Asia-Pacific Research and Training Network on Trade
Working Paper Series, No. 30, January 2007

Health-related Services in Multilateral and Preferential Trade Arrangements in Asia and the Pacific

By

Mia Mikic*

* Mia Mikic is Economic Affairs Officer, Trade Policy Section, Trade and Investment Division, United Nations Economic and Social Commission for Asia and the Pacific, Bangkok, Thailand. This paper was prepared as one of background papers for the UNESCAP 63rd Commission Session theme study document "Development of health Systems in the Context of Enhancing Economic Growth towards Achieving the Millennium Development Goals in Asia and the Pacific" (forthcoming 2007). The views presented in this paper are those of the author and do not necessarily reflect the views of ARTNeT member, partners and the United Nations. Author gratefully acknowledges assistance from Faizan Hussein and Tian Yijun in compilation of some data, and comments from Tiziana Bonapace, but author remains solely responsible for any remaining errors. The author may be contacted at mikic@un.org

Table of Contents

Executive Summary

In many developing countries, the health-care sector is under-developed, lacking basic infrastructure and human capital, and attracting little attention from investors and policymakers. While encouraging globalization and trade may aggravate those problems and create additional costs in some circumstances, trade liberalization and deeper integration into the global economy could also provide opportunities and resources to address those problems more effectively. This paper contributes to the debate by reporting on the status of liberalization achieved in the health services sector by members of ESCAP through their regional and multilateral trade liberalization commitments.

Among multilateral trading rules, the General Agreement on Trade in Services (GATS) and Trade-Related Aspects of Intellectual Property Rights (TRIPS) are particularly relevant to the health-care services sector as they regulate health-related services as well as trade and production of medicine. Of 58 regional members and associate members, 30 carry the status of full WTO membership. Only 16 of those economies had scheduled commitments related to individual health-related and social services under GATS (including the most recent acceded members, Cambodia, Nepal and Viet Nam). ESCAP members are most confident in granting full market access and national treatment in medical and dental services (as part of professional services) through Mode 1 and 2. They are even more relaxed in granting national treatment as they extend it even in Mode 3 for this particular service. All 12 members however remain closed for the delivery of professional medical and dental services via movement of natural persons (Mode 4). Hospital services are the next subsector in which countries feel more confident, as eight commit in this sub-sector, six of which accord full market access and full national treatment for Mode 1, and all eight countries for Mode 2; again, they all keep doors closed for provision through mobility of medical professionals. Only one member specifically scheduled social services and no member has committed to full or partial liberalization within Mode 4 (movement of natural persons) of any of the activities of the health sector apart as set by horizontal commitments. Almost all of these countries scheduled commitments related to life and health insurance under financial services but they did so mostly to erect barriers to foreign provision of this service. Excluding no liberalization for mode 4, most countries remain reluctant to accord market access in other three modes (the most liberalized is Mode 2 again with 12 members scheduling no limitations).

Future trade liberalization under GATS is linked to the destiny of the Doha Development Agenda negotiations. The past decade of “services trade under GATS” still awaits performance evaluation, which is complicated by incomplete statistical coverage of trade in services. The statistics for non-commercial services, such as health services, are even less complete and reliable; therefore, not much can be said about the welfare impacts of liberalization so far.

Among more than a hundred and twenty of preferential trade agreements in the ESCAP region, only 20 are in force that include either already negotiated services trade concessions or strong near-future commitments. In most of these agreements, services

concessions are negotiated following the GATS framework. This shows that many of them are still not ready to expose their services sectors to global or regional competition and they choose to reuse commitments scheduled in GATS. Most of the PTAs have some provisions in their legal texts referring either to professional services or medical/dental occupations, or to health-related and social services (services sector 8 in GATS terminology). Some of them also explore cooperation in areas of standards in goods trade that relate to health issues (SPS/quarantine matters). Reservations to the provision of health services through the movement of natural persons (Mode 4), which is noted at the global level, is also very much a feature of preferential agreements in the region. In several cases, economies use the situation of health and social services being provided for the public interests to restrict future commitments to liberalization. In summary, the health services sector is one area where preferential agreements so far have not secured any deeper liberalization compared to multilateral and unilateral liberalization efforts.

It appears that most economies in this region still rely on autonomous policies and processes of economic reform and deregulation with regard to liberalizing the health sector. This is largely due to a significant proportion of the regional economies being economies in transition or developing economies that have been undertaking reform policies and strategies either for the purpose of transition to a market economy system or as a response to developmental guidance. The role of policy makers, in consultation with all stakeholders is to find policy solutions in trying to maximize net benefits from the opening of health sectors. This can be achieved through autonomous policies (such as domestic regulation ensuring quality control, transparency of information, introduction of universal coverage by the health service, adoption of more flexible labour markets, etc.), as well as further commitments through GATS or further bilateral/regional liberalization. It is useful to remember that current or future lack of liberalization commitments under GATS does not prevent a WTO member from liberalizing unilaterally or regionally.

Key words: Health services trade, GATS, TRIPS, preferential trade agreements, Modes of services delivery, ASEAN

JEL: F13, F15, I19

Introduction

It is widely accepted that health services can be traded in many different ways (box 1). The important issue is whether (developing) countries should encourage such trade and open their health sectors both to foreign providers and to consumers of health services. The answer, of course, is not simple or singular; it very much depends on the level of development of an economy, its population size and the current state of the health sector services.

Modern global trade is regulated by trading rules that are set by national governments of the World Trade Organization (WTO) members and previously parties to the General Agreement of Tariffs and Trade (GATT). While WTO, established in 1995, introduced some new disciplines and areas in the trading rules, they remained based on the core principles preventing discrimination among foreign partners and unfair treatment of imported products in local markets. Nevertheless, during the entire existence of the GATT/WTO-protected trading rules, national governments had guaranteed rights to control trade flows of products when necessary to protect health of humans, animals and plants in accordance with GATT, Art. XX 9 (b). In short, health-related considerations (together with some other legitimate policy objectives) may be given supremacy over trade-related considerations regulated by a series of WTO agreements. However, this does not mean that trade liberalization must necessarily bring benefits to a country from the perspective of public health provision.

Current global trade rules under which trade liberalization is negotiated in the multilateral forum arguably hold many implications for the health services. Table 1 provides an overview of the most important WTO agreements and their links with health issues, both current and emerging. It is likely that by applying trade rules only, these issues would not be addressed properly, but combination of trade policies based on those rules and other national policies could be more successful. For example, food security cannot be achieved only through higher tariffs on imported food items and stricter adherence to sanitary and phytosanitary regulations, without the additional support of a national agricultural development policy and instruments thereof (including financing facilities for farmers, research and development subsidies etc.). The possibility also exists that efforts to combine trade policy with national sectoral policies may give rise to policy incoherence. In any case, there is no “one size fits all” approach; every issue is likely to require a different approach and a different combination of trade and other policies, depending on the country concerned and other circumstances.[1]

[1] More details on the use of specific trade rules for the issues listed in table 1 are available in World Trade Organization/World Health Organization, 2002, pp. 57-137.

Table 1. Selected health issues and relevant WTO agreements

Category	Agriculture	SPS	TBT	TRIPS	GATS	GATT Art. XX(b)	Other
Infectious disease control		✔	✔			✔	
Food safety		✔					
Tobacco control	✔		✔	✔	✔	✔	
Environment		✔	✔			✔	
Access to drugs				✔			
Health services					✔		✔
Food security	✔	✔				✔	
Emerging issues:							
• Biotechnology	✔	✔	✔	✔			
• Information technology				✔	✔		
• Traditional knowledge				✔			

Source: World Trade Organization/World Health Organization, 2002, box 5, p. 58.

While it is obvious that all of the above issues as well as some other trade disciplines (e.g., Trade Related Investment Measures) are potentially important in connection with any number of health-related issues, this text focuses on two sets of rules: the General Agreement on Trade in Services (GATS) and Trade-Related Aspects of Intellectual Property Rights (TRIPS). These two sets of rules are particularly relevant to the health-care services sector as they regulate health-related services as well as trade and production of medicine. The relationship of each agreement to health services trade is discussed in sections 1 and 2. Section 3 comments on the extent of liberalization in health services trade under preferential agreements in Asia and the Pacific. Section 4 offers some concluding comments.

Box 1. Health services are part of our increasingly affluent globalised lives

Health services, traditionally regarded as non-tradable, are becoming increasingly traded and a part of our globalized lives. Thus, it is not unusual to start the day with generic vitamins produced locally without a patent protection while munching cereal that passed strict package labelling control, only to spend lunch-break at the dental clinic. At the clinic, a Filipino dental technician works with an X-ray machine imported from Germany, while the dentist prescribes a medication imported from the United States of America where it is produced under the patent protection. You return to the office while smoking a cigarette from a packet labelled with health warnings.

On the way home, you stop for a Swedish massage (by a Swedish therapist) to improve circulation. Arriving home, you find last week's medical results (and a bill) that were transcribed and processed in India. You try to remember if your health insurance provided by an Australian-owned insurance company provides 75 or 80 per cent coverage.

Settling down after dinner to watch a favourite news programme on cable television, you manage to catch an advertisement for reducing weight and surplus fat while being pampered in a luxurious resort and spa in Thailand. Immediately afterwards, the news begins with details about several more cases of avian 'flu and you cannot help but think how your government is unable to protect you from this disease.

1. General Agreement on Trade in Services and Health-Related Services

GATS is one of several new agreements brought under the umbrella of the global trading rules system in the Uruguay Round package. Other such agreements include the Agreement on Agriculture (AoA), TRIPS, Trade-Related Aspects of Investment Measures (TRIMs) and Dispute Settlement Understanding (DSU).

GATS applies to all services in any sector, except those supplied in the exercising of government authority, that are defined as supplied neither on a commercial basis nor in competition with one or more service suppliers. This broad coverage of services is important, as the development process requires repositioning of the private and public sectors in some services. However, this requirement is not threatening as members are given flexibility in pursuing their own policy objectives in sectors selected for liberalization.

When considering a liberalization commitment under GATS, it is important to define the scope of the services precisely, as the commitment does not have to cover the whole sector or even a subsector. It is up to the members to decide if a broad or narrow definition of the service better reflects their needs. Many members use the WTO Services Sectoral Classification List (known as W/120), covering 12 sectors and 160 subsectors, which was developed during the Uruguay Round to help countries in scheduling their commitments. Since the use of W/120 is voluntary, many countries opted to use the United

Nations Central Product Classification (CPC).[1] These two classifications, with respect to health related services, are detailed in table 2. It is important to note that WTO members can still define the scope of the health sector according to their needs. As a precaution, a number of countries have specified that their activities refer only to private and commercial (not public) health services. Commitments, of course, apply only to the services indicated in the schedules (apart from the basic obligations that remain applicable unless specifically exempted).[2]

Table 2. List of services related to trade in health services

W/120 sector	Corresponding CPC code	Description
8. Health-related and social services		
A. Hospital services	CPC 9311	Surgical, medical, gynaecological and obstetrical, rehabilitation, psychiatric and other hospital services delivered under the direction of medical doctors chiefly to outpatients, aimed at curing, restoring, and/or maintaining the health of such patients. Military hospital services and prison hospital services.
B. Other human health services	CPC 9319 (other than 93191)	Ambulance, residential health facilities, other human health services.
C. Social services	CPC 933	Welfare services delivered through residential institutions to elderly persons and persons with disabilities. Other social services with accommodation.
D. Other		
1. Business services		