HEALTH CARE FINANCING AND DELIVERY IN THE UNITED STATES, MEXICO, AND CANADA: ESTABLISHING INTENTIONAL PRINCIPLES FOR SOUND INTEGRATION

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I.INTRODUCTION

Citizens of the United States (U.S.), with allegedly the richest health care system in the world, are looking to Mexico and further south to Latin America for health care. In Latin America, Americans find health care services and health insurance more affordable. Additionally, Americans envy their northern neighbors who have a national—although arguably good or bad—health plan.

Historically, of all legal and policy issues, financing health care services has been perceived as a domestic policy issue both in the United States and around the world. Traditionally, policy makers might look abroad for ideas for reforming health care financing and delivery, but they did not perceive financing and delivering health care as an international concern. That is no longer the case today. It is a cliché to say that globalization has shrunk the world, but it is true nonetheless. The degree of movement of goods and services, capital, and people throughout the globe is remarkable. In part, this movement has been fueled by efforts since World War II to integrate the world economically and to facilitate free trade.

Health care has become globalized as well. Medical tourism is now a cultural phenomenon.[1] Scholars are examining this phenomenon and exploring its global implications for domestic health law and policy.[2]

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1 See Michael Horowitz, Jeffrey Rosensweig & Christopher Jones, *Medical Tourism: Globalization of the Healthcare Marketplace*, 9*4) MEDSCAPE GEN. MED. 33 (2007). *See also* John Connell, *Medical Tourism: Sea, Sun, Sand and . . . Surgery*, 27(6) TOURISM MGMT. 1093 (2007).

2 *See* GLOBAL HEALTH CARE MARKETS: A COMPREHENSIVE GUIDE TO REGIONS, TRENDS, AND OPPORTUNITIES SHAPING THE INTERNATIONAL HEALTH ARENA (Walter W. Wieners ed., 2000). *See, e.g.,* Thomas R. McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT'L L.J. 3 (forthcoming 2008); Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 3 (forth-

These developments have been extensively and expertly analyzed in the 26th annual symposium of the *Wisconsin International Law Journal* on "Medical Tourism Meets Health Law: US-EU Dialogue."[3]

This article explores whether and how to integrate the financing and delivery of health care services in North America. First, the article describes the process of economic integration since World War II in Europe and the Americas. This discussion describes the provisions in various treaties that affect domestic health care sectors and focuses on how the European Union (EU) has addressed domestic health sectors in the integration and accession processes as a possible model for North America. Second, the article describes the health sectors in the United States, Canada, and Mexico. This section analyzes the comparative performance of the three North American health sectors and the impact of the North American Free Trade Agreement (NAFTA) on these sectors. Finally, the article sets forth three principles that should ensure the protection of health care sectors in the process of economic integration.

II.ECONOMIC INTEGRATION IN EUROPE AND THE AMERICAS

Economic integration has been a goal of many countries since the end of World War II. The prevailing model of economic integration has been Europe.

A. THE POST WORLD WAR II ECONOMIC ORDER

During the Great Depression (from 1929 to the late 1930s), the world witnessed a dramatic drop in trade. Indeed, between 1929 to 1933 world trade shrank 65 percent in dollar value and 25 percent in unit vo-

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coming 2008); Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 421-22 (2007); Thomas R. McLean, *The Offshoring of American Medicine: Scope, Economic Issues and Legal Liabilities*, 14 ANNALS HEALTH L. 205, 206 (2005).

[3] *See* Christopher Newdick, *The ECJ, Trans-National Health Care, and Social Citizenship–The Accidental Death of a Concept*?, 26 WIS. INT'L L.J. 3 (forthcoming 2008); Vassilis Hatzopoulos, *Financing National Health Care in a Transnational Environment: The Impact of the European Community Internal Market*, 26 WIS. INT'L L.J. 3 (forthcoming 2008); Mark L. Flear, *"Together for Health"? How EU Governance of Health Undermines Active Biological Citizenship,* 26 WIS. INT'L L.J. 3 (forthcoming 2008); Louise Trubek, Mark Nance & Tamara Hervey, *The Construction of Healthier Europe: Lessons from the Fight Against Cancer*, 26 WIS. INT'L L.J. 3 (forthcoming 2008); Scott L. Greer, *Power Struggle: the Politics and Policy Consequences of Patient Mobility in Europe*, 26 WIS. INT'L L.J. 3 (forthcoming 2008).

lume.[4] The prevailing view among economists is that the Great Depression was ignited, in part, by the increase in tariffs and other trade barriers imposed during the 1920s.[5]

During World War II, the Allies created the United Nations and other international institutions to stabilize the post-war world.[6] In 1944, forty-four countries signed the Bretton Woods Agreement,[7] which was intended to prevent national trade barriers and thereby avoid economic depression, a key factor in the instigation of World War II. The Bretton Woods Agreement set up rules and institutions to regulate the international political economy, including the International Monetary Fund[8] and the International Bank for Reconstruction and Development,[9] which was later divided into the World Bank and Bank for International Settlements. Since their inception, the Bretton Woods Institutions have been controversial, nevertheless, they have been widely acknowledged to be necessary.[10]

In 1947, twenty-three countries agreed to the General Agreement on Tariffs and Trade (GATT) to promote free trade.[11] Initially, GATT addressed trade in goods; however, since the Uruguay Round in 1984, it also addresses trade in services, capital, and intellectual property. The structure and mandate of the new World Trade Organization (WTO), founded in 1994, was also negotiated during the Uruguay Round.[12]

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4 Robert J. Samuelson, *Great Depression, in* THE CONCISE ENCYCLOPEDIA OF ECONOMICS, *available at* http://www.econlib.org/library/Enc1/GreatDepression.html.

5 Gene Smiley, *Great Depression, in* THE CONCISE ENCYCLOPEDIA OF ECONOMICS 230, 231-32 (David R. Henderson ed. 2008), *available at* http://www.econlib.org/LIBRARY/Enc/GreatDepression.html.

6 *See* Articles of Agreement of the International Monetary Fund, art. 1, Dec. 27, 1945, 60 Stat. 1401, 2 U.N.T.S. 40; Articles of Agreement of the International Bank for Reconstruction and Development, art. 1, Dec. 27, 1945, 60 Stat. 1440, 2 U.N.T.S. 134; World Trade Org., World Trade Report 2007, 179-80 (2007), *available at* http://www.wto.org/English/res_e/booksp_e/anrep_e/world_trade_report07_e.pdf.

7 *See* General Agreement on Tariffs and Trade, Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194 [hereinafter GATT].

8 Articles of Agreement of the International Monetary Fund, *supra* note 6, at 1401.

9 Articles of Agreement of the International Bank for Reconstruction and Development, *supra* note 6, at 1440.

10 *See, e.g.,* Frank J. Garcia, *Global Justice and the Bretton Woods Institutions,* 10 J. INT'L ECON. L. 461 (2007); Enrique R. Carrasco, *Critical Issues Facing the Bretton Woods System: Can the IMF, World Bank, and the GATT/WTO Promote an Enabling Environment for Social Development?*, 6 TRANSNAT'L L. & CONTEMP. PROBS. i (1996); Gerald M. Meier, *The Bretton Woods Agreement–Twenty-Five Years After*, 23 STAN. L. REV. 235 (1971).

11 GATT, *supra* note 7, at A-11.

12 Final Act Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, Apr. 15, 1994, 33 I.L.M. 1125 (1994).

The General Agreement on Trade in Services (GATS) emerged from the Uruguay Round and went into effect in 1995.[13] The treaty, which covers health care, financial services, and insurance has important implications for domestic health sectors. The GATS applies to "measures by WTO members which affect trade in services."[14] National governments must take "such reasonable measures as may be available" to ensure that regional and local governments, among others, observe GATS provisions.[15]

B. ECONOMIC INTEGRATION IN EUROPE

Europe became the first region of the world to actively pursue economic integration—primarily as a means of avoiding war. The Shuman Declaration of the French government, signed on May 9, 1950, invited the countries of Western Europe to move toward economic integration.[16] The first institution to establish economic integration was the European Coal and Steel Community—an effort to impose oversight of the German steel industry which had fueled the destructive war.[17]

Through trial and error, Europe has become a model of supranational integration with a single market for most economic goods and services in the European Union. Given Europe's predicament after World War II, the story of its economic integration is extraordinary. Yet, for the prescient Europeans who had the foresight to envision integration, the possibilities of integration were fantastic and the alternatives—discord and possible war—were horrific.[18]

Since the establishment of the European Coal and Steel Commission, Europe has worked toward greater economic integration. In 1957, the Treaty of Rome established a common market and guaranteed

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[13] The General Agreement on Trade in Services was negotiated during the Uruguay Round of Multilateral Trade Negotiations as an Annex to the WTO Agreement and came into effect on January 1, 1995. *See* General Agreement on Trade in Services, Apr. 15, 1994, 33 I.L.M. 1167 [hereinafter GATS].

[14] *Id*. art I.1, at 1168.

[15] *Id.* art. I.3(a), at 1169.

[16] Robert Schuman, Fr. Foreign Minister, Declaration of 9 May 1950, *available at* http://europa.eu/abc/symbols/9-may/decl_en.htm.

[17] Treaty establishing the European Coal and Steel Community, http://europa.eu/scadplus/treaties/ecsc_en.htm (last visited Oct. 31, 2008).

[18] *See generally* T.R. REID, THE UNITED STATES OF EUROPE: THE NEW SUPERPOWER AND THE END OF AMERICAN SUPREMACY (2004) (discussing how a unified Europe will change the world).

the free flow of persons, however, it was first and foremost a treaty to establish economic integration.[19]

After decades of relative inactivity—in terms of expansion or consolidation—the nations of the European Economic Community entered the Treaty on European Union,[20] and formally established the European Union. Under the Maastricht Treaty, the European states expanded the scope of the European Community by establishing additional spheres for common European action on an intergovernmental basis. These included defense and "justice and home affairs."[21]

The EU treaties allocate "competencies" to the governing bodies of the European Union, to the Member States, or to both. In the realm of health care, the European Community has allocated control of social security to the Member States. Specifically, Article 152(5) of the Treaty of Rome provided that: "Community action in the field of public health shall fully respect the responsibilities of Member States for the organization and delivery of health services and medical care."[22] In so doing, the Treaty of Rome allocated the competency pursuant to the subsidiary principle of EU governance. The subsidiary principle requires that a governmental function must be located at the lowest governmental authority at which it can be executed effectively.[23]

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[19] Consolidated Version of the Treaty Establishing the European Community art. 39, Dec. 24, 2002, 2002 O.J. (C 325) 51 [hereinafter Consolidated EC Treaty], *available at* http://eurlex.europa.eu/en/treaties/dat/12002E/pdf/12002E_EN.pdf. Article 39 establishes European economic integration:

> 1. Freedom of movement for workers shall be secured within the Community.
> 2. Such freedom of movement shall entail the abolition of any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment.
> 3. It shall entail the right, subject to limitations justified on grounds of public policy, public security or public health:
> (a) to accept offers of employment actually made;
> (b) to move freely within the territory of Member States for this purpose;
> (c) to stay in a Member State for the purpose of employment in accordance with the provisions governing the employment of nationals of that State laid down by law, regulation or administrative action;
> (d) to remain in the territory of a Member State after having been employed in that State, subject to conditions which shall be embodied in implementing regulations to be drawn up by the Commission.
> 4. The provisions of this article shall not apply to employment in the public service.

[20] Consolidated Version of the Treaty on European Union, Dec. 24, 2002, 2002 O.J. (C 325) 5 [hereinafter TEU], *available at* http://eurlex.europa.eu/en/treaties/dat/12002M/pdf/12002M_EN.pdf.

[21] *Id*. arts. 2, 17, 29.

[22] Consolidated EC Treaty, *supra* note 19, art. 152.

[23] *Id*. art. 5. *See* Subsidiarity, Europa Glossary, http://europa.eu/scadplus/glossary/subsidiarity_en.htm (last visited July 8, 2008).

In the Maastricht Treaty, the EU assumed a greater role in developing health policy for Europe. Specifically, Article 129 of the Maastricht Treaty Union mandated "encouraging cooperation between Member States," and "if necessary, lending support to their actions" with respect to public health.[24] Additionally, Article 129 gave the EU the power to spend money on European level health projects but forbade it to pass laws harmonizing public health measures in the member states.[25] Later, in the 1997 Treaty of Amsterdam, Article 152 added to these public health provisions and stated the EU's affirmative responsibility to ensure "a high level of human health protection" in the "definition and implementation of all policies and activities" and to work with Member States to improve public health, prevent illness, and "obviate sources of danger to human health."[26] Thus, the Treaty of Amsterdam necessitated the development of health policy at the supranational EU level.[27]

Another key principle of EU governance is "solidarity."[28] Pursuant to the solidarity principle, the EU has supported the full development of social services for all residents of Member States and the realization of the so-called European social model.[29] In 2000, the Member States of the EU articulated the social model in the Charter of Fundamental Rights of the European Union.[30] Regarding health care, the Charter provides:

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[24] Treaty on European Union, art. 129, Feb. 7 1992, 1992 O.J. (C 191) 24.

[25] *Id.* at art. 129(4)(as in effect 1992)(now article 152).

[26] Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Certain Related Acts, art. 129, Oct. 2, 1997, 1997 O.J. (C 340) 39; *See* Henriette D.C. Roscam Abbing, *Public Health in the Treaty of Amsterdam (Treaty on the European Union)*, 5 EUR. J. OF HEALTH L. 171 (1998).

[27] *See* Ben Duncan, *Health Policy in the European Union: How it's Made and How to Influence It*, 324 BRIT. MED. J. 1027, 1027 (2002); ED RANDALL, THE EUROPEAN UNION AND HEALTH POLICY 115 (2001).

[28] Charter of Fundamental Rights of the European Union, ch. 4, Dec. 18, 2000, 2000 O.J. (C 364) 15 [hereinafter Charter of Fundamental Rights]. The principle of solidarity of the European Union is "a fundamental principle based on sharing both the advantages, i.e. prosperity, and the burdens equally and justly among members." Eurofound, Solidarity principle, http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/solidarityprincple.htm (last visited Feb. 5, 2009).

[29] *See* Opinion of the European Economic and Social Committee on Social Cohesion: Fleshing Out a European Social Model, 2006 O.J. (C 309) 119. The European social model is described "in terms of values that include democracy and individual rights, free collective bargaining, the market economy, equal opportunities for all, and social protection and solidarity." Eurofound, European social model, http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/EUROPEANSOCIALMODEL.htm (last visited Feb. 5, 2009).

[30] Charter of Fundamental Rights, *supra* note 28, art. 35.

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. [31]

In 1993, at its meeting in Copenhagen, the European Council agreed that Central and Eastern European countries should be granted membership to the European Union.[32] The European Council established that accession would only occur when the country applying for membership satisfied certain economic and political conditions, including:

> Membership requires that the candidate country has achieved stability of institutions guaranteeing democracy, the rule of law, human rights, and respect for and protection of minorities, the existence of a functioning market economy as well as the capacity to cope with competitive pressure and market forces within the Union. Membership presupposes the candidate's ability to take on the obligations of membership including adherence to the aims of political, economic, and monetary union. [33]

Specifically, the approximation process—the process whereby Member States ensure conformity between domestic and EU law—involves three areas of the health care sector (1) public health, (2) health related issues, and (3) the internal market.[34] The approximation process has had a dramatic impact on the health sectors of the newly admitted countries.[35]

Since its inception, the European Community has had strict regulations for the coordination of social security benefits for employed persons and their families throughout the EU.[36] Nevertheless, in part because of the guarantee of the free flow of persons in the EU under the Treaty of Rome,[37] the EU and its Member States have faced challenges

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[31] *Id*. Tamara K. Hervey, *The 'Right to Health' in European Union Law, in* ECONOMIC AND SOCIAL RIGHTS UNDER THE EU CHARTER OF FUNDAMENTAL RIGHTS – A LEGAL PERSPECTIVE 202 (Tamara K. Hervey & Jeff Kenner eds., 2003).

[32] Presidency Conclusions, Copenhagen European Council (June 21-22, 1993).

[33] *Id.*

[34] A.P. Den Exter, *Legal Consequences of EU Accession for Central and Eastern European Health Care Systems*, 8 Eur. L. J. 556, 556 (2002). *See also* Martin McKee, Laura MacLehose & Ellen Nolte, Health Policy and European Union Enlargement (2004).

[35] *See* Mukesh Chawla, Health Care Spending in the New EU Member States: Controlling Costs and Improving Quality (World Bank, Working Paper No. 113, 2007).

[36] Council Regulation 118/97, 1997 O.J. (L 28) 1 (EC). *See* John T. Addison & W. Stanley Siebert, *The Social Charter of the European Community: Evolution and* Controversies, 44 INDUS. & LAB. REL. REV. 597 (1991).

[37] *See* Consolidated EC Treaty, *supra* note 19, art. 139, and accompanying text.

with respect to health care financing and delivery, especially after some decisions handed down by the European Court of Justice (ECJ) on health care issues. Specifically, in the 1990s, the ECJ upheld the right of residents of one Member State to receive health care services in other Member States at the expense of their national health programs.[38] The details of the ECJ decisions are outside the scope of this paper, however an in-depth description of the decisions can be found in several of the articles from this Symposium.[39] These cases have precipitated the European Commission to propose rules that further integrate the health sectors of EU Member States with more formal provisions for cross border access to health care.[40] The free flow of patients follows a longstanding and ongoing flow of physicians and other health care professionals to more prosperous EU Member States.[41]

Within the EU, there is considerable concern about what these cases and policies mean for the future of autonomous national health sectors.[42] Agencies of the EU have published several important reports on the issue.[43] With these ECJ decisions and the flow of health care professionals and other individuals, the field of EU health law and policy has emerged and evolved.[44]

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[38] Case C-157/99, Smits and Peerbooms, 2001 E.C.R. I-5473, para. 108; Case C-120/95, Decker v. Caisse de Maladie des Employes Prives, 1998 E.C.R. I-1831, para. 15; Case C-158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R. I-1931, para. 8. *See* Rory Watson, *European Court's Ruling Paves Way for Cross-Border Treatment*, 323 BRITISH MED. J. 128 (2001).

[39] *See supra* note 3.

[40] *See, e.g.,* Rory Watson, *European Commission Proposes Rules for Cross Border Health Care*, 337 BRITISH MED. J. 676 (2008); Stephen Castle, *European Plan Would Expand Health Care Access Within the Bloc*, N.Y. TIMES, July 3, 2008.

[41] See Michael Dougan & Helen Stalford, The Impact of Migration on Healthcare in the European Union, 14 MAASTRICHT J. EUR. & COMP. L. 209, 210 (2007). See also Thomas Donohoe, Here . . . Fishy, Fishy, Physician: The Effect of European Union Mandates on Physician Movement in the European Union, 18 IND. INT'L & COMP. L. REV. 437 (2008).

[42] *See, e.g.*, Newdick, *supra* note 3; Mark L. Flear, *Developing Euro-Biocitizens through Migration for Healthcare Services*, 14 MAASTRICHT J. EUR. & COMP. L. 239, 240 (2007); Christopher Newdick, *Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity*, 43 COMMON MKT. L. REV. 1645, 1646 (2006).

[43] *See, e.g.,* European Comm'n Health & Consumer Prot. Directorate-Gen., Report of the High Level Comm. on Health, *The Internal Market and Health Services* (Dec. 17, 2001), *available at* http://ec.europa.eu/health/ph_overview/Documents/key06_en.pdf; *Commission White Paper on Together for Health: A Strategic Approach for the EU 2008-2013*, COM (2007) 630 final (Oct. 23, 2007), *available at* http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf; *Commission Staff Working Document on Together for Health: A Strategic Approach for the EU 2008-2013*, SEC (2007) 1376 (Oct. 23, 2007), *available at* http://ec.europa.eu/health/ph_overview/Documents/strategy_working_document_en.pdf.

[44] European Integration and National Health Care Systems: A Challenge for Social Policy, Ghent, Belgium, Dec. 7-8, 2001, *The Influence of EU Law on the Social Character of Health Care Systems in the EU*, 2 (Nov. 19, 2001) (*prepared by* Elias Mossialos, Martin McKee, Willy Palm,

There are several enduring lessons from the EU experience that should be noted by North American policy makers. First, the EU's unequivocal requirement that Member States have comprehensive health coverage creates space for inordinate economic development among Member States. This requirement ensures a level of health protection for the entire population of the EU that is not enjoyed by the population of countries in the Western Hemisphere. Second, the free flow of individuals within the EU has required the EU to develop mechanisms by which individuals can enjoy the health coverage benefit of their state of origin while working or visiting in other parts of the EU. Such access to and coordination of health coverage does not exist to the same extent in North America.[45]

C. ECONOMIC INTEGRATION IN THE AMERICAS

Economic integration in the Western Hemisphere has been much slower to evolve than in Europe. The pattern of integration has been different as well. Rather than proceeding from a small group of countries and proceeding eastward through an accession process, the American experience has been economic integration in South America and North America in independent processes.

1. EARLY EFFORTS AND TREATIES

In 1960, seven Latin American nations, later joined by four more countries,[46] created the Latin American Free Trade Association (LAFTA).[47] Like the European Economic Community established two

Beatrix Karl & Franz Marhold), *available at* www.ose.be/health/files/summary.pdf; Martin McKee, Elias Mossialos & Paul Belcher, *The Influence of European Law on National Health Policy*, 6 J. EUR. SOC. POL'Y 263, 280 (1996). *See generally* TAMARA K. HERVEY & JEAN V. MCHALE, HEALTH LAW AND THE EUROPEAN UNION (2004); MARTIN MCKEE & ELIAS MOSSIALOS, EU LAW AND THE SOCIAL CHARACTER OF HEALTH CARE (2002). *See also* GRAINNE DE BURCA, EU LAW AND THE WELFARE STATE: IN SEARCH OF SOLIDARITY (2005) and SOCIAL WELFARE & EU LAW (Eleanor Spaventa and Michael Dougan eds., 2005).

[45] *See infra* Part III.A.

[46] Argentina, Brazil, Chile, Mexico, Paraguay, Peru and Uruguay were the original members with Colombia, Ecuador, Venezuela and Bolivia joining soon thereafter. *See* Kenneth W. Abbott & Gregory W. Bowman, *Economic Integration in the Americas: "A Work in Progress*," 14 NW J. INT'L L. & BUS. 493, 497 n.12 (1994); Lorin S. Weisenfeld, *Introduction to Treaties of Montevideo Creating a Latin American Free-Trade Area and the Latin American Integration Association*, *in* 2 BASIC DOCUMENTS OF INTERNATIONAL ECONOMIC LAW 581 (Stephen Zamora & Ronald A. Brand eds., 1990).

[47] Treaty of Montevideo Establishing the Latin American Integration Association, Aug. 12, 1980, 20 I.L.M. 672 (1981) [hereinafter Treaty of Montevideo].

years before,[48] LAFTA was dedicated to economic integration based on the lessons of the Great Depression and World War II. Unfortunately, LAFTA was not successful; most likely due to political rivalries among nations and ultimately a swing toward right-wing totalitarianism in much of Latin American in the late 1970s and early 1980s. In the meantime, groups of Latin American states were establishing intergovernmental treaties to promote economic integration, such as the Common Market of the South or Mercado Comune del Sur (MERCOSUR) comprised of Argentina, Brazil, Uruguay, and Paraguay.[49] In 1980, the same countries entered the Treaty of Montevideo to reestablish the organization for economic integration under the same name but with the Spanish acronym, ALADI.[50] The Montevideo Treaty, establishing ALADI, set as a long-term goal "the gradual and progressive formation of a Latin American common market."[51]

In the Western Hemisphere, there has been a gradual movement to integrate the economies of the hemisphere's nation states. Currently, the countries of the hemisphere are negotiating a new treaty, the Free Trade Area of the Americas (FTAA) or the Área de Libre Comercio de las Américas (ALCA).[52]

2. THE NORTH AMERICAN FREE TRADE AGREEMENT (NAFTA)

In 1993, a year after the adoption of the Treaty on European Union (Maastricht Treaty), the United States, Canada, and Mexico ratified the North American Free Trade Agreement (NAFTA).[53] One observer described NAFTA and its potential for the Western Hemisphere:

> NAFTA is the largest trading community in the world, with six trillion dollars in annual output—greater than the twelve nations of the European Union—and affects almost every facet of international business within North America. It is the first major free trade agreement between developed and developing countries and it represents a striking reorientation of economic policy both for the United States and Canada, on one hand, and for Mexico—formerly a heavily statist economy and one of the more outspoken Latin American opponents

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[48] Consolidated EC Treaty, *supra* note 19 and accompanying text.

[49] Treaty Establishing a Common Market, Mar. 26, 1991, 30 I.L.M. 1041 (1991).

[50] Treaty of Montevideo, *supra* note 47.

[51] *Id.* art. 1.

[52] *See* Free Trade Area of the Americas, Third Draft FTAA Agreement, http://www.ftaa-alca.org/FTAADraft03/Index_e.asp (last visited Nov. 5, 2008).

[53] North American Free Trade Agreement, U.S.-Can.-Mex., Dec. 17, 1992, 32 I.L.M. 289 (1993) [hereinafter NAFTA].

> of United States economic interference with the South—on the other.[54]

Unlike the European Union, NAFTA is open to any country in the world, including members of the European Union. Other trading blocks can join NAFTA upon meeting certain criteria.[55] Indeed, this universal availability of membership has had an important impact on policy development in the Western Hemisphere; mainly, to promote economic reform and ultimately achieve eligibility to join NAFTA.[56] One of NAFTA's basic purposes is to "create an expanded and secure market for the goods and services produced in their territories."[57] NAFTA applies to all economic sectors including social services, which includes health care goods and services. The national governments of the three state parties must "ensure that all necessary measures" are taken in order to give effect to the NAFTA's provisions, including their observance by state, provincial, and local governments.[58] Nevertheless, the preamble of NAFTA expressly recognizes—as a cardinal principle—the right of parties "to preserve their flexibility to safeguard the public welfare."[59]

From the health care perspective, the most important provisions of NAFTA are those dealing with investments,[60] cross-border trade in services,[61] and financial services.[62] The NAFTA investment provisions, set forth above,[63] provide comparable treatment of the investors of other state parties as to local investors.[64] Regarding cross border trade in ser-

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[54] Abbott & Bowman, *supra* note 46, at 496.

[55] NAFTA, *supra* note 53, art. 2204.

[56] See, e.g., Juanita Darling, Spotlight on Trade: Latin American Countries are Lining Up to be Part of NAFTA; Hemisphere: Many Leaders See It as the Best Way to Revive a Foundering Dream of Increased Intra-Regional Commerce, L.A. TIMES, Nov. 20, 1993, at D1; Abbott & Bowman, *supra* note 46, at 493.

[57] NAFTA, *supra* note 53, Preamble.

[58] *Id*. art. 105.

[59] *Id.* Preamble.

[60] *Id*. ch. 11.

[61] *Id*. ch. 12.

[62] *Id*. ch. 14.

[63] *Id*. ch. 11.

[64] *Id*. art. 1102. ("1. Each Party shall accord to investors of another Party treatment no less favorable than that it accords, in like circumstances, to its own investors with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments. 2. Each Party shall accord to investments of investors of another Party treatment no less favorable than that it accords, in like circumstances, to investments of its own investors with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments."); *Id*. art 1103. ("1. Each Party shall accord to investors of another Party treatment no less favorable than that it accords, in like circumstances, to investors of any other Party or of a non-Party with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments. 2. Each Party

vices, basic NAFTA principles treat producers of services in a manner comparable to national producers.[65] Comparable provisions pertain to financial services.[66]

Yet, provisions pertaining to both investments in Chapter 11 and cross-border services in Chapter 12 limit the principles regarding comparable treatment of foreign and native investors and/or service providers. In both Chapters 11 and 12, there is a provision that provides that:

> "[n]othing in this Chapter shall be construed to prevent a Party from providing a service or performing a function such as law enforcement, correctional services, income security or insurance, social security or insurance, social welfare, public education, public training, health and child care, in a manner that is not inconsistent with this Chapter."[67] Further, Chapter 14 provides: "Nothing in this Chapter shall be construed to prevent a Party, including its public entities, from exclusively conducting or providing in its territory (a) activities or services forming part of a public retirement plan or statutory system of social security . . ."[68]

The reservations and exceptions article in the chapter on investments contains provisions that protect national health programs. Specifically, both Chapters 11 and 12 have articles providing that the operative

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shall accord to investments of investors of another Party treatment no less favorable than that it accords, in like circumstances, to investments of investors of any other Party or of a non-Party with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments.").

[65] *Id.* art. 1202. ("1. Each Party shall accord to service providers of another Party treatment no less favorable than that it accords, in like circumstances, to its own service providers. 2. The treatment accorded by a Party under paragraph 1 means, with respect to a state or province, treatment no less favorable than the most favorable treatment accorded, in like circumstances, by that state or province to service providers of the Party of which it forms a part."); Id. art. 1203. ("Each Party shall accord to service providers of another Party treatment no less favorable than that it accords, in like circumstances, to service providers of any other Party or of a non-Party.").

[66] *Id.* art. 1405. ("1. Each Party shall accord to investors of another Party treatment no less favorable than that it accords to its own investors, in like circumstances, with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of financial institutions and investments in financial institutions in its territory. 2. Each Party shall accord to financial institutions of another Party and to investments of investors of another Party in financial institutions treatment no less favorable than that it accords to its own financial institutions and to investments of its own investors in financial institutions, in like circumstances, with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of financial institutions and investments."); *Id*. art. 1406. ("1. Each Party shall accord to investors of another Party, financial institutions of another Party, investments of investors in financial institutions and cross-border financial service providers of another Party treatment no less favorable than that it accords to the investors, financial institutions, investments of investors in financial institutions and cross-border financial service providers of any other Party or of a non-Party, in like circumstances.").

[67] *Id*. art. 1101, para. 4; *Id***.** art. 1201, para. 3.

[68] *Id.* art. 1401, para. 3.

provisions of each chapter do not apply if there are existing non-conforming measures, or the party establishes non-conforming measures within two years of NAFTA's adoption—so long as these non-conforming measures are reserved in the appropriate annexes of NAFTA.[69] Furthermore, both Chapters 11 and 12 have articles that provide that the operative provisions of each chapter do not apply "to procurement by a Party or a state enterprise" or "subsidies or grants provided by a Party or a state enterprise, including government supported loans, guarantees, and insurance."[70]

The U.S., Canada, and Mexico claimed the same reservations for their social service sectors, including the national treatment articles for investments and services,[71] the local presence article for services,[72] and the senior management and boards of directors' article for investments.[73] Canada claimed an additional reservation for social services—the most favored nation treatment article for services.[74]

An important and controversial feature of NAFTA Chapter 11 is the provision asserting that parties may not "directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment . . . except under circumstances such as for a public purpose."[75] Furthermore, investors are entitled to compensation in the event of expropriation.[76]

These NAFTA provisions could have important implications for economic integration of national health sectors. Mainly because private parties as well as the national parties can bring complaints before the ad-

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[69] *Id*. art. 1108, paras. 1-2; *Id*. art. 1206.

[70] *Id.* art. 1108, para. 7; *Id*. art. 1206.

[71] *Id.* art. 1102; *Id*. art. 1202. These reservations also apply to health insurance as a financial service. *See Id.* art. 1409, para. 4.

[72] *Id.* art. 1205. ("No Party may require a service provider of another Party to establish or maintain a representative office or any form of enterprise, or to be resident, in its territory as a condition for the cross-border provision of a service.").

[73] *Id.* art. 1107. ("1. No Party may require that an enterprise of that Party that is an investment of an investor of another Party appoint to senior management positions individuals of any particular nationality. 2. A Party may require that a majority of the board of directors, or any committee thereof, of an enterprise of that Party that is an investment of an investor of another Party, be of a particular nationality, or resident in the territory of the Party, provided that the requirement does not materially impair the ability of the investor to exercise control over its investment.").

[74] *Id.* art. 1203. ("Each Party shall accord to service providers of another Party treatment no less favorable than that it accords, in like circumstances, to service providers of any other Party or of a non-Party."). These reservations also apply to health insurance as a financial service. *Id*. art. 1409, para. 4.

[75] *Id.* art. 1110, para. 1.

[76] *Id*. art. 1110, paras. 2-8.

judicative bodies of NAFTA and authorized private arbitrators.[77] Consequently, through the NAFTA dispute resolution process, decisions, and the legal interpretation of treaties arbitration and more formal adjudicatory proceedings can be achieved under the treaty.[78] Similarly, private entities could bring actions against any state party through the WTO.[79]

III. FINANCING AND REGULATING HEALH CARE IN NORTH AMERICA

This section describes the health care sectors of the three North American countries and their performances, which are markedly different. In addition, this section also addresses whether and how NAFTA will influence the future development of the health care sectors of these countries.

A. THE HEALTH CARE SECTORS OF THE UNITED STATES, CANADA AND MEXICO

The three North American countries—the United States, Canada, and Mexico—have fundamentally different health care systems. Canada, a developed country, has nationally mandated universal health care coverage. Mexico has the health care sector of a developing country, with private coverage for the elite and more erratic, state sponsored, corporatist coverage for the employed population. The United States has a primarily private, largely for-profit health insurance through the employment system with public coverage available only for vulnerable groups. All three countries provide some public health insurance, although only Canada endeavors to cover its entire population. The United States and Mexico rely on safety net providers to care for the uninsured and the poor. All three countries have a for-profit insurance sector that targets the more well-to-do. Finally, all three countries are facing rising health care costs in their health care sectors.

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[77] *Id*. ch. 11, sec. B.

[78] *Id*. ch. 20.

[79] See Thomas Sebastian, World Trade Organization Remedies and the Assessment of Proportionality: Equivalence and Appropriateness, 48 HARV. INT'L L.J. 337 (2007).

Figure 1 **Common Institutions and Professionals Delivering and Financing Care in a Nation State**	
Health Care Facilities, e.g., hospitals, nursing homes, home health agencies	**Health Care Professionals,** e.g., physicians, physician extenders, nurses.
Health Care Suppliers, e.g., pharmaceutical and device companies, pharmacies and DME suppliers.	**Health Care Payers**, e.g., insurance companies, public programs.

The legal infrastructure for each country's health sector is quite different. Only Mexico addresses health care in its federal constitution.[80] The Constitutions of the United States and Canada do not specifically address health care.[81] Furthermore, both Mexico and Canada have statutes stating a definitive and affirmative national policy to assure access to health care for their populations. The Canada Health Act states that its policy goal is to: "protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[82] Mexico's Ley General de Salud (General Law of Health) has comparable goals.[83]

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[80] Eleanor D. Kinney & Brian A. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285, 333 (2004). The Mexican Constitution of 1917 (as amended to 2003) has two provisions regarding health and health care in its constitution. One provision establishes a "right to health protection" and sets forth what subordinate federal statutory law will authorize: "Every person has the right to health protection. The law will describe the basis and means for access to health care services and will establish the concurrence of the Federation and the federative entities in matters of public health . . . . Boys and girls have the right to satisfy their nutrition, health, and education needs and for healthy recreation for their total development." Constitución Política de los Estados Unidos Mexicanos [Const.], *as amended*, Diario Oficial de la Federación [D.O], art. 4, 5 de Febrero de 1917 (Mex.).

[81] Kinney & Clark, *supra* note 80, at 292.

[82] Canada Health Act, R.S.C., ch. C 6, sec. 3 (1985).

[83] *See* Ley General de Salud [The General Law of Health], *as amended*, art. 2, Diario Oficial de la Federación [D.O.], 7 de Febrero de 1984 (Mex.). *See also* Parastoo Anita Mesri, *The Violation*

The health care sector of each country is comprised of the same major economic actors: patients, providers, payers, and suppliers. These economic participants are described at Figure 1. Yet, in each country, these major institutions and professionals are organized much differently—ranging from the completely private with independent facilities and professionals paid directly by patients or insurers, to the state-sponsored health systems, which own health care facilities and employ health care professionals.[84] In each country, the health care payers have different relationships with the providers, the professionals, and the patients with whom they treat.

1. PUBLIC COVERAGE OF HEALTH CARE SERVICES

In all three countries, public involvement in the financing of health care is a relatively recent phenomenon following World War II. It is with respect to government involvement in publicly sponsored health insurance that the three countries of North America vary the most.

In the United States, the Medicare and Medicaid programs, enacted in 1965, provide health insurance coverage for the elderly, the disabled, and some poor.[85] The Medicare program is a social insurance program available to persons age sixty-five and older, those who are seriously disabled, and people suffering from end stage renal disease. Me-

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of the Human Right to Health as a Factor in the Zapatista Revolution Of Chiapas, México, 10 TULSA J. COMP. & INT'L L. 473 (2003). "In Article 2, the law states the goals of the right to health as being:

> 1. The physical and mental well-being of the person so that she/he can achieve the utmost of their abilities;
> 2. The prolongation and improvement of the quality of human life;
> 3. The protection and growth of the values that help the creation, conservation and enjoyment of health conditions that contribute to social development;
> 4. The extension of attitudes of solidarity and responsibility among the population in the preservation, conservation, improvement and restoration of health;
> 5. The enjoyment of health services and social assistance that satisfy efficiently and opportunely the necessities of the people;
> 6. The [attainment of] knowledge necessary to adequately take advantage of and utilize health services; and
> 7. The development of technological and scientific research and teaching for health.
>
> Thus the right to health in México, as dictated by national law, is broad and comprehensive and focuses primarily on a state of physical and mental well being which allows all peoples to achieve the utmost of their abilities." *Id*. at 502-04.

[84] *See generally* Julio Frenk & Avedis Donabedian, *State Intervention in Medical Care: Types, Trends And Variables*, *in* HEALTH SERVICES RESEARCH: AN ANTHOLOGY (Kerr L. White et al. eds., 1992) (offering a cross-national comparative perspective of state intervention in medical care).

[85] Social Security Amendments of 1965, 42 U.S.C. § 1395 (2005) (Medicare) & § 1396 (Medicaid).

dicaid, a jointly financed welfare program which is administered by the federal government and the states, provides health insurance for some disabled and aged poor, as well as for impoverished mothers, infants, and children. The State Children's Health Insurance program (S-CHIP) covers low income children.[86]

Since the end of World War II, the Canadian government, like the United States and Mexico, has been involved in the financing and delivery of health care services. Prior to the 1980s, Canada's health care sector was organized much like the American health care sector, with a mixture of public and private, federal and provincial health plans. However, in the 1980s, Canada reformed its financing system in the Canada Health Act.[87] This act assured that "insured persons" (which include all legal residents of Canada) had reasonably necessary coverage provided in a hospital or by a physician without any co-insurance or additional fees imposed by providers. Pursuant to the Canada Health Act, "a full cash contribution is payable by Canada to each province for each fiscal year" to fund a health plan meeting certain criteria.[88] The criterion includes (1) public administration of provincial health insurance, (2) comprehensiveness of coverage, (3) universality of the level of health care, (4) portability of health insurance, and (5) accessibility to health care facilities and providers.[89] Under Canada's foundational Social Union Framework Agreement,[90] the Canadian Prime Minister and the provincial governors restated their commitment that in Canada publicly funded

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[86] 42 U.S.C. § 1397aa.

[87] Canada Health Act, R.S.C., ch. C 6, Preamble (1985).

[88] *Id.* at sec. 5; Canada Health Act, R.S.C., ch. 17, sec. 36 (1995).

[89] Canada Health Act, R.S.C., ch. C 6, sec. 7 (1985). The Act states these criteria more fully as follows:

> *Public Administration:* All of provincial health insurance must be carried out by a public authority on a non-profit basis. They administration also must be accountable to the province or territory, and their records and accounts are subject to audits. . .
> *Comprehensiveness:* All necessary health services, including hospitals, physicians and surgical dentists, must be insured . . .
> *Universality:* All insured residents are entitled to the same level of health care. . .
> *Portability:* A resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period. This also applies to residents which leave the country . . .
> *Accessibility:* All insured persons have reasonable access to health care facilities. In addition, all physicians, hospitals, etc, must be provided reasonable compensation for the services they provide . . . *Id.* at secs. 8-12.

[90] News Release, A Framework to Improve the Social Union for Canadians: An Agreement between the Government of Canada and the Governments of the Provinces and Territories (Feb. 4, 1999), http://socialunion.gc.ca/news/020499_e.html (visited Jul. 13, 2008).

health care should exhibit comprehensiveness, universality, portability, public administration, and accessibility.[91]

Similar to the United States and Canada, Mexico took steps to expand health coverage for its population in the mid-twentieth century. Currently, there are two government sponsored social insurance programs for workers. The first, Instituto Mexicano del Seguro Social (IMSS), is for employees who work for private companies.[92] The second program, Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE), is for government employees.[93] Both of these organizations own health care facilities and hire the health professionals that deliver health care services. [94]

However, because of high unemployment rates, many Mexicans have become self-employed or sub-employed and therefore are outside the umbrella of IMSS health coverage.[95] Thus, in 2003, the Mexican Congress amended the Ley General de Salud, to establish the System for the Social Protection in Health (SPSS) for the uninsured population who were not otherwise eligible for coverage under IMSS or ISSSTE.[96] The reform includes the Seguro Popular (SP), which is a health insurance scheme financed jointly by the federal government and the states to expand health care coverage to the entire population of Mexico by 2012, starting with the poorest families.[97]

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[91] *See* Raisa Berlin Deber, *Health Care Reform: Lessons from Canada*, 93 AM. J. PUB. HEALTH 20, 21-22 (2003).

[92] *See* Ley Del Seguro Social [Social Security Act], Diario Oficial de la Federación [D.O.], 21 de Diciembre de 1995 (Mex.); Instituto Mexicano del Seguro Social, http://www.imss.gob.mxwww.imss.gob.mx (last visited Jul. 9, 2008).

[93] *See* Ley del Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado [Law of the Institute for Security and Social Services of State Workers], Diario Oficial de la Federación [D.O.], 31 de Marzo de 2007 (Mex.); Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, http://www.issste.gob.mx/index2.html (last visited July 9, 2008).

[94] *See* Julio Frenk et al., *Evidence-Based Health Policy: Three Generations of Reform in Mexico*, 362 LANCET 1667, 1668 fig.1 (2003).

[95] *Id.* at 1671.

[96] Ley General de Salud [The General Law of Health], *as amended*, art. 77, Diario Oficial de la Federación [D.O.], 7 de Febrero de 1984 (Mex.).

[97] *See* Emmanuela Gakidou et al., *Assessing the Effect of the 2001-06 Mexican Health Reform: an Interim Report Card*, 49 SALUD PÚBLICA MÉX. 88, 89 (2007); Felicia Marie Knaul & Julio Frenk, *Health Insurance in Mexico: Achieving Universal Coverage through Structural Reform*, 24 HEALTH AFF. 1467 (2005); ORG. FOR ECON. CO-OPERATION & DEV., OECD REVIEWS OF HEALTH SYSTEMS - MEXICO (2005).

2. HEALTH CARE COVERAGE AND SERVICES FOR THE POOR

All three countries—the U.S., Canada, and Mexico—make some provision for the poor, either through public health insurance programs, direct services, or a combination of both. In addition, all three countries have programs for indigenous populations not served under the conventional programs.

In the United States, both individual states and the federal government provide health insurance for some low income segments of the population, i.e., pregnant women, mothers, children, the disabled, and the aged, through the Medicaid and S-CHIP programs.[98] However, these programs do not cover all the poor. In addition, the federal government and individual states also fund direct health care services through various block grants[99] and community health centers in rural and medically under served areas through community health services.[100] Localities, depending on the terms of their founding legal authorities, also have major legal responsibilities through public hospitals and other approaches to care for those who are unable to afford health care. In contrast, in Canada, under the Canada Health Act, the poor are included in the health insurance plans.[101]

In Mexico, the federal government operates a public health system for the poor through a network of health care facilities and professional providers owned and operated by state governments.[102] Since the late 1970s, Mexico's federal government has been extending basic health care to under-served rural and urban poor populations.[103] One very important and relatively successful program is the incentive-based welfare program PROGRESA, which offers cash subsidies to poor people in exchange for adherence to several education, health, and nutritional inter-

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[98] 42 U.S.C. § 1396 (2000).

[99] 42 U.S.C. § 300w (2000).

[100] 42 U.S.C. § 254c (2000).

[101] R.S.C., ch. C 6, sec. 3 (1985). The criteria for federally-funded provincial health plans pertain to "insured persons." R.S.C., ch. C 6, secs. 10-12 (1985). Under the Act, "insured persons" are defined as residents of the province. R.S.C., ch. C 6, sec. 2 (1985).

[102] Ley General de Salud [The General Law of Health], *as atended*, art. 18, Diario Oficial de la Federación [D.O.], 7 de Febrero de 1984 (Mex.).

[103] *See* Frenk et al., *supra* note 94, at 1668.

ventions.[104] Gradually, the impoverished in Mexico are being folded into the SPSS program described above.[105]

3. PRIVATE HEALTH INSURANCE COVERAGE

Private health insurance has been widely available for purchase by individuals in all three of the North American countries since World War II, if not before. An important feature of private health insurance coverage is that it is often sponsored by employers as an employee benefit. Private health insurance coverage is also a financial service, subject to free trade protections under NAFTA.[106]

In the United States, a majority of the population is insured through private insurance plans, the bulk of which are sponsored by employers.[107]

In Canada, private health insurance is also available, although most Canadians have their health coverage through provincial health plans funded by the federal government.[108] In 2005, in *Chaoulli v. Quebec (Attorney General)*,[109] the Supreme Court of Canada ruled that Quebec statutes outlawing private health insurance in order to shore up participation in the public health insurance plans[110] violated the Canadian Charter of Rights and Freedoms[111] and the Charter of Human Rights and Freedoms.[112] As a result of this case, the possibility that health care professionals and facilities will focus their participation to patients with private health coverage at the expense of patients in Canada's Medicare program has been controversial in Canada.[113]

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[104] *Id.* at 1669-70. *See also* David P. Coady et al, *PROGRESA for Progress: Mexico's Health, Nutrition, and Education Program*, DEVELOPMENT OUTREACH, MAY 2005, *available at* http://www1.worldbank.org/devoutreach/may05/article.asp?id=296.

[105] *See* Knaul & Frenk, *supra* note 97, at 1468.

[106] NAFTA, *supra* note 53, ch. 14.

[107] Carmen DeNavas-Walt, Bernadette D. Proctor & Jessica Smith, U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2007 27 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf.

[108] *See supra* notes 87-89 and accompanying text.

[109] [2005] 1 S.C.R. 791, 2005 SCC 35 (Can.).

[110] Health Insurance Act, R.S.Q., ch. A 29, sec. 15 (2008); Hospital Insurance Act, R.S.Q., ch. A 28, sec. 11 (2008).

[111] Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).

[112] Charter of Human Rights and Freedoms, R.S.Q., ch. C 12 (2008).

[113] *See, e.g.*, DIANA GIBSON & COLLEEN FULLER, THE BOTTOM LINE, THE TRUTH BEHIND PRIVATE HEALTH INSURANCE IN CANADA (2006); COLLEEN M. FLOOD, KENT ROACH & LORNE SOSSIN, ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA (2005).

In Mexico, for those not insured through the government sponsored social security system, private health insurance is an important source of coverage in Mexico.[114] Large employers have their own social welfare organizations for their employees, which include pension benefits and health insurance.[115] Some large employers, such as Petroleos Mexicanos (PEMEX), a large state owned oil company, have social insurance programs that are designed much like ISSSTE.[116] As a result of NAFTA, U.S. insurance companies have expanded their private coverage to Mexico.[117]

Table 1
HEALTH STATUS (MORTALITY) COMPARED: THE UNITED STATES, CANADA AND MEXICO, 2005

	United States	**Canada**	**Mexico**	**OECD**
Life expectancy at birth, females, males and total population	77.8 in 2004/5	80.2 in 2004	75.5 in 2005	78.6
Infant mortality rate, deaths per 1 000 live births	6.8 in 2004	5.3 in 2004	18.8 in 2005	5.4
Sources: See OECD Sources in Note 125 *infra.*				

B. COMPARATIVE HEALTH SECTOR PERFORMANCE AND THE IMPACT OF NAFTA

The health care sectors of the United States, Canada, and Mexico are markedly different in their structure and development. They are also different in their performance. Nevertheless, the three health care sectors

[114] *See* Frenk et al., *supra* note 94, at 1667.
[115] *See* Knaul & Frenk, *supra* note 97.
[116] *See supra* notes 92-93.
[117] *See* Knaul & Frenk, *supra* note 97.

face many of the same problems. In addition, all three countries are engaged in debates over health care reform.

1. COMPARATIVE HEALTH SECTOR PERFORMANCE

Data on the comparative health status of the populations of Mexico, Canada, and the United States are displayed at Table 1. On population health status (Table 1), Canada leads, with the United States and Mexico following. While certainly not a complete explanation, the fact that Canada has universal health coverage while the United States and Mexico do not, could be a contributing factor to Canada's lead in life expectancy and low infant mortality rates.

Access to health coverage is a problem in both the United States and Mexico. Over 15 percent of the US population was without health coverage in 2007.[118] In 2003, the year when Mexico launched major reforms,[119] approximately 40 percent of the population was covered by the IMSS, 7 percent by ISSSTE, and about 2-3 percent by private health insurance.[120] The Mexican government's programs for the poor are geographically based services, rather than portable insurance coverage. Thus, when Mexicans come to the United States or Canada, their health coverage does not follow them. Generally, poorer Mexicans, who rely on geographically based services, rarely have health coverage if they come to the United States or Canada illegally. Over half of Mexican born immigrants in the U.S. are uninsured.[121]

The United States has the largest and most expensive health care system in the world with per capita expenditures far exceeding both Canada and Mexico.[122] Table 2 is a comparison of the health care expenditures for the three countries and the OECD. The percentage of public

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[118] DENAVAS-WALT, PROCTOR & SMITH, *supra* note 107, at 21 fig.7.

[119] Knaul & Frenk, *supra* note 97, at 1468.

[120] *Id.*

[121] STEVEN A. CAMAROTA, CTR. FOR IMMIGR. STUD., IMMIGRATION FROM MEXICO: ASSESSING THE IMPACT ON THE UNITED STATES 44 (2001), *available at* http://www.cis.org/articles/2001/mexico/mexico.pdf. *See also* PETER CUNNINGHAM ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE AND ACCESS TO CARE FOR HISPANICS IN "NEW GROWTH COMMUNITIES" AND "MAJOR HISPANIC CENTERS" (2006).

[122] *See* WORLD HEALTH ORG., WORLD HEALTH STATISTICS 2006 (2006), *available at* http://www.who.int/entity/whois/whostat2006_healthsystems.pdf. *See also* Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 904 (2005); Uwe E. Reinhardt et al., *U.S. Health Care Spending in an International Context*, 23 HEALTH AFF. 10, 11 (2004).

health expenditures as a total of health expenditures is less than 50 percent in the Untied States and Mexico, while it exceeds 70 percent in Canada. All three countries have experienced health care cost inflation, which has challenged the ability of governments to expand publicly covered benefits. [123]

Table 2
HEALTH CARE EXPENDITURES & RESOURCES COMPARED: THE UNITED STATES, CANADA AND MEXICO, 2006

	United States	**Canada**	**Mexico**	**OECD**
HEALTH CARE EXPENDITURES				
Total expenditure on health, % of gross domestic product	15.3%	9.8%	6.4%	9.0%
Total health expenditure per capita, US$ PPP	$6,401	$3,326	$ 675	$2,759
Public expenditure on health, % total expenditure on health	45.1%	70.3%	45.5%	72.5%
Pharmaceutical expenditure, % total expenditure on health	12.4%	17.7%	21.3%	17.2%
SOURCE: See OECD Sources in Note 125 *infra.*				

[123] ORG. FOR ECON. & CULTURAL DEV., OECD HEALTH DATA 2008: HOW DOES MEXICO COMPARE (2008), *available at* http://www.oecd.org/dataoecd/46/9/38980018.pdf; ORG. FOR ECON. & CULTURAL DEV., OECD HEALTH DATA 2008: HOW DOES CANADA COMPARE (2008), *available at* http://www.oecd.org/dataoecd/46/33/38979719.pdf; ORG. FOR ECON. & CULTURAL DEV., OECD HEALTH DATA 2008: HOW DOES THE UNITED STATES COMPARE (2008), *available at* http://www.oecd.org/dataoecd/46/2/38980580.pdf.

2. THE IMPACT OF NAFTA ON NATIONAL HEALTH SECTORS

NAFTA has influenced its parties' health care sectors. With respect to Mexico and the United States, there has been an increase in penetration of private health insurance.[124] Despite reservations in NAFTA, meant to protect public health insurance programs,[125] Canadians are fearful about the expansion of private insurance coverage in Canada and the ability of the Canadian government to expand publicly-sponsored coverage of goods and services previously provided in the private sector.[126] A recent report on the Canadian health care sector, the Romanow Commission Report, recommended that Canada's federal government prevent legal challenges to Canada's health insurance program based on international trade commitments by "[r]einforcing Canada's position that the right to regulate health care policy should not be subject to claims for compensation from foreign based companies."[127]

Another critique of NAFTA and other international trade agreements is that economic integration is an effort to force the legal and economic systems of stronger countries, such as the U.S., onto weaker countries.[128] With respect to health care, a related concern is that free trade and the U.S. policy of non-governmental financing of health insurance for non-vulnerable groups would promote the migration of private health insurance products across borders to the detriment of government sponsored health plans. However, some have persuasively argued that the

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[124] *See* NAFTA and Trade in Medical Services between the U.S. and Mexico (David C. Warner ed., 1997).

[125] NAFTA, *supra* note 53, art. 1201, para. 3.

[126] *See* MATTHEW SANGER, RECKLESS ABANDON: CANADA, THE GATS AND THE FUTURE OF HEALTH CARE (2001); FLOOD ET AL., *supra* note 113; Tracey Epps, *Merchants in the Temple? The Implications of the NAFTA and GATS for Canada's Health Care System*, 12 Health L. Rev. 3 (2003); Tracey Epps & Colleen M. Flood, *Have We Traded Away the Opportunity for Innovative Reform? The Implications of the NAFTA for Medicare*, 47 McGill L.J. 747 (2002). *See generally* HEALTH SERVICES RESTRUCTURING IN CANADA, NEW EVIDENCE AND NEW DIRECTIONS (Charles M. Beach et al. eds., 2006).

[127] COMM'N ON THE FUTURE OF HEALTH CARE IN CAN., BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA 241 (2002), *available at* http://www.cbc.ca/healthcare/final_report.pdf. *See* Heather Heavin, *The Romanow Report: NAFTA Reservations and Proposed Reform*, 66 SASK. L. REV. 577, 595 (2003).

[128] See, e.g., Mark B. Baker, No Country Left Behind: The Exporting of U.S. Legal Norms Under the Guise of Economic Integration, 19 EMORY INT'L L. REV. 1321 (2005); Philip Arestis & Eleni Paliginis, Free Trade Among Unequal Partners: the Case of the EU and NAFTA, in ECONOMIC INTEGRATION IN THE AMERICAS 145 (Christos C. Paraskevopoulos et al. eds., 1996).

expansion of private health insurance in developing countries is a positive development.[129]

A third concern, not addressed in NAFTA, is the increased movement of citizens across borders and the failure of national insurance plans to follow these individuals across borders. This has been especially true of Mexicans who have immigrated to the United States and Canada following the adoption of NAFTA.[130] Furthermore, there have been barriers to coverage for beneficiaries of U.S. public health insurance programs, such as Medicare, because the benefits of these programs are not portable outside the Untied States. [131] One most story exemplifying the problem of uninsurance in both the United States and Mexico is the recent report of a hospital's deportation of a Mexican man (with legal status) to Mexico when the man was in a coma.[132] The reason for the deportation was that the man had no health insurance.

IV. ACHIEVING SOUND INTEGRATION IN NORTH AMERICA

This section explores the potential problems and possibilities of the economic integration in the health sectors of the United States, Mexico, and Canada. All health care sectors possess both strong and weak features. It would be unfortunate if economic integration of these sectors proceeded in ways that undermined the strengths of the sectors and precipitated a race to the bottom in terms of providing accessible, high quality health care at an affordable cost.

A. THE FUNDAMENTAL VALUES CONFLICT

The economic integration of national health care services through free trade regimes directly implicates a powerful and yet unre-

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[129] *See* PRIVATE VOLUNTARY HEALTH INSURANCE IN DEVELOPMENT: FRIEND OR FOE? (Alexander S. Preker, Richard M. Scheffler & Mark C. Bassett eds., 2007); Mark V. Pauly et al., *Private Health Insurance in Developing Countries*, 25 HEALTH AFF. 369 (2006).

[130] See Ranko Shiraki Oliver, In the Twelve Years of NAFTA, the Treaty Gave to Me. . .What, Exactly?: An Assessment of Economic, Social, and Political Developments in Mexico Since 1994 and Their Impact on Mexican Immigration into the United States, 10 HARV. LATINO L. REV. 53 (2007). See also Parastoo Anita Mesri, The Violation of the Human Right to Health as a Factor in the Zapatista Revolution Of Chiapas, México, 10 TULSA J. COMP. & INT'L L. 473 (2003).

[131] *See* David C. Warner & Lauren R. Jahnke, *Toward Better Access to Health Insurance Coverage for U.S. Retirees in Mexico*, 43 SALUD PÚBLICA MÉX. 59 (2001).

[132] Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES. Nov. 8, 2008, at A1.

solved debate about health policy regarding the role of the state vis-à-vis private organizations and professionals. One perspective is that health and health care is a human right, and as such, it is the obligation of national governments to assure the realization of that human right through national health programs or other means. An opposing perspective is that health care services are conventional economic services that should be distributed as other commodities in the economic marketplace, without excessive government regulation. In all areas of the globe, the debate tends to split along the political ideological poles of liberalism on the left and neo-conservatism on the right.

1. THE HORNS OF THE DEBATE

There is a substantial body of opinion that suggests that health care is a commodity like other services and that it should be distributed through the market like other most goods.[133] In international trade systems, health care services should be treated like other services and offered for sale without government interference.[134]

One problem with the idea of health care as a commodity distributed pursuant to market forces is that, for the great majority of people, many health care services are simply not affordable.[135] The governments of all developed countries pay for much of the health care for most or all of its poorer populations, because of affordability problems.[136] The vast public subsidy for health care fundamentally compromises the notion that health care services are a conventional commodity.

On the other hand, there is also a school of thought that health and health care are a human right and should be available to all, despite a person's ability to pay.[137] There are public international and regional or-

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[133] *See, e.g.*, AMERICAN HEALTH CARE: GOVERNMENT, MARKET PROCESSES, AND THE PUBLIC INTEREST (Roger D. Feldman ed., 2000); REGINA HERZLINGER, MARKET-DRIVEN HEALTH CARE (1997) (for some exemplary examples of this vast literature). *But see* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning*, 23 HEALTH AFF. 8 (2004).

[134] *See* Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 HEALTH AFF. 358 (2006).

[135] *See* JOSEPH P. NEWHOUSE, PRICING THE PRICELESS: A HEALTH CARE CONUNDRUM (2002).

[136] *See* ORG. FOR ECON. CO-OPERATION & DEV., OECD HEALTH DATA 2008: STATISTICS AND INDICATORS FOR 30 COUNTRIES (2008).

[137] *See, e.g.*, Joseph Wronka, Human Rights and Social Justice (2008); Autonomy and Human Rights in Health Care: An International Perspective (David N. Weisstub & Guillermo Diaz Pintos eds., 2008); Elizabeth Wicks, Human Rights and Healthcare (2007); Théodore H. MacDonald, The Global Human Right to Health: Dream or Possibility? (2007); Brigit Toebes, The Right to Health as a Human Right in International Law (1999).

ganizations that have developed a body of law recognizing the international human right to health. On the international level, the United Nations (UN) has been the leader in the development of international human rights law.[138] The Constitution of the World Health Organization (WHO) defines "health" broadly as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity."[139] The WHO Constitution goes on to state that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition."[140]

Article 25 of the Universal Declaration of Human Rights (UDHR), which, in 1948 the UN General Assembly adopted, includes a right to health and health care: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness [and/or] disability . . . " [141]

The UN Covenant implementing the social and economic rights under the UDHR—the International Covenant on Economic, Social, and Cultural Rights (ICESCR)[142]—also contains language on the right to health. According to Article 12 of ICESCR, the right to health includes "the enjoyment of the highest attainable standard of physical and mental health."[143] Article 12 of ICESCR specifically provides that states "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[144] The human right to health is also recognized in numerous other UN international human rights treaties that address the needs of historically vulnerable populations who have often been the subject of discrimination.[145]

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[138] *See* DAVID P. FORSYTHE, THE INTERNATIONALIZATION OF HUMAN RIGHTS 55-86 (1991).

[139] Constitution of the World Health Organization, preamble, 62 Stat. 6279, 14 U.N.T.S. 185.

[140] *Id.*

[141] Universal Declaration of Human Rights, G.A. Res. 217A, at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948).

[142] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966).

[143] *Id.* art. 12.

[144] *Id.*

[145] International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966); Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46 (1980); Convention on the Rights of the Child, G.A. Res. 44/25, Annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989).

2. A MIDDLE GROUND

There may be middle ground between the notion of health care as a right and the notion of health care as a market commodity. The major factor that justifies a middle ground is the apparent need for public subsidies, defrayed by tax payers, to make increasingly costly health care services available to most, if not all of its members. There is no developed country in the world in which health care services are financed solely from private funds of patients.[146] Most developed countries, since World War II, have enacted public programs of some variation to defray the costs of health care for its citizens.

The report of the U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, completed during the Reagan administration, offers a middle ground, which provides sound guidance in addressing health care in trade policy.[147] The report concluded that health care was neither a right nor a pure commodity, but something in between. The Commission framed its analysis of access to health care "in terms of the special nature of health care and of society's moral obligation to achieve equity, without taking a position on whether the term "obligation" should be read as entailing a moral right."[148] The Commission defined "equitable access to health care" as requiring that "all citizens be able to secure an adequate level of care without excessive burdens."[149] The Commission concluded that "society has an ethical obligation to ensure equitable access to health care for all" because of the "special importance of health care."[150] It determined that the societal obligation is balanced by individual obligations, and described the content of an individual's obligations:

> Individuals ought to pay a fair share of their health care cost and take reasonable steps to provide for such care when they can do so without excessive burdens. Nevertheless, the origins of health needs are too complex, and their manifestations too acute and severe to permit care to be regularly denied on the grounds that individuals are solely responsible for their own health.[151]

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[146] OECD HEALTH DATA 2008, *supra* note 136 and accompanying text.

[147] *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (1983).

[148] *Id.* at 32.

[149] *Id.* at 4.

[150] *Id.*

[151] *Id*.

B. PRINCIPLES FOR SOUND INTEGRATION OF HEALTH CARE SECTORS

The inevitable economic integration of the three North American national health sectors should proceed according to intentional principles. Also, as the principles suggest, the European model of economic integration which addresses the social needs of a mobile population could well serve as a model for North America.

Ideally, the principles enumerated below should be developed through a process of democratic consensus that should reflect the aspirations and concerns of all people in each of the three respective countries. As a point of departure, below are several principles that should, at the very least, guide the integration of the health care sectors of the United States, Canada, and Mexico.

> Principle No. 1: If a nation state or a state or province of a nation state establishes a publicly funded and administered health coverage plan for any or all residents of the relevant geographic jurisdiction in a democratic process, NAFTA and other trade agreements should protect the right of the political authority to proceed with the health coverage plan without challenge under NAFTA or the other trade agreements.

If a nation has adopted an economic or social intervention in a legal and democratic process, that nation should be able to defend and grow that intervention within the confines of law and regulation. The fact that the intervention conflicts with the economic or ideological position of other NAFTA state parties or enterprises within these parties should not be permitted to undercut the intervention in promoting their business objectives and political ideologies.

> Principle No. 2: If a private health care provider or payer seeks the protection of NAFTA to engage in business within another NAFTA party, the host nation has the right to ascertain whether any profit or excess revenues was earned from public funds and obtain compensation for any financial dislocations to public programs providing health coverage.

If public funds derived from taxpayers, rather than from insurance companies, health care providers, or other participants in the health care sector are only entitled to fair compensation for services rendered. If public health insurance programs pay for services or pubic funds are otherwise defrayed to pay the expenses of health care services, then health care providers and other parties are not entitled to the type of profits that reward imaginative and extraordinary entrepreneurial efforts.

The public subsidy represents a failure in the free market for health care services, which in turn suggests that profit taking by health care providers and private insurers is problematic. If health care providers and insurers are unable to provide an affordable product for most consumers, then they should not benefit from profits which come from public funds generated by tax dollars or the insurance premiums of consumers. From an international trade perspective, trade policy should not undercut publicly subsidized programs that provide universal access to care at the expense of for-profit entities that make profits from public funds.

This principle would encompass a requirement that private entities seeking protection should price services and products in a transparent manner and conform to accepted accounting standards in their business. A real problem with health care in the

United States as well as in Mexico and Canada, where third party payers defray much of the cost of health care, is a lack of transparency in the process for billing patients and third party payers for health care services.

> Principle No. 3: In order to facilitate the protection of individuals as they travel and move to other NAFTA parties, universal access to affordable and portable health coverage as a domestic policy goal should be a requirement for participation in NAFTA and other international treaties for economic integration.

NAFTA and the countries of North America do not permit the free flow of people within the geographical area of the free trade block. However, there is movement of persons from all NAFTA parties to all other NAFTA parties at any given time. This principle would greatly enhance the protection of individuals as they move across borders, whether or not NAFTA is ever so extended. In the later event, or in the resolution of the immigration issues in North America, adherence to this principle (as it has been in the EU)[152] would do much to eliminate some of the dislocations feared by a more liberal immigration policy on the continent.

V. CONCLUSION

It is inevitable that there will be increased movements of persons throughout the three countries of North America. Economic integration

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[152] *See supra* notes 21, 38, 39 and accompanying text.

will occur independently, whether or not the three nations of North America create policy to guide the integration. Rather than suffer the inevitable dislocations that are already occurring with respect to health coverage in North America, as a result of people inevitably moving from country to country, the financing of health care services throughout the three countries could be harmonized. Ideally, with harmonization and other international policy development, citizens of all three countries would have access to their respective coverage and care throughout North America. Ultimately, universal coverage and international policy will prevent hardships for those currently without health care coverage and assure access to affordable and high quality health care for all.