The Urgent Need for Canadian Pharmacare:

How are Neoliberal Reforms and Trade Agreements Preventing its Implementation?

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Introduction

Though there is a clear and urgent need for a universal Pharmacare program in Canada, as can be seen with the growing inaccessibility to necessary prescription drugs across the country, one must wonder if it is Canada's increasingly neoliberal agenda, and resulting trade agreement obligations, that are preventing the federal government from implementing such a program. Inherent to neoliberalism is the belief that public expenditures on social programs are wasteful, that free markets are considered to be capable of solving all problems, social or otherwise, and that it is not the state's responsibility to ensure fair and equitable outcomes for its people. Furthermore, the growing number of 'new age' international free trade agreements, just one of many aspects of the neoliberal agenda, have been shaping public drug policy in two major ways; first, through arguably excessive patent protection provisions that have been correlated with a visible, and dramatic, rise in pharmaceutical prices and expenditures nationally, and second, through the inclusion of investor-state dispute settlement provisions which serve to create a 'chilling' effect for future public policies.

This difficult dual role that governments must play, in balancing the encouragement of pharmaceutical industry investment in Canada, with the needs of the public to contain costs and provide fair access to drugs, is only exacerbated by globalization and the growing push to further liberalize trade agreements. It is this expansion of trade agreements, from their original purpose of stimulating international trade in goods through the reduction of tariffs, to also cover trade of services and patent protection as well, that has had particularly far-reaching consequences across many facets of Canadians' lives. Thus one must beg the question: have Canada's numerous complex trade agreement obligations contributed to the government's inability to include Pharmacare under the Canada Health Act, despite overwhelming public support?

No room for Pharmacare in a neoliberal economy

Since the 1980s when global leaders included Margaret Thatcher, Ronald Reagan, and Brian Mulroney, a neoliberal agenda has been spread under a veil of so-called propaganda terms, such as 'free trade' and 'globalization' (Graeber, 2010). As an ideology, neoliberalism emphasizes a shrunken public sector, privatization wherever possible, minimal government intervention and investment in social services, and generally, an individualistic approach of "every man for himself" when it comes to wealth and health. Giroux argues that, in this sense, neoliberalism is inherently perverse: democracy becomes equated with profits, consumption with citizenship, and that the constant focus on competitive markets as the answer to all of the world's social problems inevitably breeds a culture of competitiveness blind to any social inequities, including those of power and wealth (Doughty, 2015). Thus from this perspective, the implementation or expansion of social programs, such as Pharmacare, are instantly deemed unaffordable, unattractive, and unfeasible to implement. This is despite the clear success of such programs in Scandinavian countries which exhibit not only more stable economies, but also greater economic and social equity (Doughty, 2015).

Neoliberal approach to Pharmacare: Higher drug expenditures, less accessibility

To understand the potential impacts that trade agreements may be having on Canada's ability to implement a Pharmacare program, one must first explore the arguments which support the public provision of drugs. Tommy Douglas, the founding father of universal healthcare in Canada, initially envisioned a comprehensive and universal health care system in Canada that, in addition to comprehensive physician and hospital services, would eventually include an expansion into the coverage of additional medical services for all Canadians as they proved to be necessary in the following decades (Taylor, 2015). In other words, the Canadian medical care

system was never intended to be a static entity. In fact, two of Douglas' criteria for health care provision were that health care be provided equally and equitably to all and that derisive means tests should no longer be used to determine eligibility for health care services (Taylor, 1987). Yet over eighty years since his call for universal healthcare, Canada's pharmaceutical coverage does not meet either of these criteria. Despite overwhelming public support as well as numerous reports, studies, and Commissions[1], that have provided compelling evidence of the social and economic benefits it would provide nationally, a comprehensive national drug plan has still yet to come to fruition.

Rather, pharmaceutical coverage in Canada is currently in the form of a multi-payer system that entails a patchwork of complex plans and subsidies. Overall, the difficult to navigate system has resulted in poor and inequitable coverage for many Canadians. In addition to the fact that the most vulnerable populations are disproportionately affected by these policies, the CCPA (2017) estimates that 1 in 5 Canadians cannot afford their prescriptions. The effects of this unaffordability of medication can be seen in the increase in use of emergency rooms to treat conditions related to non-adherence that would otherwise be avoidable (CCPA, 2017).

Importantly, many studies have found that many Canadians are threatened by incurring significant financial burdens as a result of the cost of their prescriptions (Law, Cheng, Dhalla, et al., 2012; Sinnott, Buckley, O'Riordan, Bradley, & Whelton, 2013). More specifically, Canadians who do not have private health insurance through their employment, including those who are self-employed or have precarious employment arrangements, those who have experienced a significant decrease in their salary due to illness, and those who have high out-of-pocket expenses in comparison to their income are the most severely affected by rising drug

[1] Including: the 1964 Royal Commission on Health Services, the 1997 National Forum on Health, and the 2002 Royal Commission on the Future of Health Care in Canada (more commonly known as the Romanow Report)

costs (Nelson, 2010). In addition, the majority of public sector workers have adequate drug coverage, but 45% of workers in the private sector do not (Taylor, 2015). In other words, Canada has a two-tier medical system when it comes to pharmaceuticals, in that it is inequitable across provinces, territories, occupations, ages, and incomes—the end result being that necessary prescriptions remain inaccessible to a large proportion of Canadians.

Canada's need for pharmaceuticals to be covered under the Canada Health Act is exemplified to an even greater extent when comparing Canada's pharmaceutical coverage to the international scenario. Shockingly, Canada is the only country in the world with a public health care system that does not include universal drug coverage (CCPA, 2017). In addition, Canadians pay the third highest prices for prescriptions out of all of the OECD countries, only behind the U.S. and Switzerland (CIHI, 2017). Canadian drug spending is also 30% above the OECD average, yet Canada spends the third least public dollars of all OECD countries (Gagnon, 2014). Rather, approximately 57% of prescribed drug spending in Canada falls under out-of-pocket expenses and private insurance plans, with the rest being financed by the public sector. Of this, only 2% is paid for by the federal government (CIHI, 2017). It is clear then that a significant majority of national pharmaceutical expenditures have been imposed on provincial governments and individuals, rather than the federal government, which has, in turn, resulted in very inequitable coverage between the different provinces and territories. The fact that the federal government does not currently spend a significant amount on drugs is important to note when considering why national Pharmacare has yet to be realized. If they were to implement such a program, they would be absorbing costs from the provinces that they otherwise would have been able to avoid, an additional argument not to, given the neoliberal viewpoint that pharmaceutical coverage is better regulated by a free market anyway.

Though there is clear evidence to the contrary, the main justification for not implementing a Pharmacare program thus far has been that it will not be economically feasible or efficient. Gagnon (2014), however, argues that moving from the fragmented multi-payer system currently in place to a single-payer model would not only increase its efficiency and equity, but would result in huge economic savings particularly from minimizing its administrative complexity. Furthermore, Morgan, Leopold, & Wagner (2017) found that, in general, countries that implement single-payer systems exhibit lower average expenditures on drugs when compared to countries that do not have a single-payer system in place. Although the implementation of a single-payer system would entail greater costs for the federal government, over $30 billion could potentially be saved amongst individuals, governments, and insurance providers (CCPA, 2017). This would thus translate into a net increased expenditure of only $1 billion annually, a tiny fraction of Canada's GDP.

Defining 'new age' trade agreements

As mentioned, traditionally, free trade agreements, such as the WTO's General Agreement on Tarrifs and Trade (GATT), were created with the intent of stimulating free trade in goods between countries through the reduction of tariffs. New age agreements, however, such as the Trans-Pacific Partnership (TPP-11), Canada-European Union Comprehensive Economic Trade Agreement (CETA), and North American Free Trade Agreement (NAFTA), have increasingly liberalized the definition of trade to no longer just refer to trade in goods, but also to trade in investments and intellectual property. As such, they have been intensely criticized by analysts for being convoluted and playing a large part in reinforcing existing asymmetries of power between the countries involved. Globalization, in its current form, now refers to a

complex web of regulations and standards within each trade agreement, each of which may be several thousands of pages long.

A wealth of literature exists which describes significant, though perhaps unintended, negative implications for the social safety nets and public health of many countries as a result of the expansion of trade agreements to include non-tariff barriers, such as investments and intellectual property rights[2]. There is also concern about the problematic trend of expanding trade agreements to include more and more countries. For example, 11 countries have signed the TPP and the EU includes 27 member states who are signatories to CETA. This will inevitably increase the complexity of these agreements and make it more difficult to come to a consensus regarding necessary reforms and adjustments to provisions which may impact the social programs of any of the countries involved.

A further criticism of new age trade agreements is that they are typically negotiated behind closed doors between government officials and industry stakeholders with vested interests, yet without significant public inquiry. Other concerns revolve around the regulations included in the agreements, and the often circular language used within them, that has had, in many cases, negative effects on the environment, labour standards, access to medicines, and public health regulations of the countries involved[3]. Particularly problematic are the effects that trade obligations may have on the ability of countries involved to expand their social safety nets. This is especially true for developing countries who experience the greatest asymmetry in power

[2] See footnote 2

[3] Though many different reports describe these impacts, the briefs provided to the House of Commons' Standing Committee on International Trade for its recent "Report 8: Priorities of Canadian Stakeholders Having an Interest in Bilateral and Trilateral Trade in North America, Between Canada, United States and Mexico" provide a good overview of NAFTA's impacts on Canada. See the submission by the Environmental Coalition of Prince Edward Island for impacts on the environment; the submission from Unifor for impacts on labour standards; the submission from the Canadian HIV/AIDS Legal Network regarding access to medicines; and the submission from the CCPA for public health regulations.

when compared to the biggest global players in trade, such as the U.S. or the E.U. Most significantly for the purposes of this paper, however, these increasingly liberalized trade agreements may have particularly pronounced effects on Canada's ability to expand Medicare to include a Pharmacare program.

The abolishment of compulsory licensing opened the door to a new age of patents

Currently, Canada is a signatory to two free trade agreements that have already had particularly drastic implications for Canadian pharmaceutical policy: NAFTA and the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS Agreement) of the World Trade Organization (WTO). To understand why these have been problematic, one must understand the history of how intellectual property rights (IPRs) and patent protection provisions came to be a part of these agreements.

One of the explicit consequences of neoliberalism on the affordability of prescription drugs can be seen with the weakening, then complete abandonment, of compulsory licensing in Canada. Compulsory licensing refers to regulations which allow generic versions of drugs to be produced without the need for permission from the patent holder. Before the onset of neoliberalism in the 1980s, Canada had reasonably strong compulsory licensing laws via Bill C-102—an amendment to the Patent Act that allowed for an expansion of rights for generic drug producers. These regulations proved to be so effective at lowering pharmaceutical costs that, at the time, Canada had one of the lowest overall drug expenditures of the OECD countries.

However, for apparent reasons, compulsory licensing was not in the interests of multinational pharmaceutical corporations with U.S. drug companies, in particular, left frustrated by Canadian regulations. At the same time that the Canadian government was being lobbied by

drug companies to enhance patent protection, Ronald Reagan appointed the president of Pfizer Inc., a massive multinational drug company, as the head of the US' trade advisory panel. As a result, expanded IPRs for drug companies became "the top priority of the US agenda" (Lexchin, 2001). In 1987, Canada's eagerness to gain access to the American market resulted in the asymmetric Canada-US Free Trade Agreement (CUSFTA) that many analysts argue strongly favoured American interests. In return for access to American markets, Canada passed Bill C-22 which began the trend towards further and further patent protection for American drug companies, before compulsory licensing was essentially abolished with the transition from the CUSFTA to NAFTA in 1993. Simultaneous to NAFTA's negotiations coming to completion, the WTO's TRIPS agreement was also being negotiated. According to Reichman (2009), the intellectual property chapter within NAFTA, Chapter 17, became a blueprint of sorts for Article 31 in the WTO's TRIPS agreement to which 148 countries are now signatories.

Many researchers argue that the expansion of intellectual property protection is a major contributor in restricting the availability of cheaper generic drugs and thereby, the driving up of healthcare costs (Lexchin, 2017). Yet, included in NAFTA, CETA, and the TPP, are provisions which strengthen intellectual property rights (IPRs)—a significant shift away from the previous legal framework of information owned as a time-limited monopoly. May (2006) argues that the shift towards treating ideas as one's 'right' is simply a manifestation of capitalism, an attempt to commodify information and knowledge for the express purpose of gaining profit.

In other words, IPRs 'reify' information to construct an artificial scarcity of knowledge, such that the patented pharmaceutical information may be treated like a traditional market good (May, 2006). Yet, renowned Nobel prize winning economist, Joseph Stiglitz (2008), argues, that knowledge is, and must be treated as, a public good. To do otherwise, he claims, only impedes

innovation which proves particularly important in the realm of health and in products, such as pharmaceuticals, that are 'life or death' (Stiglitz, 2008). The commodification of public goods only serves to open these sectors up to abuses of power. Furthermore, the extension of patent protection, and introduction of monopolies, is counterintuitive to the argument that free market fundamentalists (proponents of neoliberalism) most utilize: that there must be free market competition to produce the most efficient outcomes in the economy.

Though trade negotiators and Big Pharma argue that intellectual property rights are a necessary incentive for pharmaceutical companies to increase their investments in research and development (R&D) of new and innovative lifesaving drugs, research has shown that innovation has actually decreased with liberalized IPRs (Sinclair, 2017). Despite promises from brand-name manufacturers to invest 10% of sales revenues into R&D, the Patented Medicine Prices Review Board (PMPRB) found that, in actuality, R&D was at a record low of only about 4.9% in 2016 (Canadian Generics, 2017). IPRs have instead opened the door to 'evergreening', a practice in which drug companies essentially attempt to find new and innovative ways to extend their monopolies, and thus profits, past their original terms. This can range from opening several patents on the drug (in order to intentionally create a cost or time barrier for the generic companies who have far less resources) to claiming patents on 'novel' uses for the same drug (Faunce & Lexchin, 2007).

Canada's *Notice of Compliance* regulations, developed in order to conform to NAFTA, require Canadian generic drug producers to notify brand name pharmaceutical companies of their intention to create generic versions of their drugs. This has, in effect, led to further forms of evergreening by Big Pharma in attempts to prolong generic drug producers' access to the market (Faunce & Lexchin, 2007). In so doing, the Canadian Generic Pharmaceutical Association

(CGPA) claims that “the Canadian public loses out on millions of dollars in savings by having to pay for the higher-priced brand-name version for an extended period of time. The delays caused by these needless court battles have cost Canadians, their governments and private insurers hundreds of millions of dollars" (Faunce & Lexchin, 2007).

Overall, the expansion of patents as IPRs has had three major effects on Canada’s ability to implement Pharmacare. First, IPRs have severely limited Canada’s authority in enforcing compulsory licensing and protecting the generics industry to continue the production of non-brand name drugs, the availability of which would keep costs low for a feasible Pharmacare program. Secondly, the inclusion of IPRs in trade agreements has also led to expensive, and wasteful, legal battles between generics and brand-name producers that come at a huge price to tax-payers. Finally, the creation of monopolies in the industry affords companies the right to charge unfounded, often outrageous, prices that likely serve as an additional deterrent to governments from establishing a program in which they would be absorbing these massive costs.

The costs of expanded IPRs

Gleeson, Neuwelt, Monasterio, & Lopert (2015) describe that the dramatic increase in pharmaceutical expenditures globally has been driven up primarily by the costs of patented drugs; in the U.S., for example, patented drugs make up only 20% of prescriptions, but 80% of the costs. They also note that countries such as the U.S., the E.U., and Japan, which house large transnational pharmaceutical companies “tend to have stronger intellectual property protections for pharmaceuticals than countries that are primarily importers of medicines” (Gleeson, Neuwelt, Monasterio, & Lopert, 2015). Thus, understandably, there has been a growing focus in research on the corruption of pharmaceutical companies and the large influence that they tend to have in negotiating and shaping IPR provisions in international trade agreements.

Examples of IPRs proposed by pharmaceutical companies and imposed through trade agreements include tactics such as: extending data exclusivity periods (preventing generic producers from accessing the safety and efficacy data from the clinical trials conducted by the brand name producer); patent term extensions to compensate for processing or regulatory delays (with the effect that generic alternatives will be further delayed from entry to the market); and patent linkage provisions which ensure that drug regulatory authorities must scan for existing patents, provide notification to patent holders, and delay marketing approval for generic alternatives until the conclusion of dispute settlement proceedings (Gleeson & Lexchin, 2016). Lopert and Gleeson (2017) argue that by signing on to trade agreements that include these provisions, the state is essentially giving permission to pharmaceutical companies to continue 'evergreening' their drugs—the costs of which will inevitably be borne by all taxpayers, either directly through higher co-payments and out-of-pocket costs, or through their tax dollars.

Researchers, Joel Lexchin and Marc-Andre Gagnon, attempted to quantify the impact of CETA's IPR provisions on prescription drug costs in both Canada and the European Union (EU) and found that, perhaps not surprisingly, the agreement would only have a negative effect on Canadian drug costs without affecting expenditures in the E.U. (Lexchin & Gagnon, 2013). Based on figures found in a study by Grootendorst and Hollis (2011), which first estimated the consequences of CETA's IPR provisions before CETA was ratified through the analysis of 15 drugs in Canada for which there was a generic equivalent available, they attempted to update these figures using the final provisions in CETA. They found that, on average, market exclusivity for patented drugs would be extended by approximately one year which would come with a total annual cost of almost $800 million (Lexchin & Gagnon, 2013). They also found that if data exclusivity was extended to non-innovative drugs, the average delay in generic

equivalents being released to the market would be approximately two years, which would increase yearly pharmaceutical expenditures by just under $1.6 billion (Lexchin & Gagnon, 2013). Though these additional costs are based on figures retrieved from another analysis, it is worth noting that the federal government found similar figures (approximately $2 billion in additional costs for patented drugs) in an independent analysis (Canadian Press, 2012).

Though not quite as drastic, the data exclusivity provisions in the TPP could increase annual spending by as much as 5% (or $636 million) annually (Lexchin, 2017). This is an estimate based off of the calculations from the CETA study, however, and given the recent changes to the IPRs in the TPP-11, this is an area that will need to be studied further in the future to provide a better estimate of the financial consequences from the TPP's IPRs. According to Lexchin and Gagnon, drug expenditures could rise between 5 and almost 13% annually, beginning in 2023, depending on whether CETA or the TPP is ratified first (Lexchin, 2016). The vast majority of these additional costs will then be absorbed by the provinces who may be forced to limit the variety of drugs offered under their provincial plans, again affecting the most vulnerable populations with the greatest need for access to these medications.

Overall, in terms of the implications for a future Pharmacare program, the greatest concern with increasing monopoly rights for brand name pharmaceuticals, through extended patent terms and TRIPS-Plus type provisions, is that these provisions will result in even less availability of cheaper generic alternatives and will thereby drastically increase drug expenditures. The actual increase in costs, however, from prospective trade agreements have yet to be well studied and quantified aside from Lexchin and Gagnon's study. Given the small fraction of drug costs currently covered by the federal government, 2% according to CIHI (2017), it is reasonable to wonder whether they will have the appetite to absorb the increase in

the costs of drugs with a national Pharmacare program. Future research directions may include different approaches to analyzing the increased costs due to the changes in IPR provisions, though estimates will remain to be solely speculation until CETA and the TPP are fully ratified.

Overall, it is clear that the new IPRs afforded in these trade agreements have a disproportionate benefit for brand-name pharmaceutical companies, while imposing additional onerous and unnecessary barriers to affordable medicines, effectively increasing drug prices and delaying access to potentially life-saving medications. Truly, the most practicable solution for defending the future of Pharmacare, particularly in terms of pharmaceutical cost containment, is to renegotiate the IPR provisions of TPP and CETA and refuse to further liberalize those included in NAFTA.

Expropriation provisions and the ISDS undermine national sovereignty

Despite the highly controversial nature of investor-state dispute settlement (ISDS) mechanisms, they have now been incorporated into most Canadian trade agreements; notably, this includes the TPP, CETA, and NAFTA. In essence, ISDS mechanisms provide a venue for private enterprises and powerful multi-national corporations to seek compensation directly from the governments of countries who have signed on to trade agreements that include these provisions in the event that they wish to argue that their investment rights have been violated (Sinclair, 2017). In other words, if an action is taken, or legislation created, by the government that a company finds is tantamount to expropriation and interferes with their rights to earn profits in Canada, they may pursue legal action against the Canadian government. In the TPP, the language for the ISDS clause has been expanded to include interference with “expectations of profit” as the basis for initiating a claim (Canadian HIV/AIDS Legal Network, 2017). Importantly, these mechanisms also allow companies to bypass the judicial system of the country

that they have invested in, without the permission of their home country, to pursue private arbitration by a small tribunal of independent arbitrators (Canadian Centre for Policy Alternatives, 2018).

Two main perspectives exist in relation to investor-state dispute settlement mechanisms. The first sees them as a fair and reasonable method of ensuring that companies may protect their investments from expropriation via arbitration that is independent of the country's judicial system, which may arguably be biased in favour of its own government (Robinson, 2004). Conversely, many researchers, including McBride (2006), argue that by agreeing to dispute settlement procedures, governments are essentially consenting to a significant transfer of power in the decision-making of many public matters from government officials, and the public to whom they are accountable, into the hands of international, private entities. Thus, McBride (2006) argues that ISDS provisions in trade agreements only serve to undermine national sovereignty.

The most significant impact of ISDS claims is that they have the potential to result in a chilling effect against governments introducing new regulations regardless of whether they were meant to protect the environment, labour force, or public health of the nations involved. More specifically, governments may be averse to implementing regulations which could be considered tantamount to expropriation in order to avoid the massive costs associated, not only with the compensation they would be forced to provide if they lost, but also, the fees that they would incur defending themselves in a legal matter (Sinclair, 2017). In regards to Pharmacare, specifically, it is possible that the federal government may avoid creating national drug policies that could interfere with the potential or future profits of foreign companies which originate in countries involved in trade agreements that include ISDS provisions.

The CCPA further noted in their 2002 submission to the Romanow Commission that NAFTA's inclusion of ISDS in its Chapter 11 could very well be used by private firms to demand compensation for measures that expand Medicare coverage and thereby restrict private profits (Canadian Centre for Policy Alternatives Consortium on Globalization and Health, 2002). Furthermore, researchers maintain that the measures put in place to protect against foreign investors using these measures to interfere with public services are largely toothless and non-binding.

According to Epps & Flood (2002), the ability to use NAFTA's ISDS mechanism to sue the Canadian government for expropriation in health-related matters is likely to apply regardless of NAFTA's Annex II: Reservations for Future Measures provision. They explain that this was written into NAFTA to ensure that each country reserves the right to maintain or adopt new and existing regulations for social services, so long as they are provided as a public (non-commercial) service, including healthcare (Epps & Flood, 2002). However, given the precedent of previous ambiguous interpretations of this reservation, and the fact that pharmaceutical coverage is not yet entirely provided publicly, the opportunity to claim damages from the federal government remains if an affected company assumes that their right to potential future profits has been infringed upon via the new regulation in question.

One such example can be seen in the *Eli Lilly and Company v. The Government of Canada* case. Under Chapter 11 of NAFTA, Eli Lilly sought $500 million USD in damages from the Canadian government citing loss of profits and the violation of their rights to being afforded fair and equal treatment (FET) after two of its patents, that had been found to violate the 'promise utility doctrine,' were revoked by Canadian courts (Lentner, 2017). Essentially, the 'promise utility doctrine' had been put in place to ensure that the drugs produced by

pharmaceutical companies do, in fact, live up to the utilities and benefits promised in their patent applications (Lentner, 2017). Though the NAFTA tribunal eventually ruled in Canada's favour, it is still a frightening notion that a foreign pharmaceutical company is able to utilize the regulatory actions of a trade agreement to seek compensation against Canada in order to protect its investment in marketing a drug that did not even demonstrate its original utility. Had Eli Lilly won, there would have been significant impacts on generic pharmaceutical producers and their ability to continue providing affordable medicines (Canadian HIV/AIDS Legal Network, 2017). Furthermore, the threat of further expensive and time-consuming ISDS claims, by either a foreign company who currently provides medical insurance or another pharmaceutical company upset that its drugs were not included on the national formulary, may be sufficient to generate a chilling effect and be a further barrier to creating a national Pharmacare program.

Sinclair (2017) notes that, should the Canadian healthcare system begin to offer a universal Pharmacare program, the potential for claims of expropriation by an adversely affected insurance company are not far-fetched. In fact, investment disputes have arisen in Poland and Slovakia from foreign insurance companies upset by governmental attempts to return privatized health insurance systems to their former public provision (Sinclair, 2017). In *Eureko v. Poland*, Dutch-based insurance company, Eureko, who had a 30% stake in Poland's national health insurance, sued (and won) for expropriation when, due to public backlash, the Polish government decided to cancel further privatization of their health care system. Their expansion into further privatization would have allowed Eureko to own the majority of Poland's national health insurance provider's shares which meant a loss of potential profits for the company (Sinclair, 2017).

The *Eureko v. Poland* case is an important example of the "ratchet effect;" once a formerly public entity is privatized, it is near impossible to return it to the public system without damages being claimed. Importantly, this dispute arose from claims based on bilateral treaties, which involve only two countries; the inclusion of an ISDS system in CETA and the TPP opens up the Canadian health care system to challenges from foreign companies in an additional 39 countries, (not including the many bilateral agreements that Canada is involved in which also include ISDS provisions). Under NAFTA alone, Canada has been the subject of 41 disputes, almost double the number that have been filed against Mexico or the U.S. (23 and 21 claims respectively), and has spent over $300 million combined in legal costs, damages, and settlements (Sinclair, 2018). Furthermore, if Eureko v. Poland cost the Polish government approximately $1.6 billion US to settle, the potential cost to the Canadian government in ISDS claims from 39 countries is unimaginable.

Finally, it is important to note the extent to which Canada has already been sued under NAFTA's Chapter 11 alone. Sinclair (2018) found that Canada has been the most-sued country under NAFTA with 41 cases filed against the Canadian government—18 instances more than Mexico, and 20 more than have been filed against the U.S. government. Of these 41 cases, Canada also has the most losses (eight compared to Mexico's five and zero losses for the States), translating into approximately $95 million in legal costs and $219 million paid out to investors (Sinclair, 2018). Eight cases are still pending and thus the financial toll from this mechanism will inevitably increase. With CETA and the TPP fully implemented, private corporations from an additional 38 countries will have the ability to initiate ISDS claims against Canada; the potential cost this could have to the government is inconceivable.

In short, the possibility of incurring massive compensation costs from insurance companies who currently provide drug coverage and from pharmaceutical companies who may claim damages with the introduction of a national Pharmacare program may indeed be enough to put a chill on the expansion of public health insurance. Though there are few precedents which may allow these private corporations to utilize the ISDS mechanism, the vague wording included in these trade agreements, as well as the fact that cases are judged by independent tribunals separate from the regular justice system, allows for rather open interpretation. Given the chilling effect that other ISDS cases have had against the introduction of crucial public health and environmental regulations[4] in Canada, many critics argue that the best solution to prevent potential further damage from ISDS claims is to negotiate to have this problematic mechanism removed from existing and impending trade agreements altogether.

Conclusion

In short, between the worldwide trend towards neoliberalism and the growing number of 'new age' trade agreements, there are many disincentives for the federal government to establish a national Pharmacare program. Proponents of 'new age' trade agreements tout them as progressive and inevitable, despite the many indications to the contrary; overwhelmingly, the inclusion of extended patents on knowledge, ambiguous expropriation provisions, and subjective investor-state dispute mechanisms in trade agreements has had harmful effects on Canada's sovereignty, particularly in the realm of public health. Drug expenditures are growing as a result, and will continue to grow as Canada signs on to more multilateral trade agreements, while accessibility diminishes. The obligations and limitations to which the federal government is subject will become increasingly convoluted to navigate and will continue to hinder the

[4] See *Ethyl Corporation v. Government of Canada* (1997) *and S.D. Myers Inc. v. Government of Canada* (1998) respectively

realization of more equitable pharmaceutical coverage. Thus, though there is clear evidence of the need for Pharmacare to ensure fair and universal coverage of pharmaceuticals, in a neoliberal society with a growing trend towards globalization, it is unlikely to materialize.

References

Canadian Centre for Policy Alternatives. (2017). Cost savings resulting from a national Pharmacare program. Retrieved from https://www.policyalternatives.ca/publications/reports/cost-savings-resulting-national-pharmacare-program

Canadian Centre for Policy Alternatives Consortium on Globalization and Health. (2002). Putting health first: Canadian health care reform, trade treaties and foreign policy. *Commission on the Future of Health Care in Canada*, 1-67.

Canadian Generics. (2017). *New report: Canadian R&D-to-sales ratio for brand-name drug companies less than half of 10% commitment.* Retrieved from http://canadiangenerics.ca/news-release6/new-report-canadian-rd-to-sales-ratio-for-brand-name-drug-companies-less-than-half-of-10-commitment/

Canadian Generics. (2017). *North American generic and biosimilar medicines industries release priorities for renegotiation of NAFTA*. Retrieved from http://canadiangenerics.ca/wp-content/uploads/Trilateral-NAFTA-Priorities-Letter-Final.pdf

Canadian HIV/AIDS Legal Network. (2017). Towards a new NAFTA: Safeguarding public health and access to medicines (Submission to the House of Commons Standing Committee on International Trade). Retrieved from

http://www.ourcommons.ca/Content/Committee/421/CIIT/Brief/BR9174336/br-external/CanadianHIV-AIDS-LegalNetwork-e.pdf

Canadian Institute for Health Information. (2017). *Drug spending at a glance.* Retrieved from https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf

Doughty, H.A. (2015). From bad to worse: Twenty more years of the assault on the public sector. *The Public Sector Innovation Journal, 20*(2), 1-21.

Epps, T. & Flood, C.M. (2002). Have we traded away the opportunity for innovative healthcare reform? The implications of the NAFTA for Medicare. *McGill Law Journal, 47*, 747-790.

Faunce, T.A. & Lexchin, J. (2007). 'Linkage' pharmaceutical evergreening in Canada and Australia. *Australia and New Zealand Health Policy, 4*(8), 1-11.

Gagnon, M.A. (2014). *A roadmap to a rational Pharmacare policy in Canada.* Ottawa, Ontario: The Canadian Federation of Nurses Unions.

Gagnon, M.A. (2010). *The economic case for universal Pharmacare: costs and benefits of publicly funded drug coverage for all Canadians.* Ottawa, Ontario: Canadian Centre for Policy Alternatives.

Gleeson, D. & Lexchin, J. (2016). The Trans Pacific Partnership Agreement and pharmaceutical regulation in Canada and Australia. *International Journal of Health Services, 46*(4), 597-613.

Gleeson, D.H. & Lopert, R. (2017). The Trans Pacific Partnership Agreement, intellectual property and medicines: Differential outcomes for developed and developing countries. *Global Social Policy, 00*(0), 1-21.

Gleeson, D., Neuwelt, P. Monasterio, E. & Lopert, R. (2015). How the transnational pharmaceutical industry pursues its interests through international trade and investment agreements: a case of the Trans Pacific Partnership. In Dejonge, A. & Tomasic, T. (eds.) *Handbook of research on transnational corporations*. Edward Elgar Publishing Ltd. *(forthcoming)*

Graeber, D. (2010). Neoliberalism or the bureaucratization of the world. In H. Gusterson & C. Besteman (Ed.), *The Insecure American: How we got here and what we should do about it (*pp. 79-96). Los Angeles, California: University of California Press.

Grootendorst, P. & Hollis, A. (2011). The 2011 Canada-European Union Comprehensive Economic and Trade Agreement: An economic impact assessment of the E.U.'s proposed pharmaceutical intellectual property provisions. *Journal of Generic Medicines, 8*(2), 81-103.

Labonte, R., Schram, A., Ruckert, A. (2016). The Trans-Pacific Partnership Agreement and health: few gains, some losses, many risks. *Globalization and Health, 12*(25),1-7.

Law, M.R., Cheng, L., Dhalla, I.A., et al. (2012). The effect of cost on adherence to prescription medications in Canada. *CMAJ, 184*, 297-302.

Lentner, G.M. (2017). Litigating patents in investment arbitration: *Eli Lilly v Canada. Journal of Intellectual Property Law & Practice, 12*(10), 815-816.

Lexchin, J. (2001). A national Pharmacare plan: Combining efficiency and equity. *Canadian Centre for Policy Alternatives,* 1-12.

Lexchin, J. (2013). Canada and access to medicines in developing countries: intellectual property rights first. *Globalization and Health*, *9*(42), 1-8.

Lexchin, J. & Gagnon, M.A. (2013). CETA and pharmaceuticals: Impact of the trade agreement between Europe and Canada on the costs of patented drugs. *Canadian Centre for Policy Alternatives,* 1-7.

Lexchin, J. (2001). Globalization, trade deals and drugs: Heads the industry wins, tails Canada loses. *Canadian Centre for Policy Alternatives, 2*(8), 1-14.

Lexchin, J. (2017). Drug prices: How do we get to a better place? *Canadian Medical Association Journal, 189*(23), 792-793.

Lexchin, J. (2005). Intellectual property rights and the Canadian pharmaceutical marketplace: where do we go from here? *International Journal of Health Services, 35*(2), 237-256.

Mackenzie, H. (2016). Down the drain: How Canada has wasted $62 billion health care dollars without Pharmacare. *Canadian Federation of Nurses Union*, 1-16.

May, C. (2006). The denial of history: Reification, intellectual property rights and the lessons of the past. *Capital & Class, 88*, 33-55.

McBride, S. (2006). Reconfiguring sovereignty: NAFTA Chapter 11 dispute settlement procedures and the issue of public-private authority. *Canadian Journal of Political Sciences, 39*(4), 755-755.

Morgan, S.G., Leopold, C. & Wagner, A.K. (2017). Drivers of expenditure on primary care prescription drugs in 10 high-income countries with universal health coverage. *Canadian Medical Association Journal, 189*(23), 794-799.

Morgan, S.G., Law, M., Daw, J.R., Abraham, L., & Martin, D. (2015). Estimated cost of universal public coverage of prescription drugs in Canada. Canadian Medical Association Journal, 187(7), 491-497.

Nelson, C. (2010). The financial hardship of cancer in Canada: A literature review. *The Canadian Cancer Society Manitoba*, 1-35.

Reichman, J.H. (2009). Compulsory licensing of patented pharmaceutical inventions: Evaluating the options. *Journal of Law, Medicine & Ethics, 37*(2), 247-263.

Robinson, J. (2002). NAFTA and sovereignty. In S. Weintraub (Eds.), *NAFTA's impact on North America: The first decade* (341-369). Washinton, D.C.: Centre for Strategic and International Studies Press.

Sinclair, S. (2018). Canada's track record under NAFTA Chapter 11: North American Investor-State disputes to January 2018. *Canadian Centre for Policy Alternatives,* 1-48.

Sinclair, S. (2016). Major complications: the TPP and Canadian health care. *Canadian Centre for Policy Alternatives,* 1-27.

Sinclair, S. (2016). The TPP and health care. In Sinclair, S. & Trew, S (eds.), *The Trans-Pacific Partnership and Canada: a Citizen's guide* (pp. 46-65). Toronto, ON: James Lorimer & Publishers, Ltd.

Sinclair, S., Trew, S., & Mertins-Kirkwood, H. (2017). Submission from the Canadian Centre for Policy Alternatives to the standing Committee on International Trade (CIIT) on Canada's priorities in bilateral and trilateral trade in North America. *Canadian Centre for Policy Alternatives*, 1-4.

Stiglitz, J.E. (2008). Economic foundations of intellectual property rights. *Duke Law Journal, 57*(6), 1693-1724.

Taylor, M.G. (1987). Health Insurance and Canadian Public Policy 2nd ed. Montreal, McGill-Queen's University Press, 492

Taylor, D.W. (2015). Redressing the inequities in Canadian pharmacare. *Healthcare Management Forum, 28*(2), 50-54.

Vandergrift, M. & Kanavos, P. (1997). Health policy versus industrial policy in the pharmaceutical sector: the case of Canada. *Health Policy, 41*(3), 241-260.