore the uncertainty that exists about the approach a panel or tribunal will adopt.

### **Terms and Conditions of Approval**

Section 8(1) requires that all contracts between private hospitals be approved the Minister. Subsection (2) provides the Minister with the authority to impose terms or conditions as he or she deems appropriate. But NAFTA Article 1106 imposes certain constraints on the authority of Canadian governments to impose conditions on foreign investment. These constraints would, as we have noted, preclude the imposition of terms and conditions which would require:

- a private hospital to purchase or provide a preference for goods or services available locally;
- a private hospital to share with public hospitals any technological innovations that may improve the efficacy of surgical care service delivery; or,
- that certain services be made available in a particular region where the surgical facility may be the only provider of that service.

Furthermore Annex II C-9 does not apply to Article 1106, and as we have argued, Bill 11 transcends the boundaries of Annex I. Therefore any attempt to impose conditions

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<sup>30</sup> See Article 1139 provides that “investor of party means a Party or state enterprise thereof or a national or an enterprise of such party ...,” and Article 201 defines enterprise to mean “any entity constituted or organized under applicable law, whether or not for profit, and whether privately-owned or government owned .....

<sup>31</sup> Public hospitals are given the opportunity to perform certain services which may not be performed by non-hospital surgical facilities including major procedures S.2(2) and emergency services S. 29(m).

which ignore the significant constraints of this Article would render such measures fully vulnerable to trade complaint or investor-state challenge.

### **Need, the Public Interest and Other Licensing Standards.**

Section 8(3) sets out various conditions that must be met before the Minister can approve an agreement between a regional health authority and private surgical facility. He or she must be satisfied, inter alia, that: there is ongoing need for such services in the geographic area; there is an expected public benefit from the contract; and, that various performance measures have been delineated. No similar licensing regime exists with respect to the delivery of these same services by public hospitals under the Hospitals Act. Moreover there is no provision in either Chapter 11 or 12 which would justify limiting the rights of foreign investors or service providers on the grounds delineated by Section 8. This raises concerns similar to those we addressed in considering the effect of Sections 2 and 7 above.

### **Domestic Judicial Oversight vs. Investor-State Claims**

Section 23 sets out a privative clause which seeks to insulate the Minister's licensing decisions from judicial oversight. While the clause will operate to eliminate the possibility of appeal, and reduce the ambit of judicial review for errors of fact and law, it will have no impact whatsoever on NAFTA dispute processes. This is the case because no Canadian law can serve to oust the application of NAFTA disciplines - that would require an amendment to the treaty itself.

The effect of Section 23 means that no domestic public or private hospitals would have an opportunity to challenge licensing decisions made by the Minister, even where these are demonstrably mistaken or prejudicial. Of course the same limitation applies to trade unions, workers and to the consumers of health care services. Foreign investors however would maintain unfettered access to NAFTA's powerful enforcement machinery to challenge precisely these same decisions. Moreover as we have seen (see discussion about expropriation) these foreign companies would be able to claim substantive rights, particularly in the area of investment protection, that could not be asserted by their Canadian competitors.

### **Transfers**

Section 10 of Bill 11 proscribes the transfer of an approved agreement to provide surgical services, or changes in ownership of the surgical facility, without the consent of the Minister. In our view this provision violates the constraints imposed by NAFTA Article on Transfers [Article 1109] which requires that:

Each party shall permit all transfers relating to an investment of an investor of another Party in the territory of the Party to be made freely and without delay.

While Article 1109(4) allows for certain exceptions in the case of bankruptcy, securities matters, criminal offenses, currency transfers and to ensure the satisfaction of judgments, this list of exceptions is far too narrow to capture the broader considerations of performance and accountability that Bill 11 empowers the Minister to take into account. Neither the federal government nor the provinces have reserved with respect to Article 1109(4). Therefore its constraints would apply to any provincial measures that sought to interfere with the rights of investors to transfer their interests “freely and without” delay. In our opinion, even the requirement for Ministerial review, on unspecified grounds, would be in breach of these constraints.

### **Withdrawal and Termination of Service Contracts**

Sections 18 and 19 of Bill 11 describe various circumstances that may give rise to a withdrawal or termination of a designation granted by the Minister. This can occur upon a change in circumstances relating to any of the broadly defined factors pertinent to the Ministers initial decision to designate, and upon several other grounds as well.<sup>32</sup> Here again there several potential conflicts with NAFTA prohibitions.

For example Section 8(d) of the Bill requires that there be an “expected public benefit to providing the insured surgical services as contemplated.” Pursuant to Section 18, a failure of those benefits to materialize or endure, would justify a decision by the Minister to withdraw the designation he had granted. No doubt, this would meet the “public purpose” requirement of Article 1110 [Expropriation and Compensation]. But even where expropriation of an investment is justified for this reason, compensation must nevertheless be paid for the full market value of the investment.<sup>33</sup>

### **Government Procurement and Funding**

As we have argued, the protection of Annex I and II reservations is unreliable to insulate Alberta’s proposals from *National Treatment* and other NAFTA obligations, and would be further weakened should Alberta proceed with present plans. However, other safeguards included in Chapter 11 and 12 would preserve some measure of control over access by foreign investors and service providers to public funding for health care services. These exceptions concern government procurement, subsidies and grants, and can be found in Articles 1108(7), 1201(2) and Annexes to the NAFTA Chapter on procurement.<sup>34</sup> For example, article 1108(7) provides:

Articles 1102 *National Treatment*, 1103 *Most Favored Nation Treatment* and 1107 *Senior Management and Boards of Directors* do not apply to:

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<sup>32</sup> These include the failure to meet conditions of designation, contravention of the Act, a decision by the College to withdraw accreditation, the expiry or cancellation of a contract with a regional authority, or a when an operator to closes a facility permanently.

<sup>33</sup> See Article 1110 reproduced in Part II of this opinion.

<sup>34</sup> See all provincial measures are reserved under Annex 1001.1a-3 and for health and social services under Annex 1001.1b-2, Section B.

- (a) procurement by a Party or a state enterprise; or
- (b) subsidies or grants provided by a Party of state enterprise, including government-supported loans, guarantees and foreign aid programs.

A similar but broader exception from all Chapter 12 disciplines concerning services is set out in Article 1201(2)(c) and (d). These provisions are further supported by reservations listed under Chapter 10 concerning procurement which effectively exclude both provincial governments and all classes of health and social services.

Taken together, we believe these safeguards are sufficient to exclude the application of *National Treatment*, and *Most Favored Nation Treatment* disciplines to public funding for insured health services. In other words, the province of Alberta would be able to exclude US investors and service providers when granting contracts, or entering into funding arrangements, for the provision of insured health services without offending NAFTA constraints.

The importance of these safeguards must be stressed given the uncertain fate of Canadian reservations under Annexes I and II. At the same time it would be easy to overestimate the efficacy of these exceptions.

1. While Alberta maintains the right to exclude foreign investors and service providers should it proceed to contract out insured surgical services, it has made no such commitment.<sup>35</sup> Bill 11 includes no such qualification with respect to the contracts regional health authorities might negotiate, or the Minister approve.
2. The exemption from having to provide *National Treatment* in procurement and funding arrangements, has no bearing on the application of NAFTA expropriation rules or dispute procedures. If foreign investors or service providers acquire the right to deliver insured health services in the province they can invoke NAFTA dispute resolution to preserve their investments (see our response to Question #1).
3. As a practical matter it may be very difficult to exclude foreign investors from participating indirectly in contractual arrangements the province may approve with private for-profit companies. This problem arises because of the expansive way in which “investment” is defined under Section “C” of Chapter 11 to include virtually all forms of equity participation, contractual arrangements, and lending. Nor is there any threshold of financial participation, or management control that is needed to give rise to the rights that foreign investors are assured by these provisions. Thus a restriction that regional health authorities only approve contracts with Canadian controlled corporations would not eliminate the very real possibility that foreign investors might nevertheless have rights as minority share holders, lenders, or as companies with a contractual interest in the services contract.

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<sup>35</sup> Alberta Health and Wellness News Release: Health Minister Responds to Federal Government, Edmonton, Dec. 10, 1999.

It is also important to recognize the important distinction that would exist between a not-for-profit service provider, and a private for-profit corporation – both Canadian controlled. The issue of foreign investment participation is simply not a realistic concern with respect to the former. In our view, this distinction represents another important rationale for rejecting the notion of contracting out insured surgical health services to private, for-profit providers. The monitoring and enforcement of any constraints on foreign equity, debt of contractual interests would simply be too difficult to enforce.

4. The preservation of procurement and funding prerogatives should not be seen as an adequate substitute for government other government measures – law, regulation, procedure, requirement and practice – which provide tools essential for protecting Canada’s health care system. We will return to this issue when considering the potential impact of Alberta’s plan on the federal government and other provinces.

This however, is not to take away from the importance of the exceptions for government procurement and funding arrangements, which ultimately may represent the only safeguards to preserve the public character of the publicly funded health system, should Annex I and II safeguards be undermined.

In our view however, safeguards for procurement and funding measures would not be sufficient to protect Canada’s health care system over the long term. Indeed, as we have indicated, there is a clear need to significantly strengthen protection for health care, if its current character is to be preserved, not diminish it.

Finally, we should note the vulnerability of these protections to the roll-back dynamics of trade liberalization. With respect to procurement, these are codified by Article 1024, which provides:

The Parties shall commence further negotiations no later than December 31, 1998, with a view to the further liberalization of their respective government procurement ... for the purposes of seeking to expand the coverage of this Chapter, including by adding ... Procurement otherwise subject to legislated or administrative exceptions...

If these negotiations were to succeed, and Annex I and II reservations not apply, Canada’s health care funding would be entirely at the mercy of NAFTA disciplines.

**To summarize:**

We have in this part examined the implications of present Alberta proposals if they are ultimately judged to fall outside the ambit of Annex I and II reservations. But for exceptions concerning government procurement and funding, this would leave all other provincial measures fully exposed to NAFTA’s investment and services disciplines. The risk here is that provinces experiment with private sector delivery will escape whatever bounds it may have intended. This would allow US and Mexican investors and service

providers unrestricted access to the contracts that regional health authorities would be tendering.

Moreover as we have seen, several provisions of NAFTA either ignore or directly violate NAFTA constraints concerning the transfer of investments, investor-state litigation to challenge government licensing and regulatory decisions, the imposition of certain conditions on the right to invest, and the withdrawal or termination of contractual rights. In each of these instances, the application of NAFTA disciplines is unqualified by any reservation or exemption. In other cases, the extent to which provincial policy and law is constrained by NAFTA requirements will ultimately depend upon the views of a trade panel or arbitral tribunal convened to determine the ambit of NAFTA reservations. Of particular concern in this regard would be the viability of Bill 11 provisions banning private hospitals, or limiting the range of surgical services that may be provided by surgical facilities.

Exceptions for government procurement and funding measures would limit the application of *National Treatment* and other restrictions to the allocation of public health care funding. These exceptions preserve some measure of government control over access by foreign investors and service providers to public funding and contracts for the delivery of insured health services.

However, practical impediments would limit government's ability to effectively eliminate the participation of foreign investors in private Canadian companies contracted to provide such services. If such rights are established, they would, as we have noted, be very difficult to dislodge. Restricting procurement and funding arrangements to Canadian not-for-profit service providers would effectively address this problem. Ultimately however, this discussion may be moot in light of Bill 11's silence on the subject of contracting out to US private providers.

## 4. The Impact of Alberta's Plans on Canada

**In the event that private sector health care service providers are accorded new business opportunities in Alberta, would foreign investors and service providers be entitled to claim similar treatment elsewhere in Canada?**

Article 1102 defines the *National Treatment* obligations of provincial governments to require *treatment no less favorable than the most favorable treatment accorded, in like circumstances, by that state or province to investors, and to investments of investors, of the Party of which it forms a part*. This suggests that other provinces would remain free of any taint Alberta's experiment might give to the reservations that currently shelter their own health care policy and law. In other words, a US or Mexican based private company could not demand of New Brunswick, for example, the same treatment that Alberta may be providing to it, or other foreign investors.

However, the answer to this question is complicated by the impact Alberta's initiatives may on federal health care policy and law. For example, should the federal government continue to fund health care service delivery in Alberta knowing that a portion of that funding was being paid to foreign private sector companies providing services theretofore reserved to not-for-profit hospitals, it is likely to face claims that it provide equally favorable treatment to these or other foreign investors operating elsewhere in Canada.

### The Federal Government's Response

Much therefore will depend on how the federal government responds to the challenges posed by Alberta's plans. In the letter to his provincial counterpart we referred to,<sup>36</sup> Mr. Rock expresses concern about the impact of increased private investment in providing surgical services. He correctly in our view, identifies Alberta's proposals as raising "important issues relating to the underpinnings of our public health care system" but stops short of drawing conclusions about the compatibility of such measures with the provisions of the Canada Health Act.

If the federal government concludes that Alberta's plans are consistent with the requirements of the Canada Health Act, a number of consequences are foreseeable. On a practical level, we understand that at least some other provinces will be tempted to follow Alberta's lead. If they decide to follow Alberta's lead, the proliferation of private sector health care delivery of surgical services would obviously extend beyond Alberta. As noted, with greater participation by private providers, the task of defending Canada's system as one falling within Annex II parameters, becomes more difficult. Thus support for, or even acquiescence to Alberta's reforms, is likely to place Canada's health care system on a slippery slope that is likely to accelerate private sector participation in the delivery of virtually all insured health services.

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<sup>36</sup> Supra fn. 25.

## The Canada Health Act

It is beyond the scope of this opinion to assess whether Alberta's plans violate these principles of the Canada Health Act. However should Canada conclude that Alberta's scheme is consistent with the Act, and make no amendments to prevent this type of privatization, then it would be abandoning any requirement that surgical services and overnight care be provided by not-for-profit hospitals accountable to the communities they serve.

It would be reasonable then to expect private sector delivery of insured health services to grow, as would the difficulties of persuading a trade or arbitral panel that Canada's system is truly about providing a social service for a public purpose.

We should also note that the task of defending against a trade dispute or investor-state claim challenging Canada's Annex II reservation would be made even more difficult by the federal government's apparent support for the principle of private for-profit health care. Consider for example its endorsement of *Twelve Principles Underlying the Alberta Health Care System*. Among these principles are the following:

*Ensure a strong role for the private sector in health care, both within and outside the publicly-funded system.*

*Consumers have the right to voluntarily purchase health services outside assessed need.*

*Maintain the restrictions on the role of private insurance while introducing measures to expand the opportunities for the private sector to deliver services within the single-payer envelope.*

*Private clinics should have the option of becoming completely private (patient pays) or allowing them to enter into a variety of funding arrangements with the public sector to cover the full costs of insured services.*

*The same physician can practice in both the public and private systems if he/she is offering insured services which are fully paid for by the public system and non-insured services which are paid for privately<sup>37</sup>.*

It would be difficult in our view to reconcile these notions with the principles enshrined in the Canada Health Act, or to persuade a trade or arbitral panel that these are the hallmarks of a health system operating as a social service and for a public purpose. Perhaps this explains why Mme. Begin described Canada's support for these principles as "profoundly shocking," going on to add:

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<sup>37</sup> As related in remarks by the Hon. Monique Begin, supra fn 23, at p.6.

*I cannot understand how both the Department of Justice and Health Canada (and maybe the entire federal cabinet) could support the federal signature on this joint document, which is at best an extraordinary exercise in legal sophistry.<sup>38</sup>*

## **Procurement and Funding**

In the event that the sectoral reservation for health services is lost or limited for these reasons, Canada might still be able to rely upon exceptions for procurement and funding measures. However the relevance of these exceptions for federal health care funding is much less certain than is the case for provincial governments.

While the federal government has listed a broad reservation for health and social services under NAFTA's procurement rules, "procurement" is defined by Article 1001(5) of Chapter 10 to **not** include:

Non-contractual agreements or any form of government assistance, including co-operative agreements, grants, loans, equity infusions, guarantees, fiscal incentives, and government provision of goods and services to persons or state, provincial and regional governments ...

This definition would, in our view, preclude the payments Canada makes pursuant to the Canada Health Act, and the Canada Health and Social Transfer. Nevertheless, federal funding for health care might still have some degree of protection under Article 1108, and 1201 if it falls within the definition of subsidies or grants. However, the result here would be uncertain, because the *cash contributions* and *payments* made under the Canada Health Act are likely, in our opinion, to fall outside the ambit of these exceptions because they do not represent grants and subsidies to individual investors and service providers, but rather federal-provincial transfers.

The result would deny the federal government the right to impose as a condition of federal transfers, that funding only be allocated to Canadian private providers. This would obviously deny their US counterparts - *National Treatment*. Canada's position would be much stronger however, were it to simply proscribe funding to all private providers, whether Canadian or not. Such a prohibition would deny foreign investors the argument that they had been discriminated against vis-à-vis private Canadian for-profit providers. Indeed, such a blanket prohibition may offer the only way for the federal government to prevent federal funding from flowing to private foreign investors and health care service providers – that would be consistent with its obligations under NAFTA.

As we briefly noted in Question #3, procurement and funding exceptions would be of no avail to safeguard policy, programmatic and regulatory options left exposed to NAFTA disciplines should Annex I and II reservations be found wanting.

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<sup>38</sup> Idem.

**In summary:**

Many of the difficulties presented by the Alberta's proposed privatization initiatives would not arise had Canada negotiated a broad exclusion for health care under NAFTA. Less satisfactory, but still far more effective than the status quo, would have been a broad and unqualified reservation from all Chapter 11 and 12 obligations which was expressed in clear and unambiguous language. As it stands the piece-meal approach adopted by the federal government has created enormous uncertainty about the viability of our health care system given the constraints imposed by the obligations Canada has undertaken in NAFTA and the World Trade Organization.

In our view the capacity of the government to defend public health care from the corrosive influence of these international obligations will be substantially undermined if it does not move quickly to prevent the ever increasing participation of the private sector in delivering insured health care services. Should it accept Alberta's plans as being permissible within the federal framework, it will have significantly weakened its ability to protect public health care from the challenges that all too readily can arise under NAFTA's enforcement regime. This in turn would have significant repercussions for all of Canada and undermine the capacity of provincial governments to maintain the essentially public, and not-for-profit character of their own health care systems. .