FACULTY OF LAW
Professor Jane Kelsey

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau
Law School Buildings
9-17 Eden Crescent, Auckland
Telephone 64 9 373 7599 ext. 88006
Facsimile 64 9 373 7471
email: j.kelsey@auckland.ac.nz

The University of Auckland
Private Bag 92019
Auckland Mail Centre
Auckland 1142, New Zealand

28 January 2015

IMPLICATIONS OF THE TISA TRADE IN HEALTH CARE SERVICES PROPOSAL FOR PUBLIC HEALTH

The "Concept Paper on Health Care Services within TiSA Negotiations" has implications that go beyond the paper from Aaditya Mattoo and Randeep Ratindan (2006) on which it draws. What would ultimately matter in TISA is the legal text itself, irrespective of the explanations or limitations in the background document. This brief memorandum identifies a number of implications of the concept paper for nations' health care systems.

Ideology

The proposal presumes a transition in the dominant model of health care from an integrated public and social service to a market-oriented system in which citizens are consumers in a globalised health market place.

There are two rationale:

(i) countries have shortages of personnel and capital investment in their public and private health systems, which results in waiting lists. These delays can be alleviated if their citizens consume health services offshore.

(ii) some countries have a comparative advantage in providing healthcare services through price and efficiency gains, as well as lower regulatory and structural barriers.

Objectives

The proposed Annex is intended to facilitate the mobility of patients to other countries to consume health services and to take their funding entitlement for health care funding with them. The paper on which the proposal is based focuses on private insurance entitlements, and seems predominantly concerned with efficiency gains to the insurance industry. But the TISA proposal appears to cover all funding that involves individualised health entitlements, whether public or private.

Key points in the proposal

What is various described as privatisation of healthcare, offshoring of healthcare provision or 'health tourism' would involve:

- individuals will purchase offshore healthcare services from approved providers;
- funding will come at least partly from social security, private insurance or other 'creative' sources in their home country;
- host countries will provide aftercare services;
- states will decide the scope of coverage for their countries.

There is a presumption that there will be negative spillovers, but that they should be limited.

Impacts on home country health systems

People who seek treatment offshore can take their funding with them, which means that:

- money is drawn out of the national health system, whose low level of investment is cited as one of the rationale for offshore treatment, and makes the problem self-perpetuating;
- provides a justification for lower investment in the healthcare system, and training and recruitment of the healthcare workforce;
- taxpayer funding for healthcare allocated to individual patients is transferred into another country's private health system;
- countries that do not currently allocate public funding for healthcare through individual accounts, but are subject to this Annex, may face pressure to change their health care funding system to individual accounts or voucher style systems;
- private health insurance, which often benefits from tax deductions, is spent offshore;
- the home economy loses the dynamic benefits of healthcare expenditure, which accrue instead to the provider economy;
- home country facilities will have to remedy problems that arise from offshore once the patient has returned home, which would place unanticipated burdens on the home healthcare system unless additional special insurance arrangements are made;
- foreign services would be supplied by institutions accredited under some kind of recognition process, but the home country would need to develop mechanisms and criteria for accreditation and continued monitoring of compliance;
- a list of procedures that is initially limited could be expected to expand and become the thin end of the wedge for offshoring of significant parts of the national public health system, which in turn increased dependency on offshore providers.

Impacts on host country health systems

'Health exporting' countries will find

- qualified staff are diverted to health export services that often have better pay and facilities, eroding the personnel base for public facilities and perpetuating inequalities in the health care system;
- education and training funded by the home country is used to benefit foreign health care users, rather than local citizens and taxpayers;
- any 'necessary care after treatment' is the responsibility of the local facility, or more likely the public healthcare system; this wording is unclear, but it could see host countries and their taxpayers bearing the costs of funding remedial treatment where complications occur that require specialist facilities. Where those facilities do not exist in the country, they may have to pay the costs for remedial treatment elsewhere.

Impacts on patients

Offshore treatment is intended to benefit individual patients as healthcare consumers, but carries potential downsides:

- Isolation from family and support persons, especially for traumatic or difficult procedures, where the patients are vulnerable, or in cases of prolonged stays and complications;
- Where complications arise, foreign 'consumers' will be reliant on often-lower quality local health care facilities in the host country;
- Accreditation of offshore facilities may not consider language, religion, cultural knowledge and sensitivities that are important elements of healthcare;
- Difficulties in securing follow-up or remedial treatment if problems arise once the patient returns home;
- Legal liability can be difficult to pursue where providers are offshore, especially if home country insurance entitlements are limited;
- patients who are treated in their home country may face a deterioration of health care services due to lack of investment, rather than the anticipated improvement from shorter waiting lists;
- patients may face increasing formal and informal pressure to seek healthcare offshore when their preference would be for treatment at home.

Constraints on government regulation

The proposal is a concept paper and would set out the rules in an Annex. There is nothing to indicate whether TISA signatories would be able to opt out of that Annex.

The suggestion that *details* would be left to each country to decide suggests that it would bind all parties, but they would have flexibility to determine its application.

The suggested exceptions are framed in terms of 'legitimate social objectives'. Similar, but not identical, terminology is used in disciplines on governments' Domestic Regulation. Under this approach, the scope of regulation would be limited by what are considered as 'legitimate' objectives and the requirements they are directed to achieving are 'quality', consumer protection and protection of data. Broader social, cultural, and systemic objectives may be effectively excluded.

Effective regulation is directed to 'easing the patent's life', rather than broader healthcare needs and viability of quality public service.

The autonomy of governments to regulate refers to organising their systems of healthcare entitlement, not healthcare policy more broadly.

If the general exception in the GATS is imported into TISA it would not provide effective protection for public health measures. The combination of a requirement that any government regulations are 'necessary', not 'arbitrary or unreasonable discrimination' or a 'disguised barrier to trade' would make it extremely difficult to succeed. Indeed, the exception has almost never been successfully pleaded as a defence in the WTO.

The impacts of the Annex could be exacerbated by its interaction with other chapters, such as the free flow of data and no apparent privacy protections in the leaked US proposal on e-commerce, cross-border services, financial services, domestic regulation, regulatory coherence, temporary movement of personnel, at the least.

Enforcement

Service commitments on cross-border supply of services (what were known as modes 1 and 2 in the GATS) would bind a party to TISA. Under the proposed standstill and ratchet approach, once a government liberalised its health care policies in the way anticipated in the proposal it would be impossible to reverse it either partially or wholly.

A commitment to the proposed Annex would bind governments into the future.

Countries who were party to TISA could enforce these obligations against another party through the State-state dispute settlement provisions.

In addition, foreign investors could use the investor-state dispute settlement provisions where there is a bilateral investment treaty or similar investment obligations between the relevant countries. An offshore investor would not usually enjoy the protections of those agreements. But if there was a local agency established in the source country that could claim a change of policy impacted adversely on its profitability, or took away its business altogether, the government could face an investment claims for many millions of dollars. A similar claim could arise where new regulations to limit offshore health services were held to be discriminatory, for example by giving preferences to the local health system or to health providers in a specific foreign country (for example that shared cultural or religions characteristics).