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The Effects of International Trade Agreements on Canadian Health Measures: Options for Canada with a View to the Upcoming Trade Negotiations

by

Richard Ouellet

Laval University



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Highlights

- Canadians are wondering if, with the economic agreements signed during the last decade, our governments still have the necessary latitude to maintain health systems that respond to their expectations.
- Canada has, to date, consistently excluded the application of these agreements to our health systems using a variety of approaches.
- On the multilateral level, the GATT rules apply, with rare exceptions, to all products including those related to health. The *General Agreement on Trade in Services* (GATS) is built around a quite different approach, one of specific commitments. Access to a national market for a particular services sector is possible only if a WTO member has specifically undertaken to provide access to its market for that sector of services. Canada has made no such commitment in regard to health services.
- On the regional level, the NAFTA provides for liberalization of trade in goods irrespective of whether they are linked to health. However, chapters 11 and 12 are built around a special approach. They promote openness to foreign investment and liberalization of trade in services without regard to the affected areas of activity; but through reservations recorded in annexes, health care is excluded from the application of the NAFTA. This reflects a reservations and exceptions approach.
- It will be noted that while Canada has avoided the potential effects that the international economic agreements could have on health care, it has done so by taking advantage of the structure of agreements based on quite different approaches.
- If the Canadian government wishes to continue exempting our public health systems from the effects of these agreements, it will have to acknowledge that doing so by simultaneously using approaches as different as those of the GATS and the NAFTA is not without risks. What is needed is an integrated approach that reflects trade concerns while respecting the health care priorities of governments.

Executive Summary

Canadians wonder about the impact the international economic agreements signed by Canada are having or might have on our health systems. It is open to question whether, given the scope of commitments they have made in the economic agreements entered into over the last decade, our governments still have the necessary latitude to establish and maintain health systems that respond to Canadians' expectations.

To date, the multilateral, regional and bilateral trade agreements signed by Canada have had no major impact on health services provided in the country. Canada has always ensured that the application of these agreements to our health systems be strictly circumscribed or completely ruled out.

Canada has used a variety of approaches to ensure that these agreements have no effect on our health care. While this diversity of approaches has, to this point, been effective in protecting public health systems, it has some disadvantages and bears some risks. It is not implausible that, in the future, these approaches will no longer be able to adequately protect our public health systems. Therefore, it is necessary to have a clear understanding of the approaches that have been recommended, and to take a brief look at the risks involved in each approach and in the use of such differing measures to exclude health care from the application of economic agreements.

On the multilateral level, the *General Agreement on Tariffs and Trade* (GATT), which covers trade in products, makes no distinction between health-related products and others. The trade principles apply generally to all products, including those related to the supply of health care. The *General Agreement on Trade in Services* (GATS) is constructed along quite different lines. Access to a national market for a particular sector of services is possible only if a WTO member has specifically undertaken to provide market access in that sector. Thus, for some health services to be made available in Canada on a commercial basis by private suppliers from another WTO member, Canada would have to specifically commit to giving access to its market in the health services sector. But, at the present time, Canada has made no such commitment. The specific commitment approach found in the GATS context has therefore allowed the exclusion of health care provision from the effects of that agreement. Other WTO agreements such as the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (the TRIPs Agreement) also allow parties to circumscribe the effects of freer trade on health care.

At the regional level, the *North American Free Trade Agreement* (NAFTA), like the WTO agreements, provides for liberalization of trade in goods without regard to whether the goods are or not related to health. But in the case of investments and services, the NAFTA terms are rather different from those of the WTO agreements. Chapters 11 and 12, which deal with these two aspects, are built on a very particular approach. The general rules in these two chapters promote openness to foreign investments and liberalization of trade in services irrespective of the particular area of activity. Health care is excluded from the application of the NAFTA investment and trade in services provisions through exceptions and reservations recorded in annexes to the Agreement.

At the bilateral level, the few free-trade agreements signed by Canada are essentially dealing with trade in goods. The few provisions that affect trade in services are drafted in terms very close to those found in the NAFTA. These provisions cover the liberalization of trade in services irrespective of the sector or type of services provided. It is only through exceptions and reservations that health services are excluded from the application of these agreements.

An examination of the various international economic agreements to which Canada is a party and which could have an impact on Canadian health systems indicates that, while Canada has so far managed to avoid the effects that these agreements could have on health care, it has done so by taking advantage of the structure of agreements based on clearly different approaches.

In the case of the GATS, which incorporates an approach of specific commitments by WTO members, it is the absence of specific commitments on the part of Canada, or silence about them, that has prevented this general agreement from opening up the Canadian market for health services. In NAFTA's case, by contrast, it is the fact that Canada has registered clear reservations in an annex to the Agreement that has prevented it from having any effect on our health systems. A common feature of these two, largely different approaches is that both are underpinning the two major rounds of trade talks to which Canada now participates. The Doha negotiations on services are being conducted on the basis of the present GATS, while the talks surrounding the creation of a FTAA are based on NAFTA documents. If the Canadian government wishes to continue exempting its public health systems from the effects of international economic agreements, it will have to acknowledge that doing so along approaches as different as those now embodied in the GATS and the NAFTA is not without risks. What is needed is an integrated approach that reflects trade concerns while respecting the health priorities of each state.

Introduction

For half a century now, and particularly since 1994, Canada has been a member of or party to a considerable number of economic integration agreements. These agreements may be bilateral (e.g. the Canada-Chile Free Trade Agreement), regional (the North American Free Trade Agreement, or NAFTA) or multilateral (the GATT and the World Trade Organization, or WTO). Irrespective of their geographic scope, all of these agreements can have an impact on the role of our governments and on many aspects of the lives of Canadians.

As concrete expressions of the globalization phenomenon, these agreements affect the most significant areas of human activity, including the provision of health care. Many experts say unequivocally that the globalization of the economy poses a major challenge to national health care policies.

Globalization is one of the key challenges facing health policy makers and public health practitioners (McMichael and Beaglehole, 2000). While there is a growing literature on the importance of globalization for health (Lee and Collin, forthcoming), there is no consensus either on the pathways and mechanisms by which globalization affects the health of populations or on the appropriate policy responses. There is, however, an increasing tension between the rules, actors, markets that characterize the modern phase of globalization and the ability of countries to protect and promote health. (Woodward, Drager, Beaglehole et al., 2001, p.875)

There are essentially two sources for the growing tensions between health and freedom of trade.

The first source of tension is, of course, the magnitude of the interests at stake. On the one hand, there are enormous business interests linked to healthcare-related activities. Recent publications provide the clearest possible illustration of the gains to be made, for example, from the provision of health services and the manufacture of drugs (*Lexpert*, March 2002, p. 64; *Business Week*, May 28, 2001, p. 40; J. Vellinga, 2000, pp. 130-139; WTO, *Health and Social Services*, 1998, pp. 2-9). On the other hand, as one can imagine, there are social and health interests affecting Canadians' rights to accessible and quality health care. These rights are enshrined in the country's legislation but they also reflect fundamental rights recognized in international instruments such as the Universal Declaration of Human Rights (article 25, paragraph 1) and the International Covenant on Economic, Social and Cultural Rights (article 12).

The second source of tension between health and freedom of trade stems from the fact that recent economic agreements have to some degree and more or less explicitly, as the case may be, opened to market forces a whole range of areas of economic activity that directly, indirectly or potentially affect trade in health-related goods and services. Yet, even today, it is hard to gauge accurately the potential impact of such trade liberalization agreements as the NAFTA or the General Agreement on Trade in Services (GATS, of the WTO) in opening up markets for health care. Canadians legitimately want to know more about the long-term consequences of trade commitments entered into by the Canadian government, which are likely to bring some changes

in our healthcare systems. It is this latter source of tension between health values and freedom of trade that is the subject of this study.

To fully gauge the significance of the effects of multilateral trade agreements on Canadian health measures, we will examine, in the first part of the study, the legal scheme of the major economic agreements to which Canada is a party. We will briefly review the key provisions of international instruments that have potential or recognized effects on health services as they are now being provided in Canada. We will draw attention to the somewhat ambivalent status assigned to health care in the commercial rules that now prevail. We will also attempt, to the extent possible, to determine which agreements may have a material impact on Canadian health systems. In the second part of the study, we will briefly consider the different approaches to health that the government of Canada might adopt within the framework of ongoing multilateral trade negotiations. We will attempt to answer the general question in our terms of reference and assess the best options available to Canadian governments with a view to properly reconciling Canada's trade and economic commitments with a health system that is responsive to the needs and values of Canadians.

The reader will appreciate that the purpose of this study is not to describe Canadian healthcare systems or to assess Canadians' expectations about these systems. Our expertise and our investigation are limited to a brief presentation of the extent to which Canada has undertaken to liberalize its health care systems, and of how Canada may reconcile its international economic commitments with the health care systems Canadians want for themselves.

Part I: Effects of the Major International Economic Agreements to which Canada Is a Party on Canadian Health Care Measures

The general objective of the first part is to compile and review the provisions of international economic agreements that may affect the capacity of various orders of government in Canada to adopt and maintain health care measures. In addition to outlining arguments that could be used in opposition to Canada in a potential dispute, this inventory allows us to determine which agreements have the most significant bearing on Canadian health systems. The agreements examined here fall into three categories: multilateral, regional and bilateral economic agreements. In each category, we can pinpoint particular approaches that have been followed in regard to health care. Some of these approaches will form the basis for the comments we make in Part II of the study.

Section 1: Provisions in Multilateral Agreements Applicable to Canadian Health Measures

As for multilateral trade agreements, it is essentially the WTO Agreements that, at this point, have some impact on health measures in Canada. We will look in turn at the GATT, the General Agreement on Trade in Services (GATS) and, collectively, the other multilateral agreements that may affect health care provision.

The General Agreement on Tariffs and Trade (GATT)

Fundamental Principles of Liberalization of Trade in Products that Are Binding on Canada

Immediately following the Second World War, the General Agreement on Tariffs and Trade (GATT) introduced new trade rules designed to liberalize international commercial transactions. To this effect, a number of key principles were put in place, which have since become the foundation of most of international trade agreements. The most important of these are the principle of non-discrimination and the prohibition of quantitative restrictions. It is useful to describe briefly the nature of these fundamental principles developed in the GATT framework, which entail the liberalization of trade in products. These principles have a particular significance as they are replicated in virtually all international economic agreements.

Principle of Non-Discrimination

The principle of non-discrimination hinges on two rules: most-favoured-nation treatment (article I of the GATT) and national treatment (article III of the GATT).

Under article I, dealing with most-favoured-nation treatment, each member of the WTO must automatically extend to all others a treatment as favourable as that granted to any other country.

Thus, the most-favoured-nation treatment guarantees equal terms of market access to all trading partners. Linked with this rule is the rule on national treatment, which requires that each member grant to the products of all other members the treatment given to its own products. This rule applies to all national measures of internal taxation and regulation. For example, all measures affecting the sale, purchase, transportation or distribution of products must apply in the same way to both national products and like imported products.

Prohibition of Quantitative Restrictions

Quantitative restrictions generally take the form of quotas, licences or other measures designed to limit the import of foreign products onto the national territory or the export of national products. Quantitative restrictions therefore operate to disrupt if not prevent trade in certain products. Article XI of the GATT is the rule that prohibits such restrictions.

There are, however, some exceptions to these fundamental principles on which the WTO agreements on trade in products are based.

GATT Provisions Likely to Be Cited in Order to Protect Canadian Health Measures

There are a number of provisions in the GATT that allow members of the WTO to take restrictive measures in relation to health products. This is the general exception that appears in Article XX of the GATT and in certain special regimes established by other GATT provisions.

The General Exception in Article XX(b)

Article XX of the GATT sets out some general exceptions for which the principles of the Agreement will not apply, thereby recognizing the special nature of certain fundamental interests such as public morals, health, and the preservation of natural resources and national treasures. Thus, under certain conditions, measures “necessary to protect human, animal or plant life or health” are compatible with the GATT provisions.

The terms of implementation of Article XX are restrictive, since they are subject to a number of cumulative conditions. First, the contentious measure must concern one of the interests appearing in the schedule, in this instance the protection of health and human life. It is not sufficient that the measure be referred to in the schedule, it must also be necessary under the language of Article XX. This necessity criteria implies that the measure must not be excessive in relation to the contemplated purpose, that there exists a causal relationship between the measure and the intended objective, and that other means, less restrictive to the free movement of trade, do not exist. Furthermore, the introductory sentence of Article XX adds an important limitation since the measure must not be used “in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade”.

The scope of this Article XX(b) exception has been amended over time. The quasi-judicial bodies of the WTO that have had to rule on this exception have not always given it the same purview. So this exception does have its own limits and risks.

Other GATT Provisions that Allow an Override of the Fundamental Principles

Article III:8(b) allows members who so desire to grant subsidies exclusively to domestic producers. Canada could, therefore, grant subsidies in such areas of activity as the manufacture of health equipment and drugs. We should also note that since 1995, article III:8(b) must be assessed in light of the provisions of the Subsidies and Countervailing Duties Agreement, which will be examined later.

The GATT legal regime requires, therefore, that Canada comply with certain duties of equality of treatment between nations and between similar or competing products. The GATT also allows for some special circumstances where Canada could derogate from these obligations, particularly in regard to health protection measures. The GATT thus commits WTO members to a general liberalization of trade in products while recognizing that health-related issues may enjoy a certain special status. We will now look at how the general agreement governing trade in services has a significantly different regime from that of the GATT.

The General Agreement on Trade in Services

As the Canadian Minister of International Trade has stated, health services available in Canada are excluded at this time from the application of the General Agreement on Trade in Services:

“I would like to stress that we will maintain and preserve the ability of all levels of government to regulate and set policy in areas of importance to Canadians,” added Minister Pettigrew. “*We will not negotiate our health, public education or social services....*”

It is true that each member of the WTO retains discretion to submit or not each of services sector covered by the Agreement to the major rules of the GATS. As we will see in greater detail, Canada is fully entitled under the GATS not to undertake to comply with the rules of market access and national treatment set out in that agreement. It is solely up to Canada to decide the extent of the commitments it wishes to make for the liberalization of health services provided on its territory. Nevertheless, in examining the legal regime of the GATS, we note that the provision of health services may, at least indirectly or potentially, already be affected by this accord. To gauge the ambivalence that characterizes the GATS legal regime in regard to health services, we will first analyze the notion of service as adopted in the GATS. We will then consider the GATS provisions leading to the gradual liberalization of health services. Finally, we will examine the provisions allowing special status for the protection of health.

The Notion of Service

The GATS does not provide an explicit definition of the notion of services. Only trade in services is defined. In this regard, four modes of services provision are defined. These appear in Article I, paragraph 2 of the GATS, which states that:

... trade in services is defined as the supply of a service:

- (a) from the territory of one Member into the territory of any other Member;
- (b) in the territory of one Member to the service consumer of any other Member;
- (c) by a service supplier of one Member, through commercial presence in the territory of any other Member;
- (d) by a service supplier of one Member, through presence of natural persons of a Member in the territory of any other Member.

Article I, paragraph 3(b) then states that “services” include “*any service in any sector except services supplied in the exercise of governmental authority*”. (Italics added)

Article I, paragraph 3(c) provides that “‘services supplied in the exercise of governmental authority’ means any service which is supplied *neither on a commercial basis, nor in competition with one or more service suppliers*.” (Italics added)

As some specialists correctly note, the description of services in the GATS encompasses all services, including health services. (J. Vellinga, 2000, p. 138, 152; A. Pollock and D. Price, 2000, p. 1996). As such, health services are thus covered by this WTO agreement.

However, it should be noted that in some particular situations and under some specific conditions, health services will not be included within the scope of the GATS. This is clear from Article I, paragraphs 3(b) and 3(c), which state that services supplied in the exercise of governmental authority are not covered. Thus, where health care services are exclusively provided by the government, neither on a commercial basis nor in competition with one or more service suppliers, health services are then excluded from the GATS. Moreover, if some services linked to health care supplied in the exercise of governmental authority are so provided on a commercial basis or in competition with private suppliers, the latter will be covered by the GATS provisions. In this regard, the WTO background note is as explicit as can be with regard to hospital services:

The hospital sector in many countries, however, is made up of government- and privately-owned entities which both operate on a commercial basis, charging the patient or his insurance for the treatment provided. Supplementary subsidies may be granted for social, regional and similar policy purposes. It seems unrealistic in such cases to argue for continued application of Article 1:3 and/or maintain that no competitive relationship exists between the two groups of suppliers or services. (WTO, *Health and Social Services*, 1998, p. 11).

This statement has been relevant to Canada since the Alberta government opened the possibility that some health services no longer be provided solely by public agencies, but also by private entities. Consequently, in the context of multilateral trade rules, the authorization by the

government of that province of the commercial provision of some health services could effectively exclude from the notion of public services those services that would be provided by private health care suppliers which, prior to the Alberta legislation, were available in Canada only in a non-competitive context.

It will be noted, therefore, that the notions of services and public services are not clearly defined in the GATS. To establish clearly whether a service is likely to be covered by the GATS rules, we must first determine whether this service is provided by public authorities on a non-commercial basis and in a non-competitive context. But, as we can see in Canada, our governments, both provincial and federal, have a choice between opening or not opening the provision of health care services to market forces. The application of the GATS general obligations and disciplines to health services depends not only on Canada's commitments or exemptions under this agreement, but also on the possibility under its domestic legislation of allowing competition between public and private health services suppliers. In Canada, jurisdiction over health belongs to the provinces, and they may exclude health services provided on their territory from the notion of public services.

GATS Provisions Involving the Liberalization of Health Services

As in the GATT framework, the most-favoured-nation treatment and national treatment are the two ubiquitous principles promoting trade liberalization. Furthermore, the Annex on financial services also has some significant repercussions in the insurance sector, especially with regard to health insurance.

Most-Favoured-Nation Treatment (Article II)

One of the most important GATS obligations is the most-favoured-nation treatment, found in article II, paragraph 1 of the GATS:

With respect to any measure covered by this Agreement, each Member shall accord immediately and unconditionally to services and service suppliers of any other Member treatment no less favourable than that it accords to like services and service suppliers of any other country.

However, the second paragraph of article II allows some temporary easing in the liberalization of certain services:

A Member may maintain a measure inconsistent with paragraph 1 provided that such a measure is listed in, and meets the conditions of, the Annex on Article II Exemptions.

Article II, paragraph 2 substantially diminishes the scope of paragraph 1, since it allows a member, under certain conditions, to circumvent the principle contained in paragraph 1.

To find out which health services are exempted from most-favoured-nation treatment, it is thus necessary to consult the schedule in the annex referred to in paragraph 2. At the close of the Uruguay Round, eight countries exempted their professional services and certain medical,

health and social services from most-favoured-nation treatment: Bulgaria, Cyprus, Costa Rica, Honduras, Panama, the Dominican Republic, Turkey and Venezuela (WTO, S/C/W/50, 18 September 1998, pp. 18, 28). Canada has made no exemption from most-favoured-nation treatment for its health services. Thus, to the degree that health care is subject to the GATS — and we will discuss this more specifically when examining the issue of market access — Canada is bound to comply with paragraph 1 of article II of the GATS, mentioned above.

Market Access and National Treatment (Articles XVI and XVII)

During the negotiations on trade in services, the partners hoped to proceed with a progressive liberalization of services (article XIX), so that market access and the principle of national treatment are not yet general obligations as is the case in the GATT and the TRIPs Agreement. In fact, the provisions pertaining to these principles do not appear in the general GATS obligations; they are confined to the part listing the specific commitments made by each member, which are recorded in the national schedules.

Article XIV, which deals with market access, states that “each Member shall accord services and service suppliers of any other Member treatment no less favourable than that provided for under the terms, limitations and conditions agreed and specified in its Schedule.” Article XVII, which pertains to national treatment, states the following:

In the sectors inscribed in its Schedule, and subject to any conditions and qualifications set out therein, each Member shall accord to services and service suppliers of any other Member, in respect of all measures affecting the supply of services, treatment no less favourable than that it accords to its own like services and service suppliers.

How the market access and national treatment rules are applied depends, therefore, on the specific commitments made by members. The schedules provide details on the areas where a member has made commitments, the degree of openness negotiated, and the exceptions to national treatment. From then on, commitments are consolidated, that is, the member may no longer reopen them or, if that happens, the member will have to bear the related costs by granting compensation to members who have been adversely affected (Article XXI of the GATS).

Thus, members who have made specific commitments in the health services sector will have to comply with those commitments.

The Council on Trade in Services of the WTO has published a background note on health and social services that provides some clarification on the commitments made by members (WTO, S/C/W/50, 18 September 1998, pp. 15, 25). The note explains that “schedules do not necessarily provide an accurate, let alone comprehensive, picture of actual trade and market conditions.” (WTO, S/C/W/50, 18 September 1998, p. 15). It also notes that “Members generally found it easier to make commitments on health-related professional services (medical and veterinary services, etc.) than on ‘genuine’ health and social services...” (WTO, S/C/W/50, 18 September 1998, p. 16). The note explains that in relation to modes of delivery 1, 2 and 3 described earlier, 49 members have made commitments concerning medical and dental services and 39 concerning hospital services; most of these members are developing countries. In relation

to mode 4, of the 55 members who have made commitments concerning medical, dental and veterinarian services, two countries have not specified any limitation, while all the others substantially limited the scope of their commitments (WTO, S/C/W/50, 18 September 1998, p. 18). Canada has made no commitment in this regard, since its schedule makes no reference to any such commitments. (WTO, GATS, Canada, SC/16, 15 April 1994).

A priori, since Canada has made no specific commitments concerning health care-related services, it is under no obligations in such matters. However, the GATS includes an annex on financial services that may have some implications for health insurance.

The Annex on Financial Services

This annex covers the measures that hinder or prevent the supply of financial services. Among the services that are covered are those supplied in the exercise of governmental authority, which include, *inter alia*,

- (b) ... (ii) *activities forming part of a statutory system of social security or public retirement plans*; and
- (iii) other activities conducted by a public entity for the account or with the guarantee or using the financial resources of the Government. [Italics added]

At least one commentator argues that in view of the definitions cited above, Canada's commitments with regard to financial services probably have some impact on our health insurance plans. (Sanger, 2000, p. 75).

GATS Provisions Guaranteeing a Specific Status for Health

The GATS includes some general exceptions, one of which for health protection. This agreement, which has existed for only a short period, also provides for a gradual liberalization of services. Added to these provisions are others which, until now, have not really been restrictive in so far as they contain standards that remain tentative.

The General Exception (Article XIV)

Article XIV of the GATS, the corollary of article XX of the GATT, lists some general exceptions:

Subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where like conditions prevail, or a disguised restriction on trade in services, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any Member of measures: ... (b) necessary to protect human, animal or plant life or health;

No special group of the WTO has yet had occasion to interpret this provision. Owing to similarities between this provision and article XX of the GATT, it is conceivable that the same restrictive conditions apply. The protection of health is therefore recognized, but it has an exceptional status.

Progressive Liberalization (Article XIX)

Another GATS provision might actually allow members who so desire not to liberalize their health services forthwith: this is article XIX dealing with progressive liberalization. The first sentence in paragraph 2 of this article states that “The process of liberalization shall take place with due respect for national policy objectives and the level of development of individual Members, both overall and in individual sectors.”

Health is an area included in a state’s national policy objectives. Accordingly, it seems that a member could argue that total liberalization of health services would conflict with its national health policy.

Other WTO Agreements with an Impact on Health Services

Besides the GATT of 1994 and the GATS, other WTO agreements may have consequences for national measures directly or indirectly affecting health.

Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs Agreement)

A comprehensive analysis of the impact of the TRIPs Agreement requires an expert knowledge of the national and international rules of intellectual property that this author does not have. We will limit ourselves here to a few general remarks to show that this agreement has a substantial impact on health systems, and particularly drugs.

The TRIPs Agreement on health-related measures has a particular impact on intellectual property rights associated with certain products such as drugs. The purpose of these intellectual property rights is generally to reserve the commercial use of a product for a limited period in order to cover the product’s research and development costs.

The TRIPs Agreement, and more generally the rules of the industrialized countries, have been much criticized for exerting upward pressure on drug prices by substantially restricting the marketing opportunities for generic drugs. In developing countries, access to some drugs is also virtually ruled out owing to what appears to many as excessive protection of pharmaceutical company patents. The Doha Conference and the ensuing negotiations have begun to tackle this sensitive issue.

Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement)

This WTO agreement essentially governs the measures that WTO members apply at their borders to protect the health and life of humans and animals and preserve plant life within their territory. Obviously, it affects the provision of health care only indirectly, but its structure is of interest, in our opinion, in that it provides an example of the proper balancing of free trade values with the right to health.

The SPS Agreement clearly establishes that each WTO member must determine the level of SPS protection that it considers appropriate for its residents with regard to parasites, illnesses and pathogen organisms. Each member may adopt and apply the SPS measures of its choice provided it can scientifically prove that such measures are necessary in order to achieve the level of SPS protection it has set. For example, if the level of SPS protection is determined by reference to the goal of minimizing its negative effects on trade and if the measure applied is no more trade-restrictive than is necessary to obtain the appropriate level of protection, the SPS measure will be judged consistent with the GATT, and specifically with article XX(b), discussed earlier.

The rules under this agreement, consistent with the intentions of the member states in the area of health while not inconsistent with the spirit of trade liberalization, ought to be a source of inspiration for the future, in our opinion.

To put it clearly, what the SPS Agreement allows in terms of safety and wholesomeness of food should be replicable in the area of health care. Each state should be able to determine the level of care it seeks for its citizens and any liberalization of trade in goods and services should be consistent with this guaranteed level of care. We will revisit this point in the final part of the study, when making recommendations.

Section 2: Provisions of Regional Agreements Applicable to Canadian Health Measures

The commitments made by the three contracting states in the NAFTA reflect a regime that differs from that of the multilateral trade system. Although this regional agreement was negotiated concurrently with the WTO agreements, Canada, the United States and Mexico chose not to establish general agreements with specific features and applications spelled out in sectoral agreements or through schedules containing piecemeal commitments. Rather, they created a single agreement that is divided into parts and chapters comprising general commitments to liberalize trade and detailed rules of application. The agreement is complemented by voluminous annexes that contain reservations where each party to the NAFTA indicates those sectors of investment and trade in services to which the provisions of the agreement do not apply and those sectors where it reserves the right to maintain, adopt and apply in future measures that are not consistent with the terms of the Agreement. Thus, as we shall see, it is fairly easy to determine, from reading the NAFTA annexes, which aspects of our health systems are likely to be covered by the liberalization commitments contained in the Agreement.

Therefore, at this point we will briefly describe the NAFTA provisions that could have an impact on trade in health-related goods. We will also describe the provisions affecting trade in services that may affect the provision of health care. But we will pay particular attention to the reservations and exceptions which, at least until now, have kept NAFTA from having a direct and tangible application in the health services sector.

Provisions in Relation to Trade in Goods under NAFTA

Like all international economic agreements, and like the GATT, which we described earlier, the NAFTA contains many articles that apply the principle of non-discrimination between goods and facilitate trade in those goods through the abolition of tariff and non-tariff barriers. These provisions are found in Part II of the Agreement and set out the rules of national treatment, MFN treatment, market access and export subsidies in terms that are similar if not identical to those of the GATT. They are also found in Part III of the NAFTA, specifically in the chapter dealing with standards-related measures, a close relative of the WTO's Agreement on Technical Barriers to Trade. Other provisions that could affect trade in goods related to healthcare provision are found in chapter 10 of the NAFTA, which deals with government procurement. Although the effect of this chapter is, to a large extent, curtailed by a significant number of exceptions and rules dealing with the tendering entity, the type of goods purchased and the contract price, in principle nothing would prevent its application to the purchase by a Canadian public entity of health-related goods. Finally, chapter 17 of the NAFTA, which essentially forces the parties to the NAFTA to provide effective protection for intellectual property rights on their respective territory, may have effects on trade in drugs similar to those in the TRIPs Agreement described earlier. Some studies tend to demonstrate that the increase in patent protection of pharmaceuticals and the elimination of compulsory licences to comply with NAFTA have had a significant impact on the price of drugs in Canada. (Anderson, Auld, Bolton et al., 1997; Lexchin, 2001)

These trade in goods provisions may all have an effect, therefore, on trade in various health-related goods. However, up to this point they have not led to any significant change in the Canadian health systems, in the supply of health care in Canada, or in the capacity of governments to provide Canadians with the care they desire. The NAFTA provisions of interest to us, and that may have consequences, are primarily those that affect investment and services.

Provisions and Reservations in Relation to Investment and Trade in Services under NAFTA

The two chapters most likely to have some impact on the Canadian health systems are chapters 11 and 12, which deal with investments and trade in services. Related to these two chapters are some important annexes found at the end of the Agreement that significantly limit the application of both chapters. These annexes have so far prevented chapters 11 and 12 from having any real incidence on health care.

Chapter 11 of the NAFTA is divided into three sections. Section A sets out the rules relating to the treatment that each NAFTA Party must grant to investors and investments originating from the other two countries in the free-trade area. Section B governs the dispute settlement process between a NAFTA Party and an investor from another Party. Section C contains a series of definitions applicable to the terms and expressions commonly used in chapter 11.

It is Section A of chapter 11 that is relevant to our study, since it is there (essentially in articles 1101 to 1107) that the substantive obligations of the NAFTA Parties are laid down. A quick reading of this section reveals that the rules are formulated without reference to the specific commercial activity targeted by the investment. For example, there is nothing in NAFTA articles 1101 to 1107 that, at face value, would bar U.S. or Mexican investors or investments from entering Canada's health sector. It is only in article 1108, through exceptions and a reference to reservations found in Annexes I to IV of the NAFTA, that we can gauge the possible application of chapter 11 to Canada's health care sector. In fact, a careful examination of article 1108 and annexes reveals that, for all intents and purposes, Canada has not undertaken to comply with chapter 11 of the NAFTA in regard to investors and investments in the health care sector in Canada. Through reservations it has recorded in various NAFTA annexes, Canada has retained the power to override the most important obligations of chapter 11. The clearest and most complete of these reservations is found in annex II, at page II-C-8 of the Canadian edition of the NAFTA. This reservation deals with the social services sector as a whole. In addition to applying to measures in Canada that already existed when the NAFTA came into force, it covers the social services measures that Canada will adopt and apply subsequently. This reservation, by which Canada reserves the right to override the national treatment rule (article 1102) and the senior management and boards of directors rule (article 1107) reads as follows:

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.

It is true that, in legal terms, it is hard to define with certainty the contours of the protection afforded by this reservation to the Canadian health systems (Johnson 1998, 235). However, it can be noted that through this reservation and others of a more general application pertaining to all sectors of economic activity, Canada has so far managed to exclude health services from the application of NAFTA investment rules.

Chapter 12 of the NAFTA, which deals with cross-border trade in services, contains some general commitments to liberalize covered economic activities. In theory, there is nothing in the provisions of this chapter to prevent health services from being covered by the NAFTA liberalization commitments. Only paragraph 3(b) of article 1201 might put a damper on these general commitments, where it states that the NAFTA governments cannot be prevented from providing certain social services.

3. Nothing in this Chapter shall be construed to:

...

(b) prevent a Party from providing a service or performing a function such as law enforcement, correctional services, income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care, in a manner that is not inconsistent with this Chapter.

This paragraph, which refers to the same social services as Annex II-C-8, is, to say the least, obscure. It seems to mean that the provisions of chapter 12 do not prevent NAFTA Parties from providing services in a manner that is not inconsistent with the provisions of chapter 12! If this paragraph is suggesting that NAFTA governments may continue to provide some social services, its meaning is unclear as to what exactly these governments are allowed to do. It is in the reservations to which article 1206 refers that we can more readily find some indications of the limits of the liberalization commitments Canada has made with regard to health services.

The reservations bearing on the application of chapter 12, particularly the one appearing at page II-C-8 reproduced above, are the same as those that apply to chapter 11. The Canadian health systems have thus been protected up until now from the consequences of the liberalization of services provided in NAFTA.

It is worth concluding these few considerations on trade in services under NAFTA with a brief comment on chapter 16, which deals with the temporary admission of business persons and has close links, in its application, to cross-border trade in services. This chapter sets out a few guidelines as to the rules a NAFTA Party may apply when deciding to allow (or not) a national from another Party to enter on its territory in order to conduct business transactions. The annexes to chapter 16 state in a relatively precise and comprehensive way the classes of business persons whose temporary admission is facilitated by the NAFTA. Annex 1603, more precisely appendix 1603.D.1, provide for the temporary admission of physicians only for teaching or research activities. There is no provision in the NAFTA for the admission, even temporary, of U.S. or Mexican physicians who would wish to come to Canada to perform acts pertaining to the practice of medicine. This is an additional obstacle, therefore, to opening the market in health services to our NAFTA trading partners.

The NAFTA has not yet had any appreciable impact on the ability of our governments to maintain our health systems and provide to the Canadian population health care services in compliance with the criteria established in our legislation. However, as we shall see in Part II of our study, the approach adopted in the NAFTA — making general commitments and circumscribing them through reservations — is a risky one; it could, in future, no longer provide sufficient protection to our publicly funded health systems.

Section 3: Provisions in Bilateral Agreements Applicable to Canadian Health Measures

Canada is a party to 25 bilateral economic agreements that are currently in force. To our knowledge, these agreements have no material impact on health care in Canada.

Twenty-two of these bilateral economic agreements are aimed at protecting foreign investments; their complete texts can be readily located on the web site of the Department of Foreign Affairs and International Trade. Canada conducts little or almost no trade with the vast majority of the countries with which it has signed these agreements. Strictly speaking, the acknowledged potential effects of these agreements on Canada's health care are virtually nil. Moreover, the most recent — such as the Agreement Between the Government of the Republic of Croatia and the Government of Canada for the Promotion and Protection of Investments, which came into force at the end of 2001 — includes, in an annex, national treatment exceptions that cover social services, including health services. So, in our view, there is little to fear about the potential effects of bilateral investment agreements entered into by Canada.

The other three international economic agreements to which Canada is a party are the free trade agreements signed with Chile, Costa Rica and Israel. Although much less complete and comprehensive than the NAFTA, these agreements are structured to a large degree along the lines of the regional agreement between the three North American governments. All three are clearly oriented toward liberalization of trade in goods and reduction in tariffs. Only one contains separate provisions dealing with cross-border trade in services: the free trade agreement with Chile; it includes an annexed reservation identical to the one found in Annex II-C-8 of the NAFTA, that we reproduced above. Thus, on the bilateral level, Canada appears to have opted so far for what we would call the reservations approach in order to shield our health systems from the effects of international economic agreements.

Part II: The Different Approaches to Health Care that Canada Can Adopt with a View to the Upcoming Trade Negotiations

The inventory of provisions that could affect Canadian health systems in the major international instruments to which Canada is a party indicates that the interface between health care and trade has been treated in ways that vary substantially between different trade agreements. In the NAFTA, a regional agreement, and in at least one bilateral agreement, Canada has undertaken in principle to liberalize trade in goods and services while adding some significant limitations on this commitment by including or annexing some reservations and exceptions covering health care. As we noted earlier, a completely different regime has operated in the WTO context. In Part 3 of the GATS, which is of particular interest to us because it addresses market access and national treatment obligations, there is no general commitment or reservation or exception. The obligations provided for in this part of the GATS are the subject of piecemeal commitments by each member. Other WTO agreements that we briefly explained above do not contain any reservations, exceptions or possibility for piecemeal undertakings. Rather, they are based, like the SPS Agreement, on a balance between freedom of trade and protection of health.

Therefore, it is through agreements based on quite different approaches that Canada has undertaken internationally to comply with some trade liberalization rules that could have an impact on Canadian health systems. So far, these approaches have not conflicted. Canada has not had to limit the meaning of the commitments or reservations it has made in relation to health in the context of one trade agreement in order to comply with the commitments it has made in another agreement. The Canadian position on the liberalization of health care thus seems consistent. But this consistency is only apparent and could be temporary. In any event, it is rather fragile.

The fragile consistency of Canada's commitments under various economic agreements stems from the fact that the country is now engaged in major trade negotiations potentially leading to a variety of instruments that could all deal with the liberalization of health care. As for multilateral negotiations, the Doha agenda contemplates a renegotiation of the GATS. At the continental or hemispheric level, negotiations toward a Free Trade Area of the Americas proceed on the basis of the NAFTA documents. In both cases, the negotiations agenda provides for increased liberalization of trade, and particularly trade in services. It is conceivable therefore that these multinational and hemispheric talks will conclude on some international agreements that will differ from one another as much as the NAFTA and the GATS — each with their own interpretation and features. The reservations and exceptions approach, so far the preferred one at the continental level, and the piecemeal commitments approach applied in the GATS context, may ultimately lead to documents so different that they could be contradictory and irreconcilable. With, on one hand, some general commitments accompanied by reservations and exceptions and, on the other, some piecemeal commitments, it could become extremely difficult to clearly define what the Canadian government has committed itself to in terms of liberalization.

Consequently, we would like to underline here the risks related to the two approaches favoured in the NAFTA and the GATS, and stress the need for Canada and any other state concerned about defining clearly the dimensions of health care which it hopes to open to adopt an overall approach that will allow citizens and governments to have a clear understanding of what is subject to international competition and what is protected.

This second part of our study is thus intended to complement briefly the first part, where all the agreements that have some impact on our health systems were described. From the standpoint of international economics law, it represents the response that, in our view, is most pertinent to the general question submitted to us — what are the options for ensuring that Canadian governments can continue, if they so desire, to maintain a public health care system that is compatible with the agreements entered into by Canada. As we will explain, whatever the fundamental orientation chosen by Canadian governments and citizens, it is now urgent to present and defend internationally a clear and firm stand that has the same meaning in the context of all trade agreements.

By way of conclusion, we will venture some suggestions as to the approach that should be pursued as a matter of priority by the Canadian government in current trade negotiations.

Risks of the Reservations and Exceptions Approach

The reservations and exceptions approach is the one prevailing in the NAFTA and the bilateral agreements signed by Canada on trade in services. Ultimately, this approach entails some risks for Canada's health systems. On the one hand, it is acknowledged that reservations and exceptions are always interpreted in a restrictive manner. It is thus quite possible that some services that Canada sees as covered by a reservation or exception will not be considered in the same way by our trading partners, or by a panel arbitrating a dispute between Canada and another Party seeking access to our health care market for one of its nationals.

On the other hand, it is also well known that some reservations and exceptions are intended to circumvent the effect of general rules. However, in the context of hemispheric trade talks such as those now underway to create a Free Trade Area of the Americas, it is not the exceptions but the rules that are the main concern of negotiators. The rules are aimed at liberalizing trade, not at protecting social services. The motivation underlying the negotiated texts is to open up markets in accordance with agreed upon rules. If the protection of public health systems does not appear in the rules but is solely found in the exceptions, less importance may be given to the protection of public health systems. Thus, the balance sought by the Canadian government between the goal of opening markets in other countries and the protection of our own health systems is secured by legal provisions that are unequal. The goal of opening markets is enshrined in a rule, but the protection of health systems is achieved through an exception. Before deciding to give less importance to the protection of public health systems than to the goal of opening markets, shouldn't the Canadian government assess what the priorities of Canadians are? What values should be enshrined in a broad rule, and what others, possibly in contradiction with freer trade, would warrant instead an exception?

Risks of the Piecemeal Commitments Approach

The approach adopted by the WTO members in the GATS, which we refer to as the piecemeal commitments approach, would mean that only WTO members who have specifically undertaken to do so must provide access to their national market. *A priori*, if Canada has made no commitment with regard to health services provided on its territory, it is not bound to admit private suppliers of such services. Therefore, the risks in this approach, by contrast to the reservations and exceptions approach, do not lie in the wording of the commitments. A WTO member who remains silent about a services sector is not required to give access to its market in that sector. The risks, however, lie in the negotiation of commitments made by each WTO member. Because each member wants its nationals to be able to offer specific services on the territory of other members with attractive markets, a give-and-take bidding game ensues between members participating in the negotiations. For example, in return for access to markets in financial or professional services, some members will concede access to other services sectors such as transportation or audiovisual services. In the process, all services covered by the GATS are likely to enter the negotiations. Political or economic pressures may then be exerted on a WTO member to open its market in specific services sectors. Since, as we have seen, health services are potentially covered by the GATS, there is no reason to think that the gradual liberalization of trade in services will not eventually encompass health services. Here again, it is not hard to see that, while this approach has protected our public health systems until now, it is fraught with limitations the pitfalls in the long term.

Risks Related to the Absence of a Comprehensive Approach

The two agreements with the strongest potential impact on our health systems, the GATS and the NAFTA, rest on approaches that conflict with each other in at least one respect. In the GATS, a WTO member's silence on access to a services sector market allows it to protect that sector from foreign competition. But in the NAFTA, a party must be explicit in its reservations if it wishes to exempt a services sector from the application of the Agreement. Canada is now engaged in two major rounds of trade negotiations based on these contradictory approaches. Within two major forums — the WTO and the pan-American negotiations — it must articulate a consistent global policy toward trade in health services. Pressured on all sides by various stakeholders, it has to defend a common policy and express its position through commitments (or lack thereof) in one forum and through reserves and exceptions in the other. Moreover, the ultimate goal of these two rounds of trade negotiations — explicitly in the WTO case — is increased liberalization of trade in services. If, in the context of these talks, Canada wishes to argue that our health systems are not negotiable and if, above all, it seeks to establish the notion that international economic agreements should have no bearing on national health policies, in our view these principles ought to be spelled out explicitly in provisions, and no longer simply expressed through silence or through statements of exceptions recorded in annexes to international agreements.

Concluding Remarks and Recommendation on the Preferred Approach

In addition to examining which agreements are likely to have an impact on our public health systems, we were essentially asked to determine what options are available to Canada with a view to harmonizing Canadian health policies and Canada's commitments in major international economic agreements.

Although Canada has up to now used the latitude provided in the major economic agreements to which it is a party to protect our health systems, this latitude is quickly shrinking in our view and may no longer allow Canada to make international trade commitments that are consistent with the preferences of Canadians as to the effects, or lack of effect, that these agreements should have on our health systems. We can see the risks inherent in relying on exception provisions or on a piecemeal mode of commitment to exclude our health systems from the application of these agreements. These risks will surely increase with the negotiation of an FTAA and the talks now underway in the WTO. In order to give Canada and Canadians assurance that this country's trade commitments and the health systems wanted by Canadians are not in contradiction with each other, it is now time for Canada to develop a single, clear position that can be expressed in the same terms, in all forums. In this regard, we think that it would be desirable, even necessary, that Canada start to promote internationally an international instrument that balances and opposes the principles of free trade with the principles needed to establish and maintain health systems that can provide Canadians with the level of care they would like to get. In this regard, the SPS Agreement, which we briefly analyzed earlier in the study, might serve as a guide for drafting the international instrument we are suggesting. This instrument should enable each state to establish without risk of challenge the level of public health services it wishes to provide to its people. It should also require that each state justify trade measures that would limit or prevent trade in health-related goods and services by demonstrating that they are necessary for achieving the level of health care it has chosen to provide to its citizens. That international instrument would thereby reflect two cherished values in democratic countries: the right to health, and free trade. More importantly, it would also be clearly expressed by a broad rule stating that liberalization of trade in health-related goods and services cannot be achieved by undermining the right to health or the public health systems that each state has chosen to establish or maintain. While this balancing of trade principles with the principles of public health to which Canadians adhere may seem hard to achieve, in our view it is essential to reconciling the trend toward globalization with a sense of respect for the principles underlying the health systems that countries like Canada have put in place.

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