Trade in Health Services in the BIMSTEC Region: An Overview

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Abstract

The health care sector is among the most rapidly growing sectors in the world economy. The globalization of health services is reflected in the growing cross-border delivery of health services, through movement of personnel and consumers (by electronic and other means), and in an increasing number of joint ventures and collaborative arrangements. Promoting quality health services to large population segments is a key ingredient to human and economic development. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services, creating incentives for efficiencies in the healthcare system and managing constraints in government budgets. In this context this paper offers an overview of trade in health services in the BIMSTEC (Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation) region.

Keywords: Healthcare services; International trade; BIMSTEC

Introduction

Globalization over the past two decades has affected a wide range of sectors, directly or indirectly. Spurred in part by technological advances and by national political and economic compulsions, the process of globalization has led to the emergence of new forms of business opportunities, processes, and organizations. It has made necessary the establishment of international rules and regulatory frameworks in areas which were previously the exclusive domain of domestic policies. Globalization of health services is driven by many factors. These include the decline in public sector expenditures and the rise in private sector participation in health care in many countries, the liberalization of related sectors such as insurance and telecommunications, increased mobility of consumers and health service providers due to declining travel costs and greater ease of travel, and technological advances enabling the cross-border delivery of many health services. In addition, differences in costs, availability, and quality of health care across countries, the emergence of investment opportunities in the health care sector with the liberalization of investment regulations, and the general increase in demand for health services arising from rising income levels and aging populations, have also contributed to the globalization of health services. Although trade in health services is modest at present, given the rapidly growing global health care industry and the likely removal of some of the regulatory barriers to such trade at the regional, multilateral, and the national levels, trade in health services is likely to take on greater importance in the future. The health sector is one such area which has been significantly affected by globalization despite its public good and non-commercial nature. The performance of a country's health sector is critical for the well-being of its citizens. Caring for sick workers preserves a country's stock of human capital, laying the foundation for sustained economic growth. The provision of health services also has important public good characteristics, in particular when it comes to containing the spread of infectious diseases such as HIV/AIDS, tuberculosis and malaria.

Literature Review on Trade in Health Services

Until the emergence of World Trade Organization in 1995, there was no polygonal agreement to make easy trade of services. Interventions at the WTO led to the General Agreement on Trade in Services (GATS), a comprehensive agreement on the international trade in services. GATS explicitly offer for successive rounds of negotiation with a view to achieving a progressively higher degree of liberalization. A swell in trade in health services suggests a handful of developing countries a limited set of export opportunities, mainly in drawing foreign consumers to their health facilities. These gets seem slight when compared with the effects that the increased trade in health services could have on general people's right to health. Trade in health services risks exacerbating many of the problems which already plague health systems across the world. The damage may outweigh the benefits, particularly for those with little ability to pay more for publicly provided health care.

There are several studies which have focused on the economic dimensions and distributional aspects of trade in health services (Blouin *et al* 2003; Chanda 2002; Woodward 2003; Diaz Benavides 2002; Drager and Vieira 2002; Woodward *et al* 2002; Adlung and Carzaniga 2002; Chanda 2001).

Some of the studies discovered the fences of trade in health services and opportunities of liberalizing this sector. These studies also examined the state of affairs and issues such as volume and trade in health, trading partners, commercial presence, movement of personnel, barriers to trade in services, income from trade in services etc (Janjaroen and Supakankunti 2002; Gupta, Goldar and Mitra 1998; Zarrilli 1998; Wasswrman 2002; Widiatmoko and Geni. 2002; León 2000; Achouri and Achour 2002).

Some studies have tried to analysis it from a regional perspective, especially on specific issues like commitment to trade, regulation of trade, challenges and benefits of trade within the region and so on (Sabri. 2002; Rahman 2000).

The economic blow of trade in health services for developing countries and least developed countries (LDCs) is of importance because of other competing priorities. Blouin *et al* (2003) recorded a number of potential costs and benefits of trade in health services for developing countries which can be listed as follows: foreign exchange earnings and incremental incomes (mode 2); increase in the range and quality of services available (mode 2); foreign earnings and additional incomes brought about by export of health services; remittance generated by the temporary movement of nurses; physicians and health professionals (mode 4).

However, there may be costs associated with trade in health services as follows: resource diversion in terms of public funds allocated to benefit foreign patients; brain drain of health professionals due to export of health services; dual market structure in terms of imports of health services; resource diversion if public funds are allocated to attract FDI in the health sector; internal brain drain of health professionals due to the entry of foreign health professionals, and outflow of foreign exchange for profit remittance.

Similar apprehensions have been expressed by others as well. It has been argued that while trading of health care services under the various modes of GATS may have positive impacts on the overall health services in a country, the sector is also faced by potential threats likely to emanate from its globalization (Chanda 2001). Therefore, the impact of trade in health services for equity, access, costs, and quality of health services is largely dependent on the policies and safeguards governments put in place and on the existing conditions in the sector (Chanda, 2002).

The issue of probable challenges with regards to the potential for increased inequity, fragmentation of health systems and further marginalization of the public sector as a result of increased liberalization of health care system has also been focused in case studies (Mirza 2005). The importance of proper and adequate consumer protection, competition and regulatory structures has been reiterated in this regard.

It is clear that participating in trade in health services, with or without GATS commitments, holds the potential for a number of concrete benefits, but at the same time also carries some risks in relation to the attainment of objectives of the national health policy. A study on the Tunisian health service by Achouri and Achour, (2002) revealed that liberalization of trade in health services pose both risks including greater pressure on the market for health professionals and destabilizing equilibrium between public and private sector and benefits such as advancement of quality and efficiency of health care along with the access to new technology.

Generally speaking, as experience of the WTO shows, for developing countries and LDCs it is seen that very often risks are ―real‖ and benefits are ―potential‖.

Benefits may not materialize and costs may be high if liberalization of health sector is not underpinned by sound regulatory discipline, which is carefully tailored towards the achievement of national objectives. For instance, Janjaroen and Supakankunti, (2002) analysed the case for international trade in Thailand. Thailand did not make any international trading agreements in health services under GATS. They still have significant barriers to trade in the health sector which prevents FDI inflow in the health sector, lacks competition at national level and established poor healthcare infrastructure over the years. Therefore, the study advocated for free trade in health sector, easing health service laws with minimal impact on the industry and creating linkage between commercial investment and mobility of personnel as well as regulations that recognize international medical education.

Similarly, another study by Gupta, Goldar and Mitra (1998) analysed benefits to India of free trade in health services. They have concluded that opening up various areas in health services will benefit the health sector in India, both in short run and in the long run, especially through bringing in improvements in the quality and quantity of curative health care availability. However, barriers were preventing free flow of trade then. Hence, the paper recommended that GATS agreement rules need to be imposed more strongly by increasing the commitments of Developed countries towards greater market access and collaboration with developing nations. It should also relax rules concerning short-term movements of medical personnel, standardize rules pertaining to educational qualifications and establish laws that monitor both local and foreign medical facilities to eliminate illegal practices.

Zarrilli (1998) mentioned trade liberalization of the health sector can lead to improved health systems in developing countries by providing additional financial resources, exposing health professionals from developing countries to new techniques, and providing them with access to higher qualifications. Also, improvements can follow from introducing innovative management systems in developing countries, upgrading the quality of the health treatments they can provide, especially in the rural areas, and strengthening foreign and domestic competition. Leon (2000) had also found that modernization and institutional change in Chile's health system favoured the internationalization of health and so emphasized exchanges and integration among public and private health insurance programs of sub-regional countries so as to capture the demand created by tourists and foster the development of provider-center systems in some specialized and border areas.

There has been concern about the effect of health sector liberalization on the economically disadvantaged and these have been put into proper perspective. Firstly, GATS does not impose any constraints on terms and conditions under which a host country treats foreign patients. Secondly, there is no legal impediment in GATS that would affect the ability of governments to discourage qualified staffs from seeking employment in private sector, at home or abroad. The deterrent measures might include deposit requirements or guarantees. Adequate regulation can take care of any crowding-out effect, which might be to the disadvantage of the resident patients (Chanda 2001).

The potential for trade in health services has increased due to the reduction of geographical barriers to trade and the increase in mobility of potential patients. Health is one of the very few service sectors where developing countries, with adequate qualification, can be competitive exporters under several modes including the mode 2 of GATS. By capitalization of inward direct investment from GATS mode 3 commitments, developing countries attract patients from other developing countries or from adjacent developed countries as well. This is possible for countries with sufficient infrastructural resources, which not only give a local advantage but can also help ancillary service industries. But unfortunately the interests of developing countries are towards the modes of supply (Adlung and Carzaniga, 2002).

Foreign investment in the health services indirectly has a positive effect on income and employment, and may also affect related industries like construction, transport, communication and tourism. This was also hinted by Diaz and David (2002) where trade in health services offer possibilities of higher economic contribution of the health sector to the national economy.

However, Woodward etal (2002) explored the relationship among globalization, global public goods, and health. This paper actually gives importance on economic globalization as a significant determinant of health and trade in health related services. Moreover, Woodward (2003) also discussed the profit motive in trading health services, and pointed that the gain of developing country from health services trade is generally lost due to the vast differences of capacities between developed and developing countries.

Sabri (2002) focused more on the greater role of World Health Organization (WHO) in managing efficiently the consequences of trade in health services. Furthermore, he insisted the efforts to measure the volume of existing trade in health services and to make reasonable projections for the future.

Other region-wise studies proposed allowing for trade liberalization with tailored national level policies to govern the trade. For instance, Widiatmoko and Gani (2002) came up with a suggestion that telemedicine could play a substantial role in reducing the need of experts both local and from overseas in health care in Indonesia. They also argued the need for foreign investment hospitals with the development measure of equitable access to health care. Rahman (2000) offered some recommendations for efficient local health care services by analysing Bangladesh-India trade in health services. They are (a) design and strictly implement quality control measures for medical tests; (b) fiscal policy support to reduce cost of import of medical equipments; (c) review the rules pertaining to fees charged by doctors, and then strictly implement the revised rules; (d) enhanced training facilities for nurses and medical technicians; (e) setting up joint venture medical establishments to facilitate technology and knowledge transfer.

The above mentioned studies reveal that opening up of various areas of health services will be beneficial for countries as a whole in the long run in terms of both better quantity (availability) and quality. However, since the institutional and social structure varies from country to country, trade liberalization in the health sector needs a case-by-case review and not a generalized opinion. As our study focuses on South Asian countries, we will examine the health sector in the following selected South Asian countries: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

Current Trade Patterns in the Bimstec Region

Trade discussions in services typically adopt a wide definition of what constitutes trade, involving the following four modes of supply.

Mode 1: cross-border supply. This mode of supply is akin to traditional goods trade, whereby suppliers and consumers are located in different countries.

Mode 2: consumption abroad. International trade also takes place when the consumer moves to the country of the supplier.

Mode 3: commercial presence. This mode of supply describes the situation whereby producers, in the form of juridical persons (or companies), move to the country of the consumer.

Mode 4: movement of individual service providers. Similar to Mode 3, this mode of supply describes the situation whereby the producer moves to the country of the consumer, but the producer takes the form of a natural person (or individual). Mode 4 trade typically captures the movement of service workers that is of a temporary nature and does not involve permanent migration.

Trade in Health Services – an Overview

A better health services enable countries to face the challenges of environment and global commercial integration. Evidence confirms that expanding economic opportunities for people living in developing and LDCs raises their incomes. The key to expanding their economic opportunities is to help them build up their assets. Human capabilities such as health are of intrinsic value and also have powerful effects on material well-being. Broad access to such facilities is also important to the material prospects of the people. And the trade in health services can reduce their vulnerabilities. Therefore, challenges for the South Asian countries are to achieve gender equality health – national commitment, and to recognize each others standards – international commitment. In case of national commitment, the prospects for achieving gender equality in health vary considerably between countries. There has been more progress in gender equality in health (World Bank, 2005). Still, more than a third of developing countries will not achieve gender parity in health, and most of them risk not meeting the Millennium Development Goal (MDG) in 2015 if they do not take immediate action to extend health services to cover poor people. The risk is greatest for Sub-Saharan Africa and South Asia, the regions reporting the slowest progress in universal health. In case of global commitment, progress toward mutual recognition of health services differs across countries. While developed countries were successful in recognizing each others medical services, the problem get more acute in case of developing and LDCs where progress has been very limited.

Specifically, a strong asymmetry persists in terms of standards and contents of the medical services across the countries and regions. In addition, changes in the domestic and international market structures have promoted the appearance of activities closely related to health services. These new activities are designed to support health processes or systems without being "instructional activities" per se. Examples of these activities are exchange programmes in health services and health services education services. In some countries, these activities are considered to constitute health services. Given the pace of change in the Sector, definitional issues have also appeared as an important issue in any in many countries. Health services also exist as a "private consumption" item with a price determined freely by the providing institutions. Private sector expenditure on medical institutions reveals significant variations among OECD countries, ranging from 2 per cent or below of total expenditure on health in Portugal, Sweden and Turkey, to over 22 per cent in Germany,27 in Japan, Korea and the United States (WTO, 2001). Private sector expenditure is particularly significant at the tertiary level of health amounting, for instance, to over half of total private expenditure on health in Japan, Korea and the United States. Health services have become the single largest sector in many economies worldwide. It not only provides the bulk of employment and income in many countries, but it also serves as vital input for producing other goods and services. So an efficient health services sector is crucial for the overall economy. And because of this, agreement on opening up health services markets is crucial to the success of the current global trade talks.Such market opening will bring gains to all economies, including the developing world, as long as it is done in a carefully considered way. But opening up health services markets is a particularly complex challenge.

For one thing, any discussion of trade in health services has to include the thorny question of in- and out-migration issues (e. g. whether a qualified medical professional can freely move from one country to another to provide services to the patients).In South Asia, Afghanistan, Bangladesh and Sri Lanka are showing to import interests in health services. A cooperative framework may facilitate BIMSTEC countries to tap advanced expertise available in some countries such as India through telemedicine and tele-diagnostic, tele-radiology, and tele-pathology services to hospitals in other BIMSTEC countries. Trade in health services can be enhanced through Mode 2 (patients seeking treatments in other countries), Mode 3 (investment in labs and hospitals) and Mode 4 (temporary movement of health professionals like doctors and specialists). As mentioned earlier, cross-border informal trade in health sector plays a very important role in the case of services. Another problem is that there is analytical literature which purports to show that when intermediation services are explicitly represented in their true economic form, rather than being represented in ad-valorem equivalent form, the two fundamental theorems of welfare economies need not hold. Because of this property, welfare impacts from liberalization in services trade (even in small open economies) can be negative rather than positive as generally presumed in the goods like models used in the literature. Ryan (1990) study may be considered as an early piece to point this out. Chia and Whalley (1997) provided an example of welfare worsening liberalization in the case of trade liberalization in banking services. Bhatterai and Whalley (1998) have shown how explicitly modelling telecoms liberalization in a network structure can change perceptions as to the division of the gains from liberalization between small and large countries. The implication seems to be that only limited confidence can be attached to results obtained from the ad-valorem equivalent modelling used in numerical literature because the analytical structures used rule out alterative results. This problem would arise even where the results of individual studies are not contradictory with one another. Nevertheless, due to lack of information on cross-country trade in health services, we have not come across any concrete study with clear focus to measure barriers to trade in health services in case of BIMSTEC countries.

Table 1: Export of Health Tourism Services

Country	**Export Revenue**	**Number of patients**	**Origin of patients**
India	$986 million	1200 000	60% from BIMSTEC, 40% from other countries
Bangladesh	$66 million	More than 80 000	10% from BIMSTEC.
Bhutan	$31 million	Around 6500	3% from BIMSTEC
Nepal	$40 million	Around 4718	5% from BIMSTEC
Myanmar	$89 million	More than 84 000	25% from BIMSTEC
Srilanka	$77 million	Around 71 000	18% from BIMSTEC
Thailand	$719 million	960 000	27% from BIMSTEC

Source: Singapore Tourism Board, Abidin et al. (2012), Arunanondchai (2012).

Several BIMSTEC countries have become significant exporters of 'health tourism' services. These are chiefly India, Myanmar and Thailand. Table 1 presents information on export revenues and the number and origin of foreign patients for these countries. India is the largest exporter in the region, followed by Myanmar and Thailand. Interestingly, in the case of India and Thailand, the majority of foreign patients come from BIMSTEC countries (mainly Indonesia), whereas in the case of Myanmar only 25% of foreign patients are from the BIMSTEC region. For Thailand, Japanese nationals account for the largest share of foreign patients. The competitiveness of Myanmar, India and Thai hospitals primarily stalks from two factors. First, they can offer medical services at significantly lower price compared to developed countries (Table 2). Differences in labour costs are likely to account for much of the observed price differences. Second, hospitals in India and Thailand have established a reputation for high quality services. In Thailand, service quality has been explicitly promoted by an accreditation system administered by a dedicated government agency. A related aspect is that India, and Thai hospitals can offer specialized services not available in other, especially poorer, BIMSTEC countries. For a number of medical treatments, hospitals from India, Thailand and Srilanka directly compete with each other. The price comparisons in Table 2 suggest strong competition, in particular, between Thailand and India.

Table 2: Price Comparisons (US$, 2011)

Country	Coronary by-pass graft surgery	Single private hospital room per night
India	$5329	$66
Bangladesh	$6776	$124
Bhutan	NA	NA
Nepal	NA	NA
Myanmar	NA	$52
Srilanka	$6520	$72
Thailand	$6484	$96

Source: Abidin et al. (2012)

In addition, the experience of various countries suggests that it is important to adopt conscious strategies for promoting trade in health services. The strategies should aim to exploit a country's comparative advantage in niche areas, such as traditional and alternative medicines; exploit natural resource endowments; tap regional, cultural, and other opportunities; and integrate policies in the health sector with those in related areas, such as telecommunications, insurance, and education. International and regional cooperation will also be required to address emerging issues in health-services trade, including issues such as cross-border payments and insurance systems, malpractice liability, privacy in the context of telemedicine, and consumption abroad.

Finally, there is a need to develop a comprehensive and systematic database on global transactions in the health sector. This will require coordination among professional associations, ministries of health and commerce, and multilateral agencies such as the United Nations, WHO, the World Trade Organization, the International Monetary Fund, and the World Bank. In-depth case studies are also required to assess the potential costs and benefits of trade in health services for individual countries and regions.

To achieve success in regional health service trade, countries under BIMSTEC region should take positive steps such as, remove visa requirements, remove limitations on the movement of natural persons, establish common curricula in medical education, mutual recognition of diploma and other professional qualifications, ease requirements of obtaining necessary permits and authorizations etc. These policies, if implemented, would enhance heath service trade substantially among the countries under the BIMSTEC region.

References

Bettcher, D., Yach, D. and Guidon, G.E. (2000).Global Trade and Health: Key Linkages and Future Challenges', WHO Bulletin 78(4).

Bhatt, R. (1996), Regulating the Private Health Care Sector, The Case of the Indian Consumer Protection Act, Oxford University Press. (p 51-59)

Chanda, R (1999), "Movement of Natural Persons and Trade in Services: Liberalizing Temporary Movement of Labour under the GATS", Working Paper No. 51, Indian Council for Research on International Economic Relations, New Delhi.

Chandrashekhar, C.P and J. Ghosh (2001), "Information and Communication Technologies and health in low income countries: the potential and the constraints", Bulletin of the World Health Organization, 79 (9), pp. 850-55.

Frenk J., A. Gomez-Dantes, O. Adams, E. Guidon (2000), "The Globalization of Health Care", International Cooperation in Health, Oxford Medical Publications.

Laurell A. and M. Ortega (1992), "The Free Trade Agreement and the Mexican Health Sector", International Journal of Health Services, Vol. 22, No. 2, pp. 331-337.

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