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Understanding the Impact of Global Trade Liberalization on Health Systems Pursuing Universal Health Coverage

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ABSTRACT

In the context of reemerging universalistic approaches to health care, the objective of this article was to contribute to the discussion by highlighting the potential influence of global trade liberalization on the balance between health demand and the capacity of health systems pursuing universal health coverage (UHC) to supply adequate health care. Being identified as a defining feature of globalization affecting health, trade liberalization is analyzed as a complex and multidimensional influence on the implementation of UHC. The analysis adopts a systems-thinking approach and refers to the six building blocks of World Health Organization's current "framework for action," emphasizing their interconnectedness.

While offering new opportunities to increase access to health information and care, in the absence of global governance mechanisms ensuring adequate health protection and promotion, global trade tends to have negative effects on health systems' capacity to ensure UHC, both by causing higher demand and by interfering with the interconnected functioning of health systems' building blocks. The prevention of such an impact and the effective implementation of UHC would highly benefit from a more consistent commitment and stronger leadership by the World Health Organization in protecting health in global policymaking fora in all sectors.

Keywords: global health governance, globalization, health systems, trade, universal health coverage.

Introduction

In the context of reemerging universalistic approaches to health care [1,2], this article contributes to the discussion by highlighting the influence of global forces on the balance between health demand and the capacity of health systems pursuing universal health coverage (UHC) to supply adequate health care.

Increased trade and trade liberalization is a defining feature of globalization, directly and indirectly affecting health and health systems. Understanding how trade liberalization affects a country's health system and policy has been indicated as one of the complex tasks in the stewardship of a domestic health system in the 21st century [3]. Thus, global trade liberalization is analyzed in this article as policy that also affects the implementation of UHC, that is, ensuring accessible and affordable health services appropriate to the needs of all individuals within a population [4].

Until recently, the effect of trade policies on health has been studied mostly in relation to issues such as intellectual property rights and trade in health services [5]. Social vulnerabilities, however, interfere with the universality of UHC [6], and thus to know how global trade contributes to poor health translating into health care needs is equally paramount. Nevertheless, this aspect has only recently received attention, with studies beginning to document the impact of trade liberalization on social determinants of health [7].

To study the complex and multidimensional impact of global trade on a health system's capacity to respond to populations' health care needs, promoting or hindering the path toward UHC, a systems-thinking approach is suggested [8]. Following this approach, reference is made to the six building blocks of World Health Organization's (WHO's) "framework for action"—service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership governance [9]—emphasizing their interconnectedness.

In the following sections, the potential adverse effects of trade on health demand are identified, followed by an overview of how trade interacts with each of the building blocks of health systems. The four modes of service delivery described by the General Agreement on Trade in Services of the World Trade Organization (WTO) are used for this purpose: mode 1 or cross-border supply (e.g., the provision of diagnosis or treatment planning services in country A by suppliers in country B, via "telemedicine"); mode 2 or consumption abroad (e.g., movement of patients from country A to country B for treatment); mode 3 or commercial presence (e.g., establishment of or investment in hospitals in country A whose owners are from country B); and mode 4 or presence of natural

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persons (e.g., service provision in country A by health professionals who are nationals of country B) [10].

Finally, the limited scope of current global health governance arrangements is highlighted, asserting that the effective implementation of UHC will benefit highly from a more consistent commitment and stronger leadership by the WHO in protecting health in global policymaking fora in all sectors.

Trade Influence on Health Needs and Demand

A number of recent studies and empirical investigations infer a robust association between the process of globalization dominated by neoliberal economic ideas and policies of privatization, deregulation, and liberalization, and unsatisfactory health trends [11,12]. Trade can affect health outcomes via a very diverse number of direct and indirect pathways. Among them, income and its distribution, income inequality, economic insecurity, and unhealthy lifestyles link trade policy to social determinants of health and, often negative, health outcomes [5]. The following are a few examples of this complex interaction.

Trade is directly associated with the adoption of unhealthy "Western lifestyles" and a worldwide increase in chronic diseases, with a heavier burden for poorer countries. The global food industry has a direct role in the nutritional transition toward high-energy dense diets leading to the current obesity pandemic, and the growing burden and high mortality deriving from related chronic diseases [13]. The latter are equally associated with the tobacco industry and its aggressive marketing strategies, taking special advantage of the potential for growth in developing countries and pushing for increased consumption among already vulnerable population groups. Trade in alcohol follows similar patterns [14].

Hazardous wastes are globally traded and disposed in low-income countries, with highest exposure to the poorest populations [15]. The dominant development model, based on uncontrolled economic growth thriving on sustained consumption and waste, besides being unsustainable, produces increasing environmental degradation [16]. The result has been a steady increase in chronic diseases, and in some cases with irreversible transgenerational epigenetic change (i.e., changes in the genome activity that take place without modifying the DNA sequence, but may be transmitted to the progeny) [17]. In addition, related climatic changes have additional negative health outcomes, with the possibility of catastrophic epidemiological transformation [18]. The effects of privatization and trade of water promoted by international financial institutions is also the object of increasing concern in terms of reduced water security and water-related diseases [14].

Trade and investment treaties increasingly limit the policy space for public regulatory interventions to protect public health. International trade agreements are scarcely influenced by health concerns and may in fact prevent countries from regulating the import of health-damaging products (e.g., tobacco, alcohol, and unhealthy foods). Such measures are likely to be seen as trade restrictive under these agreements, which are managed under a highly structured and demanding governance system. In contrast, the global health governance domain exhibits little structural coherence, a greater diversity of actors, and weaker legal obligations on states [19,20].

Nevertheless, public health–oriented regulatory processes are possible and have been shown to be fundamental in limiting the trade and use of harmful substances. The Framework Convention on Tobacco Control led by the WHO is possibly the best example of how this agency can exercise its mandate for health through internationally binding instruments. Even international nonbinding "soft law" can limit commercial practices affecting health, as in the case of the WHO-UNICEF international code of marketing of breast milk substitutes, or recommendations concerning the formulation, nutritional labeling, and marketing of processed food [5,21].

Trade Influence on Health System's Building Blocks

Trade's interaction with health systems' supply capacity is usefully described by mapping WTO's four modes of trade in health services onto each of WHO's six "building blocks": service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership governance [9]. The interdependence and the multidimensional nature of the interaction between these blocks must, however, be kept in mind.

Service Delivery

Health services are tradable commodities under the WTO and other regional and bilateral agreements. Health is increasingly perceived as a private good at the mercy of the law of the market. The provision of health care through market relationships, investment in and production of services for profit, and health care finance by individual payment and private insurance, that is, "commercialized" health care [22], may increase the consumers' choice, but long-term dangers have been shown—such as establishing a two-tier health system, movement of health workers from the public sector to the private sector, and inequitable access to health care [14].

Opening up domestic markets to foreign direct investment (i.e., WTO "mode 3") and commercialized health care have been promoted by economic pressures and international policies since the 1980s, mainly through health sector reforms associated with macroeconomic structural adjustment programs imposed on indebted countries by the international financial institutions and donors. This has been accompanied by the dismantling of relatively equitable systems for social and economic provision [15]. Out-of-pocket payments, one of the most poverty-inducing forms of health finance, often became the rule in low-income countries. A comprehensive study conducted by the United Nations Research Institute for Social Development in 20 developing and transitional countries between 2003 and 2005 showed that unregulated commercialized health systems were highly inefficient and costly; they exacerbated inequality and provided poor quality, and at times, dangerous, care. Commercialization of primary care was also associated with the exclusion of children from both curative and preventive care [1,22].

Through "health tourism" (e.g., WTO "mode 2"—consumption of services abroad), an increasing flow of patients use elective health services in foreign countries, eventually in search of services unavailable or unaffordable in their country. Health tourism can promote the economic growth of destination countries and, potentially, reduce the emigration of their health workers in search of better opportunities. But by incentivizing the movement of health workers from rural to urban settings, and from public to private health care facilities catering to foreign consumers, private health care provision to "health tourists" can also worsen national residents' access to health services, especially of poorer groups less able to afford private care [20]. There are clear interlinkages between cross-border delivery of services through telehealth services (i.e., WTO "mode 1") and WHO's "information"-building block. These interlinkages are reviewed below.

Health Workforce

The WHO estimates a worldwide shortage of 4.3 million health workers; this constitutes a major barrier in many countries to the