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GATS and Trade in Health Insurance Services: Background Note for WHO Commission on Macroeconomics and Health

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GATS and Trade in Health Insurance Services

Background Note for
WHO Commission on Macroeconomics and Health, Working Group 4

by
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Summary

This note provides background on the treatment of health insurance services by the General Agreement on Trade in Services (GATS) of the World Trade Organization, and explains the relevance of current GATS negotiations for health insurance trade. It begins with a general description of GATS, indicates how health insurance is classified in GATS-defined service sectors, and outlines options countries have when making insurance-related market access commitments. It then explains why GATS commitments made to date have not yet had any measurable effect on changes in insurance markets. It reviews some of the issues addressed in current GATS negotiations and their potential implications for market access commitments covering health insurance. It concludes by reviewing the opportunities, risks and challenges presented by GATS for national policies and regulations affecting health insurance.

A Brief Overview of GATS

The General Agreement on Trade in Services of the World Trade Organization (WTO) came into effect in 1995, as a result of the Uruguay Round of multilateral trade negotiations. GATS establishes a framework of progressive liberalization in services trade, which allows countries substantial flexibility to determine: 1) which sectors of the service economy they wish to open up to foreign suppliers and competition and 2) what options, if any, they want to retain to restrict competition in these "open" sectors. GATS applies to all services in any sector except those supplied in the exercise of government authority, defined as supplied neither on a commercial basis nor in competition with one or more service suppliers.

WTO Members' commitments to allow for market entry in specific sectors of their choosing appear in schedules. These schedules spell out any restrictions on the extent of market access afforded to foreign suppliers, e.g. whether their numbers are restricted, and the degree of national treatment accorded to foreign companies. Once scheduled, these commitments are bound; meaning they can be modified or withdrawn if a country finds this necessary, but they are required to negotiate compensation with trading partners for the losses incurred. GATS commitments in any particular sector are undertaken with regard to four modes of supply, as defined in GATS: Mode l—cross border supply; Mode 2--consumption abroad; Mode 3--

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commercial presence; and, Mode 4--temporary movement of natural persons. For any scheduled sector, countries may vary the level of commitments by mode to accommodate domestic policy objectives.

While commitments offer investors a legally enforceable guarantee of stability and predictability in market conditions, the absence of commitments does not mean that access to a particular market is denied. The lack of a commitment in various sectors only implies that the country concerned has retained full discretion not to extend market access and national treatment in those sectors. In some cases, market access conditions for certain types of service suppliers are more liberal than those bound under the GATS.

The GATS agreement has some general (also called "unconditional") *obligations that apply across all service sectors, whether scheduled or not*. The most important of these is the most-favoured nation (MFN) principle, which obligates countries not to discriminate among foreign suppliers by offering more privileges or rights to some but not others.[2]

GATS contains a general exemption clause for health reasons. Under Article XIV, GATS states that "Subject to the requirement that such measures are not applied in a manner that would constitute a means of arbitrary or unjustifiable discrimination between countries where like conditions prevail, or a disguised restriction on trade in services, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any Member of measures. . .(b) necessary to protect human, animal or plant life or health." This suggests that health laws, programs or other measures designed to protect human health, including those related to health insurance, could be entitled to exemption from GATS requirements, as long as such measures do not discriminate among trading partners. In practice, however, WTO jurisprudence (and GATT rulings that preceded the WTO) indicate that to employ such an exemption, the measures would be subject to a narrow interpretation of what is "necessary" to protect health.

GATS' Classification of Insurance and Member States' GATS Commitments

Under the GA TS sector classification scheme, health insurance falls under the financial services sector. Financial services are divided into two sectors: 1) insurance and 2) banking and other financial services. Within insurance, there are four sub-sectors: a) life, accident and health insurance, b) non-life insurance, c) reinsurance and retrocession, and, d) services auxiliary to insurance, including broking [sic] and agency services. Despite the appearance of the term "health insurance" under the first category, many country commitments affecting health insurance services are in fact covered by the second category (non-life insurance) as that is how health insurance was classified in the GATS Annex on Financial Services. (See WTO, 1998, footnote 3)

Health professionals may regard health insurance as more properly falling within the health services sector, since the effects of private health insurance are felt so strongly within the

[2] Exemptions from MFN treatment could have been sought only at the date of entry into force of GATS; some 400 MFN exemptions have been enumerated and their duration is limited in principle to ten years.

health sector. Indeed, market conditions for private health insurance depend heavily on the role and extent of participation by private providers in national health care systems, the extent and depth of coverage by social health insurance systems, and the health regulatory environment. Yet, there is justification for classifying it under financial services. First, health insurance is often one of many lines of business offered by insurance companies. This is frequently the case in developing countries, where the development of private health insurance markets is frequently a spin-off of other lines of insurance and often serves as a loss leader for other insurance products (Chollet and Lewis, 1997). Second, mirroring its treatment in the market, many governments' regulation of private health insurance is an extension of generic insurance laws and regulations, which govern insurers' financial viability, reserves, reinsurance, and entry or exit from the market. Third, the development of private health insurance markets requires access to capital markets and reinsurance; where these financial services do not exist, private investment in health insurance has been slow to develop.

Most trade in health insurance services now occurs via the third mode -- commercial presence -- in which health insurance companies set up operations or make equity investments in other countries. There may also be trade in health insurance administrative services, such as claims processing, that are performed in another country and sent back to the originating country via the Internet, constituting cross-border supply (Mode 1). However, of the four modes of supply defined by GATS, commercial presence is the mode that most WTO members have chosen to guarantee access to domestic markets for direct [life and non-life] insurance services (Mattoo, 1998).

Financial services were among the few service sectors whose negotiations were extended beyond the timeframe of the Uruguay Round. Delegates resumed negotiations in 1995 and concluded them at the end of 1997. After these negotiations, a total of 102 WTO Members made commitments in financial services under GATS; as of September 2000, there were 106 with the addition of commitments by new WTO members. Of the total, nearly 80 Members included health insurance under the insurance sub-sector, counting the EC Member States individually.

Health Insurance Regulation under GATS

To the extent that foreign suppliers are allowed to enter the market, WTO members retain wide scope for regulating private health insurers. For example, governments can require all private insurance companies to offer a basic package of benefits, so long as the mandate applies to insurers regardless of country of origin. If specified as a limitation on national treatment in the schedule, countries may even establish rules for foreign companies that differ from domestic ones.[3]

On the other hand, if a country decides that it cannot properly regulate private health insurance, it could exclude health insurance (e.g. through a limitation on market access for an insurance commitment in mode 3), even if it allows other types of private insurance products to

[3] Such flexibility may be constrained by the dynamics of WTO negotiations, i.e. what other WTO members will accept. There may be other caveats, conditions, and exceptions that apply in specific circumstances.

be offered. Or, if it allows health insurance to be offered by foreign companies, a country can set limits on the number of foreign insurance companies that can enter the health insurance market, making the task of regulation less burdensome.

The flexibility afforded by GATS to countries to specify such limits on market access becomes important when one considers the reality of health insurance regulation in the majority of developing countries. In general, the unique features of the health insurance market (described in Sbarbaro, forthcoming) are not well understood by general insurance regulators. As a result, regulations and enforcement of rules for the health insurance industry are usually much weaker than those for other insurance lines. As of the mid-1990s, "with a few notable exceptions (Hungary, Columbia), there are virtually no comprehensive regulations for health insurance. Moreover, where there are regulations on the books, enforcement is often limited or ineffective."(Chollet and Lewis, 1997). The lack of adequate regulation makes it easier for health insurers to engage in fraud, unfair competitive practices, or other practices harmful to consumers or contrary to national health objectives.

Effect of GATS on Trade in Health Insurance Services

The last decade has seen an increase in foreign companies investing, or starting up health insurance operations, in developing countries. This trend is part of a wider process of economic policy reform, in which many developing countries are privatizing previously publicly owned and delivered services, or introducing greater competition into a range of service sectors. For example, many large US health insurers have invested in joint ventures in Latin American markets, and by mid-1999 enrolled over 5 million members; one of them indicated their revenue was growing 20% annually on average (*International Herald Tribune*, 17 June 1999). In India, insurance sector liberalization through the introduction of domestic and foreign competition began in 2000. It is not just OECD countries that are exporting health insurance services; Chilean and Colombian private health insurance plans are rapidly entering foreign markets (*The Economist*, 8 May 1999).

Yet, nearly all evidence to date suggests that current patterns and levels of health services trade are occurring irrespective of GATS or any other trade liberalization in the health service sector. Nor is it evident that foreign investment by health insurance companies has been influenced by GATS commitments in the financial services sector. Health insurance services are not alone in this regard. There is no empirical evidence in any service sector, financial or otherwise, "to link any significant increase in FDI flows to developing countries with the conclusion of GATS." (Mashayekhi, 2000)

The lack of evidence on GATS' impact on financial services markets is due to several factors. One may be the short time that has elapsed since the conclusion of the GATS negotiations on financial services. More important, most commitments in the financial services sector were bindings of existing levels or conditions on access, or even less liberal ones, rather than representing any substantial liberalization. The financial services commitments under GATS reflect, "less emphasis on the introduction of competition through new entry than on allowing (or maintaining) foreign equity participation in existing financial institutions and protecting the

position of incumbents."(Mattoo, 1998) Studies that try to examine the effect of GATS commitments on subsequent changes in services trade also find it difficult to isolate the effects of liberalization in policy from other factors affecting insurance markets, such as changes in domestic competitive and regulatory environments that may occur simultaneously. Cross-country comparative studies will be hard to conduct as well due to the lack of comparable data (WTO, 1999).

Prospects for further financial services liberalization under GATS

Article XIX of the GATS requires more negotiations, to begin within five years, to further liberalize services trade. These negotiations may be expected to widen the sector coverage of current schedules and deepen the level of existing commitments. The new services round formally began in 2000, and is supposed to cover in principle all services sectors, including financial services. Under Article XIX.2, developing countries have flexibility to undertake fewer commitments and to phase-in liberalization in line with their development needs. Further, they may make market access subject to conditions aimed at meeting the objectives of Article IV of GATS, e.g. strengthening their domestic services capacity and its efficiency and competitiveness, or improving their access to distribution channels and information networks.

Regarding the financial services sector, developed countries will seek further liberalization of market access in the insurance sector, including the health insurance sub-sector. The focus is likely to be on mode 3 commitments regarding the commercial presence of foreign suppliers (Moore, 2000). This is consistent with previous financial services commitments that concentrated on eliminating or relaxing current restrictions on commercial presence of foreign suppliers, or on foreign ownership of local financial institutions. For example, the USA and European Communities proposals both seek commitments from WTO Members to remove restrictions on a supplier's ability to establish its preferred form of commercial presence, e.g. as subsidiary , branch, or joint-venture, and at the level of equity participation preferred (See WTO documents S/CSS/W/27, 18 December 2000 for the US, and S/CSS/W/39, 22 December 2000 for the EC). In addition, the US proposal seeks the removal of quantitative limitations on the number of service suppliers and a halt on discrimination between domestic and foreign suppliers.

The potential for greater liberalization for international trade in health insurance services has different implications for developed and developing countries. Developed countries' interest in health insurance services is primarily that of obtaining stable and predictable market access for health insurance companies in other markets. A few developing countries might also share this goal, for instance Chile, whose health insurance companies are among the most developed in Latin America and are seeking new markets. But the extent to which developing countries are willing to undertake further liberalization commitments, or even bind existing levels of market access in the health insurance sub-sector, will depend on the reciprocal concessions that developed countries may be willing and able to make in return (Zutshi, 2001).

For example, developing countries might seek concessions in the temporary movement of health professionals, which is of particular importance to them. Since some developing countries see the export of trained professionals as a comparative trade advantage, developing countries can

be expected to press developed countries to relax visa requirements and other access conditions, such as work permit and licensing rules, to allow independent health professionals to temporarily migrate to, and practice in, developed countries. (See specific recommendations in a submission by India to the GATS Council, WTO document S/CSSIW/12, 24 November 2000). Developing countries might also seek changes in developed country policies or regulations allowing for the portability of health insurance to promote trade in health services under modes 1 and 2.[4]

To the extent that services are negotiated across sectors and modes of supply, there is potential for this type of direct trade-off. That is, a developing country could be asked to make a financial services market access commitment in the insurance sub-sector in exchange for commitments by developed countries to guarantee portability of insurance coverage of services received in foreign countries. Whether such types of trade-off could actually occur depends on a variety of factors, including negotiating procedures and dynamics, and the ability of developed country governments to make changes allowing for greater portability under their health insurance systems.[5]

There may also be push to make some new commitments in other modes of financial/ insurance services that would benefit developing countries. With continual advances in telecommunications and informatics, financial services trade through cross-border supply via electronic means (mode 1) will become increasingly important, and the negotiations are almost certain to seek improved access and greater security for this type of trade (Moore, 2000). In the health insurance sector, this could mean that services that developing countries can deliver more cheaply -- such as claims processing and medical transcription services -- might be given a boost.

Other GATS negotiations on certain "horizontal" issues -- those applying to all service sectors -- could also affect trade in health insurance services. GATS calls for the development of disciplines to ensure that domestic regulations regarding qualification and licensing requirements, procedures, or technical standards do not constitute unnecessary barriers to trade. To achieve this objective, some WTO members have proposed that domestic regulations must be shown to be "necessary" with regard to the attainment of a legitimate national policy objective.

In principle, GATS disciplines on domestic regulations should not diminish the right of WTO Members to adopt and enforce regulations to achieve social objectives – in this case, to protect and improve health. After all, the GATS preamble recognizes the right of Members "to regulate, and to introduce new regulations, on the supply of services within their territories in order to meet national policy objectives and [...] the particular need of developing countries to exercise this right". But there are questions and concerns about whether a national policy

[4] Portability refers to policy provisions that permit health services delivered outside the country to be treated as covered benefits, either through reimbursement to the covered beneficiary or through direct payments to qualified health care providers in other countries.

[5] For example, while the US wants greater market access for its insurance companies, the US Federal government does not have jurisdiction over health insurance for the all of the population. US law, in most cases, grants jurisdiction over health insurance regulation to the 50 states. Federal jurisdiction for health benefits policies is limited to 1) persons covered by the federal Medicare program (those over age 65 and disabled people), and 2) people covered by qualifying private employer "ERISA" plans (Employee Retirement Income Security Act). Portability of coverage outside the US would require controversial changes of federal law in both cases.

objective concerning equity in health financing would automatically justify any implementing measure --regardless of its trade restricting or discriminatory effects -- or if governments would be expected to limit "unnecessary" trade-restraining effects. This concern is based on WTO case law – and GATT jurisprudence before it – which has often interpreted the meaning of "necessary" as that which is *least* trade-restrictive, rather than that which best protects and promotes health.

Conclusion

The GATS negotiations currently under way within the WTO hold both opportunities and risks for health insurance systems and suppliers in developed and developing countries alike. To the extent that the negotiations result in greater market access for health insurance companies to enter and compete in foreign markets, there is the potential for greater competition which could result in less expensive coverage, depending on local health market dynamics. But evidence from countries where private insurers compete indicates that, even with strong regulatory systems, greater competition among health insurers segments and destabilizes the market and undermines the ability to build larger, more equitable risk pools that spread costs between rich and poor, healthy and sick (WHO, 2000, Box 5.2, citing Baeza and Copetta, 1999; see also Chollet and Lewis, 1997).

With or without commitments under GATS, greater entry of foreign health insurance suppliers presents a major challenge to national and sub-national health insurance regulatory systems. The entry of foreign suppliers makes it more urgent for countries to create an effective regulatory framework, and build capacity to enforce those regulations, for the health insurance sector. Until such a system is in place, it could be harmful for developing countries to make full binding commitments in the health insurance sub-sector under GATS financial services schedules.

The GATS negotiations, like other WTO deliberations, also highlight the need for greater dialogue among trade and health officials at the national level. At a general level, health officials can help trade officials understand the health interests at stake in the GATS negotiations, and clarify the implications of GATS commitments for health insurance, as well as for other services in the health sector, e.g. hospital, physician and nursing services. More specifically, health officials can help trade negotiators identify appropriate limits and safeguards that should be incorporated into GATS schedules, and specify the conditions under which trade-restrictive health measures might qualify as necessary for the protection of equitable health financing policies. In the absence of such dialogue and coordination, countries may find that trade liberalization comes at the expense of important domestic health objectives.

References

Chollet, D., and Lewis, M., 1997, "Private Insurance: Principles and Practice," paper presented at the *Conference on Innovations in Health Care Financing*, sponsored by the World Bank, 10-11 March 1997, Washington DC.

Mashayekhi, M., 2000. "GATS 2000 Negotiations: Options for Developing Countries,", *A Positive Agenda for Developing Countries: Issues for Future Trade Negotiations*, UNCTAD (Document No. UNCTAD/ITCD/TSB/10).

Mattoo, A., 1998. "Financial Services and the WTO: Liberalization in the Developing and Transition Economies"; World Bank.

Moore, M., 2000. "Financial Services and the WTO", Speech before the Bank for International Settlements, Basel, 11 September 2000.

Sbarbaro, J., forthcoming. "Trade Liberalization in Health Insurance: Opportunities and Challenges", Background paper Prepared for WHO Commission on Macroeconomics and Health, Working Group 4 on Health and the International Economy, draft of 15 December 2000.

WHO, 2000. *World Health Report 2000, Health Systems: Improving Performance*, World Health Organization, Geneva. [Box 5.2 cited Baeza and Copetta, 1999, "Análisis conceptual de la necesidad y factibilidad de introducir mecanismos de ajuste de riesgo y portabilidad de los subsidios públicos en el sistema de seguros de salud en Chile (Conceptual analysis of the necessity and feasibility of introducing mechanisms for risk adjustment and portability of public subsidies in the health insurance system of Chile, Santiago Chile, Centro Latinoamericano de Investigación para Sistemas de Salud and Fondo de Promoci6n de Políticas Publicas de la Universidad de Chile (in Spanish).]

WTO,1999. "The developmental impact of trade liberalization under GATS," World Trade Organization, Job #2748. Rev.1,7 June.

WTO, 1998. "Financial Services: Background Note by the Secretariat", World Trade Organization Document No. S/C/W/72, 2 December.

Zutshi, B.K., 2001, personal communication.

Note: WTO documents referred to in the text can be located using the document number to search in the WTO web site: http://docsonline.wto.org/gen_search.asp