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

By

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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		
A. Professional services		
h. Medical and dental services.	CPC 9312	General medical services and specialized medical services; dental services.
j. Services provided by midwives, nurses, physiotherapists and paramedical personnel.	CPC 93191	Supervision during pregnancy, childbirth and mother care after birth, nursing care, physiotherapy and similar

[1] CPC Version 1.1 from 2002 is still in use; version 2, 2006, is under review.

[2] These refer to MFN; transparency; review of administrative decisions and basic competition discipline. A member can take MFN exemption directly. Signing bilateral or regional trade agreements also leads to exemption of MFN clause. For more details, see C. Blouin, N. Drager and R. Smith (eds.), 2006, chapter 4.

		services.
7. Financial services		
A. All insurance and insurance-related services.		
a. Life, accident and health insurance.	CPC 8121	Accident and health insurance.

Source: C. Blouin, N. Drager and R. Smith (eds.), 2006, Annex I, pp.133-136.

While GATS does not provide a definition of a service as such, it appropriately defines what is understood as trade in services for the purposes of the Agreement. Article I:2 of GATS lists four ways of supplying services as trade in services:

(a) From the territory of one member into the territory of any other member;

(b) In the territory of one member to the service consumer of any other member;

(c) By a service supplier of one member, through the commercial presence in the territory of any other member;

(d) By a service supplier of one member, through the presence of natural persons of a member in the territory of any other member.

These four channels of supply of services are known as Modes 1 to 4 in GATS jargon. Table 3 provides some examples of concrete service trade related to the health sector under the above modes.

Table 3. Modes of delivery and examples of health services trade

Mode	Description of mode	Example
1	Delivery of service consists of pure cross-border trade.	Research and experimental development, telemedicine, laboratory services, claims processing and medical transcribing.
2	Movement of consumers to consume service in foreign territory.	Specialized hospital and surgical care (transplantation, cosmetic surgery, rehabilitation and convalescent care; alcohol and drug dependency care; traveler's dialysis; health tourism. Medical and nursing education provided to foreign students and trainees.
3	Movement of service provider to produce service in foreign territory by establishing commercial presence in that territory.	Health insurance companies; physician practices; diagnostic facilities, clinics.

4	Movements of natural persons – providers of services.	Temporary migration of physicians, nurses and allied health professions. Professional services provided through international agencies such as PAHO and UNAIDS.

Source: Adapted from Gonzales and others, 2001, table 6, p.54.

Commitments by ESCAP members on health services in GATS

At the end of the Uruguay Round, the then members of WTO differed greatly in the extent of opening in the services trade. According to Adlung and Carzaniga (2003), more then 90 per cent of the members committed to some liberalization in tourism and about 70 per cent opened the financial and telecommunication sectors, while less then 40 per cent committed to opening the health or education sectors.

Of 49 regional members and 9 associate members, 30 carry the status of full WTO membership[1] (six least developed countries [LDCs], five economies in transition and three developed economies). As of 2005[2], only 16 of those economies (Armenia, Australia, Brunei Darussalam, Cambodia, China, Georgia, India, Japan, Kyrgyz Republic, Malaysia, Nepal, New Zealand, Pakistan, Singapore, Turkey and Viet Nam) had scheduled commitments related to individual health-related and social services under GATS (including the three most recent acceded members, Cambodia, Nepal and Viet Nam). Table 4 provides details of those commitments for both market access and national treatment. Larger number of members, even 22[3] scheduled "life insurance" or "life, accident and health insurance services" under financial services. Details on those commitments are listed in table 5.

To be able to read tables 4 and 5, an understanding of GATS-specific jargon is necessary. We provide a very brief description of some terms used; coverage that is more comprehensive can be found in the WTO "A Handbook of the GATS Agreement" (2005) or on the WTO website. Market access commitment limits the use by a country of any measures that feature as restrictions to market entry in Article XVI of GATS. These are limitations on the number of service suppliers, service operations or natural persons in a sector, the value of service transactions, the type of legal entity and foreign capital participation. Full market access in a given sector and the mode of supply is considered given if a country commits to using "none" of the listed limitations and if it does not require an economic needs test. If a country maintains any of these limitations, it grants partial market access; it denies market access by scheduling "unbound" limitations.

[1] At the time of preparing the paper, two countries have completed the World Trade Organization accession process and will become members upon completion of the internal ratification process: Tonga and Vanuatu. Viet Nam completed the accession and became the 150th member of the WTO as of 11 January 2007.

[2] Except for Viet Nam whose schedule is more recent.

[3] Armenia, Brunei Darussalam, Cambodia, China, Georgia, Hong Kong, China; Indonesia, Republic of Korea, Kyrgyz Republic, Macao, China; Malaysia, Mongolia, Nepal, New Zealand, Pakistan, Philippines, Singapore, Solomon Islands, Sri Lanka, Thailand, Turkey and Viet Nam

National treatment is reflected as the absence of any restrictions that modify conditions of competition to the detriment of foreign services or foreign service suppliers, and in favour of "like" national services and service suppliers. Article XVII of GATS, which refers to this discipline, provides little guidance on specific types of measures that should not be used due to their limitation of national treatment. Without doubt, the accordance of national treatment very much depends on the interpretation of "likeness", which is made on a case-by-case basis and linked to many uncertainties (cf. Cossy, 2006).

Commitments are typically made for each mode of delivery and a specific subsector or sector. They can also be made as horizontal commitments that apply to a particular mode across all sectors or subsectors and allowing a member to place a condition on access in a particular mode for a number of sectors simultaneously (making scheduling simpler). Modal horizontal commitments will apply to all sectors listed in the schedule, even the newly added ones, unless it is clearly specified at the level of sectoral commitments that horizontal commitments do not apply.

Of all subsectors[1] listed in table 4, ESCAP members are most confident in granting full market access and national treatment in medical and dental services (as part of professional services). Seven countries have committed to full market access for Mode 1 and 11 for Mode 2, while 8 and 11 countries extend unlimited national treatment in this subsector for delivery through Mode 1 and 2, respectively. These countries express less willingness to open national markets for foreign commercial presences (only 30 per cent dare scheduling no limitations) but they are ready to accord national treatment: 9 out of 12 do so without reservation. Mode 4 remains kept for opening through the Doha Development Round. Hospital services are the next subsector in which countries feel more confidence, as eight commit in this subsector. Six accord full market access for Mode 1, eight for Mode 2 and only five for Mode 3. With respect to extending full national treatment for this subsector, six countries do it for Mode 1, eight for Mode 2 and seven for Mode 3. Only one member specifically scheduled social services. In contrast to the global pattern of commitments (Adlung and Carzaniga, 2003), only one country schedules services by midwives, nurses etc. (CPC93191). This indicates that regional economies are even more reluctant than the WTO membership on average to open labour-intensive activities compared to skill-intensive and capital-intensive activities in this sector. Thus, it is not surprising that no member has committed to full or partial liberalization within Mode 4 of any of the activities of the health sector apart from horizontal commitments.

[1] The definition of medical and health services employed by the most members for scheduling purposes includes veterinary services as well as a non-specified category of other health-related and social services.

Table 4. Regional members of ESCAP with commitments on individual health services[a]

		Medical and dental services	Veterinary services	Hospital services	Midwives, nurses etc.	Other human health services	Social services
		CPC 9312	CPC932	CPC 9311	CPC 93191	CPC 93199	CPC 933
Limitation on market access							
Total		**12**	**8**	**11**	**1**	**4**	**1**
Mode 1	None	7	6	6	1	2	1
	Partial	0	0	0	0	0	0
	Unbound[b]	5	2	5	0	2	0
Mode 2	None	11	8	10	1	4	1
	Partial	0	0	0	0	0	0
	Unbound	1	0	1	0	0	0
Mode 3	None	4	5	3	0	4	1
	Partial	7	2	8	0	0	0
	Unbound	1	1	0	1	0	0
Mode 4	None	0	0	0	0	0	0
	Partial	0	0	0	0	0	0
	Unbound[c]	12	8	11	1	4	1
Limitation on national treatment							
Total		**12**	**8**	**11**	**1**	**4**	**1**
Mode 1	None	8	6	7	1	2	1
	Partial	0	0	0	0	0	0
	Unbound[b]	4	2	4	0	2	0
Mode 2	None	11	8	10	1	4	1
	Partial	0	0	0	0	0	0
	Unbound	1	0	1	0	0	0
Mode 3	None	9	7	9	0	4	1
	Partial	2	0	2	1	0	0
	Unbound	1	1	0	0	0	0
Mode 4	None	0	0	0	0	0	0
	Partial	1	0	0	0	0	0
	Unbound[c]	11	8	11	1	4	1

[a] Based on the services database available at http://tsdb.wto.org/wto/WTOHomepublic.htm, which includes commitments by members up to December 2004.
[b] Unbound, mostly for technological reasons.
[c] For Mode 4, all except two members qualify unbound with their horizontal commitments.

The extent of health-related financial services covered in the schedules is even larger in terms of number of countries but not in terms of market access opened and national treatment extended, except for Mode 2 (table 5). Yet it is clear that life, accident and health insurance services are very important as support for the growth of other services (e.g., tourism including medical tourism, education and construction). One of the future empirical research tasks will thus be to compare this minimalist approach taken by Asia-Pacific economies, through GATS, to their opening of market access to health-related insurance services, through the foreign direct investment regulations and preferential trade arrangements.

Table 5. Health-related commitments under financial services*

A. Insurance and insurance-related services (a) Life, accident and health insurance services (CPC 8121)			
		Limitation on market access	Limitation on national treatment
Mode 1**	None	4	10
	Partial	4	0
	Unbound	13	11
Mode 2**	None	12	13
	Partial	3	1
	Unbound	6	7
Mode 3	None	4	15
	Partial	18	6
	Unbound	0	1
Mode 4	None	2	4
	Partial	1	0
	Unbound	19	18

* Based on the services database available at http://tsdb.wto.org/wto/WTOHomepublic.htm, which includes commitments by members up to 2005, except for Viet Nam.
** New Zealand does not specify commitments for Mode 1 and 2 for this type of service so total number of countries in these modes is 21.

It is useful to note that some parallels from trade in goods should be invoked when assessing trade in health services. For example, in most cases, increased exports will push up the price of an exported good or service. Therefore, concern that increased exports of health services (through providing services to foreign residents locally or by "exporting' health providers) will increase the price of such services locally is strongly justified. Standard reasoning accompanied by this price effect is that any increase in prices will not matter as such an increase can be easily absorbed by gains from increased exports. While this is correct at the aggregate national level, there are still distributional issues that are not resolved automatically and in the short term (particularly in the absence of winners-to-losers transfers). Gains are accumulated in one or few social segments while the higher price of the health-care service is paid by all, particularly the poor. The need for public policy intervention to mitigate the price impact on the poor is therefore a necessary companion of trade liberalization in health sector.

Notwithstanding the above (not unique to health services), it must be stressed that globalization might mitigate some of the problems as it could provide more opportunities for solving the problems. Chanda (2001) provides examples of increased trade potentially easing some of underlying conditions that are the root causes of the brain drain (low wages and poor working conditions, and underdeveloped infrastructure) in developing countries.

2. Trade-Related Aspects of Intellectual Property Rights

In addition to GATS, the Agreement on TRIPS has important implications for health and human development, as discussed below. One important difference between the GATS and TRIPS agreements is that GATS can be largely tailored to the developmental imperatives of a member, while TRIPS does not have such flexibility. TRIPS does integrate few alleviating conditions for implementation of developing and the least developed countries (e.g., originally only related to differing transition periods).

TRIPS is wide ranging as it incorporates what was previously covered by four intellectual property rights conventions and treaties: (a) the Paris Convention (inventions, trade names, trade marks, industrial design and appellation of source); (b) the Berne Convention on copyrights; (c) the Rome Convention on sound recordings; and (d) the Washington Treaty on layout design of integrated circuits. Placing all standards under the TRIPS Agreement was seen as advantageous as it would also allow a unified approach to the dispute settlements under WTO. Nevertheless, TRIPS has opened up many controversial issues, in particular for the developing countries.

In many developing countries, implementation of TRIPS is the very first step in the direction of forming a regime of intellectual property protection that is involved with substantial and immediate costs; however, the benefits seem to be more illusive. It is also one of the WTO multilateral agreements having a major impact on health sectors in member countries because it affects access to medicines and medical equipment in several ways:

- The impact of intellectual property rights under TRIPS will influence patent protection of medicines and other health-related products, and therefore the prices of such products are expected to rise.
- The ability to produce generic versions of patented medicines is limited due to patent restrictions and restrictions on reverse engineering.
- TRIPS has an impact on allocation of research and development funds. Claims were made that TRIPS contributed towards a boost in research and development activities in the pharmaceutical sector of developed economies, in contrast to what was originally promised from TRIPS. Those avenues of impact can lead to issues related to accessibility and affordability of medicines, and can thus undermine public health in many developing countries.

Even though there are other TRIPS issues of great significance for health and development, such as biodiversity, access to medicines at affordable prices remains the major issue of its implementation (requiring strengthening of patent laws in member countries). Therefore, this brief mainly comments on that aspect of TRIPS.

When the WTO agreements took effect on 1 January 1995, developed countries were given one year to ensure that their laws and practices conformed to TRIPS. Developing countries and (under certain conditions) transition economies were given five years, i.e., until 2000. Least-developed countries, in accordance with their capacity and

needs, were given 11 years to synchronize domestic legislation with the TRIPS rules. That transition period was later extended until 1 July 2013 to provide adequate protection for trademarks, copyright, patents and other intellectual property, and until 2016 to provide protection for pharmaceutical patents.

Since the Uruguay Round, developing countries have been demanding changes to the TRIPS Agreement in accordance with their developmental needs and concerns. To initiate the changes, the review processes built into the Agreement were used. The review of Article 27.3 (b) is the most relevant to health-related services trade, as it refers to the issue of patentable subject matter related to public health. At the Doha Ministerial Conference, the Declaration on the TRIPS Agreement and Public Health was finally adopted, requesting that implementation of TRIPS should give due consideration to the public health concerns, particularly related medicines.

An issue that remained open at the Doha Ministerial Conference was the one related to a secure and affordable access to pharmaceuticals for countries which are not able to produce them domestically. Some limited exceptions were allowed through Articles 30 and 31 of the TRIPS. In particular, Article 31 on "Other Use without Authorization of the Right Holder" to be used in national emergencies permitted someone else to produce the patented product, like pharmaceuticals, without the consent of the patent owner (but also stipulating a number of conditions aimed at protecting the interest of patent holder). The term "compulsory licensing" is most often used in connection to this right and it typically restricts the use to the purposes of supply of domestic market and not export. Thus it affected access to generic medication by poor countries not able to produce domestically. Then, prior to the Cancun Ministerial Conference, in August 2003 a temporary solution to this issue was found in a waiver. The waiver helped poorer countries to gain access to less expensive generic versions of patented medicines by setting aside a provision of the TRIPS Agreement that regulated exports of pharmaceutical products produced under "compulsory licences" to countries that were unable to produce them. Although all WTO members are eligible to import under this changed discipline, 33 developed countries (including all 3 ESCAP developed members) have announced voluntarily that they will not import products produced under "compulsory license" and 11 more agreed to use it only in circumstances of national emergencies or extreme urgencies (including Hong Kong, China, Macao, China, republic or Korea, Singapore, and Turkey from this region). The decision on the amendment of the TRIPS Agreement was adopted by the General Council on 6 December 2005, prior to the Hong Kong Ministerial Conference, bringing permanency to a decision on patents and public health originally adopted in 2003. The amendment will be formally built into the TRIPS Agreement when two thirds of the WTO members have accepted the change. The deadline is 1 December 2007, but it may be extended if necessary. As of 31 December 2006, only three members had accepted the amendment (El Salvador, Switzerland and the United States). This represents 2 per cent of the membership (3 out of 149) while the target, as mentioned above, is 67 per cent by the end of 2007. Meantime Canada, EU, India and Norway made necessary changes in domestic laws and regulations in order to implement the waiver and to allow production exclusively for export under "compulsory license" (WTO, 2006).

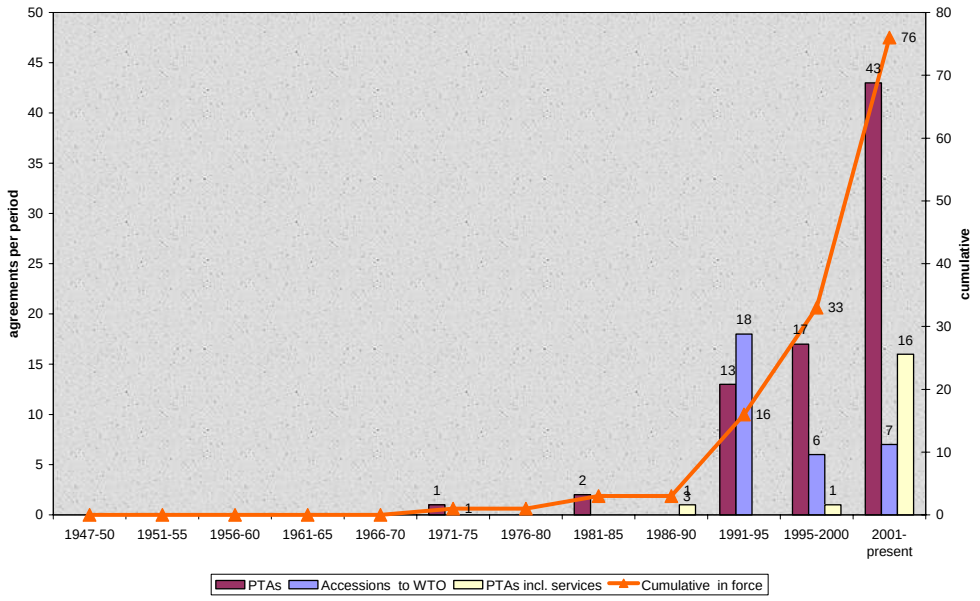
Box 2. Recent use of 'compulsory license"

As explained**,** under WTO TRIPS regulation, countries are free to define threats to public health as national emergencies and introduce "compulsory licenses" into the domestic legislation in the case of an extreme urgency without having to first negotiate with the patent holder for a voluntary license (as stipulated by TRIPS Article 31b). Such action has been already taken by several countries, most notably Brazil and India, especially in the case of HIV medicines. Most recently Thailand used a compulsory license to allow the sale of generic versions of imported drugs, two to treat HIV/AIDS and the other for heart disease, without consent of the patents holders. The government's decision to allow for either the production or purchase of generic versions of the drugs overseas was motivated by need to address health problems of thousands of people with limited budget and to set an example to other countries facing similar problems.

3. Health-related services coverage in the preferential trade agreements in Asia and the Pacific

Following the establishment of WTO and the occurrence of the Asian financial crisis in 1997, readiness to liberalize trade through channels other than mainstream multilateral liberalization became much stronger in Asia and, to some extent, the Pacific region. Increasingly, countries in the Asian and Pacific region embraced bilateral and other trade arrangements that very quickly produced a situation of entangled and overlapping preferential rules, informally named "Asian noodles" (as it closely mimics the "spaghetti bowl" phenomenon). Figure 1 shows the growing reliance on preferential negotiations among economies in the region by tracking the agreements in force (many more are being considered in either political or policy circles, but they are not plotted in the figure).

Figure 1. Growth in number of trade agreements in Asia and the Pacific



The objectives of trade agreements, as set out in the legal documents and texts of the agreements, include expanding trade, promoting investment, developing economic integration, establishing regional cooperation and coordination, promoting human rights and democracy, and improving security. Newer agreements in particular try hard to broaden the coverage of commitments from liberalization of merchandise trade to behind-the-border provisions in trade and other areas of cooperation.

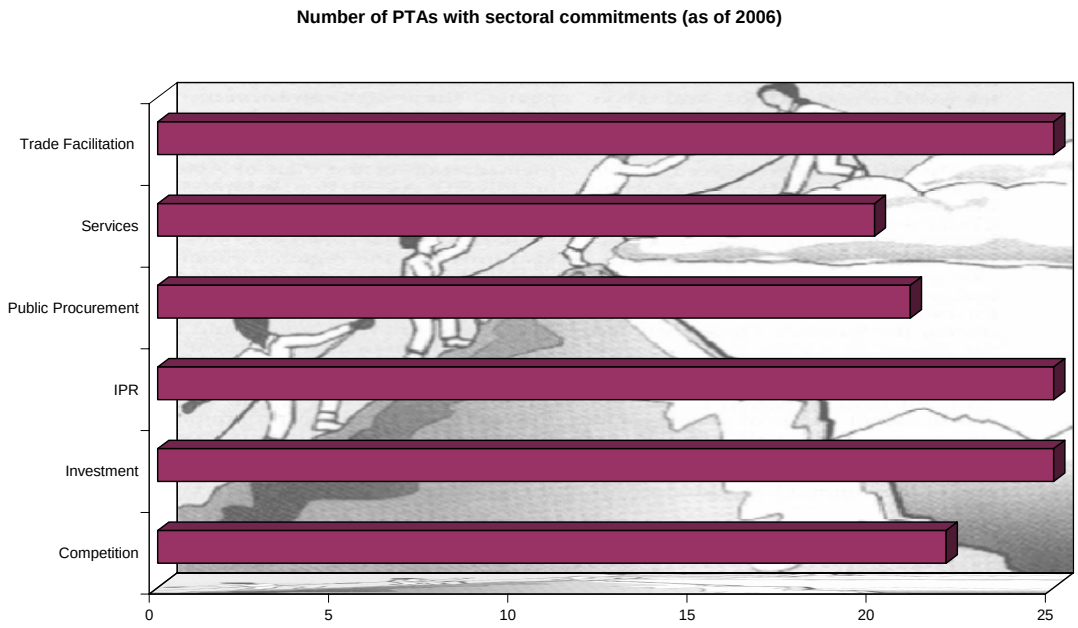
Many of these newer initiatives declare the intention to go well beyond the reduction/elimination of tariffs and non-tariff barriers, including anti-dumping and safeguards, harmonization of competition policies and standards, and customs; however, a large number just remain a collection of aspirations towards liberalization that tend to be associated with a longer negotiation process. In addition, despite these intentions to go deeper than trade integration, there is only an occasional mention of the formation of a customs union or a common market in the Asia-Pacific region.[1]

Furthermore, while a number of countries strongly argue for more freedom in movements of labour in the context of multilateral liberalization (referring to Mode 4 liberalization), when it comes to preferential trade agreements only a few address this area. A comparison of preferential trade agreements in this region to existing deals in the Americas also illustrates a form of reluctance to negotiate all-inclusive comprehensive agreements. Instead, trade agreements are often accompanied by separate agreements on services, investments, intellectual property protection, customs procedures etc. Thus, in general, Asia-Pacific agreements do not come close to what Goode (2005) painted to be a

[1] For example, the already cited "single economic market" of Australia and New Zealand. At the zenith of the 1997 Asian financial crisis, there were also calls for the establishment of a currency union. They were later merged into proposals for an East Asian Community.

good practice or a model agreement that liberalizes deeply and broadly across all areas. Figure 2 shows that Asia-Pacific agreements tend to cover areas of competition, intellectual property protection, investment and trade facilitation more than services.

Figure 2. Sectoral coverage of PTAs in Asia and the Pacific



Source: APTIAD, December 2006. Background is from Trade insight, Vol2, No 1, 2006, p.25.

The only trade agreement in this region that precedes GATS is the side Protocol on Trade in Services to the Australia–New Zealand Closer Economic Relations Trade Agreement dating back to 1988. Most regional economies only opened up to negotiating trade in services through preferential agreements after 2000. This "embracing" of the services area in trade deals was driven by, but not limited to, negotiations with partners from outside the developing Asia-Pacific region.

Table 6 lists all 18 PTAs that are in force and which include either already negotiated services trade concessions or strong 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. "When countries are not ready to liberalize their services sectors, the minimum pledge is to bind their PTA commitments in the GATS" (Feridhanusetyawan, 2005). In many cases, this means that regional services trade liberalization is "hot air" and is not really making an impact on the expansion of services trade among the member countries. Champions of regional services trade liberalization are high(er)-income countries in the region (e.g., Australia, Japan, New Zealand and Singapore) as well as the United States.

Table 6 also provides information on how these agreements cover health-related services trade. Most of the 18 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 the feature of the 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.[1] Box 3 provides more details on state of health services trade liberalization among the ASEAN members.

[1] See M. Roy, J. Marchetti and H. Lim, 2006.

Table 6. Asia-Pacific trade agreements with provisions on services trade and referring to health and social services or health-related products

Acronym	Title	Official link*	Health	Note
AFAS	ASEAN Framework Agreement on Services	http://www.aseansec.org/6628.htm	Covered by some members	Brunei Darussalam and Singapore scheduled commitments in Healthcare; GATS consistent
ANZCERTA	Australia-New Zealand Closer Economic Relations Trade Agreement	http://www.fta.gov.au/default.aspx?FolderID=285&ArticleID=231 http://www.dfat.gov.au/geo/new_zealand/anz_cer/215.pdf	A separate protocol on services does not exclude health	Reciprocal Health Care Agreement 1998
ANZSCEP	Agreement between New Zealand and Singapore on a Closer Economic Partnership	http://www.fta.gov.sg/fta/pdf/anzscep.pdf	Covered	Annex 2 of the Agreement schedules commitments; GATS consistent
ASFTA	Singapore-Australia Free Trade Agreement	http://www.fta.gov.sg/fta/pdf/FTA_SAFTA_Agreement.pdf	na	Article 6 on Cooperative Activities on Sanitary and Phytosanitary/Quarantine Matters in No. 1 and 2 refers to public health and electronic health certificates, respectively.
AUSFTA	Australia-United States Free Trade Agreement	http://www.dfat.gov.au/trade/negotiations/us_fta/final-text/index.html	Covered	Cooperation in area of therapeutic goods and medicines, government procurement, regulation and intellectual property, and aspirations to open flows of professional services (medical workforce)
BIMSTEC	Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation	http://www.bimstec.org/ http://www.bimstec.org/free_trade_agreement.asp http://www.bimstec.org/ftagreemet/3.htm	na	
CHNHKGCEPA	China-Hong Kong SAR Closer Economic Partnership Agreement	http://www.tid.gov.hk/english/cepa/tradeservices/services_measures.html	Covered	Only medical and dental services (under professional services) appear to be included
CHNMAKCEPA	China-Macao SAR Closer	http://www.economia.gov.mo/page/eng	Covered	Only medical and dental services (under

	Economic Partnership Agreement	lish/cepa_e.htm		professional services) appear to be included
EFTASGPFTA	EFTA-Singapore Free Trade Agreement	http://secretariat.efta.int/Web/External Relations/PartnerCountries/Singapore	Covered	Annex VII, GATS consistent
INDSGPCECA	Comprehensive Economic Cooperation Agreement between the Republic of India and the Republic of Singapore	http://app.fta.gov.sg/data//fta/file/India-Singapore%20Comprehensive%20Economic%20Cooperation%20Agreement.pdf	Not specifically excluded	Chapter 7 on Trade in Services and Chapter 9 on the movement of natural persons apply
JPNMYCEP	Agreement between the Government of Japan and the Government of Malaysia for an Economic Partnership	http://www.mofa.go.jp/region/asia-paci/malaysia/epa/index.html	Covered	Annex 6 of the Agreement
JPNMEXEPA	Agreement between Japan and the United Mexican States for the Strengthening of the Economic Partnership	http://www.mofa.go.jp/region/latin/mexico/agreement/index.html	na	
JSEPA	Agreement between Japan and the Republic of Singapore for a New-Age Economic Partnership	http://www.fta.gov.sg/fta/pdf/FTA_JSEPA_Agreement.pdf	Covered	GATS consistent
KORCHLFTA	(Republic of) Korea-Chile Free Trade Agreement	http://www.direcon.cl/documentos/corea/TEXTO%20FINAL%20DEL%20TRATADO%20EN%20ESPANOL%20CON%20COREA.pdf	Covered	Chapter 11, No. 4 refers to cross-border trade in health-care services
KORSGFTA	(Republic of) Korea-Singapore Free Trade Agreement	http://app.fta.gov.sg/asp/fta/pagetemplate1.asp?pg_id=korea_legal_text&ctryname=Korea&pagetitle=Legal%20Text	Covered	Annex 9A
SGPJORFTA	Singapore-Jordan Free Trade Agreement	http://www.fta.gov.sg/fta/pdf/FTA_SJFTA_Final%20FTA%20text%2015%20May%202004.pdf	Covered	Chapter 6 on Business Cooperation, Article 6.2 on Forms of Cooperation, point (a) refers to joint organization of industry-specific missions with the focus on high-growth sectors, including, inter alia, health care
TRANSPACSEP	Trans-Pacific Strategic	http://app.fta.gov.sg/data//fta/file/P3%2	Covered	Excludes health-related and social services

	Economic Partnership Agreement (Brunei Darussalam, Singapore, New Zealand and Chile)	0authentic%20Trans-Pacific%20SEP%20Text%20English_v1.pdf		for provision to the public
USSFTA	United States-Singapore Free Trade Agreement	http://www.fta.gov.sg/fta/pdf/FTA_USSFTA_Agreement_Final.pdf	Covered	Annex 6A on Working Group on Medical products Annex 8A and 8B

Source: Based on legal texts of agreements, downloaded from the Asia-Pacific Trade and Investment Agreements Database, November 2006.
* In the Asia-Pacific Trade and Investment Agreements Database.

4. Concluding comments

In explaining shallow liberalization in the trade of health services through multilateral and regional/bilateral efforts, it is necessary to refer to the socio-economic features of the region. It appears that most economies 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. Transitional efforts to, and trade policies on reform were more focused on industrial activities. Furthermore, traditionally economies in the region were responsive to trade-liberalizing efforts at the multilateral level in the area of goods trade. In other areas, including the broad area of services, enthusiasm is much weaker. Health sector is where there are still high reservations towards opening to trade.

Demographic, technological and economic developments in the region will force policy makers to using more open trade policies in reference to health-care services and other activities directly and indirectly linked to the health sector (including the manufacture of medicines and other therapeutical products, and medical insurance). As in other activities, governments need to worry about equalizing marginal social benefits to marginal social costs. When there are large discrepancies in private and social costs and /or benefits – and this is one sector where this is often the case – governments are more reluctant to let markets take over. Nevertheless, many areas offer potential benefits from further commitments to multilateral liberalization in health services (in all modes of delivery). Some of the more obvious ones are listed below:

(a) Mode 1: More consumers get access to faster, better and possibly cheaper diagnostic medical services, including some therapeutical services.

(b) Mode 2: More local consumers gain access to mostly high-quality services (overseas) at more affordable prices or without lengthy waiting times; at the same time, pressure on the domestic health sector weakens. (Although countries schedule these commitments for **sending** consumers aboard, the receiving countries have an interest in making their economic environments as attractive as possible because they will also gain. Exports of health services tend to be a higher value added activity, and earnings can support/cross-subsidize public health sector. In addition, a higher number of attractive jobs can be created.)

(c) Mode 3: Increasing the range of medical facilities offering better and new services, including the transfer of knowledge and technology, while at the same time controlling the brain drain in the medical profession.

(d) Mode 4: Making essential health-care services (nursing, long-term care and similar services) more accessible and affordable, thus increasing the welfare of all. Some positive knowledge spillover effects are also possible. (Although countries do not schedule conditions for **sending** natural persons abroad, they do benefit from the outflow mostly through stream of remittances, reduced pressure on domestic labour markets and some learning effects.)

In each of the above modes, it is possible to identify potential costs to society or private entities. The more obvious costs are:

(a) Mode 1: Possibly weak consumer protection (unless additional intercountry agreements exist).
(b) Mode 2: Access to foreign medical services affordable only by those with expensive medical insurance/wealthy, quality assurance (and for countries on the receiving end, possible crowding-out of local residents and price effects).
(c) Mode 3: A weakening of the domestic public health system as well as increasing inequalities.
(d) Mode 4: Some potential social/cultural problems and a false feeling of having a solution to long-term problems (and for countries sending service providers, a loss of skills and service domestically, bias in education pressure and similar negative effects).

The role of policy makers, in consultation with all stakeholders is to find policy solutions in trying to maximize net benefits from the above. 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 opening more options. It is useful to remember that current or a future lack of liberalization commitments under GATS does not prevent a WTO member from liberalizing unilaterally or regionally.

Furthermore, many economies use different routes – reforms of domestic regulation and foreign direct investment regulation – to improve their health sectors (e.g., Indonesia). These efforts are not without impact, but are not picked up or discussed in this paper.

Box 3. Health services trade liberalization in the Association of South East Asian Nations[10]

Arunanondchai and Fink (2005) found that members of the Association of South East Asian Nations (ASEAN) were involved in all four modes of supply of services across national borders. Their findings are summarized below. A general comment related to inadequate statistical data and its relatively low quality applies to all countries. ASEAN countries, in addition to India and China, are the largest traders of commercial services among developing countries, and trade in health services already accounts for a significant portion of their international exchange.

Mode 1: Cross-border supply or "pure" trade

It appears that the Philippines in ASEAN and India in South Asia lead in the exportation of mode 1 services, most often comprising exports of medical transcription services to the United States. The comparative advantage of these countries lies in the large pool of educated English-speaking workers. In India alone, employment in activities providing mode 1 health services increased from 30,551 in 2000 to 242,500 in 2005, while revenue jumped from US$ 264 million to US$ 4,072 million during the same period (Wibulpolprasert, 2005).

Mode 2: Movement of consumers to consume abroad

While education is an important Mode 2 service for some developed countries in the region (Australia and New Zealand), tourism is important for all of them. "Health tourism" is increasing becoming an export activity for countries such as Malaysia, Singapore, Thailand and some other countries in the region. The number of foreign patients visiting Thailand for health tourism purposes almost doubled from 550,161 in 2001 to 973,532 in 2003 (Wibulpolprasert, 2005). Only 7 per cent of those consumers came from within the ASEAN region. The advantage that Malaysia, Singapore and Thailand have in the expansion of health tourism is derived from two sources. First is the price differential relative to developed countries. The most important factor driving this price differential is the difference in labour costs, which means that this part of the advantage will be lost with the development of those countries. The second source is the established quality of service. This quality is maintained by a special accreditation system (Arunanondchai and Fink, 2005).

Mode 3: Commercial presence

Foreign participation is still very limited in the health-care sector of the ASEAN countries. In Indonesia, it accounts for just 1 per cent of hospital beds, while in Thailand it contributes 3 per cent of total investment in private hospitals. A separate brief on foreign direct investment in the health sector deals with factors influencing the movement of foreign investment in health-related activities. There is also an outward investment by the Thai health sector overseas (Bangladesh and Myanmar).

Mode 4: Movement of individual service providers to provide a service

The Philippines and Indonesia are the two largest source countries of health-care workers from ASEAN, even though the destinations of workers from those two countries differ. While the destiny of Filipino nurses and other health-care workers is English-speaking developed countries and some countries in the Middle East, Indonesian workers focus on Islamic countries of the Middle East as well as Malaysia and Singapore. Malaysia is in a unique position of being a sender and a recipient of Mode 4 health personnel; the number of foreign health-care workers travelling to Thailand is negligible due to the requirement for a licence examination in Thai.

[10] At the end of October 2006.

References

Adlung, R. and A. Carzaniga, 2003. "Trade in health services under GATS", WTO Working Paper series, November 2003, Geneva. Mimeograph.

Arunanondchai, J. and C. Fink, 2005. "Trade in health services in the ASEAN region", paper prepared for the project on trade in health services undertaken by the ASEAN Economic Forum and supported by the World Bank Institute. Mimeograph.

Blouin, C., N. Drager and R. Smith (eds.), 2006. *International Trade in Health Services and the GATS – Current Issues and Debates.* Washington, D.C., World Bank.

Chanda, R., 2001. "Trade in health services", World Health Organization Bulletin, vol. 80, pp. 158-163.

Cossy, M., 2006. "Determining 'likeness' under the GATS: Squaring the circle?" World Trade Organization Staff Working Paper ERSD-2006-08. Geneva.

Feridhanusetyawan, T., 2005. "Preferential trade agreements in the Asia-Pacific region". International Monetary Fund Working Paper WP/05/149. Washington, D.C.

Gonzales, A. and others, 2001. *Health Tourism and Related Services: Caribbean Development and International Trade*, RNM.

Goode, W., 2005. "Negotiating a free trade agreement: A guide". Asia-Pacific Economic Cooperation. (http://www.apec.org/apec/enewsletter/jul_ol6/publication.primarycontentparagraph.0001.LinkURL.Download.ver5.1.9).

Roy, M., J. Marchetti and H. Lim, 2006. "Services liberalization in the new generation of preferential trade agreements (PTAs): How much further than the GATS?" World Trade Organization Staff Working Paper ERSD-2006-07. Geneva.

Wibulpolprasert, S., 2005. "Health services and FTA", PowerPoint presentation, 2 September 2005. Mimeograph.

World Trade Organization and World Health Organization, 2002. "WTO agreements and public health", joint study by the WHO and WTO Secretariats. Geneva.

WTO, 2006. "Intellectual property (TRIPS)- fact sheet – pharmaceuticals 2 available at http://www.wto.org/english/tratop_e/trips_e/factsheet_pharm02_e.htm