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The health of nations: conceptualizing approaches to trade in health care

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"East is East and West is West, and never twain shall meet." Are not the worlds of free trade and health care as much apart as the longitudinal extremes in Rudyard Kipling's famous ballad? Or, to put it differently: the forces of the *wealth of nations,* why are they not at work for the *health of nations*?

In the last fifty years, trade liberalization has progressed and spurred economic growth. Countries have liberalized unilaterally or in concert with other countries. Incrementally, tariffs have been reduced, even removed, and other measures of protectionism have grown less significant. The structures and patterns of trade have also changed considerably. An increasing number of countries have integrated into the world economy. Multinational firms have fragmented their supply chains and used the opportunities created by trade and investment liberalization.

Yet there is one sector which remains conspicuously un-globalized and outside this trend of emerging free trade: health care. Health care has not escaped completely the forces of global integration. Input goods, like health technologies and pharmaceuticals, are

SUMMARY

Health care services have so far resisted emerging forces of globalization. But the combination of fiscally unviable national health services with modern technological and medical innovations, are opening the door to the desirability and feasibility of trade in health. Continuing opposition to liberalizing trade in health care, means this potential for the health sector is under-explored.

This policy brief assesses the current status of health and trade policies and analyses opposition to liberalizing trade in health care. It conceptualises and contrasts two international policy dialogues. One, typified by UN bodies such as the WHO, is sceptical if not hostile to increased trade in health care, particularly north-south integration. Its policy errs on the side of protectionism and favours an industrial-policy approach. The other, operating under WTO discourse, has more of a free-trade bent. And yet in policy practice, few countries in the WTO trade in health care and trade agreements typically contain little to promote liberalization.

Examples in this study from those few (mainly developing) countries that have shown initiative towards trade in health care, contradict this negative and apathetic approach. Countries as diverse as Brazil, China, Cuba, India and South Africa are already significant exporters of health care. Trade does hold some very tangible benefits for this sector, for north and south alike, and does not necessarily entail undermining government regulatory power. Further analysis of different health care systems' trade-compatibility is necessary, if the wealth of nations is to be applied to the health of nations.

traded. But the provision of health-care services are not only essentially locked to international trade agreements in most developed countries, it also remains seen as a non-tradable sector that, regardless of policy choices, cannot be traded.

This notion is fundamentally flawed. Not only *can* health be traded, it *is* increasingly traded. Yet there are several groups that nurture the non-tradable philosophy or attempt to block policy reforms that open the health sector for cross-border exchange. Some of these groups are entirely against trade and globalization; they, however, are largely street theatre on the fringes. More important and influential are established organizations and various United Nation bodies, which either explicitly oppose any suggestion of freer trade in health care (without being critical of trade in other sectors) or that, under the flag of developing-country concern, purvey industrial-policy models neglecting or rejecting trade in health care. Western public-sector unions and NGOs can be found in the former group and United Nation bodies, like the World Health Organization (WHO), in the latter group.

This paper, the first in a series of papers on trade in health care, discusses current developments concerning health care in trade, trade policy, and the trade-policy debate. Taking stock of these developments, the paper aims to scrutinize various concepts of trade in health care and outline policy approaches. Its approach to trade in health care is based on the age-old insights of the general benefits from trade, and it applies these benefits, framed in trade policy, to the world of health care. The paper mixes perspectives from developed and developing countries. At the core, however, are European health-care policies and the reality facing EU policy makers.

THE FISCAL CLAMP ON HEALTH CARE

The clearest trend in modern health-care systems, particularly in advanced industrial economies, is rising expenditure. Estimates suggest that global expenditure in the early twenty-first century was as high as 3 trillion USD.[2] The OECD estimates that average healthcare expenditure in 2007 accounted for 9 % of GDP, up from just over 5 % in 1970.[3] The rise in expenditures will be even more pronounced in the decades to come, and governments all over the world are therefore anxious to find methods to curtail spiralling costs without sacrificing service delivery.

Few methods, however, have proved successful and sustainable. Health care policies, especially in Europe, appear to be under constant reform.

Yet there is a fundamental problem in this cost-containment outlook on health expenditures: it considers rising expenditures as a concern. But there is a great deal of uncertainty about what exactly constitutes the problem. Rising expenditures alone cannot constitute a problem. Expenditures on telecom products, for example, have risen faster than health expenditures in the last 15 years, yet no one considers this to be an economic problem. Rising health expenditures can also be seen as a natural consequence of higher wealth: as economies grow, a larger share of the total income tends to be spent on health care. Health care, like telecom, is also a sector characterized by rapid innovation and has strong positive spill-over effects on the entire economy, which gives even stronger justification of increasing expenditures. Therefore, health expenditures could be seen from the opposite viewpoint: it is unnatural to artificially limit them.

The core problem is one of fiscal policy and domestic economic structures. When most of today's healthcare systems were designed in the mid-twentieth century, welfare-state financing was not itself a problem. Total expenditures and governments' share of healthcare spending grew steadily until the mid-1980s – and they could increase without impeding economic growth. Furthermore, this financing structure of health care could accommodate the cost from rising innovation in medical technology and pharmaceuticals. In the Golden era of post-war economic growth, it could also finance rapidly increasing demand.

Since then governments' share of expenditures has stopped growing and in many countries decreased substantially. The old model of financing – a rapidly growing tax base combined with increasing tax burdens (starting from low levels) – generated increasing revenues. That model is no longer viable or feasible. Tax burdens in most countries cannot increase without adverse effects. To finance increasing demand today and in the future, other sources of financing, and more efficient use of resources, are necessary.

Demand is also rising. Patients today expect more from health care than in previous times. They act more as consumers than as patients in a traditionally rationed model of health care. The fact that people live longer also implies higher costs; the elderly are the most health-care demanding strata of the population.

There is also a supply-side push of costs, coming mainly from technological development. Many new inventions certainly save resources in health-care budgets, especially when technology can substitute labour. Yet far from all of them have this quality. Many technological inventions push the boundary for what can be treated. Diagnoses that were untreatable ten years ago – or treatable only at the cost of severe side effects – can be treated today.

Medicines also display the same cost-pattern development: many pharmaceutical innovations save resources as they substitute more expensive treatments, but they also push costs due to the fact that new medicines can treat diagnoses which were previously untreatable and, thus, gave rise to less direct costs.

The fact that people live longer, and that modern health care can treat more diseases with fewer side effects, is good news. Yet, in the current fiscal structure of health care in Europe, technological development and new innovations place politicians and health administrators in a dilemma. They cannot provide public resources to pay for all new innovations and must find ways to restrict supply. Such methods, like health-technology assessments and other cost-benefit analyses of new treatments are sometimes effective. Yet they can also be arbitrary and discriminatory. The basis for using some of the models of assessments is cost containment rather than an honest cost-benefit analysis which could provide an informed view to policy makers.

There is also another concern. Many of the methods used to control costs are focused on *new* costs; expenditures on *new* treatments, technologies, investments, and drugs. Put differently, cost-containing methods are often not focused on the major part of health care expenditure, which is constituted by the annual current spending on hospitals, salaries, infrastructure, et cetera. In fact, the organization of health care delivery is a strong denominator not only of costs in general, but also of increasing costs. European health care systems, and especially the basic structure of health care, generally show discouraging results in productivity, and in many countries or fields of health care, productivity is negative, despite increasing investments to substitute labour or in other ways increase more efficient use of resources. Health-care inflation is far above standard consumer-price indexes or home-market based price indexes.[4]

HEALTH CARE AND TRADE POLICY

The potential for trade in healthcare and related services and goods is far from exploited. In fact, current trade in health care is a marginal phenomenon and there is no real systematic trade policy around for health care.

As the locus of multinational trade liberalization, the WTO has largely failed to produce results in terms of substantial advancements of healthcare or by prompting liberalization of domestic services around the world. There are some WTO agreements that are relevant to health. In the agreements of Technical Barriers to Trade (TBT), Sanitary and Phytosanitary Measures (SPS), and Trade-related Intellectual Property Rights (TRIPS), there are direct linkages to trade in health-related products, but they do not cover trade in health-care provision.

The General Agreement on Trade in Service (GATS), in which healthcare service trade is differentiated by four modes of supply, is most relevant to health service delivery and trade. As Box 1 and Table 1 show, there are areas in the GATS which relate directly to trade in health-care services. However, WTO member countries have not agreed to any substantial liberalization in these areas. In fact, GATS has arguably achieved the least to date in terms of facilitating health-related cross-border exchange. Most information to date suggests that patterns and levels of trade in health services are occurring irrespective of GATS. This is most likely attributable to country commitments that bind existing levels of market access, rather than involving any substantial liberalization.

BOX 1. THE GATS STRUCTURE

Trade in Services (GATS)

The health sector is covered under the following main sub-sectors:

1. BUSINESS SERVICES
   - A. Professional services
     - h. Medical and dental services
     - i. Veterinary services
     - j. Services provided by midwives, nurses, physiotherapists and paramedical personnel.

8. HEALTH RELATED AND SOCIAL SERVICES
   - A. Hospital services
   - B. Other human health services (ambulance; residential health facilities)
   - C. Social services.

Table 1. Categorizing trade in health care in the language of GATS

MODE OF SUPPLY	SPECIFIC HEALTH SERVICES
Mode 1: Cross-border services trade	• Telemedicine – telediagnosis, surveillance and consultation services; • Electronic care delivery; • Medical education and training; • E-health (products and services available over the internet).
Mode 2: Consumption abroad	• Movement of patients seeking treatment abroad; • Movement of medical students and health professionals studying and training abroad.
Mode 3: Commercial presence	Foreign direct investment, cross-border mergers or joint ventures for: • Establishment of hospitals, clinics, nursing homes • Management and insurance.
Mode 4: Movement of natural persons	• Skilled health personnel, i e doctors, nurses, paramedics, midwives, consultants, trainers, management.

There are very few countries that have committed themselves to full liberalization in the health and social services sector under the prevailing GATS regime. Table 2 shows the small number of those that have, under modes one, two and three.[5]

Table 2. Full Commitment to Health Service Liberalization under GATS

Medical and dental services	Brunei, Burundi, Congo, Gambia, Guinea, Hungary, Iceland, Malawi, Norway, Rwanda, South Africa, Zambia.
Midwives, nurses etc.	Gambia, Malawi, Norway, Zambia
Hospital services	Burundi, Ecuador, Gambia, Hungary, Jamaica, Malawi, Saint Lucia, Sierra Leone, Zambia.
Other human health	Burundi, Gambia, Hungary, Malawi, Sierra Leone, Zambia.
Social services	Gambia, Hungary, Sierra Leone.

What is immediately obvious looking over the countries listed in table 2 is that the majority of WTO members with full commitments across modes one to three are developing countries. This is highly surprising if one considers the fact that part of the critique of liberalizing trade in health care, especially from Europe-based NGOs, claims developing countries to be adversely affected by demands from richer countries to open health-care and other public-sector markets in the developing world. However, apart from Iceland and Norway, no developed country has committed to full liberalization.

There are some explanations for this trend, the first being that developing country governments are using GATS to lock in stable market conditions with a view to attracting foreign health providers. The second explanation, though, is that strong commitments are found in the health sector because they have found it politically easier to commit in an area where large-scale inflows are unlikely to occur, given the absence of attractive commercial opportunities. By doing so, fewer commitments in other, more sensitive, areas are easier to justify. Of the subsectors that have been committed under GATS, it is also clear that members are more prone to full commitment in medical, dental and hospital services over and above services provided by midwives, nurses etc. This would suggest that governments are less keen to liberalize the labour-intensive activities within their health services, probably due to the current provision of government services at little or no cost.

A third explanation suggests that developing countries especially have fewer vested domestic interests lobbying against opening the health-care sector for trade.

Table 3: Commitments disaggregated by mode of delivery, 2003 (Market Access and National Delivery)

		Medical and dental services	Midwives, nurses etc	Hospital services	Other human health services	Total
Mode 1	Full	45 (-2)	17 (-1)	39	23	124 (-3)
	Partial	22	12	2	2	38
	Unbound	57	39	65	19	180
Mode 2	Full	69 (-3)	24 (-1)	88	30	211 (-4)
	Partial	47	42	10	10	109
	Unbound	8	2	6	4	20
Mode 3	Full	48 (-8)	17 (-2)	51 (-32)	23 (-9)	139 (-51)
	Partial	63	47	46	18	174
	Unbound	13	3	7	3	26
Mode 4	Full	3	1	3 (-1)	1	8 (-1)
	Partial	110	63	92	40	305
	Unbound	11	4	9	3	27

NB. ( ) Reduced number of full commitments if horizontal limitations, which apply to all sectors contained in the individual country schemes, are taken into account.

NB. Partial commitments on market access include commitments that carry any of the six limitations specified in Article XVI:2 of GATS as well as commitments subject to limitations in sectoral coverage (e g exclusions of small hospitals or public sector entities) or geographical coverage within the member's territory, and any other measures scheduled in the relevant column (including domestic regulatory measures for which Article VI might have provided legal cover). Similarly, partial commitments recorded under national treatment may include cases of "overscheduling" or misinterpretations.

Source: Author's calculations, based on tables in Blouin et al, 2006.

A second GATS trend, displayed in table 3, relates to commitments under specific modes of delivery. Modes three and four contain far more limitations from all members than modes one and two. This is also not surprising from a political economy perspective. Inflows of foreign investment and/or people are more sensitive than domestic patients travelling abroad for treatments, which may actually serve to contain inward flows and the adverse costs effects of protected domestic labour markets. Whatever the precise explanations for these trends, multilateral healthcare services negotiations under GATS are as prone to interest-group pressure as any other sector.

The lukewarm reception of the liberalization opportunity presented by GATS also to a large extent reflects the historically ingrained regulatory restrictions and institutional constraints that exist in domestic healthcare sectors, reflecting traditional views of healthcare and preventing cross-border movement of services. Such constraints are problematic from a trade perspective because, at the domestic level, health services are influenced by measures not normally considered to be "trade measures." There are three types of regulation employed by states that are most relevant to services trade in terms of affecting the supply or demand of health services:

1. Qualification and licensing requirements for health professionals.

2. Approval requirements for institutional suppliers, e g the range of goods and services that hospitals are allowed to provide.

3. Rules governing reimbursement and insurance schemes. e g a regulated domestic insurer my be prevented from reimbursing the cost of treatment abroad.

Others include the direct provision of services to economically disadvantaged groups and controls designed to ensure the adequate spread of services geographically within a state. All these measures are related to quality control and equity of access. There is considerable disagreement as to whether such measures should be subjected to the scrutiny of multilateral trade considerations. While some see them as trade restricting and discriminatory, others view them as vital instruments of national social policy. As a result, multilateral negotiations have been hampered by the difficultly of designing international rules that distinguish protectionist from legitimate policies. A purely economic analysis would view much existing healthcare regulation as another form of industrial policy with all its associated adverse economic implications, but many health administrators are critical of any analysis that emphasizes trade and commercial policy objectives, to the alleged detriment of equity and social policy considerations.

TRADE POLICY FOR HEALTHCARE GOODS

The potential for trade in health-care related goods has been better exploited than trade in health-care services. Input trade is very advanced and subject to standard trade agreements for goods. Thus, equipment used in health care is often traded under a fairly ambitious trade agreement.

Table 4 (see next page) shows current applied tariff levels on health products for a selection of WTO members. Not all countries, seemingly, are supportive of trade agreements which reduce tariffs to zero or close to zero. The persistence of tariff peaks in certain countries and for certain products reveals a similar propensity to domestic protection of healthcare industries in those countries that have significant industries. Brazil, India and Thailand stand out, but they are by no means alone. Even the US and Malaysia, which claim an effective tariff rate of zero overall, still introduce quotas if imports exceed specific volumes or weights. These countries are effectively employing industrial-policy strategies, and the trend over the past two decades has been rising levels of protection.

Table 4: Healthcare related tariffs for selected WTO members

Country/ Trading entity	Tariff	Biological products for therapeutical uses	Medicaments	Health related products*	Healthcare related apparatus and instruments
Brazil	Lowest	2.86	3.71	8.80	4.75
	Average	4.20	9.74	10.27	8.74
	Highest	6.29	14.00	12.73	12.75
China	Lowest	3.00	5.29	4.68	4.41
	Average	3.00	5.36	4.68	4.66
	Highest	3.00	5.57	4.68	4.94
European Communities	Lowest	0.00	0.00	1.18	0.25
	Average	0.00	0.00	1.25	0.25
	Highest	0.00	0.00	1.79	0.25
India	Lowest	30.00	30.00	21.82	25.63
	Average	30.00	30.00	21.82	25.63
	Highest	30.00	30.00	21.82	25.63
United States**	Lowest	0.00	0.00	0.00	0.00
	Average	0.00	0.00	0.23	0.06
	Highest	0.00	0.00	0.45	0.19
Botswana	Lowest	0.00	0.00	1.82	0.00
	Average	0.00	0.00	2.73	0.55
	Highest	0.00	0.00	3.64	1.09
Indonesia	Lowest	1.43	4.64	3.18	3.59
	Average	1.97	5.32	3.53	3.59
	Highest	2.14	5.71	4.09	3.59
Philippines	Lowest	2.71	2.36	4.36	2.13
	Average	2.71	2.69	4.36	2.13
	Highest	2.71	2.71	4.36	2.13
Korea	Lowest	0.00	8.00	1.32	5.50
	Average	0.23	8.00	1.58	5.50
	Highest	1.14	8.00	2.05	5.50
Malaysia**	Lowest	0.00	0.00	1.67	0.00
	Average	0.00	0.00	1.67	0.00
	Highest	0.00	0.00	1.67	0.00
Thailand	Lowest	0.43	10.00	10.45	1.13
	Average	0.57	10.00	10.91	1.13
	Highest	0.71	10.00	11.36	1.13

* Dental cement and other dental fillings; bone reconstruction cements; First aid box and kits; chemical contraceptives and gel to be used as lubricant for surgical operations or physical examinations; waste pharmaceuticals.

** Tariff quotas.

Source: Authors calculation from WTO data.[6]

Brazil, India, and Thailand are interesting examples. They are, on the one hand, part of the rising trend of health-care tourism. They have export strategies focused on attracting patients from other countries. On the other hand, they operate under fairly high tariffs for medicaments and health-related products. Furthermore, they all have had a propensity to infringe on other's intellectual property in the field of medicines. Recently, the Brazilian National Development Bank (BNDB) announced its intention to create a pharmaceutical national champion, which would not only be controlled by the bank, but also be out of reach for foreign investors. India and Thailand have also utilised such "national champion" policy.

All this might sound appealing to a proponent of infant-industry protection: a country, such as Brazil, uses protective instruments in order to build up its own industries, which later can become exporters. However, such policies have been highly ineffective in other areas and certainly have adverse effects in the fields of health care too. Leaving aside the specific issues of infringing on protected intellectual property, which hardly is a sustainable strategy for building up export champions, input tariffs raise the price of export. The old Lerner symmetry theorem (an import tax works as an export tax) is valid in general, *but particularly so in sectors where import is needed for export*. In a country that wishes to export health care, input tariffs increase the price of its export. For developing countries, it is crucial to reduce barriers to import if they want to develop export strategies, especially if customers targeted are in developed countries and require high-quality health care. The same conclusion also applies to pharmaceuticals, and a serious drawback for countries like India and Thailand is outside hesitation over the quality of medicines coming from the domestic generic industry.

OPPOSITION TO LIBERALIZING TRADE IN HEALTH CARE

Despite the lack of any meaningful liberalization of healthcare services prompted by the WTO, the fact that health care is included in trade negotiations has drawn negative reactions. There is a large group of organizations and opinion formers who either consider trade in healthcare to be an irrelevant notion or who are fervently against it. Both perspectives are often purveyed by the same person or the same organization, and the arguments tend to

be based on the "fundamental human right" of populations to healthcare and the perceived inherent difference of interest between profit-making business and those of society at large. This leads firstly to the assumption that the inclusion of health-care services in trade agreements, especially WTO agreements, is a reflection of the spread of globalization, motivated by profit, and is threatening to outpace the ability of national governments to provide for their populations. Secondly, as the responsibility for health-care delivery must therefore remain in the public sphere, health-care services are by nature non-tradable.

Concerns have been expressed particularly over the effects on developing countries' healthcare systems if trade is increased. For example, John Hilary of Save the Children writes: "The specific provisions of GATS undermine the ability of countries to implement their own public health priorities … Governments must ensure that public health concerns are guaranteed absolute precedence over the economic aspects of services trade, in order to fulfil their responsibilities to … society as a whole."[7]

But they are not confined to developing countries. Public-sector unions in several developed countries have campaigned heavily against the GATS, especially before and in the first years of the Doha Round. The current practice of cross-subsidization within the healthcare sector is one issue that is being jealously guarded by influential bodies, such as the Royal College of Nursing in the UK. They are concerned that GATS will stop this practice altogether, as non profit-making services will be pushed out of the market.[8]

As a result of such lobbying, governments, especially in Europe, opted for huge carve outs in the health-care sector in their commitment schedules when the GATS was negotiated in the Uruguay Round. This pressure was even evident in typically free-trade minded Sweden, which also, surprisingly, made the fewest commitments in the group of EU-15 members in its initial GATS offer in the Doha Round.[9]

Trade in healthcare also seems akin to a foreign language when looking at current international discussions about healthcare delivery and priorities for co-operation between states. There are several United Nations (UN) bodies which operate in the field of healthcare, and evidence of caution, if not hostility, to increasing trade can be found amongst them. The World Health Organization (WHO), the leading UN body in the field of health, is one of them.

It is not always easy to define the WHO's policy position. This is not surprising as it is a member-driven organization which operates mostly on the basis of unanimity. The WHO does not have an official view on trade in healthcare, and it rarely happens that the WHO promulgates views on health-policy choices, since it requires endorsement of all member states. Yet policy analysis and policy formulation is a key activity of the WHO secretariat, and the secretariat largely works in a political discourse with a distinct ideological bent. Its work on trade and trade policy is no exception.

This discourse is partly defined by the instruction to the Secretariat from the member states, but only to an extent. More important to the analytical work and the policy formulation of the Secretariat is the political atmosphere in which the organization operates, i.e. the way it defines the strategic imperatives – the *raison d'être* – of the organization, framing problems and opportunities, integrating scholars and other policy makers etc.

The WHO is interesting in this context not only for the fact that it is the primary international organization for health issues. It also represents both perspectives on trade in health care mentioned above: either it is neglecting it, treating it as irrelevant, or rejecting it, especially on the basis of perceived consequences for developing countries, which, incidentally, are the group of countries who have made the strongest commitments to open health care to trade disciplines. The official approach of the WHO is not hostile to trade and investment integration in the field of health care, but its discourse clearly nods in that direction. Products of the Secretariat often opposes the underlying motivations for increasing trade in health care. It is not correct to say that this discourse is blatantly protectionist, but it errs on the side of protectionism and has a distinct industrial-policy bent. It bears far more resemblance to government (or donor)-led development planning than a strategy of economic development based on openness and the gains from trade.

CONCEPTUALIZING APPROACHES TO TRADE IN HEALTH CARE

The WHO discourse serves as a useful tool for comparison, when conceptualizing an exchange-oriented model for health care. Table 5 categorizes different features in the WHO approach to trade in health care and compares it with the view of a WTO discourse. The WTO is also a

member-driven organization and does not have a specific programme that it campaigns for. Yet the WTO, as the WHO, operates in a discourse, constituted by international economics and international commercial law, with an ideological bent in favour of freer trade, the centrality of trade rules, and non-discrimination principles. The table is not an attempt to give an exhaustive presentation of all relevant viewpoints, but to distil the key and prioritized notions in a number of conceptual categories. Naturally, the WHO discourse leans more towards health care and the WTO approach towards trade.

The table also demands some methodological notes. The table, which concerns views related to trade in health care, is built on the discourses of these two organizations. Defining the discourse is not an exact science; it is about interpretation of key documents, decisions, analytical biases, and the thrust of the policy formulation emerging from respective secretariats. Discursive analysis also requires a focus on the main features and thoughts. It follows that the interpreter needs to avoid dwelling on the finer points.

Table 5: Conceptualizing approaches to trade in health care

TOPIC	WHO DISCOURSE	WTO DISCOURSE
Approach to cross-border exchange and integration	Critical approach to the phenomenon of trade when developing countries are involved. The North-South nexus is a dominant paradigm in most of its views. Health is defined as a human right, and thus the delivery of health care is a human obligation. Critical of market-based solutions.	Market-based approach. Trade is not only a natural phenomenon in markets; it is the key feature of markets.
Determinants of exchange	Trade in health care and health-related products is a one-way relation that mostly benefits exporters in developed countries. Favours a more planned model of trade, rather than a model based on specialization and comparative advantage.	The economics of specialization and scale; comparative advantage. Market-based structure of trade, in which demand and supply determines what and with whom to trade.
Aim of trade liberalization	Trade might have good outcomes. Yet the entire structure of motivation for trade rests on its contribution to greater equity. If trade is not equitable – and equitable seems in WHO language to mean distributive equality – it does not have a justifiable aim.	Trade liberalization can be motivated by different reasons. It has winners and losers, but in the medium-and-long term perspective it encourages more efficient use of resources, creates better opportunities to increase welfare, and offers a vehicle for growth, in developed as well as developing countries. However, it is impossible to give assurances of the distributional outcomes of trade, especially assurances of greater equity, as liberalization spurs dynamic processes.
Intellectual property rights	Overhaul the system of intellectual property rights, at least as far as pharmaceutical patents are concerned. Greater flexibilities in TRIPS, such as the use of compulsory licensing for developing countries, especially for least developed countries without own production capacity. Develop other models of reward, such as prizes. Discourage TRIPS-plus provisions in bilateral trade agreements.	Favours multilateral agreements on trade-related issues concerning IPRs. TRIPS is a balance between the long-term objective of providing incentives for future innovations and creations, and the short-term objective of allowing people to use existing inventions. TRIPS establishes a basic level of protection, which needs to be safeguarded.
Industrial policy ambitions	Strong industrial-policy bent and a contingency-planning outlook. Build up domestic structure in health-care delivery: hospitals, health-care centres, etc rather than considering future trade opportunities Aid-induced exchange from developed countries to developing countries. Domestic build-up of research and innovation capacity in developing countries, especially in the pharmaceutical sector. Larger share of GDP and revenues in developing countries should be distributed to R&D and innovation with the view to build their own capacity.	Avoid situations when industrial policies distort trade or act as barriers to trade. Some flexibilities – such as policy space – might be called for on certain occasions, but they are largely ineffective and discourage trade and economic growth.
Trade agreements	Cautious approach. Appropriate information vital about effects of trade agreements, especially in the fields of services, SPS, and IPRs. Only potentially negative aspects of trade agreements are presented, also in areas where developing countries have made the highest number of commitments.	Multilateral trade agreements preferable to discriminatory agreements, but their existence and political realities are recognized.
Movement of natural persons	Movement of health professionals from developing countries to developed countries is negative. Retention schemes promoted.	Viewed as a natural part of trade, especially in services. Labour migration encouraged, as such factor movements are beneficial.

Sources of protection	Protection is a natural state of affairs in health care. It is a consequence of other and more important political choices. For developing countries protection is often a necessity. Tariffs on health technology, though, should be abolished.	Government structures of regulations (tariffs, border protection, non-tariff barriers, and regulations). Protection is essentially a home-grown phenomenon, and it typically favours a particular group at the expense of general welfare.
Governance structure	Global coordination of all issues related to health and health care. Multi-stakeholder approach involving many parties (governments, NGOs, private firms, et cetera) in common global strategies. Strong bent in favour of NGO participation as part of "global democracy;" NGOs participate in all decision-making forums in the WHO.	More co-operations with other international organizations and with the NGO community. Rests on a structure of governmental participation and a tradition of strong business participation.
Government planning	The source of health developments. Ten-year plans and very concrete action plans are favoured.	Market-based orders rather than government planning.

Each section of this table could be elaborated upon at greater length, but it is fairly obvious that these two discourses are fundamentally different. They have different origins, sets of ambitions, and understandings of policy. They represent different constituencies and come from different policy traditions. But will they, as in Kipling's ballad, never meet?

They probably *will* meet. If, for no other reason than the potential benefits of increasing trade-based integration of health care are too great not to be exploited. Three aspects deserve greater attention in this context.

Firstly, the WHO discourse stresses health care as a fundamental human right. Traditionally it has favoured a governments-only approach to the delivery of health care – the means by which this particular right can be served. But there is an increasing awareness in the WHO community that governments in many ways do not have a monopoly on the design of good health-care systems.

Secondly, increased trade in health care is not a distant hypothesis; it is a reality closing in on many health-policy matters – from the design of health-insurance policies to regulatory structure. The issue, therefore, is not whether trade will increase or not. It is fairly obvious it will. The key question is rather in which form liberalization of trade in health care should be addressed and regulated: in a multilateral or bilateral form? Even the WHO favours a multilateral approach.

Thirdly, there is not likely to be substantial liberalization of trade in health care emerging from trade agreements. Hitherto trade agreements (with the notable exception of some bilateral agreements) have hardly led to concrete liberalization of trade in health care. Not even the EU, which provides the strongest regional trade agreement on record, has provisions for such trade, let alone strong provisions for trade in services generally. Therefore, the speed of liberalization will be slow and the process will be incremental. In trade agreements, countries are likely to bind only what they already have done at home. Trade-related reforms of health care are thus likely to be home-grown and not imposed from outside organizations.

MAPPING A POSITIVE APPROACH TO TRADE IN HEALTH CARE

Health-care policies cannot only be a function of trade policy. But trade does hold some very tangible potential benefits for this sector.

Trade in health services has been boosted by recent developments in the high-tech industry. Cross-border telemedicine, care delivery, diagnosis and treatment, medical education and training, and technical expertise have become increasingly available through the adaptation of new telecommunication devices and lower transaction costs. For example, e-learning programmes have made high quality education more readily accessible.

Telemedicine remains the sector with the largest potential benefits to health-policy objectives. Up to now, however, its development has been constrained by regulatory deficiencies. National regulators have not had the tools to address the issue of medical malpractice liability in cross-border trade, and national health systems have retained diverse and cumbersome professional certification regulations. Public and private health insurances have rarely offered reimbursement of medical costs incurred abroad. As a consequence, cross-border telemedicine (or health care) is not yet fully developed and is usually used in one-way exchanges rather than in a potentially more efficient two-way exchange.[10]

The potential benefits of trade in health services are not restricted to telemedicine. One of the many problems ailing developing countries is limited access to information and research. Libraries and medical schools often suffer

from chronic deficits in subscription to medical journals and books, for example. The University of Nairobi subscribed only to twenty medical journals in 1999, compared to the five thousand subscription of the average American university. An even more striking case is the Brazzaville medical library with only forty books and a dozen journals, all from before 1993.[11] The development of databases, diffusion of information, and distant medical education can be, and in many cases are, invaluable inputs for the well-functioning of less developed countries' healthcare systems.

Developing countries in Asia in particular (but also elsewhere) have recently seized on the trade potential from consumption abroad of health services, also known as health tourism. In the past two decades, countries like Thailand, Malaysia, Singapore and Cuba have been taking advantage of low production costs to specialize in the export of hospital, medical and dental services. As such, they are becoming a reference destination for people travelling expressly to receive health care. In 1995–1996, Cuba was already generating 25 million USD in health-tourism revenues by attracting more than twenty-five thousand foreign patients.[12] As table 6 shows, health tourism has also brought considerable returns to Malaysia, Singapore and Thailand and a significant upward trend in the number of patients in Thailand. Later figures suggest a rapid increase in health tourism. In 2006, for example, Singapore had more than half a million foreign patients.

Table 6: Health tourism to Malaysia, Thailand and Singapore

	EXPORT REVENUES	NUMBER OF PATIENTS
MALAYSIA (2003)	$40 million	More than 100,000
SINGAPORE (2002)	$420 million	210,000
THAILAND	$484 million	470,000 (2001) and 630,000 (2002)

Source: Arunanondchai & Fink (2005)

Export, however, is only one source of the benefits. Import is equally important. Table 7 shows that in 2002, if only ten percent of US patients underwent surgery abroad for 15 diagnoses, the US economy could have saved 1.5 billion USD a year (taking into account travel expenditures). All these estimates are conservative.

Table 7: Gains from trade in the United States

PROCEDURE	SAVINGS IF 10 % OF US PATIENTS UNDERGO SURGERY ABROAD INSTEAD OF US ($)
Knee Surgery	380,604,366
Shoulder Arthrosplasty	8,704,809
TURP	27,581,317
Tubal Ligation	171,065,574
Hernia Repair	152,655,706
Skin Lesion Excision	151,952,860
Adult Tonsillectomy	13,588,218
Hysterectomy	250,704,845
Haemorrhoidectomy	23,160,663
Rhimnoplasty	2,284,315
Bunionectomy	5,186,290
Cataract Extraction	171,078,116
Varicose Vein Surgery	15,618,521
Glaucoma Procedures	9,670,440
Tympanoplasty	31,408,685
Total savings	1,415,264,725

Source: Matoo & Rathindran (2002)

Trade in health care also involves foreign investments, or, to use GATS language, commercial presence. There are two key positive externalities from commercial presence for the host economy. Firstly, inflows of capital represent resources previously unavailable domestically. These, if channelled appropriately, can free domestic resources to be invested in other sectors of the health system. Secondly, foreign investors may introduce managerial skills that can be passed on to national health providers. As such, the additional resources could be used to upgrade healthcare infrastructure, introduce new technology, generate employment and provide sophisticated capital-intensive medical services.

The opening of Chile's health service, for example, resulted in high investment in infrastructure and quality services. The high competition between private providers for scarce resources led them to provide differentiated and high quality services by means of importation of medical supplies and equipment. This improved not only the quality of health services provided to the population, but

also the work environment and labour demand to operate the imported equipment. It generated employment and stemmed the external brain drain in the health sector.[13]

Temporary migration also represents a channel of trade. At the international level, this has been one of the most contentious areas of services liberalization because of the association with immigration law. Most limitations on the movement of health personnel are, in GATS language, horizontal limitations, applying to all services sectors.[14] Developed and developing countries alike though, need to consider the benefits that increased immigration could bring. Importing countries gain greater availability of health professionals, who are becoming increasingly scarce in industrialized countries, exporting countries can take advantage of these professionals' remittance and the gain in human capital accumulated abroad.[15]

There are many examples of temporary flows of migrants which have been driven by conscious strategies, with the intention of earning foreign exchange and developing co-operation between governments. The Philippines, an important exporter of health professionals to ASEAN, Ireland, Kuwait, Libya, Saudi Arabia, the United States and the United Kingdom has established the Philippine Overseas Employment Administration to promote migrant labour. Other Asian countries have also been facilitating migration of medical staff to other countries as a way of increasing export and revenues. India, for example, has a significant number of doctors and nurses working in the UK and the US. Estimates from 2007 suggest 60 000 doctors of Indian origin are already working in the UK, contributing 8,9 billion USD to the UK economy. Overall, of the doctors working for the National Health System (NHS) in the UK and Northern Ireland, 30 percent are estimated to have obtained their medical training outside an EU country.[16] As there is a growing scarcity of health personnel in many developed countries, and as the old-age dependency ratio is rapidly moving upwards, developing countries are taking a greater interest in securing access to rich markets.

HEALTH SYSTEMS AND TRADE COMPATIBILITY

In order to assess the trade potential of health-related goods and services one must consider two structural aspects of a country's health system: whether the regulatory system can be broadly characterized as inward or outward-looking, and, to a lesser extent, the share of the private sector in healthcare financing.

Table 8 provides an analysis of how these factors relate to trade compatibility using the four modes of production contained in GATS as a framework for analysis. Such an analysis leads to the conclusion that the more inward-looking a country's health sector, the more its regulatory schemes stifle international co-operation (generally), the less compatible the system is with international trade in goods and services. Likewise, the trade potential in health care is a positive function of the level of the private sector's involvement in healthcare financing, as a privately financed system is likely to have less institutional barriers to foreign participation in the provision of health care services.

Table 8: Trade potential in private vs. public healthcare services

		HEALTH SECTOR REGULATORY SYSTEM	
		Inward-looking	Outward-looking
PRIVATE SECTOR'S SHARE IN THE FINANCING OF HEALTH CARE	High	*High compatibility:* • GATS (4) *Low compatibility:* • GATT • GATS (1) (2) (3)	*High compatibility:* • GATT • GATS (1) (2) (3) (4) *Low compatibility:*
	Low	*High compatibility:* • GATS (4) *Low compatibility:* • GATT • GATS (1) (2) (3)	*High compatibility:* • GATT • GATS (1) (2) (4) *Low Compatibility:* • GATS (3)

*: The involvement of the private sector is a negative function of both regulatory barriers to entry and pecuniary disincentives.
GATT: Market access of health care related goods.
GATS(x); where x E (1.4): GATS (1): Importing services from abroad; GATS (2): Consumption abroad (reimbursement); GATS (3): Commercial presence (FDI); GATS (4): Movement of service professional abroad.

Health sector regulatory system

The trade compatibility of health services is not a consequence of more or less regulation but rather of the outward-looking qualities of regulation. Thus opaque and complex regulatory systems are an obstacle to trade in health services in so far as they create asymmetric information externalities and market failures. Countries may either facilitate the movement of health professionals, as

in the case of the US or UK, or impose barriers on such flows, as in the extreme case of Zimbabwe. An immigration policy that takes into account health policy needs, along with compatible and harmonized systems of health professional certification between states, for example, could greatly facilitate trade in health services.

The compatibility of mode-two trade, which is services consumed abroad, also hinges on the portability of health insurances across boarders. Private and public insurers, more often than not, are reluctant or prohibited to finance consumption of health care abroad. As a consequence, health tourism depends mainly on out-of-pocket payments, making its costs disproportionately high, and precluding the whole system from benefiting from lower costs of health services in foreign countries. These problems could be solved relatively easily through minor relaxations in domestic regulations or bilateral agreements. For example, an agreement signed between Malta and the United Kingdom allows the Maltese to use the NHS for heart surgery, while the American insurance company AMIL is able to present its Brazilian clients with the choice of buying a policy which covers treatment in the United States.[17]

Private sector share in healthcare financing

The private sector's share in healthcare financing is related to trade compatibility through the level of foreign capital restrictions. Compatibility largely depends on two variables: firstly whether regulations allow for foreign participation in hospital services, and secondly on the ex-ante level of private participation in healthcare financing and delivery.[18] The fundamental question, therefore, is not whether foreign participation is allowed but *whether a foreign corporation will be able to operate once the investment has been made*.

If private participation is low or nonexistent, it is most likely due to regulatory or monetary disincentives, such as prohibition of private ownership of health facilities or a discriminatory policy of subsidies.[19] While there is a great variety around the world, most health-care systems would almost perfectly fit in the upper-left quadrant of the framework of analysis proposed in table 8. With the exception of Mexico, Chile and perhaps another handful of countries, health-care systems characterized by a relatively high participation of the private sector in the financing of health services more often than not present lower regulatory barriers to trade in mode three.[20]

Whether or not opportunities from trade are being exploited around the world, it is undeniable that the line separating the "international" and "domestic" aspects of health policymaking is becoming increasingly blurred. And, however a domestic healthcare system is structured, there is at least some compatibility with international trade, even in those characterized by a high level of government control. And there are a number of trade-enhancing reforms that would require only a minimum of regulatory relaxation.

CONCLUSIONS

Trade in health care is a growing phenomenon. Great benefits can be made by opening health sectors to trade and investment integration, but very few countries have undertaken such reforms. Even fewer countries have agreed to bind these structures of openness in trade agreements. The current increase in trade in health services has therefore emerged largely outside trade-policy frameworks.

Current trade agreements have only scant and weak provisions for trade in health care. Some bilateral or regional agreements have provided for some health-care integration, but most of them neglect this area. In the WTO, health care is part of the GATS agreements, but few countries have made strong commitments. Only a dozen countries, primarily developing countries, have committed to full liberalization.

The international health community, here defined through the WHO discourse, takes a sceptical if not hostile view of increased trade integration when it concerns North-South relations. It defines, erroneously, trade as being largely in the interest of developed countries, which tend to be pitted against that of developing countries. Its policy is not blatantly protectionist, but it errs on the side of protectionism and favours a strong industrial-policy approach. This is especially true in the field of input goods trade, such as in medicines, but it is also reflected in health-care policies.

This view is contrasted not only by some schedules of liberalization in the current WTO agreement, but also by the development of export strategies for health care in several developing countries. Countries as diverse as Brazil, China, Cuba, India, and South Africa are already significant exporters of health care.

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FOOTNOTES

1. Daniel Capparelli has provided excellent research assistance for this paper.
2. Chanda (2002).
3. OECD (2007).
4. Erixon & van der Marel (forthcoming) provide an analysis of health-care expenditure in Europe.
5. NB. This excludes mode four.
6. For Botswana and India tariff levels are from 2003. From other countries data is from 2006/07.
7. Hilary (2001), p 9.
8. EPHA (2003).
9. Of the EU-15 countries, Sweden also made the fewest commitments in the Uruguay Round. See Davis & Erixon (forthcoming).
10. Janjaroen & Supakankunti (2000).
11. Blouin, et al, eds (2002).
12. Chanda (2002).
13. Blouinet al, eds (2002).
14. Adlung & Carzaniga (2001).
15. Blouin et al, eds (2002).
16. Kumar & Simi (2007).
17. Blouin et al, eds (2002).
18. Adlung & Carzaniga (2001).
19. Blouin et al, eds (2002).
20. Gómez-Dantés, Frenk & Cruz (1997); Arunanondchai & Fink (2005).

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