



Trade Hot Topics

International Trade in the Health Sector: Forgotten Frontier?

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Background

Global exports of health care goods and services have grown in recent years, with trade in services increasing substantially between 1996 and 2013. The growing trade in health care goods and services is primarily attributed to the changing patterns of world demand and supply factors. Demand drivers include the changing demographic pattern of the world's population, that is, an increase in ageing populations in the developed world, and this complemented by a growing skilled work force in developing countries has generated trade in health care products and services. Other factors include continued tariff reductions, the liberalisation of cross-border movement of professionals and investment in health-related services, as well as the emergence of new technologies (i.e. big data explosion). Mobile health technologies have spurred further activity in health trade, in particular health services. While on the one hand increasing demand has revolutionised the provision of health services and products, it is, on the other hand, putting pressure on national governments and policy-makers to supply quality health care facilities to populations at a time when governments are looking to reduce public spending on social services. This is especially the

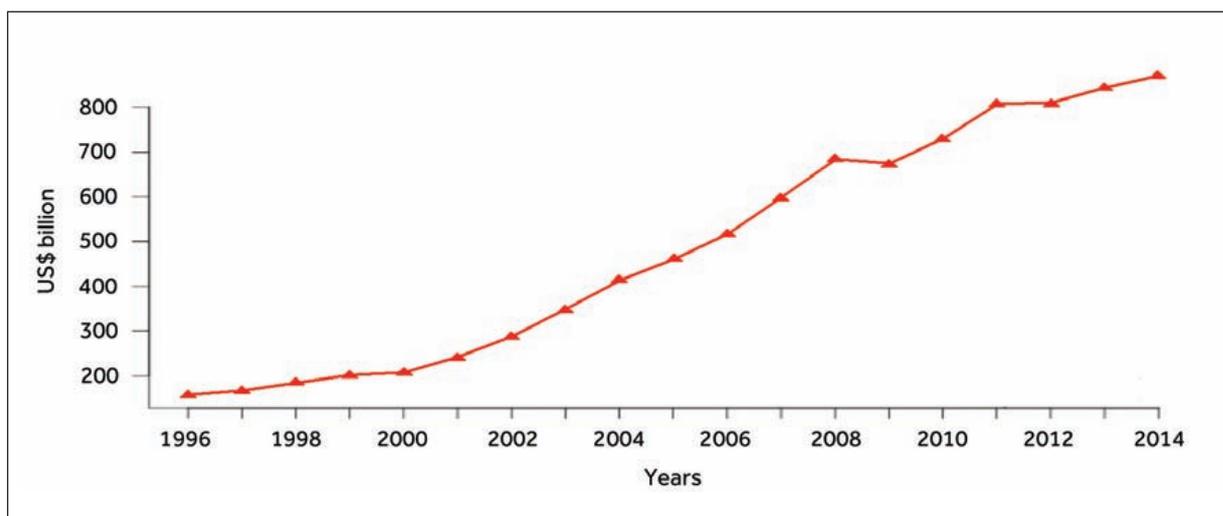
case in the European Union, where an ageing population, strict patent laws and the growing production of generic drugs by emerging economies such as Brazil, China and India are pushing the boundaries of health policy-making.

Trade agreements may also have major implications for global health and national health systems. For example, trade agreements could reduce governments' policy space to respond to public health issues, including universal health coverage, while trade in tobacco products and other unhealthy foods may have harmful effects and even contribute to an 'epidemic' of obesity and related non-communicable diseases. On a positive note, global trade can contribute to transforming the health sector, including through telemedicine, distant training of health workers, and the diffusion of other health technologies. While recognising these wider debates and the need for greater policy coherence between the trade and health sectors,¹ this issue of *Commonwealth Trade Hot Topics* specifically provides an overview of international trade in health care goods and services including the work force and highlights some of the trade opportunities and challenges, especially for developing countries.

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¹ Commonwealth Secretariat, 'Trade Agreements and Health', draft briefing paper prepared by the Health and Education Unit, February 2016.

Figure 1: Global Exports of Health Care Goods from 1996 to 2014 (US\$ billion)



Source: UNCOMTRADE, 2015

Trade in health goods and services

Trade in health can be broadly classified into three groups: (a) trade in goods, which includes health care equipment, drugs, and medical waste; (b) services that include both health and medical services;² and (c) ancillary services, including medical transcription, medical research, medical insurance, and distance medical education and training.

Trade in health care products

Trade flow estimates for health care goods, in both developed and developing countries, exhibit an upward trend over the period 1996–2014 (Figure 1). In value terms, total trade in health care products has grown from less than US\$50 billion in 1995 to over US\$875 billion in 2014. Within this sector, pharmaceuticals and non-durables (e.g. topical dressing for wounds) registered a manifold increase suggesting that the significance of trade in health care products is on the rise, mainly due to the demand drivers as discussed earlier.

Trade in health products is primarily concentrated in four groups, namely: inputs specific to the pharmaceuticals industry (HS code 29); bulk medicines (HS30); hospital and laboratory inputs (HS38); and medical technology instruments (HS90). These four groups account for nearly 98

per cent of all trade in health care products. Other product groups, that is, HS 35, 38, 40, 70, 84, 87 90 and 94,³ have a small 2 per cent share in total health products trade, suggesting concentration in a few HS groups.

There is also concentration of trading partners. Developed countries such as the USA, Germany, Belgium, France and the UK are the main trading countries in health goods. Developing countries have low participation, with the exception of China, Brazil and India, which are major suppliers of diagnostic equipment and pharmaceuticals. It should also be noted that developing countries' total export value is low compared to developed countries. An example is India, which despite being the largest global provider of generic drugs, has a share value of only 1.4 per cent in the global pharmaceutical industry.⁴ Across Organisation for Economic Co-operation and Development (OECD) countries, the total pharmaceutical spending (on generic and patented drugs) is US\$800 billion and this accounts for nearly 20 per cent of total health spending on average. While some OECD countries, including Switzerland, Italy, Greece and Japan, have introduced policies to boost the generics market, the share of these drugs remains small. These measures to boost the generics market include reducing ex-factory prices of on-patent

² Examples of such health services include: telemedicine (mode 1); medical tourism (mode 2); foreign participation or ownership of hospital (mode 3); and movement of doctors and health personnel for the purpose of commercial medical practice (mode 4).

³ HS35 and 38 include products classified as Medical equipment and other inputs; HS40 includes items such as non-durables surgical gloves of vulcanised rubber; HS70 includes items such as Laboratory, hygienic or pharmaceutical glassware; HS84 includes Medical, surgical or laboratory sterilisers; HS87 includes Carriages for disabled persons; HS90 includes medical equipment such as Electro-cardiographs; HS94 relates to Operating related furniture.

⁴ India Brand Equity Foundation (2015), India Pharmaceuticals Industry: Sectoral Report, August. Available at <http://www.ibef.org/industry/pharmaceutical-india.aspx#sthash.fLrx9cxB.dpuf> (accessed 6 February 2016).

and/or generic drugs (e.g. Greece, Ireland, Portugal and Spain) and reducing distribution margins for some categories of medicines.

Trade in health services

According to one estimate, global trade in health services has doubled since 2003.⁵ So, for example, 'over 1 million people travel to Asia each year to receive health care, contributing some US\$2 billion to the region's economy. Over 50 per cent of doctors trained in Ghana emigrate. Cuba is a regional hub for tele-radiology services. Private companies from India, Singapore and elsewhere invested more than US\$1 billion [in 2007] establishing hospitals or other ventures abroad.'⁶

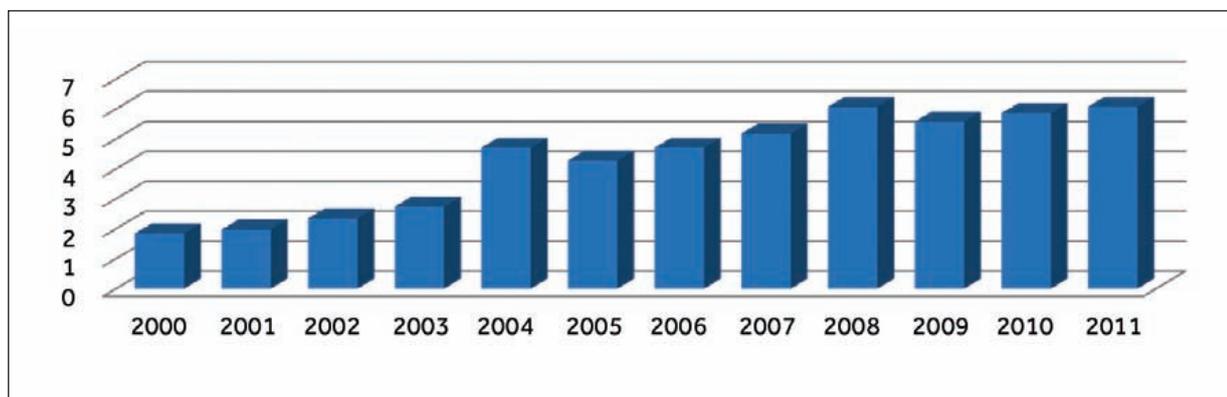
Trade in health services constitutes trade in the following categories: (a) Mode 1 'cross-border supply', where the service, but neither producer nor consumer, crosses a border; (b) Mode 2 'consumption abroad', where the consumer crosses a border to obtain a service; (c) Mode 3 'commercial presence', where companies engage in foreign direct investment (FDI) in the service sector of another country; and (d) Mode 4, which includes 'temporary movement of service providers', where skilled workers move to other countries to work for a limited period.

There is no comprehensive database that captures the different modes of trade in services, especially in health services. Two available data sources for Modes 1, 2 and 4 are the International Monetary Fund's 'Balance of Payments Statistics' (BOPS) database and the United Nations Services

Trade data. Analysis of the data suggests there are limitations to the IMF's BOPS. First, health services are included as a sub-category of 'travel', which is 'health-related travel expenditure', and data is available on export of health services only. Second, data is aggregate for 2005 to 2012, with many missing values. The UN Services Trade presents a similar case, where data on Mode 2 is available, but bilateral data is available for only 57 exporting and 76 importing countries for 2000 to 2012. Given limited statistics on Mode 2, OECD data is used below to analyse health-related travel exports.

Health-related travel exports: OECD statistics on Mode 2 services – that is, medical tourism – provides data on 'health-related travel expenditure' for the period 2000–2011. Figure 2 draws on the OECD data on health tourism and shows that the exports of health-related travel (i.e. medical tourism) have registered an increase in international health services trade in the last decade, in particular since 2004. Developing countries are the main suppliers of medical services under health tourism, and among these Thailand, Malaysia and India rank as top players.⁷ What makes these countries the main players is that these economies enjoy cost advantage over other countries and are able to deliver high quality health care at a lower cost due to the availability of highly skilled labour (including physicians and nurses) and capital at lower cost. In some countries, there are also policy initiatives by governments (state, local, or in some cases both)

Figure 2: OECD Exports of Health-related Travel (US\$ billion)



Source: OECD (2015)

⁵ Smith, R D, Blouin, C, Drager, N and Fidler, D P (2007), 'Trade in health services and the GATS', in Mattoo, A, Stern R M and Zanini, G (eds), *A handbook of international trade in services*, Oxford: Oxford University Press.

⁶ Ibid.

⁷ Bookman, M Z and Bookman, K R (2007), *Medical Tourism in Developing Countries*, Palgrave Macmillan, New York, pp. 1–19; Lunt, N, Smith, R et al. (2011), *Medical tourism: treatments, markets and health system implications: a scoping review*, OECD, Paris.

to promote health tourism through official tourism agencies. In addition, governments often also allow financial and non-financial incentives to foster health services trade.⁸

Health services in modes 1 and 4: The IMF's BOPS and UN Services Trade data show that developing countries exhibit an increase in export of professionals under this mode of services trade, especially from 2003 on, and exports have grown remarkably from 2005 to 2008. Since 2008, the movement has shown a downward trend, and has fallen sharply.

FDI in health services: Since there is no data on FDI flows specifically into the medical sector, data on mode 3 is usually drawn from secondary sources.⁹ Statistics indicate that the health and social services sector attracts a small share of world FDI flows. FDI into the health sector has increased between 2000 and 2010. In fact, some spikes are observed in FDI, such as investment into health and social services, although flows have remained relatively stable over 2001–2010. Developing countries, however, exhibit variations – some have larger number of foreign companies located regardless of the country's size.

The increase in FDI in health care is mainly attributed to phenomenal growth in mobile health technologies and the use of wearable and implantable sensors. These 'new' technologies are revolutionising health care and leading to investments by governments in health technologies.¹⁰ While 'new' technologies are transforming health care (delivered primarily in hospitals and clinics) into health (managed wherever the patient is), they are also impacting on the level of international trade and total spending by governments across countries.

International trade, development and health

Health has long been recognised as an integral part of the global development agenda. Sustainable Development Goal 3 (SDG 3) of the 2030 Agenda for Sustainable Development specifically aspires to ensure good health and well-being for all. This includes a bold commitment to end AIDS, tuberculosis, malaria and other communicable

diseases by 2030. In addition, it aspires to achieve universal health coverage, and provide access to safe and effective medicines and vaccines for all. Supporting research and development for vaccines is an essential part of this process, as well as expanding access to affordable medicines.

These health-related goals should be situated within the global trade governance framework. International trade in health products and services is governed by various World Trade Organization (WTO) agreements, including those on Technical Barriers to Trade (TBT), Sanitary and Phytosanitary Measures (SPS), Trade-Related Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS). In particular, TRIPS (Article 8) provides for rules on compulsory licensing, parallel importation and the application of patent law and is relevant for developing countries. On 30 August 2003, the General Council of the WTO adopted the Decision on Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (the August Decision). The Decision makes access to patent protected medicines easier for countries with insufficient domestic manufacturing capacities in the pharmaceutical sector and provides for the possibility of granting such compulsory licences for export purposes by waiving the application of the relevant provisions of the TRIPS Agreement.

The interpretation of TRIPS commitments has led to instances of case law relating to extraterritorial application of national laws with implications for developing countries. An example is *European Union–Seizure of Generic Drugs in Transit* (WT/DS408, May 2011), which, following the seizure of generic drugs exported by India to Brazil, has been termed an 'excessive and inappropriate interpretation' of intellectual property law. Another case is *Canada–Pharmaceuticals* (WTO/DS114), which allows countries to permit manufacturers of generic drugs to use the patented invention without the patent owner's permission and before the patent protection expires, for the purpose of obtaining marketing approval from public health authorities.

8 Reisman, D (2010), 'Health tourism and public policy', in *Health Tourism: Social Welfare through International Trade*, Edward Elgar Publishing Limited, Cheltenham, pp. 118–147.

9 Culyer, A J (ed.) (2014), *Encyclopaedia of Health Economics*, Elsevier.

10 EYGM (2015), 'Megatrends 2015: Making sense of a world in motion'. At [http://www.ey.com/Publication/vwLUAssets/ey-megatrends-report-2015/\\$FILE/ey-megatrends-report-2015.pdf](http://www.ey.com/Publication/vwLUAssets/ey-megatrends-report-2015/$FILE/ey-megatrends-report-2015.pdf) (accessed 6 February 2016).

Another WTO agreement with equally far reaching implications for developing countries is the GATS, which includes commitments by member countries on cross-border delivery of health services. The agreement has been debated from the perspective of developing countries. There is evidence in the literature to suggest that GATS may have the potential to limit regulatory jurisdiction and choice of developing countries to the detriment of social service efficiency, equity, and quality in these countries, which is a matter of concern from small developing countries' perspective.

In addition to regulations at the multilateral level, there are bilateral, regional and preferential agreements that include specific commitments from member countries to liberalise health care services. While there are no exhaustive analyses focusing on health services liberalisation, preliminary analysis of professional services liberalised within the bilateral framework suggests that countries have committed to GATS-like undertakings, though the level of liberalisation varies between agreements. For instance, Malaysia, Mexico and Vietnam have undertaken commitments under the recently concluded Trans-Pacific Partnership (TPP) Agreement that will give TPP member countries' providers of private health and allied health services greater access and operating conditions in these countries.

However, not all bilateral agreements are similar and commitments undertaken by the Andean Community (under mode 4) list reservations specific to health-related professional services for the migration of health workers in Bolivia, Colombia and Ecuador. ASEAN similarly allows only the movement of experienced medical professionals in the South-East Asia region. For example, ASEAN commitments list that medical and dental practitioners and nurses should have a minimum of five and three years of work experience, respectively in the country of origin. Health insurance is also not portable within ASEAN. Thus, in effect, despite the best endeavours and commitments to reform trade, there is incomplete liberalisation in the health sector.

Intellectual property rights (IPRs) are another issue that is rapidly gaining prominence at bilateral level, although the level of IPR commitments between the partner countries varies. Analysis suggests that TRIPS-plus standards are a norm in bilateral agreements, and increasingly a common feature of bilateral and regional trade agreements. These IPR

commitments often exceed the WTO TRIPS Agreement in that they provide for wider applicability and extended patent protection for pharmaceuticals, and impose penalties for non-compliance and violation of commitments by partner countries.

The TPP is no exception. While it reaffirms participating countries' commitment to the WTO's 2001 Declaration on the TRIPS Agreement and Public Health, it does include a specific chapter with commitments that have implications for the health sector. This agreement includes commitments on pharmaceutical-related provisions, which relate to the development of innovative medicines and the availability of generic medicines. The chapter also includes commitments on the protection of undisclosed tests and other data submitted to obtain marketing approval of a new pharmaceutical or agricultural-chemicals product.

Conclusion and way forward

The SDGs explicitly recognise health as a precondition for and outcome of policies to promote sustainable development, which highlights the importance of health trade from the perspective of developing and low-income countries. While globalisation has fuelled a steady growth in international trade of health care goods and services, with health services growing fastest in the world economy, the challenges for development especially for small states remain. The development challenge is magnified by lack of data on trade in health goods and services. As a result, it is not possible to measure the total value of international trade in health services. In the absence of health trade data, the mapping of health services supply, in line with the GATS modes, is not possible. The paucity of data thus makes the quantification of health trade a formidable challenge.

Of late, services trade has grown and this is mainly attributed to bilateral, regional and multilateral liberalisation of the health sector. While this has ushered in new opportunities for developing countries, in particular for emerging economies as a destination for health tourism, the movement of health care professionals from the developing to developed countries is an area of growing concern. In particular, emigration of trained health care professionals from the emerging and larger developing countries is resulting in 'brain drain' and eroding the already weak technical capacity base of developing countries. Other relevant issues from

the perspective of developing and low-income countries are IPR protection and access to affordable medicines. On the one hand, the flexibilities under TRIPS have promoted access to medicines in developing countries and emerging economies and some countries have become the 'pharmaceutical factory' for generic drugs and medicines for HIV-AIDS and tuberculosis. But, on the other hand, the gains from TRIPS have varied across developing countries depending on the level of their development, with some gaining more than others.

Given that globalisation influences health trade and health policy-making, it is imperative to manage liberalisation from a developmental perspective so that potential benefits for developing countries as a group are maximised. In this context, designing development focused international rules and institutions that promote and support national policies and activities especially in small and low-

income developing countries are critical. Special attention needs to be paid to the requirements of the emerging and larger developing countries if these countries are to benefit from growing trade. For instance, the existing barriers to health trade need addressing so that this group of countries can participate in health services trade effectively. Thus, for all developing countries to benefit from increasing trade in health a concerted and collaborative partnership between governments and international institutions is needed – to address the tensions between the goals of protecting health, promoting trade in goods, services and investment capital, and effectively adjusting to and managing health policy concerns. While these are challenges in themselves, there are indeed opportunities for developing countries to enhance their participation in global health trade and benefit from their competitive advantage in health services trade.

International Trade Policy Section at the Commonwealth Secretariat

This Trade Hot Topic is brought out by the International Trade Policy (ITP) Section of the Trade Division of the Commonwealth Secretariat, which is the main intergovernmental agency of the Commonwealth – an association of 53 independent states, comprising large and small, developed and developing, landlocked and island economies – facilitating consultation and co-operation among member governments and countries in the common interest of their peoples and in the promotion of international consensus-building.

ITP is entrusted with the responsibilities of undertaking policy-oriented research and advocacy on trade and development issues and providing informed inputs into the related discourses involving Commonwealth members. The ITP approach is to scan the trade and development landscape for areas where orthodox approaches are ineffective or where there are public policy failures or gaps, and to seek heterodox approaches to address those. Its work plan is flexible to enable quick response to emerging issues in the international trading environment that impact particularly on highly vulnerable Commonwealth constituencies – least developed countries (LDCs), small states and sub-Saharan Africa.

Scope of ITP Work

ITP undertakes activities principally in three broad areas:

- It supports Commonwealth developing members in their negotiation of multilateral and regional trade agreements that promote development friendly outcomes, notably their economic growth through expanded trade.
- It conducts policy research, consultations and advocacy to increase understanding of the changing international trading environment and of policy options for successful adaptation.
- It contributes to the processes involving the multilateral and bilateral trade regimes that advance more beneficial participation of Commonwealth developing country members, particularly, small states and LDCs and sub-Saharan Africa.

ITP Recent Activities

ITPs most recent activities focus on assisting member states in their negotiations under the WTO's Doha Round and various regional trading arrangements, undertaking analytical research on a range of trade policy, emerging trade-related development issues, and supporting workshops/dialogues for facilitating exchange of ideas, disseminating informed inputs, and consensus-building on issues of interest to Commonwealth members.

Selected Recent Meetings/Workshops Supported by ITP

16 - 18 December 2015: The 2030 Sustainable Development Agenda and the Multilateral Trading System, held in Nairobi, Kenya.

12 -13 November 2015: Emerging Global and Regional Trade Issues for the Commonwealth Pacific Region, held in Tonga.

15 - 16 October 2015: Meeting for Commonwealth Caribbean Countries in Preparation for the 10th WTO Ministerial Conference, held in Bridgetown, Barbados.

29 September - 1 October 2015: Expert Group Meeting on Trade in Sustainable Fisheries, held in Geneva, Switzerland.

23 - 24 June 2015: Commonwealth Trade Symposium: 'Shaping a Global Trade Agenda for Development', held in Johannesburg, South Africa.

18 - 19 June 2015: Workshop for Commonwealth African Countries in Preparation for the 10th WTO Ministerial Conference, held in Kigali, Rwanda.

18 May 2015: Workshop on Post-Bali Issues and Preparation for the 10th WTO Ministerial Conference: A South Asia Perspective, held in Colombo, Sri Lanka.

25 - 26 March 2015: Consultative Meeting of Commonwealth Expert Group on Trade, held in Malta.

3 March 2015: Meeting of Market Access and Other Issues relevant to Small States in Geneva: Options in the Post-Bali Context, held in Geneva, Switzerland.

15-16 December 2014: International Conference on 'Mega Trading Blocs: Implications for Developing Countries' held in New Delhi, India

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