

IMPLICATIONS OF INTERNATIONAL TRADE AND TRADE AGREEMENTS FOR PRIMARY HEALTH CARE: THE CASE OF SERVICES

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**IMPLICATIONS OF INTERNATIONAL TRADE
AND TRADE AGREEMENTS FOR PRIMARY
HEALTH CARE (PHC):**

THE CASE OF SERVICES

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ABSTRACT

The paper analyses the interlinkages between primary health care (PHC)-related services and rules covering international services trade. The issue is important from the perspective of policymakers seeking to minimize the risks of health services trade when seeking to deliver high quality and affordable PHC services at the national level.

The paper (a) examines whether international trade agreements contain any PHC-specific provisions; (b) touches on costs and benefits related to trade in PHC-related health services; (c) stresses the need for regulation to complement liberalization; and (d) highlights cooperation as a central element of international trade rules covering PHC-related health services.

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IMPLICATIONS OF INTERNATIONAL TRADE AND TRADE AGREEMENTS FOR PRIMARY HEALTH CARE: THE CASE OF SERVICES¹

Introduction

Global demand for services and international services trade have increased dramatically making the services economy and trade in services important engines for growth and development in developing countries (UNCTAD, 2007c). Between 1990 and 2005, the share of services in gross domestic product (GDP) has grown continuously, from 66 per cent to 73 per cent in industrialized countries and from 49 per cent to 52 per cent in developing countries. Services now account for about 72 per cent of employment in industrialized countries and 35 per cent of employment in developing countries. Moreover, over the past five years, world services exports have accelerated, with annual average growth rates of 12 and 13 per cent for industrialized countries and developing countries respectively.² In parallel, rules for international trade and investment in services have proliferated both at the multilateral (General Agreement on Trade in Services (GATS)) and at the regional levels (Regional Trade Agreements (RTAs)).

Against this background, also international trade and investment in health and health-related services are growing.³ However, such trade remains small, accounting for only about 0.4 per cent of health spending in industrialized countries (Organization for Economic Cooperation and Development (OECD)).⁴ More specifically for services related to primary health care (PHC), data are lacking, as is concrete evidence of the overall impact of international trade and international trade rules on PHC-related health services. Yet, numerous interlinkages between PHC and international services trade (and the rules covering it) exist and governments may wish to carefully assess how to use international trade and trade rules to maximize the benefits, while minimizing the risks, of health services trade when seeking to the deliver high quality and affordable PHC services at the national level.

This essay looks at international trade rules from a PHC perspective. It (a) takes GATS as an example and asks whether international trade agreements contain any PHC-specific provisions; (b) touches on costs and benefits related to trade in PHC-related health services; (c) stresses the need for regulation to complement liberalization; and (d) highlights cooperation as a central element of international trade rules covering PHC-related health services. The essay focuses on health services related to PHC.

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² Among developing countries, services exports are concentrated in a small number of developing countries, with Asian developing countries accounting for 75 per cent of all developing countries' services trade and with over half of developing country services exports originating in only six countries.

³ Such growth is occurring because of e.g., demographic change, technological developments, pressures to contain health budgets, growing demand for skilled health personnel and its cross border mobility, and trade and investment liberalization, World Health Organization (WHO) toolkit, draft, October 2007 (WHO, forthcoming).

⁴ Lautier, 2005, cited in WHO forthcoming.

There are different approaches to defining PHC. As set out in the 1978 WHO Alma Ata Declaration⁵ PHC is “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community”. The Declaration also mentions the cost⁶ of such care and the fact that PHC is “an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community”. It further defines PHC as “the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.” Along these lines, PHC would cover numerous personal care needs and different disciplines, including general practitioners, nurses, pharmacists, midwives, home helpers etc.⁷ PHC is also the focus of many policies aiming to achieve universal access to basic health services. PHC and specific universal access goals vary depending on countries’ levels of development (UNCTAD, 2006c).

I. International trade rules and PHC: the example of GATS⁸

International trade and investment agreements – and GATS⁹ more specifically – cover all services¹⁰ including health services generally, as well as PHC-related services. Taking the World Trade Organization’s (WTO’s) “W/120 sectoral classification list”¹¹ as an example, health services are included in two sectoral categories: sector 8, entitled “health related and social services”, covers hospital services, other human health services, social services and other services; and sector 1, entitled “business services”, contains the sub-sector of “professional services”, which covers, amongst others, medical and dental services and services provided by midwives, nurses, physiotherapists and paramedical personnel. None of these sectors, however, makes any specific reference to PHC-related services. This would suggest that international trade rules do not distinguish, for example, between hospital services delivered in the context of PHC and in other contexts.

This is not to say, however, that GATS would stand in the way of governments wishing to differentiate – in their liberalization commitments – between *PHC-related* and

⁵ Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, paragraph VI.

⁶ Cost should be at a level “that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination”.

⁷ For a discussion of primary care and PHC, see Primary Care in the Driver’s Seat, Saltman, Rico, Boerma, European Observatory on Health Systems and Policies series
Published by Open University Press,

http://www.euro.who.int/InformationSources/Publications/Catalogue/20060403_3.

⁸ The following analysis focuses mainly on GATS. Given the model character the World Trade Organization’s (WTO’s) services agreement has had on other RTAs covering services, many of the below considerations would also apply to RTAs and to some extent also to International Investment Agreements (IIAs).

⁹ For a detailed description of the GATS, see Markus Krajewski, National regulation and trade liberalization in services, Kluwer Law International, 2003 and, from a health perspective, WHO, Legal Review of the General Agreement on Trade in Services (GATS) from a Health Policy Perspective, WHO, http://www.who.int/trade/resource/GATS_Legal_Review_15_12_05_01.pdf and Mashayekhi/Tuerk, Strategic Considerations for Developing Countries: The Case of GATS And Health Services, in Blouin, Drager, Smith, International Trade in Health Services and the GATS: Current Issues and Debates, The World Bank, Washington, 2006 (Mashayekhi/Tuerk, 2006).

¹⁰ GATS Article I para. 3 (a) “‘services’ includes any service in any sector except services supplied in the exercise of governmental authority”.

¹¹ Negotiators developed the W/120 list of services sectors during the Uruguay Round of trade negotiations for the purpose of negotiating commitments under the GATS.

other health services. For example, with respect to the classification of the services sectors to be liberalized, each WTO member can adapt the “W/120 list” to suit its individual preferences. Examples of such adaptations exist, amongst others, with respect to health services, where some WTO Members have opted for a classification much more detailed and disaggregated than the one suggested by the “W/120” list.¹²

For example,¹³ Singapore, in its revised services offer, clarified its entry of “medical services”, by adding “specifically general medical services (CPC 93121) and specialized medical services (CPC 93122)”.¹⁴ Moreover, in its newly offered commitments under sector 8 (health related and social services), Singapore specifically included “acute care hospitals, nursing homes and convalescent hospitals as defined by the Private Hospitals and Medical Clinics Act, run on a commercial basis (CPCP 93193)”; “guidance and counseling services not elsewhere classified related to children (CPC 93322); and “welfare services not delivered through residential institutions (CPC 93323)”.

The European Commission (EC) revised offer, in its entry on “medical, dental and midwives services” qualifies in a footnote that for Slovenia social medicine, sanitary, epidemiological, medical/ecological services, the supply of blood, blood preparations and transplants, and autopsy are excluded.¹⁵ For “services provided by nurses, physiotherapists and paramedical personal” the EC schedule clarifies, in the sectoral column, that for Austria, the activities covered are: nurses, physiotherapists, occupational therapists, logotherapists, dieticians and nutritionists”. Governments wishing to distinguish between *PHC-related* and *other* health services could include similar disaggregations or specifications in their schedules.¹⁶

With respect to the rules and obligations created by GATS, the agreement’s national treatment obligation could also offer space for accommodating differences between *PHC-related* and *other* health services. According to the GATS’ national treatment provision, a WTO member, once it has fully committed a particular sector under article XVII, may not accord different treatment¹⁷ to domestic and foreign “like” services and “like” services suppliers.¹⁸ This turns the determination of what are “like” services or service providers into a central issue.¹⁹ To date, neither the legal text of GATS nor WTO jurisprudence has provided clear guidance on which factors are relevant for the definition of “likeness”, leaving the question essentially open and to be decided in future WTO dispute settlement cases. Nevertheless, one could argue that *chirurgical* services provided in the context of *PHC* are “unlike” *chirurgical* services provided, for example, for plastic surgery – hence opening space for treating *PHC-related* health services differently from *other health* services.

¹² Additionally, WTO members clarify their sectoral entries with references to the UN-CPC, a more detailed list of sectoral classifications. Amongst others, division 93 on health and social services distinguishes between general medical services and specialized medical services, offering a detailed description of each of them. For a fuller list of health related services sectors, see United Nations Provisional Central Product Classification, ST/ESA/STATIS.FR.M/77.

¹³ The following does not aim to provide an exhaustive list of examples.

¹⁴ TN/S/O/SGP/Rev.1.

¹⁵ TN/S/O/EEC/Rev.1.

¹⁶ Note that some countries also include specifications in the market access or national treatment columns.

¹⁷ Article XVII refers to “treatment no less favourable than that it accords to its own like services and service suppliers”.

¹⁸ See M. Cossy, Determining “likeness” under the GATS: Squaring the circle? in Panizzon/Pohl/Savu  (eds.), GATS and the Regulation of International Trade in Services, World Trade Forum 2006, Cambridge University Publishing (forthcoming) and staff working paper ERSD–2006–08 WTO, Sept. 2006.

¹⁹ Mashayekhi/Tuerk (2006).

Also GATS' so-called "public services carve-out" and members' attempts to clarify its ambiguous meaning, are relevant for members wishing to single out *PHC-related* services. According to article I, GATS covers all services, except those "supplied in the exercise of governmental authority". The latter are defined as services that are "supplied neither on a commercial basis nor in competition with one or more service suppliers". In light of the ambiguity and uncertainty created by this language, particularly with respect to coverage of public services, several WTO members use their individual country schedules to clarify the meaning and to carve-out all of – or parts of – public services.

Different approaches have been used,²⁰ including (a) the EC approach (inserting a horizontal limitation for "services considered as public utilities at a national or local levels", and carving out certain regulatory tools);²¹ (b) the Nordic/Swiss approach (excluding the "public works function whether owned and operated by municipalities, state or federal governments or contracted out by these governments"); (c) the approach used by Mexico and Malaysia (including specifications in the schedules' sectoral columns, clarifying that for each sector listed, the schedule/commitment relates to "private" services only); or (d) the United States–Estonian approach (clarifying in the sectoral column that the commitment only covers services "contracted by private industry").²² More recently, Jamaica, in its initial offer, included a technical clarification that "the commitments in this schedule do not apply to non-profit, public and publicly funded entities. These commitments cannot be construed as preventing the Government of Jamaica from regulating public and private services in order to meet national policy objectives".²³

Considerable legal and policy discussion and analyses have addressed questions relating to the breath of the GATS article I carve-out and the utility of different individual countries' additional carve-outs. Most of these discussions explore the interface between the GATS article I language (supply on a commercial basis/in competition) and policy choices regarding the public and/or private provision of certain services. Less attention, however, has been given to the question of how different public services carve-outs would relate to *PHC-related* services. Both approaches – (a) differentiating between services supplied commercially/in competition and others and (b) differentiating between public and private service supply – differ from the delineation between *PHC-related* and *other* health-related services. In theory, however, what members have done through individual "public services carve-outs" could also be done for *PHC-related* services.²⁴

Finally, it has to be noted that GATS – as well as RTAs – usually contains so-called "general exceptions". In the case of GATS article XIV, the provision specifies that subject to certain requirements, "nothing in this Agreement shall be construed to prevent the adoption or

²⁰ While originally, so-called public services carve-outs have been viewed as a mainly developed country issue, more recently, also developing countries consider taking such an approach: See, the example of Pakistan described in Mashayekhi/Tuerk, *Achieving Coherence between Trade and Health Policies: Selected Examples from Pakistan, the Philippines, Uganda and Peru*, in WHO, forthcoming, (Mashayekhi/Tuerk, forthcoming).

²¹ Slovenia's entry in the EC schedule additionally specifies for hospital services that "entry into public Health network is subject to concession from Institute for Health Insurance of the Republic of Slovenia" TN/S/O/EEC/Rev.1.

²² For a more detailed discussion of such approaches, their advantages and disadvantages see Mashayekhi/Tuerk (2006).

²³ TN/S/O/JAM.

²⁴ It has to be noted, however, that a WTO member aiming to include a *PHC-related* services carve-out in a Uruguay Round schedule with existing health commitments might face questions related to the possible reversal of commitments and attendant requests for compensation. At the same time, examples of post-GATS RTAs show that negotiators are creatively approaching public services carve-outs (e.g., the United States–Uruguay FTA (Free Trade Agreement) and the Southern African Development Community (SADC) draft Protocol on Trade in Services, version June 2007)).

enforcement by any Member of measures: ... (b) necessary to protect human, animal or plant life or health.” Importantly, this provision grants leeway for health policies, including PHC-related policies.²⁵

In sum it can be noted that at the conceptual level, GATS stops short of specifically referring to *PHC-related health services*. At the same time, however, through its concepts of e.g. progressive liberalization and positive listing for liberalization commitment²⁶ the Agreement allows countries to (a) determine the sectors to be subject to liberalization commitments; (b) define such sectors in light of individual country priorities; (c) carve-out public (or PHC-related) services; and (d) benefit from policy flexibility under the agreement’s general exception.²⁷ Governments’ use of these various channels for flexibility manifests itself in the commitments Members have taken, and continue to assume under GATS.

II. GATS liberalization commitments and offers in PHC-related services

A review of WTO Members’ Uruguay Round commitments and initial (and revised) offers submitted in the WTO’s Doha Work Program (DWP) shows that the liberalization of specific health-related services sectors remains limited.

Uruguay Round schedules reveal that health services (covered under health and professional services) exhibit relatively few commitments, with medical and dental services having most commitments, followed by hospital and midwives/nursing services. The country-pattern of commitments remains diffuse with some members refraining from undertaking commitments in all of the four core health-related sub-sectors (UNCTAD, 2006b). This reluctance to schedule health-related commitments is also visible in the case of least developed country (LDC) members. Amongst the organization’s 32 LDCs, less than 10 have made commitments in the “W/120’s” sector 8.

In the DWP, the United States, EC and Canada have made clear that, for them, health services are not a focus area of negotiations. A few developing countries included health services, notably in relation to the movement of natural persons in their requests.²⁸

Some developing countries, also included health services in their offers: Bahrain, Brazil, Hong Kong (China), the Republic of Korea, India, and Trinidad and Tobago, for example, offered new health-related services commitments. India, amongst others, offered new commitments for medical and dental services and for services provided by midwives, nurses, physiotherapists and paramedical personnel.²⁹ Brazil’s offer relates to veterinary services. Mexico, and on the industrialized country side New Zealand and the EC, made improvements to existing health-related services commitments. In the case of the EC, this includes, e.g., definitions for economic needs tests (ENTs).³⁰ Those countries making offers

²⁵ There are however, limitations to an approach relying on a “general exception” for pursuing legitimate policy objectives.

²⁶ Note that some international trade agreements follow the “NAFTA model” and adopt a so-called negative list approach.

²⁷ Also important is the GATS (re)affirmation of members’ right to regulate and to establish national policy objectives, which would also include PHC-related services.

²⁸ The Mode 4 plurilateral request and the LDCs’ group requests on Mode 4 refer to health related services.

²⁹ Interestingly, India’s Mode 1 offer covers the provision of the service on a provider to provider basis, with the transaction being between established medical institutions covering areas of second opinion to help in diagnosis of cases or in the field of research, TN/S/O/IND.

³⁰ TN/S/O/EEC/Rev.1.

on health services are mostly members who had previously undertaken health-related services commitments. Some countries, e.g. Canada, neither have health-related services in their Uruguay Round schedule nor do they include them in their offer, hence pointing to a certain sensitivity regarding the liberalization of health services. South Africa has commitments in medical and dental services, veterinary services, services provided by midwives and nurses and physiotherapists and paramedical personnel, but no health-related offers. Also only one of the approximately 20 plurilateral requests specifically focuses on health services: the Mode 4 plurilateral request refers to medical and dental services (CPC 9312), veterinary services (CPC 932) and services provided by midwives, nurses, physiotherapists and paramedical personnel (CPC 93191).³¹

Importantly, however, neither WTO Uruguay Round commitments nor DWP requests or offers make specific references to *PHC-related* health services.

III. Trading PHC-related services: evidence of costs and benefits

The above, quick review of commitments and offers regarding health and PHC-related health services suggests that governments are employing a fair degree of caution with respect to entering into legally binding commitments on international trade in PHC-related health services. Amongst others, such caution may be motivated by the fact that the implications which international trade in services and the respective international rules may have on PHC remain relatively unexplored. While general ideas about the relationship between international services trade and health are beginning to emerge, precise information based on the quantification of benefits and costs remains absent. This is the case for both, *health* and *PHC-related* health services subsectors.³²

More broadly, it is recognized that international trade in health services can bring about important benefits for universal access to health services (e.g. by providing new technologies and increased capital, by reducing the burden on government resources and allowing for reallocation of resources). However, trade in health services can also pose certain challenges (e.g., brain drain and cream skimming) and important uncertainties remain regarding the benefits: in fact, the expected re-allocation of resources often fails to materialize (UNCTAD, 2006a).

While most theoretical and empirical literature on services trade highlights the positive economic impact of liberalizing and eliminating trade barriers (reference is made to gains accruing from short-term allocative efficiency gains and long-term welfare gains), the health sector is usually considered distinct from other service sectors. Health services exhibit several market failures as well as strong equity considerations, therefore suggesting specific considerations (Blouin, 2006).

Any attempt to highlight the costs and benefits of trading health and health-related services has to differentiate between the four modes of trading services.³³ This would also

³¹ See also, Tuerk, Services Post-Hong-Kong (China) – Initial Experiences with Plurilaterals, in Panizzon/Pohl/ Savué (eds.), GATS and the Regulation of International Trade in Services, World Trade Forum 2006, Cambridge University Publishing (forthcoming) (Tuerk, forthcoming).

³² This is a phenomenon cutting across services sectors in general, amongst others, due to the fact that data on services trade and services activities is limited (UNCTAD, 2006a).

³³ For a more comprehensive description of potential costs and benefits arising from trade in health services across the four modes, see Savué (2008). See also Blouin (2006).

have to be done for *PHC-related health services*. However, in the context of the more narrowly defined sector of *PHC-related services*, some additional questions arise. For example, given that PHC-related services do not always offer opportunities for making profit, there are questions about the extent to which commercially viable Mode 1 and Mode 2³⁴ trade would at all occur in these services; similarly, given that FDI is primarily expected to be commercially motivated, questions arise about the extent to which FDI will flow in PHC-related health services. Also, for those aspects of PHC which focuses on bringing health care as close as possible to where people live and work, certain aspects of trade (e.g. Mode 2 trade) would appear less relevant.³⁵ Finally, concerns about Mode 4 trade, particularly in the context of brain drain, appear to be particularly important for services activities which are not particularly commercially viable.³⁶

Moreover, while conceptual understanding about the linkages between trade in health services and the quality of national health systems is growing³⁷ empirical evidence about the levels and the impact of trade in health services remains extremely limited.³⁸ Information is even more limited when the more narrowly defined category of *PHC-related health services* is considered. Moreover, some of the benefits expected with respect to trade in health and health related services more broadly, might remain absent when *PHC-related services* are more narrowly defined.

IV. The need for regulation to complement liberalization

One issue that is becoming increasingly clear is the recognition that, in order for countries to reap full benefits from international services trade, there is a need to put complementary policies in place alongside services trade liberalization policies (in the context of brain drain, these would be policies ensuring repatriation of health professionals that leave the country on a temporary basis for work abroad (Mode 4). Along these lines, it has been suggested that liberalization per se is not at issue, but that instead, attention should be focused on creating an effective regulatory framework and designing of a robust health care strategy. Under a proper enabling environment the health services sector would develop, and offer not only employment and business opportunities, but also proper care, including for the poor and marginalized.³⁹

More specifically with respect to universal access to PHC-related health services, governments are putting in place numerous and different policies, ranging from public service provision and publicly funded service provision, to universal service obligations, subsidies, microfinance, community-based and other systems. Each of them offers benefits and challenges and interacts differently with trade-liberalization objectives. Effective public provision (and financing) of *health services* can be an important tool, with public money and

³⁴ Particularly for the part of PHC which relates to the initial contact between patient and medical personnel, is it questionable whether PHC-related health tourism occurs on a major scale.

³⁵ Mode 1 or Mode 3 trade, however, could be particularly relevant in this context.

³⁶ How to turn brain drain into brain circulation is also addressed by the Global Migration Group (GMG), a collaboration between different intergovernmental organizations, including UNCTAD, aiming to make migration work for development, <http://www.un.int/iom/GMG.html>.

³⁷ See, amongst others, the valuable work undertaken by WHO in the context of assessing health services trade, e.g., the WHO toolkit.

³⁸ WHO (forthcoming).

³⁹ The rationale for State intervention to ensure universal access stems from different types of considerations including: addressing market failures (e.g. information asymmetry, monopolies and externalities) and providing merit goods (goods or services which are intrinsically desirable or socially valuable, with citizens being entitled to such goods and services, irrespective of whether they can afford them and of actual desires and preference).

public provision maybe most important for interventions, where treating one case may prevent many others from arising (e.g. communicable diseases control). However, the public sector faces challenges (e.g. changing needs of consumers, new medical technologies, expectations of health professionals) and is often seen as uncompetitive. Almost every country with a publicly funded health care system also has a parallel private system, which usually tends to serve private insurance holders. Private sector engagement and market-based policies can be an option for improving universal access to PHC, particularly where financing from the public sector is lacking, but results of privatization are mixed. Given the profit motivation of the private sector, privatization of PHC-related services remains questionable from a universal access perspective. Subsidies are widely used for universal access and PHC; they can target households (e.g. vouchers directly benefiting disadvantaged consumers), or service providers (e.g. cross-subsidies and universal access funds). Subsidies also give rise to numerous challenges, e.g. the unavailability of financial resources for providing subsidies, or the difficulties related to the proper targeting of subsidies.⁴⁰

Regulatory issues are also crucial regarding the concerns arising from increasing South–North movement of health personnel and the attendant tensions between the need for governments to regulate the health sector to achieve PHC on the one hand and trade liberalization objectives on the other. The International Council of Nurses calls for the promotion of equity, sound regulation, ethical recruitment (including ensuring adequate supply at home and providing incentives for return) and discourages recruitment of nurses from countries without sound human resource planning (UNCTAD, 2004). More recently, the Global Forum on Migration and Development⁴¹ looked at human capital development and labour mobility, particularly for health workers. Its recommendations included working on best practices for retaining, retraining and re-covering health personnel, and evaluating ethical codes of recruitment practice with a view to making them more effective (Kategekwa, 2007).

In sum, while the case for regulating services is widely acknowledged, less agreement exists on a one-size-fits-all strategy for improving regulation. Instead, it is for each government to identify a “best-fit solution” in accordance with its particular needs that meets social equity and human development objectives. This policy suggestion applies to PHC-related health services, as well as for many other services sectors.

The policy discourse on regulation has also seen calls for generating benefits through regulatory reform and regulatory audits, with some of them addressing the impacts that regulatory policies have on trade and investment. Key questions suggested in such regulatory audits concern, amongst others, the economic impact of regulation, the potential economic and trade costs of regulatory measures; the need for an efficient, transparent and impartial design of regulation; and whether the policy objective could be achieved through other means or in a manner that might lessen its restrictive impact on trade or investment, hence encouraging – where feasible, the adoption of market access friendly regulation that is supportive of both trade liberalization and privatization.⁴²

To date, however, results of liberalization, privatization and regulatory reform more broadly, are mixed, generating a call for flexibility and for policy space to allow countries the leeway needed to identify and implement their respective, best-fit regulation. Frequently, this call for policy space is combined with a call for regulation to be implemented *before* liberalization is introduced. Once a proper regulatory and institutional system is established, countries are better placed to reap the benefits of international services trade, including health services and PHC-related health services.

⁴⁰ UNCTAD, 2006b.

⁴¹ <http://www.gfmd-fimmd.org/>.

⁴² WHO (forthcoming).

Southern African Development Community (SADC) countries adopt such an approach. While SADC members are currently negotiating a Protocol on Trade in Services, health services are not amongst the six sectors identified for priority liberalization in the draft protocol.⁴³ Much earlier, however, in 1999,⁴⁴ SADC countries had signed a Protocol on Health which provides a legal and policy framework for cooperation in addressing health problems and challenges facing the region.⁴⁵

V. Cooperation as a central element at the interface between regulation and liberalization of PHC services

Objectives to strengthen PHC would benefit greatly from regional cooperative mechanisms. Cooperation is a prominent feature of regional approaches to services trade liberalization and can take various forms. Examples include regulatory cooperation, financial cooperation, cooperation for human and institutional capacity-building, for trade facilitation and infrastructure-building.

Highly relevant for both the trade and the health perspectives is cooperation regarding recognition and harmonization of qualifications, including mutual recognition agreements (MRAs). Recognition figures prominently in the European Union (EU) and also in South–South RTAs. Association of South-east Asian Nations (ASEAN) countries adopted MRAs, including e.g. for nursing services. Also, SADC promotes and coordinates regional efforts aimed at development, education, training and effective utilization of health personnel and facilities. Along these lines, cooperation could include (a) the negotiation of MRAs with developing countries and LDCs as well as technical assistance for developing country associations and government entities to participate in such negotiations; (b) means to assist developing country service suppliers to meet the standards in export markets (e.g. through technical assistance, capacity-building and financial support for developing country services suppliers); and (c) one-stop shops for the handling of administrative issues related to the provision of services through Mode 4 or accelerated procedures for verification of qualifications. All of these would be highly relevant for Mode 4 trade in health services, including PHC-related services.

As mentioned above, Mode 4 is also an area where health concerns about trade are relatively pronounced. Again, cooperation can help: in the SADC region, the SADC Project on Reversing Brain Drain in the Health Sector aims to address the potentially negative implications of movement of health personnel at the national level. Under this project, the SADC secretariat has mobilized resources for the development of policy guidelines to attract and retain health care professionals in the public sector.⁴⁶

A type of cooperation essential from a development perspective is cooperation aimed at enhancing regulatory development and institution-building (e.g. financing, technical assistance, regular information exchange and meetings, partnerships between institutions and other collaborative projects). Cooperation can also cover infrastructure services or support

⁴³ The six sectors in which initial liberalization is to be undertaken are: transport, tourism, communication, construction, financial and energy related services.

⁴⁴ The protocol came into force on 14 August 2004.

⁴⁵ For the Common Market of Eastern and Southern Africa (COMESA), the currently envisaged “regulations to liberalize regional trade in services” will adopt a positive list, but not focus on specific priority sectors. It remains to be seen to what extent individual COMESA countries will decide to liberalize PHC-related services. On the regulatory side, COMESA relies on individual countries’ national health strategies.

⁴⁶ Khumalo, Implementation of SADC Protocols Affecting Trade in Services, UNCTAD Project on Support to the SADC Regional Integration and the Multilateral Trading System, on file with the author.

institution–building or supply capacity building, with improved infrastructure as a central requirement for efficient PHC services delivery.

An example of specifically health-related cooperation can be found in the context of SADC regional integration. The SADC Protocol on Health, aims at (a) coordinating regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases; (b) facilitating the establishment of a mechanism for the referral of patients for tertiary care; (c) promoting and coordinating laboratory services; and (d) collaborating with other relevant SADC sectors. Implementation of activities has started with implementation plans and several projects, including the development of the Health Implementation Plan or the Project on Reversing Brain Drain in the Health Sector in SADC (see above).

Also, other RTAs, which increasingly cover services liberalization, contain provisions for PHC-related health services and sometimes also provisions relevant for health-related cooperation. Southern Common Market (MERCOSUR) countries, for example, adopted a staged positive list approach towards services trade liberalization.⁴⁷ While PHC-related services are not within those sectors with special annexes (financial, maritime and land transport, Mode 4), Mode 4/movement of natural persons is clearly relevant for health professionals. Overall, the MERCOSUR region is characterized by a low degree of regulatory harmonization. While national health systems differ considerably, selected regional cooperation initiatives have taken place (e.g. *tarjeta MERCOSUR*, allowing patients enrolled in the health cooperative of one country to receive health care in another country through the services of the associate cooperative).

In the Andean Community, the regime for the liberalization of trade in services adopts a negative list (together with a stand still obligation and an inventory of measures that could be maintained during the transition period). Hence, PHC-related services are also covered by this liberalization; respective cooperation is, however, less developed.

The European integration process offers an interesting example, with EU members showing certain sensitivities regarding health and health-related services. While the EU's internal market – and its recently adopted Services Directive – serve as an example for deep and far-reaching liberalization, health care and certain social services are excluded from this Directive. At the same time, European integration complements trade liberalization (internal market) with a great array of cooperation across various areas of policy making, including regulatory and cooperation in health and social policymaking.

Also, Economic Partnership Agreements (EPAs)⁴⁸ might touch on health services. In the case of EU proposal to SADC (based on a common template drawing on existing EU RTAs), the proposed services provisions adopt a three-pillar structure with regard to supply of services (different from four modes of supply under GATS).⁴⁹ Regarding PHC-related issues, the elements of positive listing could allow for (a) a careful scheduling of commitments and

⁴⁷ A more detailed analysis would be needed to determine the extent to which MERCOSUR countries made commitments in PHC-related services.

⁴⁸ Since September 2002, the Africa, Caribbean and Pacific (ACP) Group of States and the European Union negotiate EPAs, as mandated by the Cotonou Partnership Agreement (June 2000). By December 2007, a full regional EPA was initiated with the Caribbean and another EPA was initiated with Cameroon. Also several interim agreements were reached in Africa and the Pacific region. Some ACP countries (e.g. in the SADC region) continue to be opposed to the inclusion of services into an EPA and instead, favor a cooperative approach.

⁴⁹ These are (a) cross-border supply of services that combines GATS Modes 1 and 2; (b) “temporary presence of natural persons for business purpose in all economic sectors” (modeled on Mode 4); and (c) “establishment” in services and non-services sectors (modeled after Mode 3 with extended scope).

attendant exclusions of health services; (b) the existence of provisions on regulatory frameworks and cooperation – e.g. mutual recognition – albeit in hortatory manner; and (c) neither sector-specific provisions nor specific exclusions (e.g. from the establishment chapter) specifically mention health-related services. Some organizations voiced concerns that further liberalization of health services under EPAs might have negative consequences and suggest that EPAs should (a) delink negotiations of services liberalization from commitments in health and health-related services; (b) provide for formal health impact assessments in any health-related sector where liberalization is being proposed; and (c) include commitments to ethical recruitment practices in relation to health workers and modalities for EU investment in public budgets to produce and retain health workers in source countries of migration.⁵⁰ There have also been calls to strengthen the language on cooperation in the issues-specific EPA chapters (e.g. in the services chapter), rather than relegating cooperation issues to a different legal framework.

Conclusions

Evaluating the interlinkages between PHC on the one hand, and international services trade and its respective rules on the other, remains difficult. The lack of international trade data, which is typical for services, is even more pronounced for PHC-related services. While at a conceptual level, current trade rules remain silent regarding the specificities of PHC-related services, they do indeed establish rules relevant for PHC-related services, including those provided by public authorities. They also grant leeway for governments to single out PHC-related services. Moreover, there are questions as to what extent international services trade is occurring in PHC-related activities. Nevertheless, governments face the challenge of designing mutually supportive trade and health policies that can deliver optimal trade and health outcomes, including for PHC.

Enhanced information and understanding, generated for example by conducting in-depth trade and health assessment studies, can help to identify such policies. Such assessments would evaluate trade and health policies at the national level (including by analysing regulatory reform and focusing on best practices for regulatory and institutional frameworks), and trade strategies and trade agreements (including potential trade deals) with a view to anticipating the costs and benefits emanating from them. By focusing on issues specifically relevant to PHC, such assessments would allow for informed decision making by policymakers.

Additionally, governments would benefit from flexibility, allowing for the proper sequencing of trade liberalization and the development of regulatory frameworks. This would include (a) flexibility in the design of trade rules, particularly those interfacing with domestic regulations in PHC-related services sectors; (b) flexibility in the negotiation of commitments (e.g. through a positive list approach); and (c) flexibility in the implementation of trade rules such as safeguards or general exceptions. For example, the possibility of combining GATS commitments with flexibility to review – and roll back – commitments in light of their impacts on universal access and other PHC-related goals can offer a safety valve, making it easier for members to offer commitments.⁵¹ Similarly, flexibility would be needed in the context of future GATS provisions on domestic regulation, where WTO members are negotiating disciplines for, amongst others, qualification requirements and technical

⁵⁰ Protecting health in the proposed Economic Partnership Agreement (EPA) between East and Southern African (ESA) countries and the European Union, Equinet, Regional Network for Equity in Health in east and southern Africa, Policy Series No. 17, June 2007.

⁵¹ UNCTAD, 2006b.

standards, both of them essential regulatory tools.⁵² More broadly, trade deals could include provisions for a built-in review process, with a mandate to amend the agreement in light of unanticipated negative health and development impacts.⁵³

Finally, from a PHC perspective, any discussion would need to go beyond health services per se, by addressing other basic services such as the provision of water, sanitation, education and insurance services.⁵⁴ From a trade perspective, a PHC-related approach to services would be an important step towards putting development at the core of international trade negotiations and trade policies.

⁵² Mashayekhi/Tuerk, GATS Negotiations on Domestic Regulation, in Kern et al. (eds.), Brill Publishing, forthcoming, forthcoming, (Mashayekhi/Tuerk, forthcoming).

⁵³ See, for example, the suggestion for a pro-development review of the WTO's disciplines on domestic regulation, (Mashayekhi/Tuerk, see above).

⁵⁴ Sector 7 of "W/120" covers on financial services, including all insurance and insurance-related services, including life, accident and health insurance services; UNCTAD (2007a); UNCTAD (2007b).

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