HSD/GCP/November 1999
Original: English
Distr.: Restricted
Not for Quotation

Meeting Report

Interregional Meeting on Health and Trade

Washington, D.C
3-5 November 1999

Globalization, Cross-Sectoral Policies and Human Rights (GCP)
Department of Health in Sustainable Development (HSD)
World Health Organization (WHO)

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REPORT ON THE INTERREGIONAL MEETING ON HEALTH AND TRADE
Toward the Millennium Round
Washington, D.C., 3-5 November 1999

EXECUTIVE SUMMARY

The services sector is the fastest growing segment of the world economy and international trade in some of those services is outpacing traditional exports as a source of employment and foreign exchange. The next round of General Agreement on Trade in Services (GATS) negotiations will be launched at the Third Session of the WTO Ministerial Conference, in Seattle. "Negotiations … shall aim to achieve progressively higher levels of legally binding liberalization in services through the expansion of the sectoral coverage of commitments in Members' schedules and the reduction or elimination of existing limitations. […] No service sector or mode of supply shall be excluded. Special attention shall be given to sectors and modes of supply of interest to developing countries. *(Draft Ministerial Text. 19 October 1999)*

Trade in health services is rising and negotiations in such related areas as financial services, including insurance, professional services, and telecommunications could have an economic and social impact on the health sector. The potential significance of these negotiations requires careful examination by national governments and the WHO system, as does the opportunity to enter the negotiations with a clear, positive agenda for the development of national health priorities. With those interests in mind, the World Health Organization sponsored a meeting at the Regional Office for the Americas, in Washington, D.C. from 3 to 5 November 1999.

The meeting was attended by representatives from PAHO, WHO headquarters, SEARO, AMRO, and AFRO, *regions* as well as delegates from the World Trade Organization Secretariat, UNCTAD, ECLAC, the Office of the U.S. Trade Representative, the International Finance Corporation and several academic institutions. The organizers charged participants with reviewing the potential policy implications of current trends and charting preliminary approaches.

In his opening remarks, Dr. George Alleyne, the Director of WHO's Office for the Americas, noted that one of the primary reasons the organization was founded was to prevent and protect against the spread of communicable diseases that might hinder international commerce and communication. Today, the nature of the world economy has changed. The value of traditional exports has declined, and both developed and developing countries have turned to exporting resources they have accumulated in the form of information and expertise, he added. Many developing countries possess a rich reservoir of such expertise in the health sector.

Trade *per se* does not necessarily have an impact on health. The crux of WHO's concern regarding the upcoming negotiations around trade in health services, he said, is to help member governments have in place the kinds of standards that will allow their services to be competitive in the international arena. WHO also seeks to assist them so that, "when they enter the trade negotiations, the standards that are set do not disadvantage them as they have been disadvantaged by standards in primary resources trade."

The delegates to the meeting reviewed and suggested approaches on an array of trade issues affecting health, including intellectual property rights negotiations. This report

provides a synopsis of their main determinations specifically pertaining to health services. It is intended as an initial framework for senior health officials to consider as they prepare for the Third WTO Ministerial Conference and subsequent GATS negotiations. After presenting a summary of the highlights of the deliberations, this report for executives ends with a precis of the *meeting's* conclusions and recommendations. In early 2000, WHO intends to publish separately a compendium of the full textual presentations *and detailed recommendations.*

In brief, the primary observations raised at the meeting *regarding trade in health services were:*

1. In addition to trade in health-related goods, the volume, scope, and value of trade in health services are increasing whether or not formal commitments under GATS have been entered.

2. This trade takes place North-to-South, South-to-North, and South-to-South, as well as in mixed modalities thereof.

3. Trade occurs in all four of the services modes defined by GATS.

4. Many developing countries regard the emigration of their health personnel (Mode IV) as their primary health services export and seek to have barriers to the movement of persons to developed countries removed. Most developed and some developing countries consider the establishment of commercial presence (Mode III) and national treatment their primary interest, and most of the scheduled commitments involve that Mode. It should be possible to negotiate terms that favor both interests. While benefiting developing countries, Mode IV commitments also could alleviate manpower shortages in industrialized countries and facilitate their companies' international deployment of personnel. Mode III commitments could alleviate unemployment in developing countries as well as foster competition in countries where similar industries exist.

5. In countries where privatization of health insurance and service delivery schemes has occurred concurrently with trade liberalization, the presence of foreign providers of such services has increased considerably. The impact on employment, wage rates, professional drains from the public sector, and other indirect health measures is unknown. Several national experiences point to the fact that "cherry-picking" is a common insurance practice. This practice indicates the need to establish clear public health guidelines for domestic and foreign insurers. Cherry-picking, or "cream skimming" may also take the form of selective insurance (offering life or casualty, but not health coverage, for instance), which national policies may wish to address in the interests of equity.

6. Notwithstanding common knowledge of health services trade in the private sector, most public health and other government agencies lack systematic data regarding the specific characteristics of this trade. How to harness its potential benefits to protect and/or improve the quality and equity of care remains an open question, as does the best means to safeguard the public sector in the event of economic downturns or foreign investment withdrawal. Research on these issues may be warranted.

7. Studies on the impact of trade in health services are scant, largely because its volume was relatively insignificant until recently. Delegates from all WHO developing regions noted that ministries of health tend not to participate sufficiently in national trade policy discussions and health personnel often are poorly informed regarding the contents and progress of trade negotiations. Greater awareness was considered essential and activities toward that end were recommended. Such activities are in keeping with the Draft

Ministerial Text's item 77, in which it is proposed that the WTO "continue efforts to improve the transparency of WTO operations by implementing more regular outreach activities […and] promote wider availability of WTO documentation to the public."

8. Although trade in health services is increasing in most countries, many continue to regard these services as within the exercise of governmental authority and hence nontradable. This is generally the case in the European region. Others see liberalizing trade in health services as an opportunity to improve their export potential, attract foreign investment and employment opportunities, and benefit from the transfer of skills and technology. Differing views are partly a function of existing capacity and partly due to traditional national views regarding health and its relationship to development.

9. Government health ministries have not articulated clear guidelines for coordinating private trade in health services with national health policies, nor have they reviewed their service standards with the purpose of regulating trade transparently, permitting recognition, and/or establishing their competitiveness in the world market. In some countries, such issues remain to be resolved in trade in health services between states within national boundaries. Developing countries noted the need for technical cooperation and financial support in reviewing and/or setting such standards.

10. Given the lack of systematic data analysis, the impact of trade in health services on public health cannot currently be determined. Most, though not all, of the trade takes place in the private sphere. Research is required to establish its effects and assess their balance. On the positive side, does this trade create employment for national health professionals and semiskilled workers, fill or improve a market need, benefit the technological and skills base of the country, and foster other forms of beneficial investments? On the negative side, would increased trade in health-related services accentuate inequities?

11. Although the terms of international trade negotiations have evolved since their inception in 1947, they have only recently incorporated trade in services. The GATS covers trade in all service sectors (with the exception of those provided in the "exercise of governmental authority"). Most (66%) WTO member governments have not opted for explicit commitments in that area. In some cases, commitments may be seen as formalizing a process that is already underway. In others, they may be thought to restrict the capacity for discretionary national policies. Research is required to determine what policies underlie decisions to make commitments or not.

12. The international trade system accords health impact concerns special consideration. This acknowledgement was drafted in the context of trade in goods, however. The trade in services, and the inclusion of health services as trade items in their own right, may *require clarification* of some of the original GATT premises.

13. *It may be timely* for governments to consider the advantages and disadvantages of entering commitments in health services trade. While they offer opportunities, commitments also may entail obligations that governments are reluctant or unable to implement. Once entered, it is exceedingly difficult to modify a commitment. The policy of no commitments, on the other hand, also may imply benefits and disadvantages. In either case, it is the responsibility of public health and other government agencies to analyze their national situations and make informed recommendations for the next round of negotiations.

14. Governments should weigh carefully the potential health sector implications of *entering into* trade negotiations and commitments under such other service rubrics as financial

services, insurance, or telecommunications. Commitments in such related services may have an impact on the health sector, especially where horizontal or cross-sectoral liberalization and obligations are involved. In keeping with the Draft Ministerial Text's express concern regarding the importance of fostering development through trade, a positive agenda might seek concessions that strengthen the health sector as a trade-off for market entry into other related sectors (such as insurance and telecommunications).

15. Governments that conduct a situation analysis may wish *to design screens, to assess impacts, terms, and possible regulatory needs, accor*ding to a set of public health criteria.

16. Given the stated interest of the Ministerial Conference in addressing the special concerns of developing countries, and in view of the difficulty these countries have encountered in obtaining the transfer of technology in other trade sectors, this area may deserve special attention in negotiations affecting health services.

17. The trade-offs regarding employment opportunities for health personnel, drains or expansions of resources available for public health services, including environmental health services, as well as the impact of the presence of foreign competitors on national development, consumer options, and the public sector require examination.

18. In deliberating on the advisability and terms of health services commitments, specifically, but also on the health sector implications of other service commitments, governments may consider it to be in their best interests to insist that the role of WHO be acknowledged as the standard setter in health-related matters, including cross-sectoral services.

19. Finally, it was suggested that WHO, and health NGOs with which countries have longstanding working relations, be included formally as advisors to the WTO Appellate Body. Some consider that the absence of such a role could be detrimental to their interests during trade negotiations or disputes.

Speaking for WHO, *Nick Drager and Cesar Vieira* pledged the organization's commitment to assisting member governments in designing instruments for and conducting situation analyses, developing assessment criteria and standards, and sponsoring sessions to familiarize health personnel with the issues, schedules, and opportunities in upcoming trade negotiations. UNCTAD representatives, meanwhile, noted that the organization has developed software (Measures Affecting Services Trade) that may be helpful in analyzing trade in health services.

DELIBERATIONS ON SELECTED ISSUES

Until recently, international trade negotiations under GATT focused on commerce in goods. The Uruguay Round of negotiations (1986-1994) incorporated services for the first time (GATS) as trade items for which the liberalization of barriers also would be sought multilaterally. The final agreement covers all services. Commitments related specifically to health have been entered by 45 of WTO's 134 member countries. That more have not done so may in part be due to the political sensitivity of the subject. It may also be due to the complexity of implementing such commitments. Yet international trade is thriving in such health-related services as insurance, education, training, specialized medical care, professional services, telecommunications, tourism, and even managed care. Requests for further commitments to liberalization in those areas can be expected in upcoming negotiations.

There are no universal formulas for liberalization. Reasons to liberalize trade in health services or not will vary according to the specific service, the stage of development of the country, the strengths and deficiencies of its health sector, and its preexisting relations with trade partners. *In trade negotiations, if health is affected it is important - as the DG of WHO stated in her address to delegates at the 52 World health Assembly – that WHO be involved from the beginning*. The preconditions to liberalization are critical, especially since commitments are exceedingly difficult to alter once they have been entered. Even if it is possible to do so, experience indicates that considerable financial compensation would be involved. Extensive analysis by each country is required to ensure that the legal framework for commitments in *direct and indirect trade* in health services is thoroughly analyzed and carefully drafted. This process may entail the commitment of significant resources.

As a rule, countries whose industries (such as insurance, environmental services, and telecommunications) are seeking to expand their markets have a strong interest in obtaining greater commitments in Mode III (commercial presence). Many developing countries that are interested in the removal of barriers against the entry of their nationals are seeking liberalization commitments in Mode IV (movement of natural persons). Other developing countries are seeking to enhance their competitiveness in attracting patients and other health service consumers (Mode II). Cross-border trade in health services (such as remote diagnostics, other forms of telemedicine, and Internet-based data services) is largely sought by those countries that have developed the infrastructure and expertise to export it.

Most of the commitments currently scheduled for GATS involve Mode III. UNCTAD has studied the potential of developing countries and concluded that their lower production costs would enable them to become competitive exporters of services (Mode II) in addition to continuing to press for liberalization of barriers to the emigration of their nationals (Mode IV).

Among the current obstacles that limit developing country potential for expanding Mode II trade, the non exportability of health insurance coverage stands out. Currently, those countries that do export services in the form of specialized medical care, alternative medicine, spas, and tourism-related health services, tend to attract only those who can afford to pay out-of-pocket. Given the vast increase in travel for business and tourism and the lower costs of health services in developing countries, the exportability of health insurance could benefit both the countries offering the services and insurers in travelers' countries of origin.

Regarding trade in Modes I and II, developing countries generally are not well endowed with the required factors of production. This places them at a relative disadvantage in that they would be net importers of health and health related services.
As a result, even though liberalization is generally sought, the informed role of governments may become more, rather than less important. It may be especially important for the least developed countries, whose annual expenditures on health do not make them an interesting market for multinational health investments, to negotiate assistance in obtaining improvements in their health sectors as conditions for other trade commitments.

Regarding the liberalization of Mode III, foreign investment could lead to greater employment opportunities, the introduction of modern management techniques and technology, the availability of more options for consumers, and greater efficiency. Areas in which exporting countries may seek commitments are insurance, hospital, and environmental sanitation services.

A clear and enforceable legal framework is needed to ensure that, should these services enter, they do so in accordance with the informed development policies of the country. In the context of privatization, legislation against "cherry picking," discriminatory pricing, limited services (life insurance but not health insurance, for example), abusive labor practices, and environmental contamination, among other provisions, would apply to domestic as well as foreign firms. Legislation requiring the transfer of technology, especially for the development of telemedicine, and setting terms to protect the country from arbitrary cessation of services, or disinvestment, might be considered as well.
Moreover, consideration should be given the importation of values that may accompany the importation of services. Certain management practices, for instance, may run counter to national ethical and professional codes.

According to UNCTAD reviews, a major current obstacle to foreign investment in these areas that developing countries need to remove involves legislation limiting foreign equity participation in such things as hospitals. The trade-offs would require considered analysis.

Obstacles to the successful establishment of foreign environmental services and water treatment companies extend beyond the legislative realm. The capital intensive, costly nature of such services means that their market would be highly selective (only available to those who could pay the high costs). The need for major environmental improvements is common in developing countries, however, and it affects the health of the population as well as the possibility of attracting foreign investment and tourism. The magnitude of the problem is often beyond the capacity of governments to address, and few developing countries have the required industry expertise or capital. Developed countries, meanwhile, have excess capacity and an interest in exporting it.

UNCTAD suggested that one mutually beneficial approach to this area would be to obtain special international financing and cooperation in this area of mutual interest. Again, national governments need to have clear environmental and occupational health legislation in place to protect against practices that may harm their development interests. Environmental standards and commitments to entry of environmental services need to be designed with the characteristics of national economic interests in mind. Inequitable cleanup and safety standards without provisions for the transfer of technology could damage the competitiveness of national industries. Delegates also pointed out that measures to curtail current practices of waste dumping from industrial countries would need to be examined.

Trade obstacles to the transnational movement of health personnel involve nationality, visa, and residency requirements, legislation affecting the repatriation of earnings, and discriminatory licensing practices. Some developing countries feel that this is just as well, since they cannot readily afford the loss of their most qualified personnel, a diversion of resources often trained by public funds and needed to serve their own population. Yet, in prior negotiations, most developing countries have expressed their strong economic interest in the right of persons to move across national boundaries.

Dr Carlos Correa spoke to the principles, premises, and structure of the GATS/WTO system as they may affect the health sector. In brief he noted that the legal history of the GATS and WTO indicates that there are ongoing conflicts between commercial and health interests. Furthermore, the structure of the system and its norms, including conflict resolution methods, tend to privilege commercial interests over health interests. He suggested that a greater equilibrium may be needed to protect the interests of public health, especially in smaller countries, and that the Seattle Ministerial Conference may provide a good beginning to negotiating a greater balance.

The original 1947 General Agreement on Tariffs and Trade establishes in Article XX (b) that discriminatory measures are allowed if they are necessary to protect the health of the population. These provisions were drafted with traditional, post World War II commodity trade in mind. Today, while the application of the stipulations may appear relatively clear-cut where commodities such as pharmaceuticals or medical equipment are concerned, they may be less obvious when the product consists of a service such as health insurance. Measures are understood to be necessary to the extent that there are no others available that are less inconsistent with the principles of GATS. This interpretation and the process by which its application is judged, currently constitute a point of debate because of the potential restriction they entail on the ability of governments to adopt national policies that may be exceptions to trade agreements. In 1994, a dispute involving the US established categorically that no agreement shall modify national law where public health is concerned. It could be more difficult for small countries to seek enforcement of this principle.

Most, though not all, of trade in health services takes place in the private sector. The dividing line between public and private is often difficult to draw, however. All of the WHO regions represented at the meeting noted, for example, that health personnel in their constituent countries often emigrate to find employment. In a number of countries, these health workers received their training free of charge through state-run medical, nursing, and public health institutions. Issues arise regarding the drain of public resources and possible conflicts surrounding subsidy provisions.

TOWARDS A POSITIVE MULTILATERAL TRADE AGENDA FOR DEVELOPING COUNTRIES: A PRECIS OF MEETING'S CONCLUSIONS AND RECOMMENDATIONS

After reviewing the deliberations, the meeting's participants noted that trade is essential for development and well-articulated policies regarding trade in health services may contribute toward economic well being. A special concern is that, historically, the health sector has suffered disproportionately in times of economic crisis and the poor are the most affected. The meeting therefore recommended that the health sector take an active role in services trade negotiations to help fashion the possible benefits while protecting the most vulnerable segments of the population from inequities.

The meeting urged governments to evaluate potential trade commitments in the light of their developmental needs and domestic health policy goals. This would include considering the benefits of promoting trade in health services between developing countries. Specifically, the meeting urged countries to:

- Explore the positive health benefits of commitments regarding the portability of health insurance coverage (Mode II: consumption abroad). Said portability would enhance the ability of developing countries to attract and provide services to foreign patients.
- Eliminate discriminatory measures that impede trade, such as the ineligibility of foreigners for domestic subsidies.
- Evaluate the impact of commitments regarding the presence of natural persons in health service sectors. Developed countries in particular may wish to reconsider the necessity of visas and similar barriers to professional services mobility.
- Increased movements of health personnel can help to close supply gaps in the receiving countries while contributing to the economies of the originating countries through remittances and the transfer of knowledge.
- Give due attention to the recognition of foreign qualifications, licenses, and standards for health professionals and facilities. Liberalization benefits could be hampered by friction in this and other areas of domestic regulation.

- Engage in partnerships to enhance regulatory capacity in developing countries. Such capacity could enhance the trade competitiveness of developing countries. WHO should foster the participation of developed countries in these partnerships.
- Specify the economic needs tests currently referred to in their schedules of commitments. Precise language would enhance the reliability and predictability of trade conditions in the health sector and thereby encourage foreign investment.
- Improve the capacity of developing countries to negotiate on equal footing through technical assistance from developed countries to identify trade interests in the health sector. This would include assistance in analyzing the economic and legal situation in commercially attractive markets.

Regarding the need for a greater understanding of the issues, meeting participants called for conducting *training and awareness activities* for both health and trade personnel at the national level. Advocating the best policies, they noted, requires that health spokespersons be well versed in trade issues. Trade negotiators, meanwhile, need to be sensitive to the health impact of the positions they adopt.

The meeting participants recommended that WHO initiate a planned process of "training the trainers". WTO might have an informal advisory role in this process. The proposed content of the training would include:

- Familiarization with existing health and trade information, data, research, and analysis (and its location. This also would entail addressing the information lacunae and research gaps.
- A general overview of the global situation of health and trade, including country experiences and the pros and cons of liberalizing.
- The structures, processes, and objectives governing trade liberalization, a review of the WTO and its functioning, existing agreements (both legal and lay texts), and dispute settlement decisions that directly or indirectly impact on health.
- A typical trade negotiation process model to help understand the process, players, and dynamics.
- The vocabulary of trade, what it means and its ramifications.
- A familiarization with the identity and location of experts in the health and trade field (academic, government, industry, legal, policy, and NGOs).
- A discussion of the possible health sector impacts of trade in other sectors (environment, e-commerce, financial, for example).
- An overview of the markets for health services and health service products and the opportunities and risks of trade liberalization in those areas.
- Briefings on the techniques to influence the trade agenda at the national and international levels so that sound health policy is considered.
- The identification of health constituencies, their interests, and objectives and guidelines for forging alliances and collaborating in developing trade positions sensitive to health policy objectives.

The meeting participants urged WHO (HQ) to take the lead in developing multidisciplinary training/awareness materials and pilot a short (3 day) seminar in a selected region within the next six months. It requested that two additional regional workshops be held in the second half of the year 2000. The focus of the initial seminars would be on the multilateral trade agenda items most relevant to public health. The meeting also recommended that:

- WTO and UNCTAD be invited to contribute to take part in the training process.

- As the training material is developed it should be made available on the Internet.

Where *research* is concerned, the meeting participants identified a number of needs, including, analyzing the impact of multilateral trade on the health status of the population, studying the respective roles of each Mode of trade, and conducting country situation analyses.

The latter were considered particularly important to inform trade negotiations so that potential health gains are realized and adverse effects are mitigated. The participants broke the situation analysis method into several steps. First, it was recommended that the four modes of trade be ranked according to their likely impact on the health sector. The participants suggested that rankings could be based on the criteria of equity, quality and efficiency to illustrate why trade deserves the attention of decision makers within ministries of health. Countries that export substantial numbers of health professionals may wish to pay particular attention to Mode 4: movement of natural persons, while others who are promoting health tourism may wish to place greater emphasis on Mode II.

Research is also needed, the meeting participants agreed, to obtain data that will further an understanding of dynamic competitiveness in the health sector, particularly in countries that are contemplating or implementing various forms of economic integration measures. In addition, analyses of health care systems with mixed public and private financing should consider flows in both segments, or in the absence of data, acknowledge the existence of both segments. Software developed by UNCTAD, entitled 'Measures Affecting Services Trade' may be applicable to trade in health services.

The second step recommended in conducting a situation analysis is to assess the intersectoral impact of trade liberalization. For example, remittances from health professionals working abroad may be an important offset to the perception that a 'brain drain' has occurred, especially where health sector employment conditions are such that many of these professionals would be underemployed or working in other sectors.
Little is known about the motives for undertaking and not undertaking commitments in health services trade. Determining these motives also was considered a valuable research guide for countries contemplating commitments.

In light of these determinations, the meeting participants recommended that the following actions be taken:

- WHO, in concert with its regional offices and WTO and UNCTAD, develop a template for gathering basic trade flow data, where available. WHO HQ and UNCTAD will explore the applicability of UNCTAD's 'MAST' software for this endeavor.
- Assess the health impact of trade decisions according to such operational criteria as equity, effectiveness, quality, and efficiency.
- Given that trade in health services has grown despite relatively few specific commitments under the WTO, study the rationales for making such commitments or not.