10 The Impact of Trade Treaties on Health Tourism
Chantal Blouin

INTRODUCTION

In the last decade, there have been concerns about the impact of international trade agreements such as the General Agreement on Trade in Services (GATS) of the WTO on health systems: more precisely, analysts have highlighted the risk that committing to liberalisation of health-related services in a trade agreement may constrain the capacity of national governments to adopt public policies to protect public health and improve health systems (Blouin, Drager & Smith, 2006). Similarly, the rise of health tourism has led some scholars and policy experts to caution about the dangers of exporting health services: catering to foreign patients may drain human and financial resources away from domestic patients, without direct benefits for the domestic health system (Blouin, 2010).

This chapter examines the extent to which trade agreements can impact on health tourism. Given the nature of such trade, i.e. that the patient travels to the country where the services are delivered, it may seem that there are very few barriers to trade in this area, as patients are free to leave their country to purchase services abroad. A priori, it may appear that trade liberalisation, as undertaken in trade treaties, does not have a significant impact. However, there are two policy levers available to national governments which can create barriers to trade in medical tourism.

The first potential barriers to trade are constraints and limits on foreign investment in the health sector. Health tourism is often provided in clinics or hospitals that are wholly or partly owned by foreign investors. The first section of this chapter examines the levels, nature and the impact of trade commitments governments have undertaken in trade agreements, focusing on foreign investment in health-related sectors. The discussion focuses on the commitments at the WTO and whether countries that have been leaders in health tourism are also those with the strongest commitments in health-related sectors. It should be noted that some medical tourism does not involve foreign investors. For instance, many private hospitals in
India providing care to foreign patients are owned by Indian investors. Nevertheless, limiting the capacity of foreign investors to establish or buy healthcare facilities constitutes a significant barrier to health tourism.

The second potential barrier to health tourism is insurance portability. Foreign patients usually pay for healthcare services with their own resources, as public or private insurance programs in their country of residence usually do not cover non-emergency healthcare abroad. However, only a limited number of patients have the financial resources to afford travel expenses and the out-of-pocket payments for health services. Increasing the portability of private and public insurance would therefore greatly stimulate growth of medical tourism.

In a survey of medical travellers conducted by the consulting firm McKinsey, more than 70 percent of those seeking healthcare abroad were motivated by quality or access to advanced technology; they were typically travelling to the US to receive care (Ehrbeck, Guevara & Mango, 2008). Faster access to healthcare and the lower-cost of the procedures were cited by only a small number of health tourists as the driver for seeking care abroad (respectively 15 percent and 9 percent of the respondents). Nevertheless, given the lower costs of medical services offered in developing countries, the report suggests that there is a great potential for growth in the number of patients travelling to reduce their healthcare costs or their wait times, if their private or public insurance scheme would cover elective care abroad. The chapter will examine to what extent insurance portability has been part of trade negotiations.

FOREIGN INVESTMENT

Creating a business environment favourable to foreign investment in health services can have a direct impact on the growth of health tourism. Even though public healthcare establishments and healthcare establishments owned by domestic investors offer services to foreign patients, foreign investors have played a key role in the growth of this type of trade. The linkages between health tourism and inflows of foreign investment in health services are well illustrated by the case of Thailand. Indeed, the Thai government promoted foreign investment in private health facilities in the late 1980s through taxation incentives. This policy,
coupled with the economic boom during the period 1989-96, resulted in an expansion of the number of urban private hospitals; between 1987 and 1997, 190 hospitals were established using this tax incentive (Buddhasri, Saithanu & Tangcharoensathien, 2003). After the 1997 economic crisis, some private hospitals started implementing new marketing strategies based on packaged services; foreign patients were the primary targets. Health tourism grew quickly and in 2007, more than 1.3 million foreign patients visited Thailand to receive care (Arunanondchai, Pachanee & Akaleephah, 2007).

When reflecting on the impact of trade treaties on health tourism, we should remind ourselves that the binding commitments national governments undertake in the context of a trade agreement do not automatically translate into a higher level of trade, or in this case, stronger exports of health tourism. A large amount of literature on economics examines and debates the impact of trade agreements on actual trade flows, especially as one of the first empirical tests was unable to find evidence that membership in the General Agreement on Tariffs and Trade (GATT)/WTO had an effect on international trade (Rose, 2002). Subsequently, more sophisticated tests have shown that in many cases, being party to trade agreements does lead to greater trade (Subramanian & Wei, 2007). However, very few empirical studies have focused on the impact of WTO commitments on investment and trade in services, including trade in health services (see for instance te Velde & Nair, 2006). Economists may have evidence that removing barriers to international trade in services will lead to greater inflows of capital and greater level of trade (Mattoo, Stern & Zanini, 2008), but the impact of the decision to list these liberalisations in a binding agreement has not been subjected to the same level of investigation. Nevertheless, the main view is that these commitments play the role of ‘insurance policy’ where foreign investors are guaranteed that the rules of entry will remain the same; the increased predictability associated to this market access commitment is expected to increase the foreign investment in the sector.

What is the state of commitments on investments in health services at the WTO? Reading a schedule of commitments requires several analytical steps. First, social and health-related social services make up the first of twelve categories of sectors within the GATS. Other categories include transport, communications, distribution, environmental, business, financial,
educational, construction, and recreational services. Relevant categories for health tourism also include health insurance services under financial services and retail of pharmaceutical drugs under distribution services.

For each sector, members of the WTO can fine-tune their commitments by sub-sectors, by modes of supply and by types of commitment. For instance, a government can decide to make a market access commitment in hospital services for services provided through mode 3 (establishment of commercial presence) and not to make any commitments under the sub-category services provided by nurses and midwives under mode 4 (temporary movement of providers). Moreover, restrictions can also be added to the schedule of commitments. For instance, foreign investment can be capped to a specific amount or percentage of ownership or limited to establishments with a certain number of beds, professionals can be subject to language testing and entry can be conditional to a local or economic needs test. Finally, we additionally should note that WTO members can also take horizontal commitments; these are commitments that apply to all services sectors. Restrictions on foreign investment can be included in these horizontal commitments. For example, a limit to 49 percent of equity can be imposed on all services sectors if listed in the schedule of horizontal commitments.

When assessing GATS commitments overall, it appears that the health sector is one of the services sectors where members of the WTO have made the least commitments (Adlung, 2009). As of 2009, 66 countries had some commitments under medical services, 35 under services provided by nurses, midwives and other professionals, and 58 under hospital services. Most of these are ‘partial commitments,’ i.e. subjected to restrictions and limitations. Health insurance has often been the subject of commitment, with more than 100 countries registering it in their schedule of commitments, reflecting that financial services were a much more active file during the Uruguay round, i.e., the round of negotiations that led to the WTO agreements in 1994.
Table 10.1 Sectoral Commitments in Hospital Services (Mode 3)

<table>
<thead>
<tr>
<th>Country</th>
<th>Market access</th>
<th>National treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>No commitment</td>
<td>No commitment</td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>No commitment</td>
<td>No commitment</td>
<td></td>
</tr>
<tr>
<td>Cuba</td>
<td>No commitment</td>
<td>No commitment</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Commitment with restriction:</td>
<td>Commitment with no restrictions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>51 per cent ceiling of foreign equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>Commitment with restrictions:</td>
<td>Commitment with restrictions:</td>
<td>Apply to private hospitals only</td>
</tr>
<tr>
<td></td>
<td>Economic needs test, joint venture with Malaysian investor, 30% ceiling of foreign equity, hospital min., 100 beds</td>
<td>Establishment of feeder outpatient clinics is not permitted</td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>Commitment with restriction:</td>
<td>Commitment with no restrictions</td>
<td>Apply to private hospitals only</td>
</tr>
<tr>
<td></td>
<td>49 percent ceiling of foreign equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>Commitment with restriction:</td>
<td>Commitment with no restrictions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One of the owners must be a physician except in a public limited company.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>No commitment</td>
<td>No commitment</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>No commitment</td>
<td>No commitment</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>Commitment with restriction:</td>
<td>Commitment with no restrictions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needs-based limits may be imposed (plus special rules for New York state)</td>
<td></td>
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</tr>
</tbody>
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Source: Author

The reasons for the low level of commitments in health-related services are multiple. “The most obvious reason is the existence of government monopolies, in fact or in law, offering their services for free or significantly below cost. There seems to be no point in assuming external policy binding at least under mode 3 (commercial presence), if private activities are either prohibited rendered or commercially unattractive.” (Adlung & Carzaniga, 2006, p. 86).

Another reason resides in the lack of interest from commercial actors in the health sector during the GATS negotiations that led to the Uruguay Round agreements in 1994.
Indeed, when national governments make requests for commitments from other WTO members, they are usually driven by demand from the private sector based in their country seeking to enter other markets. Without such commercial interests, there are few incentives to make or request commitments. In this context, experts have described the GATS as a ‘supporting actor; not a liberalizing force,’ i.e., that the countries that have listed health-related services have not liberalised this sector more than it was before the signature of the treaty, but have increased the predictability of the existing of entry and operations for the potential investors (Adlung, 2009).

The question that remains is whether the lead countries in health tourism have used the GATS in that manner. We have verified the nature of the mode 3 commitment in hospital services for the top ten destinations for health tourism. Given the very low quality and reliability of the statistical information on the number and destinations of medical tourists, we do not have a definite list of what the destinations are. But, based on the review of the literature undertaken by the Organization for Economic Co-operation and Development (OECD) (Lunt et al, 2011), we established a list of the lead exporters of health tourism and verified the nature of their GATS commitments, as listed in the schedule of commitments of these countries, and made available on the WTO website. The results presented in Table 10.1 are surprising; several countries that are actively promoting health tourism as a key export industry, such as Singapore and Thailand, have not included hospital services in their schedule of commitments. In addition, Cuba, Costa Rica and Brazil have similarly not listed this sector, even though they are key players in the industry. Countries that have taken commitments (India, Jordan, Malaysia, Mexico, US) also included limitations such as a ceiling to the level of foreign investment, a minimum number of beds in the healthcare establishment, or that the commitments only apply to private hospitals. This would indicate that several exporter countries themselves do not consider that the lack of commitments in trade treaties will be an obstacle to health tourism, or at least to foreign investors moving into this sector of their economy.

We should conclude this section by highlighting that even if a country removes most barriers to foreign investment and has full mode 3 commitment in a particular services sector, it
does not guarantee that foreign investors will be interested in establishing a commercial presence in that country. Indeed, firms and investors consider many factors when deciding to invest abroad; these decisions are structured by several external and domestic constraints. In the health sector, India provides an example of a country that has adopted a liberal foreign investment regime and has included Mode 3 commitments in its GATS schedule of commitment on hospital services, but where there is only a weak presence of foreign investment in hospital services. (Cattaneo, 2009; Chanda, 2007) It has been suggested that several key domestic constraints explain these low levels of foreign investment:

…high initial establishment costs (e.g. prohibitive cost of procuring land), low health insurance penetration in the country (i.e. smaller consumer base for corporate hospitals), restrictions on medical training and providers (i.e. supply bottlenecks and adverse effects on the quality of the personnel), high cost of importing medical devices (and a limited domestic manufacturing capacity in this area), other regulatory deficiencies (e.g. lack of standardization, proper governance, and quality assurance), and lack of policy clarity and priority to the healthcare sector (Cattaneo, 2009, p. 8).

INSURANCE PORTABILITY

One of the most significant barriers to health tourism exports\(^3\) (Mode 2) is the lack of portability of health insurance overseas (Smith, Chanda & Tangcharoensathien, 2009). Most private and public insurance schemes do not cover healthcare abroad, except in the case of emergency while travelling in a foreign country. Within the EU, this general rule is changing, as courts now recognize the right of European citizens to receive reimbursement of the cost of care outside their country of residence, as long as it is provided by an establishment based in the EU. With these new rules of insurance portability, four percent of Europeans received healthcare abroad in 2007 (Glinos & Baeten, 2006) and 53 percent of Europeans said they would be willing to travel abroad for medical treatment (The Gallup Organisation, Hungary, 2007). In contrast, in the US, given the cost of care and the existence of a significant number of uninsured, those without health insurance are more likely to go abroad to receive care (1.4
percent of those with insurance in California went abroad for medical care compared to 7.1 percent of those without insurance (Laugesen & Vargas-Bustamante, 2010).

The lack of insurance portability is believed to “inhibit the consumption of health care abroad by consumers” and changes to the insurance rules could lead to significant cost savings (Mattoo & Rathindran, 2006). Based on a worldwide price comparison of 15 low-risk, highly tradable surgeries, they estimated the magnitude of the savings to be over $1.4 billion, even if only one in ten US patients chose to undergo treatment abroad rather than in the US. Of these annual savings, $690 million would accrue to the Medicare program alone (Mattoo & Rathindran, 2006).

An expert from the WTO secretariat has recently highlighted that countries that have undertaken full commitment under Mode 2 of the GATS for hospital services are de facto “guaranteeing insurance portability under public health schemes to nationals consuming like services abroad” (Adlung, 2009, p. 20). It is not clear that all members understood the health insurance implication of this commitment. According to this interpretation, WTO members with public insurance such as the European Community and Japan would have committed to insurance portability. In contrast, the US has explicitly excluded public health insurance portability from their GATS commitment and added a limitation stating that reimbursement of medical expenses is limited to licensed, certified facilities in the US. Poland, Latvia and Slovenia had also included similar provisions in their GATS commitments. In the recent trade negotiations between the EU and the Caribbean region, the EU has specified that its commitment relevant to hospital services only applies to privately-funded services.

The explicit integration of the health insurance portability in trade negotiations is an emerging issue. The best known example of this is the request from Thailand to Japan, during the negotiations of their bilateral free trade agreement (FTA), that medical treatment in Thailand be covered by the Japanese insurance system (Japan-Thailand Economic Partnership Working Group (JTEP Working Group), 2003). The Japanese government did not agree to this request, arguing that “the Japanese medical insurance laws clearly stipulates that the Overseas Medical Care Benefits are exceptional benefits to be provided to the insured person who can not be treated at designated medical care institutions in Japan” (JTEP Working Group, 2003).
The Japan-Thailand FTA, as signed in 2007, stipulates that “the reimbursement of expenses for medical treatment received by Japanese nationals in Thailand shall be made in accordance with Japan’s laws and regulations” (Ministry of Foreign Affairs (Japan), 2007): these regulations exclude those who travel expressly to receive care abroad.

In some cases, insurance portability may not be part of trade negotiations, but subject to bilateral agreements focusing solely on healthcare insurance portability. This is the approach adopted by Jordan. In the 1990’s Jordan began to promote its health services exports. In 1998, the Ministry of Health established an office at the Queen Alia Airport to facilitate the entry of foreign patients (World Health Organization Regional Office for the Eastern Mediterranean (WHO-EMRO), 2004). Revenue from medical tourism was estimated to have crossed the US$1 billion in 2003. The vast majority of medical tourists in Jordan come from the Arab world. The majority of patients seek treatment in cardiology, neurology, bone and other internal diseases. Some of the patients coming to Jordan are sponsored by their national funds. For instance, a protocol was signed between Jordan and the Algerian Social Security Fund in 1996, with the terms of payment for treatment received in Jordan linked to the Algerian Social Security Fund. Jordan has medical cooperation protocols with several other countries as well, while private sector hospitals in the country have their own agreements with government and private clients in foreign countries (WHO-EMRO, 2004).

In conclusion, insurance portability may still be an emerging issue on the trade and health agenda. However, given the potential implications for public insurance schemes, it may receive more attention in the near future. It would rise on the agenda when and if exporter countries begin to be more pro-active and request portability from importer countries. The impetus for change could also come from patients seeking to receive care abroad and to be reimbursed by their insurance plan. This is how pan-European health insurance portability became a reality, with patients resorting to courts. With the removal of this obstacle to health tourism, we could see a great increase in the globalization of healthcare, regardless of the nature of multilateral or regional trade treaties.
1 The survey sample included 49,980 patients. The researchers estimated that this sample represented 60-80 percent of the total health tourism market, defined as patients travelling abroad expressly to receive healthcare, therefore excluding emergency care and healthcare received by expatriates.

2 For detailed discussions of how scheduling of commitments are made within the GATS, see Blouin, Drager & Smith, 2007.

3 Consumption of medical services in a foreign country is defined economically by that country as a ‘health or medical tourism export’ since it is a source of earnings that originates from abroad.
REFERENCES


