

From GATS to TISA: Impact on the health sector

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When a service sector is opened to international trade, public providers will compete with private providers. A treaty that would further liberalize the services sectors would provide all foreign providers access to domestic markets at 'no less favourable' conditions as domestic suppliers.

Private health markets are a prerequisite for the entry of foreign health service providers.

- First of all, this could increase the pressure for privatisation in the public health sector.
- And secondly, the existence of a private health care market alongside a public service sector could severely limit the public sector and have serious implications for equity in health care access.

It's important to note that there are substantial differences to be made between public and commercial service providers. While the commercial sector primarily focuses on the maximisation of profit, public services aim to provide for the population's basic needs. Public services are not in a good position to compete, because -in principle- they have to render services to the people that have the highest needs and the least purchasing power, e.g. the poor, the disabled, the elderly, the unemployed, migrants; in short, people that have a harder time in society. Public services are therefore generally not profitable. Commercial services on the other hand focus on the people that can afford them; what you pay is what you get. The defining characteristic of a company is that it should make profit for its shareholders, whose goal is to see their investments grow. They are profitable, but they do not provide universal access to quality health care. Marijn Dekkers, CEO of the pharmaceutical company Bayer, said with regard to the cancer drug Nexavar: 'Let's be honest, we did not develop this product for the [poor] Indian market, but for Western people that can afford it'.

The impact of trade in services on the health sector can be analysed by application of the 4 GATS-modes. Here we see that a public and a commercial health sector don't usually live peacefully and complementary alongside each other.

GATS mode 1, cross-border supply of health services, refers to the provision of a service from a provider in one country to an overseas recipient. This includes E- health, which is "the application of information and communication technologies to the health sector, including clinical and non-clinical functions". There is a risk that telemedicine would divert resources away from primary healthcare in rural settings towards highly technological e-health services for the affluent few. Additionally, resources could be diverted to export of services, rather than serving the local population. E-health services are mainly provided by private for-profit providers who offer better working conditions and career prospects than the public sector and could create an internal brain drain from public to private providers, which could further exacerbate a dichotomy between the public and the private health.

Gats mode 2, consumption of services abroad refers to 'medical tourism' of elective services. Countries hope to generate financial revenue by engaging in medical tourism, which is by far the biggest advantage. Because of the high revenues, the private sector have encouraged the

government to invest in medical tourism. A clear example is the high government involvement in Thailand's medical industry. The 'Thailand Health Paradise' campaign is targeting a European audience by marketing "amazing vacations" combined with "the most advanced medical treatments". The downside is that these profits rarely reach the poorest people. Although the existence of medical tourism hubs could reverse the international brain drain and retain health workers in the country, there is a constraint of internal brain drain from the public to the private sector.

GATS mode 3 refers to Foreign Direct Investment (FDI), which reflects a lasting interest and control of a firm or individual from one country in another. There are potential risks to the presence of foreign commercial firms in the health system. Again, as with E-health and medical tourism, there is a risk of internal brain drain, with private companies enticing personnel away from public services, through higher levels of pay, better working conditions and better equipment. Another risk is the health system becoming a two-tier system with high quality care for the rich and poor quality for the poor and advantageous patient selection.

Let's take the Philippines for example. The most disadvantaged populations in the Philippines live in slums in the cities. People migrate to the city in search for work opportunities and a better life. But what they find is poverty, a life in unsanitary conditions and exposure to pollution. Although slum dwellers are the most vulnerable to diseases, they have the least access to health care. How come? One has to pay high fees for health care by private for-profit providers, while user fees have been proven to result in low utilisation of and exclusion from health care and further impoverishment. Next to that, the commercial sector in the Philippines invests mostly in specialized hospitals in the cities. Rural areas, where the majority of the population lives, and preventive primary health care are being overlooked by the private-for-profit sector. The rural and urban poor are then pushed to rely on the underfunded public health sector or poorly regulated informal providers.

GATS mode 4 refers to health worker migration, which is a form of voluntary migration and is often permanent. Destination countries would import more health workers from other countries, because this is a 'cheaper' strategy than to invest in education and employment of local health personnel. Source countries invest in export of health workers for the benefit of remittances. Again the Philippines as an example. The Philippines is one of the biggest labor exporting countries worldwide. Health workers are trained en masse for export. So there is a net surplus of health workers, but the poor in urban and rural areas are left behind with a shortage of doctors and nurses. The health worker's desire to migrate is based on a better economic and work environment in the destination country. Risks of health worker emigration are the highest for countries with fragile health systems, where the loss of the health workforce can bring the whole health system close to collapse.

In short, the biggest risk of trade liberalization in health services consists of the creation of a two tier-system with mainly private, highly technological and specialized care for the affluent few and basic, under sourced, public health services for the poor, as well as the exacerbation of an international brain drain- through health worker migration- and internal brain drain from public to private services. Because of this, the poor in rural and urban areas would have less access to quality health services. A two-tier health system raises serious concerns of equity and social justice in health care access. On top of that, the health system, being an important social

determinant of health equity, can increase or reduce inequities in health outcomes.

Private health insurances fall under the financial services section of the TISA-agreement. Universal Health Coverage -which is very popular nowadays- is often understood as universal insurance cover. Health insurances are an intervention to stimulate the consumption of health services in health markets. In a UHC insurance model one gives money to the patient to 'consume' health services instead of investing in the provision of high quality and free public services, so that patients wouldn't need as much purchasing power for the consumption of health services. Where private health insurances come in, they do "cream skinning" and attract people with the highest purchasing power and the lowest risks, which leaves the unprofitable high risk- low purchasing power patients to the public sector. The same risks of inequity in access to health care apply here.

Through the TISA, commercialization of health services is made irreversible. A commitment in the service sector effectively undermines a government's policy space, because free trade agreements are binding. Companies could take countries to court whenever investor rights have been violated. In this respect, reversing negative consequences for the health system becomes very difficult, if not impossible.

We should worry about this, because of the commercial sector's performance according to the criteria quality and efficiency in health service delivery. It is often stated that commercial health care providers would be offering better **quality**. However, if assumed that "quality care" is understood as "offering the best treatment according to the diagnosis, based on evidence and international treatment guidelines", then this is not necessarily the case. For example, in Peru and Chile higher rates of potentially unnecessary procedures, particularly caesarian sections, were reported in private-for-profit settings after privatization of obstetric services. Also in Mexico studies suggested that fee-for-service payment structures (which are more heavily present in private than in public care delivery settings) incentivized increased C-sections, while caesarian sections should only be performed on medical indication because they entail more health risks for the mother.

In Sub-Saharan Africa doctors serving in the for-profit sector would be more likely to prescribe unnecessary antibiotics to children with diarrhea, instead of the recommended oral rehydration salts. While we know that irrational prescribing practices could lead to antibiotic resistance, which poses the world population at risk.

Outsourcing health services to the private-for-profit sector doesn't seem to increase **efficiency** neither. We understand "efficiency" as "producing the best possible results with the available budget". Lebanon has one of the most privatized health systems in the developing world. The country spends two times more on health care than Sri Lanka, a country far lower on the development index of the United Nations. Despite the high public spending, the infant and maternal mortality rates are 2.5 and 3 times higher, respectively. Outsourcing healthcare to the commercial sector in China- still remembered for its former "barefoot doctors"- has led to a decline of less-profitable preventative health care; immunization coverage dropped by half in the following five years. Likewise, following extensive privatization reforms in Colombia in 1993, population vaccine coverage declined and more cases of tuberculosis occurred.

Moreover, TISA should be seen in a context of continuous tightening of the protection of patents on medicines, in all bilateral trade and investment agreements concluded by the EU, because of which many in developing countries are unable to afford essential medicines. On top of that, knowing that in developing countries 25 to 66 percent of health expenditures go to the purchasing of medicines, the price of drugs is also a critical factor in the health budget, which helps determine the level of health care.

At Third World Health Aid we see health services provision as an indispensable part of social protection. People's wellbeing should always be a prioritized. Economic development should be no more than a tool to help achieve human development. Because of the risks for equity in access to quality health care, we oppose the negotiations for the TISA agreement. We demand that public debate will be made possible by publishing integrally the content of the negotiations and want no agreement to be signed that endangers health.