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How I Learned to Stop Worrying and Love the GATS: An Examination of the Impact of the General Agreement on Trade in Services on the Canadian Health-Care System

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Brian N. Zeiler-Kligman*

How I Learned to Stop Worrying and
Love the GATS: An Examination of
the Impact of the General Agreement
on Trade in Services on the Canadian
Health-Care System

There is perhaps no more cherished Canadian institution than our universal health-care system, Medicare. Despite Canadians' fondness for Medicare, there are often allegations that various external elements threaten Medicare's viability. One of these oft-cited elements is the General Agreement on Trade in Services (GATS), which some have claimed will force the privatization of all public services. The truth in such claims is tested by examining the effect the GATS is likely to have on the Canadian health-care system. The examination includes an interpretation of GATS Article I.3 through a textual analysis. GATS' impact on this system is explored on three levels: the ability to regulate, the ability to insure/fund publicly and the ability to provide publicly. From this analysis, it is shown that the GATS poses little threat to the continued public nature of Medicare: governments can still regulate who can provide health services and their quality; governments can still fund whichever medical services they wish; whether or not governments publicly provide health services is only slightly affected by the GATS and really has no impact on the public nature of Medicare.

Il n'y a sans doute pas d'institution canadienne que nous chérissons plus que notre régime universel d'assurance maladie. Malgré l'affection que les Canadiens portent à leur régime assurance maladie, on entend souvent des allégations que divers éléments externes menacent la viabilité du régime d'assurance maladie. L'un de ces éléments souvent cités est l'Accord général sur le commerce des services (AGCS), dont certains prétendent qu'il va forcer la privatisation de tous les services publics. Le bien-fondé des déclarations de ce genre est mis à rude épreuve par l'examen des effets que l'AGCS est susceptible d'avoir sur le régime canadien d'assurance maladie. L'examen comporte une interprétation de l'article I.3 de l'AGCS par une analyse textuelle. L'effet de l'AGCS sur le régime est étudié sur trois niveaux : la capacité de réglementer, la capacité d'assurer ou de financer publiquement et la capacité d'offrir publiquement. À partir de cette analyse, il est démontré que l'AGCS ne menace pas la nature publique du régime assurance maladie : les gouvernements peuvent réglementer pour déterminer qui peut offrir des services de santé et la qualité de ces services; les gouvernements peuvent financer les services médicaux qu'ils jugent bon de financer; la capacité pour les gouvernements d'offrir publiquement des services de santé n'est que légèrement affectée par l'AGCS qui, à toutes fins utiles, n'a pas d'incidence sur le caractère public du régime d'assurance maladie.

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- I. *The treaty and the commitments done: an overview of the GATS and Canada's commitments pertaining to health-care services*
 1. *Universal obligations*
 - a. *Most-favoured nation (MFN)*
 - b. *Recognition*
 - c. *Monopolies and exclusive service suppliers*
 - d. *Dispute resolution.*
 2. *Sector-specific obligations*
 3. *Canada's GATS commitments pertaining to health-care services*
- II. *A mystery wrapped in an enigma: unbundling and defining GATS Article 1.3*
 1. *Commercial basis*
 2. *Not in competition*
 3. *Definitions in the financial services annex*
 4. *Preamble*
 5. *Summary*
- III. *This won't hurt a bit: the likely impact of the GATS on medicare*
 1. *Governmental authority exclusion*
 - a. *Medicare (its overall architecture)*
 - b. *Hospitals*
 - c. *Physicians*
 - d. *Health-care professionals*
 - e. *Home care*
 - f. *Nursing homes and homes for the aged*
 - g. *Supplementary health services*
 2. *The effect of GATS' universal obligations*
 3. *The impact of commitments in Canada's schedule*
 4. *The effect of Canada's horizontal commitments*
 5. *The ability to regulate*
 6. *The ability to insure/fund publicly*
 7. *The ability to provide publicly*

Conclusion

Canadians are known as a polite and dispassionate people. That is, until something threatens the vitality and sanctity of our public, universal health-care system ("Medicare"). In this light, it is not surprising that the system should be called "one of Canada's finest achievements and a powerful symbol of national identity"¹ or that Canadians take pride in our public health-care system, seeing it as a reflection of national values that distinguishes us from Americans.² In the last few years, at least, health care has also tended to be among the biggest election issues,³ as reflected in the federal government's statement that "no issue touches Canadians more deeply than health care" in a recent speech from the throne.⁴

Despite Canadians' attachment to Medicare, we also appear to be convinced that this public system is in continual peril. Worries of "two-tier" health-care systems abound should the private sector appear to play too large a role, with no politician wanting to be seen as advocating the growth of a private sector role in health care. For instance, in the prelude to the 2004 election campaign, then Health Minister Pierre Pettigrew said that the federal government would not object if private companies played a larger role in health-care delivery. However, the fallout from this comment was so severe that the Minister was forced to retract it just one day later.⁵

One of the more prevalent concerns voiced about perceived threats to the continued public nature of Canada's Medicare system is the impact that various international trade agreements could have on it. Indeed, this issue is seen as so important that one of the eleven chapters in the Final Report of the Commission on the Future of Health Care in Canada was devoted to "Health Care and Globalization," with a substantial portion of this chapter exploring the impact that international trade agreements might have on Medicare.⁶ One of the oft-cited culprits is the General Agreement

1. Canadian federal government lawyers quoted in CBC News, "Top Court Strikes Down Quebec Private Health-Care Ban" *CBC News.ca* (9 June 2005), online: CBC News <www.cbc.ca/story/canada/national/2005/06/09/newscoc-health050609.html>.

2. "Private Concerns" *The Economist* 375:8431 (18 June 2005) 51 at 51.

3. "Fistfuls of Health Dollars" *The Economist* 371:8378 (5 June 2004) 45 at 45. For example, in the election in 2004, all 3 major national parties (the Liberals, NDP and Conservatives) agreed that a large cash infusion to the Medicare system was how to improve it, with the size of the infusion being one of the main sources of difference. See also Communications Canada, "Spring 2002 survey results," online: Communications Canada <www.communication.gc.ca/survey_sondage/12/cs_spring2002_05.html> (date accessed: 28 March 2004).

4. Governor-General of Canada, Speech from the Throne to Open the Thirty-Seventh Parliament of Canada (2003), online: The Privy Council Office <<http://www.parl.gc.ca/information/about/process/info/throne/index.asp?Language=E¶m=sp&parl=37&sess=2>>.

5. "Fistfuls of Health Dollars," *supra* note 3 at 45.

6. Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Ottawa: The Queen's Printer, 2002) at 233-246 [*Romanow Report*].

on Trade in Services⁷, which is administered through the auspices of the World Trade Organization.⁸ Even though GATS Article I.3(b) explicitly excludes “services supplied in the exercise of governmental authority” from GATS’ scope (which is defined in GATS Article I.3(c) as services that are not provided on a commercial basis or in competition with one or more service suppliers), some commentators express the belief that the GATS seeks out, and will eventually lead to, the privatization of all public services.⁹

So, in spite of the clear domestic desire to not only keep Medicare in place, but to strengthen and expand it, claims persist that the GATS, a multilateral agreement, will force Medicare’s dissolution and privatization. In its current incarnation, Medicare is delivered by a combination of public and private agents, but the populace’s access to health services is ensured on an egalitarian basis. Underlying the claims that the GATS will result in the privatization of health services is a fear that the increased private provision of public services will upset the distributional balance of access to health care since Medicare is distributed on a needs basis, but markets distribute services on an ability-to-pay basis. Exploring the conclusions drawn from such claims, though, reveals a misunderstanding of the force of GATS’ provisions and of the elements that comprise these public services. In fact, there is an assumption that increased private provision of any public service necessarily means less government involvement and less equality in access to the service.

In this article, I seek to answer whether GATS’ provisions pose a threat to the continued public nature of, and government involvement in, the Canadian health-care system and further, whether GATS’ provisions will have any impact on Medicare or its constituent elements.

The liberalization of Medicare, as for all services sectors, will occur in two instances. The first would be if the Canadian government chose, of its own accord and without coercion, to open Medicare to market forces. In such an instance, the GATS will not be the reason for this action; rather it will be caused by the government in question. Here, the

7. *General Agreement on Trade in Services*, 15 April 1994, 1869 U.N.T.S. 183, 33 I.L.M. NG7 [GATS].

8. See, for example, S. Sinclair, *GATS: How the World Trade Organization’s New “Services” Negotiations Threaten Democracy* (Ottawa: Canadian Centre for Policy Alternatives, 2000); S. Sinclair & J. Grieshaber-Otto, *Facing the Facts: A Guide to the GATS Debate* (Ottawa: Canadian Centre for Policy Alternatives, 2002); M. Sanger, *Reckless Abandon: Canada, the GATS and the Future of Health-Care* (Ottawa: Canadian Centre for Policy Alternatives, 2001); A.S. Ostry, “International Trade Regulation and Publicly Funded Health Care in Canada” (2001) 31 *Int. J. Health Serv.* 475; and S. Shrybman, *The World Trade Organization: A Citizen’s Guide* (Toronto: Lorimer and Canadian Centre for Policy Alternatives, 2001).

9. See, for example, Sinclair, *ibid.*

GATS will simply serve as a vehicle to facilitate and enshrine this chosen liberalization (assuming that the government in question also chooses to list this liberalization in its GATS schedule).

The other instance would be if a WTO Member accused Canada of not fulfilling its GATS commitments and took this matter before a WTO Panel. If the Panel were to find the complaint to have merit, it would recommend that Canada bring its provisions into conformity with its WTO commitments. Were Canada not to make such changes, the WTO's Dispute Settlement Body (DSB) could authorize other WTO Members to withdraw negotiated benefits equivalent to those deemed to have been nullified or impaired by the measures found to be inconsistent with GATS provisions. In this instance, Canada's GATS commitments, as interpreted and applied by the WTO Panel, would be causing the liberalization of the health system in question. However, such a scenario is only possible if Medicare is subject to the GATS and thus not excluded by virtue of GATS Article I.3.

Accordingly, this paper will explore the likely outcome should a dispute that raises the scope of GATS Article I.3(b) and (c) be heard and will approach the matter in the same manner as a WTO arbiter would—by conducting a textual interpretation of the provisions in accordance with customary rules of interpretation of public international law as enshrined in Articles 31-33 of the *Vienna Convention on the Law of Treaties*.¹⁰ Further, there are three levels to Canada's public health-care system: 1) governmental regulation and/or standard-setting; 2) public/governmental financing/insuring of these health services; and 3) public/governmental provision of these services. Claims that the GATS will result in the liberalization or privatization of health care assert that government's role in each of these levels will be undermined, if not eliminated. Accordingly, the analysis of GATS' impact on Medicare herein explores these three levels.

The article is set out in three sections. The first section will provide an overview of the obligations contained in the GATS and the health-related commitments found in Canada's schedule. The second section will be devoted to the likely meaning a WTO Panel will attribute to GATS Article I.3. In the final section, these findings will be applied to the overall structure of Medicare to see what ultimate effect the GATS is likely to have on this national health-care system. This exercise will show that, given the likely interpretation to be given to GATS Article I.3(b) and (c)

10. Done at Vienna, 23 May 1969, 1155 U.N.T.S. 331 [*Vienna Convention*]; Canada is a signatory.

by a WTO Panel, there is no threat to the public administration, financing or regulation of the health-care system in Canada.

I. *The treaty and the commitments done: an overview of the GATS and Canada's commitments pertaining to health-care services*

The GATS is more appropriately seen as an amalgam of documents composed of three parts: the preamble and text comprising Annex 1B of the final results of the Uruguay Round¹¹; the sectoral annexes (in such areas as financial services and maritime transport) that have been agreed to subsequent to the conclusion of the Uruguay Round; and the national schedules of specific commitments¹² submitted by Member governments. The following discussion focuses on the text of GATS 1994 and Canada's national schedule.

Article I of the GATS establishes the scope of the agreement. Specifically, the GATS applies to all measures¹³ by Members¹⁴ "affecting trade in services," although no definition of a service is given anywhere in the agreement. Trade in services is defined in Article I.2 as the supply of a service in any one of four modes: cross-border trade (mode 1); consumption abroad (mode 2); commercial presence (mode 3); or temporary presence of natural persons (mode 4). GATS Article I.3(a) specifies that the agreement applies to all levels of government within a Member country (provincial, territorial, local, etc.), as well as any non-governmental bodies that are exercising powers delegated from these levels of government.

Despite this extensive scope, certain services are excluded from the terms of the GATS. The services governed by the GATS are defined to exclude "services supplied in the exercise of governmental authority" (the Governmental Authority Exclusion) in GATS Article I.3(b). This phrase is defined in Article I.3(c) to mean "any service, which is supplied neither on a commercial basis, nor in competition with one or more service suppliers."

In order to understand how the GATS and Canada's commitments could affect health-care services in Canada, it is necessary to define what services make up a health-care system. For the purposes of this article, the definition offered by Deber¹⁵ is adopted. She defines a health-care

11. 33 I.L.M. 44 (1994).

12. According to the WTO's website, as of July 7, 2005, all 148 Members had submitted a schedule of commitments to the WTO, <www.wto.org/english/tratop_e/serv_e/serv_commitments_e.htm>.

13. GATS Article XXVIII(a) defines measures to mean "any measure by a Member, whether in the form of a law, regulation, rule, procedure, decision, administrative action, or any other form."

14. "Member" refers to a WTO Member state.

15. R.B. Deber, *Delivering Health Care Services: Public, Not-For-Profit or Private Discussion Paper No. 17*, (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 8, online: Commission on the Future of Health <<http://www.hc-sc.gc.ca/english/care/romanow/hcc0494.html>>.

system to include: acute hospital care; chronic hospital care; ambulatory outpatient care (including physician's services); laboratories and radiology; ancillary benefits (such as dental, vision, physiotherapy, chiropractics and podiatry); ambulance and transportation; nursing homes and homes for the aged; home care; rehabilitation care; drugs; assistive devices; mental health and public health/health promotion; education and training of health professionals; and planning, research and management.

Having established the scope of services to which the GATS applies and those services which are defined to make up Canada's health-care system, we will explore the obligations GATS imposes. For those services subject to the GATS, there is both a universal framework of obligations that applies to all services and a set of specific commitments regarding the treatment of particular service activities listed by each WTO Member in its national schedule of commitments.

1. *Universal obligations*

The GATS' universal obligations are found in Part II of the agreement. As pertains to the subject of this article, only Articles II (Most-Favoured Nation), VII (Recognition), VIII (Monopolies and Exclusive Service Suppliers), and the application of dispute settlement provisions to the GATS are likely to be of importance.

a. *Most-favoured nation (MFN)*

GATS Article II contains the MFN requirement, stipulating that governments extend "immediately and unconditionally to services and service suppliers of any other Member" treatment that is no less favourable than that which it accords to like services and service suppliers from any other country. The WTO Appellate Body jurisprudence has clarified that measures cannot contain *de jure* or *de facto* discrimination, even where the measures are neutral on their face.¹⁶

The GATS' MFN obligation is more lenient than the obligation found in the GATT because GATS Article II is circumscribed in two ways: 1) by GATS Article V, that allows Members to enter into bilateral or regional agreements to liberalize trade in services (similar to Article XXIV of GATT 1947); and 2) by one-time GATS Article II exemptions (that are, in principle, to last ten years) that must be listed in the Member's schedule.

16. *European Communities – Regime for the Importation, Sale and Distribution of Bananas (Complaint by Ecuador et al.)* (1997), WTO Doc. WT/DS27/AB/R at 231, 233 & 234 (Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1996> [*Bananas Case*].

b. *Recognition*

Any Member that chooses to recognize qualifications obtained in another country as fulfilling that Member's national standards for the licensing or certification of service suppliers, whether through a formal agreement or unilateral declaration, must provide adequate opportunity for other Members to negotiate similar recognition (Article VII). Any recognition granted must not be accorded in a discriminatory manner, or operate as a disguised restriction on trade and all recognition measures must be notified to the Council for Trade in Services.

c. *Monopolies and exclusive service suppliers*

GATS Article VIII requires that any monopoly or exclusive service supplier observe the MFN requirement and not act in a manner inconsistent with scheduled commitments. Monopolies and exclusive service suppliers competing in the supply of a service that is outside the scope of their monopolist's or exclusive service supplier's monopoly rights and is listed in the Member's schedule of commitments must not abuse their monopoly position, for example by subsidizing their activities in the competitive market from monopoly profits.

The decision in *Mexico – Measures Affecting Telecommunications Services*¹⁷ may clarify what constitutes an anti-competitive practice. The Panel stated that the focus of anti-competitive practices is on a major supplier's "monopolization or the abuse of a dominant position in ways that affect prices or supply."¹⁸ While the Panel did not set out an exhaustive list of what constitutes an anti-competitive practice, it asserted that, at the very least, anti-competitive cross-subsidization, misuse of competitor information, withholding of relevant technical and commercial information and horizontal practices related to price-fixing and market-sharing agreements fall within the meaning of this term.¹⁹ This conclusion was reached by reference to the provisions of the reference paper in question,²⁰ Members' competition legislation,²¹ international instruments addressing competition policy²² and the object and purpose of the Reference Paper commitments made by Members.²³ Further, the Panel found that practices required under a Member's laws can still be anti-competitive practices.²⁴

17. (*Complaint by the United States*) (2004), WTO Doc. WT/DS204/R (Panel Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2000> [*Mexican Telecoms Case*].

18. *Ibid.* at para. 7.234.

19. *Ibid.* at para. 7.238.

20. *Ibid.* at para. 7.231.

21. *Ibid.* at para. 7.235.

22. *Ibid.* at para. 7.236.

23. *Ibid.* at para. 7.237.

24. *Ibid.* at para. 7.245.

d. *Dispute settlement*

The GATS is subject to the WTO's dispute settlement procedures under the Dispute Settlement Understanding (DSU).²⁵ However, there are some provisions specific to disputes concerning the GATS. For example, panels dealing with complaints concerning trade in services should be composed of well-qualified governmental or non-governmental individuals who have experience in trade in services and, in particular, sector-specific expertise.²⁶ As well, for complaints concerning trade in services, the DSB must only permit the removal of concessions where it thinks the breach is sufficiently serious.

2. *Sector-specific obligations*

Members are only bound by the sector-specific obligations of national treatment and market access, discussed below, to the extent that they choose, as recorded in that Member's schedule of national commitments. Canada's schedule lists commitments according to service sector, following the *Services Sectoral Classification List*,²⁷ which is based on the United Nations' Central Product Classification.²⁸ While the CPC is comprehensive, there remain tricky concepts, such as culture or health care, which are not easily pigeon-holed into a single category and may spread across a number of sectors. Members can also make what is called a horizontal commitment, which is a commitment that pertains to a particular mode of supply for all service sectors, regardless of whether or not any other commitments are listed for a given sector. An example of Canada's GATS schedule is set out below:

25. Annex 2 to the Marrakech Agreement Establishing the World Trade Organization, 33 I.L.M. 81 (1994).

26. "Decision on Certain Dispute Settlement Procedures for the General Agreement on Trade in Services" in *The Results of the Uruguay Round of Multilateral Trade Negotiations: The Legal Texts* (Geneva: GATT Secretariat, 1994) 457.

27. GATT Secretariat, *Services Sectoral Classification List: Note by the Secretariat*, GATT Doc. MTN.GNS/W/120 (1991) [*Services Sectoral Classification List*].

28. United Nations, *Statistical Paper Series M No. 77, Provisional Central Product Classification* (New York: Department of International Economic and Social Affairs, Statistical Office of the United Nations, 1991) [*CPC*].

Sector or subsector	Limitations on market access	Limitations on national treatment	Additional commitments
II. SECTOR-SPECIFIC COMMITMENTS			
1. BUSINESS SERVICES			
A*. <u>Professional Services</u>			
a*) <u>Foreign Legal Consultants</u> (advisory services on foreign and public international law only) (CPC 861*)	1) None 2) None 3) None, other than Commercial presence must take the form of a sole proprietorship or partnership 4) Unbound except as indicated in the horizontal section, and: <u>Lawyers</u> (Prince Edward Island, Alberta, Ontario and Newfoundland): Requirement to be permanent resident for accreditation (Québec): Citizenship requirement	1) None 2) None 3) None 4) Unbound except as indicated in the horizontal section	<u>Foreign Legal Consultants</u> The right to practice without meeting normal accreditation requirements is granted temporarily in the Provinces of British Columbia, Saskatchewan and Ontario on the following basis: 1. In British Columbia and Saskatchewan the FLC must be a "member in good standing" of the legal profession in his/her home country. 2. In Saskatchewan, the FLC must have practised the law of his/her country for at least three complete years and in Ontario for at least the five preceding years.

* Asterisks designate "part of."

As can be seen, each Member's schedule of commitments is set out in four columns. These columns list, by mode of supply, from left to right: 1) the specific service sector (in most cases, the schedule is more specific in that particular activities within that sector are mentioned); 2) limitations on market access; 3) limitations on national treatment; 4) any additional commitments. Under the two limitations columns entries can express one of three things: 1) 'none,' which means that the Member has placed no limitations on either market access or national treatment (depending in which column it appears) and that service/activity is subject to the full extent of the GATS measure; 2) "unbound," which means that the Member has placed absolutely no commitments as to market access or national treatment on that service/activity and is not bound in any manner by that GATS measure (this entry has also been used to indicate the technical unfeasibility of a certain mode of service supply); 3) an entry can describe in detail those measures that are otherwise inconsistent with market access or national treatment, but the government has chosen to protect from that GATS measure.

So, listing a service activity in its schedule commits a Member to accord greater liberalizing obligations to that service activity, but subject to any limitation recorded in the schedule itself. Members are free to introduce new measures: 1) for any service activity that is not listed in its schedule; 2) for any listed service activity with respect to which no obligations are being accepted because the schedule describes the commitment as "unbound" for a particular mode of delivery; or 3) in accordance with any express limitations.

While, under the GATS, each Member must submit a schedule of commitments, the agreement creates no legal obligation to make commitments, nor does it prescribe the sectoral scope or the depth of the commitments to be made. By allowing Members to choose which sectors to liberalize and to what extent, the GATS in principle imposes no constraints on a government's ability to employ regulatory measures, such as licensing or qualification requirements or internal standards, for quality and similar reasons.

GATS Article XXI allows Members to withdraw a concession in its national schedule anytime on three months' notice. Any Member that feels that such a withdrawal may affect the benefits it receives under the GATS may request consultations with the Member modifying its schedule with a view to negotiating compensation. Compensatory adjustments are only required if specifically requested by another Member, but must be extended to all Members on an MFN basis.

The GATS' architecture thus allows Members a great deal of flexibility and authority to choose how extensive their country's coverage will be,

making it less stringent than its goods counterpart, the GATT. The end result is that the GATS has different effects on different Members. There are commitments that are universal (such as MFN, which applies to all applicable services) and other commitments that are Member-specific (as a result of a Member choosing to make a commitment in a specific sector as described in its schedule of specific commitments).

These Member-specific commitments pertain to market access and national treatment. GATS Article XVI concerns market access, ensuring that Members do not impose restrictions on: 1) the number of service suppliers; 2) the value of service transactions or assets; 3) the total number of service operations or the total quantity of service output; 4) the total number of natural persons that can be employed in a particular sector; or impose limitations on 5) types of legal entities; and 6) foreign equity participation. GATS Article XVII deals with national treatment, a principle whereby a Member must treat foreign service suppliers no less favourably than national service suppliers “in respect of all measures affecting the supply of services.” Formally identical treatment is not needed to satisfy the national treatment obligations; GATS Article XVII.3 establishes that the real test of national treatment is equality in conditions of competition, thus prohibiting both *de jure* and *de facto* discrimination.

Listed service activities are also subject to two further disciplines. The first is enhanced transparency obligations, as set out in GATS Article III. The other concerns domestic regulation, which is contained in GATS Article VI.²⁹

3. *Canada's GATS commitments pertaining to health-care services*

Canada purports to safeguard its health services through what some officials have called a “belt and suspenders” approach.³⁰ First, Canada relies on the protection of the Governmental Authority Exclusion expressed in GATS Article I.3(b). Second, in case any services are left subject to the GATS, Canada has bypassed the more stringent market access and national

29. GATS Article VI deals with domestic regulation and is one of the universal obligations found in the GATS. In general, Article VI commits Members to ensure that, where a Member has undertaken a specific commitment, all measures of general application affecting trade in services are administered in a reasonable, objective and impartial manner. In particular, Article VI.4—which applies to any sectoral commitments in a Member's schedule—establishes that measures relating to qualification requirements and procedures, technical standards and licensing requirements do not constitute unnecessary barriers to trade. This paragraph further directs the Council for Trade in Services to establish any necessary disciplines in this respect. Clarification and interpretation of Article VI.4 is a controversial area that forms a main focus of the GATS negotiations that are ongoing as part of the Doha Round negotiations.

30. J.A. VanDuzer, “Health, Education and Social Services in Canada: The Impact of the GATS” in J.M. Curtis & D. Ciuriak, eds., *Trade Policy Research 2004* (Ottawa: Minister of Public Works and Government Services Canada, 2004) 287 at 293ff.

treatment obligations by not listing health services in its national schedule of commitments. In its public pronouncements, the Canadian federal government has also consistently assured Canadians that the delivery of health services is not threatened by Canada's existing commitments under GATS.³¹ In March 2001, the Canadian government strengthened its stance on this issue by declaring that, in the ongoing GATS 2000 negotiations, it would make no offers on Canada's public health, education, social services or culture, nor would it seek further openings in these areas in the negotiations.³²

Consequently, Canada does not have many specific commitments to speak of pertaining to health care. Canada has made commitments with respect to certain services consumed by the health-care system (for example building maintenance and computer consulting, maintenance and data processing).³³ Some GATS critics, notably Matthew Sanger, feel Canada's commitments in these areas will force the privatization of these services that are utilized by the health-care system, gradually leading to the erosion of the public nature of Canada's Medicare system.³⁴ This position, which reflects a lack of understanding of how both the GATS and Medicare operate, is not supported by the vast majority of commentators. Accordingly, this viewpoint seems implausible in the extreme.

Amongst the core health-care services defined above, one of Canada's commitments—that regarding health insurance—has raised some alarm. While this commitment pertains to private health insurance, as provided by private sector companies for certain health services, some have expressed concern that the commitment will extend to public health insurance.³⁵ The merits of this claim will be examined later in the article.

The elements of Canada's schedule that likely play the largest role in Canada's commitments on health care are the two horizontal limitations that pertain in some way to health care. The first limitation states that

31. Pierre Pettigrew, former Minister for International Trade, repeatedly expressed this (see, for example, *Transparency is a Key Element in the Success of Trade Negotiations*, What the Minister Said (2002), online: DFAIT <http://webapps.dfaite-maeci.gc.ca/minpub/Publication.asp?FileSpec=/Min_Pub_Docs/105386.htm>. Similarly, this pledge can be found in descriptions of Canada's obligations on various government web sites (see, for example, *FAQ on the GATS, Public Services, Health and Education*, online: Industry Canada <http://strategies.ic.gc.ca/epic/internet/instp-pcs.nsf/vwGeneratedInterE/h_sk00151e.html>).

32. See, for example, DFAIT, News Release No. 78 (2002), "Canada Makes Public its Requests in WTO Services Negotiations" *Department of Foreign Affairs and International Trade* (8 July 2002), online: DFAIT <http://wo1.international.gc.ca/minpub/Publication.asp?publication_id=379381&Language=E>.

33. Canada, *Schedule of Specific Commitments* (15 April 1994), WTO Doc. GATS/SC/16 and Supp. 1, 2, 3 and 4.

34. Sanger, *supra* note 8 at 88-90 and 94-95.

35. *Ibid.* at 76-87.

measures related to the supply of services required to be offered to the public generally in the health sector may result in differential treatment in terms of price. This limitation applies only to national treatment obligations for modes 3 and 4 (commercial presence of foreign services suppliers and foreign services suppliers temporarily present in Canada, respectively). Thus, other WTO Members cannot complain that any such discrimination regarding the prices charged to its services suppliers in listed sectors changes the conditions of competition for them in breach of the national treatment obligation.³⁶

The second limitation pertains to national treatment in mode 3 only and reads as follows: “the supply of a service or its subsidization within the public sector is not in breach of this commitment.” Exactly what this limitation is supposed to mean is unclear. A broad and expansive interpretation suggests this provision is intended to permit Canada to adopt new programs solely supplied by the government to the exclusion of foreign services suppliers in service sectors in which Canada has made specific commitments. However, such an interpretation would seriously undermine the value of Canada’s commitments in listed sectors. A more limited interpretation is that the limitation allows Canada to supply or subsidize the supply of listed services to public sector entities. However, such an interpretation seems unnecessary given the Governmental Authority Exclusion and the fact that the GATS does not apply to government procurement. A number of interpretations in between the two offered above are also possible, but none offers a clear meaning for this limitation, ultimately leaving it open to speculation and conjecture.

II. *A mystery wrapped in an enigma: unbundling and defining GATS Article I.3*

Interpreting the Governmental Authority Exclusion in GATS Article I.3(b) and (c) requires an examination of two distinct tests: 1) the service must not be supplied on a commercial basis and 2) the service must not be supplied in competition with one or more service suppliers. Health services satisfying these two tests will fall within the Governmental Authority Exclusion and will not be subject to GATS’ provisions.

The present investigation will, of necessity, be a textual analysis of the Governmental Authority Exclusion to define the parameters of the above

36. VanDuzer, *supra* note 30 at 321.

tests³⁷ since the two main sources that would be likely to provide some guidance — previous WTO jurisprudence and treatment of similar GATT provisions³⁸ — are of no assistance. To date, only a handful of WTO dispute settlement cases have interpreted the GATS and none have dealt with the meaning of the Governmental Authority Exclusion.³⁹ Further,

37. Despite the controversy surrounding this topic, only three academics have made a similar attempt. From these three academics, there are now four publications: M. Krajewski, *Public Services and the Scope of the General Agreement on Trade in Services (GATS)* (Geneva: Center for International Environmental Law, 2001) [Krajewski 2001]; M. Krajewski, "Public Services and Trade Liberalization: Mapping the Legal Framework" (2003) 6 J. Int'l Econ. L. 341 [Krajewski 2003]; D. Luff, "Regulation of Health Services and International Trade Law" in A. Mattoo and P. Sauvé, eds., *Domestic Regulation and Service Trade Liberalization* (Washington, D.C.: World Bank and Oxford University Press, 2002) 191; and VanDuzer, *supra* note 30. Of these, the work by VanDuzer offers by far the most comprehensive and methodical examination available. There was a further treatment of this subject by the British Columbia Ministry of Employment and Investment (*GATS and Public Service Systems* (Victoria: Queen's Printer, 2001)) [*BC GATS Paper*], but even the BC government and ministry have distanced themselves from this work; thus, it is not that authoritative a source.

38. As noted by, for example, F. Weiss, 'Dispute Settlement Under the General Agreement on Trade in Services', in J. Cameron & K. Campbell, eds., *Dispute Resolution in the World Trade Organisation* (London: Cameron May, 1998) 148, the treatment of GATS provisions in dispute settlement practice has largely mirrored the treatment of similar provisions in GATT jurisprudence.

39. As of July 31, 2006, the following disputes have been brought in relation to GATS provisions: *Bananas case*, *supra* note 15; *Canada – Certain Measures Concerning Periodicals (Complaint by the United States)* (1997), WTO Doc. WT/DS31/R, WT/DS31/AB/R (Panel Report and Appellate Body Report), online: WTO <www.wto.org/english/tratop/dispu_e/dispu_status_e.htm#1996> [*Canada – Periodicals*]; *United States – The Cuban Liberty and Democratic Solidarity Act (Complaint by the European Communities)* (1996), WTO Doc. WT/DS38/6, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1996>; *Japan – Measures Affecting Distribution Services (Complaint by the United States)* (1996), WTO Doc. WT/DS45/Add.1, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1996>; *Belgium – Measures Affecting Commercial Telephone Directory Services (Complaint by the United States)* (1997), WTO Doc. WT/DS80/1, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1997>; *Canada – Measures Affecting Film Distribution Services (Complaint by the European Communities)* (1998), WTO Doc. WT/DS117/1, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1998>; *Canada – Certain Measures Affecting the Automobile Industry (Complaints by Japan and the European Communities)* (2000), WTO Doc. WT/DS139, 142/R, WT/DS 139, 142/AB/R (Panel Report and Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1998> [*Canada – Autopact*]; *Nicaragua – Measures Affecting Imports From Honduras and Colombia (Complaint by Honduras)* (2000), WTO Doc. WT/DS 201/1, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2000>; *Mexican Telecoms Case*, *supra* note 16; *Turkey – Certain Import Procedures for Fresh Fruit (Complaint by Ecuador)* (2002), WTO Doc. WT/DS237/4, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2001>; *United States – Investigation of the International Trade Commission in Softwood Lumber from Canada (Complaint by Canada)* (2004), WTO Doc. WT/DS277/R (Panel Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2003> [*US – Softwood*]; *United States – Measures Affecting the Cross-Border Supply of Gambling and Betting Services (Complaint by Antigua and Barbuda)* (2004), WTO Doc. WT/DS285/R, WT/DS285/AB/R (Panel Report and Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2003> [*US – Cross Border Gambling*]. Of these, only *EU – Bananas*, *Canada – Periodicals*, *Canada – Autopact*, *Mexican Telecoms*, *US – Softwood*, *US – Cross Border Gambling* and *China – Value-Added Tax on Integrated Circuits (Complaint by the United States)* (2004), WTO Doc. WT/DS309/1, online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2004> have resulted in final decisions as of July 26, 2005.

there is no analogous GATT provision to the Governmental Authority Exclusion.

In previous decisions, the Appellate Body has determined that the treaty interpretation rules expressed in Articles 31-33 of the *Vienna Convention* are to be used as the basic rules for interpreting WTO instruments because these rules are seen as a codification of the customary international law rules of treaty interpretation.⁴⁰ As such, the general rule of interpretation is that provisions are to be interpreted in accordance with the ordinary meaning to be given in their context in light of the object and purpose (Article 31(1)). However, if it is established that the parties so intended, a special meaning shall be given to a term (Article 31(4)). There can only be recourse to supplementary means of interpretation if interpretation according to Article 31 leaves the meaning ambiguous or obscure or leads to a result that is manifestly absurd or unreasonable (Article 32).

The context for the purpose of interpreting the GATS comprises the text, its preamble and annexes, as well as any agreement relating to the treaty that was made between all the parties in connection with the conclusion of the treaty; and any instrument that was made by one or more parties in connection with the conclusion of the treaty and accepted by the other parties as an instrument related to the treaty. In the case of the GATS, the treaty in question is the *Agreement Establishing the World Trade Organization*, of which the GATS and all the other WTO agreements (such as the GATT and TRIPS) form an integral part.⁴¹ Together with the context, the following are to be taken into account: any subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions; any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation; and any relevant rules of international law applicable in the relations between the parties (Article 31(3)). WTO Panels and the Appellate Body have applied this approach by attempting to determine

40. *Japan – Taxes on Alcoholic Beverages (Complaint by the European Communities, Canada and the United States)* (1996), WTO Doc. WT/DS8, 10/AB/R at 10ff (Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1995> [*Japan – Alcohol*] and *United States – Standards for Reformulated and Conventional Gasoline (Complaint by Venezuela)* (1996), WTO Doc. WT/DS2/AB/R at 17 (Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#1995>.

41. *United States – Transitional Safeguard Measure on Combed Cotton Yarn from Pakistan (Complaint by Pakistan)* (2001), WTO Doc. WT/DS192/AB/R (Appellate Body Report), online: WTO <www.wto.org/english/tratop_e/dispu_e/dispu_status_e.htm#2000>.

the ordinary meaning of the language used at the time that the treaty was concluded.⁴²

Some commentators have discussed the significance of statements and documents from the WTO Secretariat, the Chair of the Council on Trade in Services and other WTO organs.⁴³ These commentators feel that such statements shed light on possible meanings for ambiguous provisions, such as GATS Article I.3; statements from the WTO Secretariat and similar organs reflect the operative understanding that Members have of the agreement or provision in question, according to these commentators. However, the WTO Secretariat and related organs are not “parties” to the WTO Agreement⁴⁴; consequently, their statements are not considered subsequent practice in the application of the treaty and they are not authoritative from the point of view of a WTO dispute settlement proceeding since none of these statements reflects a subsequent agreement between the Members regarding the interpretation of the treaty or shows an intention of all the Members to give a term a special meaning at the time the GATS was entered into.

Some commentators similarly feel that a 1999 joint statement by the European Community, Hungary, Poland and the Slovak Republic⁴⁵ expressing their belief that GATS Article I.3 is “similar” to Article 55 of the European Community Treaty (a provision in the treaty establishing the European Union that creates an exception from some of the investment provisions of the treaty for “activities which in that State are connected, even occasionally, with the exercise of official authority”) will be influential in interpreting GATS Article I.3. Since Article 55 of the European Community Treaty has been interpreted so narrowly that the Court has yet to find any activity that falls under the scope of the article,⁴⁶ the Governmental Authority Exclusion will be similarly narrowly interpreted and thus offer no protection to public services.⁴⁷ However, the utility of this article to the interpretation of GATS Article I.3 seems limited since the European Court of Justice has also interpreted “services”

42. One of the identified purposes for this approach is to increase the certainty of WTO rules (M. Lennard, “Navigating by the Stars: Interpreting the WTO Agreements” (2002) 5 J. Int’l Econ. L. 17 at 34-35).

43. See, for example, Sanger, *supra* note 8 at 81-86 and Sinclair & Grieshaber-Otto, *supra* note 8 at 17-25.

44. Krajewski 2001, *supra* note 37 at 15 and VanDuzer, *supra* note 30 at 373.

45. WTO, Council for Trade in Services, *Joint Communication from the European Community, Hungary, Poland and the Slovak Republic to the Committee of Regional Trade Agreements*, WTO Doc. WT/REG50/2/Add.3. The communication is referred to by, for example, Krajewski 2001, *supra* note 37 at 9; Krajewski 2003, *supra* note 37 at 363; and Sinclair & Grieshaber-Otto, *supra* note 8 at 20.

46. Krajewski 2001, *supra* note 37 at 9 and Krajewski 2003, *supra* note 37 at 365.

47. See, for example, Sinclair & Grieshaber-Otto, *supra* note 8 at 20.

to constitute an economic activity, such that certain public services where funding comes from the public purse (such as public education and health care) are not seen as “services” and are automatically excluded from the scope of the agreement.⁴⁸ Further, it seems highly unlikely that statements such as these would be used by a dispute panel, given the desire for a predictable application of GATS Article I.3—as for all other provisions of the WTO Agreements.

Against this background, we will analyze the two above-noted tests, drawing on the previous attempts to define this provision.

1. *Commercial basis*

The meaning of the term “commercial,” as well as the broader meaning of the phrase “supplied on a commercial basis,” must be clarified in order to understand which services satisfy this element. Classifying what is meant by “commercial” generally entails recourse to a dictionary definition. Such definitions suggest that the broad meaning of “commercial” is that it pertains to commerce or trade—meaning the exchange of goods or services for money.⁴⁹ Thus, going by the broad meaning of “commercial,” a service would have to be supplied free of charge to qualify.

However, GATS Article I.3 discusses the supply of services on a commercial basis. The use of this phrase indicates that not only must the service be supplied in exchange for money or something of commercial value (in other words, supplied commercially), the service must also be supplied on a commercial basis. From a logical perspective, only services supplied on a for-profit basis (those supplied with a view to a profit) can be considered services that are supplied on a commercial basis. Indeed, the fact that most definitions of “commercial” explicitly refer to the profit motive

48. Krajewski 2003, *supra* note 37 at 362-363 & 367.

49. *The American Heritage Dictionary of the English Language*, 4th ed. s.v. “commercial” as: “(1) of or relating to commerce: *a commercial loan, a commercial attaché*...3) having profit as a chief aim: *a commercial book, not a scholarly tome*.” *The Merriam-Webster Online Dictionary* (www.m-w.com) s.v. “commercial”: “(1)a)2) of or relating to commerce <commercial regulations>...2)a) viewed with regard to profit <a commercial success>.” *The Compact Oxford English Dictionary* s.v. “commercial”: “(1) concerned with or engaged in commerce. 2) making or intended to make a profit.”

supports this contention.⁵⁰ Consequently, the mere presence of user fees or prices does not tend to indicate that services are supplied on a commercial basis. The user fees or prices will have to be intended to be sufficient to generate a profit for the services to be supplied on a commercial basis. Thus, where a service has prices that are fixed by the government, that service can be supplied on a commercial basis. The same considerations as when prices are not fixed by the government will help to determine the basis on which that service is supplied. So, whether a service is supplied on a commercial basis can be discerned from the operational machinations of, and the price charged for, the service in question, with much depending on the intricacies of each case.

The price charged for a service ranges on a continuum from providing a service for free and charging a market price.⁵¹ VanDuzer finds that, as a result of the emphasis on the profit motive, exclusively not-for-profit provision of the service is a necessary, but not sufficient, condition for finding that a service is not supplied on a commercial basis. The not-for-profit aspect may have three elements: 1) no personal benefits are derived by owners, members or others contributing resources to the services supplier; 2) the mandate of the supplier in supplying the service is not to make profits, but to serve some other purpose; and 3) the supplier carries on its activities exclusively with a view to fulfilling this mandate by supplying services at prices that will generate revenues no greater than costs.⁵²

In order to give effect to the words “in the exercise of governmental authority,” in addition to this not-for-profit mandate, a significant level of government involvement in the delivery of the service is necessary. The use of the phrases “in the exercise of” and “governmental authority” would seem to include services delivered by government (which refers to

50. Commentators having considered this issue were not unanimous on the meaning of commercial basis. VanDuzer, *supra* note 30 at 378, argues that it is implicit that services sold on a commercial basis must be sold on a for-profit basis, supporting this claim with definitions that explicitly refer to the profit motive. Krajewski 2001, *supra* note 37 at 10-12 and Krajewski 2003, *supra* note 37 at 351, does not assert a conclusion on this issue, but does explain that the price charged to the consumer must be profit-motivated. On the other hand, Luff, *supra* note 37 at 194, contends that “it would be difficult to argue that the application of a provision in an agreement could vary according to the subjective view that operators have of the purpose of their operations.” While Luff makes a seemingly sensible argument, recourse to national practices with respect to corporate and commercial law show that not only can the application of a provision vary according to the view that operators have of the purpose of their operations, it is also possible to discern this purpose from objective criteria. See, for example, the Supreme Court of Canada case of *Spire Freezers Ltd. v. Canada*, [2001] 1 S.C.R. 391.

51. Krajewski 2001, *supra* note 37 at 11.

52. VanDuzer, *supra* note 30 at 380-381.

the entire executive and administrative apparatus of the state regardless of its level or the subject matter with which it deals⁵³ or on its behalf.⁵⁴

The preparatory work of the GATS confirms that functions not performed directly by the state should be included. Both the December 1990 draft text prepared for the Brussels Ministerial Meeting⁵⁵ and the December 1991 Dunkel Draft⁵⁶ contained the words “services supplied in the exercise of government functions.” There is nothing in the public record to indicate how the language change from “government functions” to “governmental authority” came about. However, the shift to “governmental authority” seems to suggest a broader exclusion that catches services not directly provided by government.⁵⁷ This change in language, in addition to the definition of the measures to which the GATS applies contained in GATS Article I.3(a)(ii),⁵⁸ suggests the inclusion of conduct that is expressly or implicitly authorized by the constitution, a statute or some other law to be carried out by a government agency or even a private party. This can be direct provision or provision by a private entity that is highly regulated by the state in terms of decision-making, the manner of service delivery and the budget.⁵⁹

As a result of all this, it would appear that both governmental and non-governmental entities that are highly regulated in particular ways by the state can offer services on a non-commercial basis in the exercise of governmental authority. The service would have to be offered on a not-for-profit basis, with any user fees involved being either not related to costs or only intended to cover some costs. Consequently, a service provided pursuant to a universal service obligation, funded by government, that charges either no or minimal user fees that are not intended to cover all

53. D.A. Dukelow, *The Dictionary of Canadian Law*, 3d ed. (Scarborough: Thomson, 2002) s.v. “government” [*Canadian Law Dictionary*]: “government” “in its generic sense – meaning the whole of the governmental apparatus of the state; the executive and administrative branch”; *Black’s Law Dictionary*, 7th ed., s.v. “government” [*Black’s*]: “government” refers “collectively to the political organs of the country regardless of the function or level and regardless of the subject matter that they deal with.”

54. VanDuzer, *supra* note 30 at 385.

55. Krajewski 2001, *supra* note 37 at 16-17; Krajewski 2003, *supra* note 37 at 357-358.

56. J.V. Reyna, “Services,” in T.P. Stewart, ed., *The GATT Uruguay Round – A Negotiating History* (1986-1992) (Deventer and Boston: Kluwer, 1993) 2335 at 2335-61, Annex I.

57. *Black’s*, *supra* note 53, defines “government function” as: “A government agency’s conduct that is expressly or impliedly mandated or authorized by constitution, statute or other law and that is carried out for the benefit of the general public” (also termed ‘governmental act’ or ‘governmental activity’). By changing to “governmental authority,” it would seem to include conduct done by non-governmental agencies given authorization by government to perform these duties.

58. “Measures” include “measures taken by ... non-governmental bodies in the exercise of powers delegated by central, regional or local governments or authorities.”

59. VanDuzer, *supra* note 30 at 385-386.

the costs of the service would appear to be a service that is offered on a non-commercial basis.

2. *Not in competition*

In order to establish what is meant by the term “in competition with one or more service suppliers” in the Governmental Authority Exclusion, two questions arise: 1) what factors must be present for there to be competition; and 2) competition between whom?

The answer to the former question appears clear. Commentators considering this issue generally agree that rivalry and substitution are the relevant competitive factors.⁶⁰ Substitution, from the consumer’s point of view, is necessary for there to be rivalry.⁶¹ Substitution is determined from the consumer’s perspective, while rivalry is determined from the suppliers’ perspective.

Establishing when there is substitutability, and thus rivalry, with respect to services presents greater difficulties. One method to determine this would be to consider whether the services are “like services.” Determining if there has been discrimination in the context of national treatment and MFN obligations turns on whether the foreign services allegedly discriminated against are “like” the domestic services benefiting from the alleged discrimination.⁶² Previous jurisprudence has indicated

60. Luff, *supra* note 37 at 195 feels that the sole factor determining competition is the presence of some financial rivalry—regardless of who is the ultimate payer. On the other hand, Krajewski 2001, *supra* note 37 at 12 and Krajewski 2003, *supra* note 37 at 352-353 finds that service suppliers are only in competition with one another when one supplier’s services are a substitute for another supplier’s services. Meanwhile, VanDuzer, *supra* note 30 at 389 contends that both rivalry and substitution are necessary components.

61. VanDuzer, *ibid.* In competition law, demand substitution is a common method employed by national authorities to determine the relevant market and assess the level of competition between two actors. See, for example, Competition Bureau Canada, *Merger Enforcement Guidelines* (2004) and European Union, Competition Directorate, *Guidelines on the Assessment of Horizontal Mergers* (2004). Demand substitution has also been employed by the WTO dispute settlement body as the appropriate way to determine the relevant market and thus assess whether there is competition between two entities (see *Mexican Telecoms Case*, *supra* note 17 at paras. 7.149-7.152).

62. This concept is well developed in GATT jurisprudence. As indicated in footnote 37, GATS jurisprudence has tended to mirror GATT jurisprudence with respect to similar provisions. Accordingly, it seems highly likely that the interpretation of like services will be similar to the interpretation of like goods (see also Gaëtan Verhoosel, *National Treatment and WTO Dispute Settlement: Adjudicating the Boundaries of Regulatory Autonomy* (Oxford: Hart, 2002) at 33-34).

that the test in such instances is the equality of competitive opportunities for suppliers.⁶³

The body of cases, under both GATT and the WTO, examining the concept of likeness of goods has made clear that, while likeness is to be examined on a case-by-case basis, four factors will help to determine its presence:

- 1) the products' end-uses in a given market;
- 2) consumers' tastes and habits, which vary from country to country;
- 3) the properties of the product, including their nature and quality; and
- 4) the product's tariff classification.⁶⁴

Unfortunately, the GATT *Services Sectoral Classification List* is not nearly precise enough for a "like" services analysis to be able to consider the fourth factor. The other three, however, can be translated into comparisons of services. Consequently, services may be considered to compete with each other where they have the same end uses, are comparable in their nature and quality and are considered substitutes by consumers. While these factors present the parameters within which an arbiter can determine "likeness," the Appellate Body has noted that there will always be an unavoidable element of "individual, discretionary judgment" involved;

63. In *European Communities – Measures Affecting Asbestos and Products Containing Asbestos (Complaint by Canada)* (2001) WT/DS135/AB/R at paras. 99 and 103 (Appellate Body Report) online: WTO <http://www.wto.org/english/tratop-eldispu_e/dispu_status_e.htm#2000>. [EU – Asbestos], the consideration of likeness for the purposes of the national treatment obligation in the GATT was described as "fundamentally a determination about the nature and the extent of the competitive relationship between and among products." See also *United States – Section 337 of the Tariff Act of 1930 (Complaint by EC)* (1989) L/6439, 36th Supp. B.I.S.D. 345. While it is not readily apparent that it is proper to import the concept of like services into an interpretation of the notion of competition in GATS Article I.3(c), this approach has been adopted by most who have considered the issue. For example, a background note on health services prepared by the WTO Secretariat suggests that this is the proper approach to take (WTO, Council for Trade in Services, *Health and Social Services: Background Note by the Secretariat*, 1998 (S/C/W/50) at 11). See also J.P. Trachtman, 'Lessons from the GATS for Existing Rules on Domestic Regulation' in A. Mattoo & P. Sauvé, eds., *Domestic Regulation and Services Trade* (2003) 61 and VanDuzer, *supra* note 30 at 390.

64. These criteria were originally suggested in GATT Secretariat, *Report of the Working Party on Border Tax Adjustments*, GATT Doc. L/3464, BISD 18S/97 (1970) at para. 18. *Japan – Alcohol*, *supra* note 40 at 19-21 noted that this approach was followed in almost all adopted GATT panel reports that considered GATT Article III.2 following the publication of this report. Following the AB's decision in *EU – Asbestos*, *ibid.*, it appears that an even broader approach may now be taken in determining whether goods are 'like.' This case confirmed the four relevant factors to consider, but noted that the health risk associated with a product might be relevant in deciding that it is not 'like' a product that poses lower health risks. Critically, health risks were not seen to be a new factor; rather, such concerns form part of the assessment of a product's physical properties and consumer preferences (para. 113). So, a comparison of services for 'likeness' should take into account all aspects in assessing whether competition is present.

thus, “it is a discretionary decision that must be made in considering the various characteristics of products in individual cases.”⁶⁵ In making this determination, the nature of the production process, as confirmed in GATS jurisprudence with regard to the MFN obligation,⁶⁶ is not a basis for finding that the services or the suppliers of the service are not alike.

However, even assuming an assessment of “likeness” can be made, the unique nature of services adds a further wrinkle that can make such an evaluation less useful. Services that are not “like” each other—as in the case of using prescription drugs or surgery to treat the same medical ailment—may still be in competition with one another. Consequently, substitutability is likely the most telling factor.⁶⁷

As for the latter question of who must be competing, the wording of the provision would seem to suggest a particular meaning is intended. Whether private sector suppliers compete for consumers with the governmental service supplier is not relevant; the governmental service supplier must operate so as to compete with the private sector providers to fall outside the Governmental Authority Exclusion (and thus within the scope of the GATS). Thus, where the government service is provided pursuant to a universal service obligation on a non-profit basis, there would be no competition with private suppliers of the same or similar services.⁶⁸

It should be noted it is not axiomatic that this one-way conception of the meaning of competition will be adopted by a dispute settlement proceeding. The Governmental Authority Exclusion’s language is sufficiently imprecise to plausibly yield an interpretation of competition that refers to any situation where private suppliers are competing with the governmental service supplier. Even so, the text’s ordinary meaning would seem to support the one-way interpretation.⁶⁹

65. *Japan – Alcohol*, *supra* note 40 at 20-21.

66. *Bananas Case*, *supra* note 16. In this instance, the services were differentiated only by the national origin of the good to which these services were applied.

67. *VanDuzer*, *supra* note 30 at 393-394.

68. *Ibid.* at 394-395. Krajewski 2001, *supra* note 37 at 12-13 agrees with this formulation, although not as strongly as VanDuzer. Luff, *supra* note 37 at 195, asserts that “to the extent services supplied by the government are not competing with services supplied under certain competitive conditions, they could be excluded from the scope of GATS.” However, he feels this is wrongly phrased and that the only question to be asked concerning the criterion of competition is whether there is some financial rivalry among suppliers of the service concerned in the country, no matter how intense the competition or how imperfect the conditions of competition prevailing for that service.

69. David Hartridge, former head of the Services Branch of the WTO Secretariat, endorsed the one-way interpretation of the ‘not in competition’ requirement in a letter to Mike Waghorne of Public Services International, cited in *VanDuzer*, *supra* note 30 at 395ff.

3. *Definitions in the financial services annex*

The Annex on Financial Services, being an integral part of the GATS, provides additional provisions that must be taken into account in the area of financial services. One of these provisions provides a further meaning for the Governmental Authority Exclusion. In the context of the Financial Services Annex, the exclusion is limited to activities undertaken by public entities and only to the subset of these activities that are for the account of government or using the financial resources of government. Private entities exercising powers delegated by the state would seem to be outside the exclusion, regardless of their means of financing.

Perhaps the most significant part of the Annex on Financial Service's definition of the Governmental Authority Exclusion (contained in Article I(b), (c) and (d) of the Annex) is that it nullifies the two requirements in GATS Article I.3(c). So long as the activity is undertaken by a public entity, it does not matter if the services are provided on a commercial basis or in competition with one or more service suppliers. However, the Annex's exclusion does not apply where a country permits financial service suppliers to conduct any otherwise excluded activities in competition with the public entity. Thus, the Annex's examination of competition is different than the one found in GATS Article I.3. In the Annex on Financial Services, it is irrelevant whether the entity exercising governmental authority competes; the only issue is whether private service suppliers are permitted to compete.⁷⁰

However, most commentators feel that the direct delivery of health services cannot be considered to be financial services. In their opinions, the Annex provides no interpretative assistance with respect to understanding the scope of the Governmental Authority Exclusion as it pertains to national health-care systems.⁷¹ As physician and hospital services are clearly not financial services (indeed, such services are listed in sectors separate from financial services in the *GATT Services Sectoral Classification List*), the delivery of such services will not come within the purview of the definitions found in the Annex on Financial Services. However, the definitions in the Financial Services Annex could have an impact on the funding of health services because the Annex applies to all "measures affecting the supply of financial services."⁷² As will be discussed later, though, this point is moot,

70. VanDuzer, *ibid.* at 403-404 notes, by reference to the fact that the definition of 'financial services supplier' found in the Annex excludes public entities, the exclusion will still pertain if other public sector suppliers were permitted to compete.

71. See, for example, Krajewski 2001, *supra* note 37 at 13-14; Luff, *supra* note 37 at 18 and BC GATS Paper, *supra* note 37 at 41.

72. VanDuzer, *supra* note 30 at 401-402.

as the funding of health services is exempt from GATS' scope regardless of which meaning for the Governmental Authority Exclusion one uses.

4. *Preamble*

Many commentators place a great deal of importance in the GATS preamble. They claim that its explicit recognition of the "right of Members to regulate, and to introduce new regulations" and the need to give "respect to national policy objectives"⁷³ assures that the adjudicators in a dispute settlement proceeding will defer to a Member's decision to adopt health-care measures that advance national policy objectives.⁷⁴ However, these commentators seem to overlook the fact that the preamble also calls for "progressively higher levels of liberalization of trade in services" just before the aforementioned passages. As such, the effect of the preamble is essentially ambiguous. Adjudicators attempting to discern the context of the GATS, by way of reference to its preamble, should give equal weight to regulations that meet national policy objectives and to measures that achieve greater liberalization. Further, the preamble is only a part of the context that serves to clarify how an agreement's substantive provisions are to be interpreted. The preamble has little intrinsic value and pales in comparison to the provisions of the agreement itself. As such, it seems unlikely to have as large an impact as these commentators suggest.

5. *Summary*

Services delivered in the exercise of governmental authority can be supplied by both public and private entities, so long as the entity is exercising the authority of government in supplying the service, meaning that there is substantial government authorization and regulation in terms of the decision-making, service delivery and the budget. As well, these services would be supplied on a non-profit basis, charging consumers either no fees or fees that are not intended to cover any or all costs. Finally, these services will be offered under a universal service obligation (*i.e.*, where the service is available to all those who are resident in a specific area, without being dependent on ability to pay or meeting other criteria), or operate under a regulatory regime that does not permit other service suppliers to supply services that are "like" the services offered by the governmental supplier (in other words, they do not have the same end uses, are not comparable in their nature and quality and they are not considered substitutes by consumers), or if like service suppliers are allowed to participate in the

73. GATS, *supra* note 7 at preamble.

74. See, for example, M. Hart, *GATS 2000 and Rules Governing Domestic Regulation: GATS Article VI:4 in Context* (Ottawa: Industry Canada, 2002) and WTO Secretariat, *GATS: Fact and Fiction* (Geneva: WTO, 2001).

market, then the governmental supplier does not compete with the private suppliers.

III. *This won't hurt a bit: the likely impact of the GATS on medicare*

Within Canada's written constitution, responsibility for health care is shared between the federal and provincial governments. By virtue of section 91 of the *Constitution Act, 1982*, the federal government has the ability to set national health standards. In addition, the federal government has the responsibility to provide direct health services to specific groups, such as veterans, Aboriginal peoples living on reserves, military personnel, the RCMP and inmates of federal prisons. On the other hand, section 92 puts the administration and delivery of health care services for all other citizens and legal residents within the purview of each individual province or territory. Consequently, the federal government has laid out uniform principles and requirements for the publicly-funded health system, but the exact system in operation varies from province to province (and territory to territory).

Our national system of health-care was kick-started by a 1947 decision by Saskatchewan's government to pay for hospital services within the province through a public insurance plan. Shortly thereafter, the federal government sought to emulate this initiative across the country; by 1961, all of the provinces and territories had signed agreements for federal cost-sharing for at least in-hospital patient care.⁷⁵ The current state of Medicare is informed by the *Canada Health Act*,⁷⁶ which establishes the framework within which Medicare operates—a universal insurance plan that provides to all Canadians first-dollar coverage for medically necessary services delivered by hospitals and doctors, with the twin objectives of ensuring that Canadians are publicly insured and have timely access to medically necessary hospital and doctor services of high quality.⁷⁷ Essentially, “the pursuit of the objective of the Canadian health care policy involves a ‘contract’ between Canadians and their governments—federal, provincial and territorial”⁷⁸—that involves the payment of taxes with the understanding that part of these taxes will be used to fund the health-care system and thus assure them of health-care coverage.

The *CHA* sets out the principles upon which the Canadian health care system is based and the guidelines under which it should be administered,

75. Health Canada, *Health Care System at a Glance*, on-line: Health Canada <www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2002/2002_care-soinsbk5_e.html> [*Health System Glance*].

76. R.S.C. 1985, c. C-6 [CHA].

77. Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role. Volume Six: Recommendations for Reform* (Ottawa: Senate of Canada, 2002) at 8 [*The Kirby Report*].

78. *Ibid.* at 8.

ensuring that all eligible residents of Canada have reasonable access to insured medical services⁷⁹ on a prepaid basis, without direct charges at the point of service for such services.⁸⁰ The primary method through which the federal government funds health-care is the Canada Health and Social Transfer (CHST)—sixty-two per cent of which is notionally attributed to health care, according to Finance Canada's estimation.⁸¹ In order to receive the full cash contribution available through the CHST, the provinces and territories must meet nine separate requirements, as outlined in the *CHA*.

There are five program criteria outlined in the *CHA* that serve as the principles upon which Canadian universal health-care coverage is based:

- **Public administration** is the overarching principle of Canada's health system. The intent of this criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.⁸² While this criterion refers simply to the funding of hospital and doctor services, the principle has been misunderstood to concern the delivery of those services.⁸³ In effect, this criterion establishes an exclusive duty in each province to pay for all insured health services delivered within the province.
- **Comprehensiveness** requires that provincial or territorial health insurance plans insure all medically necessary hospital and doctor services. As these terms are defined somewhat loosely, provinces have some flexibility over which services they insure. Consequently, the health services that are insured are not uniform across provinces. Six provinces, such as Ontario and Alberta, have legislation preventing private insurers from insuring services insured under the *CHA*.⁸⁴ In light of a recent Supreme Court decision, such legislation is likely to be struck down as being unconstitutional and thus will be of no force or effect.⁸⁵ As will

79. Defined in s. 2 of the *CHA* as: medically necessary hospital services; medically required physician services; and surgical-dental services required to be performed at a hospital.

80. Health Canada, *Canada Health Act—Overview* (Ottawa: Health Canada, 2003) at 1, online: Health Canada <[www.http/hc.sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html](http://hc.sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html)> [*CHA Overview*].

81. *The Kirby Report*, *supra* note 77 at 291.

82. *CHA Overview*, *supra* note 80 at 3.

83. *The Kirby Report*, *supra* note 77 at 7.

84. *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20, s. 26; *Health Insurance Act*, R.S.O. 1990, c. H.6, s. 14.

85. *Chaoulli v. Quebec (Attorney General)*, [2005] 2005 S.C.C. 35.

be discussed later, though, this recent development is unlikely to greatly affect GATS' impact on Medicare. In any case, the mere fact that insured services are paid for by a public authority means that private insurance companies cannot feasibly enter the market in all provinces.

- **Universality** ensures that all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. The *CHA* allows provinces or territories to require certain residency requirements or waiting periods before a resident can become insured, but these residency requirements or waiting periods cannot exceed three months.
- **Portability** ensures that all insured residents are covered under public health care insurance when they travel within Canada or move from one province to another. Should the resident move from one province to another, the original province must continue to cover the resident during any waiting periods in the new province. This provision covers Canadians who require services on an urgent basis while travelling within Canada, but does not allow residents to seek services in another province.
- **Accessibility** ensures that there are no financial barriers to the provision of publicly funded health services, such as in the form of user charges, so that needed care is available to all insured residents regardless of their income. Further legal interpretation of reasonable access has developed a "where and as available" rule. As a result of this interpretation, insured residents are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting.⁸⁶ Payment for services must be in accordance with an approved tariff set under a provincial plan or through some other system providing reasonable compensation to medical practitioners. Sections 12, 18 and 19 of the *CHA* specifically prohibit the imposition of user fees and extra-billing for *CHA* insured services. Fees charged, or

86. *CHA Overview*, *supra* note 80 at 5.

billing, in excess of the tariff set in each province results in a dollar for dollar reduction in federal transfers to that province.⁸⁷

There is only one source of funding for health care in Canada, whether public or private—the Canadian public.⁸⁸ For those services covered by Medicare (medically necessary doctor and hospital services), the Canadian public pays money to the government, which then uses this money to fund Medicare. Both the federal and provincial governments pay for insured services under the *CHA*. For all other health services (pharmaceuticals, dentistry, private long-term care, private rooms in hospitals, etc.), Canadians either pay directly out-of-pocket for these services or have private health insurance. In 2002, the most recent year for which statistics are available, about 12.6 per cent of total expenditures on health were paid for by private insurers.⁸⁹ In 2003, foreign insurers comprised approximately eleven to twenty-five per cent of the Canadian private insurance market.⁹⁰

While health-care in Canada is primarily financed through taxation, this is not the sole source of funding in some provinces. In addition to provincial and federal personal and corporate income taxes, some provinces use ancillary funding methods—such as sales taxes, payroll levies and lottery proceeds—that are nominally targeted for health care. Further, three provinces (Alberta, British Columbia and Ontario) utilize health care premiums. To keep these provincial health plans in accordance with the *CHA*, the premiums charged are not rated by risk and prior payment of a premium is not a pre-condition for receiving treatment.⁹¹

Within the last few years, the federal government has announced major spending initiatives targeted at health care. Budget 1999 allocated an additional \$11.5 billion over the period from 1999-2000 to 2003-2004. Budget 2000 and Budget 2001 saw further spending announcements targeted at health care; finally, a new provincial-federal agreement was reached in 2003. Most of these announcements have entailed additional allocations of money to the provinces to target specific programs or upgrade equipment. In 2000 and 2001, the federal government earmarked

87. *CHA*, ss. 14, 15 and 20. Between 1995 and 2001, approximately \$6 million was withheld from four provinces in which patients were extra-billed for insured services (C.M. Flood, "The Anatomy of Medicare" in J. Downie, T. Caulfield & C.M. Flood, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 2002) 1 at 30).

88. *CHA Overview*, *supra* note 80 at 9.

89. World Health Organization, WHOSIS query service, *Core Health Indicators: Canada*, online: WHO <www3.who.int/whosis/country/indicators.cfm?country=can> [*Health Indicators – Canada*].

90. Canadian Life and Health Insurance Information Association, *Canadian Life and Health Insurance Facts – 2004 Edition* (Toronto: Canadian Life and Health Insurance Information Association, 2004) at 25.

91. *Health System Glance*, *supra* note 75 at 4.

nearly \$600 million to establish and support health information systems, health-related research and technology, and information technology, such as electronic patient records.⁹²

At the primary care level, the vast majority of services are provided by physicians in private practice who operate so as to make a profit from their work. The vast majority of primary care practices are owned and managed by the physicians themselves, with "fee-for-service (FFS) payment [a]s the dominant form of physician remuneration."⁹³ Even so, twenty per cent of physicians in 1999-2000 received some payments other than on a FFS basis, such as a salary.⁹⁴ Competency standards for physician services are established and enforced by self-regulating organizations in each province and territory. Some provinces have even tried to put in place some restrictions on the number and location of physicians in the interests of controlling costs and ensuring that individuals in all parts of a province or territory have access to a physician.

The delivery of home care is different in every province and territory. Delivery runs the gamut from being provided directly by government employees in Saskatchewan and Manitoba to being supplied by for-profit and not-for-profit agencies that win the contracts through competitive tenders in Ontario (for most home-care services) and Alberta (for non-professional home-care services). On the other hand, home-care services in Quebec are provided in a partnership between the government and not-for-profit private providers. At least seven provinces provide funding, either directly or through service vouchers, to eligible disabled adults to hire their own home-care providers.⁹⁵

At the secondary level of care, most Canadian hospitals are not-for-profit entities incorporated under provincial or territorial legislation, but fully five per cent of Canadian hospitals are private for-profit institutions.⁹⁶ Most Canadian hospitals, whether for-profit or not-for-profit, are not governmental institutions. Their letters patent or articles of incorporation set out their objectives and establish whether or not they are profit-seeking.

92. *Ibid.* at 5.

93. *The Kirby Report*, *supra* note 77 at 77.

94. Canadian Institute for Health Information, *Canada's Health Care Providers* (Ottawa: CIHI, 2002) at 74, online: CIHI <www.cihi.ca> [*Canada's Health Care Providers*]. The proportion of physicians receiving payments other than on a FFS basis varies from 2% in Alberta to 40% in Manitoba (*CIHI, Health Care in Canada 2002* (Ottawa: CIHI, 2002) at 33, online: CIHI <www.cihi.ca>).

95. *Romanow Report*, *supra* note 6 at 173-175; Canadian Centre for Policy Alternatives, "Globalization and Health: Implications and Options for Health Care Reform: Report prepared by the CCPA Consortium on Globalization and Health for the Commission on the Future of Health Care in Canada" (Ottawa: CCPA, 2002) at 28 [*CCPA Report on Health*].

96. *The Kirby Report*, *supra* note 77 at 25.

Each province and territory has framework legislation in place for hospitals⁹⁷ and the government is extensively involved in their operation.⁹⁸ All hospitals, not-for-profit and for-profit, must be licensed to operate and may be ordered by the responsible minister to offer or to cease offering specific services or even to cease operations altogether. Typically, any change to their operations or facilities must be approved by the responsible minister.

Provincial governments directly finance the operations of Canadian hospitals (sometimes through a designated regional agency). The method through which hospital budgets are calculated from year to year varies from province to province. Line-by-line budgeting used to be the most popular method of hospital financing in Canada, but only two provinces (British Columbia and New Brunswick) currently use this approach as their primary means of hospital financing. Presently, a ministerial discretion method of financing⁹⁹ is the most often used primary source of hospital funding, with population-based funding and global budgets being the other primary methods utilized.¹⁰⁰ In some provinces, hospitals must raise some funds for capital expenditures from their communities.¹⁰¹

Traditionally, volunteer boards of directors have run hospitals with community and, sometimes, staff representatives. Recently, in all provinces save Ontario, many of the administrative responsibilities of hospitals have been transferred to regional health authorities that administer a number of hospitals.¹⁰² Most regional health authorities are appointed by government, though there have been recent initiatives in some provinces to allow some boards to be elected by the public.

Most of the health-care professionals who work in these hospitals, or in other private businesses operating on a for-profit or not-for-profit basis, are salaried employees. For example, most nurses are salaried employees, with approximately sixty-four per cent of them working in hospitals.¹⁰³ Still other health-care professionals are self-employed. Likely all of these businesses and practitioners seek to service the same pool of people, with more patients for one meaning less—and likely less money—for others (assuming a finite market). At the very least, the for-profit private

97. For example, Ontario's *Public Hospitals Act*, R.S.O. 1990, c. P.40; Nova Scotia's *Hospitals Act*, R.S.N.S. 1989, c. 208; and British Columbia's *Hospital Act*, R.S.B.C. 1996, c. 200.

98. Flood, *supra* note 87 at 40 states that provincial governments are so heavily involved in Canadian hospitals that they "look and act like government owned hospitals."

99. In this method of financing, funding is based on decisions made by the provincial minister of health in response to specific requests by the hospital concerned.

100. *The Kirby Report*, *supra* note 77 at 27-33.

101. Deber, *supra* note 15 at 30.

102. For example, Alberta's *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, s. 2.

103. Flood, *supra* note 87 at 39.

businesses and self-employed professionals can be characterized in this way.

All health-care professionals are subject to some form of regulation. Some categories of health-care professionals, such as nurses, are regulated in all provinces and territories. Other categories of health-care professionals are only regulated in some provinces, such as massage therapists in B.C.¹⁰⁴ Health-care professionals require either a license to practice their profession or a certificate to allow them to use a particular title. Obtaining and keeping a license depends on the professional meeting certain ethical and professional standards, while certificates can only be obtained if an individual meets certain requirements. Provincial and territorial requirements as to which professionals require licenses and/or certificates and the standards they must meet vary. Professional standards for many professionals are set by self-regulating organizations.¹⁰⁵

Finally, there are nursing homes and homes for the aged, which offer a mix of services that includes health services supplied by health professionals. Most nursing homes in Canada are run by large firms seeking to maximize their returns and are subject to a licensing regime,¹⁰⁶ while the responsible provincial ministry sets standards for admission, care and facilities. Homes for the aged, on the other hand, may be run by for-profit private businesses, by non-profit corporations or by municipalities. Some provinces have licensing requirements for homes for the aged, but this is not the case in all provinces.¹⁰⁷

Private health services entail all those health services supplementary to medically necessary hospital and doctor services (*i.e.*, dental care, optometry and prescription drugs). Such services must be privately financed. In 2002, private expenditures on health accounted for 30.1 per cent of total expenditure on health, with pre-paid insurance plans accounting for 42.1 per cent of these private expenditures on health.¹⁰⁸ There are some provincial programs to cover some of the medically-related expenses incurred by individuals. However, financial assistance is restricted under most of these programs to particular groups, such as seniors, the disabled and welfare

104. Canada's Health Care Providers, *supra* note 94 at 23.

105. L. McNamara, E. Nelson and B. Windwick, "Regulation of Health Care Professionals" in J. Downie, T. Caulfield & C.M. Flood, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 2002) 55 at 60-80.

106. For example, Ontario's *Nursing Homes Act*, R.S.O. 1990, c. N.7; British Columbia's *Hospital Act*, R.S.B.C. 1996, c. 200; and Alberta's *Nursing Homes Act*, R.S.A. 2000, c. N.7.

107. For example, neither Ontario nor Nova Scotia require licenses, while British Columbia has extensive regulation (see *Community Care Facility Act*, R.S.B.C. 1996, c. 60 and *Adult Care Regulations*, B.C. Reg. 536/80).

108. *Health Indicators – Canada*, *supra* note 89.

recipients.¹⁰⁹ These provincial supplementary benefits programs fund the same services as are covered by private insurers, thus offering duplicative coverage in the supplementary benefits market.¹¹⁰

1. *Application of the governmental authority exclusion*¹¹¹

Thorough consideration of the impact of the definitions found in the Annex on Financial Services on Medicare is beyond this article's scope. Even so, these definitions should not affect the paper's conclusion. First, Medicare should not be considered as an insurance service. While Medicare is often described as an insurance scheme, this phrasing is more accurately seen as a metaphorical tool used to help the public comprehend the nature of the program, rather than as a definitional or descriptive phrase. Unlike other insurance schemes, coverage is based on residency, not one's risk factors; further, payments by citizens are based on their level of earning (through the various tax brackets), rather than based on health risk factors.¹¹² Second, as discussed above, the definitions in the Annex on Financial Services have no bearing on the delivery of health services. Potentially, the funding mechanisms for Medicare could be considered as affecting the supply of financial services, thus bringing it within the scope of the Annex. Even if this were to be the case, the service of providing the funds for health services provided within the health-care system will be excluded from GATS' scope regardless of which set of definitions for the Governmental Authority Exclusion are employed.

a. *Medicare (its overall architecture)*

Medicare should not be subject to the GATS.¹¹³ According to the criteria established in GATS Article I.3, Medicare is not provided on a commercial basis or in competition with one or more service suppliers. As stated

109. *Health System Glance*, *supra* note 75, at 3.

110. Flood, *supra* note 87 at 33.

111. It should be stressed that the findings of this paper are not necessarily applicable to all public service regimes in all countries, or even to all national health-care systems. Analysis should be done on a case-by-case basis due to the divergent service structures across countries and the varying GATS commitments each country has made in their schedules. To determine whether a given public service comes within the Governmental Authority Exclusion, each should be investigated and evaluated separately.

112. VanDuzer, *supra* note 30 at 399-401, the only commentator to extensively explore this issue, concurs with this assessment.

113. The conclusion that provincial health insurance plans, as they currently operate, are excluded from the application of GATS under Article I.3(b) is shared by J.R. Johnson, *How Will International Trade Agreements Affect Canadian Health Care Discussion Paper No. 22* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 18; Sanger, *supra* note 7 at 76-81 (with some reservations) and *CCPA Report on Health*, *supra* note 95. The conclusion that the Medicare system is excluded from the application of the GATS under the definitions contained in the Annex on Financial Services is advanced by VanDuzer, *supra* note 30 at 408-410. *The Romanow Report*, *supra* note 6 at 237, concludes that there is a 'strong consensus' that the existing system cannot be challenged.

above, Medicare operates under a statutory regime created by the *Canada Health Act* and is administered publicly through provincial programs and agencies. The system is operated on a non-commercial basis because there is no intention to profit or recover costs from consumers. User fees are only levied in two provinces. Where user fees are charged, they are meant to prevent abuse of the system rather than to produce profits; further, payment is not a condition of treatment.

Finally, Medicare does not compete with private suppliers. There are private suppliers of health insurance in Canada, but they primarily fund services that are not covered by the *Canada Health Act*.¹¹⁴ This state of affairs could change, though, in light of the recent Supreme Court decision in *Chaoulli v. Quebec*.¹¹⁵ In this decision, the Court ruled 4-3 that legislating a ban on allowing private insurance to pay for health services covered under the provincial plan violated Quebec's *Charter of Rights*. However, the Court split 3-3 on whether such a policy violates the *Canadian Charter of Rights and Freedoms*, so there is no immediate impact on the Canadian health-care system as a whole. Consequently, there is a strong possibility that provinces, such as Ontario, that currently have legislation in place banning private insurance from paying for services covered under the provincial health-care plan will have to lift these bans.

Even with such a development, it would be difficult to say that Medicare is in competition with one or more of the private insurance suppliers. First, the Supreme Court's decision will not lead to the development of a private health market in Canada, as one which was not in competition with Medicare already existed well before the decision. There are private clinics that offer services that are scarce in the public system, such as MRI scans, to those who can afford the service, those patients covered by employer-funded workers' compensation plans,¹¹⁶ as well as the police and the army (when they are seeking speedier treatment).¹¹⁷ In fact, almost a third of the \$130 billion spent on health in Canada last year was paid for out of private pockets.¹¹⁸

Second, there are other impediments in place to private health insurance being a true competitor to Medicare. Private medical insurance is limited even in the four provinces that lacked a Quebec-style ban on private health

114. While this assessment is being challenged in certain quarters, the vast majority of opinion supports that the overall architecture of Medicare satisfies the tests articulated in the Governmental Authority Exclusion.

115. *Supra* note 85.

116. Private concerns, *supra* note 2 at 51.

117. Fistfuls of Health Dollars, *supra* note 3 at 45.

118. Private Concerns, *supra* note 2 at 51. While this figure is indicative of the presence of a private health services market, it overstates the matter, since it likely includes private payment for services, such as prescription drugs and home care, that are not covered under Medicare in the first place.

insurance.¹¹⁹ As such, it seems unlikely that the *Chaoulli* decision will lead to rampant private insurance in the other six provinces. Further, Ontario, for example, bans doctors from charging private patients more than the publicly funded fee for the same service. Such a ban should be protected by the horizontal commitment in Canada's GATS schedule discussed earlier whereby measures related to the supply of services required to be offered to the public generally in the health sector may result in differential treatment in terms of price. Ontario's price limitation on private services lessens the appeal of private medicine for practitioners,¹²⁰ which will act as a limitation on the availability of supply of private health services.

Private health services are also unlikely to compete with Medicare because they will not be able to offer the same scope of services. While primary level care, as well as diagnostics and testing, are available privately, private services at the secondary level of care are almost non-existent. Further, the provincial government decides whether hospitals, both public and private, can operate within their jurisdiction. Thus, government can regulate the extent to which private secondary health services are available.

Finally, private health insurance, even if allowed unfettered throughout Canada, does not compete with Medicare since all Canadians must subscribe to Medicare and are entitled to treatment within that system by virtue of their residency (since it is a universal service obligation). Even those who choose to obtain private health insurance are unlikely completely to forego treatment in the public system; instead, they will likely use the private system when the same quality of services cannot be obtained in the same amount of time, which reflects that Medicare and private health insurance are likely to be complements rather than substitutes.

b. *Hospitals*

Hospital services appear to be excluded from the scope of the GATS since they fulfill all of the Governmental Authority Exclusion's requirements. Hospitals are subject to state-set pricing; their management is accountable to government; their budgets require government approval and government may determine what services they offer.¹²¹ In most provinces, administrative responsibilities of hospitals are being transferred to government-run regional health authorities. Hospitals are under so much government control that one commentator has concluded that they "look and act like

119. *Ibid.* at 51.

120. *Ibid.* at 51.

121. See, for example, *Public Hospitals Act*, R.S.O. 1990, c. P.40 and *Hospital Act*, R.S.B.C. 1996, c. 200.

government owned hospitals”¹²²; even the Supreme Court of Canada has found that their actions are “governmental” in nature for the purposes of the *Charter of Rights and Freedoms*.¹²³

On balance, hospitals cannot be considered to operate on a commercial basis.¹²⁴ Almost all hospitals are non-profit institutions and they do not sell their services to patients. Billings to provincial health plans for services by staff and use of facilities are at prices fixed under provincial tariffs that are only meant to cover expenses, not to create profits.¹²⁵ Most other expenses are funded by the provinces on the basis of budgets approved by provincial authorities. On the other hand, those hospitals that operate on a for-profit basis would be operating on a commercial basis and thus be subject to GATS’ provisions.

Public hospitals do compete with one another for budgets and power. An example of this form of competition would be the recent dispute between the Hospital for Sick Children in Toronto (Sick Kids) and the Children’s Hospital of Eastern Ontario in Ottawa (CHEO) for the exclusive right to provide children’s cardiac surgery. Despite the presence of such competition, public hospitals likely are not seen as substitutes by the public and thus do not fulfill the competition requirements from a consumer’s perspective. While Sick Kids and CHEO fought for the ability to provide a particular service, only one hospital will perform children’s cardiac surgery. So, even for young patients seeking cardiac surgery in Ontario, these two hospitals are not competitors.

Supplementary hospital services beyond those insured under the *Canada Health Act* for which the patient pays directly, such as private rooms, would not fall under the Governmental Authority Exclusion. Many of these services are offered at prices that are intended to recover, at a minimum, all costs associated with the service; hospitals often seek to generate a surplus from such services. Such services would be offered on a commercial basis and thus not within the Governmental Authority Exclusion.

The above analysis pertains to public hospitals. The situation with respect to private hospitals, such as Toronto’s Shouldice Clinic for hernia operations, would be different. It is difficult fully to assess if competition will be found between these private hospitals and public hospitals. The one-way conception of competition offered earlier would seem to protect

122. Flood, *supra* note 87, at 40.

123. *Eldridge v. British Columbia*, [1997] 151 D.L.R. (4th) 577 (S.C.C.).

124. Sanger, *supra* note 8 at 93.

125. Since such billings are meant to cover expenses, there is still a possibility that public, not-for-profit hospitals will be considered to operate on a commercial basis and will thus be subject to the GATS’ provisions.

public hospitals, as public hospitals do not compete with private hospitals in that they are not servicing the same market. It has been suggested that public and private hospitals may offer quite different services, such as the absence of waiting lists, newer equipment and the presence of fees, such that no competition could be found between them. However, this assessment is not certain, since public and private hospitals are functionally the same even if they are not complete substitutes. Overall, if private hospitals were allowed to provide insured services, then competition would definitely exist.¹²⁶

c. *Physicians*

Physicians providing services insured under the *Canada Health Act*, whether inside or outside of hospitals, tend to be for-profit suppliers and thus are not subject to the Governmental Authority Exclusion. The state plays a significant role in the licensing of physicians and regulating standards within the industry, as well as fixing the prices charged for their services and setting a ceiling for their remuneration. Despite this, physicians (particularly those in private practice) can be seen as independent operators who can choose who they treat, what treatment they provide and when they provide it. Thus, they likely will not be seen as governmental in nature. Beyond that, physician services are provided on a commercial basis, as they operate for profit. Physicians earn their living from the provision of these services. So, even if the government sets the fees for such services, the doctors are still seeking to maximize their returns and are operating on a for-profit basis and, thus, on a commercial basis. As well, since remuneration depends on the amount of services provided, physicians tend to compete with each other for patients. Further, patients can and do switch between physicians. To a consumer seeking medical treatment, one physician is substitutable for another, offering services of a similar nature and/or quality. This would make physicians operate in competition with one or more service suppliers.

d. *Health-care professionals*

A similar conclusion can be reached for all health-related services provided by health professionals that are not insured under the *Canada Health Act*, such as physiotherapists, chiropractors and naturalists. Although many of these professions are subject to some regulation to ensure standards of competence, this is not sufficient regulation to make them governmental in nature. As well, delivery is done by private, for-profit service suppliers

126. VanDuzer, *supra* note 30 at 410, 412-413.

operating on a commercial basis in competition with each other for the same reasons as were noted for physicians.

e. *Home Care*

Home care is offered in different ways in different provinces. Where home-care services are supplied directly by the state without charge, as is the case in Saskatchewan and Manitoba and in Alberta and Quebec (in the case of professional services), these services may be found to be within the Governmental Authority Exclusion. The funding of such services is not done on a commercial basis, as the government does not seek to profit from its funding of these services. If either there are no private home care providers or if the government service supplier has no mandate to compete with private home-care suppliers, then there is no competition with one or more service suppliers.

Delivery of these services, though, is likely not within the Governmental Authority Exclusion. Those providing home-care services, although funded by the government, operate similarly to the health professionals described above. The companies and/or individuals earn their living from the provision of these services and seek to maximize their returns. Further, from the perspective of the province (the consumer in this instance), the health service professionals providing these home-care services provide like services and can be substituted one for the other. Thus, these service providers are in competition with one another. Particularly in those provinces, like Ontario, where most home care is delivered by private non-profit and for-profit suppliers, the service providers are operating on a commercial basis in competition with one or more service suppliers.

f. *Nursing homes and homes for the aged*

Nursing homes and other long-term care facilities supplied by private for-profit service providers are subject to GATS' provisions. Like the health professionals above, government regulation and licensing requirements try to ensure certain standards. However, in any case, these facilities operate on a commercial basis, as the fees they charge seek to more than cover their operating costs, and they compete with each other, as they likely provide the same end use and are substitutable from the consumer's perspective.

g. *Supplementary health services*

As discussed earlier, the specific services funded in each provincial health insurance plan vary. Some provinces fully fund a number of health services that are outside the definition of those that must be insured under the *Canada Health Act*. Assuming that these services do not directly compete with private suppliers and that user fees seeking to recover the cost of

the service are not charged, the funding of these services would also be excluded from GATS' scope. Thus, the funding of health services that fall within GATS' scope can vary from province to province. However, the delivery of these services, like the delivery of most services that must be insured under the *Canada Health Act*, would not be within the Governmental Authority Exclusion.

Government programs funding health services that are not insured under the *Canada Health Act*, but are funded by the government in certain circumstances (such as funding prescriptions for the elderly, funding of medical equipment and devices for the disabled) are likely to fall within the Governmental Authority Exclusion. These services are funded by the government directly. The programs typically have small fees that do not reflect the actual cost of the service, although government coverage does not kick in, in some instances, until a specific monetary threshold is surpassed. So it seems these services are not offered on a commercial basis. Finally, in this specific area, government is not competing with private insurance providers, as these programs have been set up specifically by the government to fund those who would likely not be insured by a private provider, such as those at high risk or those on welfare who cannot afford private insurance. The target market of these programs precludes competition with private providers. So the ability of the government to fund such programs is outside the scope of GATS' provisions. However, the delivery of these programs is subject to GATS. The services such programs provide are similar in nature or quality and have the same end use as those offered by private insurers and most consumers would see these services as substitutable. Thus, they are likely in competition with one another.

2. *The effect of GATS' universal obligations*

The elements of Medicare that are not within the Governmental Authority Exclusion are subject to the GATS universal obligations. Of these obligations, only MFN and the rules on monopolies are likely to have any impact.¹²⁷ Even so, these obligations are likely to have minimal effect and,

127. The other three main universal obligations (transparency, judicial review, and recognition) were arguably all satisfied in Canada for many years before GATS came into force. There is no reason to believe that having to publish any rules relating to GPs, for instance, or allowing access to Canadian courts for foreign corporations desiring to open a hospital that feel they have been mistreated will have any impact on the continued public nature of Medicare.

in any case, are of limited liberalizing impact.¹²⁸ Even laws in the future will likely not be greatly affected by the MFN obligation. However, in the event of greater foreign participation in Medicare, the MFN obligation would become more significant.

The current level of foreign participation in the Canadian health care system is likely quite low.¹²⁹ While it remains low, MFN will be a minor concern; MFN's importance will grow as more foreign service providers are allowed to operate in Canada. Even so, the MFN requirement and its effect should be taken into consideration by Canadian policymakers that choose to allow foreign providers to operate in Canada, although it would appear such allowances could be retracted in the future with little impediment.

As greater foreign participation is allowed in Medicare, MFN will have a greater impact, but greater foreign participation is not an inevitable result of complying with MFN. Nothing in GATS' MFN obligation forces Canada to open its health market to foreign service providers; it simply requires that Canada not discriminate between service providers from other countries should Canada allow foreign service providers to operate in its market.

Further, complying with MFN does not necessarily enshrine foreign access to the Canadian market. Nothing in the GATS, resulting from the MFN obligation, prevents Canada from retracting market openings, for example in the health services sector.

One note of caution regarding MFN should be sounded, though. As discussed earlier, it is unclear which services will be found to be "like" and what the MFN obligation will require if they are.¹³⁰ This uncertainty makes it difficult to predict precisely when discriminatory measures will be MFN-consistent and when they will not be.

Next, there are the provisions regarding monopolies and exclusive service suppliers. The most obvious monopolies are the provincial health insurance schemes. Since these are within the Governmental Authority Exclusion, they are not required to abide by GATS Article VIII. However,

128. Most commentators seem to agree that MFN obligations will not lead to the privatization of health services. Johnson, *supra* note 113 at 19 states that the MFN obligation will have a "minimal effect on Canada's health care system." Further, Krajewski, Luff and VanDuzer feel that the MFN obligation, in general, will not have a significant impact in relation to public services (Krajewski 2003, *supra* note 37 at 359; Luff, *supra* note 37 at 193 and VanDuzer, *supra* note 30 at 437-438). Even some GATS critics acknowledge the GATS obligation leaves Canada a "considerable degree of policy flexibility" (Sinclair & Grieshaber-Otto, *supra* note 8 at 104). Other critics, though, have come to a different conclusion (see, for example, Sanger, *supra* note 8).

129. The precise level is unclear, mainly due to a lack of resources on the subject. For a similar assessment, see VanDuzer, above note 30 at 437.

130. See notes 62-67 above and *ibid.* at 451-454.

even if these programs were to be subject to this provision, it would not pose a great obstacle. The GATS does not outlaw the existence of monopolies, so provincial health care programs with monopoly powers are not GATS-inconsistent. The monopolies must observe the MFN commitment and not undermine scheduled commitments. Observing the MFN requirement, as discussed, is not onerous and does not mandate liberalization.

Some commentators contend that provincial monopolies on health insurance programs thus undermine Canada's commitments. As already discussed, the Medicare system, while often called an insurance scheme, is not truly a system of health insurance. Beyond that, there is nothing in the GATS that would prevent Canada from limiting the areas in which private health insurance can operate, such that the provincial monopolies do not undermine the scheduled commitment. However, should the provincial plans choose to expand what is covered by public funding, thus excluding private insurers from providing these services, there is a possibility that this could be seen as a violation of Canada's market access commitments in health insurance.

3. *The impact of commitments in Canada's schedule*

As discussed earlier, Canada's "belt and suspenders" approach means that there are negligible commitments scheduled with respect to its health care. There are a few commitments made with respect to services that Canada's health services purchase, but these will likely not have any impact on Canada's health services other than possible efficiency gains by health service providers due to lower costs for these services resulting from greater (and possibly foreign) competition.

The listing of health insurance in Canada's GATS schedule has already been discussed. In all likelihood, Canada's commitment will be seen to pertain solely to private health insurance—meaning that this commitment does not include Medicare. Even if the health services available through private health insurance begin to resemble more closely the services offered under Medicare as a result of the *Chaoulli* decision, Canada's commitment with regard to health insurance poses no restriction to Canadian governments choosing to continue to fund a public universal health-care system. The most the commitment could mean in this respect is that more private health services would have to be allowed access to the Canadian market. It is unlikely that this greater access would lead to competition between the public and private systems, rather than these being complements for one another, as discussed earlier.

4. *The effect of Canada's horizontal commitments*

Due to the fact that Canada has made so few commitments with respect to its health services, Canada's horizontal commitments do not play a large role. Canada has a horizontal commitment with respect to mode 3 in national treatment only, one that retains Canada's freedom to engage in "the supply of a service or its subsidization within the public sector." Since this horizontal commitment pertains to national treatment, it would allow Canada to favour health insurance provided by Canadian suppliers (such as, say, provincial health insurance schemes) compared to health insurance provided privately by foreign service suppliers since the private providers would not be within the public sector. Further, the limitation means that Canada does not have to maintain the same conditions of competition for Canadian and foreign service providers. The horizontal commitment does not pertain to market access, so Canada could not prevent foreign health insurers from establishing themselves in the Canadian market. However, the national treatment limitation means that the foreign service providers' establishment in Canada does not assure them a right to insure services provided under the CHA.

5. *The ability to regulate*

Governments have the ability to regulate health care and public health regardless of whether or not various public services fall within the Governmental Authority Exclusion. Nothing within the GATS prevents governments from regulating and enforcing standards for competence and other aspects of quality in the delivery of health services, controlling who can provide health services within its borders, or assigning bodies to supervise the medical profession. For example, there is nothing in the GATS that will prevent the Ontario government from maintaining laws stipulating that no one can operate a hospital and provide medical services therein within its jurisdiction without receiving permission from the Minister of Health to do so. Where this regulatory capacity comes into question is when it is applied against foreign service suppliers in a discriminatory fashion that breaches MFN or national treatment or market access, such as if the Ontario government were to legislate that only hospitals owned by foreign entities would have to re-apply every three years for permission to operate. GATS Article VI does set some standards for domestic regulation, but the substantive obligations only apply to those sectors listed in a Member's schedule of commitments. Also, Canada can still determine which foreign qualifications it will recognize as satisfying domestic qualification requirements, so long as these do not become disguised restrictions on trade.

6. *The ability to insure/fund publicly*

Neither the universal obligations nor Canada's listing of health insurance in its schedule of commitments threatens Canada's ability to pay, from public funds, for all medically necessary services within Canada, regardless of the nationality of the service provider that provides them.

7. *The ability to provide publicly*

As Canada has made no commitments with respect to hospital services, there is nothing in the GATS that would require Canada to allow a foreign-owned hospital to commence operations in Canada. As such, should Canada choose to continue funding medically necessary hospital services through hospitals that are quasi-public entities, that is its prerogative. The GATS will neither force the entry of foreign service suppliers, nor the privatization of currently public health service providers.

As for physicians and other health professionals, they will continue to be private operators. These categories of health service providers were private before the enactment of the GATS and have continued to be private since the GATS came into force. Their private operations have nothing to do with the GATS and their public or private status will not change as a consequence of the GATS.

Conclusion

As shown in the preceding analysis, the controversy surrounding GATS' impact on national universal health-care systems, at least in Canada, appears unfounded. Given the likely interpretation a WTO Panel will adopt for the Governmental Authority Exclusion in GATS Article I.3, there appears to be no threat to the public administration, financing and regulation of Medicare.

This article has shown that, for a measure relating to a service to be within the Governmental Authority Exclusion, it must be: 1) not supplied on a commercial basis; and 2) not supplied in competition with one or more service suppliers. Applying these criteria to Medicare yields the result that the basic architecture of Medicare (essentially the provincial health insurance schemes and their public administration), along with the funding of many supplementary services, home care and hospital services in Canada satisfy the requirements of the Governmental Authority Exclusion and are thus excluded from the GATS; the GATS does not pose a threat to the integrity of the Canadian health-care system.

While it has been found that the GATS likely pertains to the delivery of certain elements of Medicare, the public nature and government backing of this system is assured. GATS' likely impact seems fairly minimal and does not jeopardize the universal coverage available to residents in

Canada. In total, the possibility remains that health services could be provided by domestic or foreign service suppliers. However, regardless of the nationality of the service provider, the GATS poses no threat to keeping the federal and provincial governments as the entities funding the provision of these services. Accordingly, egalitarian access to health services should be preserved.

A few caveats should be made at this time. First, the analysis in this paper is highly speculative, given the unknown nature of how a WTO Panel will approach this issue. While the analysis has tried to stay true to the WTO adjudication procedure, there is no guarantee that its results would be vindicated should such a dispute ever arise. Second, the description of Medicare is, by necessity, a broad generalization. Given the scope and length of this article, an in-depth analysis that accurately portrays every minute detail of Medicare is not feasible. The description provided, however, does accurately capture the general nature of the system and how it operates. Lastly, this paper is not necessarily an exhaustive exploration of this question. Some tangential issues—such as the treatment of subsidies and the effect of Canada being a signatory to the plurilateral *Agreement on Government Procurement*—have not been discussed due to space constraints. Further, the GATS 2000 negotiations are on-going as part of the Doha Round, and it is possible that these negotiations could produce results affecting the applicability of this paper's analysis.

So, Canadians can continue to value, and take pride in, our national health-care system. The success of Medicare demonstrates that equality of access to, and distribution of, health services is a noble goal that is not only desirable, but also attainable. A mix of public and private supply of health services has been employed to achieve the current universal level of health coverage in Canada. As shown by this article's conclusions, even in the face of the GATS, a similar mix of public and private delivery will continue to ensure that health coverage is universal. Despite the dire predictions, Medicare appears secure. As such, it is time for Canadians to stop worrying and learn to love the GATS.