

General Agreement on Trade in Services (GATS) and the Canadian Health Care System

**Submission to the
Minister of International Trade**

December 15, 2000

Ottawa, Ontario

For further information, contact

CMA's Public Affairs Directorate : 1 800 267-9703 ext. 2270



The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to provide leadership for physicians and to promote the highest standard of health and health care for Canadians.

On behalf of its members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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1.0 INTRODUCTION

The method a country chooses to fund and deliver health care demonstrates the values of its citizens and the type of nation that they wish to live in. Canadians, through their elected representatives, have placed a high value on a single-payer, tax-financed health care system with a delivery system that is essentially private and not-for-profit. The principles providing the underpinnings of the system are embodied in the Canada Health Act (CHA) and include the following: universality, comprehensiveness, access, portability and public administration.

Since the passing of the CHA, Canadians have grown increasingly passionate about these principles and have demonstrated time and again that these principles are in close alignment with their values.

Canadians have chosen tax-based financing for their health care system as it relates to hospital and physician services. The provincial and federal governments, through federal government transfers such as equalization payments and the Canada Health and Social Transfer and through provincial taxation, fund the various organizations and health care providers that deliver health care. Therefore the financing of the health care system has been socialized and publicly administered as opposed to privatized through compulsory private insurance. This indicates that Canadians view health care as not just an ordinary good, such as an automobile or a house that they pay for based on their own financial resources, but as a good whose cost should be shared by the community on the basis of the ability to pay of individuals. For those two components that are most likely to create true financial hardship for families and individuals, hospital services and physician services, the overwhelming majority of the funding is from public sources as opposed to private sources.

When it comes to the health services that are subject to the provisions of the CHA, namely hospital services and physicians' services, Canada has chosen a predominantly private delivery approach. Physicians are largely self-employed and operate within a private sector solo or group practice while community and teaching hospitals are largely private not-for-profit organizations. Most Canadian hospitals are governed by voluntary boards of trustees and are owned by voluntary organizations, municipal or provincial authorities or religious orders.

2.0 CANADIAN VALUES

The evolution of Canada's health care system has been profoundly influenced by Canadian values and as a result so will its future. The Prime Minister's National Forum on Health produced a series of documents on Canada's health care system including analyses that delved into Canadian values regarding health care and Canada's health care system in particular.

The following quotes are from Graves, Frank L. Beauchamp, Patrick, Herle, David, "Research on Canadian Values in Relation to Health and the Health Care System" Canada Health Action: Building on the Legacy, Papers Commissioned by the National Forum on Health, "Volume 5 - Making Decisions, Evidence and Information". These quotes exemplify the importance of health and the health care system in the hearts and minds of Canadians.

"There is a broad consensus that the Canadian health care system is a collective accomplishment, a source of pride, and a symbol of core Canadian values. The values of equality, access, and compassion are salient to perceptions of the system and often held in contradistinction to perceptions of the American system. Moreover, the system is seen as relatively effective and sound. It may be the only area of current public endeavour which is seen as a clear success story." p. 352

"The public perceptions of problems in the health care system reflect many of the themes evident in broader concerns about government. One of these themes is a growing wariness of "expert" prescriptions for the health care system." p. 353

"This finding reconfirms a consistent conclusion of other research in this area – the gap between expert rationality and public values. It would be prudent to acknowledge the public's entrenched resistance to a purely economic mode on health care." p. 354

"A number of key conclusions are evident. First, people were generally loath to trade-off elements of the current system against the promise of better or fairer future performance." p. 355

"The public will be resistant to a rational discourse on these cost issues because they are more likely to see these issues in terms of higher-order values. The evidence suggests that further dialogue will tilt the debate more to values than economics. The public will insist on inclusion and influence in this crucial debate and they will reject elite and expert authority." p. 356

"In response to a question on how health care was different from other commodities and services sold in the marketplace, participants agreed that its main difference lies in the fact that it was directly related to "life and death"." p. 370

"Most simply did not want efficiency to be the driving force in health policy." p. 378

“The focus group discussions augmented the belief that health care is more about values than economics.” p. 389

“Although other competing priorities emerged over the period of the discussion, it is *equality of access* that serves as the primary source of this pride. The “Canadian” values are wrapped up in equality of access – everybody gets relatively equal care when they are sick and nobody has to lose their house to pay their hospital or doctor bill. It is this feature of the system which is seen to most distinguish it from the American model (which is the point of comparison).” p. 393

“Many people readily acknowledge that their belief in egalitarianism is restricted to health care and that they are not troubled by wide discrepancies based on ability to pay or status in other areas of society. They have no trouble isolating health care in this way because they see health care as something of a completely different character than housing or automobiles or vacations.” p. 393

“There is an overwhelming consensus among Canadians about the importance of equality of access as the defining characteristic of our system. That consensus is premised upon the assumption that quality is a given, as they have perceived it to be in the past.” p. 395

“It is also true that, since Canadians recognize that a truly private system like the U.S. version might provide even greater levels or quality of freedom of choice to at least some citizens, they are choosing to sacrifice some of that from the system in order to provide equality of access to a universal system.” p. 396

Clearly, Canadians value their health care system and the principles that it is based on.

3.0 IMPLICATIONS FOR TRADE LIBERALIZATION

The core values that Canadians have expressed in relation to the health care system raise certain issues as to the impact of trade liberalization on those core values. Following is an analysis based on an examination of the various modes of trade.

3.1 Modes of Trade in Services

The Uruguay Round of trade negotiations leading to the World Trade Organization’s creation in 1995 classified services into 160 sectors. Health services are classified as a sector. In addition, trade in insurance services may affect health services where a market for health insurance exists.

The General Agreement on Trade in Services (GATS) distinguishes among four modes of trade in services. Each is briefly described below, together with examples, (involving the mythic countries 'A' and 'B') from the health sector.

Mode	Example	
1	Cross-border trade	- provision of diagnosis or treatment planning services in country A by suppliers in country B, via telecommunications ('telemedicine')
2	Consumption abroad	- movement of patients from country A to country B for treatment
3	Commercial presence	- establishment of hospitals in country A whose owners are from country B, i.e. foreign direct investment
4	Presence of natural persons ¹	- service provision in country A by health professionals who have emigrated from country B

To date, Canada has made no commitments in the health services sector. Commitments in general have been shallow in the health sector in comparison to the most liberalized sectors, telecommunications and financial services, reflecting in part the substantial uncertainty about how such commitments will affect health care systems. Many of the countries that have undertaken health sector commitments have opted for enshrining the status quo, or even the status quo with commitments that include language proficiency requirements for health care professionals.

Some WTO Members, however, have made more extensive commitments, driven in part by the hope that this will facilitate development of export opportunities and importation of foreign capital and know-how. Where developing countries have made such commitments, the general lack of resources appears to be a far more potent barrier to trade than the presence or absence of such commitments.

¹Natural Persons” – this covers the conditions under which a service supplier can travel in person to a country in
 Source: <http://gats-info.eu.int/gats-info/gatscomm.pl?MENU=hhh>

3.2 GATS and the Health System: Role of Insurance and Health System Structure

To understand trade implications for the health sector, it may be helpful to distinguish between three functions that undergird all health systems: regulation/stewardship, financing, and service provision. Since the inception of Medicare, Canadians have received their health care through a system of private providers regulated under statutes. This links them closely to a financing system comprised largely of public funds in the form of general taxation revenues disbursed to health care providers by provincial and territorial governments and drawn from provincial and federal revenues through the progressive income tax system.

The regulatory/stewardship established by the Canada Health Act and provincial regulation is pivotal to the system's structure. For example, building private hospitals need not be explicitly banned because funding levers make this a difficult business proposition as services provided there would not be automatically covered by provincially managed insurance schemes. A further useful distinction arises between input goods and services (drugs, devices, health care personnel, cleaning, laundry etc.) and the output of health care services. It is difficult to argue that the cleaning of hospitals is fundamentally part of the output of health services, rather it is similar to cleaning of other facilities and is increasingly performed by commercial entities in contractual relationships with health care facilities. These commercial entities include firms with foreign ownership or shareholders. Similarly many of the drugs and devices used in Canadian health care facilities are traded goods, moving in international trade from foreign-based suppliers and being accompanied by Canadian goods exported to other health care systems.

Another input into the health care system is medical education. Physicians have to be trained so that Canadians have access to appropriate physician resources. There is some concern about the effects of GATS on the medical education enterprise and the quality of medical education currently delivered in Canada. As well, there is international recognition of Canada's expertise in medical education and evaluation and that this is a part of the health care system that Canada should be exporting.

4.0 RESPONDING TO GATS: POTENTIAL IMPLICATIONS

In responding to GATS, it is helpful to consider each of the four modes of trade in health services, current levels of trade, and how GATS liberalization, (i.e. commitments by the government of Canada) could impact Canada's health care system.

Mode 1 - Cross-border supply

Cross border supply of health services, where the provider (health care professional) and consumer (patient) are in different jurisdictions has recently moved from the realm of science fiction to reality with advances in telemedicine. However, certain services, particularly those involving direct patient contact (nursing, rehabilitation professionals) are unlikely to be provided, regardless of advances in telemedicine. Cross-border supply appears most relevant to services involving diagnosis and treatment planning.

For example, a physician in Canada may digitize radiology films and send them for interpretation to a radiologist in the Caribbean or South Asia. Similarly, several experiments within Canada have attempted to use teleradiology to spare families long trips from remote communities to consult with highly specialized paediatricians. If this were to occur across national borders with exchange of payment for services, it would constitute a form of international services trade.

Current limits on telemedicine's growth are essentially no longer technological but rather the regulatory/stewardship issues of professional certification and payment systems for services rendered. A commitment under mode 1 would do nothing to address either of these questions, particularly the first as governments retain full authority to establish licensing and certification regimes for professionals. Within Canada, payment has been hampered by provincial insurance plan insistence that the doctor-patient encounter must occur in such a way that both are in the same physical space.

At present, efforts have been directed to establishing cross-border recognition of professional accounting certification, fueled in large part by the concentration of accounting services work within a handful of multinational firms on behalf of their increasingly globalized clients. By contrast, similar efforts directed to social sector professions are unlikely given the atomistic nature of the professionals and the institutions and organizations where they work. The absence of a concerted desire for such cross-border recognition, coupled with the powerful role of governments in regulating not only certification but also numbers of health care professionals, suggests cross-border recognition will remain unlikely for the foreseeable future.

That having been said, a commitment by Canada and other countries to mode 1 liberalization could increase pressure on licensing authorities to develop programs of cross-border recognition. If this were to happen the export of telemedicine services outside of Canada would represent physician resources that would not be available to Canadians. Given the physician workforce issues that Canada is presently facing such a commitment could exacerbate an already difficult position. In addition, there are other implications that would have to be determined through stakeholder consultation, for example: provider legal liability and malpractice insurance, patient privacy and confidentiality of medical records to name a few.

Mode 2 - Consumption abroad

Individual Canadians have long sought care in other jurisdictions, most notably the United States. This is typically paid for from private health insurance or out of pocket funds. Changes to provincial insurance reimbursement for out-of-country care have dramatically limited publicly funded consumption abroad by Canadians. Two exceptions to this are treatment for specific rare conditions and, in several provinces, contracting for radiation therapy services with American institutions. Liberalization under mode 2 would do little for Canada in affecting the outward flow of Canadian patients to the US given the ease with which Canadians can cross the Canada-US border to purchase medical care. Similarly, opportunities for Canadian professionals and facilities to attract additional foreign patients are unlikely to grow substantially should a mode 2 commitment be made.

The obvious growth potential for Canadian physicians and facilities lies in the USA but has been substantially limited by two synergistic factors. First is the non-portability of insurance coverage, both publicly financed Medicare/Medicaid benefits and most market-purchased insurance. Exclusion from health maintenance organizations' (HMOs) networks of providers are a further impediment for Canadian providers seeking to attract American consumers. Should the United States be willing to commit to the generalized portability of Medicare benefits, Canada would be a logical destination for American consumers seeking care, but that would be contingent on a commitment from the United States or other action regarding portability, rather than a specific mode 2 commitment by Canada. Commitments in this direction may, however, only be made if similar commitments are made by potential trading partners for health services, notably Canada and Mexico.

A commitment by Canada and other countries, especially the United States, to mode 2 liberalization could change the business plans or strategies to attract foreign patients by some physicians especially certain niche subspecialists. Such a change could result in access difficulties for Canadian patients as providers substitute higher-paying foreign patients for Canadian ones for which payment is fixed by provincial insurance plans.

Mode 3 - Commercial presence

Commercial presence, usually through foreign direct investment (FDI), is often necessary for providing services such as banking or supply chain management. FDI in Canada's health service sector is relatively insignificant and that would appear unlikely to change with a mode 3 commitment. As with several of the other modes of trade, the regulatory and stewardship environment creates structural impediments to FDI, specifically concerning which services will be paid for in which facilities, that a mode 3 commitment is unlikely to remove.

A related area for the health system is that of consulting services, where multinational, foreign-origin firms already play a substantial role in providing various forms of management consulting services. While some hospital boards are reported to have been approached regarding the outsourcing of their management to foreign management services firms, the extent of implementation to date has been minimal. Should hospital management be outsourced in this way or hospital facilities networked through supra-facility organizations, American based firms are logical candidates for such work and can be expected to bring with them substantial experience in shaping and constraining physician decision-making, particularly around access to expensive procedures.

Mode 3 commitments are arguably neither necessary nor sufficient for such a change in hospital governance and management when compared to the power of provincial government regulation and financing mechanisms. If Canada made a mode 3 commitment, provincial governments would still have substantial latitude to regulate financing and provision of services, so long as these regulations applied to all potential suppliers, regardless of country of origin, thus ensuring national treatment.

However, the full ramifications of such a commitment remain largely unknown and there appears little to be gained by Canada in making such commitments.

Mode 4 - Presence of natural persons

Presence of natural persons, specifically physicians and other health professionals, is one of the most pressing issues in health systems around the world. For countries like South Africa, emigration of physicians hampers efforts to deliver health services. For parts of Canada, immigration of those physicians has been essential to providing Canadians with health care, particularly in rural and remote areas.

Nevertheless, mode 4 commitments are unlikely to be particularly useful for health human resource planning. For destination countries like Canada, a mode 4 commitment to liberalize immigration of natural persons, specifically health sector professionals, does not bind that country to forego national systems of certification and licensure. Moreover, existing systems of visas and work authorizations offer far more effective control over inflows than would a mode 4 commitment. Similarly, Canadian physicians who wish to emigrate, typically to the US, do so in the absence of a Mode 4 commitment by either country. Of concern to Canadians is the increased recognition of physician shortages as demonstrated by the fact that several provinces have increased medical school enrolment. Therefore any measures that would make it easier for physicians and other health care professionals to leave Canada and to practice elsewhere, especially the United States, could exacerbate an already tight supply of human health resources in several provinces.

After a decade of efforts to reduce the number of physicians in Canada, assessments of Canadian physician supply are increasingly identifying shortages or, at the very least, chronic undersupply, in rural areas. Substantial numbers of foreign-trained physicians already reside in Canada but are unable to practice due to some combination of limited language skills, insufficient training, or 'queuing' for the various transition requirements imposed on international medical graduates (IMGs) by provincial licensing authorities.

Commitments by Canada in this area however could result in pressure on licensing authorities to modify their requirements with potential implications on quality of care. Again, there is little to be gained for Canada to pursue commitments in this area until the ramifications are fully explored.

Additional Considerations:

Two areas that are to be explored are: 1) cross-sectoral trade, and 2) equity perceptions.

'Cross-sectional trade' refers to countries offering commitments in one sector in return for commitments in other, unrelated sectors. As an example, Canada may wish to increase its access to foreign markets for financial or telecommunications services and face the choice of putting the health services sector 'into play' as part of negotiating on matters unrelated to health services. This would be potentially disastrous if Canada were to undertake specific health services commitments in the rush to secure benefits in other sectors without attention to the federal-provincial cooperation and coordination to ensure that such commitments did not undermine the foundations of Canada's health system.

Such cooperation and coordination appears to be becoming increasingly difficult and the pressure of a GATS commitment perceived to be negotiated by persons outside the health sector and health ministry would seem a surefire way to increase that difficulty.

The second issue, equity perceptions, arises from the confluence of increasing concern among Canadians about access to their health care system and the likely additional concern that would arise if Canadian physicians were perceived to be favouring foreign patients over Canadian patients. The clearest example of access concerns to date is likely that of ophthalmology services where the opportunities for these specialists to provide non-insured laser treatment to American citizens may have reduced the services available to provincially insured Canadians. Non-insured care, whether for Canadians or foreign patients is a growing part of physician revenues, but pushing for its expansion through a mode 2 commitment under GATS appears unlikely to generate benefits sufficient to offset the potential negatives when compared with other methods of expanding revenue from non-insured services.

5.0 CONCLUSION

The Government of Canada's bargaining position regarding health services in relation to the ongoing liberalization of trade in health services through the GATS will evolve from an assessment of the opportunities and costs associated with various levels of commitment. A major factor in the equation are the values of Canadians and their affinity for the publicly funded health care system.

6.0 RECOMMENDATION

“The Canadian Medical Association (CMA) recognizes that trade liberalization can have positive economic impacts on the Canadian economy, however the type of healthcare system that Canadians and health care providers want is of primary concern whereas the goals of trade liberalization in health services is of a secondary nature. Recognizing that the GATS process is an on-going and long-term approach to trade liberalization, the CMA recommends that the Federal government undertake extensive consultative sessions with the Canadian public and healthcare providers. Such a consultation process would help answer questions as to the implications of trade liberalization and would provide feedback as to what level of trade liberalization in health care services is consistent with Canadian values.”