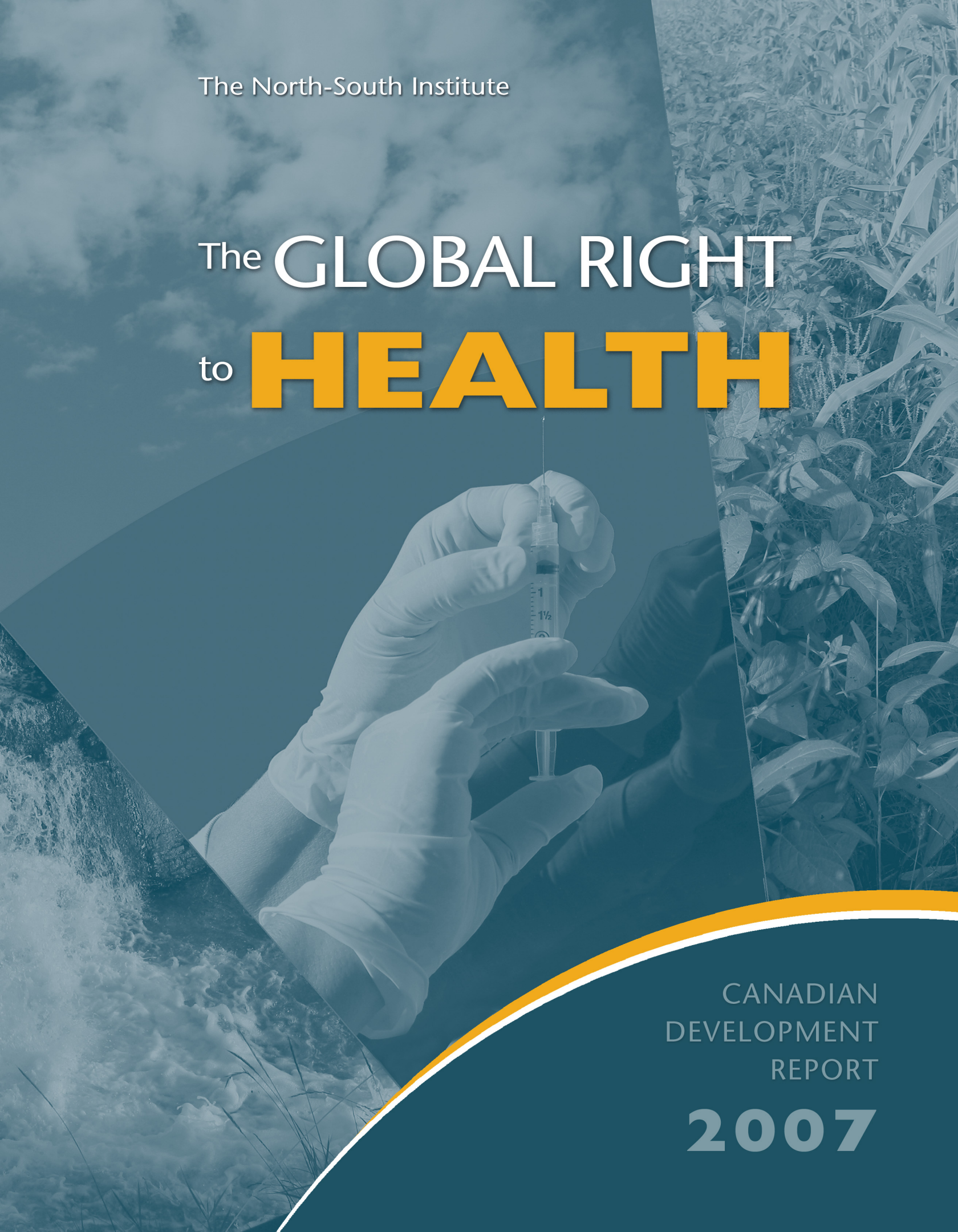
The North-South Institute

The GLOBAL RIGHT to HEALTH



CANADIAN DEVELOPMENT REPORT

2007

The North-South Institute

The North-South Institute is a charitable, not-for-profit corporation established in 1976 to provide professional, policy-relevant research on North-South issues and relations between industrialized and developing countries. The results of this research are made available to policy-makers, interested groups, and the general public to help generate greater understanding and informed discussion of development questions. The Institute is independent, nonpartisan and cooperates with a wide range of Canadian, overseas, and international organizations working in related activities. The North-South Institute thanks the Canadian International Development Agency for providing a core grant. For more information about the Institute consult our website at www.nsi-ins.ca.

The editorial content of the Canadian Development Report represents the views and findings of the authors alone and not necessarily those of The North-South Institute's directors, sponsors, or supporters, or those consulted in its preparation.

National Library of Canada Cataloguing

Canadian development report.

1996/97-
Issued also in French under title: Rapport canadien sur le développement.
Includes bibliographical references.
ISSN 1206-2308
ISBN 1-896770-88-6 (2006/2007 edition)

1. Developing countries – Social conditions – Periodicals.
2. Economic assistance, Canadian – Developing countries – Periodicals.
3. International economic relations – Periodicals.
4. Civil rights – Developing countries – Periodicals.
5. Developing countries – Foreign economic relations – Periodicals.
   I. North-South Institute (Ottawa, Ont.)

HF1413.C36 337'.09172'4 C97-9300128-3

Managing Editor: Lois L. Ross
Layout and Cover Design: Kershaw Design
Editorial Team: Lois L. Ross, Maureen Johnson, William Meyer
Translation: Société Eskénazi Inc.

Price: C$35.00

Available from: Renouf Publishing Co. Ltd.
5369 Canotek Road, Unit 1
Ottawa, Ontario K1J 9J3
Tel.: (613) 745-2665
Fax: (613) 745-7660

Email: order.dept@renoufbooks.com
Website: www.renoufbooks.com

The North-South Institute
gratefully acknowledges
the generous financial support
of the following donors in
the publication of the
Canadian Development Report
2007

BENEFACTORS

(Donations of more than $20,000)

Canadian International Development Agency

Agence canadienne de développement international

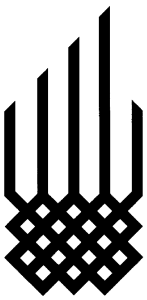
IDRC CRDI

International Development Research Centre

Centre de recherches pour le développement international

SUPPORTERS

(Donations between $4,000 and $9,999)



Aga Khan Foundation Canada
Fondation Aga Khan Canada

R. Howard Webster Foundation
La Fondation R. Howard Webster

CONTRIBUTORS

(Donations between $1,000 and $3,999)

CHF
partners in rural development

CAW TCA
CANADA

Canadian Labour Congress
Congrès du travail du Canada

Canadian Public Health Association
Association canadienne de santé publique

World Vision

DONORS

We would also like to thank Results-Résultats Canada and Power Corporation of Canada.

Canadian Development Report 2007

The Global Right to Health

TABLE OF CONTENTS

Foreword
By Roy Culpeper xi

Introduction
By James Orbinski xiii

CHAPTER ONE
Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada
By Lois L. Ross 1

CHAPTER TWO
Mobilizing Civil Society to Achieve the Right to Health
By María Hamlín Zúñiga. 33

CHAPTER THREE
Financing Health Care: for All, for Some, for Patients, or for Profits?
By David McCoy 57

CHAPTER FOUR
Canada and the Global Right to Health
By Chantal Blouin 85

Statistical Annex 103

Foreword

Roy Culpeper

Human beings throughout history, in every culture and region of the world, have valued good health as a prerequisite for their physical well-being and for their ability to participate in social and economic life. In this sense, the "right to health" is as important as other fundamental rights and political freedoms.

It seems that the crucial importance of the right to health is beginning to be recognized. However, it also seems clear that the right to health is seldom acknowledged, and therefore must be fought for by individuals, communities, and societies. This is rarely an easy fight. Since achieving and maintaining good health requires the allocation of human and financial resources, the struggle involves political, social and economic dimensions.

There is much that can be learned from past and present struggles, in the North and in the South, to establish and maintain equitable health care systems. As we know from Canadian experience, universal, accessible, and affordable health care is something that even Canadians still cannot take for granted.

I would like to thank all the contributors to this volume for making this a timely and extremely topical *Canadian Development Report*. Particular thanks are due to my colleague Lois Ross, who has gone beyond her normal role as editor-in-chief of the report to provide an insightful chapter on the Canadian experience.

Thanks, as well, to María Hamlín Zúniga, David McCoy, and Chantal Blouin for their chapters — and a special thanks to James Orbinski who provides an overview to the report in his Introduction.

Roy Culpeper,
President and CEO,
The North-South Institute

Introduction

James Orbinski

While there is a well-developed array of instruments of international law and policy that express the values of human rights for advancing health,[1] the right to health is by no means a global reality, and nor is it fixed and immutable in Canada or any country. It emerges out of political choices, and most often from activist struggles to force that choice. The 2007 Canadian Development Report explores many subtle and not- so-subtle nuances of a global right to health. And it does so brilliantly.

Lois Ross examines in Chapter One the history of universal access to health care in Canada. She shows compellingly the struggle to realize it — one rooted most intimately in the suffering and deprivations of Canadians who too often had to rely on charity when it was available, or simply suffer what they must when it was not. She aptly describes the political battles waged over 70 years in Canada — including the Saskatchewan Doctors strike of 1962 where Tommy Douglas's CCF, seeking a publicly funded universally accessible health care system, was matched against the College of Physicians and Surgeons and the Saskatchewan Medical Association (SMA). The SMA had the financial and tactical backing of the American Medical Association, and wanted to maintain private control and therein the ability to maximize profit. This struggle culminated in Medicare legislation passing the Canadian House of Commons in December 1966, and enabling legislation in July 1967. Over the next five years, all provinces and territories in Canada would come under the legislation. Ross details the ongoing challenges to universal access to publicly funded health care in Canada since, and argues persuasively that just as in Canada, the right to health care globally will not be granted by governments so much as demanded by a community prepared to organize around the issue.

And communities are organizing. María Hamlín Zúñiga describes in Chapter Two how national movements have emerged in, for example, El Salvador, and have joined together to form global organizations that link to local efforts. Her central focus is the *People's Health Movement*, now a global coalition of thousands of NGOs fighting for the right to health both

globally and locally. She details the emergence of the *People's Health Movement*, its vision and its challenges, as these have taken shape over two People's Health Assemblies — the first in Bangladesh in 2000, and the second in 2005 in Ecuador. Zúñiga describes how the *People's Health Movement* has defined its focus, and how it has become a force not to be ignored but reckoned with at the global institutional level by the World Health Organization and the World Health Assembly, by UNICEF, the World Bank and many others — and locally throughout the world through specific actions and campaigns. Zúñiga argues powerfully and through concrete example, that the right to health will be achieved through a focused, mobilized, engaged and activist civil society both locally and globally.

Finance matters to the right to global heath. All rights, if they are to be effective, make claims on the public treasury and on the state's regulatory and enforcement capacity. Rights cannot be protected or enforced without public funding and support.[2] Chapter Three describes how health care can be paid for, which ultimately defines the "who gets what, when, and who benefits and how" of access to health care and health care technologies such as drugs, vaccines, or diagnostics. In an easy engaging style, David McCoy succeeds in both making this compelling reading, and in tying health care finance to basic issues of equity, quality of care, efficient access to care, human rights, and the place of private business and government in realizing these. He moves well beyond abstract theoretical questions to examine practical policy choices and their effectiveness and implications for a global right to health. He examines public, private, and mixed health finance schemes in different countries. For example, he analyzes risk sharing and the impact of "cherry picking" lower risk, higher income patients whose political voice, commitment and financial contributions exit a universal public system, increasing the burden on the public sector, ultimately risking the creation of "poor health care for poor people". He examines the impact of commodified health care on the trust-based relationship between a health care user and provider, as well as the explosive administrative costs of private insurance schemes. He examines the impact of globally institutionalized charity for financing of appropriately structured health care systems in the developing world. Here he scrutinizes Overseas Development Assistance, Global Health Initiatives that are largely public private partnerships, the work of non-governmental organizations, and the incomplete ability of states to tax

effectively in the South. He does this not with a destructively critical view, and not by posing utopian quick-fix solutions, but by offering a series of practical policy prescriptions that can reform existing practices and governance so that the global right to health can be realized.

"When there is political will, there is a policy way."[3] Only those rights that are enabled and sustained by political choices have discernable effect, and therein, tangible meaning. Chantal Blouin's Chapter Four examines the current policy choices of the Canadian government as they affect global health. She critically reviews the limits of current legal obligations to the global right to health as constrained by the availability of financial and human resources. Despite the enfeebling "progressive realisation" that constrains significant progress in advancing human rights generally, she none-the-less identifies several key areas where state obligations do exist to actively advance the right to health. She examines Canada's support for health initiatives in developing countries, and argues that these could be strengthened, for example, by Canada adopting similar policies as France, Chile, Brazil, Norway and others in levying air travel taxes to finance global health priorities such as pharmaceuticals designed to meet the needs of children in the developing world. Blouin examines Canada's policies regarding the cross-boarder movement of health professionals, and argues for reform "at home" by training adequate numbers of nurses and doctors to meet domestic needs, as well as for new practices such as "managed migration" that encourages health professionals from the developing world to return home. She also examines Canada's political positions on issues related to the right to the health at for example, the World Trade Organization, where rules governing intellectual property have all-but crippled access to patented medicines, and threaten to further undermine Research and Development for diseases that primarily affect poor people — diseases and people for which there is little, if any, immediate return on financial investment. In each of these, she offers a critical analysis and poses practical, viable and effective foreign policy options.

At its most elemental, the global right to health is a principled idea that tries to respond rationally and politically to the dignity of both the "other" and the "self". Dignity as an intimate human experience of our common humanity finds an imperfect but nonetheless powerful expression in the language and ideas of human rights. And ideas can be profound forces — more powerful than economies or armies as, for example,

the history of social movements show. Individual rights and freedoms, and other rights such as a global right to health, depend fundamentally on vigorous state action defined by political choices. And these depend firstly and lastly on a vigorous citizen action — as in Canada and elsewhere throughout the 20th century and today — that demands and defends rights like the right to health and access to health care. This year's Canadian Development Report by The North-South Institute openly challenges government, civil society organizations and most importantly, citizens to achieve the global right to health.

JAMES ORBINSKI is a medical doctor with extensive field experience with *Médecins Sans Frontières* (MSF). He was elected MSF's international president from 1998 to 2001, and launched its Access to Essential Medicines Campaign in 1999. Also in 1999, Dr Orbinski accepted the Nobel Peace Prize awarded to MSF for its pioneering approach to medical humanitarianism, and most especially for its commitment to witnessing. From 2001 to 2003 he became chair of MSF's Neglected Diseases Working Group that created the *Drugs for Neglected Diseases Initiative* (DNDI), a global not-for-profit drug development enterprise that develops drugs and other health technologies for diseases largely neglected by profit-driven research and development. The DNDI now has 20 drugs in development. In 2004, Dr Orbinski became a research scientist at St. Michael's Hospital, and associate professor of medicine and political sciences at the University of Toronto. He has since started *Dignitas International*, a hybrid academic non-governmental organization focused on community-based care, prevention and treatment for people living with HIV in the developing world. Dr Orbinski lives in Toronto with his partner and their two boys.

1 Marks, Stephen P, ed. *Health and Human Rights, Basic International Documents.* Harvard Series on Health and Human Rights. Cambridge, Massachusetts: Harvard University Press, 2004.

2 Holmes, Stephen & Cass R. Sunstein. *The Cost of Rights.* New York: W.W. Norton & Company, 1999, Page 15.

3 Ostry, Sylvia. "The World Trade Organization: NGOs, New Bargaining Coalitions, and a System under Stress". In *Controversies in Global Politics and Societies Series.* Munk Centre for International Studies, University of Toronto. Page 21, accessed August 31, 2006 at: http://webapp.mcis.utoronto.ca/Publications.aspx

Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada

Lois L. Ross

CHAPTER
ONE

Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada

Lois L. Ross

What are the factors that encourage development within a community or society? What are the institutions, attitudes, and social framework that nudge development forward? What does it take to achieve development?

While these questions are not new, some consider they are pertinent only for developing nations of the South. But, it wasn't long ago that these very same questions underscored major challenges here in Canada. Are those of us living in the "North" — the so-called developed world — really that distant from, or immune to, the social and economic conditions we identify as belonging to countries or regions in the "South" — the so-called "developing" nations?

Some regions or areas in most countries, including Canada, may still be considered to be "developing". Conditions, for example, in Canada's Indigenous communities are often comparable to those found in developing countries. Concomitantly, Médecins Sans Frontières, best known for its work in the poorest nations and in the battle zones of this world, is now providing medical care at clinics in Paris and Marseilles for patients who are denied insurance coverage under France's latest health care reforms.[1]

This essay argues that Canada should not tread on roads already traveled, as we once again enter the fray of the public versus private health care debate. It also argues that, just as in Canada, the right to health care in developing nations will not be granted by governments so much as it will be demanded by a collective or a community prepared to organize around the issue. The right to public health care in Canada did not occur quietly or easily. While the Canadian experience may not be transplanted as is, there are lessons and parallels which the South may find useful.

This chapter recounts the roots of Canada's public health care system, relating them to the current domestic and international debates, and argues that Canadians learned through trial and error that a voluntary, private system of health care did not provide nearly the efficiencies or quality as one that was publicly-administered. There is little evidence that

much has changed, in terms of costs and quality of health care, to favour privatization. Canadians, and their governments, should be reinforcing and protecting Canada's public health care system and supporting the principle of public, universal health care, as part of sound development policy — both here at home and beyond. Physician-anthropologist Paul Farmer notes that increasing inequity in health is a form of "structural violence" — and that we need to begin "thinking globally, acting locally" to ensure it is considered a basic social right.[2] It could also be argued that because Canada has led in creating and implementing a publicly-funded and administered health structure, we have a special responsibility to support the efforts of those in greatest need elsewhere in the world — as good neighbours do.

In Canada, Tommy Clement Douglas is known as the Father of Medicare[3] because of his foresight and his courage in implementing North America's first universal and public-administered health care system. And all of this in a province that had the highest per capita debt and the second lowest per capita income in the country.[4] T.C. Douglas was indeed instrumental to the fight for Medicare, but he would also be the first to note that he did not achieve that victory on his own. Nor would he claim to be the first to have seen merit in the idea of a publicly-operated and administered health plan.

The roots of Canada's public health care system are anchored by the names of countless individuals and groups who committed time, energy, and the little cash many of them had to try and solve conditions that either created or maintained poverty in their communities. Those same conditions were causing needless pain and misery — and were not allowing for the human or community development that people saw as fundamental to a productive and caring society.

Here, then, is the story of how Canada's publicly-funded and administered health care system was created through a series of experiments, innovations, and courage. It is a story that took more than 50 years to unfold and one worth re-telling time and again, for a number of reasons. Canada's health care system is held up as an example of what is possible by many organizations in the South.

The debate over public health care in Canada continues, and without knowing what roads we have traveled, it is impossible to determine a future direction. Many Canadians do not know about the "roots" or struggles of health care and the costs and sacrifices made to achieve it. On the international stage, civil society is calling for the global right to health (see Chapter Two) — essentially a call to recognize the importance of effective and equitable health care systems, but also a call for recognition of the impact of the social determinants of health.[5]

Canadians have a story to share with the rest of the world about how people, working together, organized communities to push for the right to public health care, and how access to health care has stemmed poverty and enabled development in this part of the world. Within the development of Canada's public health care system, there have also been solid examples of emphasis on improving public health, social conditions, and preventive health care. In fact, the view that both medical care and improved social conditions are part of overall health was identified early on in Saskatchewan, the birthplace of Canada's public health care system.

Life before Medicare

As a child, I grew up on Saskatchewan stories, often told around the kitchen table…stories of hard winters, of inequality, and of the "haves and the have-nots". Stories of cooperation, of lending a hand, of human greed, and of incidents — all too common I would come to learn — that can only be regarded as cruel and unusual.

Prior to public health care, far too many families in Saskatchewan could relate heart-breaking episodes that, today, might seem more fiction than fact. There are still old-timers who mark the passage of time and events with "before Medicare" and "after Medicare" stories. In the early 1990s, while doing community work in the Saskatchewan city of Swift Current, I had a brief conversation with an elderly woman. As she tried to recall the date of a particular event, she noted that "it must have been in 1948, since my son was born by then, and he is the first baby I had that I did not have to pay for." That year — 1948 — was the year the hospitalization program was introduced in Saskatchewan, allowing for anyone who was ill enough to be hospitalized to receive free medical treatment. Not having to "pay for a baby" as she put it, was a definite milestone, since costs of giving birth in pre-Medicare Saskatchewan had driven some families into near bankruptcy, or worse (see Chapter Three for details of a similar situation in developing countries today).

There are other stories even more vivid. In my mind's eye, I see the horse-drawn cutter[6] taking a young boy and his older brother into a small southwestern Saskatchewan town in the middle of a prairie snowstorm. The town is more than six miles away from the farmstead, and the boy is suffering from acute appendicitis. The local hospital in this largely Catholic community of 1,500 is operated by the Grey Nuns. The timeframe is the mid-1930s. And though the boy arrives at the hospital before his appendix bursts, he is shown to a waiting room, while his older brother again braves the blizzard to retrace the six miles to the family farm to get their father. The 12-year-old boy is refused care until his father finally arrives at the Grey Nuns hospital. Why the delay? The father has to sign legal papers to secure the debt against the family farm for the pending medical care. Should the crops fail and the medical bill not be paid, the land will cover the debt. The boy is eventually operated on — and lives.[7] Others, in similar circumstances, were not so lucky.[8]

Only a few years ago, a friend of mine who farms in southern Saskatchewan related a very personal story. During a conversation about family and farming, I asked if his father had homesteaded[9] the land. Hesitating, he noted that the land was a "homestead". When I asked if his father was still alive, he explained that his father had died years ago. My friend's mother had had a complicated pregnancy for one of his siblings and the birth created large medical bills. From one year to the next, the crops failed, making it impossible to pay off the debt. Payment had been guaranteed against the land. One day my friend's father headed down to the dugout.[10] Hours later he was found — a victim of suicide. In the 1930s in Saskatchewan, when a person died, their debts died with them. This man had only his farm with which to try and ensure the livelihood of his family, and he likely had hopes that some of his children would take over the land when he eventually retired. The only way to keep that dream alive, in light of the medical debt, was to ensure that the debt died with him. And it did. My friend still farms the land that his father homesteaded.

The agrarian roots of public health

Saskatchewan, built on the "wheat economy," is often referred to by residents as "next year country" — meaning if this year is rough, next year will be better. And if not "next year," then the "next year" after that. Agrarian economies everywhere are built around a culture of resilience, stamina, hardship, and hope.

How did Saskatchewan, and in particular southwestern Saskatchewan, become the birthplace of public health care?

The reasons are many, but if you take a drive down the secondary roads of southern Saskatchewan, the geography and sparsely-populated landscape allows you to imagine just how tough it must have been to carve a living out of the prairie sod. When Palliser[11] surveyed this area in 1857, he called it semi-arid and unsuitable for agriculture. Searing in the summer sun, given to bone-chilling winds and snow blizzards in the winter, with an average annual rainfall of 240mm or 9.5 inches, the climate was harsh. But climate and geography are only some of the factors. These were also shared with sister provinces of Manitoba and Alberta, yet it is here in Saskatchewan that ideas of a public health care system took root.[12]

What is not so easy to understand is how, in this expanse of the Palliser triangle, people were able to organize what must certainly be considered one of the greatest innovations in social development in North America — an experiment in "social medicine" that, in time, would rival all others in the field, either on this continent or beyond. Even today, Canada's health care system is "unique in the world in that it bans coverage of core services (physician and hospital) by private insurance companies, allowing supplemental insurance only for perquisites such as private hospital

rooms. This ban constrains the emergence of a parallel private medical or hospital sector and puts pressure on the provinces to meet the expectations of middle-class Canadians."[13]

The first steps toward public health care in Saskatchewan were small, but set an example of future possibilities. Prairie pioneers, people who settled the west, came from eastern Canada and Europe in search of a better life. The federal government had promised free homesteads to those willing to occupy lands and farm them within three years of their arrival. The pioneers arrived, taking the train as far as the tracks would go, and walking the rest of the distance. They came to a land that had absolutely no infrastructure. Those early settlers had to create communities literally from scratch. There was no local government, no town, no church, no community centre, schools, doctors, hospitals or town offices. Many huddled together in makeshift structures, doing their best to endure the first few winters. Houses were erected with neighbours lending each other a hand. People learned to co-operate and "pool" their efforts — it was a matter of survival. It was in everyone's interest to lend a hand — and to ensure that as many families made a "go of it" as possible. Successful establishment — development — of a community depended on it.

Necessity honed problem-solving abilities, as individuals and communities worked to establish structures based on collective or communal efforts, and not simply based on the need for profit. The prairie wheat pools were established by farmers so that they could "pool" their grain at harvest time, all the better to fend off the *laissez-faire* market forces that many farmers felt had used their power abusively in previous years. With storage facilities and a marketing structure based on "pooling" of crops from members, farmers no longer had to negotiate individually with the "merchants of grain". Credit cooperatives were also formed, so that people had a say in how money was loaned, at what interest rate, and what terms of repayment. Access to credit was key to maintaining the family farm in "next year country". Saskatchewan still has one of the strongest Credit Union banking systems in the country. There were also attempts at cooperative farming, both production co-ops and machinery co-ops.[14]

When Saskatchewan became a province in 1905, there were six hospitals serving 250,000 people. Death rates in rural areas were higher than in urban areas, where there were often full-time public health officials. In addition, rural areas often had trouble keeping doctors because there was no guarantee from one year to the next that individuals in the community would have a good crop and be able to pay for their medical services.

One of the first steps[15] towards public administration and financing of health care in Saskatchewan was the creation of the municipal doctor system. In 1915, in an effort to keep the services of its newly-arrived physician from Illinois, Dr H.J. Schmitt, the rural municipality of Sarnia #221

agreed to pay the doctor a retainer or salary of $1,500. Dr Schmitt, who during the course of his practice covered nine townships[16] by horse and buggy, was having difficulty collecting from impoverished farmers and was considering relocating to a larger, more prosperous community. This experimental move by local government led to the passage of the Municipal Hospitals Act in 1916, allowing for rural municipalities to make a grant to physicians to supplement their incomes. Then in 1919, legislation was passed to allow for municipalities to pay the salary of a doctor, if that salary did not exceed $5,000 per year, so that the doctor could provide free medical care to the residents of the municipality.

In the years that would follow, provincial legislation would be amended several times to include the sharing of physician services between municipalities as well as to allow for a per capita tax assessment to pay for the physician. This system of financing health care — essentially the "pooling" of monies — created a footing for public health care in Saskatchewan. By 1927, there were 13 municipal doctors practising — most being paid between $3,500 and $5,000. The per capita tax ensured that no individual patient was burdened as the municipal tax system "recognized ability to pay, since the more land one held, the more one paid."[17] As the 1930s proceeded, things got only worse for those rural municipalities that had not adopted the municipal doctor plan. The Saskatchewan section of the United Farmers of Canada encouraged the municipal doctor system and its members organized to push municipal councils to adopt the plan. An information pamphlet noted the reasoning succinctly:

> *"At present we are committed to pooling our wheat and other farm products. The municipal doctor scheme is in reality a pooling of our doctor bills…and insurance against unduly high doctor bills in any one year — an equalization scheme. Are you willing to invest $4.50 per quarter section in the health of our section of the nation? A nation's first wealth is health, and levies to protect our first wealth should have priority over all others."*[18]

The municipal doctor plan was the first step in integrating the idea of "pooling" finances for health care. But it was not perfect. And it was not portable — meaning that a patient could visit only doctors contracted by the municipality and within its borders. In addition, the plan did not cover hospitalization. It could be improved upon, and early on there were ideas of how to do that.

One of these, in particular, illustrates how individuals can make a difference through organization and persistence. And how good ideas in one part of the world can be carried forward to others.

Known as the "Matt Anderson Plan," it was built on the experiences of a Scandinavian immigrant of the same name. Having lived in Norway as a boy, Matt Anderson knew about public health care systems in that country, and was troubled that Canada had nothing to compare. In addition,

"As chairman of the board, you had to collect dues...

...to make ends meet. If you had problems, and couldn't pay the nurses…then they would go somewhere else. You never knew what was going to happen if you had a bad crop. You couldn't guarantee the wages. People would only be able to make small payments (health bills)… and that would be over years…and if you saw the conditions they lived in and their children — you wondered if it was right to try and collect from these people…still you would be surprised how much they did scrape up…you would see the toddlers running around with hardly no clothes on…it makes you think…the hospital board dealt with the hospital debt, but the doctors had to collect their own bills…a person who had a bit of property was likelier to get care than those who had nothing…I wouldn't say that people were ignored…but the doctors would pick'em over and try to pick those who had some money…all of that created a lot of interest in having everybody pay a bit…but once the doctors got the drift of it and realized that they were going to get paid every month and they didn't have to go into the countryside to try and collect, they liked it…there was a lot of educational work — we had to build up the region…people were a bit against socialism…but a lot of people realized it didn't matter if it was a socialist idea or whatever, everybody ended up sick or in the hospital eventually..."

Sam Gill, *the Mayor of the town of Leader and chairman of the Hospital Board, as told to Lois L. Ross during an interview, May 6, 1991, Leader, Saskatchewan.*

like most farmers of the time, he had suffered crop losses and had heavy medical expenses to pay for his family. He was also familiar with the municipal doctor plan that some rural municipalities were adopting. Anderson proposed a medical program that included doctor visits and hospitalization — a public health insurance plan that would be based on a personal tax. Under the plan, any patient could visit a doctor anywhere. Anderson discussed the plan with doctors and neighbours in his municipality and eventually, in 1927, a resolution was put before the Rural Municipalities convention. The plan wasn't supported because municipal reeves[19] felt that raising taxes would be unpopular. Instead, the organization appealed to the provincial government to implement a plan that would allow people to look after their health, even calling for "state" hospital, medical, and health services.

Year after year, for the next 10 years, and throughout the 1930s, Matt Anderson would present the resolution at the annual Rural Municipalities convention. In 1938, he brought forward a resolution calling on the provincial and federal governments to work together to implement a public health care program based on taxes. The delegates discussed the resolution but brushed it aside, saying it wasn't possible.

"On the way home from the convention, I felt both discouraged and disappointed. As I was thinking of the problem, it came to me all at once — why not do it myself instead of asking the government to do it?"[20]

Anderson decided to see if he could start a Medicare program within his own municipality. As reeve, he approached the provincial government and requested passage of a law to allow the Rural Municipality of McKillop to levy a personal tax for the purpose. He went back to his municipality and put forward a motion, noting the Order-in-Council that made the personal levy by the municipality legal. While many had been skeptical, the rural municipality supported Anderson's Medicare plan. The plan went into effect January 1, 1939. The initial tax was $5 per person, with a maximum of $50 per family. The plan covered 2,350 people. Soon after, the provincial government expanded the legislation to allow other municipalities to levy personal taxes. As word spread, other rural municipalities became interested in passing the plan. In essence, the "Matt Anderson Plan" was the precursor to both provincial and later federal Medicare plans.

Due to changes in legislation similar to that which allowed local governments to levy taxes for health care, voluntary insurance programs were started through various associations. These plans grew slowly because most people lived in the rural areas and could either not afford membership in these associations or were lucky enough to be covered by a municipal doctor plan. But even in 1939, a cooperative medical insurance plan set up by an association of consumers faced stiff opposition by doctors in Regina. The health cooperative had hired a group of doctors to be on salary and staff a clinic supported early on by more than 1,500 members. The doctors were pressured not to join the co-op, and the group of doctors in opposition quickly moved to set up their own private medical insurance scheme. This was a sign of what was to come and the deep divisions between the entrepreneurial view of health as a "commodity" and health as a "social right". Should health care be sold through private business practices owned by doctors, and paid for on a fee-for-service basis? Or should health care be publicly-funded with physicians on salary as part of a government-sponsored system? This public/private dynamic is the same struggle that permeates national and international arenas today. By 1939, in areas of the province where the municipal doctor system had not taken hold, private insurance companies — often operated by doctors themselves — were offering coverage. The debate between public and private health care insurance was beginning to take shape.

In the first 40 years of the last century, the people of Saskatchewan had already taken large steps and made inroads toward having health recognized as a right. And while both federal and provincial governments of various stripes had noted the need for health care in their platforms, and even promised to implement an adequate system, very many people were

left out in the cold if they could not afford to pay for their own health care costs. Municipalities that had adopted the municipal doctor systems were under severe financial pressure to maintain basic health care in the face of years of poor crops. As well, in many cases, the municipalities became collection agents. While the concept of "pooling" was working, the size of the "pool", given the agrarian economic realities, was not large enough to sustain the need. The burden of financing adequate health care had fallen largely to municipal councils.

Free hospitalization comes to Saskatchewan

So when the young T.C. Douglas, with a decade of political and electoral experience under his belt, campaigned on a provincial platform providing public health and dental care, the people of Saskatchewan took note and opted for the chance. In 1944, the Cooperative Commonwealth Federation (CCF), led by Douglas, came to power — the first socialist government in North America. The new government took office on July 10 and wasted no time in planning to carry out its mandate.

Within a few months a report, written by Dr Henry E. Sigerist,[21] was filed recommending regional health districts based on preventive medicine, hospitals, rural health centres, and maintaining and developing the system of municipal doctors. Sigerist also proposed free hospitalization.

Within three months of taking office, the Saskatchewan CCF had introduced complete health treatment for those with cancer (diagnostic and curative plans), and free care for the mentally ill and those suffering from sexually transmitted diseases. Then a few months later, in January 1945, the province issued a blue card entitling old age pensioners, the disabled, and those on mother's allowance[22] to complete health care including medical, surgical, glasses, hearing aids, and prescription drugs.

In 1946, the Saskatchewan government passed legislation allowing for the first universal hospitalization program in North America. Doctors in Saskatchewan almost universally supported the creation of the program, since they could now admit patients without concern for cost.

That year the CCF government created 14 health regions, selecting one of those regions to embark on a pilot project to help build the provincial plan. In that region, known as Swift Current Health Region #1, medical and hospital care, as well as dental care for those 16 and under, would be covered. The structure, data and experience of the Swift Current Region would provide the province with a model on which to build a provincial plan, just as Saskatchewan would later become the model for Canada's Medicare system.

But as the CCF government was speedily moving toward these new programs, it was also facing tremendous financial pressures. The province was saddled with the highest per capita debt in the country. In addition,

though the federal government had indicated it would pay 50 per cent of health programs initiated by the provinces, that promise would turn out to be a hollow one for years to come. As Douglas noted: "We were confident…I was young and naïve…and of course the federal government didn't come with anything…and for 11 years the people of Saskatchewan paid the entire costs of comprehensive hospital insurance."[23]

Southwestern Saskatchewan was the poorest area of the province, and had suffered drought throughout the 1930s. In the previous generation, only one year in every seven had provided a return to farmers. For that reason, many of the municipalities and residents were burdened with debt due to unpaid health care bills — and were seeking solutions.

A full public program, which would "pool" funds from several municipalities drawing on a combination of land and personal taxes and provincial support, seemed feasible. It took several meetings among at least 10 municipalities, combined with leadership at the local level, to engender co-operation and overcome the competition that could exist between towns and municipalities. There were heated debates and votes throughout the region at municipal meetings, with some residents fearing that taxes would rise exorbitantly. But on January 17, at the organizational meeting for the newly-formed Swift Current Health Region #1, 60 delegates from the municipalities instructed the regional health board to provide comprehensive hospital and medical care as well as limited dental care "as soon as possible". The doctors in the region, many having lived through difficult times, saw the benefits of public and preventive health programs, and worked in co-operation with residents to build the pilot project.

By July 1946, universal hospital and medical care came into force throughout Swift Current Health Region #1, a full two years ahead of Great Britain's National Health Plan. It became the first region in Canada to combine public health with preventive care, and its board was made up of "staunch Liberals and Conservatives and CCFers, but they all left their politics at the doorstep."[24] The region would soon have a medical officer, seven public health nurses, a health educator, and three sanitary inspectors. By 1948, the number of doctors in the region would have jumped from 19 to 36. Over the course of the next 15 years the infant mortality rate within Health Region #1 would drop from the highest in the province to the lowest, achieving a rate of 14.4 per thousand live births by 1965. The region's infant mortality rate was far lower than that for Canada as a whole, which in the early 1960s was almost double at 27 per 1,000 live births.[25]

While the CCF government kept its promise, once the initial programs were begun it was forced to pace the rate of change to the financial reality of the province. Nonetheless, the public health programs available — in particular universal hospitalization — were superior to all others in the country and lifted the burden of health care from the shoulders of indi-

viduals and families. Communities continued their development, and the 1950s are recalled by many as the first decade in which a relatively solid bridge between prosperity and equity was created in one of the poorest regions in the province.

While the early public health care programs[26] did not meet with much opposition from the medical profession, by the mid-1950s there were signs that some doctors saw health insurance more as a product to be sold than as a public right. The Saskatchewan government, led by T.C. Douglas, implemented crucial public health care programs through the late 1940s and '50s, but it was waiting on the federal government's promise of cost-sharing to implement a universal and comprehensive province-wide Medicare program. By the late 1950s, while those areas which had municipal doctor plans maintained their programs, the system of municipal doctors was not being expanded. Meanwhile, for-profit insurance plans operated by doctors were expanding quickly. By 1959, more than 40 per cent of the Saskatchewan population was covered, in varying degrees, by these private insurance schemes.

While the Saskatchewan Medical Association had good relations with the provincial government in the early years of Douglas's mandate, and had publicly noted its appreciation of the Premier and his role as Minister of Health, there were also early signs of the diverging interests to come. For one, the culture among prairie doctors was beginning to shift: those doctors who had weathered the poverty and drought years of the 1930s were retiring and younger doctors with less experience of hardship were replacing them. Many more doctors were also moving to the cities, rather than dedicate themselves to the seemingly more difficult life of a rural physician. By 1961, 54 per cent of doctors would live in urban areas, though only 22 per cent of the province's population lived in cities. As well, with private insurance plans operated by doctors, physicians' ability to essentially set and control their own fee structure was becoming increasingly attractive.

Meanwhile, Canada's southern neighbours in the United States had for several decades been trying to engage various levels of government to adopt a publicly-funded system. In 1939, what is known as the 'Wagner Bill' was introduced nationally. One purpose of the bill was to allow the US to put a National Health Program into practice. And while consumer groups supported the move, among those who attacked the bill was the American Medical Association (AMA).[27] In fact, during much of the last century, the US citizenry has pressured at various times for public health care, most recently during the Kennedy administration of the 1960s and during the Clinton administration in the 1990s.

In 1957, the Conservative Party, led by Saskatchewan-born Prime Minister John Diefenbaker, was elected to federal office in Canada.

"When I was a boy in Scotland before World War I...

...I fell and hurt my knee. A bone disease called osteomyelitis set in and for three or more years I was in and out of hospital. We had no money for doctors, let alone specialists. After we immigrated to Canada, the pain in my knee came back. Mother took me to the outdoor clinic of a Winnipeg hospital. They put me in the public ward as a charity patient and I still remember the young house doctor saying that my leg must be cut off. But I was lucky. A brilliant orthopeodic surgeon, whose name was Smith, came through the wards looking for patients he could use in teaching demonstrations. He examined my swollen knee and then went to see my parents… Chance intervened and a specialist cured me without thought of a fee. I shall always be grateful to the medical profession for the skill that kept me from becoming a cripple, but the experience of being a charity patient remains with me. All my adult life I have dreamed of the day when an experience like mine would be impossible and we would have in Canada a program of complete medical care without a price tag."

Premier T.C. Douglas, as told to the Star Weekly, June 4, 1960

Within a year, Diefenbaker decided to make good on the idea of 50 per cent cost sharing for those provinces wanting to set up and administer a public health care program. While the idea of private insurance plans was already well underway in many parts of Canada, more than 30 per cent of Canadians had no health insurance at all.

Public medical care becomes a reality

In April of 1959, Saskatchewan Premier Tommy Douglas announced plans to implement Medicare across the province of Saskatchewan — a program based on principles that would guarantee equity by being universal, comprehensive, affordable, portable, and publicly-administered. The CCF provincial government decided to seek a fifth electoral mandate in 1960. A major component of its election program was public medical care. The Saskatchewan Medical Association (SMA) and the Chamber of Commerce campaigned — along with the CCF's main opposition, the Liberal Party led by Ross Thatcher — against Medicare.

The SMA was armed with tactics and resources from the American Medical Association, which since the 1920s had been successful in stymieing any moves toward public health care in the US. The SMA set up a system of cells, with one doctor or "key man" whom they ensured would distribute public relations material quickly and who could keep in regular contact with doctors in his area. The SMA also assessed a special $100 fee on each of the 900 doctors in the province and, with additional funds directed from the coffers of the Association, managed to dedicate more

than $95,000 toward its campaign against Medicare. The Association was not beyond pressuring, and purging, maverick doctors who did not see public health care as a threat and challenged the SMA position. The Association, borrowing a page from the AMA, worked hard to evoke the US witch hunts of the McCarthy era by "red-baiting" in their publicity kits. One piece of SMA propaganda emphasized: "The concept of universal medical coverage is not new and the approach by government to seek support is just the same as it was when first enunciated by Karl Marx in his Communistic theories of the last century literature…"[28] Essentially, the campaign was a dry run for things to come.

Nonetheless, the CCF was successfully re-elected on June 8, 1960, and moved ahead to implement its main campaign platform, Medicare, and the five key principles — universality, comprehensiveness, public administration, portability, and accessibility.

Following the recommendations of the Thompson Committee[29] — an advisory planning committee whose 12 members included six physicians — the Government of Saskatchewan moved to pass the Saskatchewan Medical Care Insurance Act in November 1961. By this time, Woodrow Lloyd was CCF Premier of Saskatchewan.[30] The Thompson Committee had accepted more than 50 briefs and had held fact-finding visits and taken opinions from experts in more than seven countries including Australia, Great Britain, Norway, and Denmark. Its main recommendation was the universal coverage of the entire population — rather than universally available coverage on a voluntary basis. The committee rejected what is now popularly known as a two-tier system, noting that it would be difficult and costly to administer, and that a voluntary system would lead to uneven coverage of the population; it would eventually cost the government more because subsidies would have to be given to those with inadequate health coverage.

Naturally those doctors who were accustomed to their own private insurance schemes and who had campaigned hard against re-election of the CCF were not happy. What is known as the "Doctors' Strike" of 1962 took place during 23 days in June and July, after repeated impasses between the doctors associations and the commission charged with implementing health care.

Essentially the College of Physicians and Surgeons and the Saskatchewan Medical Association's final position was that patients should be reimbursed by the government for health care services and charges administered by commercial companies or by doctors' plans. The public would buy insurance policies, if they chose to do so, and poor people would have their premiums paid by the government at fee rates determined by doctors. In a nutshell, the doctors' associations were pushing to ensconce private insurance schemes, with rates determined by doctors

and the government subsidizing those who could not afford the costs. By May, the doctors had decided that if their proposal was not adopted, they would begin to withdraw their services by going on strike — in effect, refusing to provide service in hospitals and doctors' offices. Some doctors would be left to deal with emergencies, but only a skeletal service would remain and some facilities would have to be closed.

The CCF government wasn't prepared to accept a plan that would endorse the "commodification" of health care — not when it had pledged since the 1930s to bring in a public and comprehensive health care system, and had just been re-elected with an increased majority on a platform mandating that it implement a public system of Medicare across Saskatchewan.

The Doctors' Strike in the summer of 1962 was hard fought. A system of organizational "cells" was up and running. "Keep our Doctors" (KOD) committees were set up by women who said that their group had been formed spontaneously over a "cup of coffee" one morning. Interestingly, the KOD committees were strikingly similar to Operation Coffee Cup, the American Medical Association's campaign of the late 1950s and early 1960s that opposed the Kennedy Democrats' plan to extend Social Security to include health insurance for the elderly, known as Medicaid.[31] It is well-documented that in 1962, just as in ensuing years, the AMA financed and encouraged, often surreptitiously, its Canadian counterparts to actively campaign against public, universal, health care.[32]

When the Doctors' Strike began on July 1, the sides were deeply polarized. The doctors were largely supported by the business community and the Chamber of Commerce, as well as the pharmacists who stopped filling prescriptions during the strike. Meanwhile, organizations representing farmers and labour supported Medicare. Still, the withdrawal of services worried many, and the province moved to accept the services of British doctors who offered to come to Canada to provide medical services in the interim. In some communities, medical practitioners who supported public health care banded together to form clinics.

For 23 days the strike continued, often pitting family members and neighbours against each other — but the provincial government led by Premier Lloyd largely followed a strategy based on calm and silence. It was a delicate, volatile situation — one that some feared could become violent. In the end, the strike lost momentum as it became clear that the doctors could not garner the public support they had hoped for. On July 23, 1962, a negotiated settlement was signed in Saskatoon — one that preserved the five principles of Medicare (universal, comprehensive, publicly-administered, portable and affordable), but which did not challenge doctors' privileges to determine fees nor close the door to public consultations on quality of care.

By August, the amendments to the legislation as outlined in the Saskatoon Agreement were passed. These amendments, which allowed for various methods of billing by doctors, included a clause allowing physicians to opt out of the plan — one which would later meet with controversy and open the door to extra-billing.[33] These amendments also precluded having doctors on salary, instead allowing a fee-for-service billing system, a point raised in the Romanow Commission report of 2002. Nonetheless, the Saskatoon Agreement was a turning point not only for the people of Saskatchewan, but also for Canada and other countries. It meant that the day when a person's health would no longer be determined by the thickness of their wallet was at hand.

Just as Swift Current Health Region #1 had been the pilot project for the provincial plan, Saskatchewan's public health care system would now provide the example that, in a few short years, would be adopted nationally.

On the federal scene, as Saskatchewan was in the throes of its public health care debate, Prime Minister John Diefenbaker announced a commission to study the issue of a national health plan. During the course of that announcement in the House of Commons in December 1960, Diefenbaker made public a letter he had received from the Canadian Medical Association (CMA) asking for the inquiry.[34] As early as 1958, a nationwide Gallup poll had found that more than half Canada's population was in favour of public health care. So, in January 1961, the prime minister appointed a prominent Saskatoon judge, Emmett Hall, to lead a Royal Commission on Health Services. The recommendations of the Hall Commission have resonated across Canada for more than 40 years. All major health organizations participated, and the Commission studied first-hand health care systems from around the world;[35] it wrote 26 background research reports, before presenting findings in June 1964 — two years after the Commissioners had begun their inquiry.

The scene that the Hall Commission encountered as it prepared for public hearings reflected in many ways the challenges that the Saskatchewan government was encountering in its quest to establish public health care in that province. Both the SMA and the CMA endorsed public health care as early as 1933; the CMA, in 1934, had actually lobbied the federal government, trying to convince the government of the day that "medical care was as basic a need as clothing or food".[36] But by the time the Hall Commission prepared to go on the road with public hearings, the organization representing Canada's doctors had changed its tune. In the early 1950s, the CMA had entered the business of private health insurance and created Trans-Canada Medical Services, a coordinating body for doctor-sponsored provincial insurance plans. In 1960, while more than 7.5 million Canadians had no health coverage at all, another four million were covered by 11 doctor-sponsored insurance plans. Those plans melded with those of private insurance companies offering health cover-

age, and in 1959 the two groups formed the Canadian Conference on Health Care. The CMA and private insurers offered this organization as being an adequate and satisfactory vehicle for national health insurance, hoping that the Royal Commission would find in favour of the new organization. While the CMA had urged the Prime Minister to strike the Royal Commission, it was hoping that public funds would be channeled through private insurance schemes to pay for coverage of those who could not afford to pay on their own — essentially public subsidization and private control.

Justice Hall was given free reign to choose his Commissioners — and the views of the Commissioners were varied, with individuals from corporate, medical, and economic backgrounds. Hall also let it be known early on that the commission had no intention of taking sides in the dispute in Saskatchewan or of simply debating Medicare. He emphasized that the commission was set to inquire into all health services, and he worked hard to maintain its independence. He also refused to follow up on the CMA's suggestion that it would be pleased to secretly vet the reports prior to final publication.

When the unanimous Report of the Royal Commission on Health Services, now popularly referred to as the Hall Commission report, was released in 1964, it gave the idea of public health care a stamp of approval. Put simply, Hall noted that private health insurance plans excluded millions of people: they charged too much for administration and refused to cover some people, either because of pre-existing health conditions, inability to pay, or because the contracts were simply terminated by the insurance company. Hall's proposal was essentially the Saskatchewan model, allowing universal coverage on a fee-for-service basis. Each province was encouraged to develop its own model, with the federal government providing 50 per cent of the cost.

Medicare becomes a national program

But the Royal Commission report went much further than basic public health care. It included recommendations on prevention of disease, a prescription drug plan, eye care and eye glasses, an air ambulance service, and free dental care for expectant mothers and children under 18; it also called for new university medical and dental schools. The report was filled with statistical data that projected costs of public administration well into the future — calculations that, while heavily criticized at the time, were very close to what would actually be paid over the next 20 years. While in 1961 all health services cost 5.2 per cent of Gross National Product (GNP), Hall argued that more should be spent for a comprehensive system; he predicted that his proposal for health coverage would cost no more than 6.4 per cent in 1971 and 7.4 per cent in 1991. "The only thing more expensive than good health care is inadequate or no health care,"[37] he pointed out.

The Hall report also called for public administration, noting that it was far cheaper and more efficient than if handled privately. Administrative costs in Saskatchewan had always been below five per cent — usually between 3.9 and 4.6 per cent — as compared to private administration which ranged from 16 to 24 per cent and did not cover all people. The Saskatchewan data also noted that the length of hospital stay and costs per patient were actually less when there were no deterrent fees, as there were in British Columbia and Alberta. "And so," noted T.C. Douglas in a 1979 speech, "Mr. Justice Emmett Hall came to the same conclusion that we in Saskatchewan had years before — that deterrent fees are nothing else but a tax on the sick."

The report's first volume also included a visionary Health Charter for all Canadians.[38] That Charter affirms the Hall Commission's view that health care is a right, but it also alludes to what we now call the "social determinants of health" (see Chapter Two). It notes that the primary objective of national policy should be to achieve the highest standard of health, and that would include improving on other factors that affect health such as housing, nutrition, water, and air pollution.

Despite the depth of its arguments, the Hall Report did not escape severe criticism from the private sector, including the Canadian Medical Association. But Hall often challenged his critics in public presentations. He also went beyond a purely humanitarian view of health care and took the view that improved health care was an investment in "human capital", essential for economic progress.

By the time the 1964 Commission report was released, the Conservative government of John Diefenbaker had been replaced by a Liberal federal government led by Lester B. Pearson. These changes, and a split within the Liberal ranks, caused some delays. But legislation allowing for Medicare passed the Canadian House of Commons in December 1966; enabling legislation came into effect July 1, 1967. British Columbia joined the plan in 1968, with other provinces following suit between 1969 and 1971. Finally, in 1972, the Northwest Territories and the Yukon also joined.

While more than 40 years after its release the Hall Report is still held up as a beacon of what is possible, it also seems that the price paid for hard-won rights is constant vigilance. During the course of the past 30 years, Canada's Medicare system has been attacked in a number of ways — some more transparent than others. In 1979, Canada's national Medicare program was little more than 10 years old but already problems of underfunding — considered a main cause of the woes that the public health system has faced over the years — were creating controversy. Instead of continuing to fund health care at 50 per cent through block funding, in 1977 Ottawa brokered a deal with the provinces to provide

cash grants along with a share of income tax collected. In return, provinces could disperse the money to health programs as they saw fit. Those changes in the funding formula, and dealing with a system of fee-for-service, are what many believe are at the root of health care problems — and have largely led to the more recent controversies over the adequacy of Canada's public health care system.

In 1980, Emmett Hall was called once again by the federal government to report on the state of Medicare in Canada. Some doctors in Saskatchewan had begun to extra-bill patients, and colleagues in other provinces were following suit. While several issues arose during the less than two years that Emmett Hall took to research and write this report,[39] released in 1980, he focused on extra-billing. Hall found that provinces had acted responsibly in the level and manner in which health money was being spent, citing that administration fees in most provinces were at 2.5 per cent, but that doctors — through extra-billing — were opening the door to expanding private health care; this was creating a two-tier health care system, one for the rich and one for the poor.

Hall recognized the threat of extra-billing for what it was — and while noting that doctors deserved "reasonable compensation," he also noted that, according to legislation, fee schedules were negotiated with the practitioners and the state did not have the right to unilaterally determine them. He also noted that in 1978 doctors were making four times the wages of an industrial worker. Still, he ventured no further on challenging the levels of compensation for doctors. When negotiations on fee schedules failed, Hall recommended that disputes be settled through binding arbitration. While it took a few years for action on Hall's controversial recommendation, his report is credited with leading to the passage of the 1983 Canada Health Act — federal legislation that effectively banned user fees for hospital and physician services.

In 1964 and in 1980, just as now, doctors guarded the fee-for-service structure jealously. Talk of putting doctors on salary surfaces from time to time, but seems to be diverted by talk of public-private partnerships, doctor shortages, and wait times for treatment. The Canadian Health Coalition (CHC), a civil society organization that works to defend public health care, emphasizes that health workers should be paid on a salaried basis, not the fee-for-service system used by physicians, some health care providers, and private laboratories. Fee-for-service (payment for the number and type of services provided) encourages over-booking, over-prescribing, over-treating, and the concentration of physicians in urban areas at the expense of rural areas, according to the CHC.

During the late 1980s and the 1990s, Canada's national health plan was ignored by successive federal governments and suffered from chronic underfunding.[40] Issues of cost-sharing and jurisdiction, as well as deficits

and debt at both the federal and provincial levels during these decades, may have been at the root of this incredible negligence and reluctance to tackle health care issues head-on. Perhaps some hoped the neglect might lead to the implosion of Canada's public health care system — and the example it could provide to those living in less fortunate regions of the world of what is possible when effort and monies are pooled for the public good.

Assessing the route traveled to achieve the right to health care in Canada, it becomes increasingly clear that, in order to maintain that right, a society must be constantly ahead of the challenges created by private interests.

Since the late 1990s, there have been a number of worrisome trends and episodes in our quest to improve Canada's health care system, and there is fear on the part of many that we may be in the process of throwing the baby out with the bath water. Recent surveys have underscored Canadians overwhelming support for public health care. More than 85 per cent of Canadians want the federal government to have a strong role in developing common standards for health care delivery and services.[41] As well, 69 per cent of Canadians are willing to pay higher taxes to improve the public health care system.[42]

While Canadians are barraged with constant reports of wait times, doctor shortages, and excessive public health care costs, there are just as many reports published that should allay those fears by spelling out solutions to the problems and assessment of actual costs — all within the public health system.

In April 2001, yet another Saskatoon lawyer and former Saskatchewan premier, Roy Romanow, was called upon to lead a Royal Commission Report into the state of health care in Canada. That eloquent report further updated the Hall Commission reports and gathered health statistics from across the country and the world. The Romanow Report[43] undertook extensive consultation with Canadians during its 18-month duration, both in public hearings and through online forums. When the final report was released in November 2002, *Building on Values — The Future of Health Care in Canada* confirmed the value and future of Canada's public health care system. Romanow found that Canadians see a public health care system as a right of citizenship, as a public good, and not as a "privilege of status or wealth," and that, in fact, Canadians are getting very good value for their tax dollars. The report noted that "Medicare has served Canadians extremely well" — both in terms of efficiency and costs of care. Romanow compared Canada's system to several countries around the world, including the United Kingdom, Australia, and Japan, concluding that our public health expenditures are in keeping with those of other countries with public systems.

Health care statistics comparing Canada to other countries – 1993-2003*

Country	Total Health Care Expenditures *% of gross domestic product* 1993	2003	Health Care Funding from Public Sector *per cent*	Average Growth Rate from 1998 to 2003 *per cent*	Health Expenditures per Capita *$US*	Practising Physicians per 1000 Population *number*	MRI Scanner Units per Million Population	Life Expectancy at Birth *years*
Canada	9.9	9.9	69.9	4.2	3,003	2.1	4.5	79.7
France	9.4	10.1	76.3	3.5	2,903	3.4	2.8	79.4
Germany	9.9	11.1	78.2	1.8	2,996	3.4	6.0	78.4
Italy	8.0	8.4	75.1	3.1	2,258	4.1	11.6	79.9
Japan	6.5	7.9	81.5	3.0	2,139	2.0	35.3	81.8
Switzerland	9.4	11.5	58.5	2.8	3,781	3.6	14.2	80.4
United Kingdom	6.9	7.7	83.4	5.7	2,231	2.2	5.2	78.5
United States	13.2	15.0	44.4	4.6	5,635	2.3	8.6	77.2

* Data are from the Organisation for Economic Co-operation and Development, *Health Data 2005: Statistics and Indicators for 30 Countries.* (Available at http://www.oecd.org/document/30/0,2340,en_2825_495642_12968734_1_1_1_1,00.html). Data are for 2003 or the most recent year available. The figure for magnetic resonance imaging (MRI) scanners in the United States is an underestimate because it refers to the number of hospitals that have at least one scanner, rather than the total number of scanners.

The cost of health care in the US is close to twice Canada's per capita cost, and an increasing number[44] of Americans — close to 46 million — have no health coverage at all.[45] Romanow found that the public share of health spending in the US "private" system is more than 60 per cent of total health care expenditures. "This has been described as tantamount to paying for national health insurance and, in return, getting a fragmented system with significant gaps in coverage — the worst of both worlds. While the United States' health care system is usually portrayed as largely private, a more apt description is 'public money, private control'."

The Romanow report found that Canada's public health care system is "as sustainable as we want it to be" — and that governments have it in their power to improve upon the system to ensure its future. It also emphasized the need for a health care system based on preventing illness — what T.C. Douglas called phase two of the public health care system — rather than simply treating it. The debate should not be about whether or not private health care would be better, but rather on how to innovate to ensure an improved public system — one that is comprehensive and cohesive across the country. Romanow challenged the use of private clinics, particularly for diagnostic purposes, and recommended that these services be included within the Canada Health Act. He found no evidence to support further privatization of the system, either through user fees, de-listing of services, or a parallel private system.

Whether the reports have been at the provincial or the federal level, from the Sigerist report and the Thompson Commission in Saskatchewan, to the Hall Reports of the 1960s and the 1980s, through to the recent Romanow Commission Report, there have been few that have promoted the "commodification" or "privatization" of health care. That said, in the last few years there have been some reports or initiatives that have pushed for "hybridization" of the public health care system. While in the 1980s, the hot-button issue was user fees, the key issue these days is wait times and medical human resources. Many Canadians live in fear, justified or not, of not being able to access necessary medical care in time to deal with a personal health crisis. Waiting lists for diagnostic tests or surgery, or simply not being able to find a family doctor, are now issues across the country. As well, the costs of medical services that have been de-listed by the provinces or medical services that have never been publicly funded (such as prescription drugs) are on the rise.

Just as the Romanow Commission was wrapping up its work in October 2002, the Kirby Report[46] was released. For two years, the standing Senate committee on social affairs, science and technology studied the state of the Canadian health-care system and the federal role in that system. Its recommendations were wide-ranging and encouraged the Canadian government to review the role of the Canada Health Act and the five guiding principles of Medicare — public administration, universality, comprehensiveness, accessibility, and portability. More specifically, the Kirby Report recommended that the federal government clarify the principle of public administration, noting that the principle should cover the administration, but not necessarily the delivery, of health care. In keeping with that argument, the Kirby report makes several recommendations which would include "partnering" with private insurers or agencies to deliver care or a prescription drug plan. One might well wonder how a system set up using these recommendations would differ from the US medical system criticized by Romanow — "public money, private control".

Senator Michael Kirby's role as chair and lead on the committee that prepared the report has been challenged, since Senator Kirby is also on the Board of Directors of Extendicare, a for-profit company based in Markham, Ontario, that owns hundreds of nursing homes across North America. Several groups, including the Canadian Health Coalition noted Kirby's participation as chair as a conflict of interest, and traced the quality of care provided by Extendicare to its elderly residents.[47]

There are, no doubt, those who yearn for the lucrative possibility of doing business in health care. Canada spent approximately $130 billion on health care in 2004.[48] Just over $90 billion of that money was spent by governments delivering public health care. Almost $40 billion was spent on private health care. Shirley Douglas, spokesperson for the Canadian

Health Coalition, Canadian actor, and daughter of Tommy Douglas, calls the public portion of health care spending "a $90 billion golden egg", noting the health industry wants to get hold of it. "We in this country have forgotten our history…we have forgotten what a medical bill is," says Douglas. "We have this strange idea that health care is free…that the government gave it to us. It is not free — we have paid for it…we pay for it — through our taxes. This health care system did not come out of sentimental times. This public health care system came out of fierce battles…with tremendous opponents…and they are still here. You may not have personally fought for it, but your family did."

There has also been movement at the provincial level to pressure the federal government to allow for private agencies to deliver medical care. In Alberta, a plan called the "Third Way" would challenge the five principles of the Canada Health Act by allowing doctors to work in both the private and public health care systems and by allowing patients to pay cash or buy insurance to avoid wait times. Both recommendations are currently on hold by the federal government, which worries about the electoral ramifications of such blatant moves toward privatization.

In Quebec, the challenge to the Canada Health Act comes through the establishment of private clinics. There are more than 90 operating in Quebec, many offering diagnostic care — creating what is essentially a "two-tier" system for those who can afford to pay for what is perceived to be faster private care. Many believe such clinics are the beginning of privatization and of two health care systems, one for the rich and one for the poor.

These provincial moves were given the green light on June 9, 2005, when the Supreme Court of Canada ruled on what has become known as the Chaoulli Decision.[49] This ruling states that the Quebec charter allows for the purchase of private health care for procedures already covered by publicly-administered Medicare. The plaintiffs in the case — a Montreal patient, George Zeliotis, and Dr Jacques Chaoulli, who wanted to set up a private clinic — asked Canada's top court to strike down sections of the Quebec Hospital Insurance Act that prevent people from buying health insurance for medical procedures covered by the public health plan.

The Kirby Report also recommended that the provinces pay for private treatment if the patient isn't treated within a certain timeframe. While the 'hot-button' issue of wait times is of genuine concern, there is sound analysis by several policy-makers providing information on how to deal with the current hold-ups within the public system. Health policy analyst Michael Rachlis[50] compares the bottlenecks to a crowd trying to get into a hockey arena. While there is a line-up at the door, once you have your ticket and are past the gate, there is a seat for everyone. So it is with health care wait lists. What is needed, according to Rachlis, is action

to streamline minor and low-risk elective surgeries through specialized publicly-funded clinics. Rachlis provides examples of two such clinics, Toronto's Queensway Surgicentre and Winnipeg's Pan Am Clinic. "The Canadian debate has wrongly assumed that the only such clinics are for-profit businesses," notes Rachlis. Rather than call for privatization of services each time there is a problem to be solved in the public system, solutions can be handled within Medicare, he suggests.

There are also other pressures on the public system that need to be dealt with if the commercialization of the health care system is to be stemmed. For one, human resource needs have to be addressed. There has been a reduction of 50 per cent in nursing graduates since the early 1990s and, with the average age of nurses increasing, there is a growing shortage. This has led to criticism over Canada's "poaching" of health care workers from developing countries (see Chapter Four). Meanwhile, there is no consensus on whether there is a shortage of physicians in Canada, but the distribution of physicians across the country varies, often leaving rural and remote communities without the necessary professionals to provide even basic health services.

To address issues of funding, the federal government signed a deal with the provinces in September 2004 to provide an additional $41.3 billion in health care funding over 10 years. While this was touted as a plan that would fix public health care, money is only one aspect. Equally important are three other facets: ensuring that the Canada Health Act and its five principles of Medicare are followed by the provinces, increased training of health care professionals, and working to reduce the skyrocketing costs of pharmaceuticals. Romanow noted that many families face bankruptcy trying to cover the costs of expensive, but necessary, prescription drugs. And there have been calls for governments to create a publicly funded and controlled Pharmacare program[51] to ensure equal access to prescription drugs.

The cost of prescription drugs is the fastest growing category of health care spending, with drug costs having reached 17.5 per cent of total health care expenditures in 2005 — almost double the 9.5 per cent reported in 1985.[52] In 2005 alone, costs of prescription drugs rose by 11 per cent to almost $25 billion. Since 1997, prescription drugs have accounted for the second-largest share of health care spending, after hospitals. If these costs are not brought under control, many believe they will lead to a new health care crisis. In 2006, the Ontario provincial government announced reforms to curb health care costs, in particular the spiraling costs of pharmaceuticals. But negotiating volume discounts, encouraging pharmacists to stock less-expensive generics, and moving to regulate the price of generics is seen as a challenge to the brand-name drug industry.

The Canadian head of GlaxoSmithKline has warned the Ontario government that it might pull its branch plants out of Ontario if the reforms go ahead.[53]

At the same time, there is growing concern about the health care industry's practice of marketing pharmaceuticals to healthy people through fear-inducing advertising techniques, in order to expand the reach and profit line.[54] Access to medicine and exploitation by the pharmaceutical industry — Big Pharma — is a global problem, no matter whether we are discussing health catastrophes related to HIV/AIDS in Africa, resistant strains of tuberculosis in Russia, or Fabry's disease in Canada.

While there are clearly challenges to preserving Canada's publicly-funded health care system — and the need for constant vigilance to maintain it — there is also an urgency to move forward, both here at home and internationally, toward a more preventive and sustainable system based on the social determinants of health.[55] The existence of Medicare allows a society to concentrate on the social determinants, and this is considered by many to go hand-in-hand with a publicly-funded and administered health care system. Ensuring that Canada's health care system remains firmly in the public sphere is seen as important to the development of Canadian communities, as well as those communities in the South.

In 2006, a group of Canadian medical doctors formed a national organization – Canadian Doctors for Medicare (CDM) — calling on physicians across the country to help strengthen and protect public access to high-quality health care. "Physicians know that Medicare faces challenges similar to those in many developed countries," notes Dr Danielle Martin, a Toronto family doctor and chair of the CDM's Board.[56] "Many Canadians don't have access to a family doctor. Many more know a friend or a family member who has waited too long for a diagnostic test or treatment. The emergence of a parallel private tier would only make these problems worse for most of our patients. These problems are best solved within the framework of universally accessible, publicly-funded Medicare."

Dr Sylvia Estrada-Claudio, a doctor from the Philippines, agrees that public health care is crucial to development. And she adds that further privatization of Canada's public system could have drastic consequences in the South. Dr Estrada-Claudio is a co-founder of Likhaan, a national women's health organization, which, for several years, has partnered with the Canadian non-governmental organization Inter Pares.

She points out: "We have a saying back home, that when the overdeveloped north sneezes, we get pneumonia. The recent attempts in Canada to privatize health care by creating a two-tier system and to evade the federal government's accountability for enforcing the Canada Health Act are the sneeze. Let me tell you what the pneumonia looks like…many

Filipinos never have to deal with long wait times because they never get into the system. It is obvious to me that many of our local struggles are against a global problem. So I say resist the privatization of health care services in Canada and hold the Minister of Health here accountable to the Canada Health Act. Make Canada rebuke those who would take away a high standard and universal health care. We will be grateful for your victories in the Philippines."[57]

LOIS L. ROSS is Director of Communications and Publications for The North-South Institute. Lois proudly notes that she was born in southwestern Saskatchewan — the area of Canada that is credited with creating the first health projects in "social medicine". For more than 20 years, Lois has worked in the field of communications, as a writer, author, editor, journalist, broadcaster/webcaster, and photographer. Part of that time has been spent working in the area of community and international development in Canada and in Latin America. Prior to accepting the position with The North-South Institute in December of 2000, Lois was Director of Communications and Political Action with the Public Service Alliance of Canada. Previous to that she spent several years as a National Representative in Communications at the Canadian Labour Congress. Lois is the author and co-author of three non-fiction books: Prairie Lives: The Changing Face of Farming; Harvest of Opportunity: New Horizons for Farm Women; and, Assault on the Worker: Occupational Health and Safety in Canada. Her short fiction works have also been published in several anthologies, and both national and international magazines have published her feature articles.

References

Books

Badgley, Robin, F. and Samuel Wolfe. *Doctors' Strike: Medical Care and Conflict in Saskatchewan.* Toronto: Macmillan of Canada, 1967.

Blouin, Chantal, Nick Drager, and Richard Smith, eds., *International Trade in Health Services and the GATS – Current Issues and Debates.* The World Bank, 2006. ISBN-10:0-8213-6211-9.

Cassels, Alan and Ray Moynihan, *Selling Sickness – How Drug Companies Are Turning Us All into Patients.* Canada: Greystone Books, 2005.

Farmer, Paul. *Pathologies of Power – Health, Human Rights, and the New War on the Poor.* University of California Press, 2005. ISBN 0-520-24326-9.

Gruending, Dennis. *Emmett Hall – Establishment Radical.* Fitzhenry & Whiteside, 2005 (originally published in 1985 by MacMillan of Canada). ISBN 1-55041-984-6.

Hadler, Norton M. *The Last Well Person – How to Stay Well Despite the Health-Care System.* McGill-Queen's University Press, 2004.

Houston, Stuart C. *Steps on the Road to Medicare – Why Saskatchewan Led the Way.* McGill-Queen's University Press, 2002. ISBN 0-7735-2550-5.

Lewis, Stephen. *Race Against Time.* Toronto: House of Anansi Press, 2005.

Margoshes, Dave. *Tommy Douglas – Building the New Society.* Montreal: XYZ Publishers, 1999. ISBN: 0-968-36014-9

Sanger, Matt and Scott Sinclair, eds. *Putting Health First: Canadian Health Care Reform in a Globalizing World.* Canadian Centre for Policy Alternatives, 2004. ISBN 0-88627-374-9.

McBane, Michael. *Ill-Health Canada: Putting food and drug company profits ahead of safety.* Canadian Centre for Policy Alternatives, 2005. ISBN0-88627-405-2.

McLeod, Thomas H. & Ian McLeod. *Tommy Douglas – The Road to Jerusalem.* Edmonton: Hurtig Publishers, 1987. ISBN 0-88830-316-5.

Ontario Coalition of Senior Citizens Organization. *Life Before Medicare – Canadian Experiences.* The Stories Project, 1995.

Ross, Lois. *Prairie Lives: The Changing Face of Farming.* Toronto: Between the Lines, 1985.

Skidmore, Max J. *Social Security and Its Enemies.* Westview Press, 1999.

Waiser, Bill. *Saskatchewan – A New History.* Canada: Fifth House Ltd., 2005.

Wright, J.F.C. *Saskatchewan – The History of a Province.* Canada: McClelland and Stewart, 1955 (published to commemorate the Golden Jubilee of the Province of Saskatchewan).

Articles & Reports

"Canada's National-Provincial Health Program for the 1980s ? 'A Commitment for Renewal'." (The Hon. Emmett M. Hall, CC, QC, Special Commissioner – Health Services Review 1979), Report published August 1980.

Canadian Centre for Policy Alternatives. "Moving Forward – Alternative Federal Budget 2006," accessed at: http://www.policyalternatives.ca/documents/National_Office_Pubs/2006/AFB2006.pdf

Canadian Health Coalition. "Extendicare is not a model for Medicare," December 2001. A submission to the Standing Committee on Social Affairs, Science and Technology, in response to the its September 2001 Interim Report, "The Health of Canadians," accessed at: http://www.healthcoalition.ca/kirby-report.html

Canadian Institute for Health Information, Annual Report, May 2006.

Commission on the Future of Health Care in Canada (Roy J. Romanow, QC Commissioner). "Building on Values – The Future of Health Care in Canada." Final Report, November 2002. ISBN 0-662-33043-9.

Duffin, Jacalyn and Leslie A. Falk. "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine." Bulletin of the History of Medicine, 1996, John Hopkins University Press.

Feather, Joan. "From Concept to Reality: Formation of the Swift Current Health Region," Prairie Forum, The Journal of the Canadian Plains Research Centre, Vol.16, No.1, Spring 1991.

Feather, Joan. "Impact of the Swift Current Health Region: Experiment or Model?", Prairie Forum, The Journal of the Canadian Plains Research Centre, Vol.16, No.2, 1991.

Hall, Emmett M., Royal Commission on Health Services, Ottawa: Queen's Printer, 1964.

O'Hara, Philip. "Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework." Edmonton Social Planning Council, May 2005. Available online at www.edmpsc.com

Rachlis, Michael M. "Public Solutions to Health Care Wait Lists." Canadian Centre for Policy Alternatives, December 2005.

Standing Senate Committee on Social Affairs, Science and Technology. "The Health of Canadians – The Federal Role." Chair, The Honourable Michael J. L. Kirby, October 2002. Web access: http://www.parl.gc.ca/37/ 2/parlbus/commbus/senate/come/SOCIE/repe/repoct02vol6part8-e.htm#APPENDIX%20A

Sigerist, Henry. "What Happened to the Health Program." John Hopkins University, June 18, 1940.

Various papers on the social determinants of health found at: http://www.who.int/social_determinants/resources/en/index.html

Websites

http://www.workingtv.com/mouseland.html
Tommy Douglas's Story of Mouseland produced by Working TV.

http://archives.cbc.ca/300c.asp?id=1-73-90
CBC website on health care.

http://scaa.usask.ca/gallery/medicare/
Saskatchewan Council of Archives and Archivists, Medicare – A People's Issue, a site that mentions key players.

http://www.dufourlaw.com/ndp/tommy.htm
Tommy Douglas speech, given in Ottawa in 1979.

www.healthcoalitions.ca Audio speech by Tommy Douglas given on the 50th anniversary of the federal NDP on the Canadian Health Coalition website.

Endnotes

1 "French Health Reform: Doctors Without Borders go into Paris clinics to fill gap," by Tom Sandborn, The Tycee.ca, April 5, 2006. The same article notes: "Le Monde, one of France's leading newspapers, editorialized in August of 2004, that 'all the reforms that are proposed in France today lean toward an American style "reform" '."

2 *Pathologies of Power-Health, Human Rights and The New War on the Poor*, by Paul Farmer, University of California Press, 2005.

3 See "Prairie Giant: The Tommy Douglas Story" two-part television series aired on CBC Television March 12 and 13, 2006. Produced by Minds Eye Entertainment, Regina, Saskatchewan. http://www.cbc.ca/tommydouglas/

4 *Tommy Douglas – The Road to Jerusalem*, by Thomas H. McLeod and Ian McLeod, Hurtig Publishers, Edmonton, 1987.

5 Social determinants are social factors which determine the quality of a person's health. Such factors include education, employment, income level and working conditions, and the environment (such as air and water quality). For more information see: http://www.who.int/social_determinants/strategy/QandAs/en/index.html

6 A "cutter" was a horse-drawn sled used by rural residents during prairie winters before the use of automobiles became affordable and common.

7 That 12-year-old boy would eventually become my father.

8 *Steps on the Road to Medicare – Why Saskatchewan Led the Way*, Stuart C. Houston., McGill-Queen's University Press, 2002.

9 A homestead was a land grant of 160 acres. A homesteader needed to live on the land for six months of the year, erect a permanent shelter, and farm at least 15 acres of the land within three years of arrival in order to retain homesteading rights. Women were not allowed to apply for a homestead.

9 *Prairie Lives: The Changing Face of Farming*, by Lois L. Ross, Between the Lines, 1985.

10 On the prairies of western Canada, a dugout generally means a small reserve of run-off water, conserved in an area which has been dug out for that purpose. Most farms had a least one dugout to ensure clean water was available for humans and animals.

11 British Captain John Palliser was sent to examine the Plains and Parkland regions of the province.

12 It is here, in this expanse of land bordered by Leader to the north, the Alberta border to the west, and by Maple Creek and the US border to the south, that Health Region #1 was created to help consolidate the Saskatchewan government's move to public health care.

13 *Perspective, Private Health Care in Canada*, by Robert Steinbrook M.D. April 20, 2006, The New England Journal of Medicine; downloaded from www.nejm.org on April 20, 2006. Also, *Canada's health care system – reform delayed*, A.S. Detsky and C. D. Naylor, The New England Journal of Medicine.

14 Ross, *Prairie Lives*.

15 In the early years of the province, public health was a branch of the Department of Agriculture. That branch, however, under the leadership of Dr Maurice M. Seymour, brought in various measures to deal with communicable diseases ranging from typhoid fever to bovine tuberculosis, and summer dysentery. In January of 1929, Saskatchewan became the first province to cover the health care costs of the diagnosis and treatment of TB patients.

16 A township consists of 36 sections, with each section being 640 acres. In the early 1930s Dr C. S. McLean, Dr Schmitt's successor in the municipality of Sarnia, drove 14,000 miles to make 1,400 house calls, saw another 1,500 patients in his office, and attended 50-70 maternity cases. (see Steps on the Road to Medicare)

17 Houston, *Steps*, page 34.

18 Ibid., page 35.

19 Elected municipal officials.

20 Badgley & Wolfe, *Doctors' Strike*, page 14.

21 Within two days of the election, the Saskatchewan Premier — eager to put the CCF campaign platform into practice — had contacted Dr Henry E. Sigerist, a medical physician and professor of Medical History at John Hopkins University in the US, to request that he head a health study commission. Sigerist, who was originally from Switzerland and had been to Canada to speak on several occasions, supported

what he called "social medicine" — the structure that determined the distribution and delivery of care — and had followed attempts to set-up state-supported medicine in various parts of the world, including the Soviet Union. Sigerist also believed very strongly that the social and technological advances in medicine needed to develop together to avoid inequities. (See article *Sigerist in Saskatchewan.*)

22 Public assistance provided for basic family needs.

23 Speech by Tommy Douglas given in Ottawa in 1979.

24 Houston, *Steps*, page 143.

25 Gruending, Dennis. *Emmett Hall – Establishment Radical.* Fitzhenry & Whiteside, 2005.

26 The municipal doctors system and the hospitalization program, and the creation of Health Region #1.

27 *What Happened to the Health Program*, by Dr Henry Sigerist, John Hopkins University, June 18, 1940.

28 Portion of Saskatchewan Medical Association publicity kit as quoted in "Doctors' Strike."

29 Badgley & Wolfe, *Doctors' Strike.*

30 T.C. Douglas had resigned as Premier of Saskatchewan in order to become the leader of the newly-formed federal New Democratic Party.

31 Max J. Skidmore. *Social Security and Its Enemies.*.

32 Mark Gayn: *Doctors vs. the People*, Volume 195, Issue # 0002, July 28, 1962, accessed via The Nation Digital Archive; Peter Calamai: *Medicare dubbed second-rate*, The Windsor Star, June 22, 1989, accessed via FP infomart.ca, February 8, 2006.

33 Extra-billing is when doctors choose to bill additional fees, over and above those established in the fee guide set by the profession and the provincial medical care insurance commission.

34 Gruending (*Establishment Radical*) notes that the CMA was hoping to have a private system of insurance endorsed nationally to preclude expansion of the Saskatchewan model.

35 The Commission, either singly or in groups, studied the programs and practices in other countries including the United Kingdom, France, Holland, Sweden, Switzerland, Austria, Italy, the US, the then USSR, Australia, and New Zealand. The two volume report of analysis and recommendations was also based on more than 400 individual and organizational submissions presented at public hearings held in each Canadian province and the Yukon.

36 Gruending, *Establishment Radical*, page 102.

37 Ibid., page 112.

38 The Health Charter for Canada was initially proposed for adoption by the Royal Commission on Health Services in Volume 1 of its report in 1964.

39 *Canada's National-Provincial Health Program for the 1980s— 'A Commitment for Renewal,'* by The Hon. Emmett M. Hall, C.C., Q.C., Special Commissioner – Health Services Review 1979 – report published in August of 1980.

40 The calculation of federal funding for health care varies depending on whether it is based on cash contributions and tax points, or simply on cash transfer to the provinces. Either calculation concludes a substantial drop in federal funds transferred to the provinces to fund the Canadian public health care system. Total federal expenditures (cash plus tax points) for hospital and physician expenditures has ranged from a high of almost 60 per cent at the end of the 1970s to a low of slightly more than 41 per cent at the end of the 1990s. Federal "cash only" transfers for the same period have ranged from a high of close to 47 per cent to a low of 14.6 per cent. (see Romanow report, page 66)

41 Health Care in Canada Survey 2001.

42 Health Care in Canada Survey 2002.

43 *Building on Values – The Future of Health Care in Canada*, Commission on the Future of Health Care in Canada, Roy J. Romanow, Q.C., Commissioner, Final Report, November 2002, ISBN 0-662-33043-9.

44 *Percentage of Uninsured Americans Rising*, by Theresea Agovina, Associated Press, April 26, 2006.

45 Even those with private health insurance are not guaranteed adequate health coverage in times of need. As many as 400,000 American families file for bankruptcy each year because of medical expenses. In an insurance system based on user pay, those who need the most care — essentially those who over time are least likely to be able to pay — actually pay the most. Many have health insurance, until they become chronically ill or need expensive prescription drugs to survive. See the front page story of a young, middle-income family from Indiana: "When Even Health Insurance Is No Safeguard", by John Leland, New York Sunday Times, Early Edition, October 23rd, 2005.

46 *The Health of Canadians – The Federal Role.* Final report of the Standing Senate Committee on Social Affairs, Science and Technology, Chair, The Hon. Michael J.L. Kirby, October 2002 – web access: http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repoct02vol6part8-e.htm#APPENDIX%20A

47 See *Extendicare is not a model for Medicare*, a submission to the Standing Committee on Social Affairs, Science and Technology, by the Canadian Health Coalition, December 2001 – accessible at: http://www.healthcoalition.ca/kirby.html see also: http://www.extendicare.com/governance/directors.html

48 *Health Care in Canada*, a report released by the Canadian Institute for Health Information, on June 8, 2005.

49 http://www.cbc.ca/story/canada/national/2005/06/09/newscoc-health050609.html

50 *Public Solutions to Health Care Wait Lists*, Michael M. Rachlis, Canadian Centre for Policy Alternatives, December 2005.

51 *Moving Forward – Alternative Federal Budget 2006*, Canadian Centre for Policy Alternatives.

52 Canadian Institute for Health Information, Annual Report, May 2006.

53 *Can Ontario stand up to Big Pharma? Brand-name drug firms deliver threat*, Thomas Walkom, Toronto Star, April 29, 2006.

54 *Selling Sickness. How Drug Companies Are Turning Us All into Patients*, Allan Cassels and Ray Moynihan, Greystone Books, Canada, 2005; see also: *Ill-Health Canada: Putting food and drug company profits ahead of safety*, Michael McBane, Canadian Centre for Policy Alternatives, 2005.

55 *Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework*, Philip O'Hara, Edmonton Social Planning Council, May 2005. Available online at www.edmpsc.com

56 *Physicians launch call to strengthen and protect Medicare*. Accessed May 29, 2006, Ottawa – see: www.canadiandoctorsformedicare.ca

57 Message delivered at Health, Justice and Democracy, the Annual General Meeting of Inter Pares, April 24, 2006. See www.interpares.ca

Mobilizing Civil Society to Achieve the Right to Health

María Hamlín Zúñiga

CHAPTER
TWO

Mobilizing Civil Society to Achieve the Right to Health

María Hamlín Zúñiga

This chapter will demonstrate how civil society has provided the main venue for debate and mobilization around health.

Over time, the organization of civil society has grown in intensity and in sophistication and has responded to changing national and international circumstances. In particular, national movements have joined together to form global organizations that link to local efforts. This requires contact with international institutions and engaging national governments, as well as providing services and participation at the local level. Only by combining these efforts can alternative visions of health be developed to take into account specific cultural aspects, spiritual needs, and basic rights to health. This approach is gaining strength, but it stands in constant contrast and conflict with increasingly market-oriented and unequal approaches to health.

This first section will show how civil society organizations (CSOs), responding to national crises, have built an international movement that links global organization to grassroots mobilization.

Health for All by the Year 2000, was the slogan of the first International Conference on Primary Health Care in Alma Ata, USSR (now Almaty, Kazakhstan), in September, 1978. It appeared to be an attainable dream at the time of the signing of the Alma Ata Declaration.[1] Convened by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), the conference included representatives from 134 countries, 67 international organizations, and many non-governmental organizations who signed on to the final Declaration and its recommendations — an ambitious agreement to embark on a process toward the social and political goal of *Health for All*.

Actually, this conference at Alma Ata was the culmination of many years of struggle for health rights over the last century, with different countries and communities evolving their own systems to manage illness and health. Primary health care programs were developed by national and regional governments, by non-governmental organizations, and by church-based groups. Community health centres were being set up in many countries including Canada and the United States. Both professionals and communities were beginning to recognize the desperate need for primary health care as a base for health services. Also, more groups were

becoming aware of the non-biological causes of ill-health, including political, economic, social, cultural, and environmental determinants.

Around the world, primary health care programs, particularly those involving community-based health workers, were inspired by the Declaration and the possibility of governmental commitment to the goals and the program of integrated comprehensive primary health care. *Health for All by the Year 2000* was the rallying cry of so many organizations and programs. They believed that the goal could be attained as they continued to implement participatory programs at the community level in countries as diverse as Guatemala, India, the Philippines, Thailand, and Bolivia.

The primary health care strategy proposed at Alma Ata took into account the multiple determinants of health, not just those that are biomedical — an important and difficult concept. Unfortunately, most governments and health ministries in the 1970s and '80s were not oriented toward intersectoral analysis and certainly not cross-sectoral planning and program implementation. So, from the central government down to the smallest districts, governments continued to work on health and education, and other social and economic interventions, in a top-down and virtually uncoordinated fashion. Governments and planners simply did not have the political will to make that difficult transition to participatory planning and empowerment of people. Civil society organizations evolved faster and more progressively than governments at this stage, and it became a challenge to persuade governments to change their perspective. Problems emerged as some governments saw the notion of change as a threat.

In fact, in some regions, suggestions of carrying out horizontal, broadly integrated, community-based programs were seen as supporting radical change. Because the concept was revolutionary, it was thought to be inspired by groups struggling for national liberation from dictatorships and was met with counterinsurgency measures. That was the case in some Central American countries where non-governmental, usually church-based, health programs were strongly involved in the promotion of integrated, comprehensive, community health and development programs starting in the mid-1960s.

As the decades passed and the health crisis became more acute, individuals and groups in various parts of the world became interested in monitoring the advances of the goal of *Health for All*. On the 10th anniversary of the Alma Ata Declaration, the WHO convened a meeting in Riga, Latvia, to discuss progress. In addition to the WHO and representatives of national governments, civil society organizations participated. They also took part in the 15th anniversary in 1993, and the 20th anniversary in 1998, both in Almaty.

Also in 1998, several networks working in health were invited by the representative of Health Action International – Asia Pacific (HAIAP) to meet in Penang, Malaysia, to discuss the possibility of an alternative global people's health assembly to be held in the year 2000. During the initial planning session, they identified important characteristics of the ongoing global health crisis:

- A retreat from the goal of national health and drug policies as part of overall social policy.
- A lack of insight into the intersectoral nature of health problems and the failure to make health a priority in all sectors of society.
- The failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread, and usually inequitable, health privatization.
- A narrow, top-down, technology-oriented view of health.

Eight networks and organizations decided to form a global organizing group with national and regional coordinating committees and an analytical working group. The objective of the exercise was to give voice to those who are unheard in the annual World Health Assembly of the Ministries of Health and the WHO. To ensure that grassroots people were involved, they began an intense process of organization at the community level.

These committed individuals and organizations worked together over a two-year period to organize the first People's Health Assembly (PHA). They included the Asian Community Health Action Network (ACHAN), Consumers International (CI), the Dag Hammarskjöld Foundation (DHF), Gonoshasthaya Kendra (GK), Health Action International – Asia Pacific (HAIAP), the International People's Health Council (IPHC), the Third World Network (TWN), and the Women's Global Network for Reproductive Rights (WGNRR).

The assembly was held from December 4-8, 2000, in Savar, Bangladesh, on the campus of Gonoshasthaya Kendra (the People's Health Centre). Attended by more than 1,453 participants from 92 countries, it was the culmination of 18 months of preparatory action around the globe. The objectives were to formulate a People's Charter for Health (PCH) and to share and increase knowledge, skills, motivation, and advocacy for change, and so improve communications among concerned actors.

The Charter was built on the views of popular movements and organizations from around the world and was first approved and endorsed at the Bangladesh assembly. It is a tool for advocacy and a rallying point for the global health movement. The Charter expresses the common concerns of the people and their vision of a better and healthier world, and it calls for radical action (www.phmovement.org/resources/phcharter).

Development of a fledgling People's Health Movement

To understand the nature of the current movement, it is useful to examine some of the core ideas and achievements of the movement in its first years.

The Vision of the People's Health Movement (PHM) states:

> "Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world — a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives."[2]

This statement has been the inspiration for the movement's growth in local communities and at the national level around the world. The movement also reaches across continents, with thematic issues being dealt with globally. Its growth has been uneven and driven by local concerns as well as the commitment and actions of the organizations and individuals involved. There are very different traditions and contexts informing the national and regional manifestations. In some countries and regions, such as India, Bangladesh, the Philippines, Central America, the Middle East, and North Africa, there are strong activist cultures that have facilitated the growth of the movement. In other regions, like southern and eastern Africa, characteristics such as hierarchical patterns of leadership have resulted in less dynamic processes and growth.

There have been considerable achievements during the five-year period from 2001 to 2005. The People's Charter for Health has been translated into more than 40 languages and disseminated around the world through mass media and medical and social sciences curricula. Local and national mobilization has taken place on every continent.

"Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns."

People's Charter for Health

The movement has joined alliances of groups concerned with global health — for example through participation in the World Social Forums. Lobbying actions on the Global Fund to Fight AIDS, Tuberculosis and Malaria, on essential drug policies, breastfeeding, poverty reduction strategies and health, and trade issues have targeted national governments and international actors such as the WHO.

In Latin America, environmental activists and health workers have successfully lobbied the members of the UN Conference of the Parties on the Convention on Biodiversity to maintain a moratorium on use of the terminator gene[3] as part of the struggle for a Latin America free of genetically modified organisms. Campaigns in such diverse places as Guatemala and Australia are educating people about the devastating effects that free trade agreements will have on the availability of essential drugs, while demanding that their governments pass legislation to protect citizens' access to medicines. And People's Health Movement activists in India have succeeded in preventing Novartis from exclusively marketing a cancer drug, and thus have made an important gain over the Indian Patent Amendment Act of 2005 that favours transnational pharmaceutical companies.

The acknowledgement of the movement extends to its recognition by the Global Forum for Health Research which has involved PHM members in its annual meetings since 2001. The former PHM global coordinator is presently a member of the Forum's Foundation Council.

The People's Health Movement and the World Health Organization

To understand the way in which the People's Health Movement is shaping current debates around health, we must look more closely at the relationship between the movement and the WHO.

> "The Charter calls on people of the world to demand a radical transformation of the World Health Organization, so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests."[4]

The engagement of the movement with the WHO has been particularly interesting. In spite of an invitation to attend the first People's Health Assembly in Bangladesh in 2000, the then Director-General of the WHO, Dr Gro Harlem Brundtland, was conspicuous by her absence. However, since 2001, a significant contingent of PHM representatives has participated in the annual World Health Assemblies.

Traditionally, these assemblies are held for WHO representatives worldwide and the national health ministers. There has been very limited participation of selected non-governmental organizations or other civil society organizations. However, since its inception, the PHM has held working sessions and workshops within the World Health Assembly and also at the NGO Forum for Health. Meetings have been held with the respective Directors-General to inform them of the movement's position on the role of the WHO and its relationship with civil society organiza-

tions. Movement representatives have been invited on several occasions to participate in formal dialogue with members of WHO units and teams — for example, with the team responsible for the HIV/AIDS strategies.

During 2003, many activities were held around the 25th anniversary of the Alma Ata Declaration and a large delegation of movement members participated at the World Health Assembly. They also participated at regional and national WHO anniversary events. Many carried out local activities to renew and revitalize concepts around primary health care strategies and their application today in the context of neo-liberal globalization.

At the 2004 World Health Assembly, the WHO's then Director-General, Dr Lee Jong-wook, called for the formation of the Commission on Social Determinants of Health. Launched in March 2005 for a three-year period, the commission is charged with recommending interventions and policies to improve health and narrow health inequities through action on social determinants.[5]

The social determinants of health are the social conditions in which people live and work, and action on these is the fairest and most effective way to improve health for all and reduce inequalities. Good medical care is vital, but unless the root social causes that undermine people's health are addressed, the opportunity for well-being will not be achieved.

The commission supports countries and global health partners that take action on the social factors leading to ill health and health inequalities. It brings together leading scientists and practitioners to provide evidence on policies that improve health by addressing the social conditions in which people live and work. It also collaborates with countries and civil society organizations to support policy change and monitor results.

Commissioners have been selected from the ranks of leading policy-makers, scientists, practitioners and civil society. The commission plans to hold three to four major meetings a year, mostly in low-to-middle income countries, and has convened processes that organize knowledge, strengthen country practice, and support leadership. These processes, called knowledge hubs, have been structured around specific themes such as early child development, urbanization and health systems; the health challenges faced by particular communities such as informal workers, indigenous peoples, and slum-dwellers; and opportunities for policy and action.

The commission is working closely with a group of countries where there is a commitment to rapid action among political leaders, health officials, civil society groups, and other stakeholders to overcome the social barriers to health.

In 2005, Dr Fran Baum, a member of the People's Health Movement, was appointed to represent the movement on the commission. She has been instrumental in the successful involvement of movement members as facilitators of the consultation processes being held in different regions of the world. PHM members are also active in the commission's knowledge hubs. Dr Monique Bégin, a former federal health minister in Canada and now with the University of Ottawa, is also a commissioner.

Global Health Watch

Another way that PHM is influencing the global debate on health is through its involvement in Global Health Watch, a broad collaboration of public health experts, non-governmental organizations, civil society activists, community groups, health workers and academics. Initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact, Global Health Watch publishes the Global Health Watch Report, a collection of critical essays about health and health care around the world. As the first issue, launched in July 2005, pointed out:

> "The Global Health Watch is a call to all health workers to broaden and strengthen the global community of health advocates who are taking action on global ill-health and inequalities, and their underlying political and economic determinants.
>
> The global community has failed to achieve 'Health for All by the Year 2000.' New targets such as the Millennium Development Goals look increasingly unachievable. Questions need to be asked about whether current policies in global health are working. The Global Health Watch for 2005-2006 looks at some of the most important problems, suggests solutions, and monitors the efforts of institutions and governments concerned with promoting health world-wide.
>
> This report arises out of many civil society and professional campaigns and struggles for better health, and was released to coincide with the Second People's Health Assembly, held in Cuenca, Ecuador." [6]

People's Health Movement Campaigns

In addition to the work related to multilateral health organizations, the movement has also been involved in direct grassroots campaigns.

PHM's initial campaign, *Health for All Now, A Million Signature Campaign*, led up to the celebration of the 25th anniversary of the Alma Ata Declaration. Its aim was educational, sharing the Alma Ata Declaration and the People's Charter for Health with people in communities all over the world and involving them in the movement in those communities.

Another global campaign, *Health Now, No War, No WTO. Fight for Peoples Health*, was launched on March 20, 2004. It calls for the removal of the occupying forces in Iraq, Palestine, and Afghanistan and for dismantling of the World Trade Organization (WTO). The campaign considers wars and the WTO to be the greatest threats to health and peace.

Two campaigns — *Free Trade or Fair Trade* and *Stop the Free Trade Agreements* — are more regionally based and respond to the growing number of bilateral free trade agreements that are being signed, particularly with the US. These campaigns allow for the building of the movement through coalitions with other organizations and social movements working on trade issues. Only through the development of alliances and coalitions that cut across sectors and issues can we hope to limit the effects of these agreements.

The Women's Access to Health Campaign (WAHC) was launched in 2003 by the Women's Global Network for Reproductive Rights (WGNRR) and PHM to raise awareness and strengthen efforts to promote women's health with a primary health care approach. This campaign functions, among other things, as a tool to promote collaboration, experience and information-sharing among WGNRR and PHM members. The campaign adds to the Alma Ata slogan *Health for All* by explicitly addressing the particular situation women face in accessing health: *Health for All — Health for Women.*

The *Watch UNICEF* campaign was launched because PHM members and constituent organizations were so alarmed by the appointment of Ms Ann Veneman as UNICEF's next executive director. They wrote and distributed a Letter of Concern, calling for a rethinking of both the appointment and the appointment process. Ms Veneman has had close relationships with industry and actively promoted the use of Genetically Modified Organisms (GMOs) during her period as the US Secretary of Agriculture.

Challenges for the People's Health Movement

As the People's Health Movement evolves, its members are increasingly aware of challenges that need to be overcome. A few of these include the uneven development of the movement in the various regions of the world, primarily due to differences in traditions and cultures of movement-building. Provision needs to be made so that processes can move forward and the more organized countries and regions can give support to the others.

In terms of language, the movement has been Anglocentric. Efforts need to be made toward a more pluralistic approach in communications and in the production of analytic documents.

The fact that the forces of global capitalism are evolving through such mechanisms as free trade agreements, means that the movement will require new structures and ways of organizing to defend against these renewed and invigorated incursions by market-oriented approaches to health.

Like any young movement, there are many questions related to leadership, governance, global versus regional representation, decentralization and regionalization, and gender sensitivity. Presently these are being dealt with through the work of PHM's newly established coordination commission.

The original eight organizations that were responsible for the first People's Health Assembly in Bangladesh and the subsequent promotion of the movement between 2000 and 2005 continue to play an important role. Most still participate at the national or regional level but have ceded their direct leadership to newer groups and younger persons. Their intention is to strengthen the movement by involving more groups and organizations and encouraging activism among younger people.

Second People's Health Assembly

The Second People's Health Assembly was held July 17-23, 2005, in Cuenca, Ecuador, with 1,492 participants from 82 countries. They gathered to discuss and debate strategies to overcome the political, economic, and social barriers to better and fairer health and to develop strategies for *Health for All*.

The objectives were to:

- promote and extend the People's Health Movement as a space that allows the revival of the spirit of "Health for All";
- strengthen global action on the right to health as a fundamental human right;
- enlarge the debate and resistance to all mechanisms that violate the right to health of the people, many represented as neo-liberal reforms, globalization or militarization;
- share knowledge and practices of alternative models for the promotion and provision of community health.

"We thus find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be considered both of these at the same time. This, I believe is the great drama of medicine at the start of the century. And this is the choice before all people of faith and good will in these dangerous times."

"Pathologies of Power: Health, Human Rights, and the New War on the Poor," by Paul Farmer

As an upcoming publication of the Europe-Third World Centre (CETIM) points out:

> "The Second People's Health Assembly was the result of intensive collective action, of planning and programming coordinated and facilitated by the Secretariat, that sought ways to overcome the existing limitations, accepted the challenge for new opportunities for discussion, dialogue, and construction of a movement based on the people, with the people, and for the people.
>
> The distinct thematic tracks — health as a fundamental human right; militarism and military occupation; environmental degradation; emerging and re-emerging pandemics; equity, poverty, and health; critical intercultural dialogue; Africa at the centre of the struggles for people's life and health; social and political violence; health in the hands of the people; health and work; natural, traditional, and bioenergetic practices; gender and health; health sector reform — were developed with a broad, integral, and global vision. This was accomplished through analysis and debate, histories, case studies, photographic exhibits, drawings, paintings, and folk art.
>
> In addition to the plenaries, workshops, forums, seminars, and exhibits, 'special events' were organized such as the Global Children's Forum; the Festival of Hope and Joy; the Ceremony and Declaration of the Native Peoples of the World, the Youth Forum; and the March for Peace, Health and the Dignity of all people. The objective of all these events was to hear the voices of the people and to provide encouragement to groups of marginalized and vulnerable persons to take a more leading role.
>
> The organizers included people who work side by side in the struggle for a healthy world, who have opposed war, militarism, the destruction of the environment, and who work for the life and health of the people. They called the people together and tried to include the voices of those who are not heard, as much as was humanly possible. Priority was given to representatives from popular organizations, given the character of the movement, without being compromised by the interests of international financial institutions or of those governments intent on the privatization of public services.
>
> Spaces were provided for international organizations and their representatives. Among the invited guests, there were

> representatives of the World Health Organization, including Dr Mirta Roses, Director of the Pan American Health Organization, Dr Michael Marmot, Head of the Commission on Social Determinants of Health, and also heads of humanist governments such as the Deputy Minister of Health of Uruguay, and the Secretary of Health of Rosario, Argentina. The intention was to convert the assembly into an expression of the diversity, energy and potential of the movement, and to a great extent we succeeded."[7]

The Cuenca Declaration reflects the results and conclusions of the debates in the plenary and workshops, and other parallel events at the Second People's Health Assembly. It calls on the PHM and other movements and organizations to demonstrate their solidarity with the struggles in Ecuador. There is an analysis of global health conditions and the need to establish the right to health in an era of hegemonic globalization. The movement also recognizes that interculturality is a fundamental element in the promotion of social equity and that health promotion must recognize the cultural context of the people. The PHM calls for: the advancement of the right to health for all in the context of gender and personal diversity; for protection of the right to health in the context of environmental degradation; for ensuring workers' health in a globalized world; for defence of the right to health in the face of war, militarization, and violence; and for comprehensive primary health care and sustainable, quality, local and national health systems.[8]

The Declaration also provides a summary of the PHM strategy for the coming years. The movement will be linking grassroots activists and national groups with global efforts by creating an awareness of burning health issues and working together to build alliances and support activists in their struggles. It will incorporate cultural and spiritual practices in all aspects of its work. It will share the results of research findings on key issues pertaining to the principles in its Charter, especially in relation to the efficacy and sustainability of initiatives in comprehensive primary health care. The movement is also adopting an approach of strengthening rights, and will support initiatives to achieve the "Right to Health and Health Care" at the local, national and international levels and will advocate with national governments, UN and other national and international agencies to influence their decision-making.[9]

The Declaration emphasizes the need to work tirelessly to build international solidarity with the oppressed and with those affected by natural disasters and civil strife, and to confront powerful forces of oppression in the struggle for economic justice, in particular through support for debt cancellation, the end of economic conditionalities, and the establishment of a fair international tax regime.[10]

A Global Right to Health Campaign

This section sets forth a clear statement of the ideas and practices of the People's Health Movement and calls for an active, progressive, global initiative to defend the right to health.

The PHM struggles for and demands the respect of *all* aspects of the right to health. This is defined as the *"right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health"* in General Comment No.14 (GC 14), of the International Covenant on Economic, Social and Cultural Rights of the United Nations.[11]

Nearly 150 countries around the world are parties to the Covenant. GC 14 of the Committee on Economic, Social and Cultural Rights (CESCR), adopted in the year 2000, elaborates on and clarifies the Right to Health by defining the content, the methods of operationalization, the violations, and the suggested means to monitor the implementation of this right. GC 14 is the most authoritative interpretation of international law relating to the right to health.

Now there is a need to launch a global process of mobilization to actually implement the provisions of GC 14 in all ratifying countries. This clearly calls for measures to review and recast all global and national health sector reform initiatives in the light of the framework of health as a right, such as the recasting of reforms that is now being pursued to achieve the Millennium Development Goals.

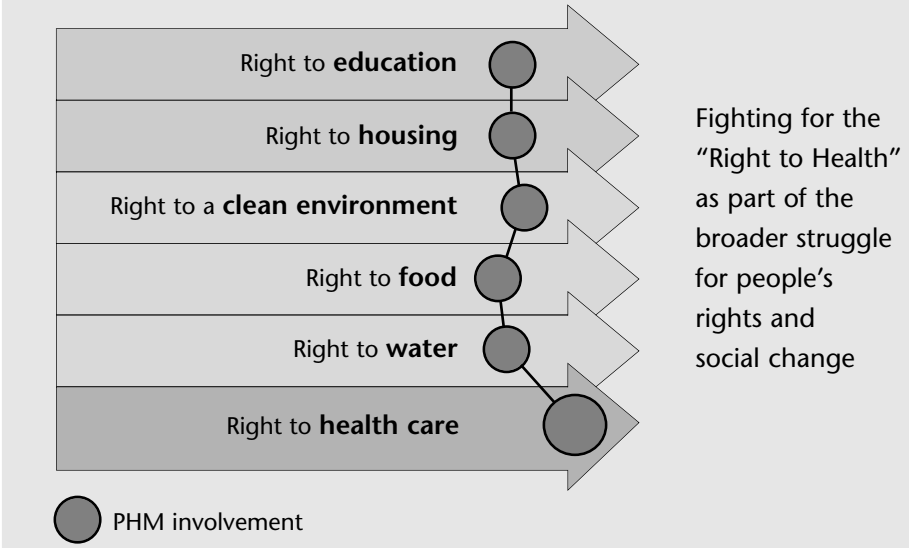
The PHM is launching a global initiative to strengthen the right to health with a focus on defending and operationalizing the Right to Health Care. Advocating for the fulfilment of children's and women's right to health is central to this endeavour. Therefore the campaign goes far beyond the Millennium Development Goals.

The movement sees the challenge primarily, but not entirely, as securing primary health care for the majority. To attain the health-related Millennium Development Goals what is actually needed is an acceleration of the shift towards community-based and community-centred paradigms in health.

The Global Right to Health and Health Care Campaign will concentrate on strengthening the Right to Health Care since we argue that the PHM has a primary responsibility regarding this issue. However, during this campaign, the documenting of violations will not be restricted to those in the sphere of health care, but will encompass denouncing violations of health rights related to the various determinants of health. The campaign will focus on tasks in which the PHM, along with partners in the global health movement, can take the lead and primary responsibility.

These two types of activities should be combined as part of a holistic and comprehensive approach to the right to health. This strategy does not reflect any judgment on the relative importance of health care versus the underlying and basic determinants of people's health; rather it is a question of a strategic choice. The overall perspective about how the global health movement should approach the right to health is depicted in the following diagram:

Figure 1



The campaign looks at what measures have to be taken now to tackle human rights violations as seen in the broader analysis of power and social inequalities. It seeks the social transformations that are necessary to resolve these inequities as they affect health. One campaign focus aims to change global and national health sector reform initiatives by putting in place mechanisms to redistribute resources through a globally coordinated effort. This should then affect the access to health care by the poor, the disadvantaged, and marginalized populations.

The PHM will build the capacity of its constituency and other civil society partners in order to document violations of the right to health and its underlying determinants. They will then plan joint actions with the people to place pressure on authorities to stop these violations.

With regard to strengthening the right to health, country-based PHM groups may also continue to expand their involvement in other initiatives to denounce violations of health rights related to the various determinants of health. The movement will also co-initiate and support specific international campaigns on particular health determinants other than

the right to health care proper — for instance, the campaign of Friends of the Right to Water, of which PHM is a member. It is not strategically possible for a global health movement such as PHM to launch a global campaign encompassing all health determinants.

The movement is convinced of the huge social mobilization potential of a *Right to Health and Health Care Campaign*. They will be demanding that decision-makers take responsibility for their actions or lack of response to the real needs of the population. There is also the potential that there will actually be favourable concrete outcomes for the benefit of the people that will lead to people's greater involvement in the struggle for the right to health.

In the campaign's first phase, PHM plans to carry out about 40 country assessments of the status of the right to health care. The countries will be determined with the different donor organizations that are being approached to co-finance this initiative. Later phases will include documentation and analysis, with preparation of country reports. This will be followed by regional assemblies, culminating in the preparation of a global action plan on the right to health care and, subsequently, a Declaration of the Right to Health for All to be submitted to the World Health Assembly.

PHM country circles — the local sectors of the movement that were formed during or after the first People's Health Assembly — will need to move beyond discussions to develop forceful, shared advocacy activities. This is crucial if they are to develop further and draw more groups into the movement. There is now a need to develop and carry out shared and more effective advocacy actions at the country level in an effort to bring about needed changes in the existing, and often deteriorating, situation.

A *Right to Health and Health Care Campaign* could prove a catalyst and unifying process, bringing together existing and new PHM circles as well as involving new partner groups and networks. The campaign has the potential to give space to new organizations and networks that have so far not been active in the movement. As a start to assessing the campaign's viability, the existence of a minimum critical mass of PHM-and-partners' strength and power in a substantial number of countries will be ascertained. The movement should make use of the momentum achieved at the Second People's Health Assembly to crystallize and plan future courses of action in the campaign, understanding that each country will move at its best (individual) pace.[12]

Toward mobilization and action: an El Salvador case study

The Alma Ata primary health care strategy did not appear out of nowhere. It was inspired by local initiatives, many of them in Latin America and other parts of the developing world. The Alma Ata conference represented a turning point, recognizing the value of these initiatives and developing them into a strategy for governments and health ministries. Primary health care, then, arose from experiences prior to Alma Ata; it was systematized and theorized there, but has continued to live on precisely among those who created it — the communities and those excluded from the global feast.

The Central American experiences of community-based health programs arose in a similar context. There was a bloody armed conflict against military dictatorships heavily backed by the US government. Alongside the war in Central America came the economic crisis of the 1980s, resulting from the huge foreign debt accrued from loans made by countries as a result of the oil boom. The costs of the crisis were transferred to the underdeveloped countries. Poverty and extreme poverty were the norm in Central America, with profound political, economic and social inequities locally, nationally, and internationally. In this context, stabilization and structural adjustment programs laying the groundwork for globalization were designed by international financial institutions and executed through programs to modernize and reform the state. To address health as part of "modernization," nations also implemented health sector reform processes headed by the World Bank, with the complicity and subjugation of many governments and institutions.

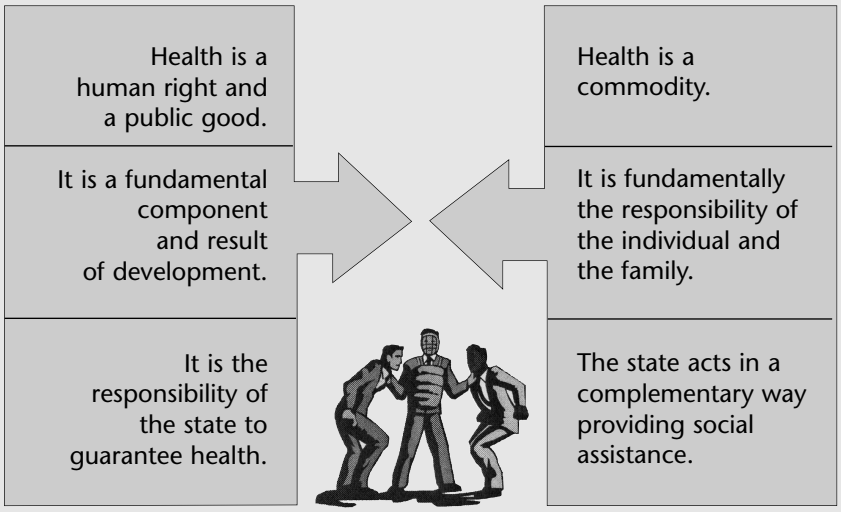
The 1993 World Bank report "Investing in Health"[13] advocates a threefold approach to health policy for governments in developing countries and in the former socialist countries. First, the fostering of an economic environment that will enable households to improve their own health; policies for economic growth that ensure income gains for the poor are essential and so, too, is expanded investment in schooling, particularly for girls. Second, the redirection of government spending away from specialized care and toward such low-cost and highly effective activities as immunization, programs to combat micronutrient deficiencies, and control and treatment of infectious diseases; by adopting the packages of public health measures and essential clinical care described in the report, developing countries could reduce their burden of disease by 25 per cent. Third, encouragement of a greater diversity and competition in the provision of health services by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by non-governmental and other private organizations, and regulating insurance markets; these reforms could translate into longer, healthier, and more productive lives for people around the world, and especially for the more than one billion poor.

Basically the report recommends the introduction of market forces into the health sector, and the "correct" assignment of public resources with efficient technical criteria through highly effective low-cost interventions. The neo-liberal logic is that the private sector is more efficient than the public sector, therefore the state must be downsized and serve as a regulator of the private sector, which will provide the services.

Reforms in the health sector have resulted in many negative outcomes. These include payment for health services and medicines, lack of medical personnel, increased unemployment and underemployment, privatization of education, increased cost of living, and privatization of basic services such as energy, water, and telecommunications, resulting in higher costs to the consumer.[14]

Figure 2

Central America: Confrontation of two distinct models of health



Health sector reform in El Salvador, Central America, has occurred in response to the directives of international institutions such as the World Bank, the International Monetary Fund, the Inter-American Development Bank, as well as the World Trade Organization, the Pan American Health Organization, and USAID. In 1994, these organizations carried out an analysis[15] and defined four components to be considered in health sector reform:

- Institutional reform of the health sector with a redefinition of the role of the state that would result in a reduction of the administration of services and their transfer to municipal governments and private institutions.

- Reform of primary health care, including the decentralization of services.
- Reform of the specialized hospital services and their transfer to private organizations.
- Strengthening of the actions related to the environment. Basically the proposal was to free the National Water and Sewage Administration from its function of providing services to the population — these would be privatized.

The Anàlisis del Sector Salud de El Salvador proposal was included in the national agenda in 1998 and generated the formation of 10 working groups. Only five groups presented concrete proposals: the National Development Commission, the Salvadoran Development Foundation, the National Health Commission, the Medical Society, and the Union of Social Security Workers.

During discussion of the proposals, the Social Security Institute began a process of "modernization," displacing administrative workers and opening the doors to private entities for services such as security guards, laboratories, and radiology, and even low-risk maternity care. This led to a labour conflict with the social security workers and resulted in a strike that lasted two months. As a result, the National Commission on Health Sector Reform was created by governmental decree in July 1999. This commission was to work toward harmonization of the proposals, but it was clearly made up of sectors favourable to privatization.

The Social Security Institute continued implementing measures for contracting out services such as food provision and housekeeping, as well as prostate surgery and ophthalmologic care. This resulted in more job losses and led to a second strike in late 1999 that lasted for four months.

In December 2000, the Reform Commission presented a controversial proposal. It contemplated the consolidation of a public/private mix for the provision of services. It did not resolve issues of the legal framework for the reform or financing, but it clearly recognized the need to establish the ability of the population to pay for services.

In January and February 2001, two earthquakes struck El Salvador and destroyed hospitals and health service infrastructure. This provided the government with the opportunity to justify further privatization of services.

When two Social Security hospitals were reopened, it was with new labour models that included individual contracts that were not bound by the laws governing wages in the sector. This generated a new conflict in September 2003 that lasted for nine months. The strike, in contrast to the earlier two conflicts, was led by the Physicians Union of the Social Security Institute; the physicians were highly affected by the new labour conditions, even though they were specialists.

The strike was built upon a strategic alliance among the health unions, the health movement, and many other sectors affected by the series of neoliberal measures. These included coffee producers, the transport sector, merchants in the markets and ambulatory vendors, churches, trade unions of privatized enterprises, and public employees at the national and municipal levels. A minimum agenda was established that included forms of struggle, a minimum platform of demands, mechanisms for direction of the struggle, spokespersons, and an inventory of resources.[16]

The resistance during the nine-month strike included legislative action, street action, denunciations, and medical brigades for raising awareness among the population.

The legislature passed a decree to guarantee public health in El Salvador and another to return labour guarantees to all the workers of the Social Security Institute. They also passed a legislative request that none of the President's privatization proposals be approved.

Street action included the blocking of key points on major highways at the national level. Transnational companies such as Coca Cola and gasoline service stations were shut down. There were seven massive "white marches" involving health workers and populist support groups. Hospitals and the Cathedral were taken over by the strikers.

Cases of corruption in the procurement of services in the Social Security Institute were reported to the Attorney General's Office. Corrupt functionaries were denounced and their removal demanded. Cases of medical malpractice because of the strike were also reported.

Medical brigades were organized to provide specialized consultations for the population, with medicines donated by local laboratories. These brigades also carried out programs to raise public awareness about their demands through distribution of educational materials and through events.

The achievements were considerable. This was the largest social mobilization since the signing of the Peace Accords in 1992. The population became aware of the impact of health care privatization, and there was a political cost to the government party in the elections of March 2003. Most important, a Citizen's Alliance against Privatization was organized at the national level to coordinate with other social sectors.

There were, however, certain repercussions. Many activists were arrested by the National Civilian Police, and police repression and surveillance continues today. Thirty activists are facing multiple criminal charges laid by the Attorney General's Office. NGOs were threatened with seizure and closure, one nurse committed suicide, and dozens of people died of malpractice. Thirty administrative workers have been fired, and a new right-wing medical society has been established.

The challenges for the future are considerable. The social organizations that formed in resistance to health care privatization still need to be consolidated, and they have to become more articulate in order to prevent further privatization. Government activity around privatization needs to be monitored constantly and protest actions should be strengthened, with development of a greater capacity for making proposals.

In conclusion, the experience of resistance in El Salvador demonstrates that neo-liberal globalization places market interests before human rights and results in divisions in society between those that defend the market and those that defend life. This is true in all countries, rich and poor. The only way to insure the right to health is to globalize the struggle of organized peoples everywhere.[17]

Conclusions

Together let us challenge the unhealthy global model of development.

As the worldwide crisis deepens and more people become aware that the current global economic system has fatal flaws, there is a need for an alternative vision of development that promotes human and environmental well-being.

Such a vision has been taking shape among many people's organizations around the world. Despite their diversity, there are common threads. These include an attempt to increase public participation to counter the concentration of economic, political and corporate power; an effort to establish healthy communities; reshaping of the global economic order to ensure environmental sustainability, equity and social justice; a call for a closer and more spiritual relationship with nature and communities; and a commitment to collective solutions that maintain considerable individual freedom.[18]

Through emphasis on the right to health and health care, the People's Health Movement hopes to use different types of action to raise awareness and empower people towards change, as well as to promote better coping strategies and to develop alternative solutions. Solidarity between and among people's organizations will be required to exert political pressure to counter policies and decision-making that benefits the few. Action should be taken in the villages, regions, nations and internationally to claim rights and to force those in power to listen. Development depends on rallying behind the call of "Health for all now!"

MARíA HAMLíN ZÚÑIGA is Global Coordinator of the International People's Health Council (IPHC). She was a founder of IPHC, as well as other national and regional organizations in Central America, including the Regional Committee for the Promotion of Community Health in Mesoamerica (1975), the Association of Community Health Services (ASECSA) in Guatemala (1978), and the Centre for Information and Advisory Service in Health (CISAS) in Nicaragua (1983). She is also a founding member of the People's Health Movement and was the international convener of the Second People's Health Assembly in Cuenca, Ecuador, in July 2005. Born in Minneapolis, Minnesota, she studied at the University of Minnesota where she received a Master's degree in Public Health. She has worked as a public health educator in the US with Indigenous Peoples and Latinos. Since 1968, she has lived in Central America and has been involved in community organization and liberating education among Indigenous and peasant communities, in particular in Guatemala and Nicaragua.

References

AGEPYM (Asociación General de Empleados Públicos y Municipales de El Salvador). Boletín Informativo, Edición No. 1, Agosto, 2003.

CETIM – Centre Europe-Tiers Monde : *La Santé pour tous! Se réapproprier Alma Ata*, éditions CETIM, novembre 2006, Geneva, Switzerland – www.cetim.ch

Espinosa, Eduardo. "Las Reformas de Salud. Contextos y Tendencias," Presentation, International People's Health University, Cuenca, Ecuador, July, 2005.

Espinosa, Eduardo. "Primary Health Care as an Instrument for Mobilization and Development: Lessons from the Communities," Second People's Health Assembly, Cuenca, Ecuador, July 2005.

Espinosa, Eduardo and Vargas Felipe. "On the Right to Health in El Salvador," Journal of Epidemiology and Community Health, 2003.

httm/EDUARDO\JECH\El Salvador social cost of neo-liberal health reform, Espinoza 57 (8) 552 — Journal of Epidemiology and Community Health.htm http://jech.bmjjournals.com/cgi/content/full/57/8/552

Farmer, Paul. With foreword by Amartya Sen. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Los Angeles: University of California Press, 2003.

People's Health Movement, GEGA, Medact. *Global Health Watch.* London, UK: Zed Books, 2005. http://www.ghwatch.org/

People's Health Movement. *Health in the Era of Globalization: From victims to protagonists.* Collection of background papers for PHA, Savar, Bangladesh, 2000. http://www.phmovement.org/pha2000/publications.html#Background%20Papers

People's Health Movement. *People's Charter for Health*, Savar, Bangladesh, 2000. http://www.phmovement.org/resources/phcharter

People's Health Movement. *Cuenca Declaration*, Cuenca, Ecuador, July 2005. http://phmovement.org/pha2/papers/cuenca_dec.php

Posada, Margarita. "Proceso de la Reforma de Salud en El Salvador: Un camino hacia la Privatización." Paper prepared for the INTERSOL Bulletin, Austria, October, 2005.

Sanders, David and David Werner. *Alma Ata and the Institutionalization of Primary Health Care*, Chapter III, "Questioning the Solution, The politics of Primary Health Care and Child Survival." Palo Alto, CA: Healthwrights, 1997. http://healthwrights.org/books/qts/qts_ch03.pdf

Shukla, Abhay and Claudio Schuftan. Proposal for a global "Right to Health and Health Care Campaign" to be launched by the People's Health Movement. Mumbai and Vietnam, December 2005. abhayseema@vsnl.com; claudio@hcmc.netnam.vn

USAID, Organización Panamericana de Salud, Organización Mundial de Salud, World Bank, and Inter-American Development Bank. *Analisis del Sector Salud de El Salvador, "La Reforma de Salud: Hacia su Equidad y Eficiencia."* May, 1994.

World Bank, *World Development Report 1993: Investing in Health, Volume 1*. Oxford University Press, 1993.

World Health Organization, *Alma Alta Declaration*, Alma Ata, USSR, 1978. http://www.who.dk/AboutWHO/Policy/20010827_1

World Health Organization, Commission on Social Determinants of Health http://www.who.int/social_determinants/en

Endnotes

1 The Alma Ata Declaration is available for review at http://www.who.dk/AboutWHO/Policy/20010827_1

2 People's Charter for Health, Savar, Bangladesh, 2000. http://www.phmovement.org/resources/phcharter

3 For more information on campaigns to halt this technology see http://www.banterminator.org/

4 People's Charter for Health.

5 http://www.who.int/social_determinants/en

6 Global Health Watch. People's Health Movement, GEGA, Medact. London, UK: Zed Books, 2005. http://www.ghwatch.org/

7 *Health By and For the People: Reappropriating Health for All after 25 Years of Neo-liberal Obstruction*; Nov. 2006.

8 Cuenca Declaration, Cuenca, Ecuador, July 2005. http://phmovement.org/pha2/papers/cuenca_dec.php

9 Ibid.

10 Ibid.

11 http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument

12 Proposal for a global "Right to Health and Health Care Campaign," Abhay Shukla and Claudio Schuftan, People's Health Movement, India and Vietnam.

13 World Development Report 1993: Investing in Health, Volume 1, World Bank, June 30, 1993, accessed at: http://wwwwds.worldbank.org/external/default/main?pagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187511&theSitePK=523679&entityID=000009265_3970716142319&searchMenuPK=64187511&theSitePK=523679

14 Sanders, David and David Werner, idem, and Espinosa, Eduardo, "Las Reformas de Salud. Contextos y Tendencias."

15 Análisis del Sector Salud de El Salvador – ANSAL.

16 The documentation for this section includes Proceedings of Meetings of the Citizens' Alliance against Privatization (Alianza Ciudadana contra las Privatizaciones), media releases, newspaper clippings, and letters to the Legislative Assembly.

17 Margarita Posada, APSAL (Acción para la Salud en El Salvador) and Dr Eduardo Espinoza, University of El Salvador, People's Health Movement members. Personal interviews. Interviewed by María Hamlín Zúñiga, March and April, 2006.

18 Health in the Era of Globalization, 2000.

Financing Health Care: for All, for Some, for Patients or for Profits?

David McCoy

CHAPTER
THREE

Financing Health Care: for All, for Some, for Patients or for Profits?

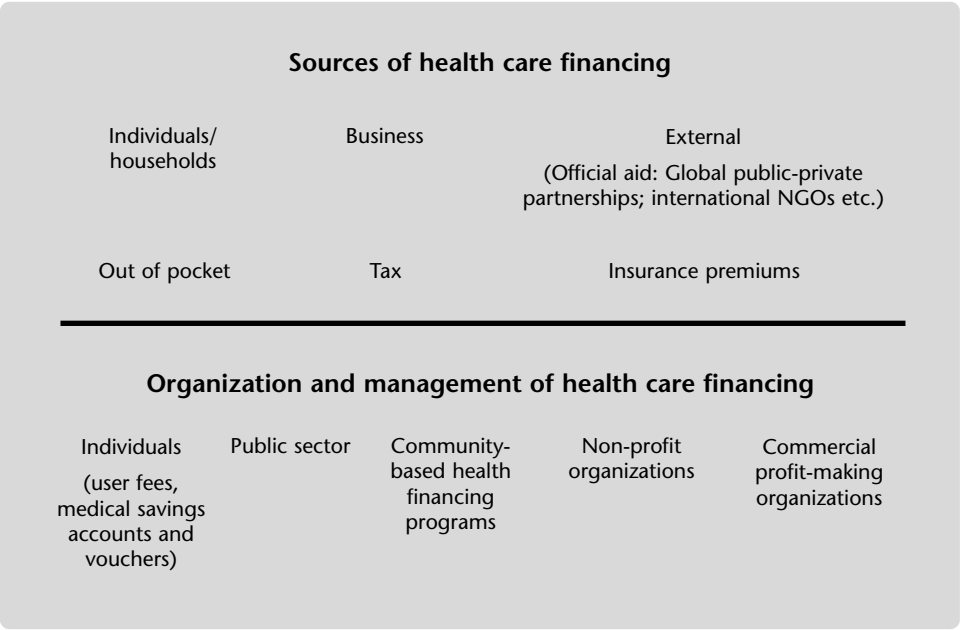
David McCoy

So what is "public health"? This is a frequently asked question, and my usual answer is: "It is everything to do with medicine and health that does not involve direct contact with patients."

But exactly what do you do? My answer: "Well, I have an interest in how health care systems are organized and financed…" At this, eyes start to glaze over. I should have said that I work on AIDS and avian flu. That sounds more exciting. The problem is that health care financing is both interesting *and* important. The challenge of this article is to demonstrate that.

There are a number of dimensions to health care financing. The most obvious is the question of how money is raised, organized, and managed to pay for health care. Figure 1 illustrates three primary sources of finance in any given country: individuals/households, businesses, and various external sources of finance.

Figure 1: Representation of the different sources, channels and actors involved in the health care financing landscape



Funds can be raised from these sources through tax; insurance premiums, which may be mandatory or voluntary; or as out-of-pocket payments. And they can be organized and managed by different actors (shown in Figure 1). Individuals manage their own "out-of-pocket payments"; government departments manage tax revenue and some external sources of funding; communities manage community-based health financing programs; and private actors manage private medical insurance schemes.

A variety of permutations are possible in arranging the source of financing with its management. For example, public financing of health can be managed by a statutory, non-profit organization that is given the mandate to run a national social health insurance scheme; and tax subsidies for private insurance can be viewed as a form of public financing managed by private companies. Furthermore, all health care systems exhibit mixed systems of health financing, which makes health care financing a complicated subject matter. A full discussion of health care financing requires a detailed understanding of the specific characteristics and structure of the health system in each country, as well as its social, economic, and political context.

This article will be able to draw out only very broad themes and principles about health care financing across the spectrum of high-, middle- and low-income countries. It begins by discussing tax-based financing and social health insurance, and the concepts of pooling and cross-subsidization. This is followed by a discussion of private forms of health insurance in which the concept of "segmented" systems of health care and the issue of commercialization is introduced. The third section discusses out-of-pocket finance and external sources of financing — key issues in developing countries. The article ends with some conclusions and recommendations about the world's challenge to finance, repair, and develop health care systems in the poorest countries of the world.

Tax-based systems of health care financing and social health insurance

Tax is a mandatory form of raising funds, from individuals or businesses, for health care. There are various ways of raising tax, which determine the extent to which public revenue is raised regressively or progressively. Progressive taxation means that richer, higher-income groups contribute proportionally more of their income to public budgets.

Tax is also a key instrument of social policy. It allows public spending on public goods and enables wealth redistribution and the cross-subsidization of services from the rich to the poor. It forms the basis of and finances the "social contract" between the state and its citizens. It is also an important instrument of economic and development policy — public investments in schools, universities, roads, effective policing, a legal and judicial system, research and science, and health care help form the foundations for socio-economic development. These investments also help

support the institutions and practices required to prevent corruption, financial mismanagement, and the inappropriate use of public revenue by the state.

Tax-based finance requires good tax-collecting infrastructure. In poor countries, inadequate tax-collecting infrastructure and the informal nature of much of the economy mean that a small proportion of a country's Gross Domestic Product (GDP) is "captured" as public revenue. Total tax revenue as a percentage of GDP in the high-income countries of the Organisation for Economic Co-operation and Development (OECD) is about 35 per cent on average, and can be as high as 44 per cent.[1] In low-income countries, tax revenue as a percentage of GDP is usually less than 20 per cent, and may be as low as 10 per cent. Poor countries therefore tend to have *a low percentage of a low GDP* available for public budgets. Table 1 illustrates this, comparing a "typical" high-income country with a typical low-income Sub-Saharan African country.

Table 1: Comparing macroeconomic and tax indicators in the United Kingdom and Malawi

	Per capita GDP 2003 (PPP $US)	% of GDP captured as public revenue	Per capita public revenue	% of government revenue allocated to health	Per capita government expenditure on health
High-income country	30,000	30%	9,000	12%	1,080
Low-income country	600	15%	90	9%	8.1

(Figures based on data obtained from UNDP Human Development Report 2005; Global Development Finance 1999, IMF Country Reports; and World Health Statistics, WHO 2005)

A rough estimate of public revenue per capita (Column 3) is obtained by multiplying per capita GDP with the percentage of GDP captured as public revenue (Columns 1 and 2). In this example, per capita public revenue is $9,000 in a high-income country and $90 in a low-income country. When this is multiplied with the proportion of government revenue allocated to the health sector, typically 12 per cent in a European country and 9 per cent in Africa, one derives an estimation of the level of government expenditure on health: $1,080 in a high-income country and $8.1 in a low-income country.

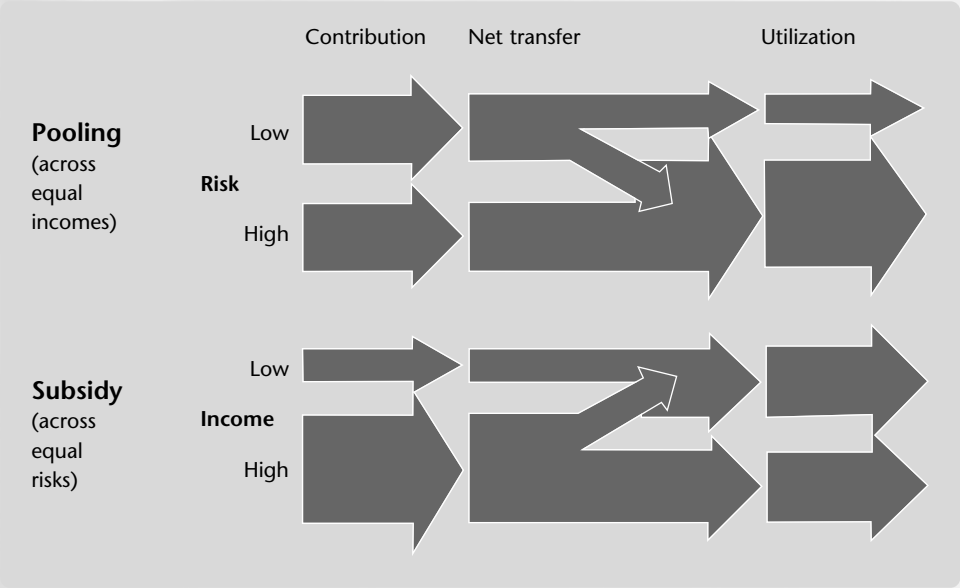
If this hypothetical low-income country increases total government revenue to 20 per cent of GDP and then increases the allocation of government revenue to health to 12 per cent, government expenditure on health would increase by 78 per cent from $8.1 to $14.4 per capita. This suggests that in poor countries, there is a potential for increasing the amount of government revenue allocated to health although, in this hypothetical case, the amount available would still remain insufficient to meet the core health challenges of most poor countries.

Social health insurance (SHI) is another form of financing that raises public funding for health care. Typically, employees and employers within the formal economy are obliged to make mandatory contributions to an SHI scheme that is usually managed by a parastatal agency or statutory non-profit public organization. The number of schemes in a country can vary. Where there are multiple schemes, mechanisms are often used to compensate for different risk profiles across the spectrum. In some countries, SHI is universal. In these instances, governments add to the SHI scheme to cover those who are unemployed or unable to make contributions.

SHI is a limited form of health care financing in low-income countries, accounting for only 2 per cent of total health expenditure. However, in low and high middle-income countries, it accounts for 15 per cent and 30 per cent of health expenditure respectively, reflecting the fact that larger shares of the total population work in the formal economy which allows financing to be deducted directly from the payroll.[2]

Health care systems predominantly based on tax or SHI are often grouped together as national or socialized systems of health care financing. The pooling of health finance at the national level allows for the risk of paying for health care (when one is ill or injured) to be borne collectively by all in society. It enables cross-subsidization and risk sharing between rich and poor, young and old, and sick and healthy (see Figure 2), particularly if tax or SHI contributions are progressive.

Figure 2: Pooling to redistribute risk, and cross-subsidy for greater equity (arrows indicate flow of funds)



Source: World Health Organization, World Health Report 2000 (Geneva: World Health Organization), p. 100.

Size and number are important — the bigger the pool, the more it can spread the financial risk of illness and injury, enable effective cross-subsidization and equitable access to health care, and take advantage of economies of scale and strong market power when negotiating with health care providers about service quality, prices, and costs. The ultimate pool is a single nation-wide pool, such as the one that exists in the United Kingdom's National Health Service and the Costa Rican social security organization.

The higher the number of schemes, the higher the administrative costs. In Argentina prior to 1996, there were more than 300 pooling organizations for formal sector workers and their families, some with no more than 50,000 members. The administrative costs and financial reserves required to ensure financial viability for the small ones, together with the low wages of their beneficiaries, meant that benefit packages were very limited.[3] This changed when smaller pools were amalgamated into fewer but larger pools.

Socialized systems of health care financing are dominant in most developed countries where they constitute between 60 per cent and 90 per cent of total health expenditure. Among rich countries, only the United States and Singapore have private expenditure shares over 50 per cent.[4] On the other hand, higher shares of private financing are associated with lower-income countries. Countries with private health expenditure shares over 70 per cent are virtually all low-income countries. And yet these are the countries most in need of functioning public institutions.

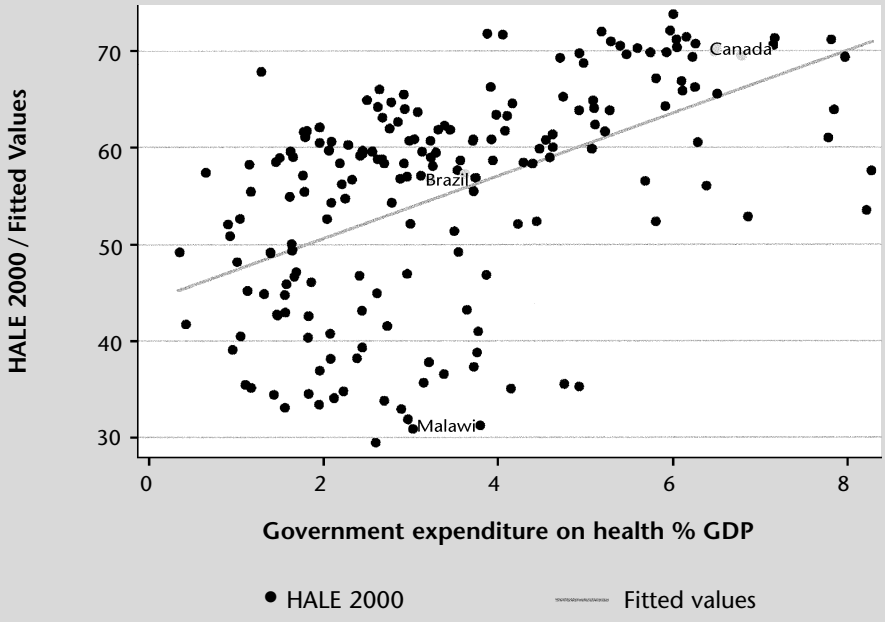
Socialized systems of health care financing are distinct in that health care finances fall under the stewardship of the government or state. They are *public* systems of financing and managing health care resources. Most importantly, they allow for the public allocation of health care resources to shape the configuration of the health care system — for example, by directing health care resources to ensure an equitable distribution of doctors, nurses, and clinics across the country, or increasing primary care expenditure relative to hospital expenditure. These objectives are more difficult and costly to achieve through multiple and fragmented pools of financing, and when finances are not linked to a coherent and integrated system of health planning.[5]

The importance of "the public" within health care systems is also understood when these systems are seen not only as a method of delivering health services, but also as a means of performing broader social functions. These include acting as an instrument for mitigating socio-economic and political disparities, promoting social solidarity, reflecting and shaping relationships between individuals within society, enabling citizens to make claims on their entitlements to health care, and manifesting the social contract between state and citizen.

However, there is no consensus about the role, responsibility, or authority of the state in providing health care. There is no agreement on what rights people have to health care, and what the obligations of the state and other actors are in fulfilling these rights. Nor is there consensus on the "acceptable" level of disparities in access to health care and the role of government in ensuring equitable access to and consumption of health care. These issues are central to the subject of health care financing and highlight the centrality of normative positions on the role of government and the nature of society.

But there may be more to the issue. How do socialized systems of health care financing compare with systems that are more reliant on private health care financing? According to Mackintosh and Koivusalo, countries that spend more of their GDP on health through public expenditure or social insurance have better health outcomes as measured by healthy life expectancy and child mortality indicators.[6] Figure 3 compares the proportion of GDP spent on health care through government and social insurance funding against healthy life expectancy. Health outcomes in richer countries are positively associated with higher incomes *but also with* more public and social health expenditure relative to GDP. Other data from low- and middle-income countries find that "better care at birth is associated with more of GDP spent by government or social insurance funds on health care, but not with more private health spending/GDP."

Figure 3: Healthy life expectancy (HALE) and government expenditure on health as per cent of GDP 2000



Organized private financing

Private health insurance is a form of pooling for individuals who contribute regular premiums, often for a specified amount of health care coverage. It may also be financed or co-financed by employers, and/or through a public subsidy in the form of tax exemptions. In some countries, government employees (including doctors and nurses) are provided with state-subsidized private medical insurance. And in a few countries, the purchase of private coverage is mandatory for parts of the population.

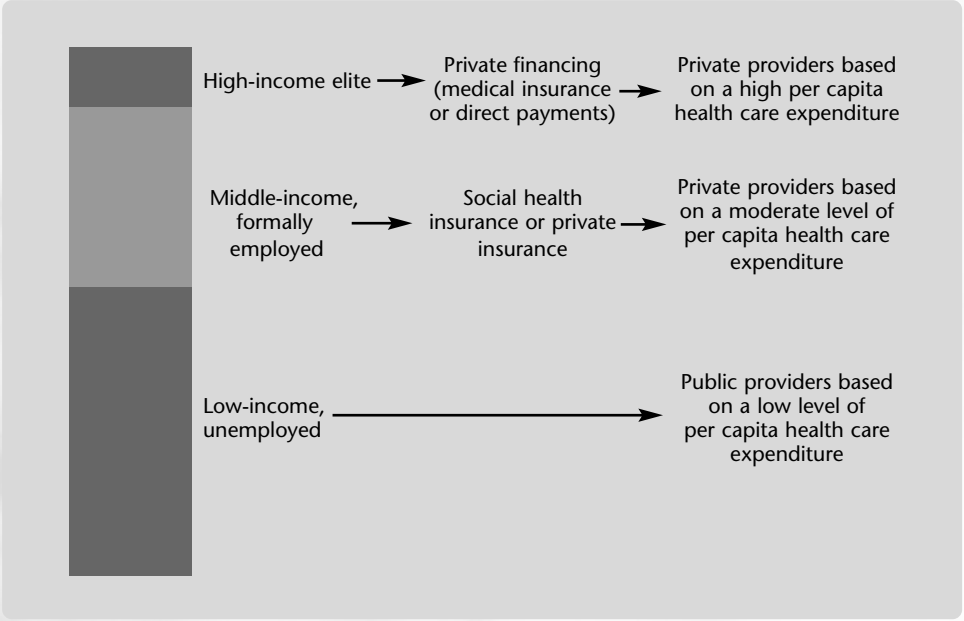
These pools of health care finance are managed privately, in parallel to the *public* management of *public* finances. However, private insurance exists in different guises and forms. Insurance provided by mutual aid organizations or non-profit organizations with a public ethos may be established to provide health care and financial protection for the poor, elderly, and chronically unwell. These forms of insurance often arise as a consequence of the failure of the state to provide basic health care. In some instances, such as with community-based health financing (CBHF) schemes that have been promoted as a strategy to improve access to health care for poor communities in developing countries, the contributions made to the scheme may be used explicitly to augment and support struggling public sector services.[7]

Many other private insurance schemes, however, are run as businesses that seek to maximize income and minimize expenditure. In order to achieve these commercial objectives,[8] they may exclude high-risk clients and "cherry pick" or "cream skim" younger or healthier low-risk clients, and place caps on spending. Instead of augmenting public services, they often encourage the growth of private provision whilst increasing the burden upon the public sector — by leaving it to finance and provide care for segments of the population with the greatest health care needs and the least income.

Private medical insurance, which is often only affordable to higher-income groups, opens the door for the exit of the voice, commitment, and financial contributions of higher-income, younger or low-risk individuals from a socialized system of public health care financing and provision, effectively "segmenting" the health care system into different age, socio-economic and health risk groups. There is a great irony therefore in civil servants working in the Ministry of Health being provided state-subsidized private medical insurance that allows them to seek health care in the private sector.

An exaggerated and simplistic illustration of "segmentation" is shown in Figure 4. It illustrates different financing and provision arrangements for different socio-economic groups, the outcome of which is to structurally differentiate the quantity and quality of health care provided to different income groups.

Figure 4: A diagrammatic representation of health care systems "segmentation"



Health care systems are obviously more complex than portrayed in Figure 4, but the purpose of the diagram is to illustrate the way in which socio-economic disparities create demands on the health care system to mirror those disparities rather than to mitigate them. Higher-income groups typically want more than what can be provided universally through a publicly financed system. They may expect better "hotel" facilities in hospital; faster and more convenient access to care and treatment; or access to treatment which is not affordable universally. And the young and healthy may be tempted to exit a health care system in which they are subsidizing the elderly.

In apartheid South Africa, private medical insurance helped to place the rich, white population in a privately-financed health care system, effectively leaving the rest of the population with a comparatively under-resourced publicly-financed system.[9] The white population also benefited from considerable public financing in the form of tax subsidies and preferential access to publicly-financed secondary and tertiary hospitals. Public and private health care financing as well as public and private provision were thereby shaped to benefit the ruling white population of apartheid South Africa, aggravating existing socio-economic inequalities (Table 2). This is an extreme version of a segmented health care system but illustrates the point about private financing potentially undermining equity and social solidarity, particularly when associated with commercial actors.

Table 2: Health care indicators in South Africa, 1992

	White population group	Black population group
Per capita health care expenditue (Rand)	591	55
Doctor: population ratio	1 : 282	1 : 53,000
Infant mortality rate per 1000 live births	7	55

Source: Health Systems Trust, South African Health Review 1995. (Durban: Health Systems Trust)

Private insurance schemes can be shaped by legal and regulatory frameworks to maximize risk-sharing and cross-subsidization across society and to minimize any harm to the public system of health care financing. For example, in post-apartheid South Africa, legislation was passed to prohibit medical insurance schemes from providing health coverage on the basis of individual risk. Laws were also passed to enforce "prescribed minimum benefits" to stop insurance companies from "dumping" patients on to the public sector once health care costs began to threaten their balance sheets.[10]

However, laws to regulate the private insurance market are often met with opposition. In addition to high-income groups wanting more than is universally available, other actors have a stake in promoting private financing and segmentation. The pharma-biomedical industrial complex, bolstered by a monopoly-friendly patent regime, wishes to expand demand for and consumption of its products and does not want to be limited to a publicly financed market, particularly if this is accompanied by regulation and guidelines to rationalize the consumption of medicines and new technologies, whether for safety, equity, or efficiency reasons. Private insurance companies and health care providers want to see more private financing because it opens up commercial opportunities. And for some health care providers, the creation of a privileged and better-resourced market, with higher than average levels of health care expenditure, offers opportunities for either profits or higher levels of income.

The way in which health care financing is organized and managed doesn't just influence patterns of expenditure and health care consumption, but can also influence the pattern and size of the income of providers within the system — a point that is far too often overlooked in public debates about health financing.

Segmentation has also been accompanied by the argument that organized and managed systems of public or non-commercial provision lack the market competition and financial incentives to motivate providers to act efficiently and responsively to "consumers". It is also claimed that unless public sector providers are forced to compete with private providers, the system is monopolistic and "unfair", resonating with the neo-liberal view that health care is a commodity that falls best under

the jurisdiction of trade rules. As a result, there has been a trend toward creating a market of public and private providers who must compete for public finance. In some countries, legislative changes have been made to remove public health facilities from civil service rules so that they can take on the characteristics of independent providers and compete for public financing.

Large health care corporations that view health care and medicine as business are now aggressively seeking entry into the largely publicly financed multi-billion-dollar-a-year European health care system. Thus far, the system has mainly been seen as a social not-for-profit enterprise that belongs under public control rather than as a market-driven institution that encourages the entry of commercial actors.

However, the arguments in favour of liberalizing the provider market to encourage competition and greater patient choice do not always hold up in practice, particularly in low- and middle-income countries where there is simply not the multiplicity of services and facilities required for competition and choice. Health care is also a service that most people do not want to choose or "shop around" for. What most people want is a locally available health service that they can trust. In contrast to other services or commodities, information asymmetry between provider and patient and the vulnerability that accompanies illness or injury require a trust-based relationship between "consumer" and provider. Trust, sympathy, and care are also therapeutic elements of health care which can be harmed by policies that shape the relationship between provider and patient as a commercial one.

There is also little evidence that such a system creates efficiency. The process of contracting out services to the private sector, managing a competitive provider market, and monitoring private sector providers is costly, and also administratively and technically complex.[11] A fragmented and competitive provider system also undermines systems-wide planning. Instead of an integrated system able to respond to changes in policy and circumstances, there is an unwieldy system of multiple organizations with large costs involved in ensuring coordination. For example, reforms that resulted in competition *within* the public sector harmed the cooperation that was necessary for effective disease surveillance in China.[12]

The problems associated with competition and markets are compounded by the presence of income-maximizing and shareholder companies within the system that will look to maximize income and profits by over-charging, over-servicing, or under-providing at the expense of patients and the public good. To counteract this, purchasers have to spend larger amounts of money on monitoring and regulation.[13] Government capacity to control overall health care costs also becomes weakened.

The business-oriented health care system of the United States, characterized by a complicated and fragmented mix of private insurers (with literally thousands of different individual health insurance plans), private providers and health maintenance organizations, has resulted in a huge administrative bureaucracy which cost US residents $294.3 billion in 1999.[14] The $1,059 per capita spent on health care administration was more than three times the per capita administrative costs of Canada's single-payer national health insurance system, highlighting the point about large pools of health care financing being more efficient than multiple, fragmented pools.

In high-income countries, one argument for the expansion of private health care financing is that tax-based revenue is unable to meet the growing demand for and cost of health care. Private financing will allow more to be raised for health care spending in total. This may be true — the US spends a very high proportion of its GDP on health care. However, in doing so, it has not created just an inefficient system, but one that is also ravaged by huge inequalities in health care consumption (with millions of families uninsured) and in the income of health care providers; and there is also the loss of resources from the health care system into shareholder profits. The size of the cake is only a part of the equation — how the cake is managed, apportioned amongst citizens, *and* used to remunerate and reward providers is equally important.

While it may be possible to increase private financing (for example, in the form of co-payments) in a way that would be equitable and augment a public or universal system of health care, this is different from private financing that segments the health care system and opens the door to commercialization, differential levels of health care consumption, and higher transaction costs. Ultimately, the view that increases in private financing are required to increase overall levels of funding portrays a political choice about "who pays and who benefits" as an economic necessity.[15]

The issue of increasing overall levels of health care spending in high-income countries also raises other controversial and morally complex issues. One is the issue of raising levels of expenditure to respond to the needs created by earlier health gains and advances in medical technology. Improved nutrition, safer environments, and better health care have resulted in longer and longer life-spans and an increasing number of elderly people. While many individuals in their 70s, 80s, and 90s lead independent and productive lives, these demographic changes are ultimately accompanied by a growing need and demand for complex and costly medical interventions as well as more nursing care to respond to the frailty and loss of function that accompanies the process of aging.

The difficult question that often doesn't get asked is whether we need to contain these escalating cost pressures, and if so, how? How much health care is enough? How far do we allow science and technology to lengthen lifespans? Developments in the fields of nanotechnology, genetic engineering, and robotics have now brought "normal" lifespans of 100-120 years well into the realms of possibility. Are the pressures in high-income countries to increase even further already high levels of health care expenditure accompanied by an unhealthy over-medicalization of life and mortality?

These are not just abstract, philosophical questions. Neither is it just a question of managing the pressure on health budgets within high-income countries. They also carry implications for the health of people in low-income countries. The longer lifespans of people who consume a disproportionate amount of the world's natural resources, along with the planet's finite capacity to absorb carbon emissions, results in profound ecological threats to health that fall disproportionately upon the world's poor. Secondly, the need to expand the health workforce in high-income countries to cope with the growing need for health care is a potent driver for the continuation of the out-migration of health workers from poor to rich countries, to the detriment of local health care systems. It has been estimated that Ghana has foregone around £35 million of its training investment in health professionals as a result of the brain drain to the UK, while the UK has saved £65 million in training costs by recruiting Ghanaian doctors since 1998.[16] By one calculation, Ghanaian-trained doctors and nurses deliver services that the UK National Health Service (NHS) values at around £39 million a year.[17]

In a way, what we now face is an increasingly globalized and segmented health care system that transcends national boundaries, particularly when one considers the additional impact of "health tourism", with high-income consumers traveling to middle-income countries to receive cheaper health care. In India, Mexico, and South Africa, private providers now cater to foreign "medical tourists" from high-income countries. At the same time, the wealthy elite in low-income countries seek health care in high- and middle-income countries.

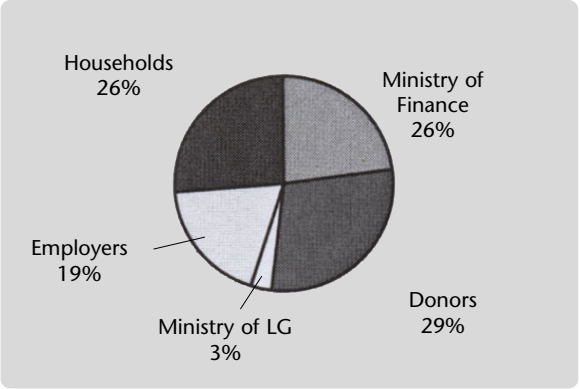
The situation in most low-income countries is different. Public financing makes up a low proportion of total health care expenditure. Much health care provision is already commercialized and privatized, often a consequence of the collapse of public services. Here, the World Bank and others have encouraged private health care financing as a way of allowing the diminished public sector to concentrate on providing comprehensive coverage for a "basic" or "minimum" package of services. By segmenting out middle- and high-income groups, it is argued that public sector health services can focus on the poorest in society.[18]

While this sounds fine in theory, the greater likelihood is increased inequality as higher-income groups take their financial resources and stronger political voice with them, and leave the public service as a "poor service for poor people". Even if private medical services are entirely privately financed, they draw on a limited pool of health professionals and, in developing countries, on limited foreign exchange for the import of drugs and equipment. A significant private medical sector weakens the public provision of health care, especially as the ratio of resources to patient load is more favourable in the private sector — it sucks out more health care resources than it relieves the public sector of workload.

Out-of-pocket and donor financing — low-income countries

Out-of-pocket financing is not pooled and usually refers to "user fees" paid directly to health care providers. It is the most inequitable form of health care financing. User fees tend to make only a small contribution of total health care expenditure in high-income countries, but in middle- and low-income countries, they represent a substantial proportion. In Malawi, one of the poorest countries in the world, 26 per cent of total health care expenditure is in the form of out-of-pocket expenditure by households (Figure 5).[19]

Figure 5: Source of health expenditure in Malawi, 2002/2003



In poor countries, user fees are a considerable barrier to health care access. In one Caribbean study, between 14 per cent and 20 per cent of people who reported illness indicated that they did not seek care because of lack of funds for treatment or transport.[20] In household surveys in rural China, 60 per cent of those referred to hospital by a doctor never follow through because they cannot afford the high user charges.[21] According to the WHO, there is evidence that out-of-pocket payments undermine adherence to anti-retroviral treatment and increase the risk of drug resistance.[22]

User fees are also a major cause of household impoverishment and indebtedness.[23] Poor households may resort to selling off assets such as land or cattle to pay for health care, or withdraw children from school to save on school fees or so that children can help with household chores while adults seek temporary jobs.[24] Although the pernicious effect of user fees is felt most acutely in poor countries, in high-income countries with an inadequate publicly financed system such as the US, health care costs are a known cause of bankruptcies.[25]

Furthermore, for large swaths of the human population, user fees are applied within an unregulated, unlicensed and, at times, anarchic private sector of primary care providers.[26] Many patients are not only impoverished by paying for health care, but are also paying for inappropriate or poor quality services.

Arguments that user fees can be means-tested to exempt or protect the poor do not stand up to scrutiny.[27] One reason is the difficulty and cost involved in effectively applying means testing, especially in low- and middle-income countries. The belief that fees increase the public's appreciation of services and prevent their "overuse" is also based on weak evidence. User fees are a blunt instrument for rationalizing health care-seeking behaviour. For most people, the high costs of seeking care results in an under-use of services.

In spite of their well-known negative effects, user fees remain a common feature of developing countries. It is, however, difficult to eradicate this barrier to health care because in situations where there is inadequate public or pooled revenue to pay for free care, user fees can be an important source of income to sustain the quality and uptake of any services.[28] In fact, they may be the lesser of two evils. In these circumstances, community-based health financing (CBHF) can help establish a local pool of funds to mitigate the harms of user fees. However, the budgetary limitations of CBHF — small pool size and the difficulty of setting up well-managed schemes — means that CBHF is only a partial solution to the absolute lack of resources for providing essential health care for all, free at the point of use.

Health care financing in developing countries is also characterized by a high dependency on external sources of finance. Figure 5 illustrates the importance of this source of financing in Malawi where it amounted to 29 per cent of total health care expenditure in 2002 (see Table 3 for figures from other countries). In spite of these funds, total health expenditure remained abysmally low and insufficient to provide a minimum package of essential care. Malawi has a doctor-to-population ratio of about one per 100,000, with the few doctors concentrated in urban centres.[29] By contrast, total per capita health expenditure in Canada was $2,222, with a doctor-to-patient ratio of about one per 500.[30]

Table 3: External sources of finance as % of total expenditures on health

Country	Year	Percentage
Afghanistan	2002	42.6%
Ethiopia	2002	29.5%
Gambia	2002	40.6%
Malawi	2002	37.6%

Source: World Health Statistics

There are several sources of external funding in developing countries. Official development assistance (ODA) from donor countries is one. Private foundations such as the Gates and Rockefeller Foundations are another. International non-governmental organizations (NGOs), such as CARE International and Save the Children, also finance health care across the world — their funds come from a variety of sources: individual donations, fundraising campaigns, as well as from private foundations and ODA programs. The World Bank (as well as other regional development banks) provides grants and soft loans to the health sector. Finally, there are a growing number of global health initiatives (GHIs) or global public-private partnerships such as the Global Fund for HIV/AIDS, TB and Malaria; Roll Back Malaria; Stop TB; Global Alliance for Vaccines and Immunization; and the Global Polio Eradication Initiative.[31] These are funded from ODA budgets, private foundations, and private companies, and tend to be focused on selective interventions or services related to a specified disease.

In Sub-Saharan Africa, ODA accounts for 55 per cent of all external health financing. However, the new GHIs are responsible for the bulk of the recent increase in external health assistance, representing 15-20 per cent of development assistance for health.[32]

These external sources of health financing are channeled into developing country health care systems in a variety of ways. In some instances, funds go into government budgets, thereby augmenting the public health care system. In other instances, funds are channeled through private organizations, mostly non-profit, to provide services directly. Funds may also be used in different ways, including supporting policy development, training, research activities, and basic service delivery.

For millions of people, services funded by sources of external financing are a lifeline. However, there are a number of problems associated with this. The first is with the very institution of "aid" within the context of a failing global poverty reduction paradigm. Poverty has actually grown worldwide at the same time that wealth has increased. Between 1981 and 2001, the number of people living in poverty in Sub-Saharan Africa increased from 289 million to 514 million.[33] And yet during the same period, world GDP increased by $18,691 billion.

Trade rules, the deregulation of finance, the global property rights regime, and the liberalization and integration of the world's economy have contributed in different ways to propping up a system that traps many poor countries in poverty and under-development, whilst allowing the accumulation of greater amounts of wealth among a small global elite.[34] The failure to live up to the promises made at the G8 meeting in 2005 to further cancel debt and increase the volume of ODA, following the high-profile Make Poverty History campaign, places question marks against the international commitment toward global development and poverty eradication. The whole concept of "aid", when divorced from this broader context, may serve only to paper over the cracks of a problem that requires more fundamental political and economic solutions, including efforts to pro-actively promote a fairer global redistribution of economic and political power.

Secondly, there is a need to question the effectiveness of aid. Much aid still comes tied to inappropriate obligations on recipient countries to procure from donors or to liberalize their economies in ways that are harmful. Funds are not reliably committed to developing country health sectors for long enough periods of time. There is still too much spent on expensive, short-term consultants of dubious quality and experience. The recent Paris Declaration on Aid Effectiveness is a welcome step in the right direction: taken by donor nations, it calls for developing countries to exercise greater control over their development policies and strategies, and for donor countries to operate in a more harmonized and transparent manner. However, many development NGOs feel that it does not go far enough, and does not outline the robust monitoring and reporting mechanisms required to ensure that the Declaration is acted upon.[35]

Finally, within the health sector, coordination between different donors, international NGOs, and GHIs is inadequate. Too often, Ministries of Health are forced to dance to the tunes of an uncoordinated orchestra of competing donors and fragmented initiatives. The selective nature of GHIs also creates a piecemeal and unsustainable approach to health improvement and health systems development. On the ground, the proliferation of external non-government initiatives aimed at shoring up the gaps in the public health system, while helpful in their own right, also create competition with the public sector for the setting of policy and priorities and for the scarce human resources within countries. Instead of supporting the development of public health care systems, independent "projects" run by non-governmental organizations can actually drain the public sector of capacity.

Recommendations for low-income countries

This article has been a whirlwind tour of several issues: the concept of pooling to optimize risk-sharing and cross-subsidization; the link between the size, number, and management of pools of finance with rational health planning, economies of scale and control over the provider system; the distinction between public and private, as well as the notion of commercialization which transcends the public-private dichotomy; the importance of cooperation and trust; the political and commercial forces that lie behind the trend toward greater marketization and health systems segmentation; and the inter-connections between health care financing and provision with provider/shareholder income.

This section, however, is focused on a set of recommendations for developing the health systems of low-income countries. Since the Health for All Declaration of 1978, many health care systems, especially in Sub-Saharan Africa, have been weakened by chronic under-investment, structural adjustment policies, and uncoordinated and piecemeal vertical interventions; a growing burden of disease, particularly in relation to HIV/AIDS; and the out-migration of skilled workers. Reversing these effects will require a coherent and long-term health systems development agenda that will require sustained political and social action, as well as technocratic reforms.

There are no quick-fix solutions. Neither are there any simplistic recipes for the restoration of effective and equitable health systems — any health systems development agenda would need to be tailored according to country- and region-specific contexts. For example, in countries in a state of civil conflict or ruled by oppressive governments, an external health systems development agenda would need to involve a more prominent role for non-governmental organizations. The recommendations that follow here refer to those countries in which there is relative stability and a democratic government.

Universalism and socialized systems of health care financing

According to the World Health Report 2000, "…single national pools, as the largest pools attainable and as non-competing organizations, might be seen as the most efficient way to organize pooling,"[36] and thereby to achieve risk-sharing, cross-subsidization, and more rational and coordinated health planning. The health sector plans of governments and the international health community should make the attainment of such socialized systems of health care financing an explicit aim. Different countries would require different timeframes depending on the institutional capacity of the state, the number of existing pools of health care finance, and the potential barriers to such reforms.

For those countries dependent on external sources of finance, this would imply revitalizing sector-wide approaches to pool donor and external health financing into a single basket that can then be amalgamated

with public finance and brought under national stewardship. Some of this external health financing should be used as a source of direct budget support to developing country Ministries of Health, whilst a proportion of it could be ear-marked toward specific programs and services. The point would be to bring available public and donor financing under a coherent planning framework.

A system of monitoring would need to be applied to the process of sector-wide planning and decision-making, and codes of conduct developed for donors and other external actors to encourage commitment toward the sector-wide approach and the institutional development of Ministries of Health. Independent research could be commissioned to monitor progress toward improved coordination and national leadership. Within donor countries, local public health associations could take on a proactive role in monitoring, evaluating, and debating the extent to which official development assistance to the health sector of developing countries is provided as budget support or through sector-wide approaches, and follows the principles of "good aid".

One of the biggest challenges for developing a sector-wide approach to planning and health systems development will be to shift the balance between the current trend toward multiple, selective health care interventions (many of which are implemented through vertical and parallel structures) and the need for a single, cross-cutting health systems plan designed to meet all the priority health needs of a country. Although selective and vertical interventions make important and urgent health gains, the present configuration of multiple, fragmented, and selective funding channels and programs acts as a hindrance to coherent health systems development. Shifting toward a more explicit sector-wide approach to health planning, with more funds being pooled nationally to develop the core, cross-cutting infrastructure of the health care system, will help improve this situation.

In order to assist in moving forward, the many new sources of financing from selective global health initiatives should gradually allocate an increasing proportion of their funds to a sector-wide budget for financing the core infrastructure of a functional health care system and developing a shared set of health systems goals. These would include agreement on the principle that certain dimensions of health systems, such as the supply and distribution system of medicines and laboratory services, should never be duplicated so that parallel systems exist for different diseases or programs.

At the global level, there is a need to debate the current architecture of global health policy making and governance; this would include a discussion as to whether there are too many separate international and global health initiatives adding to the uncoordinated field of official

donor agencies, and whether there is a need for a shift in the way the international community responds to the health crisis in Sub-Saharan Africa and other poor regions/countries. For example, rather than multiple strands of health funding attached to disease-based or selective interventions, there could be a single fund for comprehensive health systems financing that would *then* form the platform for disease-based or selective interventions.

As far as existing private pools of finance are concerned, these are generally not very significant in the poorest countries. However, where they exist, steps should be taken to ensure effective regulation of these schemes in a way that maximizes customer protection, efficiency, and equity. Regulations to ensure a prescribed set of minimum benefits and prohibit individual rating may help pave the way for the amalgamation of smaller pools of private financing into more efficient and equitable larger pools.

Finally, indicators and targets to monitor progress toward effective socialized systems of health financing could be developed — for example, the proportion of total health expenditure that comes from a single sector-wide budget that falls under national public stewardship, or targets to reduce the number of small and fragmented pools of private finance.

Restoring commitment to the public

Socialized systems of health care finance require effective and accountable national stewardship by Ministries of Health, which in turn requires a committed plan of action to resurrect and revitalize the "public" within health care systems and ensure that governments are able to secure the fulfilment of rights to health care (but without public services becoming marginalized as "poor care for the poor").

The goal of achieving socialized systems of health care financing is inextricably linked to the challenge of public institution building. However, many developing countries have become tarnished by a reputation of bureaucratic mismanagement, corruption, and shortcomings in democracy that have bred skepticism toward the use of official development assistance to support public sector budgets; this has entrenched a view that government bureaucracies in developing countries are inherently inefficient or corrupt. However, the problem of poorly functioning governments does not negate the principle and purposes of socialized forms of health care financing.

A holistic health systems development agenda must therefore incorporate initiatives to combat mismanagement and improve the accountability and efficiency of state bureaucracies. For example, funds could be allocated toward financing independent budget-monitoring initiatives. One example of this is the work of the Institute for Democracy in South

Africa (IDASA), an independent public interest organization that monitors government budgetary allocations. Through its innovative applied budget research, it has contributed to the development of budget literacy amongst advocacy organizations and citizens, and provided training to elected representatives and government officials on various aspects of public finance.[37]

A commitment toward revitalizing the "public" within health care systems does not imply a diminished role for non-government actors. On the contrary, those that operate with a public ethic have an important role in developing public sector capacity to provide more effective health care, as well as providing services where there is a lack of functioning government infrastructure. In addition, non-government actors can help enhance community involvement within health programs as well as public sector accountability.

There is also a need to shift the characterization of the public sector as rigid and monolithic bureaucracies toward systems that are decentralized, involve "public-public partnerships" within the public sector as well as between government and non-governmental organizations, and apply effective non-market incentives to encourage innovation and enterprise. A public ethos of service provision can be encouraged through peer recognition, public praise of good performance, and opportunities to advance career and learning prospects. Non-financial rewards can be used as incentives for public sector managers and clinicians to act ethically, effectively, efficiently, and accountably if there is also a program to make up lost ground in the deterioration of public service salaries, both in absolute terms as well as relative to the private sector.

Finally, revitalizing the "public" in health care systems requires a renewed appreciation of public administrations and bureaucracies. The view that the private sector is better than the public sector and that markets result in better and more efficient performance than hierarchies is not borne out by evidence. Public sector social welfare has been the bedrock of European social and economic development since the Second World War and many low-income countries, including Sri Lanka, Costa Rica, and Cuba, have had well-performing public health services for decades.

To help achieve the goal of a strong, effective, and publicly-based health care system, more investment needs to be directed at strengthening public sector health management capacity at all levels. Human resource planning and management requires particular attention. Improving financial management capacity within the health sector also needs to be strengthened; this could be assisted by the regular production of national health accounts to describe the way in which health care is

financed, as well as the pattern of health care expenditure, including measurements of the per capita expenditure variations between geographic areas, between socio-economic groups, and between secondary/tertiary hospitals and district health services.

Expenditure targets could be set over three- to five-year timeframes and monitored to ensure the most effective equitable use of public finance. These could include:

- expenditure on district health services to be at least 50 per cent of total public health expenditure, of which half (25 per cent of total) should be on primary level health care;
- expenditure on district health services to be at least 40 per cent of total public and private health expenditure; and
- a ratio of total expenditure on district health services in the highest spending district to that of the lowest spending district to be less than 1.5.

Reining in commercialization

Efforts to revitalize the "public" in health care systems must be accompanied by efforts to rein in commercialization. In most of the poorest countries, the bulk of health care provision is carried out by the private sector — much of it in the form of small-scale, disorganized private dispensaries and clinics. Many governments do not have the capacity either to regulate the sector or improve the quality and safety of care provided. Governments (and donors) must give issues of private sector regulation and quality assurance a much higher profile in their health policies and plans, and use their political and legal muscle to shift disorganized and commercialized health care markets toward a more equitable and efficient direction. Policy instruments to regulate the private sector include licensing requirements, formal accreditation, and price controls.

Health systems research to describe and study the interface between the public and private sector is also important and should be used to promote greater public discussion of health systems and financing reforms, while ensuring the presence and voice of the poor in such discussions. Ultimately, it is important to consider ways of breaking the link between the income of health care providers and the delivery of health care — arguably one of the most critical conditions for the development of ethical and cost-effective behaviour within health systems. Public service offers the one means of achieving this, but only if public sector health workers are paid a living wage and operate within an institutional context that rewards and encourages ethical behaviour and a public service ethos.

Raising finance and redistributing wealth

Low-income countries face an absolute resource shortage. The WHO's Commission for Macroeconomics and Health reported in 2002 that the minimum expenditure for scaling up essential interventions was on average US$34 (current US$) per person/year. At the time, among the 48 least-developed countries, average total spending for health was only US$11 per person/year of which US$5 came from out-of-pocket expenditures (1997).

As a first step, there is a need for every country to develop an indicative budget of what is required to finance essential health care; this would then be used to measure the financing gap between it and current expenditure. This should be followed by a country-specific plan to plug the gap with additional domestic and external financing.

Within countries, governments must be enabled to strengthen their capacity to increase tax revenue in a fair manner, and prevent unethical capital flight. Countries should set a target to raise at least 20 per cent of their GDP as tax revenue, and to allocate at least 15 per cent of total government expenditure to health. A complementary target would be for public health expenditure (government and donor finance) to be at least 5 per cent of GDP.

As far as external sources of financing are concerned, high-income countries should rapidly reach the long-standing target of allocating 0.7 per cent of GDP to ODA. Donors should commit to long-term and reliable funding for periods of five to 10 years to allow predictable budgeting and stable planning cycles. At the same time, the international community must recognize the limitations of aid programs and voluntary "public-private partnerships" to finance health systems development. New strategies and sources of public financing are required to fund global health, as well as enable a more effective means of resource redistribution globally.

This should include the development of an international tax authority to assist countries to reduce the hundreds of billions of dollars of lost public revenue due to tax avoidance (and tax competition). Global economic transactions now make it harder and harder for the poorest countries to raise public revenue through national tax authorities. In addition to generating public revenue, the more effective regulation of capital flight, tax havens, and secret bank accounts will contribute toward the cleaning of corruption and bribery within governments. Other sources of global public financing could include the introduction of a currency transaction tax, and airline, arms trade, or fuel taxes.

At the same time, the global public health community needs to engage much more forcefully and robustly with the political and structural determinants of poverty, given that the current development paradigm is failing to lift countries and households out of poverty. The outright cancellation of unpayable debt, fair trade reform, increased and improved levels of overseas development assistance, and new forms of global financing, such as currency transaction taxes, have to be part of the global agenda for health systems development.

DAVID McCOY is a public health specialist in London, England. He is also a managing editor of the alternative world health report Global Health Watch, and a Steering Committee member of the People's Health Movement. After graduating as a medical doctor, David worked in England before spending two and half years in a rural hospital in northern KwaZulu, South Africa, during which time he became the District Medical Superintendent. He subsequently worked as a senior policy research fellow at the University of Capetown's Child Health Unit and then for six years for the Health Systems Trust, a South-Africa based NGO involved in transforming the apartheid health care system. David has also served as a consultant to the WHO and other health agencies, and provides technical advice and support to a variety of NGOs. Three years ago, he conceptualized and initiated production of Global Health Watch under the auspices of the People's Health Movement, the Global Equity Gauge Alliance, and Medact, a UK-based charity. He completed a doctorate in public health at the London School of Hygiene and Tropical Medicine in 2004.

Endnotes

1 Source: OECD, *Revenue Statistics 1965-2003* (Paris: OECD, 2004), p. 18.

2 Gottret, P. and G. Schieber. *Health financing revisited: A practitioner's guide.* Overview. (Washington: World Bank, 2006). http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFR_SAOverview.pdf

3 World Health Organization, World Health Report 2000 (Geneva: World Health Organization), p. 101.

4 Mackintosh, M. and M. Koivusalo (eds). Health systems and commercialization: in search of good sense. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses.* (Palgrave: Basingstoke, 2005).

5 One variant of public financing that *reduces* the role of public departments is the voucher system; vouchers (or cash payments) are given to individuals *in lieu* of the provision of services. They are intended to give individuals greater control over their choice of health care provider. However, critics of voucher systems argue that often there is no real "consumer choice" and that by fragmenting public purchasing power, vouchers reduce the responsibility and ability of public departments to shape the provider market on behalf of citizens.

6 Mackintosh, M. and M. Koivusalo (eds). Health systems and commercialization: in search of good sense. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses.* (Palgrave: Basingstoke, 2005).

7 However, the impact of CBHF is limited in that it does not enable cross-subsidization and pooling between high- and low-income members of society, and the majority of the world's population living on less than two dollars a day per capita are unable to raise much in the form of financing and CBHF.

8 Commercialization refers to the provision of health care services through market relationships and where investment in, and production of, services are exchanged for financial income. The concept of commercialization is often associated with private sector actors. However, market relationships also exist between patients and public sector providers, and public sector facilities can end up acting "commercially" if they have to compete for income in a competitive provider market. It is, however, important to distinguish the differences between the market-led and commercial behaviour of for-profit actors compared to non-profit or public actors in terms of their accountability and commitment to meeting public aims and goals.

9 Mcintyre, D. et al. *Health sector financing and expenditure in South Africa.* (Durban: Health Systems Trust, 1993).

10 Pearmain, D. *Impact of changes to the Medical Schemes Act.* In Ntuli, A. et al (Eds.). South African Health Review 2000. (Durban, South Africa: Health Systems Trust, 2001). http://www.hst.org.za/uploads/files/chapter8_00.pdf

11 Bennett, Sara and Ann Mills. *Government capacity to contract: health sector experience and lessons.* Public Administration and Development 18(4): 307–26, 1998.

12 Liu X. and A. Mills. *Financing reforms of public health services in China: lessons for other nations.* Social Science and Medicine 54:1691-8, 2002.

13 Batley, Richard. *The new public management in developing countries: implications for policy and organizational reform.* Journal of International Development 11: 761–65. 1999b.

14 Woolhandler, S., T. Campbell, and D.U. Himmelstein. *Costs of Health Care Administration in the United States and Canada.* New England Journal of Medicine, 349:768-775, Aug 21, 2003.

15 Evans, R. G. *Raising the money: Options, consequences and objectives for financing health care in Canada.* Paper presented to the Commission on the Future of Health Care in Canada, 2002.

16 Martineau, T., K. Decker and P. Bundred. *Health Professionals: Levelling the Playing Field for Developing Country Health Systems.* Liverpool School of Tropical Medicine, 2002. http//www.liv.ac.uk/lstm/research/documents/InternationalMigrationBriefNote.pdf http://www.dh.gov.uk/assetRoot/04/09/79/99/04097999.pdf

17 Save the Children and Medact. *Whose Charity? Africa's Aid to the NHS.* (London: Save the Children). Briefing paper, available at: http://www.medact.org/content/Skills%20drain/Whose%20charity%204%20page.pdf

18 Gwatkin, D. *Free government health services: Are they the best way to reach the poor? 2003.* http://poverty.worldbank.org/files/13999_gwatkin0303.pdf Accessed March 24, 2005.
International Finance Corporation. *Investing in private health care: Strategic directions for IFC.* (Washington DC: 2002).

19 Ministry of Health and Population, Malawi National Health Plan 1999–2004, Lilongwe, 1999.

20 Theodore, K. *Health sector reform and equity in Jamaica.* Report to the Pan-American Health Organization. Washington: PAHO, 1999.

21 Fu, W. *Health care for China's rural poor, international policy program.* Washington: World Bank, 1999.

22 World Health Organization. World Health Report 2004. (Geneva: World Health Organization).

23 Ensor, T. and S. Pham. *Access and payment*

for health care. The poor of Northern Vietnam. International Journal of Health Planning Management, 11: 69-83, 1996.

Whitehead, M., G. Dahlgren and T. Evans. *Equity and health sector reforms: can low-income countries escape the medical poverty trap?* Lancet 358:833-36, 2001.

[24] Tipping, G. *The social impact of user fees for health care on poor households.* Commissioned report to the Ministry of Health, Hanoi, Vietnam, 2000.

[25] Gottlieb, S. Medical bills account for 40 per cent of bankruptcies. British Medical Journal, 320: 1295, 2000.

[26] Bloom, G. and H. Standing. *Pluralism and Marketisation in the Health Sector: Meeting Health Needs in Contexts of Social Change in Low and Middle Income Countries.* IDS Working Paper 136, 2001.

[27] Russell, S. and L. Gilson. *User fee policies to promote health service access for the poor: a wolf in sheep's clothing?* International Journal of Health Services, 27: 359-79, 1997.

[28] Akin, J., N. Birdsall and D. Ferranti. *Financing health services in developing countries: an agenda for reform.* (Washington: World Bank, 1987).

Griffin D. *Welfare gains from user charges for government health services.* Health Policy Plan 1992; 7: 177-80.

[29] Aitken, J. M. and J. Kemp. *HIV/AIDS, equity and health sector personnel in southern Africa.* EQUINET discussion paper number 12, 2003. http://www.equinetafrica.org/bibl/docs/DIS12aids.pdf

[30] World Health Statistics 2005.

[31] *Good Intentions with Side Effects: Information on Global Public Private Initiatives in Health.* (The Netherlands: Wemos, 2004). http://www.wemos.nl/documents/Goodintentionswithsideeffects.pd

[32] Gottret, P. and G. Schieber. *Health financing revisited: A practitioner's guide.* Overview. Washington: World Bank, 2006. http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFR_SAOverview.pdf

[33] Woodward, D. and C. Simms. *Growth isn't working: the unbalanced distribution of benefits and costs from economic growth.* (London: New Economics Foundation, 2006).

[34] Global Health Watch. www.ghwatch.com

[35] *More progressive aid effectiveness targets demanded* http://www.eurodad.org/articles/default.aspx?id=629

[36] World Health Report 2000 (Geneva: World Health Organization), p. 104.

[37] See http://www.idasa.org.za/ for further information.

Canada and the Global Right to Health

Chantal Blouin

CHAPTER
FOUR

Canada and the Global Right to Health

Chantal Blouin[1]

What is the right to health and why should Canadians get involved?

The implementation of the right to health is a legal obligation of the Canadian government, a commitment to ensure that all citizens achieve the highest attainable standards of health. This obligation derives from Canada's ratification of the International Covenant on Economic, Social and Cultural Rights and several other international and regional treaties, as well as customary international law. What are the implications of this legal obligation? How can it guide the decisions of policy-makers in Canada and around the world?

A first element to understand about the right to health is that it is constrained by the availability of financial and human resources. National and local governments in poor countries are not in a position to offer a wide range of excellent health care services to their citizens. Human rights law reflects this reality and allows for the progressive realization of the right to health, based on the capacity of government to offer these services. However, as Paul Hunt points out: "…progressive realization is subject to various conditions, otherwise pursuit of the right to health might be constantly postponed, emptying the right of any meaning... The right to health imposes various other obligations of immediate effect, notwithstanding resource constraints and progressive realization. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health."[2]

National governments are accountable to their citizens to adopt policies leading to rapid progress in terms of the availability, accessibility, and quality of health facilities, goods and services.[3] Access to health care is therefore one important part of the equation. But we should note that the right to health also includes the underlying determinants of health (such as access to safe drinking water and adequate sanitation) and the socio-economic conditions of the population (such as housing, working conditions, and poverty) that have significant impacts of health outcomes.[4] The World Health Organization (WHO) is currently examining how the improvement of social and economic conditions can contribute to the achievement of the right to health. Indeed, the Commission on Social Determinants of Health has been mandated to identify and promote the most effective policies to improve health through action on social determinants.[5]

The actual means and instruments used to achieve progress on the right to health will vary from one country to another, as populations with different social and political preferences will adopt different strategies. But the right to health means that policy-makers have to consider how and to what level the allocation of public expenditures for health can be increased, as well as developing and implementing a national action plan to work toward progress. By stressing non-discrimination as a key principle, a right to health approach also tells us that examining the impact of policies focusing on the average condition of the whole population can be misleading: it can hide a decline in availability and access for some groups. Therefore, policy-makers have to focus on the rights of vulnerable and marginalized people, including poor women, minority groups, and Indigenous People.

The accountability of national governments to fulfill the right can be envisioned in a legal as well as political way. The right to health has been recognized in more than 100 national constitutions. In many of these countries, citizens have used domestic courts to challenge their government's action or inaction.[6] The constitutional right to life has also been interpreted by some domestic courts as implying the right to health. In Sri Lanka, for example, the Supreme Court stated that the government could not apply a very high level of patent protection on pharmaceutical drugs if it meant reducing access. National governments can also be held accountable for their fulfilment of the right to health through international monitoring. Such monitoring takes place through the treaty-compliance monitoring bodies of the United Nations (UN), in particular the Committee on Economic, Social and Cultural Rights, and through regional intergovernmental bodies, including the Inter-American Commission on Human Rights and the related court.[7] As we can see in the paper from María Zúñiga, the right to health is not only a legal instrument, but also a political instrument in the hands of citizens' groups to remind their governments of their obligations.

What are the implications of the right to health for Canada's role in global health? Human rights are first about the obligation of a state vis-à-vis its own citizens, but international cooperation to achieve human rights is also an obligation included in the UN Charter.[8] Beyond that legal obligation, one has to see that the achievement of the right to health around the globe is in Canadians' own interests. As the Romanow Commission on the Future of Health Care in Canada noted, "…in an increasingly interconnected world, Canada cannot isolate itself from the health issues in other countries."[9] Given that reality, the commission recommended that the federal government play a leadership role in global health.

How is the health of Canadians affected by the health of other nations? First, the cross-border transmission of infectious diseases is one concern that has put global health increasingly high on the foreign pol-

icy agenda. The 2003 SARS epidemic and the ongoing international surveillance of the recent strain of the avian flu are just two cases that highlight how infectious diseases do not stop at the border. Moreover, Canadians themselves are crossing borders by traveling, working, and studying abroad and are therefore directly affected by the health situation in nations across the globe. With more than 18 per cent of the Canadian population born outside Canada, our close ties to families, friends, and communities in our places of origin breach the walls between what is considered global health and health at home.

In addition to these direct impacts on the health of Canadians, the health of other nations matters to us because of its impact on world prosperity and security. As the policy statement of the Canadian International Development Agency (CIDA) put it, "Canada cannot be safe in an unstable world or healthy in a sick world."[10] Indeed, our development assistance policy is, in part, inspired by our self-interest, as we realize that our long-term prosperity and well-being benefit from supporting human development abroad. Assisting in the realization of the right to health globally is a very effective means of reducing poverty in developing countries and supporting social and economic development. Indeed, research undertaken by the WHO Commission on Macroeconomics and Health clearly shows that ill-health is an important obstacle to economic development. "Until recently, economic growth was seen as a precondition for real improvements in health. But the Commission turned this notion around and provided evidence that improvements in health are important for economic growth. […] The Commission showed that increased life expectancy and low infant mortality are linked to economic growth. Healthy people are more productive; healthy infants and children can develop better and become productive adults. And a healthy population can contribute to a country's economic growth. The Commission says that increased investment in health would translate into hundreds of billions of dollars per year of additional income which could be used to improve living conditions and social infrastructure in poorer countries."[11]

Finally, the health of developing nations also matters for Canada in terms of its broader impact on global security and political stability. Increasing levels of disease are linked to a decline in state capacity, and can lead to state failure and national and regional conflict. As Price-Smith points out, "State failure frequently produces chaos in affected regions... An example of this is the wide-ranging conflict in Central Africa, where the collapse of governance in Zaire has generated a wide conflict."[12] In a context where pandemics like HIV/AIDS can destabilize whole regional systems, preventing disease and improving health becomes a security issue of direct interest to Canadians.

Canadians and their national government are already involved in working to achieve the right to health globally, but their contribution

could be much more significant. This essay examines three areas for action: our financial support for health initiatives in developing countries, our policies regarding the cross-border movement of health professionals, and our political positions on issues related to the right to health in international forums. The right to health is more than a slogan: it could translate into concrete changes in Canadian foreign policy. The conclusion will highlight the steps that we can take collectively to become leaders on the global right to health.

What is Canada doing globally for the right to health? What should we be doing?

Development assistance for health

Through its financial support to health systems and health interventions in developing countries, Canada can contribute to the achievement of the right to health at the global level. And indeed, the Canadian government has recently put greater emphasis on health in its development assistance: financial support for health-related assistance has increased 44 per cent in the last five years. Bilateral programs focusing on health have gone from $78 million in 1999 to $118 million in 2003-04. This number rises to $268 million if we include those that are health-related, such as population, water, and sanitation programs (see Tables 1 and 2).

Table 1: Country-to-country health-related ODA disbursements by sector and percentage, 2003-2004 (C$ million)

Sector	Geographic Programs	Canadian Partnership (voluntary sector and others)	Canadian Partnership (Private sector)	IDRC	Total
Health	$90.46	$20.85	$0.86	$5.89	$118.06
Population programs	$65.88	$31.17	$0.07	$1.91	$99.03
Water, supply and sanitation	$48.20	$5.42	$4.93	$2.25	$60.80

Source: CIDA, Statistical Report on Official Development Assistance, annual.

Table 2: Country-to-country health-related ODA disbursements by sector and percentage, 1999-2000 (C$ million)

Sector	Geographic Programs	Canadian Partnership (voluntary sector and others)	Canadian Partnership (Private sector)	IDRC	Total
Health	$37.42	$26.32	$0.36	$14.72	$78.82
Population programs	$24.21	$10.93	$0.18	$13.19	$48.51
Water, supply and sanitation	$26.27	$6.19	$4.34	$3.24	$40.04

Source: CIDA, Statistical Report on Official Development Assistance, annual.

Moreover, funding for multilateral activities focusing on health has also increased in recent years. New high-profile initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the WHO's 3 by 5 Initiative are due to receive more than $600 million between 2001 and 2007.[13] In addition to these new projects, Canadian multilateral assistance for health is now more than $100 million per year (see Table 3).[14]

Table 3: Multilateral assistance health-related disbursements – funds coming from CIDA envelope unless otherwise noted (C$ million)

	1999-2000	2000-2001	2001-2002	2002-2003
WHO			12.32	
– from the Canada Fund for Africa				20.00
– from DFAIT funds		12.5	12.22	11.23
WHO Tropical Disease Program	1.40	1.40	1.40	1.83
WHO Canadian International Immunization Initiative	4.10	4.35	9.65	4.15
PAHO (from DFAIT funds)		15.07	16.74	15.57
UN Fund for Population Activities (UNFPA)		10.00	9.10	13.70
UN Program for HIV/AIDS	3.40	3.55	3.50	5.95
UNICEF	13.50	14.00	13.50	15.00
– from the Canada Fund for Africa			28.40	11.5
UNICEF – Canadian Immunization Initiative	4.10	4.35	9.15	4.15
UNICEF – Global Alliance for Vaccines and Immunization			3	3
Other UNICEF health-related initiatives	1.12	1.55	1.36	0.96
Micronutrient Initiative			28.37	28.16
International Union against TB and lung disease – DOTS expansion			2.76	19.09
TOTAL	27.62	66.77	151.47	154.29

Source: CIDA, Statistical Report on Official Development Assistance, annual.

This increase in funding for health reflects that this sector has been identified as a priority for Canadian development assistance. In 2000, CIDA launched a framework for action on social development to double the funding allocated to basic health, nutrition, and education in the next five years. This focus on basic human needs results from the foreign policy framework issued in 1995 by the Government of Canada. A clear mandate was given to CIDA to support poverty reduction in developing countries by concentrating at least 25 per cent of its official development assistance (ODA) on basic human needs — defined as primary health care, family planning, basic education, nutrition, water and sanitation, and shelter. According to CIDA, social development now represents more than 40 per cent of its funding.[15]

In addition to more traditional assistance to health programming, Canada created the innovative Global Health Research Initiative in 2001.

Four Canadian agencies — CIDA, the International Development Research Centre (IDRC), Health Canada, and the Canadian Institutes of Health Research (CIHR) — are now collaborating to address the gaps in health research that are relevant to the needs of developing countries. Indeed, as CIHR points out, "…an enormous discrepancy exists between the magnitude of disease burden in the world and the allocation of research funding. The discrepancy is now widely recognized as the '10/90 Gap.' Of the approximately US$73.5 billion invested in health research and development worldwide in 1998, only 10 per cent was allocated to 90 per cent of the world's health problems, which are concentrated in poor countries."[16] The Global Health Research Initiative aims to harness Canadian research capacity and funding toward the health needs of developing countries. Up to now, the agencies have committed more than C$8.5 million to this initiative.

In addition to giving consideration to ways of increasing our bilateral funding for health systems in developing countries, Canada should take a more active interest in the various innovative development financing mechanisms that are being discussed on the international stage and, in some cases, implemented. For instance, the French government has announced that, starting July 1, 2006, all passengers taking off from France will pay an air-ticket levy; the funds will be used for the purchase of pharmaceutical drugs for the battle against HIV/AIDS, tuberculosis, and malaria in developing countries. Chile, Brazil, Norway, and others have already stated their intention to follow suit. Many of the innovative financing mechanisms being discussed are focusing on the health needs of poor people; these would not only mobilize more resources to finance the achievement of the right to health, but also more predictable sources of financing than current development assistance. Canada has been almost invisible in these discussions up to now.

Amid the talks about scaling-up assistance for health in poor countries, some have expressed concerns about its potential impact on macroeconomic stability. More precisely, some are worried that a large increase in aid for health may lead to an appreciation in the currency of the recipient countries (the so-called Dutch disease) and impede their capacity to export, thereby reducing economic growth. In policy circles, these concerns have been especially present within the International Monetary Fund (IMF) and the World Bank. There have been cases in African countries, such as Uganda and Mozambique, where these concerns appear to have translated into ceilings on health spending; such ceilings would be real obstacles to the fight against HIV/AIDS and the achievement of the health Millennium Development Goals (MDGs).[17] The IMF formally denies that concerns with macroeconomic stability led to recommendations regarding health caps.[18] This controversy about what the International Financial Institutions (IFIs) have been saying to Ministries

of Finance in Africa regarding the Dutch disease continues.[19] Meanwhile, given that reliable evidence on this issue is limited, donors like the United Kingdom's Department for International Development (DFID) have stated that these risks are manageable with proper monetary policy and are relatively limited in the face of the costs of not scaling-up.[20] Indeed, health crises such as the HIV/AIDS pandemic have large negative impacts on economic growth and human development. Canadians need to ask whether the costs of illness and premature deaths are included in IFI calculations. The Canadian Ministry of Finance should also suggest to the IMF and the World Bank Boards that when the risks of macroeconomic instability are real, the focus should be on intervention to the adjustments of scaling-up rather than on limiting financial resources available for health.

The brain drain in health personnel

The progressive realization of the right to health in developing countries is impeded in many instances by shortages of health personnel. The WHO's most recent World Health Report estimated that there is a world shortage of 4.3 million nurses, midwives and physicians, with the most critical shortages in Sub-Saharan Africa.[21] The migration of physicians and nurses from developing countries to industrial countries is a key factor in understanding these shortages. For example, USAID reported in 2003 that "…in Zambia, out of more than 600 doctors trained in the country since independence, only 50 remain. In Zimbabwe, out of 1,200 doctors trained in the 1990s, only 360 are reported to be practising domestically. The Government of Kenya advertised 100 doctor vacancies in 2001, but only eight applied."[22] The situation with nurses is also critical. The vacancy rate for nurses stands at 35 per cent in the Caribbean, with at least 500 nurses a year leaving the region to work in Canada, the US or the UK.[23] Canada may not be the main destination country for these health professionals but it is nevertheless an important actor. For instance, 1,845 physicians trained in South Africa worked in Canada in 2003; this represents 7.7 per cent of the physicians remaining in South Africa.[24]

This migration has many negative impacts on the health systems of these countries: patients refused access to services and care, long wait times, low morale among the remaining health workers, and lower quality of services. It also translates into loss of fiscal resources for developing countries — public funds invested in the training of the health professionals leave the country. Unless, the professionals return to work in their country of training after some years working abroad, the investment in high-skilled training is lost. As Chanda points out, "The estimated costs of health worker emigration for South Africa range between $500 million to $1 billion a year. Between 1999 and 2000, the cost of nurses migrating from Caribbean countries was estimated at 16.7 million dollars."[25]

What could Canada do to confront this brain drain and its negative consequences for access to health services in developing countries? The key policy action here is improved planning of health human resources in Canada.[26] If Canadian universities and colleges could train sufficient numbers of health professionals for the growing needs of the aging Canadian population, it would reduce the "pull factors". This human resources planning toward self-sufficiency also needs to include measures to increase retention of health personnel within the professions, especially in the case of nurses. This is a clear example of the international implications of the policies we adopt at home.

Another Canadian response to this problem could be adoption of a strategy of managed migration of health personnel from developing countries. Some examples of this already exist. Indeed, the negative impact of recruitment of nurses and physicians from developing countries has been recognized by many organizations around the world, and actions undertaken to limit the adverse effects. For example, in 1999, the UK Department of Health adopted guidelines on international recruitment of nurses which state that it "is essential that all employers ensure that they do not actively recruit from developing countries who *(sic)* are experiencing nursing shortages of their own." In 2001, a code of practice was developed for all health care professionals; recruitment should be undertaken only as part of government-to-government cooperation agreements that encourage the temporary exchange of personnel and formal training.[27] The UK now has bilateral agreements with India, China, and the Philippines, each with different conditions. Cuba, as a sending country, also has bilateral agreements on the provision of physicians with Botswana, South Africa, Namibia, Zimbabwe, and Guyana, and is developing new agreements with Venezuela and Bolivia.

The objective of a Canadian strategy of managed migration of health personnel would be to increase the likelihood that their stay is of a temporary nature rather than permanent migration. One recent proposal along these lines was developed in a study prepared for the Commonwealth Secretariat, with Canada creating a bilateral program for nurses from the Caribbean region.[28] This proposal would set up a special "Canada Bound" training and placement program for Caribbean nursing graduates, with participants paying market-based tuition fees to remove the drain on public resources. The Canadian government would offer student loans to the participants but, as an incentive for the nurses to return to work in their home country, the loans would be partially forgiven after a certain work period in Canada. The Canadian government should seriously consider this proposal, as well as other models, with a view to creating an institutional framework that allows both sending and receiving countries to reduce the negative impacts of the migration of health personnel and maximize its potential benefits (for example, improved skills), while respecting the rights of individuals who wish to work abroad.

The combination of improved human resources planning at home and the creation of institutions to better manage migratory movement could improve policy coherence. We all want to avoid having a development assistance agency from a particular country spend millions of dollars every year to support health systems in developing countries, while health establishments from that same country potentially sabotage efforts by "raiding" the human resources. Finally, developing countries' governments also have a responsibility to improve the health system and infrastructures, as well as the working conditions of health workers in their countries, in order to reduce the likelihood that their health workers will want to leave.

Canada's political role in international forums

In addition to financial contributions for the improvement of health conditions and a strategy on health human resources, Canada could promote the right to health through political leadership on the international stage in several multilateral, regional, or bilateral forums. One area of international policy where the right to health has received attention is the impact of trade agreements on access to essential medicines. In the last decade, a number of international trade agreements have included the protection of intellectual property, including the protection of patents on pharmaceutical drugs. The first major agreement to do so is the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPs), adopted in 1995 by the World Trade Organization (WTO). The level of protection offered to intellectual property in this agreement, such as a 20-year monopoly for patent-holders, reflects the standards already established in industrialized countries.[29] However, this regime of protection is a major change for most developing countries that previously have had little or no patent protection.

The problem with the TRIPs agreement is that mandating patent protection for pharmaceutical drugs increases prices and reduces access to essential drugs. Patents increase the price of drugs by reducing or preventing competition in the manufacturing of medicines. Competition usually brings down the prices. For instance, "…generic competition reduced the price of a triple-combination of antiretrovirals from $10,000 to $300 in one year. When patent protection is too strict in a developing country, and does not balance the rights of the patent holder with the public interest, patents can block access to medicines."[30]

Reducing accessibility, instead of increasing it, violates the principle of progressive realization. Some argue that patents are important incentives for research and innovation and therefore contribute to making life-saving drugs more available. However, this argument is invalid when it comes to drugs for diseases of the poor. The British Commission on Intellectual Property Rights found that "all the evidence we have examined suggests

Is Canada implementing the Covenant on Economic, Social and Cultural Rights?

Canada's fulfilment of Covenant rights, including the right to health, has just been reviewed by the United Nations Committee on Economic, Social and Cultural Rights. A significant number of Canadian organizations submitted testimony to the committee and several were present when Canadian officials had to defend Canada's record at committee hearings in Geneva in May 2006.[31] This review provides a useful window through which to see Canada's current Covenant status. Among the concerns raised by Canadian groups regarding Canada's implementation of the Covenant as it relates to the health are:

- The rise of privatization, which makes the Government of Canada "ineffective in ensuring access to adequate health care without distinction based on ability to pay."
- The continued lack of a universal, accessible, comprehensive, and portable drug plan (such as the Catastrophic Drug Transfer proposed by the Romanow Report).
- The Charter Committee on Poverty Issues raised a number of dimensions of the *Chaoulli* decision of the Supreme Court, including the fact that it ignored arguments for interpretations consistent with the UN Committee's General Comment No. 14.[32]

The Committee on Economic, Social and Cultural Rights, having studied the Canadian government's reports on implementation, examined submissions from non-governmental organizations (NGOs) and heard answers from Canadian officials as well as concerns from NGO spokespeople. It was quite specific in its critique of Canada's record in fulfilling its Covenant obligations. Positively, it noted the government's announced plans to strengthen health care and the launch of the Public Health Agency. It welcomed extension of maternal and parental benefits from six months to one year, greater pay equity, and reduced unemployment. However, it also noted that Canada takes a "restrictive interpretation" of its obligations. The Committee concluded that Canada has not enacted legislation recognizing economic, social, and cultural rights, with the consequence that there is a lack of awareness in provinces and territories of legal obligations under the Covenant. There is lack of legal redress for individuals and governments that encourage courts to deny protection of Covenant rights.

The lack of a legally-enforceable right to adequate social insurance is fundamental, and while contributions through the Canada Health Transfer have been increased, support for social assistance and social services through the Social Transfer have not been restored to even 1994-1995 levels. The right to water (see the Committee's General Comment No.15 – 2002) is not recognized as a legal entitlement in Canada. The Committee also notes the possible impact of other international agreements, such as the North American Free Trade Agreement (NAFTA), on the ability of Canada to fulfill its obligations, stating that trade liberalization may have a wealth-generating potential, but does not necessarily lead to a positive environment for the realization of economic, social and cultural rights.

The Committee's "Concluding Observations" ought to elicit action by Canadian authorities. However, the repetition of concerns in the 2006 report that were raised in their last review (1998) means that serious consideration of the recommendations is in question.[33]

A key opening for individuals who have suffered violations of their rights and found no recourse in domestic legal processes is the complaints mechanism of the relevant international body. Canada has, for example, ratified the Optional Protocol to the UN Covenant on Civil and Political Rights, which provides this option.[34] A similar provision has been under discussion for some time with regard to economic, social and cultural rights, in what is called the Open Ended Working Group on an Optional Protocol.

While the US, Poland and Australia have opposed the Protocol, Canada calls itself a "skeptic state", not openly opposed but raising concerns, including restricting the clauses of the Covenant that would be open to complaints or an "à la carte" approach which would leave it up to states which complaints they accept.

A number of Canadian NGOs have pressed Canada to move forward on the Protocol, and to make it applicable to *all* Covenant rights. Until it does, no Canadian individual or group will have the right to seek redress internationally under the Covenant.

Prepared by John Foster, The North-South Institute

that it hardly plays any role at all, except for those diseases where there is a large market in the developed world (for example, diabetes or heart disease) […] Therefore, we believe that presence or absence of IP protection in developing countries is of at best secondary importance in generating incentives for research directed to diseases prevalent in developing countries."[35] When most patients are poor and do not have the capacity to buy drugs, there is no market, even if millions suffer from a disease.

What role can Canada play on the international scene to ensure that patents do not impede access to drugs? First, Canada should ensure that developing countries are in a position to use the flexibilities embedded in the 1995 TRIPs agreement. One example of these is the right of governments to issue compulsory licences. These are licences to a third-party to produce or import a drug that is still under patent, without the consent of the patent-holder. Such measures are not restricted to cases of national emergencies, but can also be used when deemed necessary by the public authorities. The legal right of countries to resort to the flexibilities of TRIPs, such as the issuance of compulsory licences, was reaffirmed by the members of the WTO in 2001 in the Declaration on TRIPs and Public Health adopted at the meetings of trade ministers in Doha, Qatar.

However, the flexibilities included in TRIPs did not meet the needs of the poorest countries because these countries lacked the domestic manufacturing capacity to produce drugs. There is no point in issuing a compulsory licence if there is no organization able to produce the drugs under patent. Moreover, TRIPs included provisions which restricted the capacity of these countries to import generic drugs. After very long negotiations, WTO members agreed in 2003 to remove these restrictions and allow countries to produce generic drugs to be exported to those countries without manufacturing capacity. Canada was the first country to implement this decision and adopt legislation in 2004[36] that allows Canadian generic companies to produce drugs still under patent in Canada for export to developing countries.

Despite the delays and the problems identified with the details of the legislation, we can applaud this initiative as a contribution to improving access to drugs and to achieving the right to health. The mechanisms created by the legislation have yet to be used by any developing country or generic producer, so the impact of this initiative is yet to be measured. To ensure that developing countries are taking advantage of the existing TRIPs flexibilities, including the importation of generic drugs from Canada or other countries, we should also ensure that ongoing and future capacity-building activities on intellectual property supported by CIDA clearly explain how to resort to these safeguards. This should also apply to capacity-building activities provided by regional and multilateral organizations such as the WTO or the World Intellectual Property Organization (WIPO). Knowledge about TRIPs provisions may not be sufficient in some

cases. Indeed, the capacity to resort to these flexibilities can be constrained by political pressures by foreign governments or large pharmaceutical companies, as was seen in the case of South Africa.[37] In these cases, Canada has to be willing to move away from the passive stance adopted up to now.

The second element of a Canadian strategy to limit the impact of patents on access to drugs is to resist the wave of bilateral treaties with TRIPs-plus protection — that is, patent protection even stronger than in the WTO agreement. In recent years, we have seen a number of bilateral trade treaties, often signed between the US and developing countries, such as the US-Central American free trade agreement (CAFTA), which includes TRIPs-plus provisions.[38] If this trend is not curbed, the expansion of the global regime of protection will become an increasingly important obstacle to achieving the right to health in developing countries. The position of the Canadian government on this is that we do not seek higher norms in protection of intellectual property. Therefore, bilateral treaties between Canada and developing countries do not include TRIPs-plus provisions. Nevertheless, Canada could play an international role to limit the expansion of the global regime of patent protection. One option is to engage in a dialogue with our trade partners, and especially US officials and business representatives, to discuss the problems linked to higher protection of drug patents in developing countries. Another option is to support the work of organizations and actors who monitor and assess trade negotiations. For example, when discussing the US-Peru bilateral trade negotiations after his mission to Peru, the UN Special Rapporteur on the Right to Health recommended that "the United States should not apply pressure on Peru to enter into commitments that either are inconsistent with Peru's constitutional and international human rights obligations or by their nature are 'WTO-plus.'"[39] Such monitoring may help counterbalance the pressures from patent-holders on the governments of industrial countries to strengthen patent protection. Finally, Canadian support for capacity building of trade and health officials involved in negotiations of "TRIPs-plus" provisions can enable them to better assess the impact of these provisions and offer alternatives at the negotiating tables.

Promoting the right to health

Canadians across the country have already embarked in many activities to promote the right to health globally. Some are directly involved in the delivery of health care in developing countries through organizations such as Médecins Sans Frontières or the Red Cross. Academics in Canadian universities are involved in health research relevant to the needs of the poor, or in training and exchange programs to build capacity in health systems in the South. Canadian aid workers are involved in the improvement of the underlying determinants of health, such as access to

clean water. Canadian civil society organizations are advocating here and abroad for more respect for human rights, including the right to health.

Our national government is also engaged in global health through its financial support for health programs and its actions on the international stage. This essay has identified many steps that we should take to become leaders on the global right to health. Whether it is through supporting and implementing an innovative development financing mechanism, better management of our health human resources at home, or a more active role at the UN and in trade forums, our guiding principles remain the same. What can we do to ensure that the citizens of the poorest countries gain better access to health care services, to essential drugs, and to the living conditions that lead to good health? The HIV/AIDS pandemic is the most powerful reminder that health can no longer be considered at the margins of our foreign policy. The right to health, which is implicitly recognized in our domestic policy on the health care system through the principles of universality and accessibility, should guide our actions as we re-position global health as a key element of our foreign policy.

CHANTAL BLOUIN joined The North-South Institute in August 2000. Her research focuses on the impact of multilateral and regional trade agreements on developing countries, and her recent research has examined the impact of trade on governmental or public capacity in the health sector. She has concentrated on the following areas: trade in health services in developing countries for the World Health Organization (WHO); Canadian foreign policy and global health for the Romanow Commission on the Future of Health Care in Canada (2002); the impact of trade agreements on cross-border labour mobility; and the gendered impact of the agreement clauses, including a case study on the mobility of nurses in North-America. Prior to joining The North-South Institute, Chantal was the MCI-Worldcom Fellow with the American Political Science Association's Congressional Fellowship Program. She was also a Norman Robertson Fellow at the Department of Foreign Affairs and International Trade in Canada. She holds a PhD in Political Science from the University of Toronto.

References

Blouin, Chantal, John Foster and Ron Labonte. "Canadian Foreign Policy and Health: Toward Policy Coherence," in Sanger, Matt and Scott Sinclair (eds), *Putting Health First: Canadian Health Care Reform in a Globalizing World.* Ottawa: Canadian Centre for Policy Alternatives, 2004.

Commission on Intellectual Property Rights. *Integrating intellectual property rights and development policy.* Report of the Commission on Intellectual Property Rights. (London: 2002) www.iprcommission.org.

Commission on Macroeconomics and Health [CMH]. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva: WHO, 2001.

WHA. Resolution WHA57.19, *International migration of health personnel: a challenge for health systems in developing countries.* 2004.

Endnotes

1 The author would like to thank Roy Culpeper, John Foster, and Sunday Khan for their suggestions on the earlier version of this chapter.

2 Hunt, Paul. *The Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health*: Mission to the WTO, Commission on Human Rights, 2004, p. 8.

3 United Nations Committee on Economic, Social and Cultural Rights, *The Right of the of Highest Attainable Standard of Health, General Comment 14*, December 4, 2000.

4 Hunt, Paul. *The Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health: Annual report.* Commission on Human Rights, March 2006.

5 For more information on the Commission, see http://www.who.int/social_determinants/en/

6 Hogerzeil. Hans V, Melanie Samson and Jaume Vidal Casanova. *Ruling for access: Leading court cases in developing countries on access to essential medicines as part of the fulfillment of the right to health.* Geneva: World Health Organization Department of Essential Drugs and Medicines Policy, 2004.

7 CESCR has just completed the fourth and fifth periodic reviews of Canada's reports on the implementation of the Covenant. Information on the CESCR, including detailed documents on its review of Canada, can be found at: www.ohchr.org/english/bodies/cescr/index.htm. Information on the Inter-American Commission can be found at www.cidh.oas.org/ While Canada has ratified the relevant international Covenant, it has not yet ratified the relevant regional American Convention and Protocol of San Salvador on Economic, Social and Cultural Rights.

8 WHO. "Investing in Health," A Summary of the Findings of the Commission on Macroeconomics and Health, 2002.

9 http://www.hcsc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf, p. 240.

10 http://www.acdi-cida.gc.ca/INET/IMAGES.NSF/vLUImages/IPS_PDF_EN/$file/IPS-EN.pdf, p. 1.

11 WHO. "Investing in Health," A Summary of the Findings of the Commission on Macroeconomics and Health, 2002.

12 Price-Smith, A. The health of nations: Infectious diseases, environmental change and their effect on national security and development, Cambridge, MA, The MIT Press, 2002, p.19.

13 http://www.theglobalfund.org/en/funds_raised/pledges/

14 Note that these figures do not include the health programming funding allocated by multilateral agencies such as the World Bank, the UN Development Program, and regional development banks to which Canada provides financial support.

15 http://www.acdi-cida.gc.ca/whatwedo.htm

16 Canadian Institutes of Health Research, http://www.cihr-irsc.gc.ca/e/7365.html

17 ActionAID International et al. *Blocking Progress: How the Fight against HIV/AIDS is being Undermined by the World Bank and the IMF*, September 2004. This report looks more generally at how the anti-inflation policies of the IMF and the Bank affect the policy choices of developing countries. We should note that another issue under scrutiny is the conditionality of the IFIs that has frozen employment and wages in the public sector, including the health sector. See also High-level Forum on the Health MDGs, *Harmonization and MDGs: A Perspective from Tanzania and Uganda*, December 2003. http://www.hlfhealthmdgs.org/ and High-level Forum on the Health MDGs, *Fiscal Space and Sustainability from the Perspective of the Health Sector*, Paris: November 2005. This forum and others note that such concerns regarding the scaling up of aid may not be relevant for the health sector. Indeed, most developing countries do not produce the drugs or medical equipment that they need. If aid is used to directly finance such purchases, it should not have any impact on the exchange rate or the inflation rate. It therefore depends on the share of increased aid that will involve foreign exchange transfers.

18 IMF, *A Response to ActionAid International and Other Organisations*, September 30, 2004. http://www.imf.org/external/np/vc/2004/093004.htm

[19] Ooms, Gorik and Ted Schrecker, "Expenditure ceilings, multilateral financial institutions and the health of poor populations," The Lancet, Volume 365, May 21, 2005, pp.1821-1823. Sarbib, Jean-Louis and Peter Heller, "Fiscal Space: response from the World and IMF," The Lancet, Volume 365, June 18, 2005, p.2085.

[20] DFID, Macroeconomic Issues for Scaling-Up Aid Flows, Macroeconomics, Note No. 2, October 2004.

[21] WHO. *Working Together for Health.* Annual World Health Report. Geneva: 2006. http://www.who.int/whr/2006/en/index.html

[22] USAID. *The Health Sector Human Resource Crisis in Africa: An Issues Paper*, February 2003, p.16.

[23] Dawson, Laura et al. *A Managed Temporary Movement Programme for Nurses: Preliminary Assessment of Policy Options for the Managed Temporary Movement of Caribbean Nurses to Canada, the United Kingdom and the United States.* (London: Commonwealth Secretariat, May 2005).

[24] Chanda, Rupa. "Trade Policy and Health Human Resources Planning", in Blouin, Chantal, Nick Drager and Jody Heymann (eds), *Trade and Health Working Together for Human Development* (tentative title), forthcoming.

[25] Chanda, forthcoming.

[26] WHO report, 2003.

[27] UK Department of Health, 2001.

[28] Dawson, 2005.

[29] Lanoszka, Anna. "The global politics of intellectual property rights and pharmaceutical drug policies in developing countries." International Political Science Review 24 (2): 181-197, 2003.

[30] http://www.accessmed-msf.org/campaign/faq.shtm

[31] For an initial examination of the issues around the extent of the jurisdiction and effect of findings of such bodies see Law Commission of Canada. *Crossing Borders: Law in a Globalized World.* Discussion paper. Ottawa, March, 2006. Available at http://www.lcc.gc.ca

[32] Compilation of Summaries of Canadian NGO Submissions to the UN Committee on Economic, Social and Cultural Rights in Connection with the Consideration of the Fourth and Fifth Periodic Reports of Canada. March 31, 2006.

[33] United Nations. Economic and Social Council. Committee on Economic, Social and Cultural Rights. Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights. Canada. E/C.12/CAN/CO/4, E/C.12/CAN/CO/5. 19 May 2006. Can be found at www.ohchr.org/english/bodies/cescr/docs/E.C.12.CAN.CO5.pdf

[34] Commission on IPR, 2002: 33.

[35] Commission on Intellectual Property Rights, *Integrating intellectual property rights and development policy, Report on the CIPR, London 2003*

[36] Bill C-9/Jean Chrétien's Pledge to Africa Act.

[37] Blouin, Chantal and Ann Weston, *Canadian Development Report.* Ottawa: The North-South Institute, 2003.

[38] On US-CAFTA, see Roffe, Pedro, Johanna von Braun and David Vivas-Eugui. "Seeking policy coherence in trade and health in the new generation of regional and bilateral trade agreements: Lessons from the US-CAFTA," in Blouin, Chantal, Nick Drager and Jody Heyman, *Trade and Health Working Together for Human Development* (tentative title), forthcoming.

[39] Hunt, 2005, p.15.

Statistics 2007

Luigi Scarpa de Masellis

Table of Contents

Progress Toward the Millennium Development Goals

Table A Sub-Saharan Africa 106

Table B Latin America and the Caribbean 107

Canada's Relations with Developing Countries

Table 1 Canada and other High Human Development Economies (2003) 109

Table 2 The Developing Countries: Selected Social and Economic Indicators (2003) 113

Table 3 Canadian Official Development Assistance: Basic Data (2003-04) 117

Table 4 Canadian Bilateral Official Development Assistance by Channel and by Country (2003-04) 121

Table 5 Canadian Bilateral Official Development Assistance by Sector (2003-04) 127

Table 6 Canadian Technical Assistance to Developing Countries (1998-2003) 129

Table 7 Canadian Multilateral Official Development Assistance by Agency and by Country (2003-04) 133

Table 8 Canadian Balance of Merchandise Trade with Developing Countries (2004) 137

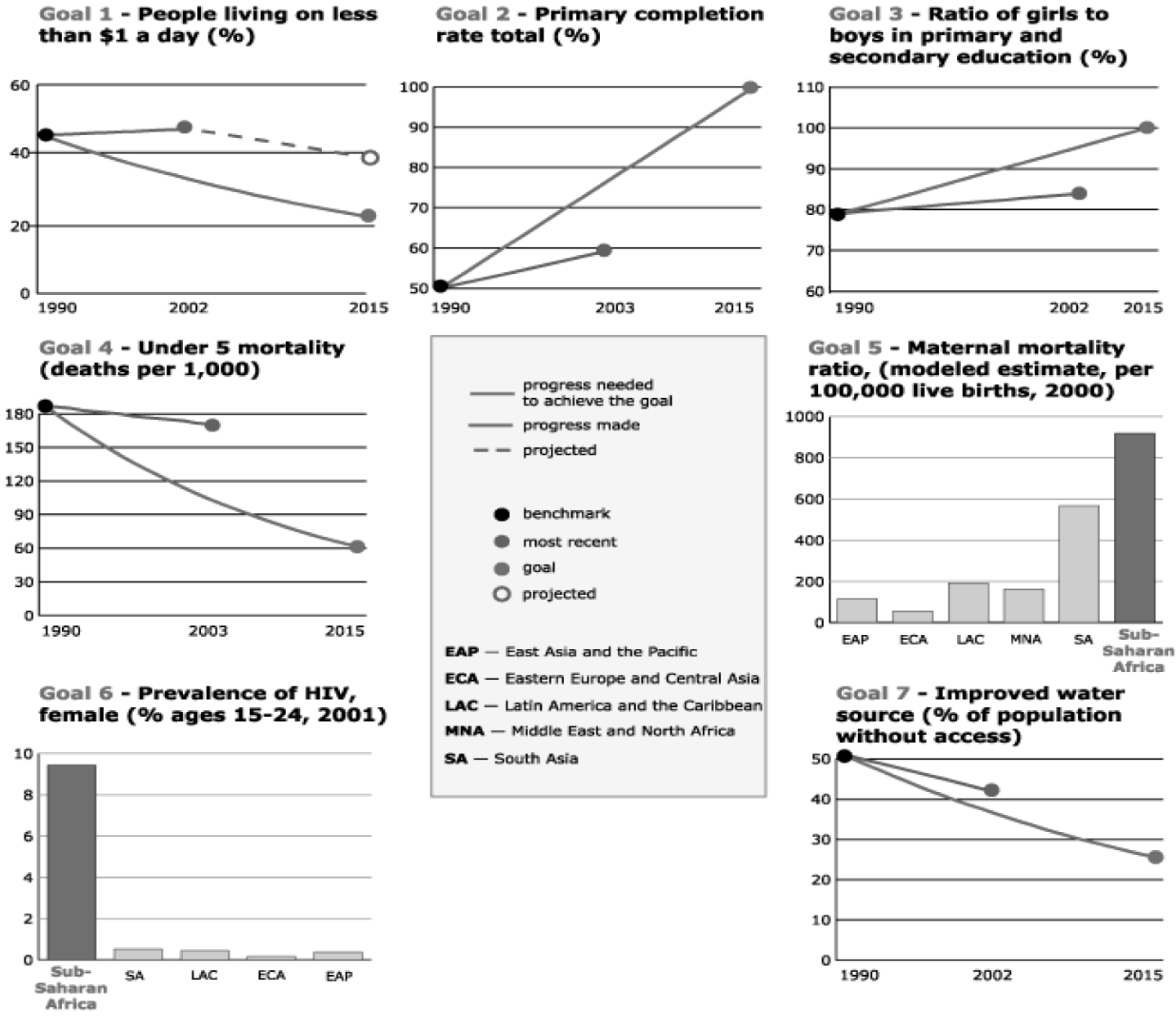
Table 9 Finance and Investment Flows between Canada and Developing Countries (2004) 141

Table 10 Immigration to Canada from Selected Countries (1995-2004) 145

Technical Notes 147

Progress Toward the Millennium Development Goals

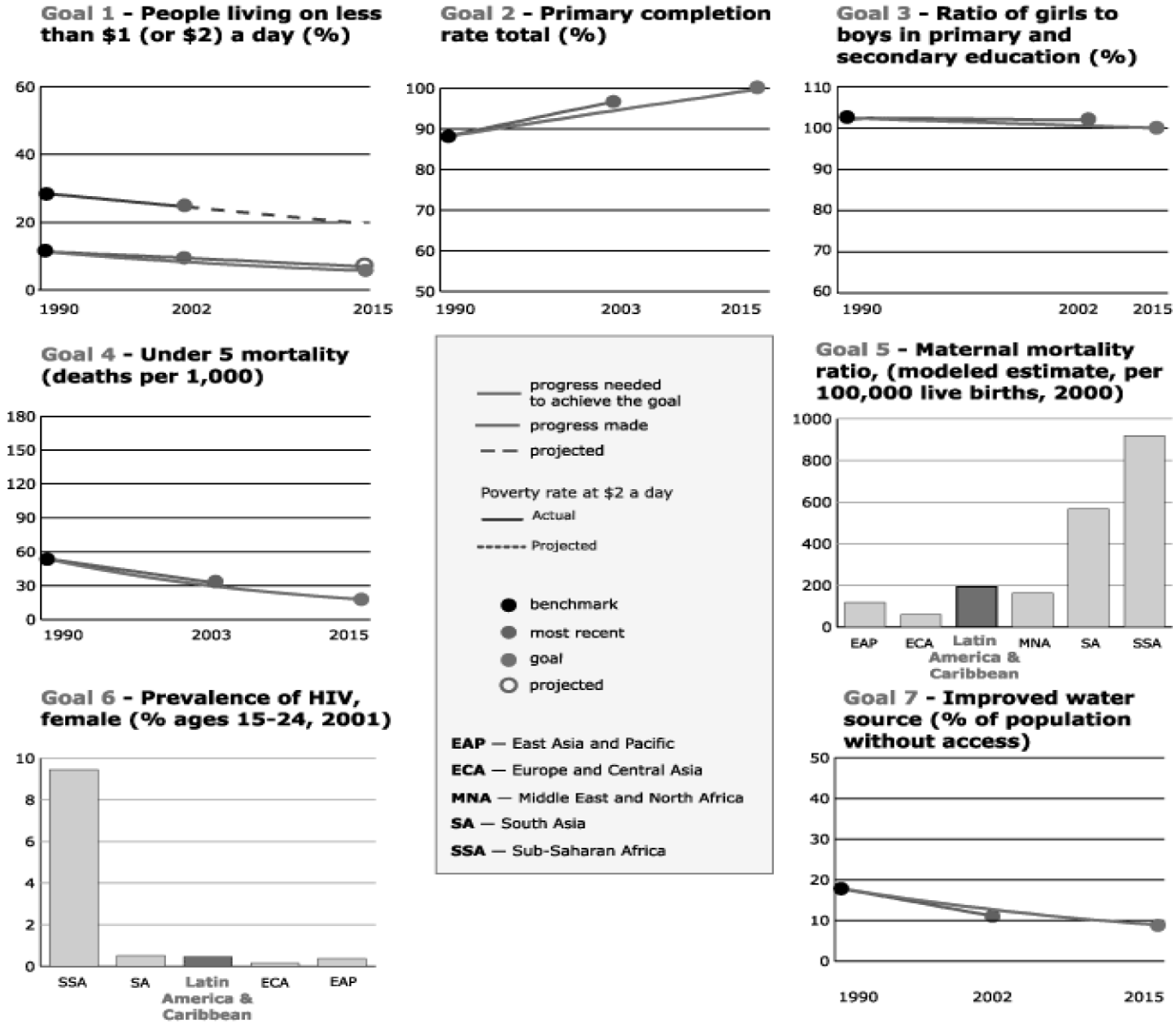
Table A **Sub-Saharan Africa**



Source: World Bank, *World Development Indicators 2005.*

Progress Toward the Millennium Development Goals

Table B **Latin America and the Caribbean**



Source: World Bank, *World Development Indicators 2005.*

Canada's Relations with Developing Countries

Figure 1.1 Net ODA as Percentage of GNI of the DAC Members (2003)

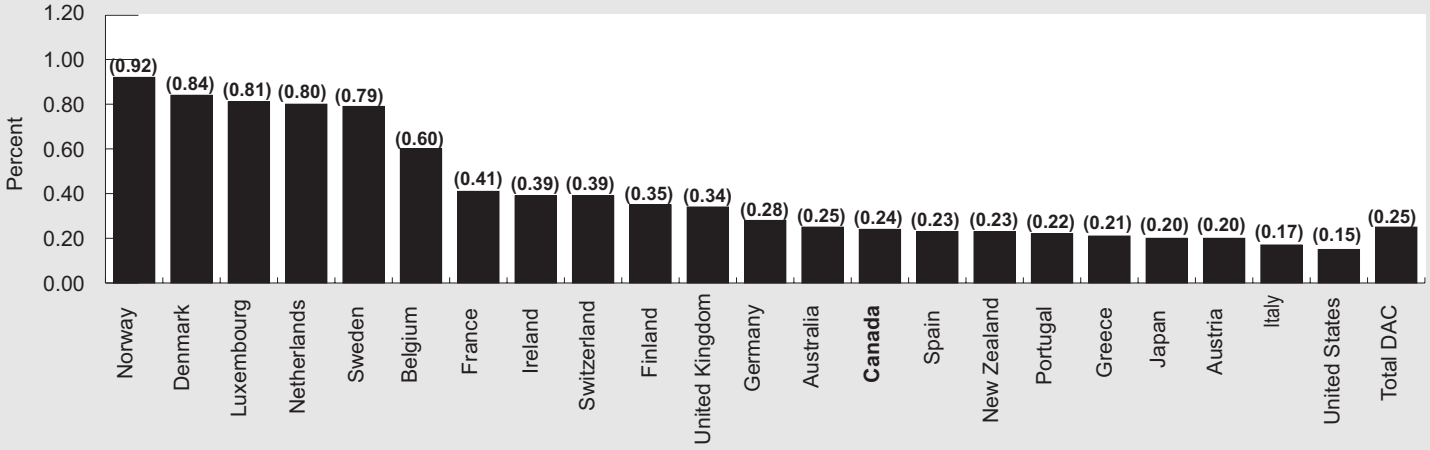


Figure 1.2 Total DAC Countries

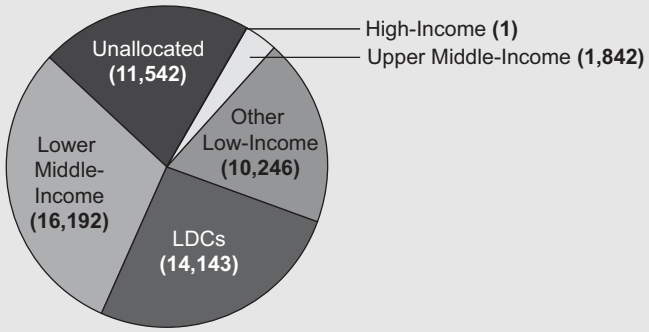
Gross Bilateral ODA, 2002-03 average, unless otherwise shown

Net ODA	2002	2003	Change 2002/03
Current (USD m)	58,292	69,029	18.4%
Constant (2001 USD m)	58,292	61,062	4.8%
ODA/GNI	0.23%	0.25%	
Bilateral share	70%	72%	
Net Official Aid (OA)			
Current (USD m)	6,317	7,106	12.5%

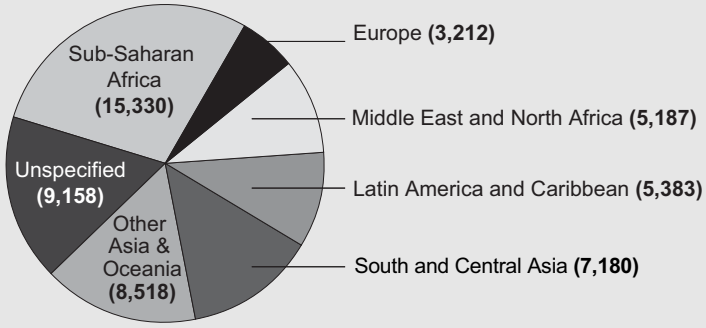
Top Ten Recipients of Gross ODA/OA

		(USD million)
1	Congo, Dem. Rep.	2,760
2	China	2,028
3	India	1,680
4	Indonesia	1,596
5	Pakistan	1,420
6	Serbia and Montenegro	1,387
7	Egypt	1,268
8	Mozambique	1,232
9	Afghanistan	1,110
10	Russia (OA)	1,108

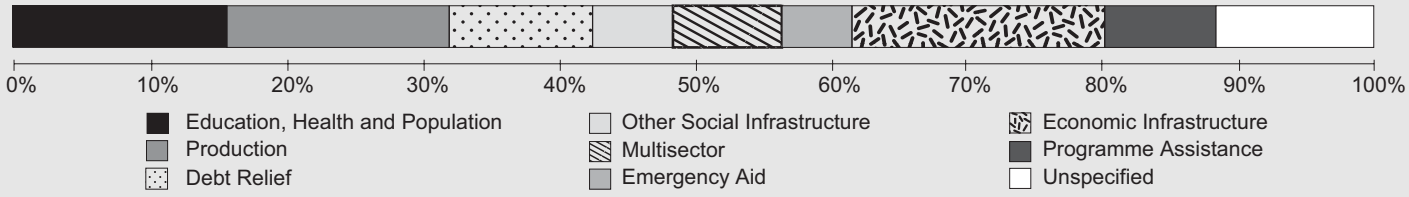
By Income Group
(USD m)



By Region
(USD m)



By Region



Source: OECD, Development Assistance Committee (DAC), *The DAC Journal: Development Co-operation Report 2004*.

Table 1 **Canada and Other High Human Development Economies (2003)**

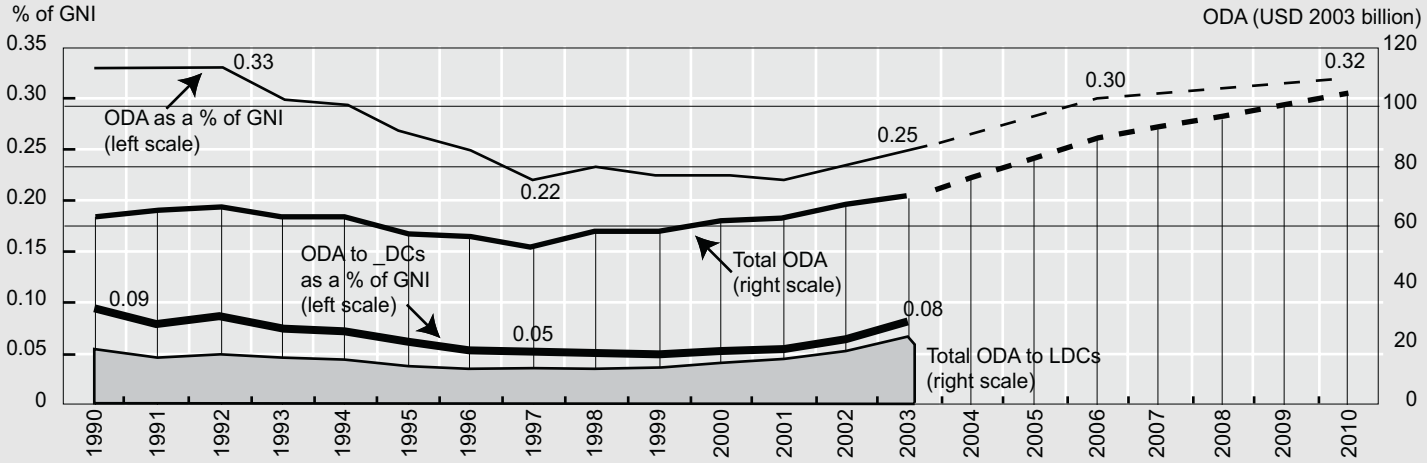
Selected indicators of relations with developing countries

Table 1.1 High Income OECD Countries

Countries	UNDP Human Development Index	UNDP Gender-Related Development Index	GNI Per Capita (PPP$)	Net ODA (US$ millions)	Previous Year (real terms)	ODA/ GNI Ratio	Rank Among DAC Countries	Share as % of Net ODA	Grant Share of Total ODA	Net ODA to Low Income Countries	Share of Total Exports to Developing Countries	Share of Total Imports from Developing Countries	Net Private Financial Flows to Developing Countries (long-term) (US$ millions)
	1	2	3	4	5	6	7	8	9	10	11	12	13
Canada	**0.949**	**0.946**	**30,040**	**2,031**	**-12.7**	**0.24**	**14**	**33.6**	**99.6**	**63.7**	**5.7**	**20.0**	**2,711**
Australia	0.955	0.954	28,780	1,219	0.4	0.25	13	20.0	100.0	77.6	48.3	41.2	1,374
Austria	0.936	0.926	29,740	505	-20.5	0.20	20	54.7	100.0	53.0	25.2	23.9	824
Belgium	0.945	0.941	28,920	1,853	40.7	0.60	6	20.8	99.6	79.1	14.5	16.9	-1,752
Denmark	0.941	0.938	31,050	1,748	-12.8	0.84	2	41.0	98.5	74.7	16.3	19.1	106
Finland	0.941	0.940	27,460	558	0.3	0.35	10	44.8	98.8	67.2	31.3	26.2	-622
France	0.938	0.935	27,640	7,253	8.7	0.41	7	28.1	89.0	65.7	23.3	20.3	-3,123
Germany	0.930	0.926	27,610	6,784	5.3	0.28	12	40.2	91.9	61.6	27.0	31.5	-519
Greece	0.912	0.907	19,900	362	5.7	0.21	18	37.0	100.0	29.6	43.0	34.5	33
Iceland	0.956	0.953	30,570	~	~	~	na	~	~	~	7.8	21.5	~
Ireland	0.946	0.939	30,910	504	3.8	0.39	8	30.2	100.0	79.0	9.5	14.8	1,547
Italy	0.934	0.928	26,830	2,433	-15.3	0.17	21	56.4	87.7	73.6	29.4	31.5	2,044
Japan	0.943	0.937	28,450	8,880	-9.2	0.20	19	28.7	57.1	67.4	55.3	63.7	-731
Korea, Rep.	0.901	0.896	18,000	~	~	~	na	~	~	~	56.2	49.0	~
Luxembourg	0.949	0.944	55,500	194	8.4	0.81	3	22.7	100.0	62.7	7.9	19.0	0
Netherlands	0.943	0.939	28,560	3,981	-3.2	0.80	4	25.9	100.0	72.9	13.6	30.4	7,766
New Zealand	0.933	0.929	21,350	165	6.9	0.23	16	21.8	100.0	59.7	34.1	31.7	21
Norway	0.963	0.960	37,910	2,042	4.6	0.92	1	28.4	98.2	68.1	9.6	20.7	1,264
Portugal	0.904	0.900	17,710	320	-19.4	0.22	17	42.9	99.8	82.2	11.2	16.6	823
Spain	0.928	0.922	22,150	1,961	-7.8	0.23	15	41.3	78.0	38.0	20.1	25.6	4,633
Sweden	0.949	0.947	26,710	2,400	-2.8	0.79	5	25.9	98.7	72.6	20.3	17.0	-1,153
Switzerland	0.947	0.946	32,220	1,299	19.7	0.39	9	27.3	97.6	68.0	23.0	12.1	2,104
United Kingdom	0.939	0.937	27,690	6,282	14.0	0.34	11	38.5	92.8	69.6	20.8	25.3	-1,016
United States	0.944	0.942	37,750	16,254	20.4	0.15	22	10.2	99.7	53.4	45.0	52.0	14,147
Average or Total	**0.938**	**0.935**	**30,215**	**69,029**	**4.8**	**0.25**		**27.8**	**90.0**	**63.9**	**24.9**	**27.7**	**30,481**

Table 1 *(continued)*

Figure 1.3
DAC Members' ODA: 1990-2003 and Simulations to 2006 and 2010



Note: LDCs represent the 50 countries classified by the UN as Least Developed Countries

Source: OECD, Development Assistance Committee (DAC), *The DAC Journal: Development Co-Operation Report 2004*.

Table 1.2 Other High Income Countries

Countries	UNDP Human Development Index 1	UNDP Gender-Related Development Index 2	GNI Per Capita (PPP$) 3	Share of Total Exports to Developing Countries 4	Share of Total Imports from Developing Countries 5
Antigua and Barbuda	0.797	~	9,730	~	~
Bahamas	0.832	~	~	26.3	43.6
Bahrain	0.846	0.837	~	21.1	52.2
Barbados	0.878	0.876	15,060	59.6	35.3
Brunei	0.866	~	~	40.2	62.9
Cyprus	0.891	0.884	19,600	30.4	28.0
Hong Kong, China	0.916	0.912	28,680	59.4	71.7
Israel	0.915	0.911	19,440	24.1	22.4
Kuwait	0.844	0.843	19,480	56.4	34.9
Malta	0.867	0.858	17,780	45.5	30.3
Qatar	0.849	~	~	42.9	38.4
Singapore	0.907	~	24,180	60.9	57.2
Slovenia	0.904	0.901	19,100	35.6	26.5
United Arab Emirates	0.849	~	~	46.8	46.9
Average or Total	**0.892**	**0.897**	**18,796**	**42.2**	**42.3**

Sources: UNDP, *Human Development Report 2005*; World Bank, *World Development Indicators 2005*; OECD, Development Assistance Committee (DAC), *The DAC Journal: Development Co-operation Report 2004*; IMF, *Direction of Trade Statistics Yearbook 2004*.

Figure 2.1

Human Development Index (2003)

Figure 2.2

GNI Per Capita in 2003 (PPP$)

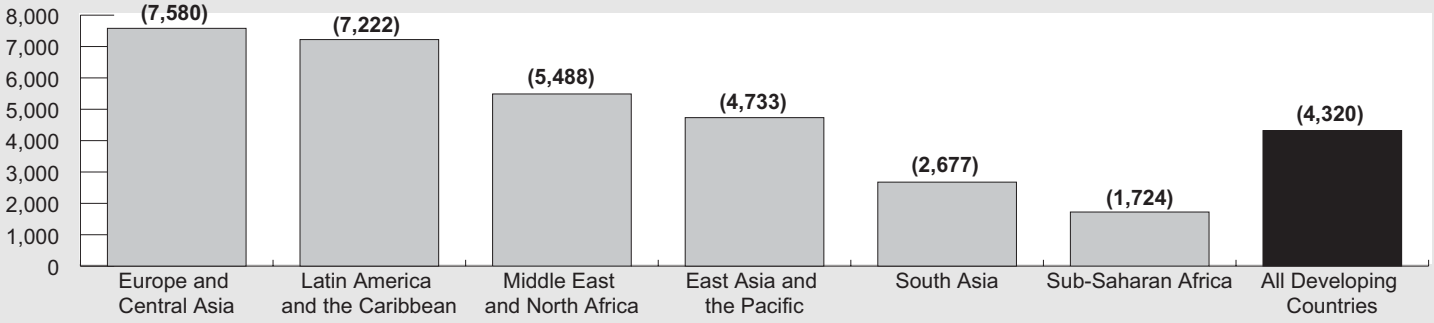


Figure 2.3

Total Debt Service/GNI and Aid/GNI (2003)

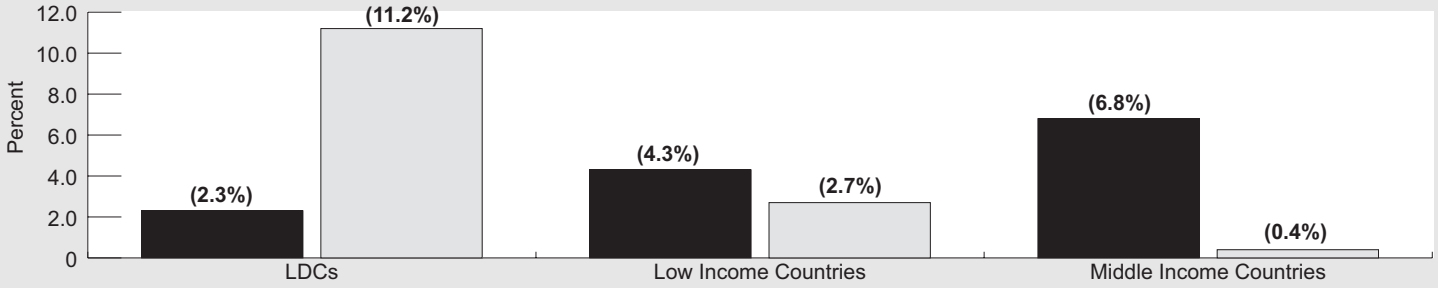


Table 2 **The Developing Countries: Selected Social and Economic Indicators (2003)**

Regions and Countries	UNDP Human Development Index	UNDP Gender-Related Development Index	GNI Per Capita (PPP$)	GDP (US$ millions)	GDP/ Capita Growth Average Over Previous Year (%)	Population (millions)	Adult Literacy Rate (%)	Under-5 Years Mortality Rate (per 1,000 live births)	External Debt/ GNI (%)	Total Debt Service/ GNI (%)	Aid/GNI (%)
	1	2	3	4	5	6	7	8	9	10	11
SUB-SAHARAN AFRICA											
Angola	0.445	0.438	1,910	13,189	1.4	13.5	66.8	260	104.0	12.5	4.6
Benin	0.431	0.419	1,110	3,476	2.2	6.7	33.6	154	65.0	1.7	8.5
Botswana	0.565	0.559	8,370	7,530	4.8	1.7	78.9	112	9.0	0.7	0.4
Burkina Faso	0.317	0.311	1,170	4,182	4.1	12.1	12.8	207	54.0	1.2	10.8
Burundi	0.378	0.373	630	595	-3.1	7.2	58.9	190	210.0	5.1	39.0
Cameroon	0.497	0.487	1,990	12,491	2.6	16.1	67.9	166	96.0	3.8	7.5
Cape Verde	0.721	0.714	5,130	797	2.4	0.5	75.7	35	74.0	2.8	18.3
Central African Republic	0.355	~	1,080	1,198	-8.8	3.9	48.6	180	125.0	0.1	4.2
Chad	0.341	0.322	1,080	2,608	8.2	8.6	25.5	200	75.0	2.0	10.6
Comoros	0.547	0.541	1,720	323	0.1	0.6	56.2	73	109.0	0.8	7.6
Congo, Dem. Rep.	0.385	0.373	660	5,671	3	53.2	65.3	205	222.0	2.7	99.9
Congo, Rep.	0.512	0.507	730	3,564	-0.1	3.8	82.8	108	242.0	2.3	2.6
Côte d'Ivoire	0.420	0.403	1,400	13,734	-5.6	16.8	48.1	192	107.0	4.4	1.9
Equatorial Guinea	0.655	0.641	~	2,915	11.9	0.5	84.2	146	~	~	~
Eritrea	0.444	0.431	1,020	751	0.8	4.4	56.7	85	76.0	1.3	34.2
Ethiopia	0.367	0.355	710	6,652	-5.6	68.6	41.5	169	112.0	1.4	22.8
Gabon	0.635	~	5,500	6,057	0.6	1.3	71.0	91	87.0	7.2	-0.2
Gambia	0.470	0.464	1,740	395	4.3	1.4	37.8	123	170.0	5.4	16.2
Ghana	0.520	0.517	2,190	7,624	3.3	20.7	54.1	95	128.0	6.5	12.2
Guinea	0.466	~	2,080	3,630	-0.9	7.9	41.0	160	106.0	3.6	6.6
Guinea-Bissau	0.348	0.326	680	239	-2.3	1.5	39.6	204	369.0	6.7	63.6
Kenya	0.474	0.472	1,030	14,376	0.0	31.9	73.6	123	54.0	4.0	3.4
Lesotho	0.497	0.487	3,100	1,139	2.4	1.8	81.4	84	66.0	4.8	5.7
Liberia	~	~	~	442	-31.1	3.4	55.9	235	603.0	0.1	28.3
Madagascar	0.499	0.483	800	5,474	6.8	16.9	70.6	126	105.0	1.3	10.0
Malawi	0.404	0.396	590	1,714	2.3	11.0	64.1	178	181.0	2.1	29.8
Mali	0.333	0.323	960	4,326	3.5	11.7	19.0	220	97.0	1.8	12.7
Mauritania	0.477	0.471	1,870	1,093	2.6	2.8	51.2	183	218.0	4.7	20.9
Mauritius	0.791	0.781	11,280	5,224	2.2	1.2	84.3	18	54.0	4.5	-0.3
Mozambique	0.379	0.365	1,060	4,321	5.1	18.8	46.5	158	139.0	2.1	25.1
Namibia	0.627	0.621	6,660	4,271	2.2	2.0	85.0	65	~	~	3.2
Niger	0.281	0.271	830	2,731	2.3	11.8	14.4	262	93.0	1.2	16.7
Nigeria	0.453	0.439	900	58,390	8.0	136.5	66.8	198	78.0	3.3	0.6
Rwanda	0.450	0.447	1,290	1,637	0.3	8.4	64.0	203	91.0	1.3	20.0
São Tomé and Principe	0.604	~	~	59	2.4	0.2	83.1	118	723.0	13.1	75.0
Senegal	0.458	0.449	1,620	6,496	4.0	10.2	39.3	137	84.0	3.8	7.0
Seychelles	0.821	~	~	720	-6.4	0.1	91.9	15	87.0	11.7	1.4
Sierra Leone	0.298	0.279	530	793	4.6	5.3	29.6	284	216.0	3.3	39.0
Somalia	~	~	~	~	~	9.6	~	225	~	~	~
South Africa	0.658	0.652	10,130	159,886	0.8	45.8	82.4	66	23.0	2.8	0.4
Sudan	0.512	0.495	1,760	17,793	3.6	33.5	59.0	93	123.0	0.2	3.8
Swaziland	0.498	0.485	4,850	1,845	0.6	1.1	79.2	153	27.0	1.5	1.4
Tanzania	0.418	0.414	620	10,297	5.0	35.9	69.4	165	77.0	0.9	16.3
Togo	0.512	0.491	1,640	1,759	0.5	4.9	53.0	140	116.0	1.0	2.6
Uganda	0.508	0.502	1,430	6,297	1.9	25.3	68.9	140	78.0	1.4	15.6
Zambia	0.394	0.383	850	4,335	3.5	10.4	67.9	182	172.0	9.3	13.4
Zimbabwe	0.505	0.493	~	~	~	13.1	90.0	126	50.0	~	~
Total Sub-Saharan Africa	**0.449**	**0.438**	**1,724**	**413,039**	**2.4**	**704.5**	**59.7**	**165**	**65.8**	**3.2**	**6.0**

Table 2 *(continued)*

Regions and Countries	UNDP Human Development Index	UNDP Gender-Related Development Index	GNI Per Capita (PPP$)	GDP (US$ millions)	GDP/ Capita Growth Average Over Previous Year (%)	Population (millions)	Adult Literacy Rate (%)	Under-5 Years Mortality Rate (per 1,000 live births)	External Debt/ GNI (%)	Total Debt Service/ GNI (%)	Aid/GNI (%)
	1	2	3	4	5	6	7	8	9	10	11
MIDDLE EAST and NORTH AFRICA											
Algeria	0.722	0.706	5,930	66,530	5.1	31.8	69.8	41	41.0	6.7	0.4
Djibouti	0.495	~	2,140	625	1.8	0.7	65.5	138	65.0	2.4	12.1
Egypt	0.659	~	3,940	82,427	1.4	67.6	55.6	39	35.0	3.4	1.1
Iran	0.736	0.719	7,000	137,144	5.2	66.4	77.0	39	9.0	1.2	0.1
Iraq	~	~	~	~	~	24.7	~	125	~	~	~
Jordan	0.753	0.74	4,290	9,860	0.5	5.3	89.9	28	90.0	11.8	12.6
Lebanon	0.759	0.745	4,840	19,000	1.4	4.5	86.5	31	104.0	17.9	1.3
Libya	0.799	~	~	~	~	5.6	81.7	16	~	~	~
Morocco	0.631	0.616	3,940	43,727	3.6	30.1	50.7	39	51.0	10.0	1.2
Oman	0.781	0.759	~	~	~	2.6	74.4	12	19.0	~	~
Saudi Arabia	0.772	0.749	13,230	214,748	4.1	22.5	79.4	26	~	~	0
Syria	0.721	0.702	3,430	21,499	0.1	17.4	82.9	18	112.0	1.6	0.8
Tunisia	0.753	0.743	6,850	25,037	4.4	9.9	74.3	24	74.0	6.7	1.3
West Bank and Gaza	0.729	~	~	3,454	-5.6	3.4	91.9	24	~	~	25.3
Yemen	0.489	0.448	820	10,831	0.7	19.2	49.0	113	57.0	1.8	2.4
Total Middle East and North Africa	**0.693**	**0.682**	**5,488**	**634,882**	**3.0**	**311.6**	**67.6**	**47**	**40.0**	**4.8**	**0.8**
SOUTH ASIA											
Afghanistan	~	~	~	4,708	~	28.0	~	257	~	~	~
Bangladesh	0.520	0.514	1,870	51,914	3.4	138.1	41.1	69	37.0	1.2	2.5
Bhutan	0.536	~	~	697	3.9	0.9	47.0	85	79.0	1.2	13.2
India	0.602	0.586	2,880	600,637	7.1	1,064.4	61.0	87	22.0	3.4	0.2
Maldives	0.745	~	~	715	6.8	0.3	97.2	72	45.0	3.1	2.6
Nepal	0.526	0.511	1,420	5,851	0.8	24.7	48.6	82	57.0	1.9	8.0
Pakistan	0.527	0.508	2,040	82,324	2.6	148.4	48.7	103	50.0	3.8	1.3
Sri Lanka	0.751	0.747	3,740	18,237	4.7	19.2	90.4	15	62.0	3.3	3.7
Total South Asia	**0.587**	**0.571**	**2,677**	**765,083**	**6.1**	**1,424.0**	**57.9**	**89**	**27.3**	**3.3**	**0.6**
EAST ASIA and the PACIFIC											
Cambodia	0.571	0.567	2,000	4,228	3.3	13.4	73.6	140	82.0	0.6	12.5
China	0.755	0.754	4,980	1,417,000	8.6	1,288.4	90.9	37	15.0	2.6	0.1
Indonesia	0.697	0.691	3,210	208,312	2.7	214.7	87.9	41	80.0	9.3	0.9
Korea, Dem. Rep.	~	~	~	~	~	22.6	~	55	~	~	~
Laos	0.545	0.540	1,730	2,122	2.6	5.7	68.7	91	155.0	2.4	14.3
Malaysia	0.796	0.791	8,970	103,737	3.3	24.8	88.7	7	55.0	9.7	0.1
Mongolia	0.679	0.677	1,820	1,274	4.3	2.5	97.8	68	127.0	23.0	19.7
Myanmar	0.578	~	~	~	~	49.4	89.7	107	~	~	~
Papua New Guinea	0.523	0.518	2,250	3,182	0.4	5.5	57.3	93	87.0	10.8	8.1
Philippines	0.758	0.755	4,640	80,574	2.5	81.5	92.6	36	77.0	11.9	0.9
Thailand	0.778	0.774	7,450	142,953	6.2	62.0	92.6	26	41.0	10.7	-0.7
Timor-Leste	0.513	~	~	341	-7.0	0.9	58.6	124	~	~	47.9
Vietnam	0.704	0.702	2,490	39,164	6.1	81.3	90.3	23	45.0	2.1	4.5
Oceania	0.706	0.742	4,401	3,533	2	2.1	87.4	26	67.0	1.9	11.9
Total East Asia and the Pacific	**0.740**	**0.742**	**4,733**	**2,006,420**	**7.2**	**1,854.7**	**90.3**	**39**	**29.2**	**4.6**	**0.3**
EUROPE and CENTRAL ASIA											
Albania	0.780	0.776	4,710	6,124	5.4	3.2	98.7	21	28.0	0.9	5.4
Armenia	0.759	0.756	3,790	2,805	14.4	3.1	99.4	33	45.0	3.3	8.5
Azerbaijan	0.729	0.725	3,390	7,138	10.4	8.2	98.8	91	28.0	3.7	4.4
Belarus	0.786	0.785	6,050	17,493	7.3	9.9	99.6	17	18.0	1.5	0.2
Bosnia and Herzegovina	0.786	~	6,250	6,973	2.0	4.1	94.6	17	48.0	2.5	7.4
Bulgaria	0.808	0.807	7,540	19,860	4.9	7.8	98.2	15	83.0	6.0	2.1
Croatia	0.841	0.837	10,610	28,797	4.2	4.4	98.1	7	102.0	12.3	0.4
Czech Republic	0.874	0.872	15,600	89,715	3.1	10.2	99.0	4	48.0	6.4	0.3
Estonia	0.853	0.852	12,680	9,082	5.5	1.4	99.8	9	100.0	14.3	1.0
Georgia	0.732	~	2,610	3,988	12.2	5.1	100.0	45	54.0	4.5	5.5
Hungary	0.862	0.860	13,840	82,732	3.4	10.1	99.3	8	73.0	19.3	0.3
Kazakhstan	0.761	0.759	6,280	29,749	9.2	14.9	99.5	73	94.0	18.9	1.0

Table 2 *(continued)*

Europe and Central Asia *(cont'd)*	UNDP Human Development Index	UNDP Gender-Related Development Index	GNI Per Capita (PPP$)	GDP (US$ millions)	GDP/ Capita Growth Average Over Previous Year (%)	Population (millions)	Adult Literacy Rate (%)	Under-5 Years Mortality Rate (per 1,000 live births)	External Debt/ GNI (%)	Total Debt Service/ GNI (%)	Aid/GNI (%)
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Kyrgyzstan	0.702	0.700	1,690	1,909	5.7	5.1	98.7	68	125.0	7.4	10.7
Latvia	0.836	0.834	10,210	11,073	8.2	2.3	99.7	12	93.0	8.5	1.0
Lithuania	0.852	0.851	11,390	18,215	9.4	3.5	99.6	11	58.0	37.4	2.1
Macedonia, FYR	0.797	0.794	6,750	4,666	2.7	2.0	96.1	11	47.0	5.3	5.0
Moldova	0.671	0.668	1,760	1,964	6.7	4.2	96.2	32	100.0	7.0	5.1
Poland	0.858	0.856	11,210	209,563	3.8	38.2	99.7	7	49.0	9.3	0.6
Romania	0.792	0.789	7,140	56,951	5.2	21.7	97.3	20	45.0	6.5	1.1
Russia	0.795	~	8,950	432,855	7.8	143.4	99.4	21	50.0	4.6	0.3
Serbia and Montenegro	~	~	~	20,729	3.7	8.1	96.4	11	94.0	4.5	6.4
Slovakia	0.849	0.847	13,440	32,519	4.0	5.4	99.6	8	72.0	10.8	0.5
Tajikistan	0.652	0.650	1,040	1,553	9.5	6.3	99.5	118	96.0	6.1	9.9
Turkey	0.750	0.742	6,710	240,346	4.2	70.7	88.3	39	77.0	11.8	0.1
Turkmenistan	0.738	~	5,860	6,201	15.2	4.9	98.8	102	~	~	0.4
Ukraine	0.766	0.763	5,430	49,537	10.2	48.4	99.4	20	38.0	7.5	0.7
Uzbekistan	0.694	0.692	1,720	9,949	3.1	25.6	99.3	69	49.0	8.3	2.0
Total Europe and Central Asia	**0.782**	**0.773**	**7,580**	**1,402,486**	**6.6**	**472.2**	**99.2**	**29**	**59.1**	**8.8**	**0.7**
LATIN AMERICA and the CARIBBEAN											
Argentina	0.863	0.854	11,410	129,596	8.0	36.8	97.2	20	104.0	11.5	0
Belize	0.753	0.734	6,320	988	6.0	0.3	76.9	39	125.0	15.0	1.3
Bolivia	0.687	0.679	2,490	7,867	0.5	8.8	86.5	66	74.0	5.6	12.3
Brazil	0.792	0.786	7,510	492,338	-1.4	176.6	88.4	35	50.0	12.0	0.1
Chile	0.854	0.846	9,810	72,415	2.1	15.8	95.7	9	66.0	12.2	0
Colombia	0.785	0.780	6,410	78,651	2.2	44.6	94.2	21	43.0	11.2	1.1
Costa Rica	0.838	0.829	9,140	17,427	4.8	4.0	95.8	10	34.0	5.1	0
Cuba	0.817	~	~	~	~	11.3	96.9	8	~	~	~
Dominica	0.783	~	5,020	259	-0.8	0.1	88.0	14	123.0	7.0	4.6
Dominican Republic	0.749	0.739	6,310	16,541	-1.8	8.7	87.7	35	34.0	6.0	0.5
Ecuador	0.759	~	3,440	27,201	1.1	13.0	91.0	27	74.0	9.4	0.7
El Salvador	0.722	0.715	4,910	14,879	0.0	6.5	79.7	36	50.0	3.6	1.3
Grenada	0.787	~	7,030	439	4.6	0.1	96.0	23	99.0	7.9	3.0
Guatemala	0.663	0.649	4,090	24,730	-0.5	12.3	69.1	47	22.0	1.9	1.0
Guyana	0.720	0.716	3,980	742	-1.1	0.8	96.5	69	215.0	8.3	12.4
Haiti	0.475	~	1,730	2,921	-1.4	8.4	51.9	118	39.0	1.8	6.9
Honduras	0.667	~	2,590	6,978	0.5	7.0	80.0	41	87.0	6.1	5.7
Jamaica	0.738	0.736	3,790	8,147	1.4	2.6	87.6	20	73.0	11.0	0.0
Mexico	0.814	0.804	8,980	626,080	-0.2	102.3	90.3	28	23.0	6.6	0
Nicaragua	0.690	0.683	3,180	4,083	-0.3	5.5	76.7	38	178.0	5.2	21.0
Panama	0.804	0.800	6,420	12,887	2.5	3.0	91.9	24	75.0	7.9	0.3
Paraguay	0.755	0.742	4,690	6,030	0.1	5.6	91.6	29	52.0	5.1	0.8
Peru	0.762	0.745	5,080	60,577	2.2	27.1	87.7	34	54.0	4.4	0.9
St. Kitts and Nevis	0.834	~	10,740	346	0.0	0.0	97.8	22	102.0	14.5	0.0
St. Lucia	0.772	~	5,310	693	0.8	0.2	90.1	18	59.0	5.1	2.3
St. Vincent and the Grenadines	0.755	~	5,870	371	4.0	0.1	88.1	27	67.0	4.0	1.8
Suriname	0.755	~	~	1,154	4.0	0.4	88.0	39	~	~	0.9
Trinidad and Tobago	0.801	0.796	10,390	10,511	12.4	1.3	98.5	20	31.0	2.4	0.0
Uruguay	0.840	0.836	7,980	11,182	1.9	3.4	97.7	14	86.0	8.1	0.2
Venezuela	0.772	0.765	4,750	85,394	-11.0	25.7	93	21	35.0	10.7	0.1
Total Latin America and the Caribbean	**0.786**	**0.784**	**7,222**	**1,721,427**	**0.0**	**532.4**	**89.3**	**31**	**44.5**	**9.0**	**0.3**
Total Developing Countries	**0.666**	**0.627**	**4,320**	**6,943,337**	**5.2**	**5,299.4**	**77.0**	**68**	**41.8**	**6.4**	**0.8**
Of which:											
LDCs	**0.459**	**0.426**	**1,273**	**201,939**	**1.7**	**701.0**	**53.3**	**145**	**85.0**	**2.3**	**11.2**
Low Income Countries	**0.560**	**0.540**	**2,242**	**1,275,799**	**4.8**	**2,538.7**	**62.9**	**105**	**49.6**	**4.3**	**2.7**
Middle Income Countries	**0.762**	**0.700**	**6,180**	**5,667,538**	**5.7**	**2,760.7**	**89.7**	**34**	**40.0**	**6.8**	**0.4**
High Income Countries	**0.938**	**0.935**	**30,215**	**29,340,557**	**1.5**	**944.3**	**98.7**	**6**	**na**	**na**	**na**

Sources: UNDP, *Human Development Report 2005*; World Bank, *World Development Indicators 2005*; World Bank, *Global Development Finance 2005*.

Note: Bold-italicized countries are not ODA eligible (see Technical Notes) but official assistance (OA) to these countries was used in constructing Column 11. Data for External Debt/GNI (%) included in Column 9 represents an average for the years 2001-03.

Figure 3.1

Total Canadian Bilateral Allocated ODA (2003-04)

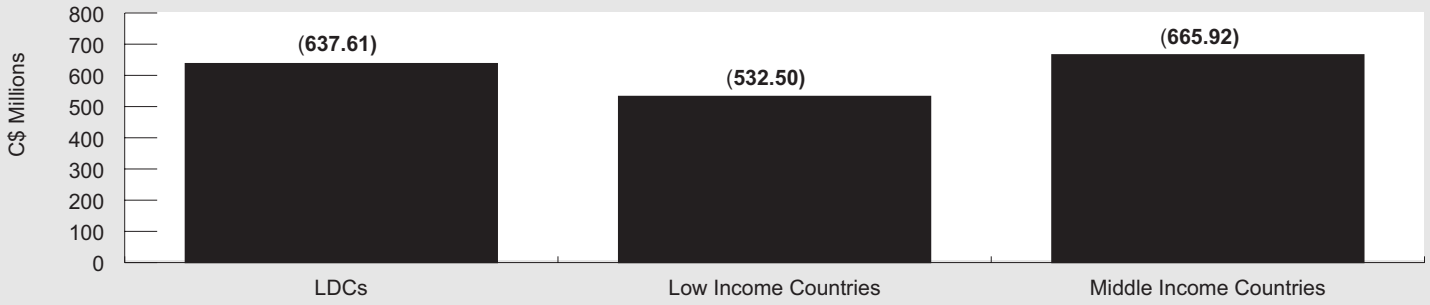


Figure 3.2

Total Canadian Bilateral Allocated ODA (2003-04)

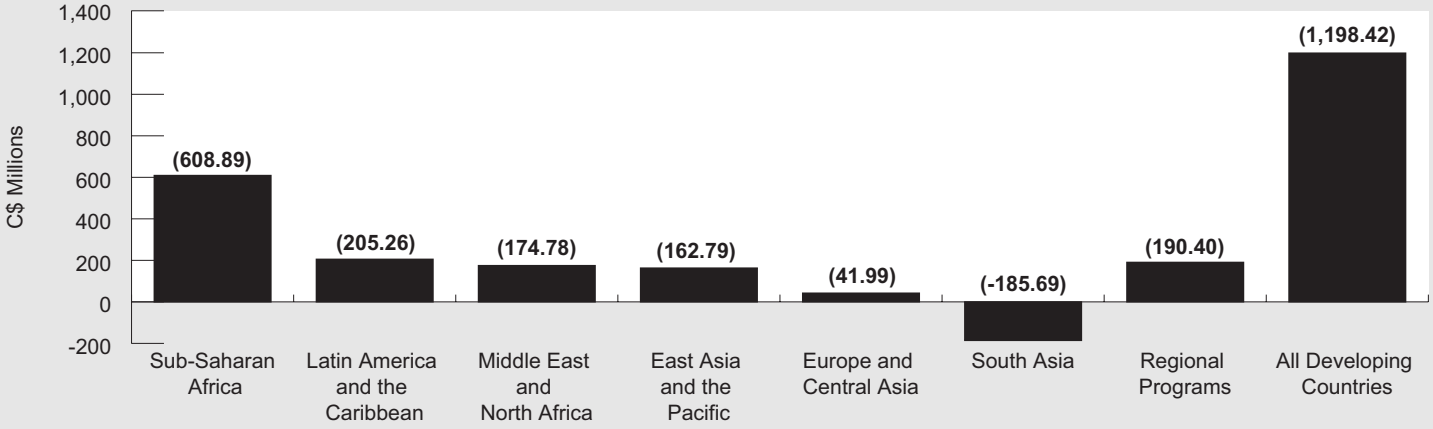


Figure 3.3

Top 10 Recipients of Total Canadian Allocated ODA (2003-04)

	Countries	C$ millions	%
1	Iraq	117.29	6.74
2	Afghanistan	102.35	5.88
3	Ethiopia	87.58	5.04
4	Bangladesh	86.36	4.96
5	Poland	74.11	4.26
6	Tanzania	69.04	3.97
7	Ghana	66.32	3.81
8	Mali	57.04	3.28
9	China	53.60	3.08
10	Cameroon	51.40	2.96
	Top 10 Total	**765.09**	**43.99**
	Total Canadian ODA Allocated	**1,739.38**	

Table 3 **Canadian Official Development Assistance: Basic Data (2003-04)**
(In millions of Canadian dollars)

	Bilateral						
	Total Bilateral	Total Bilateral	Real Percent Change Per Year	Rank of Canada Among DAC Bilateral Donors in Recipient Country	Total Multilateral (all agencies)	Total Canadian Aid (all sources)	Rank of Recipient Country for Total Canadian Aid (including multilateral) (if in top 50)
	2003-04	1993-94 (2003 prices)	1993-2003	2003	2003-04	2003-04	2003-04
Regions and Countries	1	2	3	4	5	6	7
SUB-SAHARAN AFRICA							
Angola	9.14	21.23	-8.08	14	1.91	11.05	49
Benin	7.47	5.31	3.47	10	3.29	10.76	
Botswana	1.46	8.28	-15.93	7	1.41	2.87	
Burkina Faso	19.51	15.91	2.06	8	9.53	29.04	16
Burundi	5.73	8.55	-3.92	6	2.70	8.43	
Cameroon	47.07	20.18	8.84	4	4.33	51.40	10
Cape Verde	0.60	0.44	3.05	12	2.42	3.02	
Central African Republic	1.20	0.36	12.78	5	1.12	2.32	
Chad	1.28	0.76	5.40	8	7.07	8.35	
Comoros	0.26	0.12	8.03	4	1.06	1.32	
Congo, Dem. Rep.	28.53	3.01	25.20	8	8.64	37.17	14
Congo, Rep.	0.66	0.30	8.19	9	1.32	1.98	
Côte d'Ivoire	12.38	7.41	5.27	5	2.91	15.29	40
Equatorial Guinea	0.62	0.12	17.84	4	0.31	0.93	
Eritrea	6.86	3.77	6.17	10	3.95	10.81	
Ethiopia	66.70	25.13	10.26	7	20.88	87.58	3
Gabon	2.41	4.72	-6.50	3	0.65	3.06	
Gambia	1.05	1.03	0.16	6	3.24	4.29	
Ghana	48.48	43.97	0.98	7	17.84	66.32	7
Guinea	10.73	14.28	-2.82	5	5.15	15.88	39
Guinea-Bissau	0.78	0.46	5.51	9	2.29	3.07	
Kenya	21.29	17.97	1.71	8	7.22	28.51	18
Lesotho	0.58	1.80	-10.72	7	2.15	2.73	
Liberia	3.09	5.39	-5.42	8	0.44	3.53	
Madagascar	2.60	1.19	8.14	9	9.48	12.08	48
Malawi	21.31	2.55	23.67	6	7.05	28.36	19
Mali	40.86	34.58	1.68	4	16.18	57.04	8
Mauritania	3.24	1.02	12.24	6	4.39	7.63	
Mauritius	0.44	0.44	-0.10	4	0.83	1.27	
Mozambique	33.81	29.38	1.42	10	14.52	48.33	12
Namibia	0.82	1.26	-4.21	14	0.32	1.14	
Niger	10.72	8.32	2.56	8	10.07	20.79	27
Nigeria	23.25	2.87	23.27	3	4.96	28.21	20
Rwanda	9.72	15.15	-4.34	7	4.60	14.32	43
São Tomé and Principe	0.81	0.16	17.90	7	0.52	1.33	
Senegal	22.37	28.50	-2.39	6	12.46	34.83	15
Seychelles	0.41	0.14	11.02	3	0.99	1.40	
Sierra Leone	5.61	0.41	29.95	14	4.16	9.77	
Somalia	1.35	5.69	-13.40	11	0.87	2.22	
South Africa	17.09	21.32	-2.19	12	0.28	17.37	34
Sudan	19.33	14.95	2.60	9	2.87	22.20	25
Swaziland	0.85	1.25	-3.78	5	0.70	1.55	
Tanzania	36.61	14.47	9.72	9	32.43	69.04	6
Togo	7.41	1.02	21.92	4	0.97	8.38	
Uganda	13.38	7.09	6.56	12	14.73	28.11	21
Zambia	24.35	5.91	15.21	11	14.21	38.56	13
Zimbabwe	14.67	19.35	-2.73	5	1.75	16.42	37
Total Sub-Saharan Africa	**608.89**	**427.53**	**3.60**		**271.17**	**880.06**	
MIDDLE EAST and NORTH AFRICA							
Algeria	3.14	2.10	na	8	0.37	3.51	
Djibouti	0.61	0.30	7.35	5	1.21	1.82	
Egypt	13.54	35.76	-9.25	7	4.12	17.66	33
Iran	1.30	0	na	14	0.71	2.01	
Iraq	115.86	1.20	57.92	5	1.43	117.29	1
Jordan	7.79	8.13	-0.43	7	2.48	10.27	

Table 3 *(continued)*

Middle East and North Africa *(cont'd)*	Bilateral: Total Bilateral 2003-04	Bilateral: Total Bilateral 1993-94 (2003 prices)	Bilateral: Real Percent Change Per Year 1993-2003	Bilateral: Rank of Canada Among DAC Bilateral Donors in Recipient Country 2003	Total Multilateral (all agencies) 2003-04	Total Canadian Aid (all sources) 2003-04	Rank of Recipient Country for Total Canadian Aid (including multilateral) (if in top 50) 2003-04
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Lebanon	2.79	2.64	0.55	8	1.58	4.37	
Libya	0	0	0	na	0	0	
Morocco	8.34	14.15	-5.15	7	0.78	9.12	
Oman	0	0	0	na	0	0	
Saudi Arabia	0	0	0	na	0.99	0.99	
Syria	2.03	1.23	5.18	14	4.09	6.12	
Tunisia	2.33	0.52	16.26	6	0.49	2.82	
West Bank and Gaza	16.11	1.77	24.74	11	0.00	16.11	38
Yemen	0.94	0.52	6.17	9	4.47	5.41	
Total Middle East and North Africa	**174.78**	**68.30**	**9.85**		**22.72**	**197.50**	
SOUTH ASIA							
Afghanistan	99.38	8.56	27.78	6	2.97	102.35	2
Bangladesh	66.31	82.09	-2.11	6	20.05	86.36	4
Bhutan	1.14	0.88	2.66	9	0.63	1.77	
India	-388.72	70.29	na	21	36.63	-352.09	
Maldives	0.33	0.04	24.79	5	0.34	0.67	
Nepal	9.32	10.23	-0.93	9	4.89	14.21	44
Pakistan	17.81	1.86	25.34	4	6.62	24.43	24
Sri Lanka	8.74	7.67	1.31	8	7.76	16.50	36
Total South Asia	**-185.69**	**181.62**	**na**		**79.89**	**-105.80**	
EAST ASIA and the PACIFIC							
Cambodia	11.29	7.34	4.40	8	2.76	14.05	45
China	46.07	85.62	-6.01	6	7.53	53.60	9
Indonesia	24.08	46.18	-6.30	6	4.95	29.03	17
Korea, Dem. Rep.	8.79	0	na	4	0.53	9.32	
Laos	2.69	0.97	10.71	13	2.25	4.94	
Malaysia	0.57	8.47	-23.65	8	0.86	1.43	
Mongolia	1.77	0	na	12	1.14	2.91	
Myanmar	1.68	0.32	17.88	10	0.90	2.58	
Papua New Guinea	0.55	0.11	17.67	6	0.43	0.98	
Philippines	19.09	46.02	-8.42	7	1.19	20.28	28
Thailand	6.17	22.06	-11.96	6	0.81	6.98	
Timor-Leste	7.31	na	na	7	0.21	7.52	
Vietnam	31.31	13.74	8.58	9	19.78	51.09	11
Oceania	1.42	0.47	11.73	na	3.83	5.25	
Total East Asia and the Pacific	**162.79**	**231.31**	**-3.45**		**47.17**	**209.96**	
EUROPE and CENTRAL ASIA							
Albania	2.00	0.04	49.43	15	2.52	4.52	
Armenia	1.00	0.68	3.86	13	3.05	4.05	
Azerbaijan	1.20	0.82	3.92	8	2.83	4.03	
Belarus	0.01	na	na	na	0	0.01	
Bosnia and Herzegovina	7.82	na	na	11	0	7.82	
Bulgaria	2.47	na	na	na	0	2.47	
Croatia	1.42	na	na	8	0	1.42	
Czech Republic	0.87	na	na	na	0	0.87	
Estonia	0.74	na	na	na	0	0.74	
Georgia	2.65	2.40	0.99	10	1.73	4.38	
Hungary	1.03	na	na	na	0	1.03	
Kazakhstan	0.83	0.55	4.15	9	0.08	0.91	
Kyrgyzstan	0.60	0.12	17.45	10	1.27	1.87	
Latvia	0.61	na	na	na	0	0.61	
Lithuania	0.46	na	na	na	0	0.46	
Macedonia, FYR	1.30	na	na	15	0	1.30	
Moldova	0.75	na	na	13	0.75	1.50	
Poland	74.11	na	na	na	0	74.11	5

Table 3 *(continued)*

Europe and Central Asia *(cont'd)*	Bilateral						
	Total Bilateral	Total Bilateral	Real Percent Change Per Year	Rank of Canada Among DAC Bilateral Donors in Recipient Country	Total Multilateral (all agencies)	Total Canadian Aid (all sources)	Rank of Recipient Country for Total Canadian Aid (including multilateral) (if in top 50)
	2003-04	1993-94 (2003 prices)	1993-2003	2003	2003-04	2003-04	2003-04
Regions and Countries	1	2	3	4	5	6	7
Romania	2.61	na	na	na	0	2.61	
Russia	18.86	na	na	na	0	18.86	31
Serbia and Montenegro	14.60	na	na	14	0	14.60	42
Slovakia	1.68	na	na	na	0	1.68	
Tajikistan	7.88	na	na	5	0.60	8.48	
Turkey	-1.14	-2.99	-9.19	18	0.45	-0.69	
Turkmenistan	0.11	na	na	6	0.08	0.19	
Ukraine	21.26	na	na	na	0	21.26	26
Uzbekistan	0.97	na	na	10	0.13	1.10	
Total Europe and Central Asia	**41.99**	**1.62**	**38.46**		**13.49**	**55.48**	
LATIN AMERICA and the CARIBBEAN							
Argentina	3.28	5.32	-4.72	7	0.57	3.85	
Belize	0.89	0.73	1.96	2	0.92	1.81	
Bolivia	19.36	17.62	0.95	11	6.32	25.68	23
Brazil	10.70	9.43	1.27	6	9.23	19.93	30
Chile	3.94	5.10	-2.56	5	0.16	4.10	
Colombia	10.52	8.26	2.44	9	0.50	11.02	50
Costa Rica	3.59	10.88	-10.50	6	0.55	4.14	
Cuba	10.26	0.34	40.75	3	0.05	10.31	
Dominica	0.43	2.44	-15.93	3	2.40	2.83	
Dominican Republic	2.58	1.31	7.02	6	0.51	3.09	
Ecuador	8.02	9.60	-1.78	8	0.58	8.60	
El Salvador	7.41	4.25	5.71	7	0.69	8.10	
Grenada	0.62	0.19	12.43	3	1.35	1.97	
Guatemala	13.34	4.20	12.24	8	0.69	14.03	46
Guyana	10.19	14.82	-3.68	3	4.71	14.90	41
Haiti	26.31	22.89	1.40	3	1.20	27.51	22
Honduras	17.18	11.06	4.50	6	3.06	20.24	29
Jamaica	10.98	20.51	-6.06	1	2.29	13.27	47
Mexico	6.69	7.30	-0.87	5	0.87	7.56	
Nicaragua	11.68	17.13	-3.76	12	5.01	16.69	35
Panama	1.47	0.25	19.28	5	0.33	1.80	
Paraguay	2.22	0.59	14.20	5	0.16	2.38	
Peru	17.14	31.50	-5.91	7	1.45	18.59	32
St. Kitts and Nevis	0.09	0.19	-7.31	1	0.59	0.68	
St. Lucia	0.69	9.88	-23.37	2	1.48	2.17	
St. Vincent and the Grenadines	0.46	1.83	-12.88	3	0.65	1.11	
Suriname	0.48	0.04	29.56	5	0.03	0.51	
Trinidad and Tobago	1.27	1.67	-2.70	3	0.33	1.60	
Uruguay	2.23	2.22	0.04	5	0.15	2.38	
Venezuela	1.24	3.36	-9.50	6	0.31	1.55	
Total Latin America and the Caribbean	**205.26**	**224.93**	**-0.91**		**47.14**	**252.40**	
Regional Programs	**190.40**	**315.15**	**-4.91**		**59.38**	**249.78**	
Total ODA Allocated	**1,198.42**	**1,448.85**	**-1.88**		**540.96**	**1,739.38**	
Of which:							
LDCs	**637.61**	**408.44**	**4.55**		**267.33**	**904.94**	
Low Income Countries	**532.50**	**669.01**	**-2.26**		**386.30**	**918.80**	
Middle Income Countries	**665.92**	**779.83**	**-1.57**		**154.66**	**820.58**	
Countries not Specified	102.58	278.77	-9.51		205.70	308.28	
Unallocable by Country	668.21	700.96	-0.48		1.65	669.86	
Total ODA	**1,969.21**	**2,428.57**	**-2.07**		**748.31**	**2,717.52**	

Notes: Bold-italicized countries are not included in Canadian ODA totals (see Technical Notes).

Sources:
CIDA, *Statistical Report on ODA 2003-2004;* CIDA, *Statistical Report on ODA 1993-1994;* OECD, *Geographical Distribution of Financial Flows to Aid Recipients*, *1999-2003.*

Figure 4.1

Canadian Bilateral Allocated ODA by Channel (2003-04)

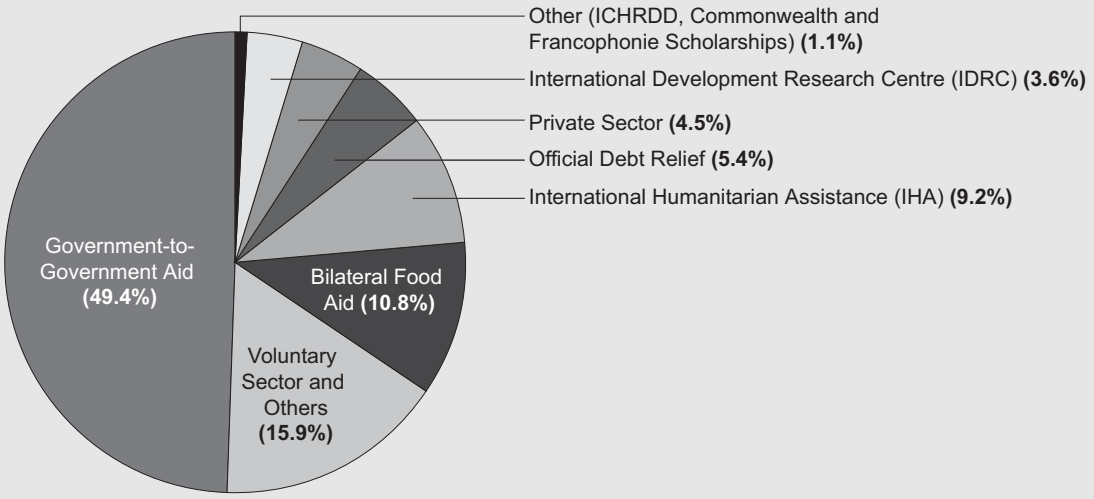


Figure 4.2

Top 3 Recipients of Canadian Bilateral ODA in Each Region (2003-04)

		C$ millions
	Sub-Saharan Africa	
1	Ethiopia	66.70
2	Ghana	48.47
3	Cameroon	47.07
	Middle East and North Africa	
1	Iraq	115.86
2	Egypt	13.55
3	Morocco	8.35
	South Asia	
1	Afghanistan	99.37
2	Bangladesh	66.31
3	Pakistan	17.81
	East Asia and the Pacific	
1	China	46.07
2	Vietnam	31.30
3	Indonesia	24.09
	Europe and Central Asia	
1	Poland	74.11
2	Ukraine	21.26
3	Russia	18.86
	Latin America and the Caribbean	
1	Haiti	26.31
2	Bolivia	19.36
3	Honduras	17.18

Table 4 **Canadian Bilateral Official Development Assistance by Channel and by Country (2003-04)**
(In millions of Canadian dollars)

					Partnership Branch						
	Government-to Government Aid	Rank of Recipient Country (if in top 30)	Bilateral Food Aid	Official Bilateral Debt Relief	Voluntary Sector and Others	Private Sector	International Humanitarian Assistance (IHA)	International Development Research Centre (IDRC)	International Centre for Human Rights and Democratic Development (ICHRDD)	CIDA and Commonwealth Scholarships	Total
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
SUB-SAHARAN AFRICA											
Angola	0.41		3.00	0	0.53	0.11	5.07	0.02	0	0	9.14
Benin	4.33		0	0	2.83	0.21	0	0.09	0	0.01	7.47
Botswana	0.17		0	0	1.16	0.06	0	0	0	0.07	1.46
Burkina Faso	13.54	22	0.88	0	4.41	0.44	0	0.24	0.01	0	19.52
Burundi	2.10		0.02	0	0.88	0.01	2.72	0	0	0	5.73
Cameroon	6.30		0	39.28	1.33	0.03	0	0	0	0.13	47.07
Cape Verde	0.60		0	0	0	0	0	0	0	0	0.60
Central African Republic	0.46		0	0	0.74	0	0	0	0	0	1.20
Chad	0.77		0.11	0	0.05	0.10	0.25	0	0	0	1.28
Comoros	0.24		0	0	0.01	0	0	0	0	0	0.25
Congo, Dem. Rep.	11.31	26	8.76	1.61	1.29	0.86	4.70	0	0	0	28.53
Congo, Rep.	0.37		0	0	0.17	0	0	0.02	0.10	0	0.66
Côte d'Ivoire	3.60		1.38	5.44	0.77	0.39	0.75	0.04	0.02	0.01	12.40
Equatorial Guinea	0.35		0	0	0	0.26	0	0	0	0	0.61
Eritrea	0.79		5.00	0	0.19	0	0.88	0	0	0	6.86
Ethiopia	30.14	8	27.29	0.01	3.51	0.10	5.59	0.04	0	0.02	66.70
Gabon	1.86		0	0	0.10	0.45	0	0	0	0	2.41
Gambia	0.30		0.09	0	0.61	0	0	0	0	0.04	1.04
Ghana	39.49	4	0.48	4.54	3.51	0.15	0	0.07	0	0.23	48.47
Guinea	8.22		0	0	0.85	0.48	1.13	0.04	0	0.01	10.73
Guinea-Bissau	0.55		0	0	0.20	0.03	0	0	0	0	0.78
Kenya	13.00	23	1.27	0	4.73	0.06	0	1.99	0.03	0.21	21.29
Lesotho	0.21		0	0	0.34	0	0	0	0	0.02	0.57
Liberia	0.17		0.75	0	0.18	0	2.00	0	0	0	3.10
Madagascar	0.45		0	1.38	0.56	0	0.20	0	0	0	2.59
Malawi	15.88	18	1.60	0	3.39	0	0.19	0.20	0	0.05	21.31
Mali	33.47	6	1.32	0	4.86	1.07	0	0.14	0	0	40.86
Mauritania	2.42		0	0	0.68	0.13	0	0	0	0.01	3.24
Mauritius	0.31		0	0	0.08	0	0	0	0	0.05	0.44
Mozambique	30.51	7	0.54	0	2.55	0	0	0.21	0	0	33.81
Namibia	0.04		0	0	0.77	0	0	-0.01	0	0.01	0.81
Niger	7.68		0.75	0	2.24	0.03	0	0.01	0.01	0	10.72
Nigeria	21.58	11	0	0	1.00	0.16	0	0.31	0.06	0.14	23.25
Rwanda	8.03		0	0.06	1.48	0	0	0.14	0.01	0.01	9.73
São Tomé and Principe	0.35		0	0	0.02	0.43	0	0	0	0	0.80
Senegal	17.46	15	0.39	0.29	2.92	0.41	0	0.89	0	0.01	22.37
Seychelles	0.35		0	0	0.02	0	0	0	0	0.04	0.41
Sierra Leone	1.48		0	0	2.11	0	1.89	0.02	0.03	0.08	5.61
Somalia	0.31		0	0	0.14	0	0.87	0.02	0	0	1.34
South Africa	10.95	29	0	0	2.67	1.40	0	1.96	0.01	0.08	17.07
Sudan	2.95		7.54	0	0.21	0	8.61	0	0	0	19.31
Swaziland	0.30		0	0	0.60	0	0	0	0	0.05	0.95
Tanzania	29.23	9	0.62	0	4.13	0.01	1.25	1.27	0	0.10	36.61
Togo	1.40		4.37	0	1.54	0.02	0	0.06	0.03	0	7.42
Uganda	4.37		2.21	0	4.14	0.18	1.32	1.00	0	0.16	13.38
Zambia	8.51		1.66	11.67	1.89	0	0.50	0.02	0	0.10	24.35
Zimbabwe	7.70		4.31	0	2.06	0	0.21	0.34	0	0.04	14.66
Total Sub-Saharan Africa	**345.01**		**74.34**	**64.28**	**68.45**	**7.58**	**38.13**	**9.13**	**0.31**	**1.68**	**608.91**

Table 4 *(continued)*

Figure 4.3

Canadian Bilateral ODA Allocated to the Voluntary Sector and Others (2003-04)

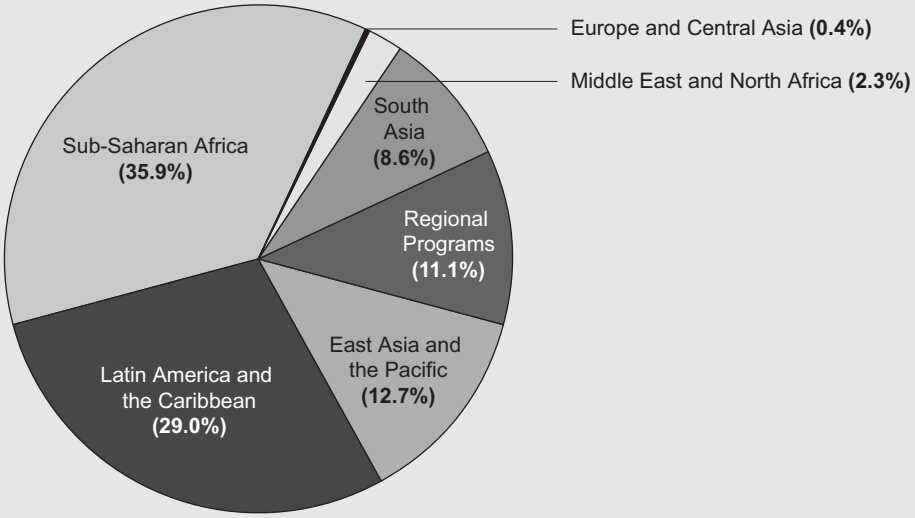


Table 4 *(continued)*

					Partnership Branch						
	Government-to Government Aid	Rank of Recipient Country (if in top 30)	Bilateral Food Aid	Official Bilateral Debt Relief	Voluntary Sector and Others	Private Sector	International Humanitarian Assistance (IHA)	International Development Research Centre (IDRC)	International Centre for Human Rights and Democratic Development (ICHRDD)	CIDA and Commonwealth Scholarships	Total
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
MIDDLE EAST and NORTH AFRICA											
Algeria	1.21		0	0	0.01	1.72	0.20	0	0	0	3.14
Djibouti	0.50		0	0	0	0.11	0	0	0	0	0.61
Egypt	11.19	27	0	0	0.66	1.50	0	0.20	0	0	13.55
Iran	0		0.25	0	0	0	1.05	0	0	0	1.30
Iraq	65.85	2	19.30	0	0.01	0	30.70	0	0	0	115.86
Jordan	6.44		0	0	0.45	0.51	0	0.39	0	0	7.79
Lebanon	1.44		0	0	0.57	0.49	0	0.30	0	0	2.80
Libya	0		0	0	0	0	0	0	0	0	0
Morocco	5.56		0	0	1.22	0.90	0.15	0.41	0.11	0	8.35
Oman	0		0	0	0	0	0	0	0	0	0
Saudi Arabia	0		0	0	0	0	0	0	0	0	0
Syria	2.00		0	0	0.02	0	0	0.02	0	0	2.04
Tunisia	0.92		0	0	0.31	1.02	0	0.07	0	0	2.32
West Bank and Gaza	11.54	25	0	0	1.10	0	2.70	0.77	0	0	16
Yemen	0.44		0	0	0.05	0.20	0.16	0.09	0	0	0.94
Total Middle East and North Africa	**107.09**		**19.55**	**0**	**4.40**	**6.45**	**34.96**	**2.25**	**0.11**	**0**	**174.81**
SOUTH ASIA											
Afghanistan	86.39	1	3.46	0	0.31	0.27	8.56	0.24	0.14	0	99.37
Bangladesh	53.25	3	10.00	0	2.31	0.33	0	0.17	0	0.25	66.31
Bhutan	0.86		0	0	0.13	0.02	0	0	0	0	1.01
India	-407.08		3.12	0	9.32	4.53	0	1.07	0	0.32	-388.72
Maldives	0.15		0	0	0.01	0.06	0	0	0	0.11	0.33
Nepal	5.15		0.12	0	1.99	0.73	0.90	0.41	0	0.01	9.31
Pakistan	16.55	17	0	0	0.41	0.14	0	0.50	0	0.21	17.81
Sri Lanka	3.34		0	0	2.01	1.55	1.44	0.25	0	0.15	8.74
Total South Asia	**-241.39**		**16.70**	**0**	**16.49**	**7.63**	**10.90**	**2.64**	**0.14**	**1.05**	**-185.84**
EAST ASIA and the PACIFIC											
Cambodia	6.97		0.94	0	1.70	1.32	0	0.37	0	0	11.30
China	33.85	5	0.15	0	3.65	7.66	0	0.64	0.07	0.05	46.07
Indonesia	18.69	13	0.81	0	2.13	1.47	0.87	0.09	0.03	0	24.09
Korea, Dem. Rep.	0		8.74	0	0.01	0	0	0.03	0	0	8.78
Laos	1.27		0	0	0.68	0.31	0.24	0.18	0	0	2.68
Malaysia	0		0	0	0.14	0.36	0	0	0	0.06	0.56
Mongolia	0.80		0	0	0.62	0.17	0	0.18	0	0	1.77
Myanmar	0.96		0	0	0.03	0	0.60	0	0.09	0	1.68
Papua New Guinea	0		0	0	0.39	0.12	0	0	0	0.05	0.56
Philippines	14.13	20	0	0	2.89	1.47	0	0.49	0	0.10	19.08
Thailand	-0.26		0.70	0	2.31	3.34	0	0.07	0	0	6.16
Timor-Leste	3.67		0	0	2.29	0	1.34	0	0	0	7.30
Vietnam	23.07	10	0	0	6.17	1.05	0	0.99	0	0.02	31.30
Oceania	0		0	0	1.31	0	0	0	0	0.11	1.42
Total East Asia and the Pacific	**103.15**		**11.34**	**0**	**24.32**	**17.27**	**3.05**	**3.04**	**0.19**	**0.39**	**162.75**
EUROPE and CENTRAL ASIA											
Albania	1.97		0	0	0.02	0.01	0	0	0	0	2.00
Armenia	0.96		0	0	0.04	0	0	0	0	0	1.00

Table 4 *(continued)*

					Partnership Branch						
	Government-to Government Aid	Rank of Recipient Country (if in top 30)	Bilateral Food Aid	Official Bilateral Debt Relief	Voluntary Sector and Others	Private Sector	International Humanitarian Assistance (IHA)	International Development Research Centre (IDRC)	International Centre for Human Rights and Democratic Development (ICHRDD)	CIDA and Commonwealth Scholarships	Total
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Azerbaijan	1.18		0	0	0.02	0	0	0	0	0	1.20
Belarus	0		0	0	0	0	0	0	0	0	0
Bosnia and Herzegovina	6.42		0	0	0.10	0.01	1.28	0	0	0	7.81
Bulgaria	2.46		0	0	0.02	0	0	0	0	0	2.48
Croatia	1.31		0	0	0.01	0.10	0	0	0	0	1.42
Czech Republic	0.79		0	0	0.01	0	0.07	0	0	0	0.87
Estonia	0.72		0	0	0.02	0	0	0	0	0	0.74
Georgia	2.21		0	0	0.24	0	0.20	0	0	0	2.65
Hungary	0.69		0	0	0.05	0.30	0	0	0	0	1.04
Kazakhstan	0.75		0	0	0.07	0	0.02	0	0	0	0.84
Kyrgyzstan	0.58		0	0	0.01	0	0	0	0	0	0.59
Latvia	0.60		0	0	0	0	0	0	0	0	0.60
Lithuania	0.42		0	0	0.03	0	0	0	0	0	0.45
Macedonia, FYR	1.30		0	0	0	0	0	0	0	0	1.30
Moldova	0.74		0	0	0.01	0	0	0	0	0	0.75
Poland	0.88		0	73.05	0.01	0.17	0	0	0	0	74.11
Romania	2.57		0	0	0.03	0.01	0	0	0	0	2.61
Russia	16.61	16	0	0	0.15	0.10	2.00	0	0	0	18.86
Serbia and Montenegro	14.56	19	0	0	0.02	0	0.02	0	0	0	14.60
Slovakia	1.68		0	0	0	0	0	0	0	0	1.68
Tajikistan	4.44		0	0	0.07	0	3.37	0	0	0	7.88
Turkey	-1.43		0	0	0.03	0.26	0	0	0	0	-1.14
Turkmenistan	0.11		0	0	0	0	0	0	0	0	0.11
Ukraine	21.07	12	0	0	0.19	0	0	0	0	0	21.26
Uzbekistan	0.92		0	0	0.06	0	0	0	0	0	0.98
Total Europe and Central Asia	**36.02**		**0**	**0**	**0.70**	**0.38**	**4.89**	**0**	**0**	**0**	**41.99**
LATIN AMERICA and the CARIBBEAN											
Argentina	2.66		0	0	0.46	0.01	0	0.15	0	0	3.28
Belize	0.43		0	0	0.34	0.06	0	0.04	0	0.02	0.89
Bolivia	13.85	21	0	0	4.33	0.68	0	0.50	0	0	19.36
Brazil	5.13		0	0	3.75	1.29	0	0.51	0	0.01	10.69
Chile	1.19		0	0	1.68	0.88	0	0.16	0	0.02	3.93
Colombia	5.56		0	0	1.24	0.29	2.93	0.43	0.03	0.04	10.52
Costa Rica	0.58		0	0	2.08	0.76	0	0.17	0	0	3.59
Cuba	4.33		0	0	4.28	1.37	0	0.23	0	0.04	10.25
Dominica	0.36		0	0	0.06	0	0	0	0	0.02	0.44
Dominican Republic	0.69		0	0	0.66	1.21	0	0.02	0	0	2.58
Ecuador	4.33		0	0	2.38	0.63	0	0.69	0	0	8.03
El Salvador	3.23		0	0	3.23	0.52	0.37	0.06	0	0	7.41
Grenada	0.07		0	0	0.40	0.07	0	0	0	0.08	0.62
Guatemala	9.56	30	0	0	3.22	0.16	0	0.36	0.04	0	13.34
Guyana	9.42		0	0.04	0.63	0.01	0	0	0	0.09	10.19
Haiti	17.54	14	1.17	0	4.92	0.02	2.65	0	0.01	0	26.31
Honduras	12.42	24	0	0	3.01	1.64	0	0.11	0	0	17.18
Jamaica	9.33		0	0	1.39	0.14	0	0.02	0	0.09	10.97
Mexico	0.50		0	0	4.20	1.56	0	0.35	0.07	0.01	6.69
Nicaragua	6.03		0	0	5.24	0.29	0	0.11	0	0	11.67
Panama	0.55		0	0	0.74	0.07	0	0.11	0	0	1.47
Paraguay	1.39		0	0	0.69	0	0	0.14	0	0	2.22

Table 4 *(continued)*

Latin America and the Caribbean (cont'd)	Government-to Government Aid	Rank of Recipient Country (if in top 30)	Bilateral Food Aid	Official Bilateral Debt Relief	Partnership Branch: Voluntary Sector and Others	Partnership Branch: Private Sector	International Humanitarian Assistance (IHA)	International Development Research Centre (IDRC)	International Centre for Human Rights and Democratic Development (ICHRDD)	CIDA and Commonwealth Scholarships	Total
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Peru	11.12	28	0	0	4.49	0.97	0.20	0.35	0.02	0	17.15
St. Kitts and Nevis	0.04		0	0	0.01	0	0	0	0	0.03	0.08
St. Lucia	0.41		0	0	0.10	0.11	0	0	0	0.08	0.70
St. Vincent and the Grenadines	0.09		0	0	0.34	0	0	0	0	0.03	0.46
Suriname	0.35		0	0	0.13	0	0	0	0	0	0.48
Trinidad and Tobago	0.37		0	0	0.43	0.36	0	0.04	0	0.07	1.27
Uruguay	0.59		0	0	0.86	0.40	0	0.37	0	0.01	2.23
Venezuela	0.59		0	0	0.05	0.60	0	0.01	0	0	1.25
Total Latin America and the Caribbean	**122.71**		**1.17**	**0.04**	**55.34**	**14.10**	**6.15**	**4.93**	**0.17**	**0.64**	**205.25**
Regional Programs	**119.66**		**7.18**	**0**	**21.17**	**0.02**	**11.77**	**22.74**	**0.57**	**7.39**	**190.50**
Total ODA Allocated	**592.25**		**130.28**	**64.32**	**190.87**	**53.43**	**109.85**	**44.73**	**1.49**	**11.15**	**1,198.37**
Of which:											
LDCs	**412.47**		**82.59**	**15.02**	**61.61**	**8.25**	**50.28**	**5.87**	**0.33**	**0.99**	**637.41**
Low Income Countries	**175.06**		**102.70**	**64.28**	**102.16**	**16.64**	**57.02**	**11.61**	**0.57**	**2.24**	**532.28**
Middle Income Countries	**417.19**		**27.58**	**0.04**	**88.71**	**36.79**	**52.83**	**33.12**	**0.92**	**8.91**	**666.09**
Countries not Specified	0		19.10	0	26.63	1.14	9.07	38.89	4.22	3.54	102.59
Unallocable by Country	na		na	na	na	na	na	na	na	na	668.21
Total ODA	**592.25**		**149.38**	**64.32**	**217.50**	**54.57**	**118.92**	**83.62**	**5.71**	**14.69**	**1,969.17**

Note: Bold-italicized countries are not included in Canadian ODA totals (see Technical Notes).

Source: CIDA, *Statistical Report on ODA 2003-2004.*

Figure 5.1

Canadian Bilateral ODA Allocated by Sector (2003-04)

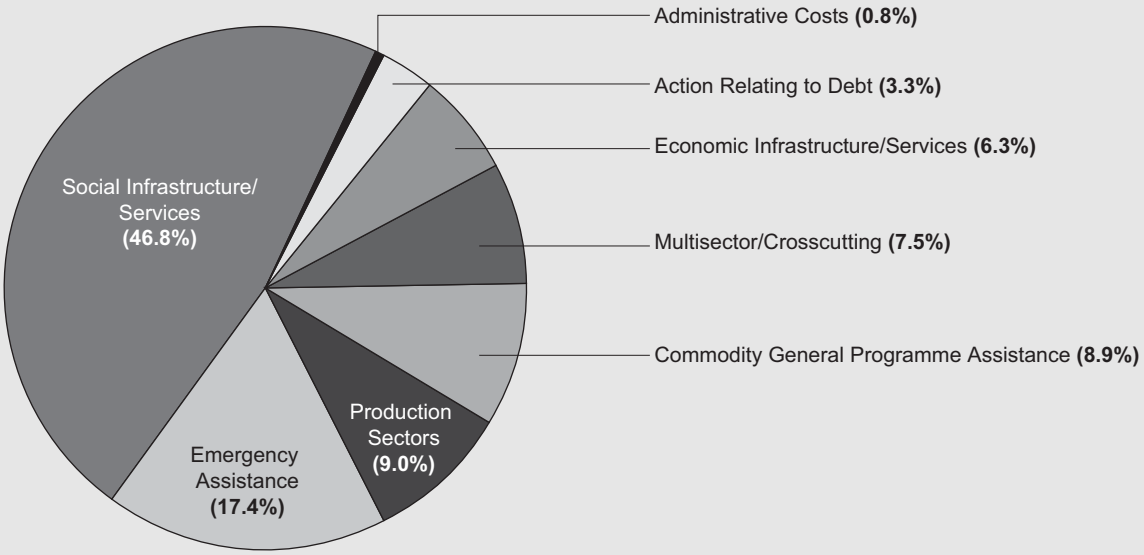


Figure 5.2

Canadian Bilateral ODA Allocated to Sector by Channel (2003-04)

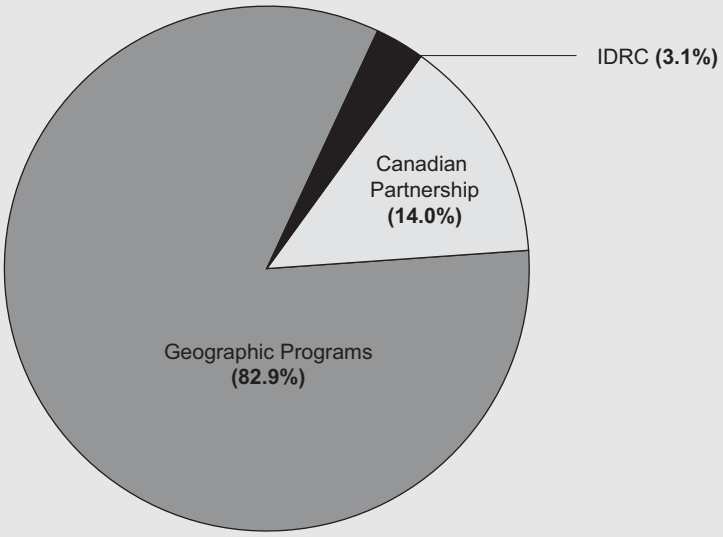


Table 5 **Canadian Bilateral Official Development Assistance by Sector (2003-04)**
(In millions of Canadian dollars)

SECTOR	Geographic Programs		Canadian Partnership				IDRC		TOTAL Country to Country	
			NGOs, INGOs, ICD		Industrial Cooperation					
	$	%	$	%	$	%	$	%	$	%
SOCIAL INFRASTRUCTURE/SERVICES										
Education	168.03	10.44	42.86	19.80	2.52	4.63	1.89	3.10	**215.30**	11.09
Education Level Unspecified	66.01	4.10	13.74	6.35	1.37	2.52	1.54	2.53	**82.66**	4.26
Basic Education	80.32	4.99	15.16	7.00	0	0	0.10	0.16	**95.58**	4.92
Secondary Education	12.75	0.79	4.07	1.88	0.05	0.10	0	0.01	**16.88**	0.87
Post-Secondary Education	8.96	0.56	9.88	4.56	1.09	2.01	0.25	0.41	**20.18**	1.04
Health	90.46	5.62	20.85	9.63	0.86	1.58	5.89	9.68	**118.07**	6.08
Health General	26.00	1.61	7.19	3.32	0.58	1.06	4.62	7.58	**38.38**	1.98
Basic Health	64.46	4.00	13.67	6.31	0.28	0.52	1.28	2.10	**79.69**	4.10
Population Programs	65.88	4.09	31.17	14.40	0.07	0.12	7.91	3.13	**99.02**	5.10
Water Supply and Sanitation	48.20	2.99	5.42	2.50	4.93	9.06	2.25	3.70	**60.80**	3.13
Government and Civil Society	279.47	17.36	57.03	26.34	2.74	5.03	9.79	16.08	**349.03**	17.97
Other Social Infrastructure and Services	59.00	3.66	5.48	2.53	0.91	1.68	1.71	2.80	**67.10**	3.46
Employment	12.54	0.78	1.34	0.62	0.27	0.50	0.72	1.18	**14.88**	0.77
Housing	2.88	0.18	0.88	0.41	0.34	0.62	0	0	**4.10**	0.21
Other Social Services	43.58	2.71	3.25	1.50	0.30	0.56	0.99	1.62	**48.12**	2.48
Sub-Total	**711.04**	**44.16**	**162.81**	**75.20**	**12.03**	**22.10**	**23.44**	**38.50**	**909.32**	**46.82**
ECONOMIC INFRASTRUCTURE/SERVICES										
Transport and Storage	3.76	0.23	0	0	6.63	12.18	0	0	**10.39**	0.54
Communications	11.47	0.71	1.61	0.74	2.43	4.47	9.73	15.99	**25.25**	1.30
Energy	20.85	1.29	0.18	0.08	6.66	12.23	0	0	**27.68**	1.43
Banking and Financial Services	27.88	1.73	7.04	3.25	0.86	1.58	0.58	0.95	**36.35**	1.87
Business and Other Services	15.82	0.98	2.71	1.25	2.55	4.68	0.73	1.20	**21.81**	1.12
Sub-Total	**79.78**	**4.95**	**11.54**	**5.33**	**19.12**	**35.13**	**11.04**	**18.14**	**121.49**	**6.26**
PRODUCTION SECTORS										
Agriculture	61.75	3.83	15.43	7.13	2.46	4.51	7.85	12.89	**87.48**	4.50
Forestry	8.26	0.51	2.21	1.02	0.69	1.27	1.21	1.98	**12.36**	0.64
Fishing	1.52	0.09	0.47	0.22	0.63	1.17	0.69	1.13	**3.31**	0.17
Industry	25.32	1.57	2.50	1.15	12.79	23.50	1.70	2.80	**42.31**	2.18
Mining	4.71	0.29	0.23	0.11	0.97	1.79	0.82	1.35	**6.74**	0.35
Construction	0.50	0.03	0	0	0.80	1.47	0	0	**1.31**	0.07
Trade	14.68	0.91	0.75	0.35	0.30	0.56	4.07	6.69	**19.81**	1.02
Tourism	0.25	0.02	0.58	0.27	0	0	0.02	0.04	**0.85**	0.04
Sub-Total	**117.00**	**7.27**	**22.17**	**10.24**	**18.65**	**34.27**	**16.36**	**26.88**	**174.18**	**8.97**
MULTISECTOR/CROSSCUTTING										
General Environment Protection	46.38	2.88	8.28	3.82	3.94	7.24	4.30	7.06	**62.89**	3.24
Women in Development	0.36	0.02	0	0	0	0	0.52	0.85	**0.88**	0.05
Other Multisector	72.34	4.49	4.59	2.12	1.13	2.08	3.43	5.63	**81.48**	4.20
Sub-Total	**119.08**	**7.39**	**12.86**	**5.94**	**5.07**	**9.31**	**8.24**	**13.54**	**145.25**	**7.48**
COMMODITY GENERAL PROGRAMME ASSISTANCE										
Structural Adjustment Assistance with World Bank/IMF	0.01	0	0	0	0	0	0	0	**0.01**	0
Food Aid Excluding Relief Food Aid	170.53	10.59	0.05	0.02	0	0	0.11	0.17	**170.68**	8.79
Other General Programme and Commodity	2.64	0.16	0.33	0.15	0	0	0	0	**2.97**	0.15
Sub-Total	**173.17**	**10.75**	**0.38**	**0.18**	**0**	**0**	**0.11**	**0.17**	**173.66**	**8.94**
ACTION RELATING TO DEBT	64.33	4.00	0	0	0	0	0	0	**64.33**	3.31
EMERGENCY ASSISTANCE										
Relief Food Aid	0.51	0.03	0	0	0	0	0	0	**0.51**	0.03
Non Food Emergency and Distress Relief	337.95	20.99	0	0	0	0	0.03	0.06	**337.99**	17.40
Sub-Total	**338.46**	**21.02**	**0**	**0**	**0**	**0**	**0.03**	**0.06**	**338.46**	**17.43**
ADMINISTRATIVE COSTS OF DONORS SUPPORT TO NON-GOVERNMENTAL ORGANIZATIONS	7.40	0.46	7.26	3.35	0.14	0.25	1.69	2.76	**16.50**	0.84
TOTAL ALLOCATED BY SECTOR	**1,610.26**	**100.00**	**216.50**	**100.00**	**54.43**	**100.00**	**60.88**	**100.00**	**1,942.07**	**100.00**

Note: For convenience, figures on food aid channelled through NGOs are added to NGOs.

Source: CIDA, *Statistical Report on ODA 2003-2004.*

Figure 6.1

Experts on Assignment Abroad (2003)

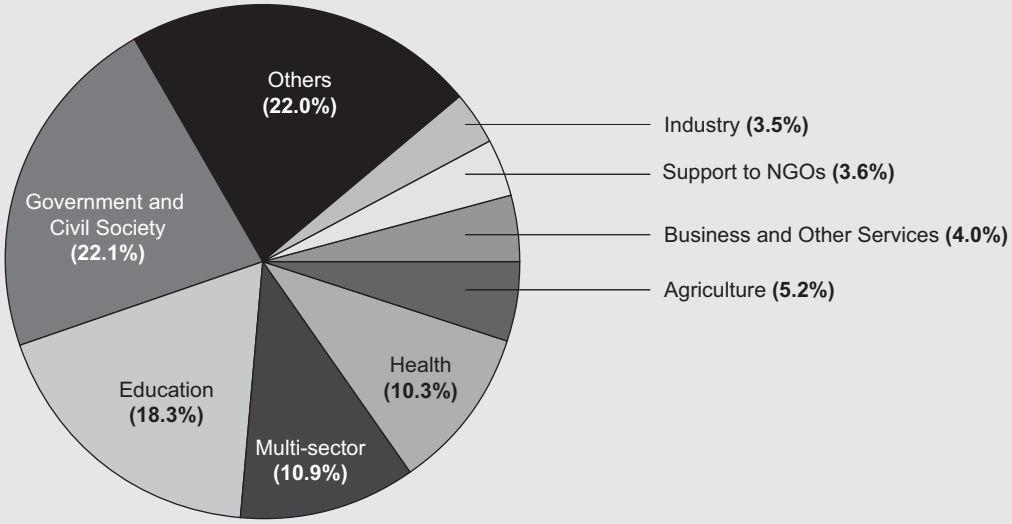


Table 6 **Canadian Technical Assistance to Developing Countries (1998-2003)**

Table 6.1a **Experts on Assignment Abroad by Area of Expertise and Duration**

Area of Expertise	Total Experts 2003		
	Women	Men	Total
Government and Civil Society	883	1,136	**2,019**
Education	902	765	**1,667**
Multi-sector	400	596	**996**
Health	523	418	**941**
Agriculture	135	338	**473**
Business and Other Services	118	248	**366**
Support to NGOs	192	136	**328**
Industry	44	273	**317**
Social Infrastructure and Services	160	150	**310**
Energy	45	259	**304**
Banking and Financial Services	79	194	**273**
Water Supply and Sanitation	78	192	**270**
Communications	60	107	**167**
Transportation	10	136	**146**
Other	201	338	**539**
Total	3,830	5,286	**9,116**

Area of Expertise	Total Experts 1998		
	Women	Men	Total
Institutional Support and Management	614	1,304	**1,918**
Education	601	749	**1,350**
Human Resources Development	526	494	**1,020**
Environment	215	652	**867**
Industry	136	582	**718**
Agriculture	156	504	**660**
Energy	73	499	**572**
Population and Human Settlements	243	326	**569**
Health and Nutrition	300	206	**506**
Communications	124	179	**303**
Transportation	25	231	**256**
Women in Development	201	22	**223**
Water Sanitation and Infrastructure	29	190	**219**
Forestry	38	148	**186**
Other	80	446	**526**
Total	3,361	6,532	**9,893**

Table 6.1b **Experts on Assignment Abroad by Region of Assignment and Duration**

Region of Assignment	Total Experts 2003		
	Women	Men	Total
Americas	1,375	1,562	**2,937**
Africa and Middle East	1,173	1,452	**2,625**
Asia	864	1,459	**2,323**
Europe	352	693	**1,045**
Multinational	39	99	**138**
Oceania	27	21	**48**
Total	3,830	5,286	**9,116**

Region of Assignment	Total Experts 1998		
	Women	Men	Total
Americas	1,080	1,785	**2,865**
Asia	895	1,947	**2,842**
Africa and Middle East	961	1,812	**2,773**
Europe	386	947	**1,333**
Multinational	20	32	**52**
Oceania	19	9	**28**
Total	3,361	6,532	**9,893**

Notes:

Experts, either fully or partially supported by CIDA, working for CIDA directly, or through private firms, institutions, associations, and non-governmental organizations.

Tables 6.1a and 6.1b for 2003 include 1,667 experts from developing countries, 710 experts sent to non-ODA countries in Central and Eastern Europe as well as 8 experts sent to non-ODA more advanced developing countries.

Tables 6.1a and 6.1b for 1998 include 831 experts from developing countries, 1,177 experts sent to non-ODA countries in Central and Eastern Europe as well as 48 experts sent to non-ODA more advanced developing countries.

Table 6 *(continued)*

Figure 6.2

Students and Trainees by Field of Study (2003)

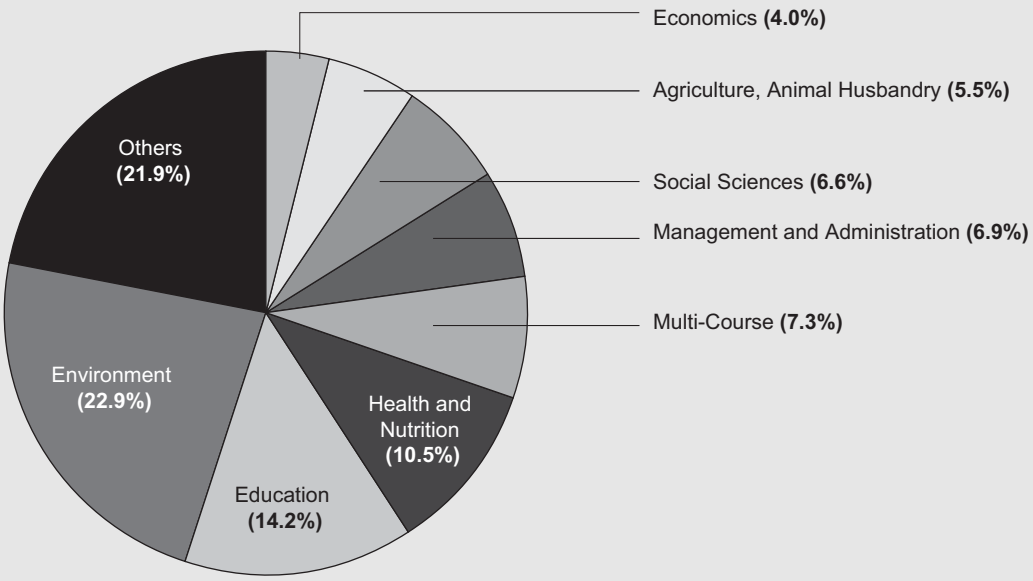


Table 6.2a **CIDA's Investment in Training and Education by Field of Study**

Field of Study	Total Students and Trainees 2003		
	Women	Men	Total
Environment	3,019	2,849	**5,868**
Education	1,959	1,685	**3,644**
Health and Nutrition	1,697	995	**2,692**
Multi-Course	1,123	747	**1,870**
Management and Administration	881	887	**1,768**
Social Sciences	856	833	**1,689**
Agriculture, Animal Husbandry	359	1,052	**1,411**
Economics	375	654	**1,029**
Human Settlements, Urban Development	334	346	**680**
Law	313	260	**573**
Transportation	104	439	**543**
International Trade	123	192	**315**
Communications	93	213	**306**
Engineering and Technology	97	204	**301**
Computer Science	72	145	**217**
Other	1,386	1,290	**2,676**
Total	12,791	12,791	**25,582**

Field of Study	Total Students and Trainees 1998		
	Women	Men	Total
Management and Administration	1,052	2,091	**3,143**
Social Sciences	623	511	**1,134**
Engineering and Technology	234	836	**1,070**
Environment	241	457	**698**
Education	314	305	**619**
Health and Nutrition	289	214	**503**
Communications	171	314	**485**
Agriculture, Animal Husbandry	166	269	**435**
Law	83	274	**357**
Fisheries	86	258	**344**
Computer Science	107	209	**316**
Energy	44	262	**306**
Finance and Credit	151	141	**292**
International Trade	103	160	**263**
Human Settlements, Urban Development	86	172	**258**
Other	327	612	**939**
Total	4,077	7,085	**11,162**

Table 6.2b **CIDA'S Investment In Training and Education by Region of Origin and Location of Study**

Location of Study	Total Students and Trainees 2003					
	Africa and Middle East	Americas	Asia and Oceania	Europe	Multi-national	Total
Country of Origin	2,736	8,927	5,667	1,741	0	19,071
Canada	1,173	747	1,198	626	125	3,869
Third Country	1,216	852	173	256	145	2,642
Total	**5,125**	**10,526**	**7,038**	**2,623**	**270**	**25,582**
Of which:						
Women	2,816	5,569	2,936	1,371	99	12,791
Men	2,309	4,957	4,102	1,252	171	12,791

Location of Study	Total Students and Trainees 1998				
	Africa and Middle East	Americas	Asia and Oceania	Europe	Total
Country of Origin	944	1,113	2,313	284	4,654
Canada	1,567	1,144	1,626	969	5,306
Third Country	556	361	236	49	1,202
Total	**3,067**	**2,618**	**4,175**	**1,302**	**11,162**
Of which:					
Women	806	1,060	1,602	609	4,077
Men	2,261	1,558	2,573	693	7,085

Notes:

Tables 6.2a and 6.2b include both fully and partially supported students and trainees.

The total for 2003 includes 30 students and 1,861 trainees from non-ODA countries in Central and Eastern Europe as well as 1 student and 8 trainees from non-ODA more advanced developing countries.

The total for 1998 includes 11 students and 1,182 trainees from non-ODA countries in Central and Eastern Europe as well as 2 students and 37 trainees from non-ODA more advanced developing countries.

Sources:

CIDA, *Statistical Report on ODA 2003-2004;* CIDA, *Statistical Report on ODA 1998-1999.*

Figure 7.1

Canadian Multilateral ODA Allocated by Agency (2003-04)

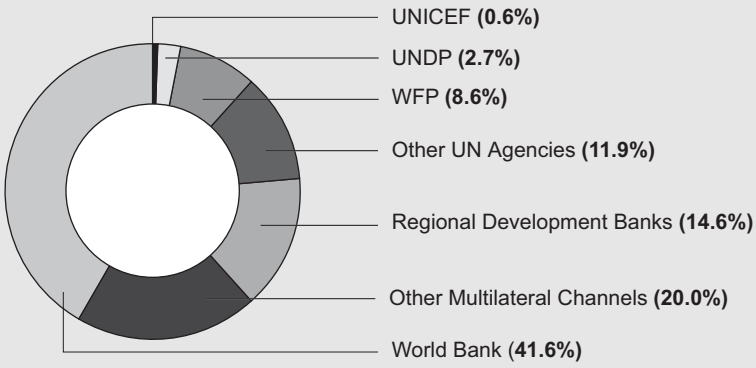


Figure 7.2

Canadian Multilateral ODA Allocated by Region (2003-04)

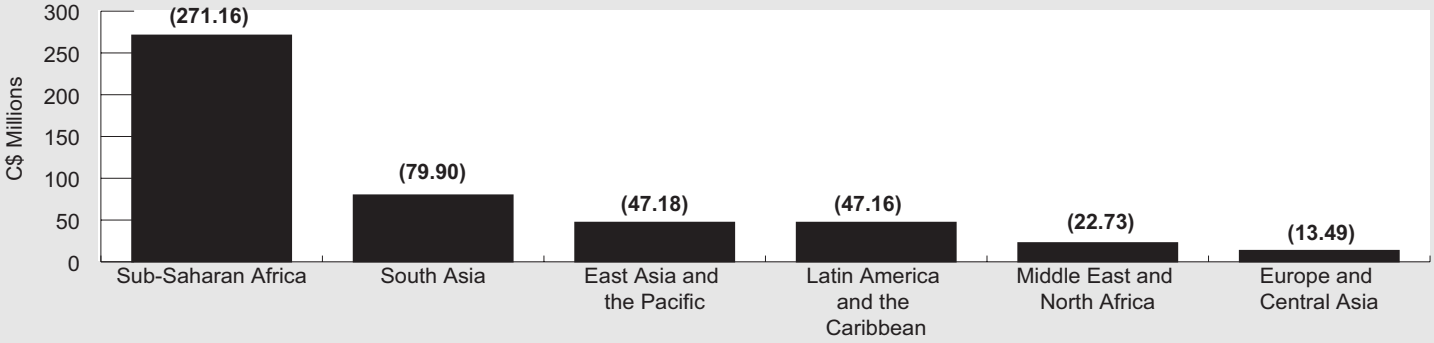


Figure 7.3

Canadian Multilateral ODA Allocated by Income Group (2003-04)

Table 7 **Canadian Multilateral Official Development Assistance by Agency and by Country (2003-04)**
(Estimated in millions of Canadian dollars)

		International Financial Institutions				UN Agencies					
	Total International Financial Institutions	World Bank (IDA)	IMF (PRGF)	Regional Development Banks	Total UN Agencies	WFP	UNDP	UNICEF	Other UN Agencies	Other Multilateral Channels	Total
Regions and Countries	1	2	3	4	5	6	7	8	9	10	11
SUB-SAHARAN AFRICA											
Angola	0.18	0.16	0	0.02	0.87	0	0.20	0.09	0.59	0.86	1.91
Benin	2.39	1.17	0	1.22	0.67	0	0.26	0.02	0.40	0.23	3.29
Botswana	0.02	0	0	0.02	0.16	0	0.02	0.01	0.12	1.23	1.41
Burkina Faso	6.70	2.12	0	4.58	0.70	0	0.30	0.05	0.35	2.13	9.53
Burundi	1.36	1.36	0	0	0.82	0	0.31	0.03	0.47	0.53	2.70
Cameroon	2.62	1.22	0	1.41	0.38	0	0.10	0.02	0.25	1.33	4.33
Cape Verde	1.40	0.64	0	0.75	0.09	0	0.02	0	0.06	0.93	2.42
Central African Republic	0	0	0	0	0.23	0	0.11	0.02	0.11	0.88	1.12
Chad	5.02	3.34	0	1.69	0.41	0	0.27	0.03	0.12	1.64	7.07
Comoros	0.30	0.30	0	0	0.07	0	0.02	0.01	0.05	0.69	1.06
Congo, Dem. Rep.	6.27	5.87	0	0.40	1.72	0	0.46	0.15	1.11	0.64	8.63
Congo, Rep.	0.81	0.81	0	0	0.37	0	0.10	0.02	0.25	0.16	1.33
Côte d'Ivoire	1.90	1.75	0	0.15	0.61	0	0.22	0.04	0.35	0.40	2.91
Equatorial Guinea	0.13	0	0	0.13	0.06	0	0.03	0.01	0.03	0.12	0.31
Eritrea	3.22	1.96	0	1.26	0.73	0	0.17	0.02	0.54	0.00	3.95
Ethiopia	10.01	7.76	0	2.25	9.25	7.12	0.55	0.13	1.46	1.62	20.88
Gabon	0	0	0	0	0.14	0	0.01	0.01	0.13	0.51	0.65
Gambia	2.56	0.46	0	2.10	0.22	0	0.12	0.01	0.10	0.45	3.24
Ghana	16.15	8.12	0	8.03	0.84	0	0.18	0.03	0.63	0.84	17.84
Guinea	3.30	1.50	0	1.80	0.98	0	0.05	0.03	0.91	0.87	5.15
Guinea-Bissau	1.54	0.55	0	0.99	0.14	0	0.12	0.01	0.01	0.61	2.29
Kenya	4.42	4.07	0	0.35	1.36	0	0.32	0.06	0.98	1.43	7.22
Lesotho	1.03	0.53	0	0.50	0.15	0	0.03	0.01	0.11	0.97	2.15
Liberia	0	0	0	0	0.32	0	0.05	0.05	0.22	0.12	0.44
Madagascar	8.44	7.07	0	1.37	0.66	0	0.25	0.04	0.37	0.38	9.48
Malawi	6.02	2.55	0	3.47	0.53	0	0.24	0.04	0.25	0.50	7.05
Mali	9.14	3.57	0	5.57	5.34	4.68	0.20	0.05	0.42	1.69	16.18
Mauritania	3.46	1.61	0	1.85	0.26	0	0.11	0.01	0.14	0.67	4.39
Mauritius	0	0	0	0	0.06	0	0.01	0	0.04	0.77	0.83
Mozambique	9.32	5.48	0	3.85	4.15	2.88	0.46	0.07	0.75	1.04	14.52
Namibia	0.00	0	0	0	0.10	0	0	0.01	0.09	0.21	0.32
Niger	7.37	2.81	0	4.56	0.57	0	0.29	0.06	0.22	2.13	10.07
Nigeria	2.33	2.12	0	0.22	1.83	0	0.25	0.19	1.40	0.80	4.96
Rwanda	2.42	1.29	0	1.14	0.71	0	0.18	0.03	0.50	1.47	4.60
São Tomé and Principe	0.35	0.07	0	0.28	0.05	0	0.02	0.01	0.03	0.12	0.52
Senegal	5.67	4.05	0	1.62	3.78	3.15	0.14	0.02	0.47	3.00	12.45
Seychelles	0	0	0	0	0.00	0	0.00	0	0.00	0.98	0.99
Sierra Leone	2.17	1.06	0	1.11	1.17	0	0.19	0.03	0.95	0.82	4.16
Somalia	0	0	0	0	0.53	0	0.22	0.04	0.26	0.35	0.87
South Africa	0	0	0	0	0.28	0	0.11	0.01	0.16	0.00	0.28
Sudan	0	0	0	0	1.25	0	0.22	0.05	0.98	1.62	2.87
Swaziland	0.15	0	0	0.15	0.06	0	0.02	0.01	0.03	0.50	0.70
Tanzania	20.69	14.80	0	5.90	8.99	7.17	0.35	0.07	1.40	2.74	32.43
Togo	0.05	0	0	0.05	0.18	0	0.14	0.01	0.03	0.74	0.97
Uganda	11.62	9.34	0	2.27	1.11	0	0.23	0.05	0.83	2.01	14.73
Zambia	4.99	3.34	0	1.65	7.36	6.48	0.13	0.03	0.72	1.86	14.21
Zimbabwe	0	0	0	0	0.33	0	0.13	0.02	0.18	1.42	1.75
Total Sub-Saharan Africa	**165.54**	**102.84**	**0**	**62.70**	**60.62**	**31.48**	**7.91**	**1.67**	**19.56**	**45.00**	**271.16**
MIDDLE EAST and NORTH AFRICA											
Algeria	0	0	0	0	0.26	0	0.05	0.01	0.20	0.12	0.37
Djibouti	0.94	0.87	0	0.07	0.12	0	0.01	0	0.11	0.15	1.21
Egypt	2.81	1.10	0	1.70	0.62	0	0.06	0.02	0.53	0.70	4.12
Iran	0	0	0	0	0.71	0	0.04	0.02	0.65	0	0.71
Iraq	0	0	0	0	1.43	0	0.08	0.03	1.32	0	1.43
Jordan	0	0	0	0	2.25	0	0.03	0.01	2.22	0.23	2.48
Lebanon	0	0	0	0	1.47	0	0.03	0.01	1.43	0.12	1.58
Libya	0	0	0	0	0	0	0	0	0	0	0
Morocco	0.13	0	0	0.13	0.26	0	0.04	0.01	0.20	0.38	0.77
Oman	0	0	0	0	0	0	0	0	0	0	0

Table 7 *(continued)*

Middle East and North Africa (cont'd)	Total International Financial Institutions	International Financial Institutions			Total UN Agencies	UN Agencies				Other Multilateral Channels	Total
		World Bank (IDA)	IMF (PRGF)	Regional Development Banks		WFP	UNDP	UNICEF	Other UN Agencies		
Regions and Countries	1	2	3	4	5	6	7	8	9	10	11
Saudi Arabia	0	0	0	0	0.87	0	0	0	0.87	0.12	0.99
Syria	0	0	0	0	3.98	0	0.06	0.01	3.91	0.12	4.09
Tunisia	0	0	0	0	0.04	0	0.02	0.01	0.02	0.45	0.49
West Bank and Gaza	0	0	0	0	0	0	0	0	0	0	0
Yemen	2.97	2.97	0	0	0.69	0	0.24	0.03	0.42	0.81	4.47
Total Middle East and North Africa	**6.85**	**4.95**	**0**	**1.90**	**12.70**	**0**	**0.66**	**0.16**	**11.88**	**3.18**	**22.73**
SOUTH ASIA											
Afghanistan	1.17	1.17	0	0	0.64	0	0.03	0.13	0.48	1.16	2.97
Bangladesh	17.33	17.33	0	0	2.22	0	0.81	0.10	1.31	0.51	20.05
Bhutan	0.23	0.23	0	0	0.17	0	0.06	0.01	0.10	0.23	0.63
India	30.91	30.91	0	0	3.27	0	1.00	0.23	2.04	2.45	36.63
Maldives	0.12	0.12	0	0	0.05	0	0.04	0.00	0.01	0.18	0.34
Nepal	3.42	3.41	0	0	0.79	0	0.28	0.04	0.47	0.70	4.90
Pakistan	3.95	3.94	0	0	1.99	0	0.38	0.11	1.50	0.70	6.63
Sri Lanka	6.74	6.74	0	0	0.60	0	0.16	0.01	0.42	0.42	7.76
Total South Asia	**63.84**	**63.84**	**0**	**0**	**9.72**	**0**	**2.77**	**0.62**	**6.33**	**6.34**	**79.90**
EAST ASIA and the PACIFIC											
Cambodia	2.08	2.09	0	0	0.67	0	0.21	0.03	0.43	0	2.75
China	4.72	4.72	0	0	1.42	0	0.44	0.11	0.87	1.39	7.53
Indonesia	3.04	3.04	0	0	1.21	0	0.30	0.05	0.86	0.70	4.95
Korea, Dem. Rep.	0	0	0	0	0.41	0	0.08	0.02	0.31	0.12	0.53
Laos	1.61	1.61	0	0	0.30	0	0.11	0.01	0	0.35	2.26
Malaysia	0	0	0	0	0.06	0	0.02	0.00	0.04	0.80	0.86
Mongolia	0.97	0.97	0	0	0.17	0	0.05	0.01	0.11	0.00	1.14
Myanmar	0	0	0	0	0.56	0	0.30	0.06	0.20	0.35	0.90
Papua New Guinea	0.00	0	0	0	0.08	0	0.05	0.01	0.03	0.35	0.43
Philippines	0.00	0	0	0	0.61	0	0.10	0.02	0.48	0.58	1.19
Thailand	0	0	0	0	0.23	0	0.02	0.01	0.20	0.58	0.81
Timor-Leste	0	0	0	0	0.21	0	0.11	0.02	0.08	0.00	0.21
Vietnam	18.96	18.96	0	0	0.51	0	0.02	0.04	0.45	0.31	19.78
Oceania	0.09	0.09	0	0	0.04	0	0.02	0.02	0.01	3.69	3.82
Total East Asia and the Pacific	**31.48**	**31.48**	**0**	**0**	**6.48**	**0**	**1.84**	**0.40**	**4.24**	**9.21**	**47.18**
EUROPE and CENTRAL ASIA											
Albania	2.03	2.03	0	0	0.50	0	0.08	0.01	0.41	0	2.52
Armenia	2.58	2.58	0	0	0.47	0	0.04	0.01	0.42	0	3.05
Azerbaijan	2.51	2.51	0	0	0.32	0	0.13	0.01	0.19	0	2.83
Belarus	0	0	0	0	0	0	0	0	0	0	0
Bosnia and Herzegovina	0	0	0	0	0	0	0	0	0	0	0
Bulgaria	0	0	0	0	0	0	0	0	0	0	0
Croatia	0	0	0	0	0	0	0	0	0	0	0
Czech Republic	0	0	0	0	0	0	0	0	0	0	0
Estonia	0	0	0	0	0	0	0	0	0	0	0
Georgia	1.45	1.45	0	0	0.28	0	0.08	0.01	0.20	0	1.73
Hungary	0	0	0	0	0	0	0	0	0	0	0
Kazakhstan	0	0	0	0	0.08	0	0.03	0.01	0.04	0	0.08
Kyrgyzstan	1.08	1.08	0	0	0.19	0	0.08	0.01	0.09	0	1.27
Latvia	0	0	0	0	0	0	0	0	0	0	0
Lithuania	0	0	0	0	0	0	0	0	0	0	0
Macedonia, FYR	0	0	0	0	0	0	0	0	0	0	0
Moldova	0.53	0.53	0	0	0.22	0	0.05	0.01	0.16	0	0.75
Poland	0	0	0	0	0	0	0	0	0	0	0
Romania	0	0	0	0	0	0	0	0	0	0	0
Russia	0	0	0	0	0	0	0	0	0	0	0
Serbia and Montenegro	0	0	0	0	0	0	0	0	0	0	0
Slovakia	0	0	0	0	0	0	0	0	0	0	0
Tajikistan	0.44	0.44	0	0	0.17	0	0.10	0.02	0.05	0	0.60
Turkey	0	0	0	0	0.21	0	0.04	0.01	0.16	0.23	0.45
Turkmenistan	0	0	0	0	0.08	0	0.04	0.01	0.03	0	0.08
Ukraine	0	0	0	0	0	0	0	0	0	0	0
Uzbekistan	0	0	0	0	0.13	0	0.07	0.02	0.04	0	0.13
Total Europe and Central Asia	**10.61**	**10.61**	**0**	**0**	**2.65**	**0**	**0.75**	**0.10**	**1.80**	**0.23**	**13.49**

Table 7 *(continued)*

		International Financial Institutions				UN Agencies					
	Total International Financial Institutions	World Bank (IDA)	IMF (PRGF)	Regional Development Banks	Total UN Agencies	WFP	UNDP	UNICEF	Other UN Agencies	Other Multilateral Channels	Total
Regions and Countries	1	2	3	4	5	6	7	8	9	10	11
LATIN AMERICA and the CARIBBEAN											
Argentina	0.15	0	0	0.15	0.19	0	0.01	0	0.18	0.23	0.57
Belize	0.53	0	0	0.53	0.01	0	0	0	0	0.39	0.92
Bolivia	5.63	5.20	0	0.43	0.35	0	0.09	0.01	0.24	0.35	6.32
Brazil	0.28	0	0	0.28	8.37	0	0.05	0.01	8.31	0.58	9.23
Chile	0.01	0	0	0.01	0.04	0	0.01	0	0.02	0.12	0.16
Colombia	0.07	0	0	0.07	0.31	0	0.06	0.01	0.25	0.12	0.50
Costa Rica	0.01	0	0	0.01	0.07	0	0.02	0.01	0.04	0.46	0.55
Cuba	0	0	0	0	0.05	0	0.03	0.01	0.02	0	0.05
Dominica	1.34	0	0	1.34	0.01	0	0	0	0.01	1.05	2.40
Dominican Republic	0.16	0	0	0.16	0.24	0	0.02	0.01	0.21	0.12	0.51
Ecuador	0.16	0	0	0.16	0.30	0	0	0.01	0.29	0.12	0.58
El Salvador	0.18	0	0	0.18	0.40	0	0.02	0.01	0.37	0.12	0.69
Grenada	0.83	0.05	0	0.78	0	0	0	0	0.02	0.50	1.35
Guatemala	0.11	0	0	0.11	0.34	0	0.03	0.01	0.31	0.23	0.69
Guyana	3.30	0.76	0	2.55	0.10	0	0.05	0.01	0.04	1.31	4.71
Haiti	0.21	0	0	0.21	0.25	0	0.16	0.02	0.07	0.73	1.20
Honduras	2.13	1.50	0	0.64	0.70	0	0.04	0.01	0.65	0.23	3.06
Jamaica	1.31	0	0	1.31	0.04	0	0.02	0.01	0.00	0.94	2.29
Mexico	0.02	0	0	0.02	0.51	0	0.04	0.01	0.46	0.35	0.87
Nicaragua	4.30	4.03	0	0.27	0.25	0	0.12	0.01	0.13	0.46	5.01
Panama	0.01	0	0	0.01	0.20	0	0.02	0	0.18	0.12	0.33
Paraguay	0.13	0	0	0.13	0.03	0	0.01	0.01	0.01	0	0.16
Peru	0.04	0	0	0.04	0.72	0	0.04	0.01	0.67	0.70	1.45
St. Kitts and Nevis	0.44	0	0	0.44	0	0	-0.01	0	0	0.17	0.59
St. Lucia	1.23	0.05	0	1.19	0.01	0	0	0	0.01	0.23	1.48
St. Vincent and the Grenadines	0.31	0.02	0	0.29	0.00	0	0	0	0	0.33	0.65
Suriname	0	0	0	0.00	0.02	0	0.02	0	0.01	0	0.03
Trinidad and Tobago	0.01	0	0	0.01	0.07	0	0.01	0	0.06	0.24	0.33
Uruguay	0	0	0	0.01	0.02	0	0.01	0	0.01	0.12	0.15
Venezuela	0.01	0	0	0.01	0.19	0	0.02	0.01	0.16	0.12	0.31
Total Latin America and the Caribbean	**22.94**	**11.60**	**0**	**11.34**	**13.80**	**0**	**0.89**	**0.17**	**12.75**	**10.42**	**47.16**
Regional Programs	**2.85**	**0**	**0**	**2.85**	**22.80**	**15.12**	**0.03**	**0.05**	**7.60**	**33.73**	**59.38**
Total ODA Allocated	**304.10**	**225.31**	**0**	**78.79**	**128.76**	**46.60**	**14.85**	**3.17**	**64.15**	**108.12**	**540.99**
Of which:											
LDCs	**167.21**	**114.54**	**0**	**52.66**	**60.55**	**31.48**	**8.67**	**1.68**	**18.72**	**39.58**	**267.33**
Low Income Countries	**261.11**	**198.85**	**0**	**62.26**	**75.42**	**31.48**	**12.53**	**2.59**	**28.81**	**49.79**	**386.31**
Middle Income Countries	**42.99**	**26.47**	**0**	**16.53**	**53.35**	**15.12**	**2.32**	**0.58**	**35.33**	**58.33**	**154.68**
Countries not Specified	30.48	0	0	0	130.11	115.09	0	2.28	12.73	45.11	205.70
Unallocable by Country	0	0	0	0	0	0	0	0	0	0	1.65
Total ODA	**334.58**	**225.31**	**0**	**78.79**	**258.87**	**161.69**	**14.85**	**5.45**	**76.88**	**153.24**	**748.34**

Note: Bold-italicized countries are not included in Canadian assistance totals (see Technical Notes).

Source: CIDA, *Statistical Report on ODA 2003-2004.*

Figure 8.1

Canadian Balance of Merchandise Trade with Developing Countries (2004)

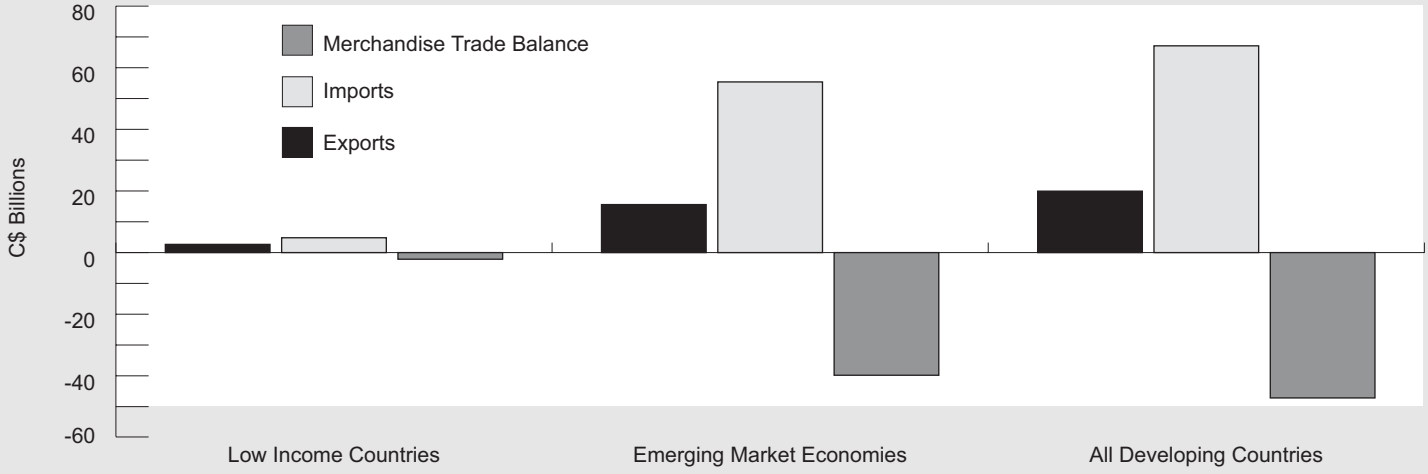


Figure 8.2

Top 10 Export Countries in 2004

Countries		C$ millions	%
1	China	6,002	30.1
2	Mexico	2,852	14.3
3	Brazil	919	4.6
4	India	828	4.2
5	Indonesia	652	3.3
6	Saudi Arabia	562	2.8
7	Venezuela	480	2.4
8	Thailand	457	2.3
9	Philippines	401	2.0
10	Colombia	386	1.9
	Top 10 Total	**13,539**	**67.9**
	Total Canadian Exports	**19,935**	

Figure 8.3

Top 10 Import Countries in 2004

Countries		C$ millions	%
1	China	24,084	35.9
2	Mexico	13,404	20.0
3	Algeria	3,109	4.6
4	Malaysia	2,633	3.9
5	Brazil	2,341	3.5
6	Thailand	2,015	3.0
7	India	1,576	2.3
8	Russia	1,384	2.1
9	Venezuela	1,311	2.0
10	Chile	1,308	1.9
	Top 10 Total	**53,165**	**79.2**
	Total Canadian Imports	**67,109**	

Table 8 **Canadian Balance of Merchandise Trade with Developing Countries (2004)**
(In thousands of Canadian dollars)

Regions and Countries	Total Exports 2004	Total Imports 2004	Balance of Merchandise Trade 2004	Total Exports 1994 (2004 prices)	Total Imports 1994 (2004 prices)	Balance of Merchandise Trade 1994 (2004 prices)	Real % Change Per Year Exports 1994-2004	Real % Change Per Year Imports 1994-2004	Total Tariff Revenue Collected 2004	Average Tariff Rate (%) 2004
	1	2	3	4	5	6	7	8	9	10
SUB-SAHARAN AFRICA										
Angola	21,945	48	21,897	5,435	5,225	209	15.0	-37.4	0.05	0.11
Benin	5,512	4	5,508	4,904	5	4,899	1.2	-2.1	0.03	0.69
Botswana	16,187	22,721	-6,534	2,931	107	2,823	18.6	70.8	32.19	0.14
Burkina Faso	7,928	188	7,740	18,317	46	18,272	-8.0	15.2	0.43	0.23
Burundi	722	234	488	399	0	399	6.1	na	10.84	4.63
Cameroon	9,819	14,169	-4,350	19,564	9,819	9,745	-6.7	3.7	12.75	0.09
Cape Verde	43	19	24	99	~	na	-8.0	na	0.09	0.46
Central African Republic	667	84	583	148	413	-265	16.3	-14.7	0.66	0.78
Chad	3,362	100	3,262	49	62	-13	52.7	5.0	0.43	0.43
Comoros	231	88	143	19	593	-574	28.1	-17.4	0.10	0.11
Congo, Dem. Rep.	9,220	256	8,964	8,397	22,532	-14,135	0.9	-36.1	0.19	0.08
Congo, Rep.	10,243	4,915	5,328	377	140	237	39.1	42.7	19.79	0.40
Côte d'Ivoire	9,589	113,706	-104,117	9,284	40,454	-31,169	0.3	10.9	145.73	0.13
Equatorial Guinea	1,576	340,849	-339,273	0	~	~	na	na	0.13	0
Eritrea	613	20	593	~	~	~	na	na	0.01	0.04
Ethiopia	12,760	6,405	6,355	22,197	7,848	14,349	-5.4	-2.0	7.49	0.12
Gabon	10,240	833	9,407	2,539	358	2,181	15.0	8.8	0.25	0.03
Gambia	206	63	143	105	188	-83	7.0	-10.3	0.36	0.57
Ghana	64,218	30,637	33,581	22,200	6,166	16,034	11.2	17.4	63.49	0.21
Guinea	4,803	23,520	-18,717	2,845	19,823	-16,978	5.4	1.7	0.48	0
Guinea-Bissau	14	0	14	6	1	5	9.4	-100.0	0	0
Kenya	21,392	15,085	6,307	21,476	18,944	2,531	0.0	-2.3	611.70	4.08
Lesotho	27	13,997	-13,970	108	3,777	-3,668	-13.0	14.0	272.32	1.95
Liberia	2,424	8,544	-6,120	1,100	45	1,055	8.2	69.1	0.11	0
Madagascar	836	27,840	-27,004	398	10,336	-9,937	7.7	10.4	306.37	1.10
Malawi	2,491	1,525	966	399	2,428	-2,029	20.1	-4.5	24.07	1.58
Mali	7,328	410	6,918	3,604	2,771	833	7.4	-17.4	2.46	0.60
Mauritania	5,339	436	4,903	5,662	389	5,273	-0.6	1.1	11.86	2.72
Mauritius	3,504	10,427	-6,923	2,667	11,316	-8,649	2.8	-0.8	998.87	9.58
Mozambique	18,436	248	18,188	18,246	284	17,962	0.1	-1.3	0.65	1.16
Namibia	1,260	40,516	-39,256	1,396	37,752	-36,356	-1.0	0.7	31.95	0.08
Niger	1,592	2,188	-596	945	5,864	-4,919	5.3	-9.4	434.44	19.84
Nigeria	74,843	94,137	-19,294	17,494	627,298	-609,804	15.6	-17.3	18.12	0
Rwanda	607	56	551	1,907	87	1,819	-10.8	-4.4	0.05	0.08
São Tomé and Principe	11	140	-129	39	3,657	-3,619	-11.8	-27.8	0.48	0.34
Senegal	24,630	674	23,956	9,297	177	9,120	10.2	14.3	6.14	0.91
Seychelles	412	4,031	-3,619	155	72	82	10.3	49.5	0.71	0.02
Sierra Leone	3,105	3,838	-733	635	7,490	-6,855	17.2	-6.5	64.03	1.67
Somalia	66	81	-15	10,356	62	10,295	-39.7	2.8	0.32	0.40
South Africa	351,636	648,193	-296,557	324,222	303,669	20,553	0.8	7.9	3,810.22	0.62
Sudan	75,559	15,015	60,544	11,845	554	11,291	20.4	39.1	0.67	0
Swaziland	2,643	2,692	-49	146	5,724	-5,578	33.6	-7.3	194.61	7.23
Tanzania	30,230	13,501	16,729	6,953	1,666	5,287	15.8	23.3	20.75	0.15
Togo	5,248	689	4,559	2,083	32,357	-30,273	9.7	-32.0	0.11	0.02
Uganda	5,465	4,926	539	10,732	4,951	5,780	-6.5	-0.1	19.01	0.38
Zambia	16,475	213	16,262	6,835	2,970	3,865	9.2	-23.2	0.31	0.15
Zimbabwe	7,101	3,348	3,753	9,989	33,026	-23,037	-3.4	-20.5	22.14	0.82
Total Sub-Saharan Africa	**852,558**	**1,471,609**	**-619,051**	**588,503**	**1,231,446**	**-642,943**	**3.8**	**1.8**	**7,147.98**	**0.49**
MIDDLE EAST and NORTH AFRICA										
Algeria	276,391	3,108,632	-2,832,241	547,874	252,356	295,518	-6.6	28.5	6.74	0
Djibouti	1,933	183	1,750	504	~	~	14.4	na	0.07	0.04
Egypt	194,783	199,385	-4,602	109,142	14,910	94,233	6.0	29.6	3,743.68	1.88
Iran	169,548	77,401	92,147	508,594	115,802	392,791	-10.4	-3.9	350.81	0.46
Iraq	21,648	1,101,570	-1,079,922	0	15	-15	na	206.8	1.01	0
Jordan	38,862	6,723	32,139	16,073	659	15,413	9.2	26.1	852.45	12.68
Lebanon	36,719	9,907	26,812	35,664	3,703	31,961	0.3	10.3	201.82	2.26
Libya	98,348	85,560	12,788	86,983	1	86,982	1.2	211.6	~	~

Table 8 *(continued)*

Middle East and North Africa *(cont'd)*	Total Exports 2004	Total Imports 2004	Balance of Merchandise Trade 2004	Total Exports 1994 (2004 prices)	Total Imports 1994 (2004 prices)	Balance of Merchandise Trade 1994 (2004 prices)	Real % Change Per Year Exports 1994-2004	Real % Change Per Year Imports 1994-2004	Total Tariff Revenue Collected 2004	Average Tariff Rate (%) 2004
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Morocco	155,093	92,490	62,603	84,180	49,458	34,722	6.3	6.5	1,990.82	2.16
Oman	52,561	7,282	45,279	12,645	170	12,475	15.3	45.6	~	~
Saudi Arabia	561,919	1,227,999	-666,080	677,579	537,152	140,427	-1.9	8.6	~	~
Syria	33,834	24,448	9,386	20,878	995	19,883	4.9	37.7	330.97	1.35
Tunisia	30,751	23,915	6,836	32,801	2,825	29,976	-0.6	23.8	2,063.29	8.67
West Bank and Gaza	na	na	na	na	na	na	na	na	~	~
Yemen	34,238	173	34,065	19,914	4,205	15,709	5.6	-27.3	1.01	0.59
Total Middle East and North Africa	**1,706,628**	**5,965,668**	**-4,259,040**	**2,152,830**	**982,250**	**1,170,076**	**-2.3**	**19.8**	**9,542.66**	**0.16**
SOUTH ASIA										
Afghanistan	8,637	371	8,266	190	345	-155	46.5	0.7	11.58	3.27
Bangladesh	108,958	490,545	-381,587	115,496	73,655	41,841	-0.6	20.9	4,294.46	0.88
Bhutan	78	19	59	25	~	~	12.0	na	0.11	0.58
India	827,667	1,576,252	-748,585	321,148	455,593	-134,445	9.9	13.2	98,732.00	6.26
Maldives	4,076	3,131	945	5,015	234	4,780	-2.1	29.6	112.75	3.60
Nepal	11,655	14,795	-3,140	4,531	4,813	-282	9.9	11.9	523.04	3.54
Pakistan	341,735	244,997	96,738	79,769	197,253	-117,484	15.7	2.2	30,335.55	12.38
Sri Lanka	44,278	114,056	-69,778	18,088	67,192	-49,104	9.4	5.4	13,310.34	11.67
Total South Asia	**1,347,084**	**2,444,166**	**-1,097,082**	**544,262**	**799,085**	**-254,849**	**9.5**	**11.8**	**147,319.83**	**6.03**
EAST ASIA and the PACIFIC										
Cambodia	1,281	139,984	-138,703	6,363	177	6,186	-14.8	94.9	1,753.04	1.25
China	6,002,170	24,084,411	-18,082,241	2,418,738	3,829,307	-1,410,569	9.5	20.2	936,824.59	3.89
Indonesia	652,257	930,072	-277,815	513,208	518,570	-5,362	2.4	6.0	41,264.26	4.43
Korea, Dem. Rep.	30,545	46	30,499	489	207	283	51.2	-13.9	~	~
Laos	668	8,719	-8,051	51	980	-929	29.3	24.4	144.95	1.66
Malaysia	386,199	2,632,705	-2,246,506	308,893	1,205,390	-896,497	2.3	8.1	27,014.05	1.03
Mongolia	7,557	56,004	-48,447	~	~	~	na	na	3,373.81	6.02
Myanmar	1,646	24,703	-23,057	543	16,690	-16,148	11.7	4.0	~	~
Papua New Guinea	3,383	1,588	1,795	2,342	1,906	437	3.7	-1.8	0.21	0.01
Philippines	400,511	954,841	-554,330	220,189	465,913	-245,724	6.2	7.4	23,502.07	2.46
Thailand	457,495	2,014,511	-1,557,016	453,105	889,371	-436,267	0.1	8.5	56,520.46	2.81
Timor-Leste	60	398	-338	na	na	na	na	na	0.01	0
Vietnam	101,503	449,801	-348,298	27,510	34,148	-6,638	13.9	29.4	36,180.54	8.05
Oceania	4,933	6,934	-2,001	3,337	29,673	-26,337	4.0	-13.5	246.73	3.56
Total East Asia and the Pacific	**8,050,208**	**31,304,717**	**-23,254,509**	**3,954,768**	**6,992,332**	**-3,037,564**	**7.4**	**16.2**	**1,126,824.72**	**3.60**
EUROPE and CENTRAL ASIA										
Albania	2,261	2,736	-475	84	59	26	39.0	46.9	~	~
Armenia	2,564	1,979	585	67	97	-30	43.9	35.2	230.26	12.53
Azerbaijan	9,135	816	8,319	7	0	7	105.4	na	4.51	0.55
Belarus	4,433	11,159	-6,726	1,618	5,668	-4,051	10.6	7.0	482.40	4.32
Bosnia and Herzegovina	1,747	3,930	-2,183	~	~	~	na	na	~	~
Bulgaria	44,851	81,721	-36,870	7,844	38,064	-30,219	19.0	7.9	6,053.00	7.53
Croatia	17,825	24,724	-6,899	~	~	~	na	na	1,110	4.63
Czech Republic	103,236	235,569	-132,333	42,499	59,043	-16,543	9.3	14.8	2,928.48	1.27
Estonia	9,658	24,163	-14,505	4,537	2,788	1,748	7.8	24.1	866.06	3.58
Georgia	8,342	11,002	-2,660	0	432	-432	na	38.2	10.49	0.10
Hungary	40,172	209,717	-169,545	33,134	46,300	-13,166	1.9	16.3	5,061.98	2.46
Kazakhstan	66,969	48,098	18,871	7,881	30,445	-22,564	23.9	4.7	70.07	0.15
Kyrgyzstan	4,004	103	3,901	627	5,273	-4,646	20.4	-32.5	16.16	15.65
Latvia	26,615	12,176	14,439	1,881	312	1,569	30.3	44.3	534.33	4.91
Lithuania	20,422	154,618	-134,196	3,028	7,320	-4,291	21.0	35.7	1,908.36	1.24
Macedonia, FYR	6,108	3,212	2,896	~	~	~	na	na	378.13	12.28
Moldova	2,851	2,476	375	255	2,124	-1,869	27.3	1.5	356.72	14.47
Poland	201,452	387,911	-186,459	62,127	101,337	-39,209	12.5	14.4	11,087.30	2.92
Romania	85,403	169,136	-83,733	135,977	72,473	63,505	-4.5	8.8	7,840.55	4.66
Russia	361,064	1,384,489	-1,023,425	209,761	359,966	-150,205	5.6	14.4	5,328.70	0.40
Serbia and Montenegro	10,361	10,055	306	~	~	~	na	na	~	~
Slovakia	28,729	115,001	-86,272	7,341	34,090	-26,749	14.6	12.9	5,292.12	4.63
Tajikistan	875	78	797	163	2,704	-2,541	18.3	-29.9	3.02	3.84
Turkey	350,358	609,263	-258,905	159,283	118,980	40,303	8.2	17.7	28191.01	4.63

Table 8 *(continued)*

Europe and Central Asia *(cont'd)*	Total Exports 2004	Total Imports 2004	Balance of Merchandise Trade 2004	Total Exports 1994 (2004 prices)	Total Imports 1994 (2004 prices)	Balance of Merchandise Trade 1994 (2004 prices)	Real % Change Per Year Exports 1994-2004	Real % Change Per Year Imports 1994-2004	Total Tariff Revenue Collected 2004	Average Tariff Rate (%) 2004
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Turkmenistan	15,861	4,506	11,355	692	4	688	36.8	102.1	505.63	11.22
Ukraine	50,950	160,898	-109,948	9,309	17,494	-8,184	18.5	24.8	1615.54	1.01
Uzbekistan	4,118	36,309	-32,191	17,805	15,209	2,597	-13.6	9.1	857.19	2.36
Total Europe and Central Asia	**1,480,364**	**3,705,845**	**-2,225,481**	**705,922**	**920,181**	**-214,259**	**7.7**	**14.9**	**80,732.21**	**2.18**
LATIN AMERICA and the CARIBBEAN										
Argentina	118,412	287,754	-169,342	221,766	131,816	89,949	-6.1	8.1	1,815.12	0.68
Belize	5,384	8,356	-2,972	5,433	17,484	-12,050	-0.1	-7.1	58.57	0.70
Bolivia	10,833	23,143	-12,310	21,342	11,307	10,036	-6.6	7.4	163.10	0.70
Brazil	918,846	2,340,629	-1,421,783	1,087,061	953,868	133,194	-1.7	9.4	39,869.81	1.73
Chile	337,797	1,307,966	-970,169	340,794	236,522	104,272	-0.1	18.7	841.78	0.07
Colombia	386,462	416,961	-30,499	462,766	255,636	207,130	-1.8	5.0	8,440.96	2.02
Costa Rica	70,711	315,641	-244,930	40,755	149,696	-108,941	5.7	7.7	1,527.16	0.48
Cuba	239,101	590,117	-351,016	133,039	193,066	-60,027	6.0	11.8	354.00	0.06
Dominica	4,945	312	4,633	1,835	420	1,415	10.4	-2.9	9.07	2.90
Dominican Republic	95,023	128,171	-33,148	71,102	51,514	19,588	2.9	9.5	5,753.34	4.60
Ecuador	160,480	125,202	35,278	93,730	126,397	-32,667	5.5	-0.1	2,867.38	2.29
El Salvador	50,138	53,324	-3,186	20,608	39,797	-19,190	9.3	3.0	4,857.12	9.10
Grenada	5,976	1,259	4,717	2,203	440	1,763	10.5	11.1	1.90	0.15
Guatemala	140,684	181,310	-40,626	41,915	72,227	-30,313	12.9	9.6	5,946.54	3.28
Guyana	10,563	197,703	-187,140	6,276	205,020	-198,743	5.3	-0.4	12.12	0.01
Haiti	17,025	22,787	-5,762	7,392	486	6,907	8.7	46.9	2,049.67	9.00
Honduras	22,860	133,095	-110,235	16,643	39,247	-22,604	3.2	13.0	12,093.68	9.15
Jamaica	158,552	347,626	-189,074	101,909	209,982	-108,073	4.5	5.2	164.82	0.05
Mexico	2,852,430	13,404,300	-10,551,870	1,200,074	4,493,918	-3,293,844	9.0	11.5	14,638.04	0.11
Nicaragua	16,259	61,244	-44,985	10,167	8,949	1,218	4.8	21.2	580.35	0.95
Panama	63,814	46,916	16,898	32,562	11,447	21,115	7.0	15.1	110.88	0.24
Paraguay	5,147	18,405	-13,258	26,274	1,720	24,554	-15.0	26.7	56.31	0.31
Peru	156,826	456,722	-299,896	95,307	95,661	-354	5.1	16.9	4,578.36	1.00
St. Kitts and Nevis	3,856	8,189	-4,333	4,662	1,883	2,779	-1.9	15.8	162.58	1.99
St. Lucia	8,040	366	7,674	11,860	483	11,377	-3.8	-2.7	0.65	0.18
St. Vincent and the Grenadines	5,092	123	4,969	3,430	252	3,178	4.0	-6.9	0.26	0.21
Suriname	12,182	142,332	-130,150	4,188	431	3,757	11.3	78.6	5.05	0.00
Trinidad and Tobago	120,786	156,286	-35,500	74,166	16,244	57,922	5.0	25.4	247.64	0.16
Uruguay	19,763	130,185	-110,422	24,871	23,827	1,044	-2.3	18.5	12,320.55	9.47
Venezuela	480,199	1,310,967	-830,768	344,701	504,121	-159,420	3.4	10.0	719.03	0.05
Total Latin America and the Caribbean	**6,498,186**	**22,217,391**	**-15,719,205**	**4,508,833**	**7,853,862**	**-3,345,029**	**3.7**	**11.0**	**120,245.81**	**0.54**
Total Developing Countries	**19,935,028**	**67,109,396**	**-47,174,368**	**12,490,871**	**18,857,717**	**-6,324,568**	**4.8**	**13.5**	**1,491,813.20**	**2.22**
Of which:										
LDCs	**459,666**	**1,171,609**	**-711,943**	**314,089**	**238,185**	**75,276**	**3.9**	**17.3**	**10,076.13**	**0.86**
Low Income Countries	**2,661,110**	**4,815,459**	**-2,154,349**	**1,382,345**	**2,216,165**	**-833,845**	**6.8**	**8.1**	**219,197.96**	**4.55**
Middle Income Countries	**17,273,918**	**62,293,937**	**-45,020,019**	**11,108,526**	**16,641,552**	**-5,490,723**	**4.5**	**14.1**	**1,272,615.24**	**2.04**
Total Other Countries[a] (excluding US)	**38,526,593**	**79,255,091**	**-40,728,498**	**33,279,129**	**46,079,589**	**-12,842,738**	**1.5**	**5.6**	**1,291,720.46**	**1.63**
Total Emerging Market Economies[b]	**15,579,972**	**55,392,618**	**-39,812,646**	**8,885,420**	**14,980,848**	**-6,095,428**	**5.8**	**14.0**	**1,314,911.89**	**2.37**
United States	**325,991,283**	**208,873,078**	**117,118,205**	**196,880,919**	**136,390,492**	**60,490,428**	**5.2**	**4.4**	**279,231.85**	**0.13**
Total World	**384,452,904**	**355,237,565**	**29,215,339**	**242,650,919**	**201,327,797**	**41,323,122**	**4.7**	**5.8**	**3,062,765.52**	**0.86**

Notes: Bold-italicized countries are not ODA eligible -see Technical Notes.

[a] Export and Import totals for the former Yugoslavia have been added to the developing country total for 1994.

[b] See the Technical Notes for a description of the country group.

Sources: Statistics Canada, *Exports by Country January-December 2004*, *Imports by Country January-December 2004*, *Exports by Country January-December 1995*, *Imports by Country January-December 1995*; Finance Canada, International Trade Policy Division.

Figure 9.1

Official and Commercial Debt Owed to Canada by Region (2004)

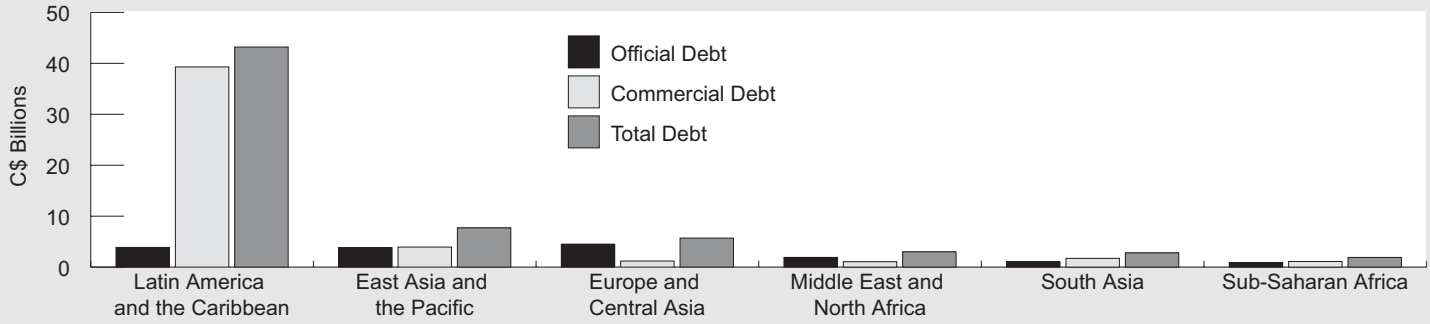


Figure 9.2

Stock of Canadian Foreign Direct Investment Abroad (2004)

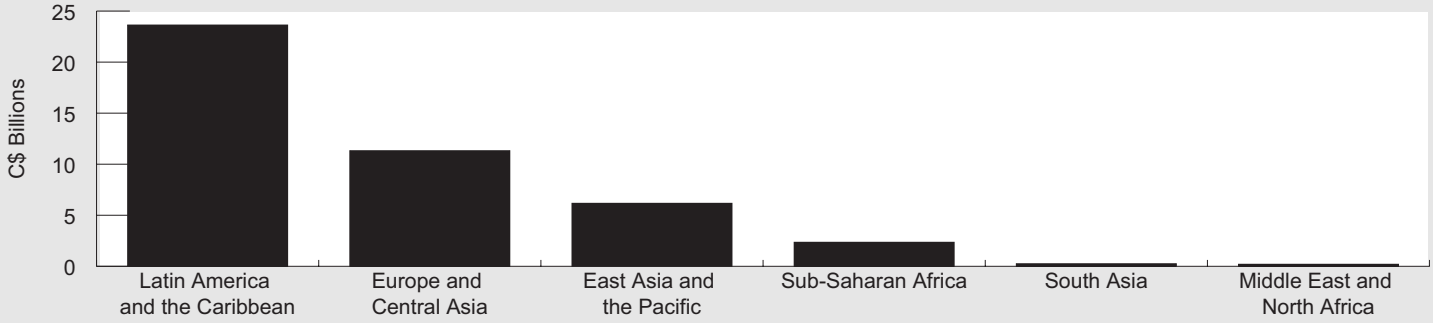


Figure 9.3

Top 10 FDI Countries in 2004

	Countries	C$ millions	%
1	Hungary	10,049	18.1
2	Chile	6,571	11.8
3	Brazil	6,402	11.5
4	Argentina	4,368	7.9
5	Indonesia	3,547	6.4
6	Mexico	2,755	5.0
7	Peru	2,121	3.8
8	Turkey	766	1.4
9	Thailand	740	1.3
10	Malaysia	651	1.2
	Top 10 Total	**37,970**	**68.4**
	Total Canadian FDI	**43,923**	

Table 9 **Finance and Investment Flows Between Canada and Developing Countries (2004)**
(In millions of Canadian dollars)

	Public or Official Debt			Private or Commercial Debt			
	Non-Concessional	Concessional	Total Official Debt	Total Canadian Chartered Bank Claims	Total Canadian Debt Claims (Estimate)	Stock of Foreign Direct Investment Abroad	Stock of Foreign Direct Investment in Canada
	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	2004	2004
Regions and Countries	1	2	3	4	5	6	7
SUB-SAHARAN AFRICA							
Angola	3.9	0	3.9	~	3.9	~	0
Benin	0	0	0	~	~	0	0
Botswana	0	0	0	~	~	~	~
Burkina Faso	0	0	0	~	~	~	0
Burundi	0	0	0	~	~	~	~
Cameroon	245.8	15.3	261.1	~	261.1	~	0
Cape Verde	0	0	0	~	~	~	~
Central African Republic	0	0	0	~	~	~	0
Chad	0	0	0	~	~	~	~
Comoros	0	0	0	~	~	~	~
Congo, Dem. Rep.	46.1	0	46.1	~	46.1	~	0
Congo, Rep.	47.9	0	47.9	~	47.9	0	0
Côte d'Ivoire	151.5	0	151.5	~	151.5	~	0
Equatorial Guinea	0	0	0	~	~	~	~
Eritrea	0	0	0	~	~	~	0
Ethiopia	0	0	0	~	~	~	0
Gabon	43.1	11	53.8	~	53.8	~	~
Gambia	0	0	0	~	~	0	0
Ghana	0.3	0	0.3	~	0.3	79	~
Guinea	0	0	0	~	~	~	0
Guinea-Bissau	0	0	0	~	~	~	0
Kenya	20.0	7.4	27.4	~	27.4	~	~
Lesotho	0	0	0	~	~	~	0
Liberia	0	0	0	~	~	~	~
Madagascar	32.1	0	32.1	~	~	~	0
Malawi	0	0	0	~	~	0	0
Mali	0	0	0	~	~	~	0
Mauritania	0	0	0	~	~	~	0
Mauritius	0	0	0	~	~	10	0
Mozambique	27.4	0	27.4	~	27.4	0	0
Namibia	0	0	0	~	~	10	0
Niger	0	0	0	~	~	~	0
Nigeria	0.1	0	0.1	~	0.1	~	~
Rwanda	0	3.1	3.1	~	3.1	0	0
São Tomé and Principe	0	0	0	~	~	~	~
Senegal	7.1	0	7.1	~	7.1	~	0
Seychelles	0	0	0	~	~	0	0
Sierra Leone	0	0	0	~	~	~	0
Somalia	0	0	0	~	~	~	~
South Africa	98.4	0	98.4	1,076	1,174.4	304	266
Sudan	11.2	0	11.2	~	11.2	~	~
Swaziland	0	0	0	~	~	~	~
Tanzania	0	0	0	~	~	~	~
Togo	0	0	0	~	~	0	0
Uganda	0	0	0	~	~	~	0
Zambia	67.5	0	67.5	~	67.5	~	0
Zimbabwe	0	0	0	~	~	27	0
Sub-Saharan Africa unspecified	0	0	0	24	24.0	1,922	14
Total Sub-Saharan Africa	**802.4**	**36.5**	**838.9**	**1,100**	**1,906.8**	**2,352**	**280**
MIDDLE EAST and NORTH AFRICA							
Algeria	601.9	45.5	647.4	173	820.4	3	~
Djibouti	0	0	0	~	~	~	~
Egypt	236.8	56.2	293.0	~	293.0	~	~
Iran	19.5	0	19.5	~	19.5	~	~
Iraq	715.3	0	715.3	~	715.3	~	0

Table 9 *(continued)*

Middle East and North Africa *(cont'd)*	Public or Official Debt			Private or Commercial Debt			
	Non-Concessional	Concessional	Total Official Debt	Total Canadian Chartered Bank Claims	Total Canadian Debt Claims (Estimate)	Stock of Foreign Direct Investment Abroad	Stock of Foreign Direct Investment in Canada
	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	2004	2004
Regions and Countries	1	2	3	4	5	6	7
Jordan	29.3	0	29.3	~	29.3	~	0
Lebanon	0.5	0	0.5	~	0.5	0	~
Libya	0	0	0	~	~	~	0
Morocco	4.6	113.6	118.2	~	118.2	~	~
Oman	0	0	0	~	~	~	~
Saudi Arabia	1.5	0	1.5	216	217.5	4	~
Syria	0	0	0	~	~	~	0
Tunisia	18.7	61.8	80.5	~	80.5	191	0
West Bank and Gaza	0	0	0	~	~	~	~
Yemen	0	0	0	~	~	~	0
Middle East and North Africa unspecified	0	0	0	671	671.0	~	~
Total Middle East and North Africa	**1,628.1**	**277.1**	**1,905.2**	**1,060**	**2,965.2**	**198**	**0**
SOUTH ASIA							
Afghanistan	0	0	0	~	~	~	~
Bangladesh	0	0	0	~	~	0	0
Bhutan	0	0	0	~	~	~	~
India	308.1	59.8	367.9	1,720	2,087.9	251	62
Maldives	3.7	0	3.7	~	3.7	~	~
Nepal	0	0	0	~	~	0	0
Pakistan	136.0	447.5	583.5	~	583.5	~	~
Sri Lanka	0	99.2	99.2	~	99.2	1	~
South Asia unspecified	0	0	0	~	~	~	~
Total South Asia	**447.8**	**606.5**	**1,054.3**	**1,720**	**2,774.3**	**252**	**62**
EAST ASIA and the PACIFIC							
Cambodia	0	0	0	~	~	0	~
China	2,231.1	561.6	2,792.7	1,205	3,997.7	647	220
Indonesia	548.1	244.4	792.5	~	792.5	3,547	~
Korea, Dem. Rep.	0	0	0	~	~	0	0
Laos	0	0	0	~	~	~	~
Malaysia	0	2.2	2.2	1,428	1,430.2	651	102
Mongolia	0	0	0	~	~	~	0
Myanmar	0	8.3	8.3	~	8.3	~	0
Papua New Guinea	0	0	0	~	~	448	~
Philippines	169.7	1.9	171.6	238	409.6	131	1
Thailand	3.0	31.4	34.4	313	347.4	740	3
Timor-Leste	0	0	0	~	~	~	~
Vietnam	4.7	0	4.7	~	4.7	5	~
Oceania	0	0	0	~	~	~	~
East Asia and the Pacific unspecified	0	0	0	746	746.0	~	~
Total East Asia and the Pacific	**2,956.6**	**849.8**	**3,806.4**	**3,930**	**7,736.4**	**6,169**	**326**
EUROPE and CENTRAL ASIA							
Albania	0	0	0	~	~	~	0
Armenia	0	0	0	~	~	~	0
Azerbaijan	0	0	0	~	~	~	~
Belarus	0	0	0	~	~	~	~
Bosnia and Herzegovina	4.9	0	4.9	~	4.9	~	~
Bulgaria	0	0	0	~	~	~	~
Croatia	30.6	0	30.6	~	30.6	~	0
Czech Republic	10.3	0	10.3	~	10.3	111	~
Estonia	0	0	0	~	~	~	~
Georgia	0	0	0	~	~	~	0
Hungary	1.0	0	1.0	~	1.0	10,049	~
Kazakhstan	4.0	0	4.0	~	~	~	~
Kyrgyzstan	0	0	0	~	0.0	~	~
Latvia	0	0	0	~	~	~	0
Lithuania	0	0	0	~	~	0	0
Macedonia, FYR	0	0	0	~	~	~	~
Moldova	0	0	0	~	~	~	~
Poland	1,736.7	0	1,736.7	148	1,884.7	192	6

Table 9 *(continued)*

Europe and Central Asia *(cont'd)*	Public or Official Debt			Private or Commercial Debt			
	Non-Concessional	Concessional	Total Official Debt	Total Canadian Chartered Bank Claims	Total Canadian Debt Claims (Estimate)	Stock of Foreign Direct Investment Abroad	Stock of Foreign Direct Investment in Canada
	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	31-Mar-2005	2004	2004
Regions and Countries	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Romania	424.7	0	424.7	~	424.7	7	~
Russia	1,878.6	0	1,878.6	50	1,928.6	188	~
Serbia and Montenegro	190.1	0	190.1	~	190.1	0	~
Slovakia	0	0	0	~	~	9	~
Tajikistan	0	0	0	~	~	~	0
Turkey	101.8	123.9	225.7	~	225.7	766	~
Turkmenistan	0	0	0	~	~	0	0
Ukraine	1.3	0	1.3	~	1.3	~	0
Uzbekistan	0	0	0	~	~	~	~
Europe and Central Asia unspecified	0	0	0	993	993.0	~	~
Total Europe and Central Asia	**4,384.0**	**123.9**	**4,507.9**	**1,191**	**5,694.9**	**11,322**	**6**
LATIN AMERICA and the CARIBBEAN							
Argentina	341.4	0.2	341.6	139	480.6	4,368	5
Belize	0	0	0	~	~	~	0
Bolivia	0.8	0.7	1.5	~	1.5	64	~
Brazil	507.6	3.3	510.9	1,744	2,254.9	6,402	2,055
Chile	476.1	1.2	477.3	4,078	4,555.3	6,571	~
Colombia	40.4	0.3	40.7	~	40.7	261	3
Costa Rica	0.1	0	0.1	~	0.1	82	~
Cuba	24.4	9.5	33.9	~	33.9	~	~
Dominica	0	0	0	~	~	~	0
Dominican Republic	140.6	4.4	145.0	~	145.0	88	0
Ecuador	35.4	5.1	40.5	~	40.5	292	~
El Salvador	17.4	0.1	17.5	~	17.5	58	0
Grenada	0	0	0	~	~	0	0
Guatemala	10.4	2.2	12.6	~	12.6	~	~
Guyana	0	0	0	~	~	58	~
Haiti	2.4	0	2.4	~	2.4	~	0
Honduras	10.4	0	10.4	~	10.4	~	0
Jamaica	81.0	7.4	88.4	~	88.4	~	~
Mexico	1,001.4	0	1,001.4	22,289	23,290.4	2,755	427
Nicaragua	0	0	0	~	~	~	0
Panama	18.2	0	18.2	721	739.2	146	45
Paraguay	0	0.2	0.2	~	0.2	~	0
Peru	562.2	0	562.2	331	893.2	2,121	~
St. Kitts and Nevis	0	0	0	~	~	~	~
St. Lucia	0	0	0	~	~	~	0
St. Vincent and the Grenadines	0	0	0	~	~	~	~
Suriname	0	0	0	~	~	~	0
Trinidad and Tobago	41.5	0	41.5	1,480	1,521.5	111	~
Uruguay	0	0	0	~	~	1	~
Venezuela	517.6	0	517.6	367	884.6	252	~
Latin America and the Caribbean unspecified	0	0	0	8,153	8,153.0	~	~
Total Latin America and the Caribbean	**3,829.3**	**34.6**	**3,863.9**	**39,302**	**43,165.9**	**23,630**	**2,535**
Total Developing Countries	**14,048.2**	**1,928.4**	**15,976.6**	**48,303**	**64,243.5**	**43,923**	**3,209**
Of which:							
LDCs	**201.4**	**11.4**	**212.8**	**~**	**187.7**	**~**	**~**
Low Income Countries	**1,660.2**	**785.8**	**2,446.0**	**1,720**	**4,166.0**	**3,904**	**62**
Middle Income Countries	**12,388.0**	**1,142.6**	**13,530.6**	**35,996**	**49,526.6**	**38,097**	**3,133**
Unspecified Countries	**0**	**0**	**0**	**10,587**	**10,587.0**	**1,922**	**14**

Sources: Finance Canada, International Finance and Economic Analysis Division; Bank of Canada, *Banking and Financial Statistics, July 2005*; Statistics Canada, Balance of Payments Division.

Figure 10.1

Immigration by Top Five Source Countries (2004)

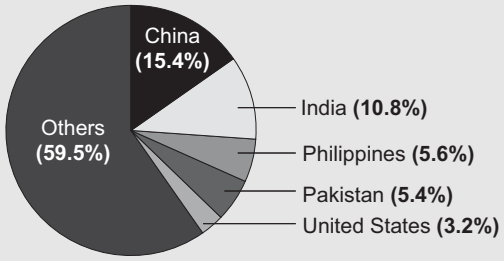


Figure 10.2

Immigration by Level of Education (2004)

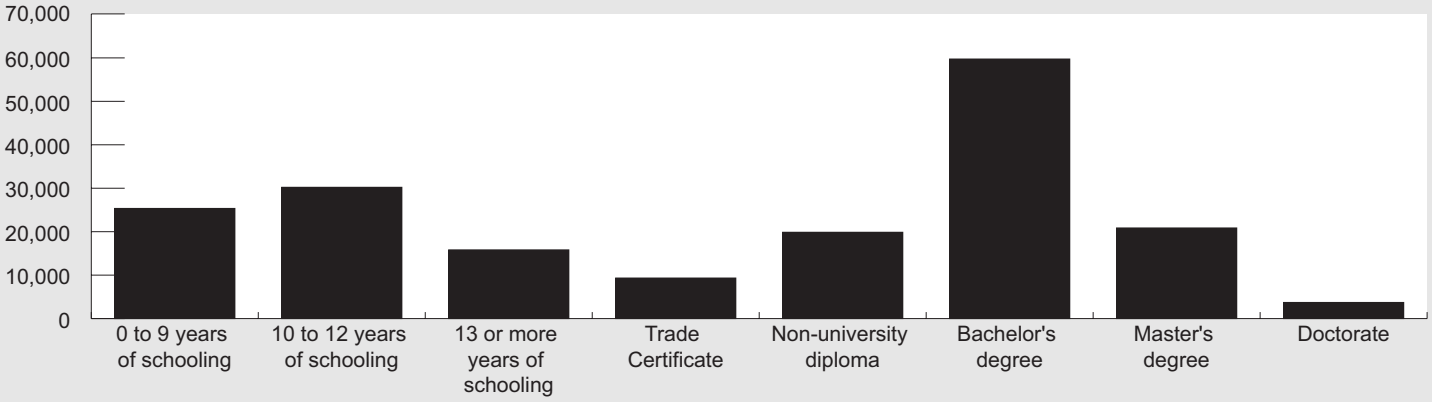


Figure 10.3

Immigration by Labour Market Intention and Occupational Skill Level (2004)

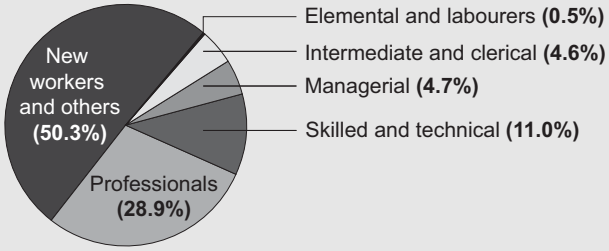


Table 10 **Immigration to Canada from Selected Countries (1995-2004)**

Table 10.1 **Immigration Summary by Source Area**

Principal Applicants and Dependants

REGION	1995 #	1995 %	1999 #	1999 %	2004 #	2004 %
Africa and the Middle East	32,928	15.5	33,548	17.7	49,520	21.0
Asia and Pacific	112,891	53.0	96,554	50.8	114,544	48.6
South and Central America	20,464	9.6	15,273	8.0	22,248	9.4
United States	5,195	2.4	5,532	2.9	7,494	3.2
Europe	41,351	19.4	38,982	20.5	41,848	17.7
Not Stated	40	0.0	77	0.0	170	0.1
Total	**212,869**	**100**	**189,966**	**100**	**235,824**	**100**

Table 10.2 **Immigration by Top Ten Source Countries**

Principal Applicants and Dependants

COUNTRY	1995 #	1995 %	1995 Rank	1999 #	1999 %	1999 Rank	2004 #	2004 %	2004 Rank
China	13,309	6.3	4	29,138	15.3	1	36,411	15.4	1
India	16,261	7.6	2	17,452	9.2	2	25,569	10.8	2
Philippines	15,160	7.1	3	9,202	4.8	4	13,301	5.6	3
Pakistan	4,002	1.9	10	9,303	4.9	3	12,796	5.4	4
United States	5,195	2.4	9	5,532	2.9	7	7,494	3.2	5
Iran	3,692	1.7	15	5,909	3.1	6	6,063	2.6	6
United Kingdom	6,170	2.9	8	4,479	2.4	10	6,058	2.6	7
Romania	3,851	1.8	14	3,467	1.8	14	5,655	2.4	8
Korea, Republic of	3,467	1.6	17	7,216	3.8	5	5,337	2.3	9
France	3,894	1.8	12	3,919	2.1	11	5,026	2.1	10
Sri Lanka	8,938	4.2	5	4,726	2.5	9	4,134	1.8	13
Russia	1,726	0.8	31	3,781	2.0	12	3,683	1.6	14
Taiwan	7,690	3.6	6	5,481	2.9	8	1,992	0.8	27
Hong Kong	31,769	14.9	1	3,670	1.9	13	1,544	0.7	33
Yugoslavia (former)	2,987	1.4	18	1,492	0.8	29	708	0.3	59
Bosnia and Herzegovina	6,295	3.0	7	2,809	1.5	17	181	0.1	109
Total for Top Ten only	**114,789**	**53.9**		**98,438**	**51.8**		**123,710**	**52.5**	
Total Other Countries	**98,080**	**46.1**		**91,528**	**48.2**		**112,114**	**47.5**	
Total	**212,869**	**100**		**189,966**	**100**		**235,824**	**100**	

Table 10.3 **Immigration by Gender and by Class**

Principal Applicants and Dependants

CLASS/GENDER	1995 #	1995 %	1999 #	1999 %	2004 #	2004 %
Family Class						
Male	32,249	41.7	21,463	38.8	23,712	38.1
Female	45,134	58.3	33,803	61.2	38,533	61.9
Total	**77,383**	**36.4**	**55,266**	**29.1**	**62,245**	**26.4**
Economic Immigrants						
Male	53,727	50.4	57,835	52.9	70,073	52.4
Female	52,907	49.6	51,422	47.1	63,673	47.6
Total	**106,634**	**50.1**	**109,257**	**57.5**	**133,746**	**56.7**
Refugees						
Male	15,437	55.0	13,205	54.1	16,978	51.9
Female	12,649	45.0	11,192	45.9	15,708	48.1
Total	**28,086**	**13.2**	**24,397**	**12.8**	**32,686**	**13.9**
Other Immigrants						
Male	477	62.7	539	52.3	3,392	47.5
Female	284	37.3	492	47.7	3,754	52.5
Total	**761**	**0.4**	**1,031**	**0.5**	**7,146**	**3.0**
Not Stated	5	0	15	0	1	0
Total						
Male	101,890	53.8	93,042	41.2	114,155	45.8
Female	110,974	58.6	96,909	42.9	121,668	48.8
Grand Total	**212,869**	**100**	**189,966**	**100**	**235,824**	**100**

Table 10.4 **Immigration by Level of Education**

	1995		1999		2004	
EDUCATION•	**#**	**%**	**#**	**%**	**#**	**%**
0 to 9 years of schooling	32,753	19.7	22,483	15.3	25,354	13.7
10 to 12 years of schooling	48,221	29.1	27,859	18.9	30,219	16.3
13 or more years of schooling	16,015	9.7	12,471	8.5	15,817	8.6
Trade Certificate	15,230	9.2	11,162	7.6	9,334	5.0
Non-university diploma	12,304	7.4	13,397	9.1	19,868	10.7
Bachelor's degree	31,563	19.0	43,963	29.8	59,740	32.3
Master's degree	7,714	4.6	13,135	8.9	20,861	11.3
Doctorate	2,138	1.3	2,931	2.0	3,714	2.0
Total	**165,938**	**100**	**147,401**	**100**	**184,907**	**100**

*Applies to those 15 years of age or older.

Table 10.5 **Immigration by Labour Market Intention and Occupational Skill Level**

	1995		1999		2004	
OCCUPATIONAL SKILL LEVEL	**#**	**%**	**#**	**%**	**#**	**%**
Managerial	3,287	3.0	2,865	2.8	5,798	4.7
Professionals	22,164	20.2	32,781	32.6	35,941	28.9
Skilled and technical	21,352	19.4	14,499	14.4	13,683	11.0
Intermediate and clerical	8,385	7.6	5,065	5.0	5,752	4.6
Elemental and labourers	10,137	9.2	1,153	1.1	649	0.5
Total occupational skill level identified	**65,325**	**59.5**	**56,363**	**56.1**	**61,823**	**49.7**
New workers (>15 years)	41,432	37.7	42,485	42.2	61,463	49.4
Industrial codes (>15 years)	3,062	2.8	1,709	1.7	1,156	0.9
Total occupational skill level not identified	**44,494**	**40.5**	**44,194**	**43.9**	**62,619**	**50.3**
Total intending to work	**109,819**	**100**	**100,557**	**100**	**124,442**	**100**
Children, students, retirees and others	103,050		89,409		111,382	
Total immigrants	**212,869**		**189,966**		**235,824**	

Table 10.6 **Refugees by Source Area**

Principal Applicants and Dependants

	1995		1999		2004	
REGION	**#**	**%**	**#**	**%**	**#**	**%**
Africa and the Middle East	7,143	25.4	8,499	34.8	12,593	38.5
Asia and Pacific	9,608	34.2	7,260	29.8	12,158	37.2
South and Central America	2,087	7.4	1,417	5.8	4,597	14.1
United States	53	0.2	30	0.1	132	0.4
Europe and the United Kingdom	9,195	32.7	7,182	29.4	3,172	9.7
Not Stated	1	0.0	9	0.0	34	0.1
Total	**28,087**	**100**	**24,397**	**100**	**32,686**	**100**

Source: Citizenship and Immigration Canada, *Facts and Figures 2004: Immigration Overview.*

Technical Notes

General Comments

Virtually all data in these tables is available or derived from existing, publicly accessible information issued by the Government of Canada, the Organization for Economic Co-operation and Development (OECD), the World Bank, and United Nations agencies. The North-South Institute selects the data for this annex chiefly for its development interest. However, data availability, including annual updates, also is an important factor. Some additions (and deletions) have been made to this year's report.

Selection of Developing Countries

The statistical annex lists developing countries under country groupings which reflect the six Millennium Development Goal (MDG) reference regions as set by the World Bank. The country groupings are the following: Sub-Saharan Africa, Middle East and North Africa, South Asia, East Asia and the Pacific, Europe and Central Asia, Latin America and the Caribbean. Tables 2 through 4 and 7 through 9 list this common set of developing countries. The Europe and Central Asia grouping includes 12 countries that are ineligible for official development assistance (ODA) according to the criteria of the OECD Development Assistance Committee (DAC). The treatment of these countries is discussed below.

None of the countries on the list is a dependent or colonial territory. However, the entities listed in these tables and identified in italics—Hong Kong, the West Bank and Gaza, Oceania, Taiwan, and former Yugoslavia—are not "independent countries." Hong Kong became the Hong Kong Special Administrative Region (SAR) of China on 1 July, 1997. The West Bank and Gaza, at the time of writing, had not yet been granted independent status. Oceania comprises the Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, Nauru, Palau, Samoa, the Solomon Islands, Tonga, Tuvalu, and Vanuatu.

ODA Ineligible Countries

There are 12 countries categorized as "developing" that were ineligible for official development assistance in 2003-04. These are Belarus, Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, the Russian Federation, the Slovak Republic, and Ukraine. Although these countries may receive "official assistance" from Canada and other donors, that aid is not included in calculations of ODA. Statistics for these countries are excluded from regional, world, and income-based totals in Tables 3, 4, and 7.

Year of Coverage

Data generally is given for the latest calendar year for which complete information exists—normally 2003. However, in the case of Official Development Assistance in Tables 3 through 7, the figures are for fiscal year 2003-04 (April 1, 2003, to March 31, 2004). In other cases where the data is not for calendar year 2003, the relevant date is indicated.

Symbols

na = "not applicable"

~ = "not available"

0 = zero

Unless otherwise indicated, figures are in Canadian dollars.

Income-Grouped Totals

Sub-totals for country income-groupings can be found at the bottom of columns in Tables 2 through 4, and 7 through 10. These groupings follow the World Bank's classification of countries by income level, as listed in the UNDP *Human Development Report* and in the Canadian International Development Agency's (CIDA) *Statistical Report on Development Assistance* for fiscal year 2003-04. The list of least developed countries (LDCs), low income countries, and middle income countries is provided below.

LDCs: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Laos, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, Sao Tome and Principe,

Senegal, Sierra Leone, the Solomon Islands, Somalia, Sudan, Tanzania, Timor-Leste, Togo, Tuvalu, Uganda, Vanuatu, Yemen, and Zambia.

Low-income countries: Afghanistan, Angola, Azerbaijan, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Georgia, Ghana, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Kenya, Democratic Republic of Korea, Kyrgyzstan, Laos, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Moldova, Mongolia, Mozambique, Myanmar, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, the Solomon Islands, Somalia, Sudan, Tajikistan, Tanzania, Timor-Leste, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia, and Zimbabwe.

Middle-income countries: Albania, Algeria, Argentina, Armenia, Belarus, Belize, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria, Cape Verde, Chile, China, Colombia, Costa Rica, Croatia, Cuba, Czech Republic, Djibouti, Dominica, Dominican Republic, Ecuador, Egypt, El Salvador, Estonia, Fiji, Gabon, Grenada, Guatemala, Guyana, Honduras, Hungary, Iran, Iraq, Jamaica, Jordan, Kazakhstan, Kiribati, Latvia, Lebanon, Libya, Lithuania, Macedonia FYR, Malaysia, Maldives, the Marshall Islands, Mauritius, Mexico, Micronesia, Morocco, Namibia, Northern Mariana Islands, Oman, Palau, Panama, Paraguay, Peru, Philippines, Poland, Romania, Russia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Saudi Arabia, Serbia and Montenegro, Seychelles, Slovakia, South Africa, Sri Lanka, Suriname, Swaziland, Syria, Thailand, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Ukraine, Uruguay, Vanuatu, Venezuela, and the West Bank and Gaza.

Note that totals by income-group may differ from totals for all developing countries because income-group totals are based on country-specific information only, while overall totals for developing countries also include allocations to regions that cannot be attributed to specific countries.

Emerging Market Economies

In Table 8 this country grouping is included alongside the income-based grouping. This grouping is not, strictly speaking, income based because it includes low, middle, and high-income countries (but no LDCs). These are countries that are considered to have fairly dynamic economies, which have already undergone significant levels of industrial and financial development, and achieved substantial integration into international capital markets. The countries (included in the "Emerging-market indicators" section of The Economist) are: Argentina, Brazil, Chile, China, Colombia, the Czech Republic, Egypt, Hungary, India, Indonesia, Malaysia, Mexico, Peru, Philippines, Poland, Russia, South Africa, Thailand, Turkey, and Venezuela.

Table 1
Canada and other High Human Development Economies: Selected Indicators (2003)

Table 1.1 includes the 22 OECD DAC Member Countries and two other high-income OECD Member Countries (Iceland and the Republic of Korea). Table 1.2 includes 14 other high-income countries. The HDI and gender-related development index (GDI) are from the UNDP's *Human Development Report 2005*. The GNI per capita (PPP$) figures are from the World Bank's *World Development Indicators 2005*. Data on foreign aid and net private financial flows are taken from the OECD's DAC *Development Cooperation Report 2004*. Numbers for the shares of exports to and imports from developing countries are from the IMF's *Direction of Trade Statistics Yearbook 2004*.

Again, per capita incomes were reported in PPP$ rather than US$ and this will continue into the future. The PPP$ is a more accurate standardization of the 'value in consumption' of income across all reporting countries. This denomination, therefore, forms a better basis for comparing incomes across countries. In addition, exchange rate changes can significantly alter the recorded US$ incomes of countries from year to year, even when it is averaged (as in the World Bank's Atlas method) and can therefore give misleading information about actual changes in domestic income.

Table 2
The Developing Countries: Selected Social and Economic Indicators (2003)

Figures on the GDI, HDI, Adult Literacy, and Under-5 Mortality rates are taken from the UNDP's *Human Development Report 2005*. Figures on GNI per capita, total GDP, annual GDP per capita growth rate, population, external debt/GNI and aid/GNI are taken from the World Bank's *World Development Indicators 2005*. Figures on total debt service/GNI (a new column) are taken from the World Bank's *Global Development Finance 2005*.

Country groupings totals for columns 1, 2, 3, 5, 7, and 8 are weighted by population. Country groupings totals for columns 9, 10, and 11 are weighted by GNI (current $US).

As in Table 1, per capita estimates are also reported in PPP$. The justification given above applies here as well.

Table 3
Canadian Official Development Assistance: Basic Data (2003-04)

Table 4
Canadian Bilateral ODA by Channel and by Country (2003-04)

Table 5
Canadian Bilateral ODA by Sector (2003-04)

Table 6
Canadian Technical Assistance to Developing Countries (1998-2003)

Table 7
Canadian Multilateral ODA by Agency and by Country (2003-04)

The basic data on Canadian official development assistance in Tables 3 through 7 are taken or derived from the "Statistical Report on Development Assistance" for fiscal year 2003-2004, published by CIDA's International Development Information Centre. Information in the tables is taken from "Table L: Country-to-Country ODA Disbursements by Sector and Percentage", "Table M: Total Disbursements by Country", "Table N: Experts on Assignment Abroad by Area of Expertise", "Table O: Experts on Assignment Abroad by Region of Assignment", "Table P: Students and Trainees supported by CIDA by Region of Origin and Location of Study" and "Table Q: Students and Trainees supported by CIDA by Field of Study". To ensure conformity with CIDA totals, aid allocations for developing countries, which do not match NSI criteria (such as South Korea and Bahamas), are included as Regional Africa, Caribbean, Latin America, and Asia, and as Other Americas, Asia, and Europe. Information on Canada's rank among other bilateral donors in recipient countries is derived from the OECD's *Geographic Distribution of Financial Flows to Aid Recipients 1999-2003*.

In Table 3, for better comparison purposes the 1993-94 total bilateral ODA flows have been translated into 2003 prices using the Consumer Price Index (CPI). Included under the classification "Unallocable by Country" at the bottom of Tables 3, 4 and 7 are imputed administrative costs, interest costs, other government department costs and services, provincial government support to development, CIDA's Public Outreach (Development Information) Program as well as other costs.

Finally, in table 7, the imputed shares of Canadian Multilateral Assistance by Agency and Country were computed from supplementary information provided to The North-South Institute by CIDA. These figures only estimate the allocation of Canadian funds to particular countries by multilateral agencies. The figures understate the amount of multilateral aid going to relatively small developing countries.

Table 8
Canadian Balance of Merchandise Trade with Developing Countries (2004)

The data on exports and imports are obtained from Statistics Canada *Catalogues # 65-003* and # *65-006* for 2004 and 1995. Export and import prices for 1994 were translated into real terms using the respective implicit price indices (Fisher index formula). The Department of Finance provided the information on customs revenue on imports from developing countries.

Table 9
Finance and Investment Flows between Canada and Developing Countries (2004)

Data on the stock of public Canadian claims were made available by Finance Canada's International Finance and Economic Analysis Division and by Export Development Canada (EDC). Data on the stock of private Canadian claims were taken from the Bank of Canada's *Banking and Financial Statistics*, July 2005.

Public or official debt is constituted by non-concessional and concessional loans.

Non-concessional loans are: EDC's Corporate Account (sovereign and commercial) loans which include principal outstanding, recognized accrued revenue, and unrecognized accrued revenue; EDC's non-concessional loans under the Canada Account; Department of Finance loans; and the Canadian Wheat Board loans (sovereign and commercial).

Concessional loans are: CIDA loans; and EDC's concessional loans under the Canada Account.

Private or commercial debt includes total claims booked worldwide vis-à-vis non-residents by Canadian chartered banks.

Statistics Canada's Balance of Payments Division provided the figures on Canadian direct investment abroad in developing countries and foreign direct investment by developing countries in Canada. The symbol "~" in the two columns relating to foreign direct investment signals that data are not available in order to protect confidentiality. Hence, country-grouping and income-grouping totals underestimate the total stock of foreign investment.

Table 10
Immigration to Canada from Selected Countries (1995-2004)

The Department of Citizenship and Immigration was the source of information on immigration to Canada from developing countries. *Facts and Figures: Immigration Overview 2004* provided figures on immigration by level of education, by source area, by top ten source countries, by gender and by class, by labour market intention and occupational skill level, as well as on refugees by source area. Definitions of immigrant categories and occupational skill levels are the following:

Family class: Permanent residents sponsored by a Canadian citizen or a permanent resident living in Canada who is at least 19 years of age. Family class immigrants include spouses and partners (i.e., spouse, common-law partner, or conjugal partner); parents and grandparents; and others (i.e., dependent children, children under the age of 18 whom the sponsor intends to adopt in Canada, children of whom the sponsor is the guardian, as well as brothers, sisters, nephews, nieces, and grandchildren who are orphans under the age of 18, or any other relative if the sponsor has no relative as described above, either abroad or in Canada).

Economic immigrants: Permanent residents selected for their skills and ability to contribute to Canada's economy. The economic immigrant category includes skilled workers, business immigrants, provincial or territorial nominees, and live-in caregivers.

Refugees: Permanent residents in the refugee category include government-assisted refugees, privately sponsored refugees, refugees landed in Canada, and refugee dependants (i.e., dependants of refugees landed in Canada, including spouses and partners living abroad or in Canada).

Other immigrants: Permanent residents in the other immigrant category include post-determination refugee claimants, deferred removal orders, retirees, temporary resident permit holders, and humanitarian and compassionate cases.

Occupational skill level: Five skill levels, based on the National Occupational Classification, have been determined for permanent residents 15 years of age or older as well as for foreign workers.

- Skill level O (management): management occupations.
- Skill level A (professional): professional occupations in business and finance; natural and applied sciences; health; social science, education, government service, and religion; and art and culture.

Educational or training requirements: university degree.

- Skill level B (technical and skilled): technical or skilled occupations in administration and business; natural and applied sciences; health; law, social service, education, and religion; art, culture, recreation and sport; sales and service; as well as trades and skilled transport and equipment operators; skilled occupations in primary industries; and processing, manufacturing and utilities supervisors and skilled operators.

  Educational or training requirements: two to three years of post-secondary education, or two to five years of apprenticeship training, or three to four years of secondary school and more than two years of on-the-job training, occupation-specific training courses or specific work experience.

- Skill level C (clerical and intermediate): clerical occupations; assisting occupations in health services; intermediate occupations in sales and services; transport, equipment operations, installation and maintenance; primary industries; as well as processing and manufacturing machine operators and assemblers.

Educational or training requirements: one to four years of secondary school education, or up to two years of on-the-job training, training courses or specific work experience.

- Skill level D (elemental and labourers): elemental sales and service occupations and labourers in construction; primary industries; and processing, manufacturing and utilities.

  Educational or training requirements: no formal educational requirements; short work demonstration or on-the-job training.