Saturday 17 November 2001

BMJ

The World Trade Organization's health agenda

Opening up the health services markets may worsen health equity for the poor

At the World Trade Organization's ministerial conference held last week in Doha, Qatar, world trade leaders from the organisation's 142 member governments focused attention on a critical health issue. Trade ministers debated the flexibility in the organisation's agreement on trade related aspects of intellectual property rights (TRIPS) for countries to protect public health in emergencies. Such clarification is critical for developing countries to improve access and affordability of essential medicines for millions of poor people suffering from HIV/AIDS and other life threatening diseases. But access to essential drugs is not the only health issue affected by global trade rules. Agreements made by the organisation also shape national policies and regulations on issues ranging from food safety and imports of hazardous goods to duties on tobacco.

And there is more to come. The World Trade Organization's negotiations launched in 2000 to further liberalise trade in services under the General Agreement on Trade in Services (GATS) could increase the organisation's influence on financing and delivery of health care. In contrast with other agreements, GATS gives countries considerable flexibility to decide which service sectors to open to foreign competition and to set limits on access to markets. About 60 members of the organisation have already made commitments related to market access in health services. Few of these represent any loosening of existing national policy. But that could change, as the intent of the current GATS negotiations is to "deepen and widen" sectoral commitments.

Some of the proposals under negotiation regarding GATS indicate that developing countries will be asked to open up health service markets to foreign competition. In some cases this could improve the efficiency and quality of health services. But experience in middle income countries indicates that foreign competition in health service markets tends to worsen equity in financing and reduce access to care for the poor. Even when competition between public and private health providers raises quality, it primarily benefits the well off and concentrates on high end care, which has higher profit margins.[1] In Thailand the entry of foreign owned private health providers has lured physicians away from the public sector, increasing shortages of staff and unequal access to care by different socioeconomic groups.[2] Multinational firms with contracts to manage public hospitals in Argentina have sought to reduce the proportion of uninsured patients.[3]

BMJ 2001;323:1139–40

Some argue that such risks to health equity arising from trade liberalisation can be reduced through regulation, and that GATS explicitly recognises the right of the World Trade Organization's members to do so.[4] But health regulatory systems are weak or non-existent in most developing countries and where they exist, enforcement is limited or ineffective.[5] GATS negotiators could make regulation in the health sector even more difficult if they restrict the ability of governments to limit foreign entrants or require regulations to not unduly hinder trade. These proposals, currently under discussion in the organisation's GATS council, would apply to all service sectors including health, even if governments did not make commitments to open up health service markets.

Even if members of the organisation choose not to liberalise trade in health services, health care is directly affected by other sectors that are the focus of current negotiations. Financial services, which includes health insurance, is one.[6] The United States and the European Community have proposed that members of the organisation grant greater market access in financial services, by eliminating or relaxing restrictions on investment by foreign companies—commercial presence, in GATS parlance.[7] The health implications of such decisions rarely occur to trade negotiators. For example, as part of its negotiations to join the World Trade Organization, China agreed to open up its market to foreign health insurers without assessing the impact on efforts to broaden social health insurance coverage. Private health insurers in Latin America, including those that are foreign invested, compete by selecting the healthiest people and dumping high cost patients on to the public sector.[8]

The agenda of developing countries for liberalisation of services trade includes proposals to ease the way for temporary employment of professionals from less developed countries in more developed ones.[9] Developing countries see their skilled labour as a competitive advantage in the global economy and therefore want barriers to such trade reduced. As professionals in all sectors would be covered by such a change, this could, however, increase the medical brain drain and aggravate shortages of health personnel in source countries.

In view of the risks to health equity and access, the negotiating positions of members on GATS should be informed by evidence about the effects on the health system of liberalisation of services trade and trade policy. Yet there are almost no empirical studies on the

impact of reducing trade barriers on health equity, efficiency, access, or quality.

More immediately, health policy makers and practitioners can take advantage of the raised consciousness of trade ministers, following the meeting in Qatar, about the importance of trade policy to health. After trade related aspects of intellectual property rights and access to drugs, the next major health issue on the agenda of the World Trade Organization may well arise in the course of negotiations on trade in services. Health professionals need to work with trade officials to minimise the risks to health equity from liberalisation of services trade, and ensure that any resulting economic gains in health related service sectors generate tangible public health benefits.

The opinions expressed in this editorial are solely those of the author and should not be interpreted as those of WHO.

Debra J Lipson *health policy analyst*

Department of Health and Development, World Health Organization, Geneva, Switzerland (lipsond@who.int)

1 Kirchheimer B. Global ambition: US for-profits staking claims in Europe, South America to capture share of growth markets. *Modern Healthcare* 2001;31:30-33,36.
2 Sitthi-amorn C, Somrongthong R, Jangaroen WS. Some health implications of globalization in Thailand. *Bull WHO* 2001;79:889-90.
3 Stocker K, Waitskin H, Iriart C. The exportation of managed care to Latin America. *N Engl J Med* 1999;340:1131-6.
4 Adlung R, Carzaniga A. Health services under the general agreement on trade in services. *Bull WHO* 2001;79:352-64.
5 Chollet D, Lewis M. Private insurance: principles and practice. In: *Innovations in health care financing*. Washington, DC: World Bank, 1997.
6 Lipson DJ. GATS and trade in health insurance services. Background note for WHO Commission on Macroeconomics and Health. www.cmhealth.org.
7 WTO document S/CSS/W/27 (US), 18 December 2000, and S/CSS/W/39, 22 December 2000 (EC). www.wto.org
8 World Health Organization. *World health report 2000. Health systems: improving performance*. Geneva: WHO, 2000:10-2.
9 WTO document S/CSS/W/12, 24 November 2000; and Colombia, S/CSS/W/97 and S/CSS/W/98, 9 July 2001. www.wto.org

National smoking cessation services at risk

They are effective and cost effective and must be made permanent

Twenty two years ago Russell and his colleagues showed the effectiveness of brief advice from doctors in persuading smokers to stop,[1] but only in the past few years has treatment for dependent smokers finally been taken seriously. Treatment services have been established throughout the NHS and are an integral part of the government's plans to reduce deaths from coronary heart disease and cancer.[2] Smokers are now offered behavioural support to stop plus NHS prescriptions of nicotine replacement therapy or bupropion, treatments shown to be effective by a huge body of research and based on national clinical guidelines.[3] These services have achieved impressive throughput and success rates, but they are now under threat because of the government's failure to confirm their future funding.

In England between April 2000 and March 2001 about 127 000 smokers set a quit date and 48% of these stopped at one month. This has been achieved by just over 500 new staff[4] and at a total cost of £21.4m.[5] Using these figures and conservative assumptions, Stapleton has calculated the cost effectiveness of the new services at just over £600 per life year gained for treated smokers aged 35-44 and £750 for those aged 45-54.[5] These estimates are consistent with estimates published with the original national guidelines.[6]

Helping smokers to stop is thus one of the most cost effective interventions in the NHS today. Statin therapy to lower blood cholesterol concentrations ranges from about £4000 to £13 000 per life year gained,[7] and judging from the first 22 interventions assessed so far by the National Institute for Clinical Excellence, £30 000 per life year gained is emerging as a guide level for recommending new treatments.[8]

This outstanding cost effectiveness means that treating tobacco dependence will release resources for other uses, and relatively quickly. For example, the risk of myocardial infarction or stroke falls by around a half within the first two years after stopping smoking,[9] and the potential savings to the drugs bill if more smokers stop is considerable. Over 80% of patients currently prescribed statins would fall below the threshold for needing these drugs if they stopped smoking,[10] yet in 2000 the NHS spent about 12 times as much on statins as on smoking cessation.

The development of NHS smoking cessation services also means that general practitioners can now raise the issue, give brief advice about stopping, prescribe a pharmacotherapy, and refer to the local service, rather than spend time trying to meet all the needs of smokers trying to quit.

Establishing new treatment services nationally in three years is a remarkable achievement, reflecting the dedication and professionalism of those now delivering them, as well as the government's commitment to preventive medicine through its allocation of new funding of about £20m a year. This effort and investment must not be wasted, and these services need to be embedded permanently in the NHS. Unfortunately this may not happen unless action is taken now.

The ringfenced funding for these services will end in March 2002. Almost all staff involved in running them are on fixed term contracts, and some have already left or are starting to look for new posts. One (far from atypical) smoking cessation coordinator has told us, "One of our project workers left in July, and another is currently applying for other jobs. And I have

BMJ 2001;323:1140–1