Trade in Health Services and ASEAN

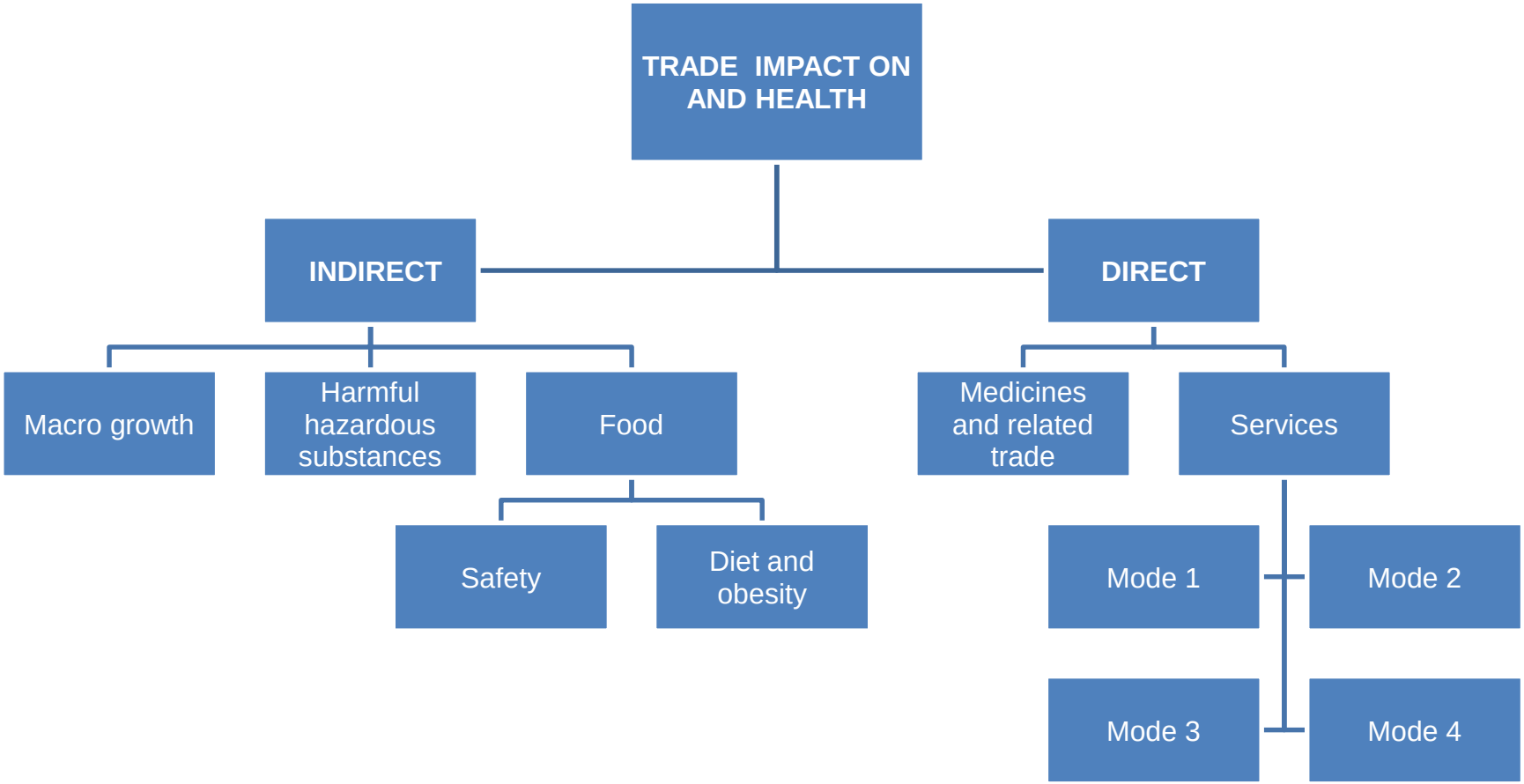
19 November 2019

Matthias Helble, PhD
Economic Resesearch and Regional Cooperation Department
Asian Development Bank

Outline

i. Trade and Health Linkages
ii. Modes of Supply
iii. Opportunities and Risks
iv. Policies to Make Trade Work for Health
v. Conclusion

Trade and Health Linkages



Mode 1: Cross-Border Delivery

- Telehealth or telemedicine
- Exchange of medical data or provision of medical services remotely using IT technologies.

Main drivers:

- **Unavailability or undersupply** of medical services in some countries (e.g. telepathology services by India's doctors to hospital in Nepal and Bangladesh)
- Benefit from **lower costs** of health services abroad (e.g. second opinion by Indian radiologists to US colleagues, medical transcriptions for the US undertaken in the Philippines)

Challenges for the provision:

- Patient data protection
- Modern IT infrastructure
- Availability of health personnel
- Qualification of health personnel

Mode 2: Consumption Abroad

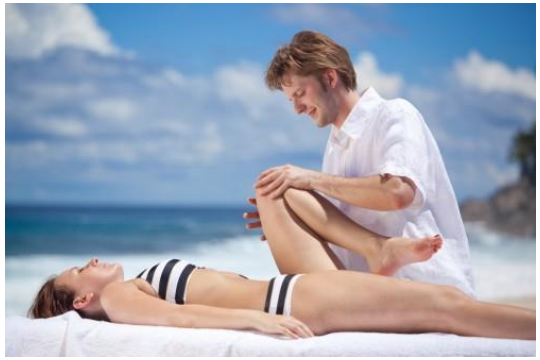
- Movement of patients across borders for diagnostics, treatment and rehabilitation services (medical travel).
- Occurs among developed, developing, and between developed and developing countries.

Main Drivers:

- **Unavailable or undersupply** of health services
- **Differences in quality** of health services
- **Cost** considerations

Challenges for the provision:

- Portability of health insurance
- Follow-up services
- Patient safety
- Cross-border liability
- Availability of health care workers



Mode 3: Commercial Presence

- Health care centers (hospitals, diagnostic centers, nursuring homes, etc.) are established abroad by private companies.
- Growing trend of regional regional health-care networks, ex. Singapore-based Parkway group is present in Malaysia, Indonesia, Sri Lanka and India.

Main Drivers:

- Increasing **demand** for health services unmatched by government supply
- **Business opportunity**
- Facilitated by more **open FDI regimes**

Challenges:

- Availability of related infrastructure
- Access to necessary equipment and supply

Mode 4: Movement of Natural Persons

- Temporary movment of health personnel (doctors, nurses, paramedics, midwives, trainers, etc.)
- Mode 4 trade is NOT permanent migration
- Both developed and developing countries are engaged.

Main drivers:

- High demand for health care workers, as almost all countries suffer from **lack of health care workers**
- Earning opportunities

Challenges:

- Mutual recognition of qualification
- Visa requirements

Health Implications of Cross Border Delivery of Health services (Mode 1)

Opportunities

- Health care delivery to remote and underserviced areas
- Alleviates human resource constraints
- Enables more cost-effective disease surveillance
- Improves quality of diagnosis and treatment
- Upgrades skills, disseminate knowledge through interactive electronic means

Risks

- High cost telecommunications and power sector infrastructure
- Capital intensive: possible diversion of resources from basic preventive and curative services
- Exacerbates inequity if catered to a small segment of the population

Health Implications of Consumption of Health Services Abroad (Mode 2)

Opportunities

For exporting countries:

- Generates foreign exchange earnings to increase resources for health
- Helps to upgrade health infrastructure, knowledge, standards and quality

For importing countries:

- Reduces shortages of physical and human resources in speciality areas
- Patients receive more affordable treatment

Risks

For exporting country:

- Creates a dual (two-tiered) market structure
- Crowds out local population - unless services available to local population
- Diverts resources from the public health system

For importing country:

- Costs of medical travel gone wrong

Health Implications of Commercial Presence of Health Service Providers (Mode 3)

Opportunities

- Generates additional resources for investment in upgrading of infrastructure and technologies
- Reduces the burden on public resources
- Creates employment opportunities
- Raises standards, improves management, quality, improves availability, improves education (foreign commercial presence in medical education sector)

Risks

- Large initial public investments needed to attract FDI (risk of potential diversion of resources from the public health sector)
- Two-tier structure of health care establishments
- Internal brain drain from public to private sector
- Crowding out of poorer patients, cream-skimming phenomena

Health Implications of Movement of Health Personnel (Mode 4)

Opportunities

For sending country:

- Gains from remittances and transfers
- Upgrading of skills and standards (provided service providers return to the home country)

For receiving country:

- Mitigates shortages of health care providers (improves access, quality and contains costs)

Risks

For the sending country:

- Permanent outflows of skilled personnel
- Adverse effects on equity, availability and quality of services

For receiving country:

- Few downsides given chronic skills shortages
- Discriminatory treatment of medical professionals trained abroad

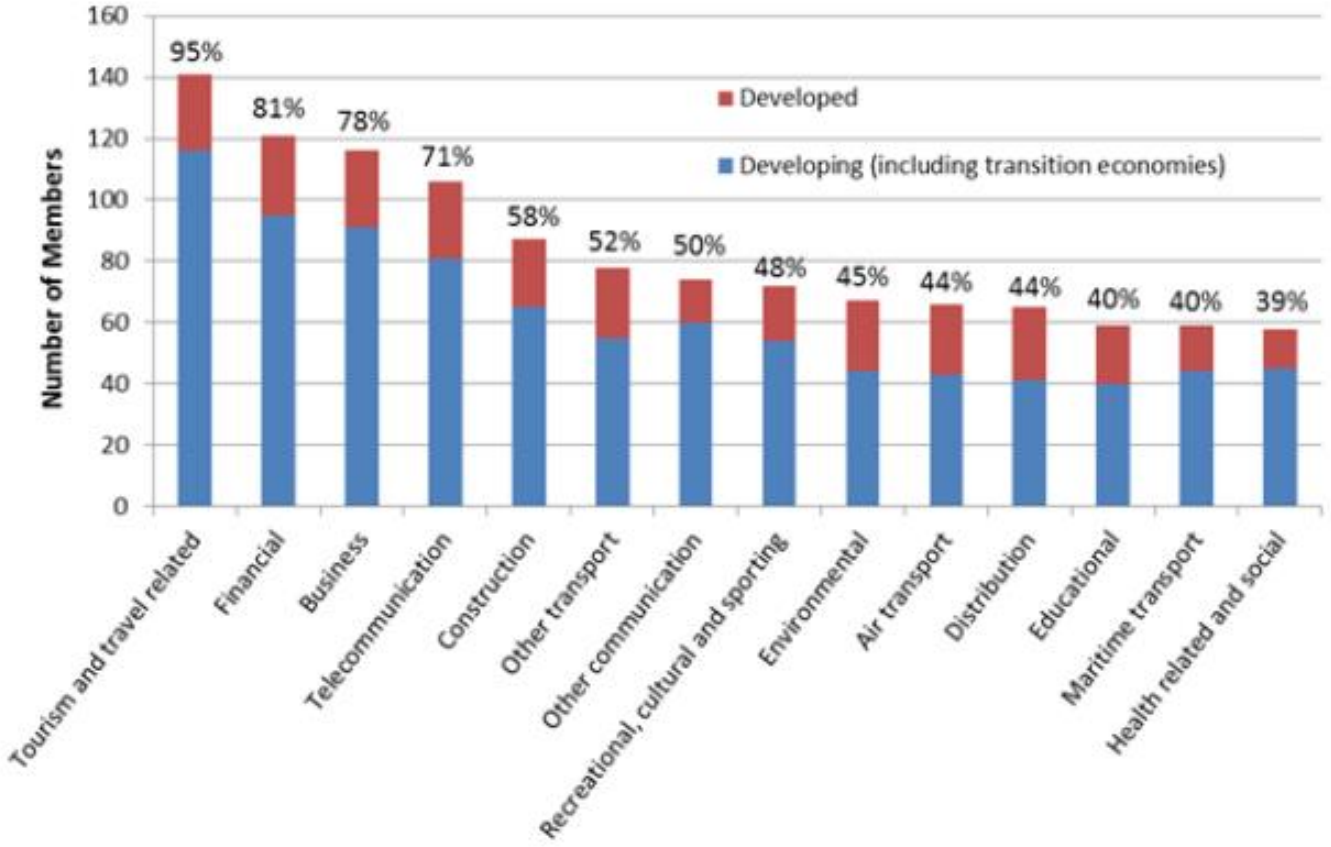
General Agreement on Trade in Services (GATS)

- GATS provides **multilateral framework** for liberalizing international trade in services
- **Services of many kinds** play role in promotion of health.

Managing the GATS process from a health policy perspective:

- **Improving access and affordability** of health-related services as goal of liberalization of trade in health-related services.
- Liberalized trade in health-related services should not disrupt balance between preventive and curative services.

GATS Commitments



Source: WTO-World Bank, I-TIP Service Database, 2015

GATS Commitments in Health Services

- With the development of tele-medicine, cross-border supply of services (Mode 1) is of increasing importance. Nevertheless, there are **fewer commitments for Mode 1** than for any other mode.
- **Mode 2 commitments rather liberal** as most governments have limited ability to prevent consumers from seeking medical treatment abroad.
- Over **40 WTO members have made mode 3 commitments**, often subject to restrictions, such as economic needs tests (a test using economic criteria to decide whether the entry into the market of a foreign firm is warranted on economic grounds), and limitations on the share of foreign capital.
- Overall, **Mode 4 commitments** (movement of natural persons) remain **limited** in scope in this as well as in all other service sectors.

Reasons for Low Level of Commitments

- GATS commitments are **binding and effectively irreversible**.
  - Violations only possible when the measures in question are «necessary to protect human, animal, or plant life of health».
  - WTO members must demonstrate that their measures are the least trade restrictive measures reasonable available to acheieve the level of intended health proection
- Presence of government monopolies that offer services for free or below cost.
- GATS applies to health-related services provided for profit. **GATS excludes services provided pursuant to the exercise of governmental authority** as long as such services are not provided on a «commercial basis» or «in competition» with other service suppliers.

Opportunities and Risks

Does the country wish to have or expand **private-sector involvement** in the provision of health services?

Will increased trade liberalization lead to better health outcomes?

Opportunities:

- **Increase in efficiency** through increased competition
- Help to **alleviate shortages in supply**
- **Increase amount and type of services** available to patients

Risks:

- **Private sector** attracts health care workers
- Exacerbates **rural-urban divide**
- Increase in **prices**

Mitigating Risks

What can be done to **limit the possible risks** of trade?

- GATS does not impose any constraints on terms and conditions under which a potential host country treats foreign patients (extra charge for treatment).
- Government can take measure to discourage health care workers to work from private sector.
- Government can require private hospital to reserve minimum percentage of **beds for free** treatment.

However: Developing countries might not have **regulatory experience**.

Possibility to **experiment with liberalization** outside of GATS before making GATS commitments.

Managing the GATS Process from a Health Policy Perspective:

- GATS provides countries with **choices** to make liberalization commitments that are in their best interests.
- Sophisticated **understanding necessary** of how trade in health-related services affects health systems and policy (informed decisions).
- **Health principles and criteria** should drive policy decisions on trade in health-related services in the GATS negotiations.

Health Services in ASEAN

10th Package of Commitments under ASEAN Framework Agreement on Services
(protocol to implement the 10th AFAS package was signed last 29 August 2018)

Sector: **Health Related Services**

Mode 1: Cross-border supply
Mode 2: Consumption abroad
Mode 3: Commercial presence
Mode 4: Presence of natural persons

Health related services	Brunei	Cambd.	Indon.	Lao PDR	Malay.	Myan.	Philipp.	Singap.	Thail.	Viet N.	Sum of full
Mode 1	Full	Full	Full	Full	Full	Full	Partial	Partial	Full	Full	8
Mode 2	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	10
Mode 3	Full	Full	Partial	Full	Partial	Partial	Full	Full	Partial	Partial	5
Mode 4	None	None	Partial	Partial	Partial	Partial	Partial	None	Partial	None	0
Sum of full	3	3	2	3	2	2	2	2	2	2	

Source: https://i-tip.wto.org/services/default.aspx

Full: No limitations on market access
Partial: Member: (i) remains free to introduce / maintain measures inconsistent with market access or (ii) have partial limitations to market access in some subsectors
None: No commitments

WHO Recommendations

- Identify a **focal point** for trade in health-related services within the Ministry of Health.
- Collect and evaluate relevant **data** on the effect of existing trade in health-related services within the country.
- Subject all requests for, and offers of, liberalization of trade in health-related services to a **thorough assessment of their health policy implications**.
- Develop a sustainable mechanism for **monitoring the impact** of trade in health-related services.

Questions to answer:

- Do the commitments fit the strategies and directions identified by **national health policy**?
- **What effect** would the commitments have on government-provided health-related services?
- What **regulatory burdens** do liberalization create for the government in health-related sectors?
- Can the commitments be crafted both to protect health policy and to liberalize trade progressively?

Mode 1: Cross-border supply (ASEAN examples)

Tele-radiology Reporting & Integration

NHG Diagnostics in Singapore sending X-rays in Bangalore, India where trained radiologists analyze each one, make a diagnosis and send most of the reports back within 30 minutes.

Source: https://diagnostics.nhg.com.sg/ourservices_details.aspx?id=180

St. Luke's Medical Center in the (Philippines) while having a video conference with Kyushu University (Japan)

http://www.temdec.med.kyushu-u.ac.jp/html/katsudo/ATS/2018ATS/presentations/Katherine.pdf

Philips Enterprise in (Malaysia) providing a telestroke package to a patient in (Singapore)

https://www.philips.co.za/healthcare/solutions/enterprise-telehealth

Mode 2: Consumption Abroad

Cost of medical procedures (in US$)

Medical Procedures	Philippines	Singapore	USA
Heart bypass surgery:	11,500-17,500	11,797 - 18,378+	70,000 - 133,000
Liver Transplant	120,000-150,000	290,000 - 300,000+	490,000 - 575,000
Hip replacement:	5,000-7,600	6,285 – 9,446	33,000 - 57,000
Knee replacement surgery:	5,200-7,700	8,637 - 12,569	30,000 - 53,000
Prostate surgery (TURP procedure)	1,500-2,700	5,000 - 7,500+	10,000 - 16,000
Kidney Transplant	23,000-25,000	75,000 - 95,000	200,000 - 250,000
Dental Implant	500 - 600	2,900 - 3,350	3,500 - 5,500

Source: https://www.pacificprime.sg/medical-tourism/
https://www.health-tourism.com/philippines-medical-tourism/
https://medigence.com/hospitals/

Mode 3: Commercial Presence (ASEAN examples)

An Indonesian company which divested its US$19.5 million hospital and clinic in Myanmar, to Singapore' OUE Lippo Healthcare Ltd

A Malaysian company which has 15 hospitals in Malaysia, 4 hospitals in Singapore, 33 hospitals in India and 21 hospitals in Turkey

A Philippine company which has a hospital in Guam.

A Singaporean company which targets to open a branch in Shanghai.

A Thai company which acquired controlling interest in Ulaanbaatar Songdo Hospital (UBSD), one of the leading hospitals in the capitol of Mongolia

Mode 4: Presence of natural persons

Singaporean Doctors in Cambodia

https://www.phnompenhpost.com/business/singapore-run-medical-centre-slated-open-phnom-penh

Filipino Nurses in Singapore

https://www.straitstimes.com/singapore/health/10000-more-healthcare-workers-needed-in-next-3-years

A Japanese Dentist on a 3-day consultation workshop in the Philippines

http://shinagawa.ph/dr-tai-visits-shinagawa-orthodontics-for-3-day-consultation-guidance/

Density of Healthcare Professionals in ASEAN

Country	Latest Available Year	Physicians (per 1,000 people)	Nurses and Midwifery personnel (per 1000 people)	Sum of Medical Personnel (per 1,000 people)
Brunei Darussalam	2015	1.8	6.6	8.4
Cambodia	2014	0.2	1	1.2
Indonesia	2017	0.4	2.1	2.5
Lao PDR	2014	0.3	1	1.3
Malaysia	2015	1.5	4.1	5.6
Myanmar	2017	0.9	1	1.9
Philippines	2010	1.3	3.3	4.6
Singapore	2016	2.3	7.2	9.5
Thailand	2017	0.8	3	3.8
Viet Nam	2016	0.8	1.4	2.2

Source: World Bank Data
Notes: "*green*" = met SDG thresholds (4.5), "*yellow*" = met WHO thresholds (2.3), "*red*" = doesn't mean any thresholds

Mode 4: Presence of natural persons

Despite clear aspirations within ASEAN to create an effective framework to facilitate movements among skilled professionals progress on the ground has been slow and uneven due to:

- Difference in qualification standards
- Automatic recognition vs. Partial recognition
- Recognition of Diploma ≠ Right to Practice the Profession
- Language and cultural barriers

A recent study by Te et al. (2018) finds that the MRAs themselves do not appear yet to have facilitated the freer movement of health workers.

Mixed Mode of Supply

source: https://www.phnompenhpost.com/business/phnom-penh-looks-medical-tourism

Singapore Medical Center in Cambodia

- established by Singapore Medical Center (a Singaporean company) and Sear Rity (a Cambodian company), with partners from AJT Holdings (a Thai health care management company). **(Mode 3)**
- The facility will have six medical professionals from Singapore, the US and Thailand and will employ approximately 30 Cambodian staff **(Mode 4)**
- The SMC will also target people from Laos, as well as expats from China and Taiwan **(Mode 2)**

Conclusion

- Opening of trade in health services offers **opportunities** and comes with **risks** in ASEAN.
- Proactive and **informed approach** is needed to facilitate gains and limit negative effects.
- **More data** is urgently needed.
- **Supply side** constraints in health sector need to be tackled to export health services successfully.
- Trade policy in health services needs to be **coordinated with other services sectors**, such as tourism, insurance, education and telecommunication services.

Thank you for your attention

Matthias Helble

Asian Development Bank

Email: mhelble@adb.org

www.adb.org

References:

- Chandra, R. (2017), «Trade in Health Services», in: *Win–Win How International Trade Can Help Meet the Sustainable Development Goals*, M. Helble and B. Shepherd (eds), ADBI Press.
- Sauvé, P., C. Blouin, A. Bhushan and O. Cattaneo (2017) «Trade in Health Services», in: *Trade and Health: Towards building a National Strategy*, Smith, R., C. Blouin, Z. Mirza, P. Beyer, N. Drager (eds.) World Health Organization.
- Smith, R., C. Blouin, N. Drager and D. Fidler (2011) «Trade in Health Services and the GATS», in: *Handbook of International Trade in Services*, A. Mattoo, R. M. Stern and G. Zanini (eds.), Oxford University Press.
- Te, V., Griffiths, R., Law, K., Hill, P. S., & Annear, P. L. (2018). The impact of ASEAN economic integration on health worker mobility: a scoping review of the literature. *Health policy and planning*, *33*(8), 957-965.

Mode Specific Questions

- **What is being traded (imports and exports)?**
- **What are the offensive/defensive interests?**
- **What are the health implications of trade policy?**
- **What are the trade implications of current health policies?**
- **What is the existing regulatory framework?**
- **What are the key flanking policies under consideration?**

Policy Coherency?

What level of coherence is there is trade and health policy?
98.1. Describe briefly how services trade policy is formulated in your country. What structures, if any, exist to conduct inter-agency coordination, promote a whole of government approach and conduct a policy dialogue with external stakeholders?
98.2. Does a process exist specifically for shaping policy and negotiating positions on trade in health services? Who does the government consult in taking decisions in this area? Is this process institutionalized or *ad hoc* in character?
98.3. How does your government identify and assess its offensive and defensive interests in services trade generally and trade and investment in health-related services in particular? Describe how your country deals with negotiating requests formulated by your trading partners in the health services sector. Describe the process through which your country addresses its own negotiating requests to key trading partners.
98.4. Is there a trade and health unit or function in the Ministry of Health? Is there an inter-agency coordination process to promote regular two-way dialogue between the trade and health policy communities at the national level?

Capacity Gaps?

Core Question 99
What is the current level of capacity and key gaps?
99.1. Is there an analytical deficit domestically in policy research on services trade and investment for which remedial technical assistance, capacity and institutional strengthening building are required?
99.2. Are the government's services trade policy objectives generally underpinned by policy research? Is such research conducted in-house (i.e within government agencies); by in country research institutions or through recourse to international expertise?
99.3. What is the negotiating capacity of trade and health officials?
99.4. For each of the four modes of supplying services, indicate whether data on trade in health services is available for your country, nationally and/or internationally? What are the identified gaps/limitations in your country's data for each mode of supplying health-related services?
99.5. What is the comparability of data available at the national and international levels and with other countries?
99.6. What are the concerned national (governmental or otherwise) and international *agencies* that collect such data? In which national and international *publications* does this data appear? What are the identified problems with the organizational structures and mechanisms for data collection and dissemination for each mode of supplying health-related services in your country?