Globalizing Health Services: A Policy Imperative?

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Abstract

This paper's thesis is that international trade agreements, U.S. health system characteristics, and global economic conditions will lead to the globalization of health services. Drawing on political, economic, legal, and globalization literatures, propositions about the impact of these domains on health services' globalization are advanced. The paper argues that U.S. health services are no less immune to globalization pressures than U.S. manufacturing or other services without regard to trade agreements negotiations. Health services may actually be more subject to globalization, but U.S. providers should not assume that gains from globalization will necessarily accrue only to the US. The paper concludes with unanswered globalization questions, proposes a possible arena in which U.S. health services would have comparative advantage on the world market, and suggests that policy makers and trade negotiators understand the implications of trade agreement on U.S. health services.

Keywords: Globalization, Trade in services, International trade agreements, Healthcare, Trade liberalization

"All politics is local," (Thomas P. [Tip] O'Neill, Jr., former Speaker of the U.S. House of Representatives).

1. Introduction

For many in the U.S., health services and politics have one thing in common: both are delivered locally. People go to their local doctors and hospitals, and their major concerns are the local impact of political decisions. U.S. public policy debates over the appropriate place for market and government solutions in health services delivery and cost control are often fractious, but neither within nor between U.S. political parties is there much question that health services are local. However, other professional services such as education, accountancy, and law are moving rapidly toward globalization, and globalization processes in those professions are understood (Beke, 2010). In trade union countries such as the EU countries, it is necessary to consider cross-border services along with health services reforms, but these concepts are little understood in the US.

This paper develops the thesis that free trade agreements, coupled with current trends in the U.S. health services system and current economic conditions, may promote and accelerate the globalization of health services despite developed country efforts to the contrary. Policy decisions aimed at limiting globalization, e.g., prohibition against reimportation of pharmaceuticals to the US, are unlikely to do more than slow the process. Globalization, in turn, may constrain all democratic societies' abilities to make market vs. state sponsored policy trade-off choices due to international enforcement of trade laws. However, countries taking actions now will be in better positions to control their global market place stances and to avoid future situations over which they have no choice. To make this argument, the paper draws on the globalization, legal, health services, and economic literatures. It argues that U.S. health services are no less immune to globalization pressures than manufacturing or other services providers, and actually health services may be more subject to globalization because of non-trade related factors. In addition to reviewing the pressures for globalization emanating from international trade negotiations, the paper shows how national trends in health services may be contributing to the pressures for globalization and how the U.S. economic situation may exacerbate those pressures. Specifically, based on current U.S. health services trends, current economic situations, and the trade related activities of nations and supra-national entities, propositions about the likelihood of U.S. health services and globalization are advanced. The paper is thus organized into the following broad sections: a first section that reviews the major points of the critical and economic literature on international trade and globalization; a second section that discusses how trends in U.S. health services, U.S. labor and insurance costs, and developments in other countries' trade in

services all contribute to the possibilities of globalization in health services; a final section that asks the remaining question, draws conclusions, and suggests areas of possible global competitive advantage for U.S. health services.

This paper is topical for policy makers because it shows how national initiatives and policies may interact with economic conditions and trade law to change the probability that a specific sector, in this case health services, will be globalized. Researchers may find the paper of interest because it contributes to the on-going free trade policy discussion without being an analysis of the possible benefits accruing to nations from globalization or a discussion of how those benefits will be distributed. Health services providers will be interested because the paper suggests ways that they might develop competitive positions in the world market. Patients and U.S. tax payers will find that the paper questions some of the basic assumptions made about U.S. health services delivery, and points toward ways of controlling the amount spent on health care in the US.

2. Conceptual Framework

2.1 Globalization

Global cross-border trade in services was about $3.5 trillion in 2008, and has grown in each of the past 10 years (World Trade Organization, 2010). Total world trade in merchandise and services was about $15.7 trillion, so trade in services represents almost 23 percent of world trade, up from only about 20 percent of 2005 world trade (Hoekman, 2006). Even so, international trade in services is a relatively new concept. With a few exceptions, until the advent of recent new technologies, services were provided and consumed locally. Public monopolies (e.g., education and telephone services), access regulations (e.g., license or credential requirements in various professional services), and the need for direct physical contact (e.g., in healthcare), also contributed to the low level of trade in services (Adlung & Carzaniga, 2001). However, with advances in communication and transportation technologies, many barriers to trade in services are rapidly falling. New telecommunication technologies and the Internet make information dispersion and scientific discoveries across long distances easy. Telemedicine makes diagnoses across thousands of miles as easy as emailing a medical record across those miles. But despite rapid incursions by globally oriented health services companies such as Singapore based Parkway Group, already with two U.S. offices, in the US, most health services organizations remain locally oriented and view competition from a local, regional, or at most a national perspective.

"Globalization" is much used in the popular press, but it may be unclear to some. Here, globalization means the reduction or elimination of "barriers—whether technological or legislative—to economic exchanges between nations" (Ethier, 2005). Among the results of globalization are free (or freer) world trade in goods and services. In the ideal, globalization would eventually result in a worldwide common market in goods and services, including health services. Since World War II, globalization has been advanced through multilateral and bilateral trade negotiations that seek reductions in international trade barriers and that codify these reductions into international trade law. The analyses in this paper are predominately based on the General Agreement on Trade in Services (GATS), but also pertain to most regional or bilateral agreements such as the North American Free Trade Agreement (NAFTA). The U.S. and 142 other nations are signatories of GATS and are thus bound by its rules. Appendix A explains international trade agreement mechanisms in greater detail.

The academic literature examining trade in health and other publicly regulated "welfare" (Holden, 2003) services such as education, in general has included a wide variety of economic studies (e.g., Copeland & Mattoo, 2008), structural analyses (e.g., Francois & Manchin, 2007; Holden, 2003), political/critical political studies (e.g., Alvarez, Salmon, & Swartzman, 2011; Arnold & Reeves, 2006b; Higgott & Weber, 2005), and legal analyses (e.g., Mclean, 2005). Most researchers in these widely varied perspectives conclude that GATS signatory countries have a "duty to participate in successive (trade agreement) negotiating rounds to progressively liberalize trade in services" (R. Smith, Blouin, Drager, & Fidler, 2008: 449). The implication is that all services, including health services, will eventually be traded internationally. "Having signed the GATS, the United States has undertaken its unconditional obligations with respect to all service sectors of the economy, including health" (Beisky, Lie, Mattoo, Emanuel, & Sreenlvasan, 2004: 143). The press has called attention to the many problems with the current so-called Doha Round (DDA) of trade negotiations, but a country's duty is not obviated by problems with DDA (see Appendix A). All GATS signatories are legally committed to on-going negotiation rounds, in the DDA or in future rounds, just as bilateral signatory countries are committed to the trade provisions by their signatures.

In this paper, GATS serves as the reference for many other trade in services agreements. GATS and many other bilateral agreements define health services subject to international trade agreements to include health insurance, hospital services, services delivered by health professionals, and medical education, research and development. Also included are all healthcare related clerical functions, e.g., insurance claims processing and medical records transcriptions, and health related distribution processes, e.g., those related to pharmaceutical distribution. (Note 1)

Services delivery methods, or modes of supply (Sampson & Snape, 1985) are also defined in the GATS framework (Note 2) and are shown in Table 1. Five common provisions found in trade agreements--most favored nation (MFN), recognition, domestic regulation, national treatment, and market access provisions--are explained in greater detail in Appendix B. These five are important because any of the non-tariff or regulatory barriers to trade discussed in this paper is likely to be in violation of one of them.

Insert Table 1 - here

2.1.1 Impacts of globalization

There is broad disagreement about the nature of globalization and the impact globalization will have on individual nations' political institutions. Held and McGrew (2003: 2) characterize the disagreement as being between "globalists" and "skeptics." They identify "globalists" as those (e.g., Giddens, 1990; Hardt & Negri, 2000; Strange, 1996) who see contemporary globalization as a watershed historical development, which will result in regional and national social structures becoming "embedded within more expansive sets of interregional relations and networks of power" (Held & McGrew, 2003: 3). In contrast, the "skeptics" (e.g., Alvarez et al., 2011; Callinicos, 1994; Hirst & Thompson, 1996; Hoogvelt, 1997; Tang, 2008) view globalization as a fashionable "myth," or even as an "ideological construction" which "helps to justify and legitimize the neoliberal global project, that is, the creation of a global free market and the consolidation of Anglo-American capitalism within the world's major economic regions" (Held & McGrew, 2003: 5). In other words, "globalists" see globalization as representing a substantive change in the spatial and temporal ordering of social and political relations, while the "skeptics" view it as new variation on an old theme of Western economic imperialism.

Another way to examine different opinions on globalization and its impact is a stakeholder perspective. Stakeholders can be generally classified into "official experts" and "intellectual experts" (Waitzken, Jasso-Aguilar, Landwehr, & Mountain, 2005: 902). Like the globalists, official experts tend to maintain that global market activities are the route to a better human condition. For them, reality resembles "earlier constructions that conveyed economic competition as a religious value" (903), much like the quasi-religious values expressed in the *Protestant Ethic and the Spirit of Capitalism* (Weber, 2002) or exemplified by "the invisible hand" (A. Smith, 2006/1896). Intellectual experts, like the skeptics, usually focus on powerful political and economic relationships that worsened conditions for disadvantaged or disenfranchised groups. For them, capitalism should serve the nation instead of the inverse (Waitzken et al., 2005).

Official expertise and the globalist view has tended to predominate in policy decisions during most of the decades since the mid 1940s, but the DDA slowdown is a demonstration of the growing strength of intellectual expertise and the skeptical view in the policy arena. The arguments can finally be distilled to disagreements about who will benefit and who will lose in an increasingly globalized world. This paper does not address either side of the debate, and tries to adopt none of these positions (e.g., Arnold & Reeves, 2006a), but understanding the positions advances the arguments presented.

2.1.2 Gains from globalization?

In general, economists theorize that trade between countries occurs either because one country has a comparative advantage over another country, or because one country gains from specialization which emerged as a result of trade (Copeland & Mattoo, 2004). These two differ mainly in terms of the timing: the former is present before international trade occurs, while the latter develops during the course of international trade and confers a comparative advantage on the country in question. Differences in attributes such as abundant natural resources, lower labor costs, or more highly developed technology can lead to a comparative advantage for the country with the attribute. Trade in services differs from trade in goods because trade in services can only occur through movement of some factor of production, such as the movement of service professionals or the movement of capital, and not of the service, itself. Determining which factor among the many required provides comparative advantage and whether that factor is present now or will develop in the future may be difficult, but the gains due to international trade under both conditions are similar. In perfectly competitive markets, a country as a whole benefits from trade in goods or services because it can consume more goods and/or services after trading than before (e.g., Copeland & Mattoo, 2004; Mattoo, Rathindran, & Subramaniam, 2006).

One reason for disagreement among international trade scholars is the pattern of gain distribution due to international trade liberalization. It is highly unlikely that gains will be evenly distributed across all sectors. Using an intra-sectoral, albeit not services specific model, Ethier (2005) concluded that out-sourcing some services may raise the wages of highly-skilled workers and create skill-biased technical change in both of two trade partner countries, while less skilled workers will benefit from higher wages in one country and suffer job and income loss in the other. In discussion of health services globalization, demonstrations of the overall benefits usually distribute gains to consumers (patients) and/or society, in general, with the caveat that national regulations are decreased as globalization is increased (e.g., Copeland & Mattoo, 2008). For example, looking at

consumption of health services abroad (Mode 2), and using very conservative assumptions, Mattoo et al. (2005) found that even including transportation costs, the U.S. would save $1.4 billion annually if 15 low-risk, but usually highly successful surgeries were to be performed abroad for just 10% of the patients who needed the procedures each year. Both U.S. patients and society would be gainers under this scenario. In contrast, off-shoring of medical transcription seems to benefit those health services organizations that get cheaper transcribing and should, in turn benefit patients and/or payers through decreased costs, but will leave U.S. medical transcriptionists with fewer and probably lower paying jobs (Kshetri & Dholakia, 2008) so there may be no net gain. Brown et al. (2009) suggest that Mode 2 primary care may impact insurance demand, and it is likely that unintended consequences of Mode 2 services might develop in other countries (Vijaya, 2010).

Importantly, a growing literature shows that appropriate institutional and domestic regulatory schemas are necessary in order that a country gain from globalization of services. As Mattoo et al. (2005) pointed out, to attract a broad base of U.S. patients, offshore health services organizations would first have to overcome American patients,' payers,' and providers' institutional mindsets, including a belief in U.S. healthcare superiority. Other research has found that such things as a rational and functioning legal system or an efficiently run and reliable telecommunication infrastructure are a precondition for gains under globalization of services, and that they have a large impact on the pattern of gain accruing to a country (e.g., Holden, 2003, 2005; International Monetary Fund, 2008; Loayza & Raddatz, 2006). Additional non tariff barriers to free trade in services include such things as concerns or laws related to national security issues (Copeland & Mattoo, 2008), to countries' sovereignty (Chanda, 2003), e.g., sovereign wealth funds controlling another country's major economic endeavors, to qualifications, or to quality standards, e.g., state licensure for health services professionals and health insurance (Mclean, 2006). The following sections discuss some of the barriers in greater detail, but a complete discussion of non tariff and structural barriers to free trade and of all gains and loses is beyond the scope of this paper. A summary of all likely beneficiaries and losers, and the effects of various regulatory and institutional arrangement, can be found in Copeland et al. (2004; 2008) and Hoekman (2006). The important point for this study is that the degree of world trade liberalization and its impacts are not influenced solely by trade agreements. That is, barriers or facilitators to free trade may be outside the globalization arena.

3. Discussion and Propositions

3.1 Ex-trade Agreement Trends and Globalization

Thus far, I have discussed the impact international trade agreements can have on the globalization of services such as health services. However, despite slow Doha Round progress, factors outside the international trade arena may be facilitating a more rapid move toward globalization of health services, especially in the US. Those trends can be divided into three categorizes: trends within the U.S. health services sector; trends within the U.S. economy; infrastructure and technological trends in other countries.

3.1.1 U.S. health services trends facilitating globalization—Quality initiatives

In a series of reports (Institute of Medicine, 2001, 2002, 2004), the Institute of Medicine (IOM) has defined quality in health services in terms of processes, which include development and implementation of evidence based, best-practices medical procedures and clinical practice guidelines, standardization of performance measures, computerizing clinical information, and reporting comparative quality measures in easily accessible, publicly available media. Other groups such as the Leapfrog Group (2007) have adopted and advocated for similar quality standards, resulting in a high level of health services quality consciousness in the US. Perhaps more importantly, these initiatives have advanced quality measurement techniques and technologies.

A basic premise of the quality initiative is that providers who follow the same quality guidelines are interchangeable (Mclean, 2005). It appears that U.S. medical tourists going to other countries for procedures, for example, expect the same or similar conditions to prevail in foreign venues as they have at home (Perfetto & Dholakia, 2010). Given high health services costs in the U.S. and interchangeable providers, providers from other countries are providing or will soon be able to provide lower-cost, but almost identically high-quality health services, and these services may come with greater amenities ("Sun, shopping and surgery.," 2010). Assuming that payers would prefer lower-cost to higher cost services, with quality and all else being equal, it follows that:

P1: The greater the emphasis on health services quality, as defined by the IOM, the greater the probability that health services will be more rapidly and more completely opened to globalization even without agreed upon trade agreements.

3.1.2 U.S. health services trends facilitating globalization--Patient empowerment and consumer-managed health services

As a method to decrease costs, insurers and other payers have begun to emphasize patients' involvement in their

own healthcare using mechanisms such as medical saving accounts or tiered insurance plans that allow the patient to choose the health services upon which she will spend her medical dollars. Just as consumers of other goods and services educate themselves about the goods or services before spending on them, so it is likely that consumers of health services will educate themselves. This is especially likely with advances in technology that allow easy Internet access to an almost infinite amount of medical information and to easily accessible quality information about providers. "Physicians view the Internet as a cheap way to lure patients who are directing their own medical care into their cyberspace office. What these patients are looking for in cyberspace is a physician with a good outcome reputation and someone who can be trusted. The actual location of the physician is only a secondary concern to many of these patients. . . . Given such a mindset, in the near future, patients will likely not be bothered if the physician of their choice is located in a foreign country" (Mclean, 2005: 217). We can thus propose:

P2: The more consumers are empowered with medical and health services quality and other information, the greater the probability that health services will be more rapidly and more completely opened to globalization even without agreed upon trade agreements.

3.1.3 U.S. health services trends facilitating globalization--Regulatory measures

The World Health Organization (WHO) defines telehealth as the "integration of telecom systems into the practice of protecting and promoting health" and telemedicine as "incorporation of these systems into curative medicine" (Singh, 2004). Supported by constituents with quality concerns, several key pieces of U.S. health services legislation have advanced telehealth and telemedicine through advancing telecommunication and computerization in health services. These are the Telecommunications Act of 1996, the Balanced Budget Act of 1997, the Federal Food, Drug, and Cosmetics Act as amended in 2000, the Health Insurance Portability and Accountability Act (HIPPA) ("Balanced Budget Act of 1997," 1997; "Federal Food, Drug, and Cosmetic Act," 2000; "Health Insurance Portability and Accountability Act (HIPPA)," 1996; "Telecommunications Act of 1996," 1996) and the American Recovery and Reinvestment Act of 2009 ("American Recovery and Reinvestment Act of 2009," 2009). By forcing companies to provide universal telephone service across all sections of the US, and by requiring that remote residents not be exorbitantly charged, the Telecommunications Act of 1996 laid the ground work for the advancement of computerization in health services. The Balanced Budget Act of 1997 mandated a mechanism for federal reimbursement of telemedicine services. Private insurers followed by reimbursing for some telemedicine services and at least six states have mandated reimbursement for telemedicine (Mclean, 2005). The Federal Food, Drug, and Cosmetics Act as amended in 2000 imposed safety standards and guidelines for telemedical devises, thus providing guidance that decreases the risk of entering this relatively new manufacturing field. Likewise, despite the costs of implementation, HIPPA standards and regulations tend to level the playing field for those who store, transmit, or process patient specific information, even as it also provides for substantial penalties for failing to comply with the act. The American Recovery and Reinvestment Act provides incentives for U.S. providers to use digital records and record storage.

Greater use of telecommunication and computer technology makes it easier to use computer techniques to diagnose or monitor patients--as in telemedicine or teleradiology, and to provide treatment--as in cybermedicine or robotic surgery, in addition to facilitating computerization of all patient records and reimbursements. The IOM maintains that greater computerization of health services will facilitate quality health services at lower costs (Institute of Medicine, 2002). Increased use of telemedicine also diminishes the need for physical proximity of provider and patient, especially when distant providers may be cheaper, quicker, or better qualified. For example, teleradiology outsourced to a foreign provider may be a higher quality, lower cost alternative to a resentful, sleep-deprived local radiologist during a hospital's night shift. Moreover, telemedicine (Mode 1) used in conjunction with medical tourism (Mode 3) seems to be a rapidly developing trend (George & Henthorne, 2009).

Telemedicine and increases in telecommunication technology may also contribute to the development of specialized centers of excellence in other countries (Vequist & Valdez, 2009). Decreases in both costs and error rates, due to the economies of scale, have been found at such U.S. centers of excellence that specialize in one or two procedures (Institute of Medicine, 2000). Reimbursement agencies have begun to realize that concentrating clinical work in such centers is advantageous to both patients and payers (Mclean, 2006), and with advances in technology, centers of excellence could be located anywhere in the world. The implication is that:

P3: The greater the increases in telecommunication technology and telemedicine in health services, the greater the probability of more complete and more rapid globalization of health services even without agreed upon trade agreements.

3.1.4 U.S. health services trends facilitating globalization--Franchising

The Mayo Clinic, with a home office in Minnesota, has established franchise clinics in Arizona and Florida in an

effort to gain national market share based on name recognition, a reputation for high quality, and the use of innovative procedures (Mclean, 2005). If health services franchising becomes common in the US, then foreign providers with stellar reputations and names will have the incentive to follow suit. This is especially the case given the wide use of the Internet in the U.S. to find health information, and requests from other countries for liberalization of non-trade barriers (see Appendix B).

P4: The greater the success of health services franchising, the greater the possibility of more rapid and more complete globalization of health services.

3.2 U.S. Labor, Chronic Disease, and Insurance Costs

The possible globalization in U.S. health services does not represent a new phenomenon: globalization in blue-collar manufacturing work provides an historical illustration. During World War II, increases in wages were regulated, so some employers added health insurance benefits in lieu of wages in an effort to attract and keep employees (Styring, 1998). After World War II a rapidly increasing demand for consumer goods could not be as rapidly fulfilled because of continuing labor shortages due to war casualties, and due to the GI bill. The GI bill allowed many returning military men to attend college instead of going to work, and in the process, it changed U.S. higher education and moved the U.S. work force toward more white-collar workers (Mclean, 2005). In this situation, for the first time, labor gained negotiating power and was able to demand wage concessions from major employers.

However, wage increases resulted in inflation by the mid 1960s. To curb the inflationary impact of wage increases, employers provided workers with additional benefits such as health insurance instead of higher wages. By the mid 1970s, employee health insurance costs were rising more rapidly than general inflation at the same time that life expectancy of workers was dramatically extended. Employers turned to the government for assistance. A key issue for passing the HMO and ERISA Acts ("Employee Retirement Income Security Act (ERISA)," 1974; "Health Maintenance Act (HMO)," 1973) was the desire to help employers control health services costs (Mclean, 2006).

Today we can see that employee health services cost increases were not staunched by the HMO and ERISA Acts. The Council on Foreign Relations estimates that GM spent over $5.6 billion on health care expenses for employees and retirees in 2006, which is about $1500 to $2000 per automobile produced (Teslik & Johnson, 2008). Health services expenses for U.S. employees, in effect, acted as a tax that increased the cost of U.S. manufactured products. Off shoring of manufacturing jobs to countries where labor is cheaper usually also eliminates worker health care costs and other benefits. Coupled with regulatory compliance costs such as the cost of maintaining a safe workplace environment as mandated by the Occupation Safety and Health Act (OSHA) ("Occupation Safety and Health Act," 1970), worker health care costs are a strong incentive toward globalization in manufacturing jobs.

Globalization of white collar and professional jobs can be viewed as analogous to globalization in manufacturing (Mclean, 2005). Ironically, increased worker health care and insurance costs may have as large an impact in health services jobs as in blue-collar positions. U.S. health services employees are, then doubly squeezed: they are told to cut costs in providing health care, and they also face off-shoring of their positions due to the high costs of their own health care benefits. Whether the jobs are in manufacturing or service sector, the implication is that:

P5: The greater the increases in worker benefits in a sector, including health care or insurance, the greater the probability that the sector will be more rapidly and completely globalized.

Increases in life expectancy around the globe have been accompanied by the tendency of the longer-lived population to develop chronic diseases. Two factors result. First, chronic disease will drive payers and patients to seek less expensive but reliable care options. Secondly, in developed country sectors such the automobile industry that usually provide health care for retirees, chronic disease states add to the already longer retiree healthcare payout period and increase the sector's expenses. Like payers and patients, companies in these sectors will seek cheaper alternatives (Stuart, 2010). It follows that:

P6: The greater the proportion of elderly in a nation, the more likely the probability that health services will be more rapidly and more completely globalized.

Finally, just as technology makes it possible for consumers to search the Internet for health services, so the tendency toward technological standardization and greater use of technology, especially telecommunication technology, in many sectors of the U.S. economy makes it easier for companies facing high health care costs to compare health services providers. Assuming that other countries continue to develop and use compatible technologies, U.S. companies may soon be inclined to search across the world for the lowest cost health services. Thus:

P7: The greater the use and spread of technology, the more likely the probability of rapid and more complete globalization of U.S. health services.

4. Implications

4.1 Other Pressures for international trade in health services

The U.S. and European perspective is that economic and power gains due to greater services globalization will accrue to developed countries. These countries will be able to expand into the newly developing market places and find new customers who will be happy to buy services unavailable in their home economies. In contrast, developing countries assume that some gains, at least, will accrue to them, and they try to negotiate international trade based on perceptions of sectors that will gain under greater liberalization.

4.1.1 Pressures from other countries for greater globalization

Health services are professional-labor intensive. Developing countries with good professional education systems, especially those in which English is one of the languages of instruction, may actually have a competitive advantage. Professionals' lower salary expectations give the countries the advantage of much lower labor costs and they may seek to benefit from that advantage in trade negotiations. The recent increases in medical tourism (e.g., see Hazarika, 2010; Koster, 2009; Lazzaro, 2011; Lin, 2010; "Medical tourism: game-changing innovation or passing fad?," 2010; "Sun, shopping and surgery.," 2010) demonstrate the power of such a competitive advantage, and also demonstrate why developing countries with such labor advantages would seek greater globalization.

Foreign health services providers seeking U.S. patients can also easily move toward compliance with U.S. quality, information, and documentation standards and meet U.S. regulations if they have advanced information and telecommunication systems. A country with a highly developed IT system and the employees trained to implement quality systems would, thus, be in a very favorable position to compete globally with U.S. health services. For example, India has established a thriving and growing medical transcription sector using Mode 1 cross border delivery of services (Kshetri & Dholakia, 2008).

In Mode 2 consumption of health services abroad, several Asian hospitals are gaining a reputation for performing high-quality, much less-expensive-than-US-prices surgical procedures. The number of medical tourists from the U.S. in 2007 was estimated to be from 50,000 (Johnson & Garman, 2010) to 750,000 (Stanley, 2010), with estimates that the number for 2012 will be more than 1.5 million U.S. medical tourists (Stanley, 2010). U.S. employers are being offered advice on how best to choose medical travel facilitators and destinations for their employees (Koster, 2009; Lazzaro, 2011). The AARP website reproduces an article that lists pros and cons of medical tourism, compares the price of a range of procedures at Bangkok's Bumrungrad hospital with the average for the same procedures performed in U.S. hospitals, and provides average airfares. Other articles on the site give detailed descriptions of individuals' medical tourism experiences, discuss the insurance implications with lists of U.S. insurers that pay for procedures done abroad, explain international quality standards and evaluations, and provide links to sites for four health travel agencies that will plan trips to combine health services and vacations (AARP, 2011; see also Mattoo & Rathindran, 2006; Woodman, 2007).

Despite advances in globalization, to date, foreign providers generally have not pushed for globalization through Mode 3 establishment in another signatory's territory of foreign owned service provision facilities. Global Choice Healthcare, owned by Singapore based Parkway Group, does not provide services at its two U.S. facilities although it will arrange travel to Parkway hospitals abroad. There is no immediately apparent trade agreement reason that Bangkok's Bumrungrad International Medical Center, with accreditation from the Joint Commission International (JCI), the overseas arm of the nonprofit Joint Commission that accredits U.S. health facilities, should not capitalize on its reputation by opening hospitals in the US. The reason given by most researchers is U.S. health services' propensity toward non-tariff and regulatory barriers to free trade, including licensing and malpractice rules establish by each of the fifty individual states. Such non-tariff and regulatory barriers are probably in violation of one of the five common trade agreement provisions (see Appendix B), so countries are beginning to change their behaviors and outlooks. "Japan, Norway, Australia, and India have asked the U.S. to standardize licensing and qualification requirements and/or allow service providers licensed in one state to practice in all states" (Arnold & Reeves, 2006b: 320). Apollo Group Corporation, and Indian hospital chain, is rapidly expanding in southeast Asia (Holden, 2005) and U.S. trade representatives have met with the Apollo Group chairman (US Trade Representative Press Office, 2009) to explore options.

As the short history of U.S. blue collar manufacturing and globalization provided above has shown, non-tariff and regulatory barriers, like high employee benefits' costs or national license requirements, are not usually effective in the long-run. "In the long-run, the medical community will no more be able to resist the forces that compel the off shoring of medical jobs than the blue-and other white-collar professions were" (Mclean, 2005: 233). Moreover, based on the economic literature, it is probable that increased globalization of U.S. health

services, like increased manufacturing globalization, would provide U.S. patients with a choice of higher quality services and/or greater access to service. On its web site, Thai Air advertises luxury vacation packages with medical services. The Canadian government opened the Center for Minimal Access Surgery in Hamilton, Ontario (CMAS, 2004) to provide care for individuals in remote regions of Canada. Similar services could easily be provided across Canada's southern border. In ancillary services, in addition to medical transcription, foreign providers are developing ways to take on services for U.S. medical billing, disease management, acute care monitoring, teleradiology, and cybersurgery. The implications are that other countries have started to push toward greater health services globalization in general, and in the U.S. in specific.

4.1.2 Some missing pieces in the U.S. health services globalization puzzle

Healthcare services sectors in most developed countries are embedded in not-for-profit or government sector institutions that are societally perpetuated and professionally reinforced (Scott, Ruef, Mendel, & Caronna, 2000). Such institutions are difficult to change because they are socially constructed and maintained by cognitive frames, normative values, and regulatory regimes (Scott & Meyer, 1994). In addition to licensing and insurance regulations, included are the institutionalized doctor-patient relationships common in the US, and U.S. concepts of liability.

Neo-institutional theory would predict institutional change in institutionalized sectors in the face of strong external pressures (Greenwood & Hinings, 1996), and indeed, there is evidence that the traditional doctor-patient relationships are being broken down with greater use of the Internet and with the opportunity of medical tourism (Perfetto & Dholakia, 2010). Analyses of GATS and other trade agreements (Arnold & Reeves, 2006a, 2006b), expose the possibility that many high-priced medical procedures may be off-shored to developing countries, yet such pressure has not yet globalized U.S. health services. The impediments seem to be U.S. regulatory and legal factors (Gulick, 2000; Mclean, 2006), the factors being negotiated at the DDA and in other trade negotiations because other countries are pushing for change.

A limitation of this paper is that for the most part, it ignored problems associated with providers' legal liability and the jurisdiction in which legal actions might be brought. That does not mean that these problems are not present in any health services globalization processes. On the contrary, both have exercised many legal minds and have not yet been decided. Although a complete discussion of the legal issues associated with globalization is outside the scope of this paper, in order to provide suggestions for the future, it is appropriate to point out the major legal questions. These questions include the following. How is jurisdiction established? Does international trade law grant U.S. courts jurisdiction over foreign providers? A related question is upon what basis should a global health services provider's domicile be determined? Given the level of technology normally found in globalized health services, how is negligence of offshore providers to be distinguished from cyberspace failure--including electromagnetic interference, computer viruses, hacking, defective or poorly maintained machines—and which may involve harm to third parties who are not involved with the alleged negligence incident? Is it appropriate to apply negligence tort law developed for industrial accidents to the cyberspace provision of health services? In regard to providers' qualifications, legal questions include considerations such as should providers be nationally licensed and if so, upon what basis will the qualifications be established? Should providers who practice across borders be licensed differently than those who practice within a country, and if so, what different criteria should be included? It is noteworthy that international professional standards are at the forefront of WTO negotiated items.

5. Conclusions and recommendations

Overall, this paper contributes to the social science, health services, and organizational literatures by showing that globalization in health services is not solely dependent on trade negotiations. It attempts to combine views on the nature of globalization--including globalist, skeptic, official expert, and intellectual expert concerns--as it proposed that U.S. health services must inexorably move toward greater globalization even without considering developments in international trade negotiations. Specifically, many of the non-trade factors contributing to greater liberalization of trade in health services were discussed and the implied propositions spelled out. These factors may be all beneficial for U.S. health services but some may be harmful. Moreover, lacking any evidence to the contrary in the literature, it appears that the U.S. has no real comparative advantage when its health services are compared on the world stage. The country appears to be headed toward a health services sector breakdown of massive proportions as it struggles with untenably escalating health services costs and with demands for higher quality. Viewed from another viewpoint, however, the factors influencing the move toward globalization may also provide the U.S. with a basis for a globally competitive stance. The U.S. could capitalize on its high tech in health services and health services quality measurement.

A penultimate question about globalization involves the determination of health services quality. Should health services' quality be determined by the structure of the organization in or through which services are provided, by

the processes performed by the providers, or by the outcomes of the service? Answers to this question make up a voluminous literature and are not the subject of this paper. However, it is in this question and in the legal questions posed above that U.S. health services may be able to develop and maintain a world wide comparative advantage.

The U.S. is far advanced among nations in thinking about how to measure and provide health services quality through high tech procedures, in part due to its regulations. Providing the most innovative quality health services and exporting both the technology to perform those services and the techniques to measure their quality would give the country an comparatively advantageous position currently unoccupied in global trade. With the exception of Canada, it is unlikely that any other countries would consider challenging such a U.S. position. If lower wages in the global market place were allowed to deal with a majority of the US's escalating health services cost factor, U.S. providers could focus on developing high tech, high quality services, in effect taking its place in the world market place as a provider of differentiated services to a relatively small market of people who require advanced technological procedures. This course of action would not result in gains from globalization across all sectors of the economy, but would allow the U.S. to realize a net gain from globalization while using to best advantage its unique country characteristics.

If any gains from health services globalization are to accrue to the US, quick and proactive use of necessary resources is warranted. The nation's best course of action would be to regain its hegemonic position in health services related technology, and to eschew the many non-tariff and regulatory barriers in place that, in the long run serve only to raise the hackles of developing countries. By these actions, a reconciliation of divergent views and stakeholder positions on globalization's nature may be started. Thus, the final question to ask is: Will the U.S. continue to protect all domestic health services through non tariff and regulatory barriers doing business as usual, or will the country open its borders to lower cost global trade in health services while it maintains a firm position as the world's major exporter of superior health services technologies? No matter what the outcome of the Doha Round negotiations, health services will eventually be globalized along with other services. Countries may try to control the globalization process to their advantages or they can allow the markets and trade negotiations to take control. U.S. health services providers might consider the longer-term implications of globalized services in the market decisions they make today.

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Notes

Note 1. Services covered can be found in the WTO, Secretariat, Service Sector Classification List, MTN.GNS/W/120, which lists service sectors and sub-sectors, and cross references them to the United Nation's classification registry (CPC codes)(United National Statistics Division, UN Classification Registry).

Note 2. GATS Article I(2) lists modes, which include: 1) cross-border supply, 2) consumption abroad, 3) commercial presence, and 4) presence of natural persons. Definitions are also found in the United States International Trade Commission, U.S. Schedule of Commitments under the General Agreement on Trade in Services, August 1998, Appendix E (USITC, 1998).

Table 1. Modes of supply and examples of trade in health services

	Trade in health services	Trade in ancillary services	Associated trade in goods
MODE 1 Cross Border Supply	Telemedicine; laboratory samples tested abroad	Distance medical training; Medical transcription	
MODE 2 Consumptions abroad	Medical tourism; medically assisted residence for retirees	Hotel, restaurant, paramedical services, etc. associated with medical tourism; training of foreign nationals	Health and health care equipment;
MODE 3 Commercial presence	Medical facilities owned by foreign nationals, e.g., Singapore's Parkway Group owns UK hospitals	Foreign owned or sponsored medical education or research facilities	Pharmaceuticals; Medical waste; Prostheses
MODE 4 Presence of natural persons	US hospitals recruiting foreign nurses	Cross border movement of medical personnel for purposes such as training	

Adapted from Cattaneo (2009)

Appendix A

Many trade negotiations related to health care and health services provision are carried out under the aegis of the World Trade Organization (WTO), including the General Agreement of Trade in Services (GATS) (World Trade Organization (WTO), 1996), the General Agreement on Tariffs and Trade (GATT) (World Trade Organization, 1994/1947), and the Trade Related Aspects of Intellectual Property Rights (TRIPS) (World Trade Organization, 1994). The first deals specifically with trade in services, the second deals with trade in goods and products such as pharmaceuticals, and the third is a separate agreement about intellectual property such as patents, copyrights, and designs. In general, WTO negotiations are global in nature and bind all signatory members of an agreement. The GATS gives the WTO power to enforce trade agreements though a binding dispute settlement mechanism. According to its web site, there are 153 WTO member nations, of which 128 nations were GATT signatories, and all of which are GATT signatories.

The North American Free Trade Agreement (NAFTA) (Office of the United States Trade Representative, 2009) is one among many regional free trade agreements that have been adopted or are being contemplated in order to create a common market within a specific geographic region. NAFTA is an agreement between the North American countries of the United States, Canada, and Mexico. Other examples include the European Union (EU), the Association of Southeast Asian Nations (ASEAN) Free Trade Area (AFTA), The Southern Common Market (MERCOSUR), the Common Market of Eastern & Southern Africa (COMESA), and the Central American Free Trade Agreement (CAFTA).

WTO negotiation rounds are named for the city in which the first in a series of negotiation talks are held. The current round is named for Doha, the capital of Qatar, and is referred to as the Doha Round or the Doha Development Agenda (DDA) (US Trade Representative, 2011). Even though the talks shift each year to another location, the name of the original host city identifies negotiations until the round is declared closed. During 2008, WTO DDA trade discussions were brought to standstill by lack of cooperation among WTO members and by NGOs critical of globalization. However, in 2010, at their summer meeting, the G-20 nations stated commitment to on-going trade negotiations (Wessel, 2010) and several heads of state commissioned a report on how to reinstate productive talks ("A deadline for Doha.," 2011), with the hope that talks could resume sometime in 2011.

A country's duty with respect to trade in services is not obviated by problems with the DDA for three reasons. First, although GATS is being negotiated along with GATT during the Doha Round, it is unclear if GATS negotiations have been completely subsumed under GATT, so even if the Doha Round collapses completely, GATS negotiations could still be open. Secondly, the G-20 commissioned report, which gained backing from the International Chamber of Commerce, states that the benefits would add about $360 billion in new global trade each year, an amount that is especially enticing in hard economic times ("A deadline for Doha.," 2011). Economically strapped nations such as the U.S. will be anxious to continue to negotiate in good faith because of the economic benefits. Thirdly, ex-WTO negotiations continue on a bilateral basis and the agenda for greater globalization in services is likely to be maintained in these negotiations. However, it is difficult to predict whether new interest in the Doha Round will actually lead to progress.

Appendix B

Most international trade in services agreements are based on five provisions. All of them may not be found in every trade agreement, and the particular services to which each is applied may vary by agreement, but the general sense of each of the following provisions is often included. Any U.S. non-tariff or regulatory barrier to free trade in health services violates at least one of the provisions. 1) A **"most favored nation"** (MFN) provision(Note 1) states that treatment accorded by one signatory to another must also be accorded to all signatories. This means that a nation cannot grant greater trade privileges to one country without providing the same privilege to all other nations that want it. 2) A **"recognition"** provision(Note 2) requires that when a signatory nation recognizes the professional credentials (e.g., education, licenses, or certifications) of service providers (nurses, doctors, hospitals) obtained in another country, it must then allow all other signatory nations to negotiate comparable credentials recognition. This means, for example, that if the U.S. recognizes the legal education provided in the UK and allows a UK trained lawyer to practice in the US, all other countries must be allowed to negotiate the recognition of their similar educational preparation. Like the MFN principle, the recognition provision usually applies ("top down") to all services including health services, not just to specific service providers. 3) GATS has a **domestic regulation** provision(Note 3) that empowers the WTO to write rules to ensure that WTO Members' domestic laws and regulations related to licensing, qualifications and technical standards "do not constitute unnecessary barriers to trade in services" and are "not more burdensome than necessary to ensure the quality of services." In implementing this provision, the WTO chose rules for professional services as the first to be negotiated. 4) A **national treatment** provision(Note 4) is aimed at ensuring that signatories' laws and regulations do not discriminate against foreign service suppliers. It usually states that treatment of foreign services suppliers (e.g., doctors, nurses, hospitals, health insurers, HMOs) can be no less favorable than that accorded to domestic suppliers. 5) A **market access** provision(Note 5) is a very powerful rule because it applies to all "measures" (i.e., regulations, proclamations, or laws), whether or not they discriminate against foreign suppliers, that inhibit free trade. National treatment and market access provisions apply only to nations that choose to be bound by them. So, for example, each WTO Member decides through the negotiation process, first, whether or not it will "bind" health-related sectors and sub-sectors to the GATS' "market access" and "national treatment" rules, secondly, which "modes" of supply will (or will not) be bound, and finally, what limitations, if any, will be placed on the scope of these obligations (Arnold & Reeves, 2006b). The market access rules outlaws monopolies, exclusive service providers, quotas, or other limitations on the number of service providers, and other business practices impeding free trade of services. For example, under NAFTA rules, governments must compensate investors if states "directly or indirectly nationalize or expropriate an investment … or take a measure tantamount to nationalization or expropriation" (Office of the United States Trade Representative, 2009: Article 1110). NAFTA arbitration panels have interpreted this provision broadly to apply to a wide range of regulatory measures that deprive companies of business opportunities and profits (Public Citizen, 2005.

Notes

Note 1. For example, GATS Article II discusses the two major general obligations of all signatories--Most Favored Nation Treatment and Transparency.

Note 2. e.g., GATS Article VII.

Note 3. e.g., GATS, Article VI.4

Note 4. e.g., GATS, Article XVII.

Note 5. e.g., GATS, Article XVI