

What's the Big Deal?

Understanding the
Trans-Pacific
Partnership

Major Complications

The TPP and Canadian Health Care

Scott Sinclair





CCPA

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Major Complications: The TPP and Canadian Health Care

Introduction

With refreshing clarity, the prime minister's mandate letter to the new health minister states the government's "overarching goal will be to strengthen our publicly-funded universal health care system and ensure that it adapts to new challenges."¹ The purpose of this paper is to review the potential impacts of the Trans-Pacific Partnership Trade Agreement (TPP), negotiated by the previous Conservative government, on this objective and the Canadian health care system overall.

Negotiations on the TPP, a major trade and investment treaty, concluded in October 2015 and the 12 participating countries, including Canada, are expected to sign the deal in February 2016.² The TPP will only come into force when ratified by at least six TPP signatories representing 85% or more of the GDP of the proposed trading bloc. As even its proponents admit, the agreement would have only a marginal impact on actual trade volumes and economic growth.³ But its 30 chapters and thousands of pages of rules would place many new constraints on government policy in areas not strictly related to trade, including public health.

While Canada's public health care system is partially shielded from the commercializing pressures of the TPP, the overarching impacts of the proposed treaty would be to weaken our public health care system, undermine health regulation, and obstruct efforts to renew and expand public health care in the face of new challenges.

Canadians already pay too much for prescription drugs and the TPP would worsen this situation by extending patents and impeding cost-saving measures. Research clearly shows that extending monopoly protection and boosting brand-name drug company profits in hopes of generating higher levels of research and development (R&D), and more innovative medicines, has been a failure. The TPP would burden the Canadian health care system with higher drug costs while frustrating efforts to find a better balance between needed innovation and the affordability of medicines.

The TPP includes strong foreign investor protections and a highly controversial investor–state dispute settlement (ISDS) mechanism. The paper will discuss how entrenching and expanding ISDS through the TPP would threaten stronger public health regulation and make preserving and extending our publicly funded, universal health care system – for example through publicly insured pharmacare – more difficult and costly. The benefits and limitations of the TPP's novel carve-out for tobacco control measures will be assessed.

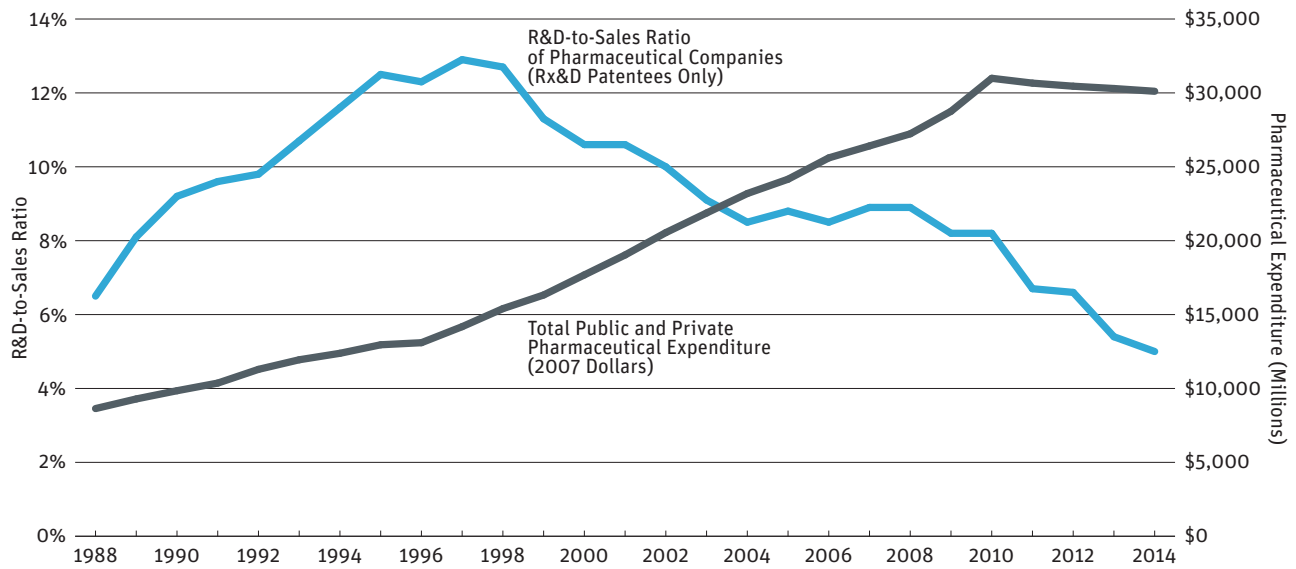
The paper will also review a range of other TPP provisions governing cross-border trade in services, temporary entry of professionals, and government procurement. In most of these areas, the new impacts of the TPP on the Canadian health care system would be minimal or in line with existing trade and investment treaty obligations. But even in these sectors, flaws found in previous trade and investment agreements are repeated, while some specific new aspects are raising concerns.

The TPP and Drug Costs

Without doubt, the TPP's single biggest direct impact on the Canadian health care system would be to increase drug costs as a result of extending patents. Canada already has an industry-friendly system of intellectual property protection for pharmaceutical patent holders. This is reflected in the high prices Canadians pay for prescription drugs.

Per capita, drug costs in Canada are the fourth highest among countries in the Organization for Economic Co-operation and Development (OECD).⁴

FIGURE 1 R&D Spending vs. Drug Costs in Canada



Sources The Patented Medicine Prices Review Board, “Table 16: Total R&D Expenditures and R&D-to-Sales Ratios of Reporting Companies, 1988–2014,” Patented Medicine Prices Review Board Annual Report 2014 (Ottawa: Patented Medicine Prices Review Board, 2014): p. 44, <http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1217>. Canadian Institute for Health Information, “Table G.14.1: Expenditure on Drugs by Type, by Source of Finance, Canada, 1985 to 2015,” National Health Expenditure Trends, 1975 to 2015: Complete data tables (Ottawa: Canadian Institute for Health Information, 2015), https://www.cihi.ca/sites/default/files/document/nhex_2015_datatables_en.zip.

According to the latest OECD data, Canadians pay an average of US\$713 annually for pharmaceuticals, significantly higher than the OECD average of US\$515.⁵

The TPP will further increase these costs by requiring the federal government to extend the term of patents to account for supposed regulatory delays in approving drugs for sale. Specifically with respect to patented drugs, TPP parties must “make available an adjustment* of the patent term to compensate the patent owner for unreasonable curtailment of the effective patent term as a result of the marketing approval process.”⁶

The TPP does not specify precisely how countries must meet this obligation, leaving individual countries some flexibility to define their own patent term restoration systems. Canadian officials have indicated the federal government will meet this obligation through the so-called *sui generis* patent extension system required by the signed, but not yet ratified, Canada–European Union Comprehensive Economic and Trade Agreement (CETA).

It should be stressed that when the previous federal government insisted the TPP would require no changes to Canada’s *existing* intellectual property regime for drugs, it was already including the *future* changes Canada would have to make to comply with the CETA. The pact with the EU, signed more

than a year ago, is currently stalled over strong public opposition in Europe to its inclusion of an ISDS process. By agreeing to the TPP system of patent term restoration, the federal government concedes that our drug costs will rise, whether the CETA goes ahead or not.

The TPP and CETA requirements for patent term restoration are roughly equivalent.⁷ Under its proposed *sui generis* approach, Canada plans to limit the patent term adjustment to a maximum of two years. Carleton University professor Marc-André Gagnon estimates that if the patent term restoration system required by the TPP were implemented in Canada today it would increase the average market exclusivity for patented drugs by 287 days.⁸ By further delaying the availability of cheaper generic medicines, this would result in an annual cost increase of \$636 million, or 5% of the annual cost of patented drugs in Canada, beginning in 2023.⁹

Provinces have demanded compensation for the fiscal impacts of these changes. Yet even if the new federal government were to abide by the vague pledges of compensation made by the previous regime, it simply means that Canadian taxpayers would pay at the federal rather than the provincial level in order to boost the profits of the brand-name pharmaceutical industry. People paying for their drugs out of pocket or through private insurance will be hit twice – through higher drug costs *and* an increase in their federal taxes (or reduced public services).

Despite claims to the contrary by brand-name manufacturers, higher drug costs are unlikely to be offset by increased R&D expenditures in Canada. Since 2003, Canadian brand-name manufacturers have consistently failed to meet previous pledges to invest 10% of their sales revenues in researching and developing new products. According to the latest data from the Patented Medicine Prices Review Board (PMPRB), the R&D-to-sales ratio of the brand-name pharmaceutical industry fell to 5% in 2014. This is its lowest level since the PMPRB began collecting data in 1988.¹⁰

In fact, data collected by the PMPRB totally dispels the argument that providing stronger patent protection will spur higher pharmaceutical investment in Canada. The PMPRB report notes that several comparable OECD countries, “which have patented drug prices that are, on average, substantially less than prices in Canada, have achieved R&D-to-sales ratios well above those in Canada.” Furthermore, it observes, “[a]lthough price levels are often cited as an important policy lever for attracting R&D, the data has not supported this link domestically or internationally.”¹¹

The most recent PMPRB annual report emphasizes that the patent restoration system envisaged under the CETA: “will require amendments to the

Patent Act to provide pharmaceutical patentees with up to two years of additional market exclusivity. Such a change would come at a time of high drug prices and record low R&D, causing some to question the effectiveness of the PMPRB and whether a policy balance conceived over 25 years ago continues to serve its intended purpose.”¹²

Even in the U.S., which has led the charge for more industry-friendly patent protection in the TPP, there is outrage over a tax-avoiding merger between the U.S.-based multinational Pfizer and the smaller European firm Allergan.¹³ By shifting its headquarters to Ireland, Pfizer plans to garner a windfall in profits by reducing its corporate income tax rate. With many asking why the U.S. government should champion the cause of a company that refuses to accept its fair share of taxes, this aggressive maneuver could well spill over into the congressional debate on the TPP.

In the developing world, access-to-medicine advocates such as Médecins Sans Frontières/Doctors without Borders (MSF) have strongly decried the adverse impacts of the TPP on drug costs and the affordability of life-saving medicines. MSF concludes that, “although the text has improved over the initial demands, the TPP will still go down in history as the worst trade agreement for access to medicines in developing countries.”¹⁴ The group’s continuing concerns include the TPP requirements for patent term restoration, provisions that facilitate “ever-greening” (the practice of patenting new uses or formulations to extend monopoly protection for drugs whose patents are about to expire) in developing countries, and the requirement for up to eight years of data protection and market exclusivity for biologic drugs.

With the exception of the previously discussed patent term extensions, such provisions are generally in line with Canada’s existing drug patent regulations. But the hardships that would be inflicted on the poor, the sick, and already strained public coffers in developing countries such as Vietnam and Malaysia are reason enough for Canadians to reject such “abusive” intellectual property (IP) provisions.¹⁵ What’s more, by establishing a new high-water mark for corporate-friendly IP protections, the treaty sets a terrible precedent for future agreements involving developing countries. By accepting the TPP approach to intellectual property and pharmaceuticals, the Canadian government would fail citizens in developing countries and diminish its standing in the developing world.

Extended patent terms would clearly be the most directly harmful impact of the TPP’s IP chapter. Accepting the patent extensions required by the TPP would increase costs to consumers and patients at home and abroad, reward broken promises by the brand-name pharmaceutical industry, perpetuate a

failed approach to consumer protection and industrial policy, and diminish Canada's standing globally. The TPP could also have adverse effects on the criteria that Canada uses to decide on drug safety and effectiveness, how it approves or does not approve new drugs for marketing, post-market surveillance and inspection, the listing of drugs on public formularies, and how individual drugs are priced in the future. This broader range of issues is explored in detail in the companion CCPA study by Joel Lexchin.¹⁶

Investor Rights and Investor–State Dispute Settlement

The TPP investment chapter is essentially modelled on NAFTA's chapter 11 and its modifications in subsequent U.S. bilateral investment treaties. There are some minor interpretive glosses to the obligations on minimum standards of treatment, national treatment, and indirect expropriation that aim to curb some of the most problematic interpretations of these provisions by arbitral tribunals.¹⁷ There is also a partial carve-out for tobacco control measures, which will be discussed below.

But on the whole, the chapter heavily reflects the traditional U.S. approach of creating strong investor rights that apply to both established and planned investments, with only minimal or weak exceptions for government regulation in the text itself.¹⁸ This compels governments to rely on country-specific reservations to protect vital public interest regulations and public services, even in critical areas such as health.

The TPP also contains an investor–state dispute settlement (ISDS) mechanism that enables foreign investors to sue governments for violating the treaty's broadly worded investment protections. Such claims bypass the domestic courts and are adjudicated by largely unaccountable arbitration tribunals. While the tribunals cannot directly overturn a government measure, they can order financial compensation. Such monetary awards are fully enforceable in the domestic courts of any TPP country.

Locking in Privatization and Impeding Medicare Expansion

A major concern about ISDS and TPP-style investor protections is that they effectively lock in privatization. For example, once foreign investors become established in a health sector previously insured or delivered exclusively through the public system, investor–state compensation claims make it costly to reverse course and return these services to the public health care system.

A closely related concern is that ISDS interferes with the expansion of public health insurance into areas currently insured by private providers. The prospect of incurring potentially large compensation costs, determined by a private tribunal outside the reach of domestic courts and legislature, can chill the expansion of public health insurance into new areas such as pharmacare. Investor–state litigation creates uncertainty and potential liabilities for the taxpayer, and can tip the political balance in favour of foreign commercial interests opposed to expanding a public health care system.

The TPP actually makes such claims more likely to succeed by allowing financial services providers, such as health insurance companies, to launch investor–state claims alleging violations of the minimum standards of treatment obligations, something that is not permitted under existing Canadian trade and investment agreements.¹⁹ These provisions have been rightly criticized as a “strikingly flexible catch-all standard,” allowing arbitrators to impose their own preferences and prejudices in a dispute.²⁰ The minimum standards of treatment obligation is the most frequently invoked by investors in investor–state arbitration claims.²¹

These are not abstract or hypothetical concerns. In Europe, foreign investors have used investment treaties to challenge reversals of privatization in public health insurance systems. In at least two instances they succeeded.

In 1999, a Dutch-based insurance firm, Eureko, acquired a 30% stake in Poland’s national health insurance provider. In 2001, the Polish finance ministry announced it intended to issue more shares to private companies, a move that would have allowed Eureko to acquire a majority stake. The planned privatization generated considerable political controversy and was subsequently cancelled by the Polish government. Eureko then sued Poland under a Netherlands–Poland Bilateral Investment Treaty (BIT). In 2005, the investor–state tribunal ruled two-to-one in Eureko’s favour, asserting the cancelled shares offering violated investor protections in the BIT. The Polish government eventually settled the dispute for an estimated US\$1.6 billion.

Slovakia similarly experimented with health insurance privatization in 2006–07. A newly elected government then took steps to reverse this policy.²² A Dutch holding company, Achmea, which owned an insurer that had entered the Slovakian market, launched a pair of investor–state claims against Slovakia under the Netherlands–Czechoslovakia BIT. In the first case, the company was awarded 22.1 million euros (\$33.5 million) after the tribunal decided the regulatory requirement to reinvest profits in the health insurance system (rather than transferring them as dividends to investors), and restrictions on the transfer of insurance portfolios, violated the fair and equit-

able treatment (FET) provisions of the BIT. The Slovak government, even though backed by the European Commission, was unsuccessful in having that monetary award set aside in the European courts.²³

A second, even more aggressive claim by the same investor attempted to persuade a tribunal to take pre-emptive action against the Slovak government to stop the establishment of a single-payer public health insurance system. The Slovak government won that case, although the tribunal's ruling emphasized Achmea would be able to bring a claim for damages if the government proceeds with a public health insurance plan that harm the company's investments.²⁴

As discussed in the next section on cross-border trade in services, Canada's health reservations do not in any way protect against challenges under the articles dealing with expropriation or minimum standards of treatment (equivalent to the fair and equitable treatment provision in European BITs). These TPP provisions apply with full force to the Canadian health care system. An expansion of Canadian public health insurance or a reversal of future privatization at any level of government would therefore be vulnerable to investor claims similar to those experienced by Eastern European governments.

The TPP not only fails to redress these serious flaws in the ISDS process, it expands their application. By covering foreign investors from more countries (including Japan, which is home to approximately 2.5% of Canadian foreign direct investment), the TPP significantly increases the likelihood of future claims. If ratified in its current form, the TPP would also greatly complicate future efforts to reform investment protections and ISDS, since adjustments to the treaty would require reaching consensus among 12 governments, a far more difficult undertaking than in NAFTA where three countries need to agree.²⁵

Public Health Regulation

The number of investor–state claims is burgeoning worldwide.²⁶ Increasingly they involve challenges to public health regulation. Among the most notorious of these are cases brought by tobacco giant Phillip Morris against plain packaging laws in Australia and health warnings on packages in Uruguay.²⁷ Canada is also the target in a high-profile investor–state challenge by U.S. pharmaceutical firm Eli Lilly, which is seeking \$500 million for the invalidation of two of its extended patents by the Canadian courts.

The TPP investment chapter contains no general exception insulating health regulatory measures from ISDS. This contrasts with other chapters of the TPP, such as trade in services and trade in goods, where governments can invoke a WTO-style general exception to defend measures *necessary* to protect health that would otherwise be inconsistent with the TPP obligations.²⁸ While such exceptions are difficult for governments to invoke successfully, it is still alarming that the TPP chapter with the most powerful provisions and the most intrusive dispute settlement mechanism should lack such a basic safeguard.

Instead of an effective general exception, the investment chapter contains a cynical article that masquerades as one. TPP Article 9.15 states, “Nothing in this Chapter shall be construed to prevent a Party from adopting, maintaining or enforcing any measure *otherwise consistent with this Chapter* that it considers appropriate to ensure that investment activity in its territory is undertaken in a manner sensitive to environmental, health or other regulatory objectives (emphasis added).” As many analysts have noted, this wording is circular and self-negating.²⁹ If a health measure is consistent with the chapter, it would not need protection. If it is inconsistent, this wording provides no defence. The article is mere window dressing, leaving health and other regulatory measures exposed to investor–state challenge.

Chapter 29 of the TPP does, however, include a more meaningful exclusion for tobacco control measures, which permits a TPP member to deny foreign investors the right to bring an investor–state claim against such measures.³⁰ If Canada proceeds with plain packaging, as pledged in the new federal health minister’s mandate letter, it could use this exclusion to disallow investor–state claims under the TPP.³¹ If the TPP comes into effect, Canada should certainly take advantage of this opt-out to protect future plain packaging regulation.

It must be stressed that the exclusion of tobacco control measures from ISDS falls short of a full “carve-out” for tobacco control measures. Future Canadian plain packaging laws would still be exposed to state-to-state challenges under the TPP. The U.S. government, for example, could launch a dispute on behalf of its tobacco industry. Moreover, the U.S. tobacco industry could bring an investor–state claim on its own behalf against Canadian plain packaging laws by using NAFTA’s ISDS mechanism. In this sense, the TPP carve-out provides greater protection against ISDS claims to countries such as Australia, whose pre-existing free trade agreement with the U.S. does not include ISDS, than to Canada.

The TPP tobacco exception is a positive step for tobacco control regulation that makes it harder for multinational tobacco firms to make an ISDS claim. But at a deeper level the specific carve-out for tobacco implicitly highlights the broader threats posed by the TPP and ISDS. The very need for such a tobacco carve-out recognizes that ISDS poses a threat to health regulation. And if tobacco requires a carve-out, why have other critical areas of health regulation been left exposed to ISDS? For example, nothing would prevent foreign investors from bringing investor-state claims challenging new regulations restricting the commercial marketing of unhealthy food and beverages to children, tougher regulations to eliminate trans fats in processed foods, or restrictions governing the sale of legalized marijuana.³²

During the TPP negotiations, there were other, more robust options on the table to protect health regulation from investor–state claims. Malaysia, for example, consistently advocated a full carve-out for tobacco control measures that would have protected them from all challenges, investor–state or government-to-government. Dozens of health groups from many TPP countries, including the American Public Health Association, the American Medical Association, the American Cancer Society, and the National Association of Attorneys General, endorsed Malaysia’s approach.³³ The Australian government also proposed that government measures that are “manifestly non-discriminatory and for legitimate public welfare objectives, such as public health, safety and the environment,” should not be subject to investor–state claims.

Unfortunately, neither of these sensible proposals survived the cut and thrust of negotiations. Clearly, the weak protection for public health in the TPP is neither an accident nor an oversight. It is an accurate reflection of the priorities of the U.S. government and corporate lobbies who deliberately placed investor rights over public interest regulation, including measures to protect public health.

Cross-Border Trade in Services

Chapter 10 of the TPP governs cross-border trade in services. As with other parts of this trade and investment agreement it reflects a bias toward commercial rights at the potential expense of the public good, including public health. Its key obligations include the following:

- *National Treatment* – no government may discriminate in favour of local service suppliers;

- *Most-Favoured-Nation Treatment* — the best treatment given to any foreign service supplier must be extended to all foreign services or suppliers;
- *Market Access* — governments cannot limit the number of service suppliers in a sector or require services to be delivered through a specific type of legal entity (such as not-for-profits); and
- *Local Presence* — governments are prohibited from requiring foreign service providers (e.g., of telemedicine) to be resident in a jurisdiction in order to supply the service.

These obligations, with their emphasis on globalizing and commercializing services, run counter to fundamental principles of the Canadian medicare system. In principle, Canada’s public sector health insurance monopoly, and the strict regulations around who can provide health care services to Canadians and on what terms, contradict many of these provisions.³⁴ In practice, however, these TPP obligations are subject to reservations, or country-specific exceptions, that each party has the opportunity to negotiate for the protection of vital interests such as health care.

In the TPP, as in previous trade and investment treaties, Canada relies on two key reservations to protect its public health care system. These exemptions shield government measures in the health sector from some, but not all, of the TPP’s investment and services obligations. The first of these, Annex I, includes a general reservation that allows Canadian provincial and local governments to maintain all their existing non-conforming measures, including those in the health sector. The Annex I reservation applies against National Treatment (Articles 9.4 and 10.3), Most-Favoured-Nation Treatment (Articles 9.5 and 10.4), Market Access (Article 10.5), Local Presence (Article 10.6), Performance Requirements (Article 9.9), and Senior Management and Boards of Directors (Article 9.10).³⁵

Under the terms of the Annex I reservation any “existing, non-conforming measures” are bound, meaning they can only be amended to make them more TPP-consistent. As the United States Trade Representative’s summary of the TPP services chapter explains, “In listing a measure in Annex I, the country commits to a ‘standstill,’ which ensures that the measure will not become more restrictive in the future, as well as a ‘ratchet,’ which means that if the measure is amended in the future to become less restrictive, the new, more favorable treatment will set the benchmark for the standstill re-

quirement.”³⁶ Accordingly, if a non-conforming measure is rescinded or amended it cannot later be restored by a future government.

Canada also negotiated a second reservation that excludes the Canadian health care sector from only some provisions of the TPP’s investment and services chapters. The Annex II reservation is unbound. This means it protects existing non-conforming measures and, in addition, allows Canadian governments to take new measures that would otherwise be TPP-inconsistent. The reservation, however, stipulates that any such measures must be related to health to the extent that it is “a social service established or maintained for a public purpose.”³⁷ These terms are undefined and have been subject to sharply differing interpretations by the U.S. and Canadian governments.³⁸

The TPP Annex II reservation is virtually identical to its NAFTA counterpart. The TPP version is stronger in one respect: it applies against the most-favoured-nation treatment clause of the TPP investment chapter.³⁹ This means that in the sectors excluded by the reservation, investors from all TPP parties would not automatically be entitled to the best treatment Canada provides to investors from other countries (e.g., European investors under CETA).⁴⁰

These two reservations are vital in ensuring Canadian governments at all levels have the ability to maintain existing health measures and to adopt new health measures that would otherwise be inconsistent with the TPP. But like reservations under previous trade and investment treaties, they are also incomplete and flawed.

Significantly, the Annex II reservation does not clearly exclude so-called ancillary health services such as food services, cleaning services, maintenance services, computer and data management services, hospital administration, and other support services that are critical to the health care system. Where such services are contracted out or privatized, attempts to re-regulate or to return them to the public sector could be exposed to legal challenge under the TPP and other trade and investment agreements.

The limited scope of Canada’s Annex II reservation can be illustrated through a recent controversy over testing for registered nurses’ certification. Nurses’ unions have expressed serious concerns over the decision by Canadian nursing regulatory bodies to move implementation of the Computerized Adaptive Testing (CAT) registered nurses exam to the National Council of State Boards of Nursing, a U.S. body. These concerns include testing geared to U.S. rather than Canadian nursing practice, inadequate translation and lack of preparatory materials in French, higher rates of failure following the adoption of the U.S. exam, and concerns over the privacy of nurs-

es' personal data becoming subject to intrusive U.S. security laws such as the Patriot Act.

Canada's Annex II reservation only excludes measures related to "public training." The NCSBN is a private, not-for profit organization. Consequently, measures regulating the testing and training services provided by this U.S. service provider would fall outside the scope of the Annex II reservation.⁴¹ If provincial governments or the regulatory bodies move to address nurses' concerns, complaints by the U.S. service provider could result in a government-to-government or investor-state dispute under the NAFTA or the TPP. In addition, the TPP chapter on e-commerce prohibits requirements to store data, including personal information, locally. Efforts to address the privacy concerns related to nursing candidates' personal information by requiring that such data be stored securely within Canada could be disallowed by these TPP e-commerce rules.⁴²

The TPP also includes a new NAFTA-plus mechanism for applying pressure around non-conforming measures at the provincial level. The agreement states: "If a Party considers that a non-conforming measure applied by a regional level of government of another Party, as referred to in subparagraph 1(a)(ii), creates a material impediment to the cross-border supply of services in relation to the former Party, it may request consultations with regard to that measure. These Parties shall enter into consultations with a view to exchanging information on the operation of the measure and to considering whether further steps are necessary and appropriate."⁴³ While such consultations are non-binding, they do provide a direct channel for pressuring Canadian provincial governments to amend or rescind reserved measures in any sector, including health.

The TPP also contains new, unique provisions restricting non-discriminatory domestic regulation. Much of them apply on a "best endeavours" basis. The binding part requires that each signatory country "shall ensure that all measures of general application affecting trade in services are administered in a reasonable, objective and impartial manner." These terms are undefined, leaving trade tribunals considerable discretion in interpretation. Fortunately, the TPP domestic regulation obligations do not apply to health services to the extent that these are reserved from national treatment and market access obligations under Canada's Annex I and Annex II.⁴⁴

Overall, the TPP trade-in-services provisions largely preserve the status quo with respect to Canada's health care services and trade treaties. The Canadian reservations are essential, but still leave certain areas of the health care system exposed. In failing to fully exclude Canada's health care sys-

tem, the trade-in-services provisions repeat the mistakes made in previous agreements, including NAFTA.

Temporary Entry of Health Professionals⁴⁵

Like most of Canada's existing trade treaties, the TPP includes a chapter on the temporary entry of business persons (Chapter 12). Basically, this chapter allows certain types of workers from TPP countries to enter other TPP countries on a temporary basis without going through the usual immigration process.

Historically, temporary entry provisions in trade agreements have had implications for the health sector. In the 1990s, thousands of Canadian nurses used NAFTA's temporary entry provisions to move to the United States to work, and many still do today.⁴⁶ NAFTA's rules for "professionals" allow an unlimited number of nurses to migrate between Canada, the United States, and Mexico on a temporary basis. Other health-related occupations covered by NAFTA include dentists, pharmacists, psychologists, and medical technologists.⁴⁷

The TPP is unlikely to have a similar impact because the scope of the temporary entry provisions in the health sector are far more limited. In the category of "professionals," which is of greatest concern, Canada has excluded "all health, education, and social services occupations and related occupations" for each TPP country that would otherwise be covered. That means Canada offers no new access to health services professionals in the TPP other than that provided under existing agreements or programs.

Most TPP countries make similar exceptions, but there are some apparent variations. Australia and Brunei have not listed any sectoral reservations for professionals in their annexes to Chapter 12, so presumably all health services are covered. Malaysia has explicitly offered access for occupations in the category of "specialized medical services." Mexico offers access to all "technician professionals in health," which includes nurses, pharmacists, and physiotherapists, although these professions are already covered for Canadians under NAFTA.

The potential access to Australia for Canadian health services professionals may be most significant, although it is unlikely to rival the access that NAFTA affords to Canadian health workers in the United States. Australia has clarified that all potential TPP "professionals" require employer

sponsorship and must meet the “domestic standard” in Australia for their profession, which is subject to interpretation.

Like previous agreements, the TPP also accords temporary entry rights in the category of “intra-corporate transferees” (ICTs). There are no sectoral restrictions for ICTs in the TPP and the rules are essentially the same for all TPP countries. In theory, this category could be used by private, multinational health services firms to move some health workers into and out of Canada from certain TPP countries. The firm would need to have a presence in both countries and the worker would need to qualify as a “specialist,” defined as “an employee possessing specialized knowledge of the company’s products or services and their application in international markets, or an advanced level of expertise or knowledge of the company’s processes and procedures.” Since this definition is subject to the interpretation of immigration agents it is impossible to say at this point exactly which occupations might be covered.

It appears unlikely that the ICT provisions will facilitate meaningful numbers of health services workers into or out of Canada, although these rules may gain significance if more aspects of the health system are privatized.

TPP and Procurement

Overview of the Procurement Package

When Canada entered the TPP talks in 2012, a key ambition was to get an exemption from the Buy America requirements applied by the U.S. federal government on transfers to fund state and municipal infrastructure projects.⁴⁸ With the U.S. refusing to make concessions, Canadian negotiators made no progress on this issue. The Buy America requirements on federally funded projects remain fully intact.

Under the final deal, Canada will expand its coverage of government procurement at the federal level. Procurement by over 20 Canadian federal agencies and a dozen federal Crown corporations has been added to Canada’s existing commitments under the WTO Agreement on Government Procurement (GPA). In return, the U.S. government has agreed to provide Canadian suppliers with access to procurement by six federally owned energy utilities, such as the Tennessee Valley Authority.

At the provincial level, Canada did not go beyond its existing commitments under the GPA, which mainly applies to purchasing by provincial ministries and agencies. Procurement by municipalities, academic insti-

tutions, school boards, and hospitals (the MASH sector) is not covered by the TPP procurement chapter. Because the U.S. refused to budge on its Buy America preferences, Canada did not extend its sub-national coverage to the U.S., only to other TPP governments. This move is mainly symbolic, since the U.S. is a GPA signatory and will have access to the same Canadian provincial procurement under this agreement.

The federal government also committed over 20 service categories that were not covered under previous Canadian procurement agreements, including telecommunications-related services, business network services, and vocational, technical and professional training. Such contracts could have indirect implications for health care. However, Canada has excluded health services from the TPP procurement obligations, as has been the practice in previous trade agreements, including the GPA.

This exclusion, combined with the absence of new coverage at the provincial level and the exclusion of MASH-level procurement, means that the direct implications of the TPP government procurement obligations for Canadian health care will likely be minimal. But there are other TPP obligations related to government purchasing and the health care sector that raise concerns.

Public-Private Partnerships

Despite their serious shortcomings and negative track record, public-private partnerships (P3s) are increasingly used as an alternative to direct government provision and/or conventional government procurement of services. The investment chapter of the TPP contains provisions that would allow foreign investors to submit an investor–state claim on the grounds that a government has breached “investment authorisations” or “investment agreements.”⁴⁹

It should be stressed that these provisions enable international investment arbitration tribunals to adjudicate not only breaches of investment treaties, but also disputes regarding the investment agreement itself. This is the case even if the P3 contract obliges the parties to use other forms of dispute resolution.

It is astonishing that Canada would agree to rules that allow the private party in a P3 to disregard contractually agreed upon dispute resolution provisions and bypass the domestic courts in favour of investor–state arbitration under the TPP. Investor–state arbitration is a very lengthy, complex, and costly procedure for resolving disputes. Even more troubling is the fact

that arbitration tribunals tend to exhibit a pro-investor bias at the expense of the public and taxpayer interests, and fail to exercise the judicial restraint typically shown by domestic and international courts in similar contexts.⁵⁰

These draconian rules would apply to new P3s at the federal level in Canada. In defining investment agreements, the TPP investment chapter includes typical public-private partnerships such as those between a central government and an investor to “supply services on behalf of the Party for consumption by the general public for: power generation or distribution, water treatment or distribution, telecommunications, or other similar services supplied on behalf of the Party for consumption by the general public.”⁵¹ A footnote to this definition explains: “For the avoidance of doubt, this subparagraph does not cover correctional services, *healthcare services*, education services, childcare services, welfare services or other similar social services (emphasis added).”⁵²

While this clarification certainly excludes core health care services that might be provided through P3s, it does not clearly exclude services such as maintenance, computer and data management services, administration, and other health care support services. Indeed, even if a future P3 contract attempted to exclude such matters as related to health care it would be futile. Since the TPP gives foreign investors the right to bypass the dispute resolution mechanisms specified in the P3 agreement, sensitive decisions about the scope of the loosely worded exclusion for health care services will be made by investor arbitration panels that are beyond the reach of domestic law and the courts.

The Transparency Annex and Drug Pricing

Another aspect of the TPP that raises concern is Annex 26-A, entitled “Transparency and Procedural Fairness for Pharmaceutical Products and Medical Devices.” The annex does not cover the direct procurement of drugs (e.g., those medicines used in hospitals). But its purpose, as Dr. Deborah Gleeson notes, is “to discipline national pricing and reimbursement schemes for pharmaceutical products and medical devices.”⁵³

Throughout the TPP talks, the U.S. and Big Pharma targeted New Zealand’s government agency Pharmac, which does an exemplary job of controlling drug costs. Pharmac negotiates with both brand-name and generic companies over the costs of drugs that it approves for use in the country’s health care system. As a result, New Zealand’s per capita drug costs are among the lowest in the OECD. In the transparency annex, the U.S. pur-

sued new rights for brand-name companies to contest the decisions of public drug agencies and tilt the playing field toward “market-based” pricing, increasing costs to governments and the health care system.

New Zealand and Australia strongly resisted this push, and the final wording of the annex has been considerably watered down from the initial U.S. proposal that was leaked in 2011.⁵⁴ The annex is still generally biased in favour of industrial interests and against those of taxpayers and consumers, as Joel Lexchin discusses in the accompanying CCPA analysis. Initially, the restrictions apply only to the four TPP countries that already operate “national healthcare programs” regarding the reimbursement and pricing of drugs. These are Japan, the U.S., Australia, and New Zealand. The annex explicitly states, “Canada does not currently operate a national healthcare programme within the scope of this Annex.”⁵⁵ Nevertheless, Canada bowed to U.S. pressure to prospectively cover federal health care authorities under the annex. Consequently, if Canada develops a future national health care programme covering drug pricing and reimbursement it will come under pressure to comply with the transparency annex.

While most drugs in the Canadian public health care system are purchased or have the costs reimbursed by provincial governments, the federal government pays the cost of medications for Aboriginal peoples, the military, and some other groups. Encumbering the federal government in its future ability to get the best therapeutic value for taxpayers’ money when it pays for medicines sets a bad precedent. The TPP transparency annex could also hamper Ottawa’s future ability to co-operate effectively with provincial and territorial governments in joint measures to make drugs more affordable. For example, the annex would require that drug companies be given new rights to contest decisions not to list their drugs on a national formulary, even when there are lower-priced, medically effective alternatives available. While not an insurmountable obstacle, this would unnecessarily complicate the creation of a cost-effective national pharmacare program.

Conclusion

As a legal advisor to the 2002 Romanow Commission on the Future of Health Care in Canada observed, if the NAFTA investor protection provisions “and the accompanying investor-state dispute settlement mechanism procedures had existed in the 1960s, the public health system in its present form would never have come into existence.”⁵⁶ The commission, after extensive study,

recommended that in all future trade treaties Canada should seek a full exclusion for health care that makes “explicit allowance for both maintaining and expanding publicly insured, financed and delivered health care.” The TPP safeguards for health do not come anywhere close to attaining this essential goal.

Instead, the TPP would result in increased drug costs, a significant burden Canada’s medicare system simply can’t afford. The TPP also aims to expand the already controversial rights of foreign investors to challenge health regulation, lock in privatization, and impede the future expansion of Canada’s public health insurance. The treaty’s only innovative, beneficial public health safeguard – the partial carve-out for tobacco control – actually serves to underline the broader risks to health regulation.

While a strong and balanced international trade regime is critical to Canada’s economic success it should not, and need not, come at the expense of our public health system. Indeed, international trade barriers are already so low that imposing unnecessary costs and unpredictable risks on the Canadian health care system in exchange for slightly improved market access is a very poor bargain. The increased burden on taxpayers and consumers from higher drug costs alone would likely exceed the full savings to Canadian consumers from the TPP’s elimination of tariffs on imports into Canada, undercutting one of the chief arguments for liberalized trade.

Moreover, the TPP’s inclusion of extended patents and ISDS would erode the democratic authority of Canadian governments to renew and expand Canada’s most important social program. While health care is better protected from TPP restrictions than many other sectors, the TPP can still be expected to deepen corporate influence over health care systems in Canada and the other partnering countries.

Proponents tout the TPP as a “21st century trade agreement,” but it is actually backward and regressive in terms of safeguarding public health care and regulation. The TPP entrenches the structural defects of previous trade treaties while at the same time exposing public health systems to new threats.

Notes

1 Prime Minister of Canada. “Minister of Health Mandate Letter.” November 2015. <http://pm.gc.ca/eng/minister-health-mandate-letter>.

2 Founding TPP countries include Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, the United States and Vietnam. Canada already has free trade agreements in place with four of these countries (Chile, Mexico, Peru and the United States).

3 The most widely cited pro-TPP study — done by the Peterson Institute in 2012 — projected a 2.6 % increase in Canadian exports and a one-time boost to the Canadian economy of 0.5 percent of GDP by 2025. See Petri, P., M. Plummer and F Zhai. “The Trans-Pacific Partnership and Asia-Pacific Integration: A Quantitative Assessment”, Policy Analyses in International Economics 98, Peterson Institute for International Economics. 2012. A more recent study that builds on the Peterson Institute model, but relaxes its assumptions of full employment and invariant income flows, projects only a tiny increase of 0.28% to Canadian GDP over the next ten years if the TPP is implemented. Significantly, it estimates that Canada will lose 56,000 jobs. And Jeronim Capaldo and Alex Izurieta. “Trading Down: Unemployment, Inequality and Other Risks of the Trans-Pacific Partnership Agreement.” Tufts University. January 2016. Available at: http://www.ase.tufts.edu/gdae/policy_research/TPP_simulations.html.

4 The overall figures put Canada in fourth place behind Greece, but a senior economist with the OECD health division in Paris “pointed out that because the figures provided by Greece include other costs, it may be more accurate to put Canada in the third-highest spot for drug spending.” Elizabeth Church. “Canada among top pharmaceutical spenders on OECD list.” Globe and Mail. Nov. 04, 2015.

5 OECD. Health at a Glance 2015. November 2015. Chapter 10. “Pharmaceutical Expenditure.” Pp. 178 ff.

6 TPP Article 18.48 (2). Government of Canada. Consolidated TPP text. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-ptp/text-texte/toc-tdm.aspx?lang=eng>.

7 The TPP specifies certain grounds for excluding delays caused by factors, such as “periods of time that are attributable to the patent applicant.” By contrast, the CETA provides an automatic extension: that is even if the delay is due to factors beyond the regulator’s goal, the extension must be granted (up to the maximum of 2 years).

8 This estimate is based on calculations of the cost impacts of CETA, adjusted to reflect the specific requirements of the TPP. See Joel Lexchin. “Involuntary medication: The possible effects of the Trans-Pacific Partnership on the cost and regulation of medicine in Canada.” Canadian Centre for Policy Alternatives. January 2016.

9 Joel Lexchin and Marc-André Gagnon. “CETA and pharmaceuticals: impact of the trade agreement between Europe and Canada on the costs of prescription drugs.” *Globalization and Health*. May 6, 2014. Available at: <http://www.globalizationandhealth.com/content/10/1/30>.

10 Patented Medicine Prices Review Board. *Annual Report 2014*. Table 16 “Total R&D Expenditures and R&D-to-Sales Ratios of Reporting Companies, 1988–2014”. December 10, 2015. Available at: <http://www.pmprb-cepmb.gc.ca/en/reporting/annual-reports>.

11 Patented Medicine Prices Review Board. *Annual Report 2014*. p. 47.

12 Patented Medicine Prices Review Board. *Annual Report 2014*. p. 1.

13 Barney Jopson. “Hillary Clinton plans ‘exit tax’ to tackle inversions: Move could deter deals such as Pfizer’s planned \$160bn takeover of Allergan.” *Financial Times of London*. December 7, 2015. Available at: <https://next.ft.com/content/50dd21ca-9d39-11e5-8ce1-f6219b685d74> (Subscription required).

14 Doctors Without Borders/Médecins Sans Frontières. “The negative impact on public health will be enormous: Statement by MSF on the conclusion of Trans-Pacific Partnership negotiations in Atlanta.” October 5, 2015.

15 Doctors Without Borders/Médecins Sans Frontières. “The negative impact on public health will be enormous: Statement by MSF on the conclusion of Trans-Pacific Partnership negotiations in Atlanta.” October 5, 2015. Available at: <http://www.msf.ca/en/article/the-negative-impact-on-public-health-will-be-enormous-statement-by-msf-on-the-conclusion-of>.

16 Joel Lexchin. “Involuntary medication: The possible effects of the Trans-Pacific Partnership on the cost and regulation of medicine in Canada.” Canadian Centre for Policy Alternatives. January 2016.

17 Yet, as Gus van Harten notes, “Anything new and apparently better in the TPP, compared to NAFTA, is very likely lost because the TPP adds to, instead of replacing, existing trade agreements.” Gus Van Harten, “Seven Ways TPP Favours Mega-rich Foreign Investors, Not Canadians”. The-Tyee. Jan 18, 2016. Available at: <http://thetyee.ca/Opinion/2016/01/18/TPP-Foreign-Investors/>.

18 Nathalie Bernasconi-Osterwalder. “How the Investment Chapter of the Trans-Pacific Partnership Falls Short.” International Institute for Sustainable Development. November 6, 2015. Available at: <http://www.iisd.org/commentary/how-investment-chapter-trans-pacific-partnership-falls-short>.

19 TPP Chapter 11, Financial Services, Article 11.2(2): Scope. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-ptp/text-texte/11.aspx?lang=eng>.

20 Gus van Harten. *Sovereign Choices and Sovereign Constraints: Judicial Restraint in Investment Treaty Arbitration*. Oxford University Press. 2013. p. 102.

21 For example, foreign investors invoked the minimum standards of treatment provision (NAFTA Article 1105) in 69 out of 77 investor-state claims filed by January 1, 2015. See Scott Sinclair (with Hadrian Mertins-Kirkwood). “NAFTA Chapter 11 Investor-State Disputes to January 1, 2015.” Can-

adian Centre for Policy Alternatives. January 14, 2015. Available at: <https://www.policyalternatives.ca/publications/reports/nafta-chapter-11-investor-state-disputes-january-1-2015>.

22 Those efforts to re-regulate the health insurance market were themselves reversed by a subsequent government. The debate about whether to create a single-payer system is ongoing.

23 Luke Eric Peterson. “German court sees no clash between Achmea v. Slovakia arbitral award and EU law, and is unmoved by persistent arguments of European Commission.” *Investment Arbitration Reporter*. January 8, 2015. (Subscription required).

24 Joel Dahlquist and Luke Eric Peterson. “Arbitrators nixed DCF valuation of temporary harms In Achmea v. Slovakia I case, and declined to order state to refrain from future BIT breach.” *Investment Arbitration Reporter*. June 18, 2014.

25 During the 20 year history of NAFTA, consensus on binding interpretive notes has only been reached once, in 2001 regarding interpretive notes on transparency and minimum standards of treatment.

26 As of 2015, UNCTAD identifies 667 investor-state cases worldwide. United Nations Conference on Trade and Development. “Investment Agreements Navigator.” Available at: <http://investmentpolicyhub.unctad.org/IIA>.

27 In December 2015, Phillip Morris’s legal challenge against Australia under a Hong-Long Bilateral Investment Treaty was terminated. Because the claim was dismissed on jurisdictional grounds, the substantive issue of whether or not plain packaging rules run afoul of international investment treaties remains unresolved. “Philip Morris Suit Against Australia Dismissed On Jurisdictional Grounds.” *Inside U.S. Trade*. December 23, 2015.

28 The TPP contains an exception from certain of the chapter’s performance requirements prohibitions, for measures “*necessary* to protect human, animal, or plant life or health.” The inclusion of this exemption from aspects of one TPP obligation will likely be read as inferring that the drafters intended to make public health measures subject to other TPP provisions, unless explicitly exempted. Article 9.9 (3) (d): Performance Requirements. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-tppt/text-texte/toc-tdm.aspx?lang=eng>.

29 “(T)he treaty partners assured the public that language ‘underscores that countries retain the right to regulate in the public interest, including on health, safety, the financial sector and the environment.’ That provision, however, is subject to compliance with all of the other investor protections in the chapter, fully negating the preservation of policy space.” Lisa Sachs and Lise Johnson. “TPP would let foreign investors bypass the Canadian public interest.” *Globe and Mail*. Nov. 25, 2015.

30 According to the text: “A tobacco control measure means a measure of a Party related to the production or consumption of manufactured tobacco products (including products made or derived from tobacco), their distribution, labeling, packaging, advertising, marketing, promotion, sale, purchase, or use, as well as enforcement measures, such as inspection, recordkeeping, and reporting requirements. For greater certainty, a measure with respect to tobacco leaf that is not in the possession of a manufacturer of tobacco products or that is not part of a manufactured tobacco product is not a tobacco control measure.” TPP Article 29.5: Tobacco Control Measures. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-tppt/text-texte/toc-tdm.aspx?lang=eng>.

31 The mandate letter directs the health minister to “Introduce plain packaging requirements for tobacco products, similar to those in Australia and the United Kingdom.” Prime Minister of Canada. “Minister of Health Mandate Letter.” November 2015. Available at: <http://pm.gc.ca/eng/minister-health-mandate-letter>.

32 These are all regulatory priorities of the new federal government as set out in the ministerial mandate letter. Prime Minister of Canada. “Minister of Health Mandate Letter.” November 2015. Available at: <http://pm.gc.ca/eng/minister-health-mandate-letter>.

33 See Center for Policy Analysis on Trade and Health — CPATH. “Protect public health in TPP talks.” Available at: <http://www.cpath.org/id59.html>.

34 See Jim Grieshaber-Otto and Scott Sinclair. *Bad Medicine: trade treaties, privatization and health care reform in Canada*. Canadian Center for Policy Alternatives. 2004. Available at: <https://www.policyalternatives.ca/publications/reports/bad-medicine>.

35 For transparency purposes, Canada has including an illustrative, non-binding list of non-conforming measures maintained at the sub-national level of government. But all existing non-conforming measures, whether they appear on the list or not, are protected. TPP Annex I: Non-Conforming Measures - Canada. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-ptp/text-texte/31-1-a3.aspx?lang=eng>.

36 United States Trade Representative. TPP chapter summary: Cross Border Trade in Services. Available at: <https://ustr.gov/sites/default/files/TPP-Chapter-Summary-Cross-Border-Trade-in-Services.pdf>.

37 The full reservation reads, “Canada reserves the right to adopt or maintain a measure for providing public law enforcement and correctional services, as well as the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care.” TPP Annex I: Non-Conforming Measures - Canada. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-ptp/text-texte/31-2-a3.aspx?lang=eng>.

38 For a discussion of the differing views of Canadian and U.S. governments during the NAFTA sub-national reservations exercise, see Matthew Sanger and Scott Sinclair. *Putting Health First: Canadian Health Care Reform in a Globalizing World*. (Canadian Centre for Policy Alternatives, 2004). Endnote 1, pp. 13–15 and *Inside NAFTA*. November 29, 1995.

39 NAFTA Annex II-C-9 applies against the national treatment (1102, 1202), the services chapter’s most-favoured nation treatment (1203), local presence (1205) and senior management and board of directors (1107) articles.

40 Nevertheless, through NAFTA’s most-favoured nation treatment clause, U.S. and Mexican investors would be entitled to the most favourable treatment given to European investors under CETA in the Canadian health care sector. Furthermore, this amounts to a unilateral, non-reciprocal commitment by Canada. Non-conforming U.S. sub-national measures would still enjoy the protection of the NAFTA Annex I general reservation, as carried over into the TPP. Meanwhile, only those Canadian sub-national measures that are expressly reserved under CETA’s negative listing approach would be protected from challenge by U.S. or Mexican investors.

41 The RFP for the testing services could arguably be excluded from the TPP trade-in-services chapter by virtue of being government procurement. But since the provincial nursing bodies are independent entities, the success of such an argument is questionable.

42 See Michael Geist. “How the TPP may put your health care data at risk.” Toronto Star. Oct. 13 2015. Available at: <http://www.thestar.com/business/2015/10/13/how-the-tpp-may-put-your-health-care-data-at-risk-geist.html>.

43 TPP Article 10.7.3. Non-Conforming Measures. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-ptp/text-texte/toc-tdm.aspx?lang=eng>.

44 “Paragraphs 1 through 7 shall not apply to the non-conforming aspects of measures that are not subject to the obligations under Article 10.3 (National Treatment) or Article 10.5 (Market Access) by reason of an entry in a Party’s Schedule to Annex I, or to measures that are not subject to the obligations under Article 10.3 (National Treatment) or Article 10.5 (Market Access) by reason of an entry in a Party’s Schedule to Annex II.” TPP Article 10.8.8. Domestic Regulation. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-tpptp/text-texte/toc-tdm.aspx?lang=eng>.

45 This section was written by CCPA trade researcher Hadrian Mertins-Kirkwood.

46 Blouin, Chantal. “NAFTA and the Mobility of Highly Skilled Workers: The Case of Canadian Nurses,” *The Estey Centre Journal of International Law and Trade Policy*, vol. 6, no. 1 (2005).

47 See Appendix 1603.D.1 in “Chapter Sixteen: Temporary Entry for Business Persons,” *Text of the North American Free Trade Agreement (NAFTA)*. Available from Global Affairs Canada at <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/nafta-alena/text-texte/16.aspx?lang=eng>.

48 John Ivison. “Trans-Pacific talks provide opportunity to put an end to Buy American protectionism.” *National Post*. March 3, 2013. <http://news.nationalpost.com/full-comment/john-ivison-trans-pacific-partnership-talks-provide-opportunity-to-put-an-end-to-buy-american-protectionism>.

49 Trans-Pacific Partnership. Chapter 9: Investment. Article 9.18: Submission of a Claim to Arbitration. Accessible at: <https://ustr.gov/trade-agreements/free-trade-agreements/trans-pacific-partnership/tpp-full-text>.

50 Gus van Harten. *Sovereign Choices and Sovereign Constraints: Judicial Restraint in Investment Treaty Arbitration*. Oxford University Press. 2013.

51 A footnote to the TPP definition of investment agreement explains that: “For the avoidance of doubt, this subparagraph does not cover correctional services, healthcare services, education services, childcare services, welfare services or other similar social services.” Trans-Pacific Partnership. Chapter 9: Investment. Article 9.1. Definitions. P. 9–4. Accessible at: <https://ustr.gov/trade-agreements/free-trade-agreements/trans-pacific-partnership/tpp-full-text>.

52 Trans-Pacific Partnership. Chapter 9: Investment. Article 9.1. Definitions. P. 9–4.

53 Deborah Gleeson. “Preliminary analysis of the final TPP Healthcare Transparency Annex: Annex 26-A: Transparency and Procedural Fairness for Pharmaceutical Products and Medical Devices.” School of Psychology and Public Health, La Trobe University. December 12, 2015. P. 1.

54 Trans-Pacific Partnership: Transparency Chapter - Annex on Transparency and Procedural Fairness for Healthcare Technologies. June 22, 2011. Available at: <http://www.citizenstrade.org/ctc/wp-content/uploads/2011/10/TransPacificTransparency.pdf>.

55 Trans-Pacific Partnership: Annex 26-a. Transparency and Procedural Fairness for Pharmaceutical Products and Medical Devices. Schedule to Annex 26-A. Available at: <http://www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/tpp-tpptp/text-texte/26.aspx?lang=eng#26a>.

56 Jon Johnson. “How Will International Trade Agreements Affect Canadian Health Care?” in *Putting Health First: Canadian Health Care Reform in a Globalizing World*. Matthew Sanger and Scott Sinclair, eds.. Canadian Centre for Policy Alternatives, 2004.



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