Trade and Health: A Policy Paper

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Abstract

Globalization is manifested as increases in cross-border flows that have extended to health and health related goods and services, even in the absence of specific liberalization commitments. A proposed framework linking the international trading environment to health highlights the need for consistent trade-related health policies, and for strategic information to guide the policy process. Globalization poses several risks and opportunities that have to be managed in order to achieve health sector objectives. In the area of access to medicines, there is concern that obligations to the TRIPS agreement increase monopolistic tendencies and could contribute to the already high prices of drugs. Trade in health services could exacerbate unmet health needs or contribute to meeting supply shortfalls. As traditional medicine services and medicinal plants grow in trade value, there is increasing concern about its protection, and ensuring minimum quality standards for practitioners of traditional or alternative medicine. The net impacts depend on the regulatory environment, the requisite infrastructure to realize the gains, safeguards that government can put into place and removal of constraints stemming from domestic policies and laws that prevent us from taking advantage of flexibilities in trade agreements.

Keywords: globalization, trade-health policies

Introduction: The Imperative for Trade Related Health Policies

Globalization has brought about increases in cross-border flows which have extended to health and health related goods and services. International trade in

goods has grown as reflected by the lowering of tariffs, the removal of non-tariff barriers, and the liberalization of foreign exchange controls and capital controls. An example in the health sector is the increased variety and sources of food imports now available to consumers.

Flows have also changed with respect to structure. Cross-border flows of services, formerly considered as "non-tradeable" items, have become possible as developments in communications technologies eliminated the need for both supplier and consumer to be located in one place. The health sector has thus witnessed the development of "telemedicine," and "e-health," where consultation and diagnostic services are provided across country boundaries.

Movement of persons for travel and tourism has supplemented cross-border movements of persons for migration. As tourists from countries with relatively expensive medical services visit countries with less costly medical services, medical tourism packages have evolved to combine traditional tourist activities with medical interventions.

And, even as travel and tourism flows increase, migration flows of health personnel continue. These flows can be temporary in nature like the outflow of Filipina nurses for contract work in the Middle East. However, these can also turn into permanent migration, as Filipina nurses in North America eventually convert their working visas to more permanent residency status.

Increased cross-border flows have also stimulated the development of global institutions and sets of rules that govern the trading system, even as these institutions and rules have in their turn encouraged the growth of these flows. The World Trade Organization (WTO) was established in 1995, incorporating the trading rules of the General Agreement on Tariffs and Trade (GATT). In addition, the WTO agreement expanded to include multilateral trading rules governing international trade in services, the General Agreement in Trade in Services (GATS). The shift in dependence from physical capital to "intellectual capital" is reflected in the inclusion of the Agreement on Trade Related Aspects of Intellectual Property (TRIPS) as part of the WTO agreement. This introduced intellectual property rules into the

multilateral trading system for the first time. Parts of the WTO agreement are market access commitments in trade in goods and services.

Recognizing the benefits to trade, regional and bilateral trading agreements have sought to advance the opening up of economies beyond those indicated in WTO commitments. The Association of South East Asian Nations (ASEAN) is working toward the establishment of an ASEAN Free Trade Area (AFTA). The ASEAN Framework Agreement in Services (AFAS) signed in 1995 is aimed at substantially eliminating restrictions to trade in services in order to improve the efficiency and competitiveness of ASEAN suppliers. Working within the rules set out by the WTO, the liberalization of services trade under AFAS is directed towards the GATS-Plus principle, i.e., achieving commitments beyond member countries' commitments under GATS. Our membership in these regional trading agreements has not precluded us from engaging in bilateral free trade arrangements, for instance, the Japan Philippines Economic Partnership Agreement (JPEPA).

While the GATT and GATS agreements guarantee the Members' right to take measures to restrict imports and exports of products (service and service suppliers) when those measures are necessary to protect the health of humans, animals and plants or otherwise relate to the conservation of natural resources, there is really a preference for policies that would not unduly restrict trade or would pose significant trade barriers [1]. Our membership and accession to the rules-based trading system and to these regional trade agreements therefore places certain restrictions on how we use policies and regulations to achieve certain national objectives, including health sector goals and objectives.

Ongoing negotiations as part of the WTO and regional trading agreements also place additional pressures on the public sector to come up with its own requests and offers for specific commitments, as well as to assess other countries' requests for and offers of liberalization in health-related goods and services. Trade facilitation measures such as harmonization of standards and mutual recognition agreements place added burdens on the regulatory capacities of member countries.

Increases in cross-border flows have occurred even in the absence of specific liberalization commitments (especially in the health services sector). Opening up

of the sector as part of our trade agreements, for instance the AFAS, would further contribute to these flows.

Thus, globalization poses both risks and opportunities for the achievement of our health sector objectives. These risks and opportunities are varied and have to be managed in order to limit the negative effects on health and increase opportunities for health improvement and achievement of health sector objectives.

This paper attempts to contribute to the discussion of selected global health issues that carry potential impact on the health and quality of life of Filipinos. In particular, this paper (1) reviews current developments in the international trading environment including, but not limited to international commitments and WTO Agreements, specifically as they relate to the health sector, (2) reviews current policy and policy initiatives that are related to international transactions in health and health-related goods and services, and (3) identifies selected policy issues, policy gaps and policy options.

The paper is roughly divided into two parts. The first part begins by describing a general framework that can be used to identify and analyze the linkages between cross-border flows and health outcomes. Some key policy questions that can be used as a guide in policy formulation are identified and an overview of the various health aspects that are affected by trade policies is given.

The second part of this policy paper is focused on a more detailed discussion of three particular aspects: (1) trade and access to medicines, (2) trade in health services and (3) trade-related aspects of traditional medicine. They conveniently represent trade in goods and services, as well as "trade in knowledge" or intellectual property rights.

The policy options in this paper are couched in general rather than specific terms as the information on various cross-border flows related to health and the linkages between these flows and health outcomes remain to be collected, collated or processed in a more systematic manner. They should then be considered as initial steps toward drawing up more specific and concrete policies once the appropriate and specific information becomes available.

I. Linking Trade and Health Outcomes

A Conceptual Framework

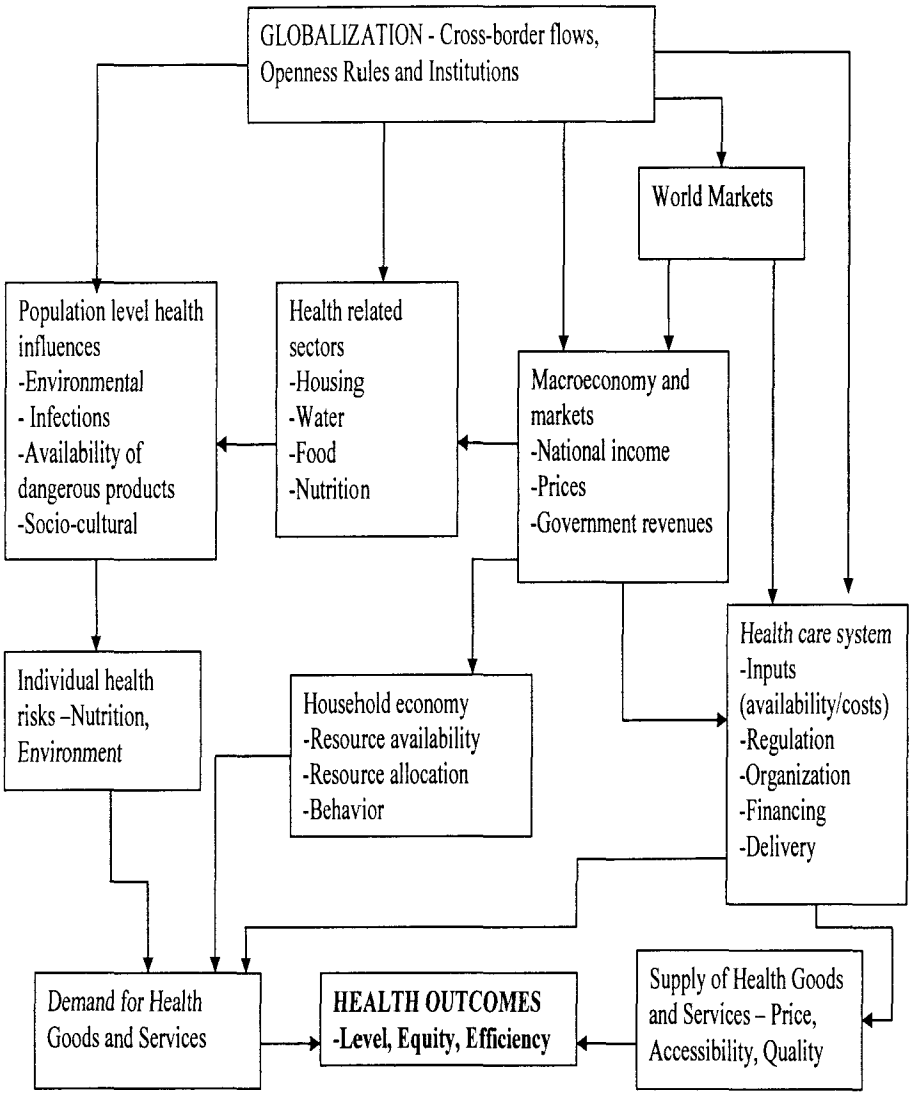
Before appropriate policy responses can be formulated, it is necessary to assess the health impacts of globalization and the pathways of these impacts. An analytical framework for understanding and analyzing the economic aspects of globalization and its health impacts is also necessary to inform the development of a research agenda that is more responsive to policy requirements.

I propose to adopt a conceptual framework as shown in Figure 1 adapted from Woodward, et al [2]. It posits that utilization of health goods and services that in turn determine health outcomes are the result of the interaction of demand and supply for these health goods and services. The effects of globalization must then ultimately work either through demand or supply factors. The emphasis on demand and supply as intermediate to outcomes highlight that trade effects work through consumer and provider incentives. Outcomes are the result of behavioral responses of consumers as well as suppliers of health care goods and services to these incentives. As such, policy responses aimed at altering incentives can be employed to influence outcomes.

The framework links globalization to health (operating through demand and supply) directly or indirectly. Direct effects include: (1) impacts on health at the population level such as the cross-border transmission of infectious disease through movement of people and goods, which in turn influence individual health risks, (2) impacts on the health system operating directly (e.g., effects of country specific commitments, migration of health personnel affecting available supplies, increased drug imports providing competition to local suppliers and manufacturers) and (3) impacts on the health system operating indirectly through world markets (e.g., the effects on pharmaceutical prices of the TRIPS). Globalization indirectly operates through (1) macroeconomic effects such as overall increases in national income, export revenues, remittances and reduction in inflation that get translated to increases in household real incomes, and (2) increased availability of government resources and reductions in exchange rates and input prices that get translated to increased real public spending on health and other social services.

A feature of the framework is that improvements in health and well-being should be the central objectives of policy. Particular policy proposals should trace the potential effects on health so that decision-making takes explicit account of the implications for health.

Figure 1. A Framework to Link Globalization and Health



Source:[2]

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This framework recognizes that indirect effects on health outcomes may be substantial and therefore should not be ignored in the reckoning of benefits and costs. This link also highlights some of the policy trade-offs inherent with the globalization process. For instance, should labor migration be encouraged given that worker remittances increase household incomes available for health spending and thus increasing utilization levels of health care or should it be discouraged as the quantity and quality of available health personnel supplying services decrease? Even among the direct linkages, increasing openness and globalization involves potential positive and negative effects on outcomes. For instance, opening up the health service sector to foreign patients and foreign providers may result in quality upgrading of facilities. However, significant portions of the population may be displaced by foreign patients or the increase in facilities may not significantly increase access to health care by the poor.

These trade-offs highlight the need for a unified policy making body to act on health and trade-related matters. Such policy-making body should have an overall view of the sector and would be tasked with coordinating the policy responses for trade-related issues. While the Department of Health can take the lead role in such a body, greater inter-agency coordination and even private sector participation are required. These are required as responsibility for general trade policies and negotiations for trade agreements may be primarily vested in other government agencies, specifically the NEDA-Tariff and Related Matters Committee (TRM), the DTI-Bureau of International Trade Relations and the Philippine International Trading Corporation in the case of imports of drugs. Other government agencies such as the Department of Foreign Affairs, the Philippine Overseas Employment Administration (POEA), and the Professional Regulation Commission (PRC) and

other private groups such as medical professional societies are also tasked with licensing and accreditation of service providers that could serve as barriers or constraints to opening up of the sector. A DOH Technical Working Group (TWG) on GATS and TRIPS has been created with the end in view of developing comprehensive and realistic offers and requests to trading partners[2]. The creation of the TWG is a good first step towards the crafting of trade related health policies and reflects that the current DOH leadership is aware of the urgency of these trade issues. Support for the work of the group should be forthcoming. However, mechanisms should be in place that would ensure that the findings and recommendations of the group are regularly transmitted to and discussed with the DOH leadership in order to ensure consistency of negotiating positions with avowed health goals, policies and programs. Mechanisms for greater participation of other concerned agencies should also be ensured.

The framework also recognizes that the health impacts may be unequal across consumers, and that effects are not limited to public sector providers. Further, private and public sector providers may be affected differently. For instance, the GATS exempts public sector services from coverage of commitments. Health impacts of migration and health tourism may be more keenly felt among private sector providers. Private participation in health sector service trade may be more feasible than public sector participation. Private-public sector initiatives may be warranted as the government may need to create an enabling environment for beneficial private sector participation, or adaptive policy measures to ensure that private sector participation does not compromise the achievement of health objectives. Executive Order 372 created a public-private sector task force for the development of globally competitive Philippine service industries. A component of this is the Philippine Medical Tourism Program (PMTP) aimed at attracting foreign clients for needed medical care and wellness services coupled with sightseeing and vacation packages.

Key General Policy Questions and Concerns

Since the pathways from globalization to health are varied and complex, policy formulation requires the collection and analysis of empirical evidence on the nature and strengths of the different linkages. Thus, a policy proposal of this paper is the identification of data necessary to monitor the impacts of greater openness and trade on health outcomes, the regular and systematic collection and collation of such data, and the processing of the data in a form useful for policy. The framework can be utilized as a tool to synthesize and organize the existing empirical evidence on these linkages, as well as to pinpoint areas where evidence is scant or lacking.

The following is a list of key questions that need to be answered by health policy makers in designing trade related health policies and in coming up with commitments and negotiating positions for international agreements in a health or health-related goods or services sector [3].

1. To what extent are cross-border flows and trade already occurring in the goods/service sector and what have been the impacts on the health sector? To what extent is the goods/ service sector already open to foreign competition?
2. What are the potential benefits and costs to further opening of the sector?
3. Would fostering trade and increasing international commitments fit the strategies and directions identified by national health policy?
4. Can commitments be crafted both to protect/fulfill health objectives and to liberalize trade progressively?
5. If trade is to be fostered and for its beneficial impacts to be realized, what constraints in terms of physical, human and regulatory capacities must be addressed? What barriers that prevent growth of trade and prevent realization of benefits must be removed?
6. If opening up and liberalization involve social costs, how can these be minimized?
7. What are the regulatory concerns posed by current trends and commitments? What are the effects (weaken, strengthen, neutral) of increased flows and commitments on regulatory approaches necessary for the protection and promotion

of health? What regulatory burdens would international commitments create for government in health and health related goods and services?

Overview of Health Aspects of Global Trade

As an initial step in identifying some of the linkages between the international trading environment and health, the actual and potential linkages between WTO agreements and health are presented in Table 1 [1]. Eight health issues are identified in the rows and the specific agreements that could impact on these issues enumerated in the columns. This provides an overview of the direct effects of globalization on the health systems and population level health influences. However, this matrix is by no means exhaustive. To particular health issues on this matrix we can add access to health care devices and technology, which would be affected by GATT rules and technical barriers to trade. As also noted, the trading environment goes beyond WTO rules and agreements.

Table 1. Relevance of WTO Agreements to Specific Health Issues
World Trade Agreements or Rules

Health issues:	Agriculture	Agreement on Sanitary and Phyto-Sanitary Measures	Agreement on Technical Barrieris to Trade	TRIPS	GATS	GATT (Article XX(b)	Others
Infectious disease control		X	X			X	
Food safety		X					
Tobacco control	X		X	X	X	X	
Environment protection		X	X			X	
Access to drugs and vaccines				X			
Access to Health services					X		X
Food security	X	X				X	
Emerging issues:							
-biotechnology	X	X	X	X			
-information technology				X	X		
-traditional knowledge				X	X		

Source: [1]

II. Selected Health Issues and Trade Policy Analysis

The relationships of the specific health issues with the different WTO agreements that affect them merit a separate discussion that space limitations do not permit. The next sections are therefore confined to a more detailed discussion of selected issues, i.e., access to medicines, health services trade and traditional knowledge.

A. Access to Affordable Medicines

Philippine drug prices have been observed to be one of the highest in Asia [4]. Branded off-patent medicines are observed to be more than double the price of the same medicines in India and Pakistan (Table 2).

These high prices imply reduced acess to medical care by the poor and the consequent irrational drug use as in use of ineffective remedies and improper dosages. Since people cannot afford the drugs they need, they resort to under-medication for essential drugs (such as antibiotics) and over-medication for the cheaper symptomatic preparations [5]. While cost and quality differences are emphasized by pharmaceutical companies as justifications for price variations across countries and within countries, international and local monopolistic pricing practices are also cited as reasons [6]. Roughly 70% of sales is accounted for by the big multinational companies who contract nearly 80% of their toll manufacturing to a single firm, Interphil Laboratories [5].

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Table 2. Comparison of Prices of branded off-patent medicines in different countries, 2004

Medicine	Manufacturer	RP	India	Pakistan
Ponstan 500mg tab	Pfizer	20.98	2.80	1.46
Buscopan 10mg tab	Boehringer	9.26	2.45	0.60
Bactrim 400/80mg tab	Roche	14.80	0.75	1.09
Adalat Retard 20mg tab	Bayer	37.56	1.50	3.85
Lopid 300mg cap	Pfizer	34.66	13.17	2.89
Lasix 40mg tab	Aventis	8.56	0.53	1.28
Plendil ER 5mg tab	AstraZeneca	35.94	5.95	8.25
Diamicron 80mg tab	Servier	11.00	7.57	5.00
Ventolin 100mcg inh	Glaxo	315.00	132.38	65.88
Voltaren 50mg tab	Novartis	17.98	0.92	3.92
Isordil 5mg SL tab	Wyeth	10.29	0.26	0.23
Imodium 2mg cap	Janssen	10.70	3.27	1.94
Fortum 1g inj	Glaxo	980.00	418.72	322.75

Source [5]

These monopolistic tendencies are heightened by patent protection. Patent protection is recognized as instrumental in promoting the invention, development and marketing of new drugs, by providing incentives for research and development. However, patent protection on products or processes grants exclusive right to the patent holder to manufacture the product or use the process, thus granting monopoly rights on the holder. As member countries of the WTO are obliged to introduce and recognize patent protection as part of the obligations to the TRIPS agreement, there is concern that TRIPS could lead to higher prices of drugs.

The extent of the price effects of patents depends in part on the proportion of drugs utilized in the Philippines that are still covered by patent protection. Nearly 80-85% of essential drugs are already off-patent [5]. Thus, adherence to the TRIPS agreement and its effects on prices should be a concern for the 15-20% of essential drugs that are currently on patent. A cause of concern would be newer drugs developed for emerging diseases such as pandemic influenza from the avian flu[3].

How can trade be utilized in order to achieve the objective of lowering drug prices and encouraging rational drug use? Imports of drugs can be used as a means to increase competition to local manufacturers in the sector to reduce prices for both off- patent and patented drugs. For imports to exert competitive pressure however, they should be of sizeable volume and value. The special policy concern regarding patented drugs would be the mitigation of the potential effects on prices of the TRIPS agreement. Flexibilities in the TRIPS agreements could be taken advantage of and policies regarding patent laws could be harnessed in order to reduce monopolistic tendencies.

The WTO TRIPS agreement is not entirely unconcerned about the potential health impacts of the agreement. Article 8 of the TRIPS states that:

> "Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development,...Appropriate measures, ..., may be needed to prevent the abuse of intellectual property rights by right holders or the resort to practices which unreasonably restrain trade or adversely affect the international transfer of technology."

Some of the key safeguards include [7]:

(a) Parallel importation - the importation of a patented or trademarked product from a country where it is marketed either by the right holder or with his consent. The rights of the right holder are deemed to have been "exhausted" or used in another country so that imports from that country are permissible,

(b) Limited exceptions to exclusive rights (Article 30) - This contains among others the "Bolar" or early working exception. This enables generic manufacturers to import or make patented substances while it is still on patent for the purpose of obtaining regulatory approval of generic sales. This enables the generic manufacturer to quickly supply the market with generic equivalents as soon as the drug goes off patent.

(c) Compulsory licensing[4] - When issued by a government authority, a compulsory license allows for generic competition while a product is still

on patent. Licenses can be issued to government agencies (government use) which constitutes another flexibility,

(d) Protection of data (non-exclusivity) – Although countries are required to provide some form of protection to data submitted for regulatory approval of pharmaceuticals, it does not require that protection be in the form of exclusivity.

The DOHA Declaration on TRIPS and Public Health sought to further clarify these flexibilities by stating that the "Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all." The declaration also reaffirms the rights of WTO members to use the provisions of TRIPS which provide flexibilities. These include paragraphs:

(5b)Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.

(5c)Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

(5d)The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

Paragraph 5b leaves to members the grounds for issuing compulsory licenses. Thus, members can use public health or public interest grounds, aside from the possible grounds listed in Article 31 of TRIPS such as anti-competitive practices and national emergencies. Paragraph 5c is important in that public health crises can be considered as national emergencies thereby allowing for the granting of compulsory licenses when provided for under national laws. Reference to the particular diseases implies that emergencies may be chronic and therefore not limited

in time. Paragraph 5d reassures members that it can apply an international exhaustion principle [7].

Barriers to the taking advantage of the TRIPS flexibilities are the absence of national laws and appropriate rules regarding compulsory licenses, parallel imports and national emergencies. The TRIPS flexibilities per se do not automatically translate to national laws and thus do not protect government from suits or complaints when it decides to use the flexibilities. Domestic regulations may in fact be barriers to such flexibilities.

A domestic regulation that served as a non-tariff barrier for parallel imports was the Special Counterfeit Drug Law of 1997 (RA 8203). The original implementing rules of the law stated that unregistered imported drug products that have counterpart registered brands in the Philippines shall be considered as counterfeit. The implementing rules and regulations have since been amended.

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Recently, Senate Bill 2139 was filed to amend the Intellectual Property Code of the Philippines by incorporating rules on early working or Bolar provision, providing a clear and legally secure framework for parallel importation, providing legal protection for government officials involved in parallel importation and shielding parallel importations from temporary restraining orders or injunctions. Included among the proposed amendments is a provision that would consider new uses of molecules or compounds of a patented invention like drugs and medicines as part of the original patent. New patents cannot be applied for previously patented drugs or processes to cover newly discovered benefits, thus preventing the prolongation of

the period of protected and monopoly position in the market. In a recent forum sponsored by the Intellectual Property Office of the Philippines[5], intellectual property experts warned of "frivolous patents" such as those regarding new packaging of drugs or new dosage forms and patents on secondary uses.

As this bill seeks to remove some of the barriers to taking advantage of the TRIPS flexibilities, it should, in principle, be supported and endorsed by health policymakers and the members of the Senate Committee on Health subject to a thorough study of all of its provisions and their implications.[6] Efforts to prevent powerful lobbies from subverting the bill should be encouraged.

The Philippine International Trading Corporation (PITC) was tapped as the lead implementing agency for the government's parallel importation program for pharmaceuticals in 2001 and was eventually designated as the lead coordinating agency in ensuring that quality and affordable medicines are accessible to all.[7] Initial efforts were directed at supplying government-owned hospitals and facilities at both the national and local levels. However, data indicate low participation rates among LGUs and DOH-retained hospitals in parallel drug importation [8]. Between 2001 and 2004, sales from imported drugs reached P 502 million or one fifth of a percent of the total pharmaceutical industry [9]. About P 130 M of these were sold directly to DOH retained hospitals, P 40 M to the Botika ng Barangays, and about P 332 M were directly sold to local government units [5]. From 2002-2004, only about 129 local government units participated in the program comprising of 47 provinces, 37 cities (out of the 113 cities in the country) and 45 municipalities (out of 1,496 municipalities).

Expanding drug sales to LGUs would require overcoming the lack of information among LGUs of the facility, as well as the perception that these drugs are of inferior quality [8]. Wider dissemination of information on the quality, safety and efficacy of these imported products may be warranted. Manuals of procedures would also be helpful inputs to local government units wishing to avail of parallel drug imports. Measures to ensure the quality of drugs imported would also be useful in demonstrating the quality and efficacy of the drugs.

Even as parallel drug imports provide price reductions on the cost of drugs, coursing the drugs through the dominant single company on drug wholesaling and

distribution, Zuellig Pharma, and the dominant single company in drug retailing, Mercury Drug chain, could erode price reductions as these firms charge distribution and retailing mark-ups [6]. Initiatives such as the Botika ng Bayan program of the PITC provide for an alternative distribution network as well as a way to tap the private sector. The Botika ng Bayan program seeks to accredit privately-operated retail drugstores nationwide to carry a full range of branded and generic, over the counter, or prescription drugs supplied by the PITC, including those that are parallel imported.

Encouraging participation of small retail outlets in the program and sustaining its viability entail generating enough demand for their drugs sold in these outlets. Wider dissemination of information on the presence of a Botika ng Bayan and on the comparative drug prices between Botika ng Bayan outlets and other outlets should be pursued. The other measure that would indirectly support demand generation is ensuring the quality and efficacy of the drugs supplied to these outlets. As these drugs are proven to be of the same quality, consumers would prefer to purchase these drugs at the Botika ng Bayans rather than the established retail giants.

The provisions of EO 442 mandate the Department of Health (DOH) and the Bureau of Food and Drugs (BFAD): (1) to ensure the quality of the medicines sourced and imported by PITC, (2) to establish express lanes for licensing of retail outlets "subject to BFAD's capacity," and (3) to facilitate registration of new products to be sourced/imported by PITC "subject to BFAD's capacity." BFAD has been tasked with ensuring that all batches of parallel imports undergo the BFAD standard laboratory tests prior to shipment, upon arrival in the Philippines and while the product is on sale in the market. The importance of this task cannot be overemphasized as one of the downsides of parallel importation is the danger of importing counterfeit drugs from foreign companies that are beyond the full regulatory control of the Philippines.

From the provision of the law, it also appears that expanding the number of Botika ng Bayan depends in part on the length of time it takes BFAD to process applications and license retail outlets. Thus, it would seem that increasing BFAD's capacity would be a factor to ensuring the program's success.

While the PITC has been designated as a lead agency for parallel drug importation, what it is currently undertaking is not parallel drug importation in the true sense of the word, i.e., importing patented drugs from a third country. Current drug imports of the PITC are branded off-patent drugs and not currently in the parallel drug import watchlist. This practice is seen as a strategic move to highlight the fact that the same branded off-patent drugs are cheaper elsewhere [5].[8] Resource constraints may also be behind this strategy. However, to further reduce prices, the PITC should consider importing good quality generic drugs and perform true parallel importation for those essential drugs that are still patented and distributing these among the Botika ng Bayan. Sustainability of this move should come from a stricter enforcement of the 1988 Generics Act such that generic drugs are readily sold and consumed.

B. Health Services

The GATS creates the legal framework for international trade in nearly all types of services. Excluded among services covered are those supplied in the exercise of government authority, defined as those that are provided neither on a commercial basis nor in competition with one or more service suppliers (Article I:3(c)). However, as governments co-exist with private health care providers, and commonly provide similar services and charge user fees, the scope of this exclusion remains ambiguous.

The GATS distinguishes between four modes of supplying services:

(1) Mode 1: *Cross-border supply* is defined to cover services flows from the territory of one Member into the territory of another Member. Health services falling under this mode include the shipment of laboratory samples, diagnosis and clinical consultations via telecommunications or mail.

(2) Mode 2: *Consumption abroad* refers to situations where a service consumer, such as a tourist or patient, moves into another Member's territory to obtain a service. Consumption abroad also covers movements of health professionals and students receiving medical education services abroad.

(3) Mode 3: *Commercial presence* refers to situations when a service supplier of one Member establishes a territorial presence, including through ownership or

lease of premises, in another Member's territory to provide a service. Health service examples include the establishment of hospitals, clinics, diagnostic and treatment centers and nursing homes, and foreign health insurance companies establishing branches here.

(4) Mode 4: *Presence of natural persons* consists of citizens of one Member entering the territory of another Member to supply a service, e.g. doctors, nurses, physical therapists and other skilled and trained professionals. Mode 4 services strictly cover only temporary movements of persons.

Trade in one mode may involve trade in other modes. Interaction of Mode 3 and Mode 4 is exemplified by the hiring of foreign consultants and managers to manage foreign-owned hospitals. Mode 3 and Mode 2 are related as foreign-owned hospitals cater to foreign patients.

Table 3 summarizes the Philippine commitments under GATS relative to other Asian countries. Only Singapore, Malaysia and India have made specific commitments in health services. They are major players in health services trade in Asia especially in Mode 2 [10]. Thailand, though it has not made any commitments, is also a major player. The Philippines and India, however, are major players in Mode 4 for health professionals.

Similar to the case of Thailand, health service trade is already occurring in the Philippines even as we have not made any commitments under any of the modes for health services under the GATS. However, under the ASEAN Sectoral Protocol for the Integration of Health Services, measures are to be pursued by Member states in order "to enable the progressive, expeditious and systematic integration of the health sector." Some of the measures identified include the setting up of clear targets and schedules of service liberalization for priority sectors towards achieving freer flow of trade in services by 2010, the acceleration of mutual recognition arrangements (MRAs)[9] and acceleration of the completion of MRAs to facilitate free movement of experts, professionals, skilled labor and talents in ASEAN taking into account Members States' domestic laws and regulations.

Table 3. Specific Commitments under GATS

	Philippines	Thailand	Singapore	Malaysia	India	Indonesia
Accounting and Finance			X	X	X	
Advertising		X	X	X		
Legal	X					
Architectural and Engineering		X	X	X	X	X
Telecommunications		X	X	X	X	X
Audiovisual		X	X	X	X	
Construction/Engineering			X	X	X	X
Distribution		X				
Education		X				
Health		X	X	X		
Travel and Tourism		X	X	X	X	X
Recreation/Culture/Sports						
Transportation	X	X				
Courier		X				

Source: [10]

These measures highlight the urgent task of coming up with offers and requests based on health policy objectives. The key question that should be answered is whether trade in health services would, in the net, be instrumental in achieving health sector goals and objectives. Note that trade in health services means not just "exports" but also "imports" of services. *An analysis of the costs and benefits of engaging in the various modes of trade should be vigorously pursued.*

The net impacts of trade in health and health related services depend on the specific national health care system, the regulatory environment, the measures adopted toward trade restriction or facilitation, the requisite infrastructure to realize gains, and the safeguards governments put in place. Some of the opportunities, risks, and barriers accompanying trade in health services identified in the literature are discussed in turn for each of the various modes.

Mode 1: Cross-border supply

Major advances in communications and electronic technologies, as well as their decreasing costs, have facilitated the growth of "telehealth" and "telemedicine" services under Mode1 trade. Telehealth has been broadly defined as the "integration of telecom systems into the practice of protecting and promoting health" while telemedicine "incorporates these systems into curative medicine" [11]. These services are provided using interactive audiovisual and data communications services. Telehealth services include telepathology, teleradiology, telepsychiatry, telediagnosis, survelliance and consultation services.

Most of the applications of telemedicine are still limited within national systems an example of which is the UP-PGH Telehealth Center, and from developed countries to developing nations, such as service flows provided by US hospitals to hospitals in Gulf countries and Central America.

The delivery of health services through telemedicine can be utilized to increase care to remote and underserved areas. They can also address human resource constraints as providers need not be physically present in some areas in order for diagnostic and curative care to be delivered. Quality of care differences can be addressed as better quality diagnosis and treatment can be had from online providers. It can also be utilized to update medical education via teleconferencing and online courses, and can be used to reduce migration of health professionals for training purposes.

To take advantage of its benefits, the requisite telecommunications infrastructure, computer hardware and software should be available especially at the receiving end of the service. These would require substantial investments and resources which could be at the expense of public investments in basic preventive and curative care. These cost considerations should be weighed carefully before going full-scale into telehealth services. An inventory of the reach of telecommunications infrastructure, electricity lines and internet access may be instrumental in estimating the resource requirements necessary to enable access to telehealth or telemedicine services. Some pilot tests and studies can be conducted, perhaps just even within the country, where those in high quality, specialized centers

can provide diagnostic and simple curative services to remote areas. The results would indicate whether telehealth and telemedicine can be cost-effective means of delivering better quality services.

Aside from the preference of patients to be seen and physically examined by their physicians, some other barriers to the growth of this mode of trade concern issues with privacy of patient information, recognition of licenses and standards, and liability issues. In this regard, it is a "buyer beware" market unless care is accessed from reputable providers. If the Philippines were to start providing telehealth services to residents of other countries, it may be worth it to set up an accreditation system for online providers, albeit for a limited number of services.

Mode 2: Consumption Abroad

Increased movements of patients abroad for medical care are attributed to several factors. Increasing medical care requirements of ageing populations is one. These requirements are not adequately met as some countries experience shortages in selected health professionals such as nurses and caregivers. Higher costs of treatment and relatively long waiting times for selected procedures drive patients to seek care from countries where such care is cheaper and waiting times not as long. Poor health facilities in some developing countries drive the affluent from those countries to seek care from developed country hospitals or in neighboring developing countries with improved medical technology, better medical facilities, and higher quality standards [10, 11].

To make the utilization of health services abroad more attractive, medical services have been packaged with tourism services such as holidays and sightseeing tours, hence the development of "health or medical tourism" as a category of service flows. The World Tourism Organization includes services related to medical care, sickness and well-being, and rehabilitation and recuperation in health tourism.

In the Philippines, the Department of Tourism has been designated as the lead agency for the Philippine Health Tourism Program. The program includes medical care, health and wellness, traditional and alternative healthcare as well as long-term tourism and international retirement health zones (IRHZ) [12]. The last component

targets the retirees market where elderly foreigners move to countries where costs are lower and climates are better, and elderly returning nationals wishing to retire in their countries of origin.

The extent of Philippine participation in Mode 2 services, either as exporter or importer is not well documented. Surgical services including kidney transplantations[10], cosmetic services, dental services and lasik eye surgeries are among services currently accessed by foreigners in the Philippines. However, the number of services performed, as well as the revenues earned by both public and private sector from the provision of these services are not yet well documented. No registry of foreign patients exists. Outward flows of patients and financing are likewise not monitored. Further documentation of these flows is warranted together with an inventory of facilities that currently or potentially can cater to foreign patients. These would be helpful in monitoring the programs' contributions.

The benefits to encouraging trade in health services via consumption abroad have been noted in the literature [10, 11, 13, 14]. By generating foreign exchange earnings and providing additional resources for investments in the health sector, provision of services to foreign patients can result in improvements for the national health system. Facilities can be upgraded, skills and medical knowledge of staff can be updated, and technological capacities and health care standards improved. By generating additional demand for health care services in the country, services to foreign patients can be utilized as a "pull" factor to retain health human resources and personnel. Training opportunities for health human resources are also cited as advantages.

One concern with provision of services to foreign patients has to do with the possible emergence of or exacerbation of dual and exclusionary health systems with a higher quality, expensive segment catering to foreign patients and high income nationals and a lower quality, resource-constrained sector catering to the poor. Crowding out of the local population may result if services are not equally available to nationals. This is more likely if the incentives granted to participating facilities result not in the establishment of new facilities but in the conversion of existing hospitals and clinics that used to serve local patients to those serving foreign patients exclusively. Those crowded out of private facilities catering to foreign patients may

be additional burdens on public providers. The high resource costs necessary to bring facilities up to par to international standards may divert resources for public health purposes. Cost escalation due to investments in higher level technology may also result. Internal "brain drain" may also occur as doctors and other trained personnel move from rural areas to urban areas where the specialized centers are located.

These concerns center on several basic issues: (1) the extent to which public funds are used to subsidize health care providers who cater to foreign patients, (2) the degree to which the quantity and quality of services to the general population improves, and (3) the degree to which linkages with the rest of the health sector is maximized.

Resources needed to make health facilities attractive to foreign patients and to gain accreditation with foreign health systems and private health insurance firms can be substantial. Facilities would have to invest in good organizational management systems including quality and risk management, service management, human resource, service provider availability and facility management. Facilities should also provide for safe and appropriate environment for their patients that would ensure physical privacy, emergency and security systems, and appropriate external areas. Systems for managing health services would have to be put up including pre-entry systems, assessment of service delivery requirements, patient education, referrals to other health services and exit, infection control management, management of waste/hazardous substances, and discharge and transfer systems among others [12].

For the government specialty centers participating in the program, foreign financing and assistance or direct budget allocations and subsidies would have to be tapped for the necessary investments. These resources may otherwise be used to finance other public health investments. Thus, the terms under which the specialty centers participate in the medical tourism program need to be evaluated thoroughly. Cost-benefit analysis has to be undertaken. Potential revenue gains from foreign patients that could be used to reduce budget allocations in the future, increase subsidies to indigent patients or increase investments in facility upgrades should be carefully estimated. Appropriate pricing policies can be proposed to ensure that

subsidies accruing to foreign patients are kept to a minimum or at zero. Training opportunities for health personnel should be incorporated among the conditions for foreign assistance to the program. Conditions can also be included assuring that certain amounts of services and beds be allocated for the local population, or for certain numbers of local patients to be treated at reduced costs.

Subsidies for private sector hospitals participating in the health tourism program on the other hand, come in the form of tax and fiscal incentives embodied in the 2005 Investment Priorities Plan (IPP). Projects under the healthcare and wellness products and services include hospital services, medical and dental services, other human health and wellness services in the field of nursing care, rehabilitation and recuperation, spas, retirement villages and related services located either in identified medical zones or outside Metro Manila when catering mainly to foreigners and non-residents. Medical tourism facilities accredited by the Department of Tourism that may qualify for pioneer incentives or six-year income tax holidays are new tertiary or secondary care hospitals with a minimum capacity of 100 beds and an investment cost of at least $10 million. Other facilities qualifying for incentives are (1) primary care hospitals locating outside Metro Manila, Metro Cebu, and Metro Davao, (2) specialized services such as cancer centers ($ 6 million investment), (2) heart, lung and kidney centers ($ 1 million each minimum investment), (3) ambulatory surgical services ($2 million), (4) dental services ($ 1 million), and (5) retirement villages [15].

The design of the incentive schemes specify that these facilities cater mostly to foreign patients and non-residents. The potential for exclusion and crowding out of local patients is therefore a possibility and the beneficial effects on quality of facilities and personnel may not be forthcoming. To manage such risks, modifying the conditions for the grant of incentives should be explored. Tie-ups with local facilities for training of personnel and networking can be included among the conditions.

Focusing on elderly overseas Filipinos and returning migrants for retirement here may have the most potential to spread the benefits of medical tourism to regions outside Metro Manila. Most overseas foreign workers and returning migrants would most likely want to retire in their hometowns. For them to do so, they have to have some assurance that their health service requirements would be adequately

addressed and financed. This requires investments in facility and staff upgrading and equipment purchases. These are also necessary in order for the facilities to be accredited by international institutions which would pave the way for these facilities to be accredited by the insurance carriers of the retirees. One solution that has been suggested is to link these local facilities to a central hospital that can be accredited [10].

The establishment of health and retirement zones in areas outside Metro Manila can also be venues for infrastructure upgrade of local facilities. Investments in these zones are included in the 2005 IPP. However, one issue for investors seeking to infuse capital into some tertiary hospitals is the requirement that fifty percent of revenues should be from exports, i.e., provision of services to foreign patients, starting in the first year. This may prove difficult to accomplish as networks with foreign medical partners or markets abroad are still being established.

To address financing requirements for capacity and facility upgrades, foreign investments may have to come in as the local private hospital system is constrained by increasing hospital operating expenses, high levels of bad debts and uncollected accounts and scarce long-term financing options. However, the hospital industry is included in the Negative List of Foreign Investments. Foreign ownership is restricted to 40 percent by law. The possibility of relaxing the 40 percent ownership rule as part of the opening up in relation to Mode 3 services should then be explored. Other forms of investments can also be explored, including management contracts similar to the case of Asian Hospital and Bumrumgrad Hospital in Thailand.

Aside from the health facility challenges that must be addressed, other constraints may need to be worked on in order for health tourism to take off. Several agencies are currently involved in accrediting and licensing medical facilities for health tourism. A streamlined process may be necessary, with the possibility for a one-stop accreditation system. A "Gintong Sigla" seal has been proposed to designate accredited facilities for medical tourism [12].

Ensuring financing for health care services accessed here by foreign patients require that health care providers be accredited with international bodies utilized by health care insurers. However, the process for accreditation is a lengthy one, taking about two years to comply with the standard set of medical equipment and

services required of a tertiary hospital, plus about two to three more years after the visit by the accreditors. Thus, application for international accreditation needs to be worked into the medium and long term hospital plans [10].

Another issue that has to be addressed is the portability of insurance. Some public health systems in developed countries and even private insurance carriers do not cover the costs of treatment provided by foreign providers. Solving the accreditation problem partly solves the problem of portability. However, the portability of insurance coverage may be one of the requests that can be tabled for negotiations with countries that are targeted as sources of patients. In exchange for this, the Philippines may allow the establishment of branches of private insurance carriers.

The presence of adequate support facilities and capabilities are also essential to the success of the medical tourism program. One such support capability involves addressing the language barrier to partly lessen the costs of seeking treatment abroad.

Mode 3: Commercial Presence

Countries have become increasingly open to foreign commercial presence in the health care sector. Developing countries such as India, Indonesia, Nepal, Sri Lanka and Thailand have allowed collaboration in the health sector. Forms of collaboration include direct equity participation and joint ventures involving acquisition of facilities, management contracts and licensing arrangements. Local participation is sought to gain access to qualified and licensed personnel and markets. Joint ventures in health facilities are exemplified by the establishment of regional health care networks and chains such as the Gleneagles International, an international chain of hospitals developed by Singapore based Parkway Group through joint ventures with partners in Malaysia, Indonesia, Sri Lanka and India. Health education and training institutions are also potential areas for foreign commercial presence, where well-known medical and paramedical schools may establish joint ventures with local schools. Investment opportunities and joint ventures may also be open to firms involved in accreditation and medical standards. Some countries have also opened up their health insurance markets to some extent.

Discussion of foreign commercial presence in the Philippine health care sector is most commonly linked to the discussion of medical tourism. These arise as joint ventures target foreign patients as main clients. The interaction of Mode 3 with Mode 4 services involves contracting foreign based managers and other staff in these joint ventures.

Unlike Thailand and Indonesia, foreign commercial presence is relatively limited in the Philippines. As earlier stated, only 40 percent maximum foreign ownership is allowed in the hospital sector. Bumrungrad International was only able to enter the Philippine health care industry by way of partnership in the form of a management contract with Asian Hospital.

Discussions on whether or not to allow greater foreign participation in the sector has been brought to fore as a provision on ASEAN economic integration suggests 100 percent ownership of medical establishments to include general practitioner clinics, pharmacies, dental clinics and wellness centers by December 2008. The language has since been revised to "increasing foreign ownership" in the Jakarta meeting in June 2004 [16, 17, 18]. Inclusion of healthcare and wellness products and services among the priority areas for investment in the 2005 IPP implicitly recognizes the need for foreign investments in the sector.

The benefits to increasing commercial presence are similar to those related to consumption abroad. These include (1) the generation of additional resources for investment and upgrade of facilities, (2) the reduction of unemployment and underemployment of health personnel, (3) enabling the provision of expensive and specialized medical services and increasing the competitive capacity and productivity of health care services, and (4) generation of quality improvements through the introduction of improved management techniques and information systems.

Similar to the case of consumption abroad, foreign commercial presence can result in two-tier health systems. Investments may be in high end technology not suited to the broader needs of the population. Huge initial public investments to attract foreign investments may divert resources away from the public health system. Internal brain drain from rural to urban centers and from public to private facilities may aggravate shortages of health personnel and worsen distribution between rural and urban areas.

In drafting policies related to commercial presence, the following points regarding the GATS should be emphasized: (1) member countries alone may decide to allow foreign presence in some sectors; (2) a member country may decide to open only a sub-sector within the health system; (3) if a member country decides to allow foreign firms in a specific sector, it may or may not include it in its schedule of obligations under the WTO; (4) there is no requirement under GATS to grant national treatment, and (5) member countries retain their rights to formulate and enforce regulations that must be observed by all health service providers, whether foreign or national [13].

Some clarifications regarding these points are in order. While foreign firms can be allowed even without specific commitments, there may be reasons for including these commitments in the WTO or in other trade agreements. A country may specify a commitment to obtain similar concessions from other countries or because it wants to secure a more stable and legal environment needed to attract foreign investments in the sector. Thus, specifying commitments in commercial presence can be considered only when there are requests from other WTO members as a condition to investment. If such requests are not forthcoming, specific commitments may not be entered into.

Since national treatment is not required, special conditions and regulations can be imposed that foreign firms but not national firms may have to comply with. These pave the way for the suggested establishment of regulatory frameworks to ensure that benefits of upgrading are extended to all patients.[11] Further exploration and study on other possible arrangements that can be implemented may be warranted. However, such frameworks require capacities in enforcing contractual arrangements between the government and private health care establishments. If such policies are to be implemented, they should be applied to all foreign services providers, otherwise the country would be in violation of the most favored nation principle. Likewise, these policies should be transparent so as to prevent one of being accused of posing a disguised barrier to trade.

Member countries can formulate and enforce regulations that must be followed by all health care providers, foreign and national. There is no reason that foreign owned providers cannot be subject to licensing and accreditation requirements. If

there are fears that foreign providers cannot be regulated, it may be because of the absence of these rules and regulations. This is a policy gap that has to be addressed.

Our foreign equity ownership rules serve as barriers to foreign participation. However, liberalizing foreign participation need not require allowing 100 percent foreign ownership. Foreign ownership ceilings can be set at levels that allow for sufficient control of the enterprise.[12] The ceilings that can be recommended discussed with the participation of both private health sector stakeholders, interested foreign players and the government to arrive at a workable consensus. However, changing foreign equity participation rules may require the introduction of amendments to RA 7042 or the Foreign Investments Act of 1991. Section 8 of the law states that "amendments of List B may be made upon recommendation of the Secretary of National Defense or the Secretary of Health, endorsed by NEDA, approved by the President and promulgated by a Presidential Proclamation."

Other barriers mentioned in the literature include discriminatory tax arrangements, and quantitative limits on numbers, location, staffing and management of foreign establishments.

Mode 4: Movement of Natural Persons

Strictly speaking, Mode 4 services under GATS include only services provided by employees of service suppliers who are sent to render services to foreign-based clients or to self-employed natural persons who render services on a temporary basis. Thus, Mode 4 commitments do not apply to citizens who seek residence or employment on a permanent basis. Thus, permanent migration of health professionals is not within the purview of agreements covering Mode 4 services. However, the permanent migration of health professionals is also discussed in this section as the effects of permanent or temporary migration, especially long-term or recurring employment contracts in the latter, are similar.

The Philippines is considered as a major supplier of health professionals especially for nurses. According to the World Health Organization, the Philippines is the largest global exporter of registered nurses [19]. From 1992 to 2003, Filipino health human resources working abroad have been estimated at being close to

97,000, of which more than 86,000 are nurses [20]. There has also been a rapid increase in deployment of Filipino nurses in recent years. The POEA estimates that from 1992 to 2003, some 87,852 nurses have left the country [21]. The Philippines has also been mentioned as one of the five main source countries for nurses in the United Kingdom [22].

The benefits and costs for both sending and receiving countries of this mode of trade have been noted in the literature. Aside from substantial remittances, exporting countries could benefit through the increases in clinical knowledge and skills upgrading of the service providers, and increasing standards of health care in the sending country. Recent literature on the brain drain theorize that the availability of foreign markets result in increased investments in skills and an increase in the quality of students who enroll in health professional courses [23]. However, these benefits are conditional on the service providers staying and or returning to the home country. From the individual health care providers, it provides an opportunity for wage gain, personal development and skills training. At the macro level, Mode 4 service provider flows reduce unemployment in addition to the generation of foreign exchange remittances.

From the receiving country, inflow of foreign workers are important means to overcome personnel shortages, thereby improving access to health care services and containing cost pressures [11]. Savings in training and education costs constitute a form of "free riding." Receiving countries also benefit from migrant's flexibility of working, indicated by their willingness to be assigned to less desirable areas of work (example mental health services or night shifts) and less geographically desirable areas [24].

Adverse impacts of these service flows can be noted at various levels. Disruptions in family and marital relations occur at the individual and family level. At the health professional and health systems level, flows may lead to a reduction in the pool of skilled health workers, a depletion of trained medical staff and increased turnover of personnel. These can in turn affect health service delivery at the frontline and may have implications on the sustainability and quality of health programs in the community. At the national level, public subsidies to health personnel trained at government schools or health facilities are lost especially if the

temporary movement becomes permanent. Additional government resources are spent in training new recruits for vacated positions and retooling old personnel to take on new tasks [20].

The impact of migration on the health system depends on whether the exodus of medical professionals results in real shortages. While private hospitals warn of the impending medical care crisis due to staff shortages, labor officials claim that enough are being produced out of the educational system to supply these needs [21]. It has also been recognized that the Philippines systematically produce surplus nurses and medical practitioners for export to richer countries [25].

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The ambiguity of the net impacts of migration highlights the need for a careful assessment and possible estimation of its costs and benefits, as well as of the supply and demand for health professionals. However, data on Philippine health human resources is sadly inadequate. The Department of Health only monitors the number of health personnel that are employed in its retained facilities, therefore missing out on a significant portion of health service delivery. One of the main means of estimating the number of practicing physicians and nurses is through the count of licensees from the Professional Regulation Commission (PRC). However, as licenses are not regularly

renewed, this count may not be as accurate. Table 4 shows estimates of the distribution of health workers in the Philippines presented in a recent forum. As can be seen, there is a large number of health professionals, usually more than half of the estimated production, classified as being in "others." One may suspect that this is a catchall classification that should most likely be labeled as "unknown." Likewise, no estimates exist for several classes of health professionals (nurses included!) that are in the private sector.

Table 4. Distribution of Health Workers Produced in the Philippines, 1998

	Government	Abroad	Private	Others	Total
Nurses	9778	39174	nd	214959	263911
Dentists	1963	242	10513	18320	31038
Doctors	7671	495	18425	38546	65137
Pharma.	229	302	nd	28324	28855
Midwive	15893	1196	nd	103412	120501
MedTech	1560	2090	nd	2739	31046
OT/PT	76	3300	nd	2602	5978

Source: [20]

Some data on wage rates are available (Table 5). However, wage data is not sufficient to perform a more nuanced analysis of the pull and push factors in migration as well as the coping and adjustment mechanisms that are open to health facilities to ensure that service delivery is not hampered. Total compensation should be analyzed, including the value of benefits and training that are given health workers. Data on working conditions, time allocation, total compensation and productivities would also be necessary. As the movement of health personnel is expected to continue, serious thought should be given to the systematic and sustained collection of data on health human resources.

The pull from richer countries for migrant workers is expected to increase as their provision of health care expands and as their population ages. The demand for additional manpower would be exacerbated by pressures to reduce working hours in these countries. Large disparities in wages and compensation are unlikely to be addressed, and differences in living conditions are likely to persist in the medium term. Thus, policy makers would have to accept that migration flows would be

continuing. Policies to address migration must consider that freedom of movement is a human right. Policy issues center on protecting the health interests of the country in the face of migration flows [24-25].

Table 5. Average Monthly Wage Rates of Private Medical and Other Health Professionals, 1997, 1999 and 2002

	1997	1999	2002
Medical Doctors	8121	9813	12971
Medical Technologists	6168	6899	9898
PTs/OTs/SPs	5849	6633	9869
Professional Nurses	5849	6633	9869
Professional Midwives	5162	5817	9194

Source: [20]

From the Philippine side, policy responses could include those that would (1) improve strategies for attracting and retaining staff; (2) consider or allow other staffing strategies; (3) allow the entry of foreign suppliers or providers; (4) provide additional income through demand side strategies and; (5) provide more flexible employment options.

Strategies for attracting and retaining staff should consider not only wage benefits but also improvements in working conditions, educational opportunities and recognition. To a certain extent, migration can be viewed as a symptom of the deteriorating health system. Improvements in health systems could therefore provide a pull factor for health human resources.

Alternative staffing strategies entail the utilization of substitute health care providers for tasks usually performed by health professionals who usually migrate. These encompass proposals (1) to train low-level workers in the provision of basic preventive and curative services, (2) to expand training of certain health professionals to substitute for doctors especially in underserved areas, and (3) to utilize nursing aides and nursing assistants for some tasks performed by registered nurses [20]. The last proposal is being explored by a medical school with a hospital tie-up in Cebu. In anticipation of such a move, the medical school has proposed to offer courses for nursing aides and assistants.[13] However, enactment of such substitutions may currently be prohibited in the Professional Practice Acts. Other constraints include DOH mandated ratios of personnel for certain facilities. A review of the

provisions in the Professional Practice Acts that may serve to constrain such substitutions, as well as studies on the technical feasibility of such substitutions, should be undertaken. Studying the possibility of amending the acts should be the subject of further study and discussion with the professional associations and other stakeholders.

Recruitment of foreign health workers to take on jobs vacated by departing health professional has also been floated as a possible strategy. Currently, the practice of profession is limited to nationals. Article 12, Section 14 of the 1987 Philippine Constitution states that "the practice of all professions in the Philippines shall be limited to Filipino citizens, save in cases prescribed by law." The professional acts reiterate these provisions, limiting to nationals even the act of taking the board examinations unless a foreign doctor or nurse can show that Filipinos are allowed to practice medicine in their country ("reciprocity"). Special licenses may be issued to foreign doctors in cases of special consultations for definite cases, and to doctors attached to international agencies or organizations undertaking specific work for a definite time (e.g, medical missions). The reciprocity provisions also appear in the Nursing Act of the Philippines. While the "save in cases prescribed by law" provides a possible flexibility, the process of introducing these "special laws" or amendments to the existing professional acts may be lengthy and contentious.[14] A basic first step would be to hold consultations and discussion on these issues with concerned stakeholders such as the professional associations, private hospital owners, professional regulatory bodies and the Department of Health.

Some disagreement or opposition to the entry of foreign providers may be somewhat alleviated if it can be shown that they have the same if not superior training to our health professionals. Licenses can also be issued to nurses licensed in foreign countries if the requirements for licensing are basically the same as ours. Hastening the development of mutual recognition arrangements would be steps in this direction. A multi-agency body would have to participate in the process of evaluating the curriculum, licensing and other requirements for other professionals. This would include the specialty societies, the Commission on Higher Education and the Professional Regulatory Commission.

Any salary adjustment for government health personnel would have to go through the budget process. Additional budget has been recently sought to implement the provisions of the Magna Carta for Health Workers and to pay for 30 percent salary adjustment for DOH doctors and nurses [26]. Leeway for adjusting the salaries of local level health providers may not be as easy, especially for lower class municipalities. Thus, additional financing for health services provided in these facilities may have to be generated. One source that can be tapped is Philhealth reimbursements. Increasing enrollment in PhilHealth, especially for indigents can provide additional financing for health facilities which can then be redistributed as additional compensation for health personnel. Alternative compensation schemes such as bonus payments tied to the delivery of quality care can be explored. Aside from leveraging for quality, these can be means to provide additional compensation that can be significant pull factors for health workers.

The proposal to provide for flexible employment modes stems from the acceptance that migration is inevitable and thus should just be actively and responsibly managed [24]. This might entail arrangements where government workers who decide to work on temporary contracts abroad may be allowed to return to their employment (and position) at home once their contract expires. Bilateral arrangements or agreements can be made where these temporary migrants gain skills relevant to the country's needs on temporary contracts, with the proviso of returning home once their contracts expire. However, these may require strict enforcement, probably with the help of the recipient countries, as these government workers may no longer return to their previous employment.

Receiving countries save on training and educational costs of migrant health personnel, sending countries partly pay for these to the extent of the subsidies given to education and training of health personnel. The issue of reparations for these losses has therefore cropped up. Development assistance programs in the formulation and implementation of human resource development strategies covering migration policies can be means for giving back resources to the recipient countries. These may be developed with funding from aid agencies or development partners (especially the recipient countries for health personnel). This is a strategy that can be explored to assist in managing the migration process in the Philippines.

C. Traditional and Alternative Health Care: An Emerging Trade Issue

Traditional medicine was officially recognized by the WHO as a source of primary health care in the Alma Ata Declaration (1978). The Traditional Medicine Program of the WHO defined "traditional medicine" as having a long history and comprising:

> the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences, indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.

Why is traditional medicine emerging as a trade issue? While reliable data on expenditures on traditional medicine is scarce, the Secretariat of the Convention on Biological Diversity (CBD) has estimated that the world market for traditional medicines has grown from 5 to 15 percent [27]. Traditional and alternative health care has also been identified as a component of the Philippine medical tourism program (Mode 2). Companies providing health and wellness services as well as recuperation services and spas are qualified for incentives under the 2005 IPP. Interest of foreign companies in providing alternative or non-conventional treatments has been noted in the previous section (Mode 3). Traditional medicine as a health trade issue is recognized by the AFAS as it identifies measures related to traditional medicines and health supplements.[15] Traditional medicine is also one of the areas that is being considered as one of the services that would be offered in GATS.

As traditional medicine services and medicinal plants grow in trade value, there is increasing concern about its protection and ensuring a fair and equitable sharing of its benefits. Protection is sought against "biopiracy"[16] by entities that have technology or money to convert biological resources into commercially viable products without acknowledging knowledge in the country of origin. The most appropriate form of protection for traditional knowledge and medicine is still under much discussion and debate, involving international agencies such as the WTO, the CBD, and the World Intellectual Property Organization (WIPO). Such forms of protection would depend on: (1) whether traditional medicine is ancient or

contemporary; (2) whether it is codified or non-codified; and (3) whether it relates to products or processes [27].

The export potential of traditional medicinal herbs and supplements, the need to look at regulations for traditional medicine providers, the need to look into various means of safeguarding and protecting traditional knowledge and materials, and the need to consider offers and requests for traditional medicine services highlight the need for government to inventory and document traditional knowledge and materials, to inventory traditional and alternative medicine providers and to set accreditation and standards/processes for practitioners of traditional or alternative medicine.

At present, the Philippine Institute for Traditional and Alternative Health Care (PITAHC) is tasked with the formulation of codes of ethics and standards for the practice of traditional health care modalities, and the formulation of standards and guidelines for the manufacture, marketing and quality control of different and alternative health care materials and products for approval of the Bureau of Food and Drugs (BFAD). However, there are several obstacles that inhibit its performance; one of which is the lack of funds, the other being the lack of information among consumers on traditional and alternative health care.

The PITAHC has had perennial annual losses, thus requiring subsidies from the government to make their operations profitable. It had incurred net losses before subsidies of about P 33 million in 2001, P 32 million in 2002, P 31 million in 2003, P 34 million in 2004 [28]. This may be due to the fact that its four herbal processing plants are not turning a profit. Currently, PITAHC manufactures herbal medicine (Lagundi, Sambong and Tsaang-gubat), herbal teas, herbal ointments and herbal soaps. One possible policy option that PITAC can consider would be to stop its manufacturing operations and let private domestic pharmaceutical companies manufacture the herbal medicines instead. A licensing or franchising scheme could be explored where the license or franchise fees would be PITAHC's source of revenue. This would partially overcome its constraints of lack of marketing field staff and lack of marketing know-how. This would free PITAHC from the operational problems and it could just concentrate, together with the Bureau of Food and Drugs, on developing and enforcing the standards and processes for

manufacture of the products. Ceasing operations of the herbal processing plants would not be in violation of its mandate as stated in RA 8423, the Traditional and Alternative Medicine Act of 1997.

To make these manufacturers viable, there should be a ready market for the herbal medicine products. Sambong and Lagundi tablets are already available in NFA rolling stores. Hopefully, they would also be available in Botika ng Bayan and Botika ng Barangays. Information campaigns should be sustained to market the products to the public.

Information should also be sustained to correct misconceptions about traditional and alternative health care. However, these should simultaneously be conducted with the development, implementation and enforcement of standards, codes of ethical practice and accreditation systems of different traditional and alternative health care modalities. This would assure the public that there are "quality" providers of alternative health care and would differentiate the true practitioners from the "quacks."

III. Concluding Notes and Policy Recommendations

This paper has been an attempt to provide, in broad strokes, initial policies and steps with respect to trade related aspects of health. Various options and recommendations for three aspects have been discussed for trade and access to medicines, trade and health services and trade and alternative and traditional health care.

Several points can be emphasized from the analysis and discussion of the previous sections. One is the need for a unified body to come up with consistent trade related and health policies that would be aligned with the country's health sector goals and objectives. Such a body may be a multi-agency and multi-sectoral in nature, with the participation of stakeholders in the health sector.

The other is the need for more and better evidence to inform the policy process. This is apparent as trade in health and health related goods and services implies costs and benefits to the health sector that must be analyzed and monitored.

The third point is the fact that there are flexibilities in trade agreements that can be used to shield the local health sector from potential adverse effects of trade. However, constraints to the maximization of these flexibilities stem not from existing trade policies but from domestic health policies and other policies, e.g., intellectual property laws, themselves. Addressing such constraints therefore entail the review of domestic policies and laws.

To a certain extent, the potential adverse consequences of globalization stem not from globalization per se but from existing domestic distortions and conditions. Thus, the impact of trade on health would depend in large part on the policies that would seek to address these domestic distortions and conditions as well as the safeguards that the government can put into place.

Notes

[1] Assistant Professor, UP School of Economics. This paper was part of the World Health Organization (WHO), the Department of Health (DOH) – Bureau of International Health Cooperation (BIHC) and the Foundation for Integrative and Development Studies (FIDS) "Policy Development on Selected Global Health Issues" project. The discussion of the various aspects would draw heavily from the inputs provided by resource persons in the 2nd Global Health Forum conducted in October 2005. The author would also like to thank a referee for insightful comments made on the paper. All mistakes are solely the author's.

[2] Created by Department Order No. 1325 dated July 5, 2004 as amended by Department Personnel Order No. 2005-1333 dated June 30, 2005, the TWG has been tasked to: (1) review reference materials on GATS and TRIPS, (2) review current regulatory policies and requirements related to health services that may be deemed relevant or applicable to GATS and TRIPS, (3) review and evaluate the technical and economic impact of possible offers and requests on health services using different Modes of Supply under GATS, (4) coordinate with other concerned government agencies like DOF, NEDA, DFA, DTI, BOI, DOLE, PRC for consultations on various aspects of GATS and TRIPS, (5) develop and recommend offers and requests in the context of negotiations on health services related to GATS and TRIPS, (6) provide technical/briefing/materials/reports for international forums/negotiations or as required by DOH management, and (7) represent DOH in international and local meetings as may be designated by the Secretariat of Health or the Undersecretary of Health for Regulation/External Affairs.

[3] For instance, the drug indicated to be the most likely to be effective against human strain of the avian flu, Oseltamivir, is manufactured by Roche under the brand name Tamiflu.

[4] Compulsory licenses- when the authorities license companies or individuals other than the patent owner to use the rights of the patent — to make, use, sell or import a product under

patent (i.e. a patented product or a product made by a patented process) — without the permission of the patent owner.

5 1st Philippine Intellectual Property Rights and Public Health Forum, October 20-21, 2005, Intercontinental Hotel, Makati City

6 The provisions on authorizing only the government and its agents to perform parallel importation should be studied. Resource constraints of the government may prevent the achievement of sizeable volumes.

7 This was formalized with EO 442 designating the Philippine International Trading Corporation as the lead coordinating agency to make quality medicines available, affordable and accessible to the greater masses of Filipinos, dated July 4, 2005.

8 We also speculate that this may be related to the lawsuit filed by the Pharmaceutical and Healthcare Association of the Philippines (PHAP) against PITC claiming that their intellectual property rights have been violated.

9 Mutual Recognition Arrangements (MRAs) enables the qualifications of professional services suppliers to be mutually recognized by signatory member countries, hence facilitating easier flow of professional service providers.

10 Patients from Micronesian countries obtain transplant services from the The National Kidney and Transplant Institute.

11 Examples of such conditions include special provisions for the poor such as the assignment of a certain percentage of beds in new hospitals for free or at subsidized rates.

12 In an interview with a member of the TWG, it was mentioned that allowing about 49% foreign ownership may be considered as providing for sufficient control.

13 These were indicated in an interview with Dr. Kenneth Ronquillo of the DOH, October 2005.

14 This is evidenced by a recent position paper of the Philippine College of Physicians on HB03295 or the "Investments and Incentives Code of the Philippines" that objected to the opening up of the profession to foreign providers.

15 Included here are: (1) the exchange, review and analyze information in the existing regulatory framework/regime including standard definition, terminologies, and technical infrastructure in Member countries, (2) identify areas for possible harmonization and MRAs, (3) study the existing regulatory frameworks/regime of selected countries and internationally accepted technical guidelines, and (3) formalization of a post-marketing alert system for unsafe traditional medicine or health supplements.

16 Biopiracy refers to the privatization and unauthorized use of biological resources by entities outside of a country which has pre-existing knowledge. Particular activities covered by the term include commercialization of traditional communities' knowledge on biological resources, and patenting of biological resources. (http://en.wikipedia.org Accessed October 12, 2005)

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