CETA Threats to Public Health Care in Canada

Remarks to the House of Commons Standing Committee on International Trade

Study of the Canada-European Union Comprehensive Economic and Trade Agreement (CETA)

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Introduction

On behalf of the Canadian Health Coalition I want to thank members of this Committee for the opportunity to raise with you serious concerns about the negative impact of the Canada-European Union Comprehensive Economic and Trade Agreement (CETA) on Canada's health care system.

The Canadian Health Coalition (CHC) is a public advocacy organization dedicated to the preservation and improvement of public health care in Canada. We were founded as a non-partisan organization in 1979 following the S.O.S. Medicare conference which featured Justice Emmett Hall, Tommy Douglas, and Monique Bégin. Our membership is comprised of national organizations representing nurses, physicians, health care workers, seniors, churches, anti-poverty, women and trade unions, as well as affiliated health coalitions in 9 provinces and one territory.

The CHC has been working on international trade issues as they impact on public health care for over twenty years. Despite the announcement of a CETA Agreement-in-Principle in October 2013, the text of the CETA remains secret. Nonetheless, a parliamentary committee mandated to study CETA must have access to the text of the CETA.

I would like to raise two issues with the committee:

First, the general threats to Canada's health care system from the flawed reservations for health care in the CETA;

Second, the specific threats to the sustainability of Canada's prescription drug plans from the pharmaceutical provisions of the CETA.

1. The legal principles in the *Canada Health Act* that govern Canada's public health care system are in blunt opposition to the principles that regulate the market. The *Canada Health Act* removes the delivery of health services from market rules to ensure access based on need. So-called "un-profitable" services, "unprofitable" populations and "unprofitable" regions are not abandoned by a reliance on market-driven health care.

Canada's public health care system reflects Canadians' values. In the words of the Romanow Commission: *"Canadians view medicare as a moral enterprise, not a business venture."* [1] Health care in Canada is legislated as a public good not a commercial commodity. Our public system is based on the *Canada Health Act*, where

[1] Commission of the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Saskatoon: The Commission), 2002, p. xx, online: http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

health care is delivered solely on the criterion of the need of patients, without regard for their ability to pay or their socio-economic status. The *Act* also offers the best guarantees of cost effectiveness and sustainability. [2]

The central objective of international trade agreements, including the CETA, is trade liberalization through the reduction of barriers to trade. The rationale is that goods and services are to be allocated solely on the basis of purchasing power and concern with equity of distribution and access to services is seen as a barrier to trade.

The mix of public and private interests on the delivery side of the health care system make it difficult to draw a sharp line between what is public and what is private. This causes problems when applying Canada's reservations and exemptions in trade agreements like NAFTA and the GATS, as well as the CETA. These trade agreements assume a clear demarcation between public and private. [3]

Both Canada and the European Union have said they intend to exclude health services from the CETA. However, one of the EU's highest priorities in the CETA negotiations is to expand access to provincial and local government services. Accordingly, the EU has demanded that Canada abandon the general reservation in the NAFTA Annex I, which provides some protection for health services. Canada has reportedly agreed, which means provincial and territorial governments will be required to negotiate exemptions for specific non-conforming measures in the health sector or else to rely exclusively on protection in the Annex II reservation.

The Annex II reservation does not shield the health care sector from the full force of trade agreements. Instead, it is a *limited* and *qualified* reservation that only shields a health service *to the extent that* it is "*a social service* established or maintained for *a public purpose*". The scope of this protection is uncertain because the Canadian and American governments have a fundamentally different interpretation of what these terms mean. As a result of this uncertainty in the language of Annex II-C-9 of NAFTA and responding to pressure from provincial governments and civil society, including a legal opinion commissioned by the Canadian Health Coalition in 1996, the Government of Canada negotiated a second general reservation in the NAFTA. [4] **This reservation will be removed under CETA.**

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[2] Marie-Claude Prémont, "The Canada Health Act and the Future of Health Care Systems in Canada", *Commission on the Future of Health Care in Canada*, Discussion Paper No. 4, July 2002, online: http://publications.gc.ca/collections/Collection/CP32-79-4-2002E.pdf

[3] Tracey Epps, "Merchants in the Temple? The Implications of the NAFTA and GATS for Canada's Health Care System", *Health Law Institute*, Volume 12, No. 1 (2003), on line: http://www.law.ualberta.ca/centres/hlidev1/userfiles/01_Eppsnew.pdf

[4] Bryan Swartz, "NAFTA Reservations in the Area of Health Care", March 4, 1996, online: http://www.healthcoalition.ca/archive/chc-legalopinion.pdf

To address the seriously flawed nature of the reservation the Government of Canada is relying on to protect federal, provincial and territorial health services from the rules of international trade agreements, the Romanow Commission of the Future of Health Care recommended Canada negotiate a new, more effective exemption for health care in all future trade and investment agreements. In order to provide maximum protection for health services and to safeguard its ability to expand coverage of public health insurance, a new exemption for health services is required - a complete carveout for health services. [5]

RECOMMENDATION 1: That the Government of Canada negotiate a new exemption that reads: "*Nothing in the CETA shall be construed to apply to measures adopted or maintained by a party with respect to health care, health services or health insurance.*"

2. Canadians are also concerned about the fact that the Harper government has negotiated a trade agreement that will result in higher prescription drug costs. According to a recent independent study, the recently announced details of the CETA agreement will likely cost Canadians hundreds of millions of dollars more for prescription drugs. The report says concessions by the federal government to cement the deal will delay the arrival cheaper generic drugs. **This delay will add between $850 million and $1.65 billion annually** — or up to 13 per cent — to the total drug bill paid annually by Canadians, either directly, through insurance plans or by provinces. [6]

The study examined the latest revelations about the tentative trade agreement and finds it will:

- commit Canada to creating a new system of patent term extension that will delay the entry of generic medicines by up to two years;
- lock in Canada's current terms of data protection, making it difficult or impossible for future governments to reverse them; and
- implement a new right of appeal under the patent linkage system that will create

[5] For further details see: Scott Sinclair, "The CETA and Health Care Reservations
A briefing note for the Canadian Health Coalition", CCPA, March 2011, online:
http://healthcoalition.ca/wp-content/uploads/2011/03/CETA-and-Health-Care-CCPA.pdf

[6] Joel Lexchin and Marc-André Gagnon, CETA and Pharmaceuticals: Impact of the trade agreement between Europe and Canada in the costs of patented drugs, CCPA, October 2013, online:
http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2013/10/CETA_and_Pharmaceuticals.pdf

further delays for the entry of generics.

On a per capita basis, Canadian drug costs are already the second highest in the world, after the United States.

According to the study, the federal government has promised to compensate the provinces for any additional costs related to CETA. However, that simply means that instead of Canadian taxpayers paying at the provincial level, they will be paying at the federal level. Importantly, people paying for their drugs out-of-pocket or through private insurance will be hit twice—through higher drug costs and their federal taxes.

While the text of the CETA is being kept secret by the Harper government, one thing is clear: the agreement will seriously impact the ability of Canadians to afford quality health care. It is also a matter of public record that the Minister of International Trade told Canadians: *"It is a myth that a Canada-EU free trade agreement would increase drug and health care costs."* [7]

Canadians are being misled by the Harper government's claim that the CETA provisions dealing with pharmaceutical industry: *"strike a balance between promoting innovation and job creation and ensuring that Canadians continue to have access to the affordable drugs they need."* [8]

A critical examination of the pharmaceutical industry's economic performance in Canada in recent decades revel that there is no link between higher drug industry profits and innovation or job creation. Nor is it credible to claim that Canadians will continue to have affordable drugs with access to cheaper generic drugs further delayed, as proposed in the CETA.

According to the federal government's own agency, the Patented Medicines Prices Review Board (PMPRB), in its most recent annual report, "Several comparator countries which have patented drug prices that are, on average, substantially less than prices in Canada, have achieved R&D-to-sales ratios well above those in Canada." [9] France and the U.K. have an R&D-to-sales ratio that is more than twice that of Canada and their prices are at least 10% lower than Canada's.

It should be noted in this context that, with the adoption of the 1987 amendments to the Act, the brand name drug industry made a public commitment to increase their

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[7] Department of Foreign Affairs and International Trade, "Myths and Realities About Canada's Free Trade Agreements," April 2012, online: http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/eu- ue/myths-mythes.aspx?view=d (last accessed July 2, 2012).
[8] Ibid, p. 13.
[9] PMPRB, Annual Report 2012, Ottawa, October 2013, Online: http://www.pmprb-cepmb.gc.ca/english/view.asp?x=1779&mid=1714

annual R&D (Big Pharma) expenditures to 10% of sales revenues by 1996.

The Rx&D ratio has been less than 10% for the past 10 consecutive years. [10]

This means that Canadians began paying 15 to 20% more for new patented drugs since the Mulroney government, in exchange for a "promise" of innovation and jobs. The higher prices in Canada for new brand name drugs are costing us at least an additional $2-billion a year. The provisions in the CETA on patent extension would cost at least another $1-billion annually.

These billions in subsidies to the drug industry is corporate welfare negotiated by the federal government but paid out of provincial health budgets and the pockets of seniors and the sick.

To add salt to the wounds, imagine how the provinces and territories feel about being lectured to by Prime Minister Harper about getting their health-care costs under control.

To make matters worse, the drug industry uses this money, not for innovation, but to buy influence with the federal regulator, physicians, politicians, consumers and the media through their advertising departments.

Is there a word for 'being bribed with your own money'?

Canadians get nothing in return for these major concessions. No jobs, no research, no innovation, no benefits whatsoever—only higher drug bills.

Some say this one single concession in the CETA is worth more than what Canada's saves from reduced tariffs with Europe. [11]

This failed industrial policy does tremendous damage to the integrity of our health-care system, not to mention our democracy.

The time has come to stop rewarding brand-name pharmaceutical companies because they have stopped innovating and broken their commitment to R&D in Canada. **We now invest twice the amount in the form of various subsidies to the brand-name drug industry than we receive in benefits.**

According to Professor Marc-André Gagnon of Carleton University, in 2009, Canadians paid at least $1,647 billion in public financial support in order to generate about $662 million in private R&D expenditures. While total pharmaceutical R&D in the brand-name sector was $1,272 billion, $610 million of

[10] Ibid.

[11] Tariff savings to Canadian exporters are estimated at $225 million annually. Source: Mike Blanchfield and Julian Beltrame, "CETA to give European exporters bigger duty savings than Canadians," The Canadian Press, October 29, 2013.

that was government subsidies in the form of tax credits. This means the brand-name pharmaceutical industry only invested some $662 million of their own money in R&D in Canada. [12]

Access to essential medicine and access to generics are key elements in a sustainable public health-care system. Canadians don't want this traded away.

RECOMMENDATION 2: That the Government of Canada remove all matters related to pharmaceutical patents from the CETA and from all future trade and investment negotiations. Instead, Canada needs to impose conditions on the pharmaceutical industry that benefit the public interest and protect the common good from private monopoly.

[12] Marc-André Gagnon, "Potential Impact of the European demands in the context of Canada-European Union CETA Negotiations," November 2011, Online: http://healthcoalition.ca/wp-content/uploads/2012/02/MAG-Eye-for-Pharma.pdf