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国際公務労連

45, avenue Voltaire, BP 9 • Tel.: +33 450 40 64 64
01211 Ferney-Voltaire Cedex • Fax: +33 450 40 50 94
France • www.world-psi.org

Secret proposal for trade in health services in direct conflict with global agenda[1] for health

A recently leaked proposal tabled by Turkey in the TiSA negotiations argues for a system that promotes insurance reimbursement (for those who have health insurance) for treatment at lower cost in another country.

The unauthored document appears to have been inspired by a paper by Aaditya Mattoo and Randeep Rathindran[2]. In their paper, the authors advance the case that insurance companies in the United States should reimburse patients to travel abroad for a range of low-risk surgical treatments in order to take advantage of lower costs and to realize gains from this trade, representing savings to the insurance industry. The incentive for patients would be less co-payment outlays, whether or not the travel costs are covered, selectively lower co-payment rates or selectively lower premiums for patients who travel abroad for treatment. The leaked proposal suggests that the savings that the authors of the paper assume will accrue to private insurance companies in the USA – there is no evidence advanced for any such savings from free trade in health care to have occurred in reality - would be generalizable to the global level.

The economic and ethical issues arising from the inclusion of health dimensions in trade agreements and negotiations are already being debated quite widely. There is a great amount at stake: the weighted average GDP that goes to health in the 50 countries in the TISA negotiations is 12.5 per cent, and together their GDP expenditures on health amount to over USD 6, 000 billion per annum, which represents over 90 per cent of annual global expenditure on health[3].

Here, we focus on a very narrow area of proposed trade in health services that relies on patient mobility and health costs differentials, and we argue that the approach in the proposal and in the paper is faulty on three grounds: it is based on the assumption that health services are a commodity like another, as such are compatible with the laws of supply and demand and can be handled by the market; assumes that patients will behave as consumers and follow low prices; and that all parties will gain from the tradability of health services due to patient mobility.

Comparative advantage incompatible with a global public good

The proposal states that comparative advantage applies to trade in services and is 'explicitly observed' in the health sector. But it focuses on price alone, asserting that 'quality factors are in eclipse'. At the same time, the proposal recognizes that 'health is not a typical commodity or service but a public good' and should therefore be 'compatible with other legitimate social objectives like universal access'.

[1] "Open Working Group proposal for Sustainable Development Goals", full report of the Open Working Group of the General Assembly on Sustainable Development Goals. New York, United Nations, 12 August 2014 [A/68/970].

[2] Aaditya Mattoo and Randeep Rathindran: "How Health Insurance Inhibits Trade in Health Care", *Health Affairs,* 25, no.2 (2006):358-368.

[3] Based on 2012 data; GDP data from the World Bank (http://data.worldbank.org/) and health expenditure data from WHO Global Health Expenditure Data Base (http://apps.who.int/nha/database). See also http://apps.who.int/nha/atlasfinal.pdf for total global annual expenditure on health in 2012 .

Yet the proposal does not address steps that could be taken to protect the public good, but rather extolls the 'huge untapped potential' of trade in healthcare services that can have 'a number of benefits not only for the business partners involved in trade, but for the population as a whole'. The conceptual argument is not coherent and the order of benefits is significant in reflecting the true underlying priorities; gains to business first and only then for the populations served. The proposal sees health insurance portability as economically desirable: 'Patient mobility…would be a real value-added', but the question of who gains most from the value-added needs addressing, especially as the value-added was not demonstrated in the paper that inspired the proposal. There is some acknowledgement that gains are not the only outcome possible: 'the main challenge for us will be to find adequate accompanying provisions that maximize the positive spill-overs and minimize negative spillovers of trade in health services'.

Yet there is good evidence that the free market fails to adequately supply public goods such as health knowledge, and health systems which give access to critical health benefits[4]. This means that government action is the more efficient intervention. There are several means at government disposal to achieve their role, through their policies on taxation, on regulation and on expenditures. And globalization having vividly raised the importance of global public goods, the same applies to the global market, which creates a basis for collective action in the same policy areas.

Comparative advantage in international trade has meaning in the free market, but not for these global public goods basic to health. A notable tension regarding the status of health services in the legal provisions of the European Union clearly illustrates this[5]. There is reason enough for the fundamental incompatibility of relying on comparative advantage to supply access to health. But in addition, governments, individually and collectively, have greater responsibilities when it comes to health and they set their sights higher, on goals based on recognizing that 'health is a fundamental human right indispensable for the exercise of other human rights'[6], and on upholding social justice.

Tourists should be covered for healthcare, but health financing shouldn't drive tourism

Clearly, tourists should be able to access health services when they travel. There are other good reasons to promote coverage for treatment outside one's country. Reciprocity of national health

[4] *Global public goods and global finance: does global governance ensure that the global public interest is served?* by Joseph E. Stiglitz and *Public goods: a positive analysis* by Inge Kaul in "Advancing public goods", edited by J.P. Touffut. Paris: Cournot Centre for Economic Studies; Cheltenham, UK & Northampton, MA: Edward Elgar, 2006; also "Global Public Goods and Health: concepts and issues" by David Woodward and Richard D. Smith and "Global Public Goods for Health: Use and Limitations" by Richard D. Smith and David Woodward. WHO: Trade, foreign policy, diplomacy and health, accessible online at http://www.who.int/trade/trade_and_health/en/ at 22.01.2015).

[5] Article 14 of the Lisbon Treaty (2007) provides that as services of general economic interest occupy a place in the shared values of the European Union and promote social cohesion (inter alia), they should therefore operate on principles that are established to enable them to fulfil their missions (http://www.lisbon-treaty.org/wcm/the-lisbon-treaty/treaty-on-the-functioning-of-the-european-union-and-comments/part-1-principles/title-ii-provisions-having-general-application/156-article-14.html). The Protocol on Services of General Interest then specifies that this refers to services regarding which the values, include, inter alia, a high level of quality, safety and affordability, equal treatment and the promotion of universal access and of user rights (http://www.lisbon-treaty.org/wcm/the-lisbon-treaty/protocols-annexed-to-the-treaties/679-protocol-on-services-of-general-interest.html). The Protocol also leaves out the qualifier "economic", introducing Services of General Interest. According to the Protocol, health would be a service of general interest in the European legal context (see http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52007DC0725&from=EN) but is deemed a "particular situation", being a priori neither a service of general economic interest, nor a non-economic service. But if the European Court of Justice has conclude that it is the nature of an activity that determines whether a service is of general economic interest or is non-economic, then health services can be defended to be a non-economic activity. Those who argue that health can contain both economic and non-economic activities are denying a comprehensive approach to health services, which, to the contrary, is being increasingly promoted under the new global agenda for development. But it is in the grey area where health is not comprehensive and not defined that arose the EU Directive on the application of Patients' Rights in Cross-Border Healthcare (DIRECTIVE 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients' rights in cross-border healthcare http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF). Even so, the directive was issued only after extensive consultation, and in full transparency.

[6] "General Comment N°14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)", Committee on Economic, Social and Cultural Rights. New York: United Nations, 2000 [E/C.12/2000/4].

insurance schemes is desirable between countries that have opened their border to cross-residency and labour market access, such as in the European Union. There are also gains for cross-border cooperation in specific areas of healthcare: the treatment of rare or orphan diseases benefits from cumulating cases that might be too few in any one country to conduct the needed research, and rare surgery shows better results in specialized centres able to cumulate experience, which could be in few countries. But such needs are unlikely to be addressed through the private sector, either in their provision or their financing. Moreover vertical de-linking of any specialized service from access to basic health care and opening up vertical, but not horizontal services in health to market competition is contrary to the efficiency benefit that is intrinsic to comprehensive health services which is increasingly underscored for successful implementation of the new global agenda for health.

It is a different matter that some patients who can afford discretionary health expenditures seek healthcare in another country because the treatment they want is not covered by their insurance or is not available in their country. This could justify complaints that insurance companies are conservative. But it's a far cry from the call in the paper for insurance companies to make tourists out of patients, enhancing company profits by incentivizing patients to seek versions of the treatments they need in countries where they are cheaper, which is essentially because the wages of healthcare workers are lower. Indeed, the difference in cost would be less due to the cost of technology in light of the argument advanced in the paper that quality is not sacrificed, either because of the 'presumption that there are not large quality variations…' (even with the acknowledged 'lack of data on quality of care in developing countries'), or thanks to the imposition of quality controls.

Regulatory policy and regulation are also global public goods, and they are quintessentially government functions. But cross-border accreditation is complex, expensive and fallible in its enforcement.

A patient is a patient, not a consumer

The authors of the paper term patients in need of treatment consumers. Indeed, driving patient tourism to meet health financing objectives requires a consumer view of healthcare as much for patients as insurance companies. But patients are not consumers when it comes to health. Patients don't "shop health" objectively like they shop for goods and services, because other factors count that are purely subjective – our experience of physical well-being is vital and intimate, in a class apart from our material welfare. Also, the knowledge implied to "shop health" perfectly, to fully capture the range of needed information on treatment alternatives, contraindications and sequelae, is not available even to patients with medical knowledge. This approach is, moreover, highly likely to deepen differentials in access to health through health services that is based on income and education. Absent universal access to information to "shop health", more advantaged and privileged segments of any society are more likely to be able to purchase advisory information and to benefit from any savings whereas less advantaged groups are more likely to follow the default option of services at home, to reap none of the savings benefit, and possibly to cope with higher costs.

There is ample evidence that demand for healthcare is inelastic to both income and price changes outside of elective surgery (e.g. cosmetic surgery), or care that is not deemed by the patient to be a necessity, a judgement which is individual and personal[7]. Many if not most of the surgical treatments that the authors suggest patients should seek in lower-cost countries could be considered necessities

[7] Ringel et al. "The Elasticity of Demand for Health Care". California: Rand Corporation, 2002.

by patients, even if they may be low-risk, including knee surgery, shoulder joint replacement, prostate surgery, hernia repair, and cataract extraction. Arguably, only "rhinoplasty" (plastic surgery on the nose) could be widely viewed as a luxury rather than a necessity, of the 15 procedures retained by the authors for out-of-country surgery.

The authors of the paper do recognize that incentives will be required to move patients outside their comfort zones and to 'overcome consumer inertia'. Yet the authors propose that insurance companies should direct patients to foreign healthcare services, once vetted or accredited, based essentially on price and with the expectation that the patients will be responsive to the financial advantage.

"First-world treatments at third-world prices": Gainers and losers

The proposed trade in health services is founded on inequality. Savings and efficiencies to insurance companies and to the relatively better-off patients of industrialized countries from patient tourism are based not only on the lower wages of healthcare workers in developing countries, as well as in some other industrialized countries, but on unequal access to health services, especially inside developing countries.

Trade in health services worsen the two-tier system that is crystallizing in many developing countries, whereby health services for more advantaged segments of society are private and demand driven, aspiring to international standards, whereas the majority of the population receives health care in the publicly provided health services that are relatively supply driven and generally underfunded and understaffed.

The demand for high technology, state of the art medical care may be met in developing countries, but being accessible to only a few, may not make possible the economies of scale that some equipment requires or manage to pay salaries that attract and keep high quality personnel on staff. In that case, rather than undersell surplus capacity in response to national need, medical facilities will get better returns from patients from wealthier countries who can pay more and help meet the costs of the equipment and the salaries of staff[8].

The authors extoll the virtues of 'reputable medical facilities' with 'internationally trained physicians' and 'high surgical success rates' in developing countries. Indeed, it would be foolish to believe that countries like India or Turkey would not stand to benefit from changes in cross-border consumption of health services, and there are medical facilities already geared - or gearing up - for that purpose in a number of countries.

Insurance companies are major gainers in this scheme, even if they have to adjust the way they do business: 'Irrespective of how gains from trade are shared between insurer and consumer, the main point is that a simple modification of insurance schemes can help realize the gains from trade'.

But the authors are more concerned about the problems that could hinder profitmaking by insurance companies – malpractice suits and fraudulent claims in particular – than about the potential for losers in the process.

[8] Clearly, this trade niche also could drive wage demands by healthcare workers, raising the incomes of physicians and nurses, and reducing the incentive to emigrate. But the workers concerned will benefit only inside their tier, treating wealthy patients and tourist patients, and could have little effect on the wages of most healthcare workers in the public sector.

Clearly, the losers are …everyone else… and the global health agenda.

In industrialized countries, patients with no access to either health insurance or the extra insurance "push" to travel elsewhere for treatment will pay more for their health services, and in a number of social protection systems, will cost the government more. Whether or not sicker patients do not travel for surgery, the savings they make will leave a higher proportion of fixed costs for the patients who do not travel. If those who travel are indeed less sick or belong to more advantaged groups based on income and education, then patients at greater risk of complications as well as at greater risk of morbidity and mortality in general (given the relationship of morbidity and mortality with socio-economic indicators) will comprise a larger proportion of those patients treated at home, which will sharpen the relative cost of their care relative to cost coverage[9]. The authors' proposed 'tax on treatment abroad' to remedy this is merely cosmetic against the larger problem of unequal access. Efforts at home would be better put to increasing access for all to health treatments, not to a select few.

In developing countries, local health costs will go up. Even if most patients in developing countries already have no access to the medical facilities that will cater to tourist patients, and put up with two-tiered access to healthcare, their situation can worsen as national health investments target the benefits of health tourism to the detriment of public provision of healthcare, and the demand from wealthier patients – nationals as well as tourists – raises the cost of healthcare. Recipient country insurers are not likely to thank the insurers in the sending countries for the increased cost of health, and may not collaborate on monitoring international claims as the authors propose. The increased costs will be reflected not only in the private healthcare coverage, but also in government health expenditures, whereas there will be few or no benefits to the general population.

Again, the authors' proposals for remedy of 'taxing these export revenues' to allow governments to 'cross-subsidize care for the poor', or requiring 'private providers to … directly provide a proportion of their services to the poor' are weak in the face of massive inequality in access to health globally and difficult to enforce. They divide human populations into the "poor" and the "not poor" and these divides can persist and worsen. Governments would do better to base national fiscal and expenditure policies on universal access, and to design means to pre-empt – or arrest the development of - two economies of health.

Nor are the authors' proposed workarounds in the slightest commensurate with the level of remedies implied by the fast approaching global development agenda for health. To promote further private gains and divert national investment in health away from the public provision of health services needed for universal access is not a proposal to promote 'trade in health care', but the edict of an ideology that places the commercial value and benefits of trade well above those of healthcare.

Yes, inequality is circumstantial and contemporary, and some might say a fact of life. But we need to address the fundamental underlying moral question that health immediately provokes: in the

[9] It may also lead to differential surgical outcomes. To the extent that the results of surgery are related to the numbers of procedures, the removal of a proportion of surgical procedures can lead to lower rates of success, even if only marginal. Patients who do not travel abroad for surgery will then eventually face higher risks, whereas centres abroad that specialize in attracting surgical patients will benefit eventually from higher rates of success, which will benefit patients who travel for surgery.

domain of access, should our efforts and resources be spent on taking advantage of inequality, or in striving to remove it?