

Health Policies and Economic Blocks

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Foreword

This paper analyzes the roles of health goods and services markets within the regional integration process. It is a known fact that the consolidation of integrated markets is slower regarding social goods and services (as health and education) than among other goods and services (e.g. durable and non-durable consumption goods). The paper discusses the nature of the health sector and its global dimension, showing the peculiar features of health goods and services marked by economic complexity and (according to Arrow) information asymmetry. Despite that, the paper emphasizes old and new reasons that place health as a pre-requisite to commercial integration. It approaches the role played by the State in health financing, provision and regulation and the commercial integration process. Moreover, it brings relevant concepts on the topic studied, like the factors that lead to regional public health financing, the concept of Regional Public Good and its use in the health sector, additionally to the concerns related with health care reciprocity among countries. Finally, it approaches health markets regional integration in the European Union, NAFTA, and MERCOSUR.

List of Abbreviations

AIDS	:	Acquired Immune Deficiency Syndrome
EEC	:	European Economic Community
UR	:	European Union
ERISA	:	Employment Retirement Income Security Act
FONASA	:	Chilean National Health Fund
GDP	:	Gross Domestic Product
HIPPA	:	Health Insurance Portability and Accountability Act
IMSS	:	Mexican Institute for Social Security
ISAPRES	:	Chilean Private Health Plans
JACHO	:	Joint Commission for Accreditation of Hospitals
MEDICAID	:	US Health Program for the Poor
MEDICARE	:	US Health Program for the Elderly
MERCOSUR	:	Common Market of South Cone Countries
MISSSE	:	Mexican Institute for Social Security of Civil Servants
NAALC	:	North American Agreement on Labor Cooperation
NAFTA	:	North America Free Trade Agreement
RPG	:	Regional Public Goods
UNDP	:	United Nations Development Program
USA	:	United States of America

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1. Introduction

National and Regional integration are processes that flows naturally along the time.. In different moments of the global history, particularly after Renaissance, natural processes of market integration came along. These characterized a gradual conversion of economic and social standards, since trade make countries increase their degree of interdependence (DEVLIN; CASTRO, 2002). However, most of integration or globalization processes were reverted after an expansion period. This happens due to changes introduced by economic crises, political clashes or to the pursuit of new processes, which may redefine existing commercial partnerships and political alignment among nations. Yet, that reversion does not lead to situations less integrated than the one starting each integration process. They indeed add and retain some degree of integration even after receding. Therefore, one could state that throughout human history, there has been an inexorable trend towards intensifying regional and global contact among countries.

Globalization can surely lead to increasing social unbalances, once it brings hastened benefits to countries that manage to be integrated in a more competitive way to global markets.¹ Nevertheless, negotiation, regulation, and enforcement of consensual rules can reduce these social disparities.

The intensified globalization process in more accelerated pace than that in previous decades marked the 1990's. Which effects did it bring to global economy in general? Taking into consideration the changes in social indicators from 1990 to 1999 (according to the UNDP report for 2002), by the end of the 90's the population in absolute poverty was reduced from 29% to 23%; child mortality rate dropped from 96 to 56 per thousand live-born babies; the rate

of children schooling enrollment increased from 80% to 84% and 140 of the around 200 countries in the world chose their representatives through universal vote.

One of the effects typically associated with any globalization process is the gradual standardization of consumption at a global scale. The progressive establishment of similar consumption standards and living styles lead countries to increasing foreign market oriented production based on their own comparative advantages. They also end up replacing part of their domestic production with imports.

Politically driven regional economic cooperation processes may also help develop integration. Governments of neighboring countries may develop, in a consensual and ruled basis, regional markets, or economic blocks. These might be built to avoid that mislead coordination, associated with globalization processes, shatter the nations' internal economic basis, and also breaking the promotion of mutual benefits. Thus, countries negotiate and implement policies oriented to common benefits in areas such as the military, defense and environmental protection, sanitary and epidemiologic control, among others. Countries use different tools of economic policy, like fiscal and commercial policies, labor patterns standardizations and social policy reciprocity, thus fostering the use and development of comparative advantages, in an agreed political environment. Then, drawing upon common ideas, neighboring countries may establish a sort of regionalism based on shared policies and purposes.

Since the post-war period two kinds of regionalism have successively emerged in developing countries. State leadership from the 1950's to the 1970's characterized the first regionalism, along with commercial links subordinated to import substitution. The new regionalism that comes to live as of the 1990's

¹ Countless economic concepts, such as innovation gains, diffusion gains or foundation gains have support this idea along the economic history.

has the following main characteristics: commercial openness based on private markets, and political development based on open and democratic societies. That does not mean there were no new roles assigned to the State in the integration process. Rather, the State led the commercial opening process, within a context of increased regional cooperation aimed at institutional modernization and social and economic growth.

In that new context some free trade international areas were developed, which became economically integrated areas or regional markets. The European Economic Community (EEC), the North American Free Trade Agreement (NAFTA), and the Southern Common Market (MERCOSUR) are some examples of economic blocks established in the second half of the twentieth century with those purposes.

The process of commercial integration advances in an unsynchronized way, and varies according to the nature of goods and services demanded in the international market. It is faster amongst traditional goods and services (such as *commodities*, durable and non-durable consumption goods and services as transports, tourism, and etc...) or associated to a new technological process that increases productivity (as new information technology standards). It develops in a slower pace in social goods and services². This relative unsynchronized process in the integration of social goods and services to the globalization process is associated with the special nature of such goods and services.

Economic integration processes seem to be associated with improved health conditions. A study held in 17 countries, based on the 1977 and 1997 indicators evidenced that, among those where commercial integration expanded³, life expectancy increased 7.5 years on average, while child mortality was reduced in 45%. In countries where commercial integration has not

expanded, or even reduced⁴, life expectancy increased less (4.5 years) and child mortality went down only 39%.

This paper analyzes health goods and services markets behavior within the regional integration process and economic blocks formation. The paper is divided into four sections, being this introduction the first one. The second section will discuss the economic nature and global dimension of health production, with emphasis on its role generating public and private goods. The third section will approach some aspects of health economic integration. It includes public production of global or regional public goods and also goods that although private, should be produced by the State, in order to cope with eventual market failures. There are equity aspects that may hasten or delay the integration process associated with those goods. The section will present the discussion on the concept of reciprocity as a mean to acknowledge social rights to any individual inserted in the same economic block.

The fourth section will debate health economic integration aspects associated with private markets. Although the debate comprises complex commercial issues, like basic health inputs, medications, equipment, and patents associated with the use of technology, it will focus the discussion on private health services as a tool for regional integration. In that sense, the concept of portability as the process that allows for transferring access rights to public and private health markets among countries will be analyzed as an advanced way of integrating health markets in a regional and international context.

The fifth and final section approaches the development of this health integration process under three different international realities: the EU, the NAFTA, and the MERCOSUR.

² See Castro & Musgrove (2000).

³ Bangladesh, China, Malaysia, Mali, Mexico, Nepal, Paraguay and Turkey.

⁴ Benin, Bolivia, Center African Republic, Cyprus, El Salvador, Haiti, Liberia, Malawi, Niger, Peru and South Africa.

2. Health's Economic Nature and Its Global Dimension

The discussion concerning health's economic nature and its global dimension comprehends three relevant topics at least. The first one deals with the distinctive character of health goods and services, or "what kind of goods and services are being considered?" The second one is "how sophisticated is this health production?" And finally, the third one is: "how has health contributed to the global integration process?"

2.1 The Distinctive Character of Health Goods and Services

Since the 1960's economic literature has produced broad discussion on health goods and services specific issues and markets. How the sector works and the effectiveness with which health services meet social needs are different from traditional competitive markets. Kenneth Arrow (1963) pointed out that health markets' difference from competitive markets arises from: (a) the nature of its demand, which is marked by irregularity and unpredictability, thus restraining consumers ability to foresee or estimate demand for goods and services; (b) the expected behavior of physicians, as once product consumption and production takes place simultaneously, consumers cannot try products before using it; (c) the uncertainty in relation to the product's quality, a reflex of huge information asymmetry in between those who buy and those who sell healthcare products; (d) supply conditions, since health activities require high levels of skills and regulation associated with licensing the activity and professionals involved. This poses strong barriers to new suppliers' access to the market; (e) prices are not established according to market conditions, but to individuals' level of income, and health institutions' contracting mechanisms. These range from payment for medical care to pre-payment of assumed risk, associated with a set of prospective goods and services.

Arrow also stated that health production fails to meet one or more of the three main pre-

conditions that define competitive features on a given market. The first would be the existence of competitive balance associated with the good in question; the second is marketability or quality of a good being purchased/sold in the market. It arises from the behavior and costs for the producer and its respective usefulness to consumers. The third is the existence of scale earnings to ensure at each optimum competitive state a given degree of income distribution and compatible prices in those markets. Should one of those pre-conditions fail, the market is imperfect.

For example, the immunization case does not fit into the marketability criteria. A person could (hypothetically) refuse to consume vaccination against a given transmissible disease. That would put in risk not only the person's health, but others' health also. At an ideal price system, that person should somehow compensate any other individual who catches that disease due to the negative externality resulting from the refusal in taking the vaccination. Another way would be to have everyone paying that person an amount for him to get vaccinated. That kind of pricing system would not be feasible and would require for some sort of collective intervention such as a subsidy, a tax or mandatory ruling to become feasible. In that case, the State would work by means of incentives or coercion to ensure through mechanisms external to market laws that such individual would take the vaccination despite his unwillingness to pay for it. Another example would be the fact that many hospitals, particularly in small towns, must work below their production scale in order to rip satisfactory earnings below market conditions. In order to keep on working and serving that population, these hospitals should be granted public subsidies.

The problems associated with market imperfection take to deeper discussions on the nature of health goods and services: In the

economic light, are they public or private goods? Are they tradable or not?

Are they Public or Private? Public goods are not necessarily those produced by the government. Economic theory classifies them as goods or services that if supplied to one person, would be available to all, without any additional costs. On the other hand, these goods do not face any competition. If a person consumes a public good, it would not cease to be available to others, in the same amount, to be consumed.⁵ This differentiates public goods from private goods, where the consumption by one person excludes the possibility of anyone else to consume it, at least in the same amount. When someone can be excluded from public good production, or when the consumption of such good is not irreplaceable, this good is considered to be an impure public good or mixed good. This phenomenon is surely much closer to reality than pure public goods, which are much more rare.⁶

The actions in sanitary, epidemiologic, borders, airports and harbor surveillance -- services that are not based on the market but do provide the same benefits to all -- are the best-known public health goods. The structuring of sanitary surveillance automatically benefits all by reducing its risk of catching transmissible diseases or having its health affected by the environment's poor quality.

The case of vaccination in health would be one of the most controversial examples of public good and in some contexts, can be associated

⁵ Paul Samuelson affirms that public goods report two basic characteristics: (a) have no competitor consumption and (b) do not exclude anybody from its consumption, i.e., once produced one cannot prevent others from consuming it. In that sense, public goods cannot work in private markets, since nobody can ensure that they are consumed only for those who can afford with them.

⁶ Both public and mixed goods do not manage meeting the Pareto's efficiency principle, since the increment of its consumption to the individual may increase its benefit or usefulness without posing any additional cost.

with mixed goods. It is true that everyone is benefited when an individual is vaccinated, since everyone else benefits from not being exposed to contamination. Therefore, the collective benefit entailed by vaccination increases as everybody gets vaccination. If the government provides vaccination for everyone who is in risk, either latent or potential, the vaccination becomes a typical public good. But things change in a scenario where there are not enough vaccines for everybody. The principle of competitor consumer (if one individual is vaccinated, another will not be vaccinated) arises, and the place of said public good becomes impure characterizing a mixed good.

The provision of a public good depends on collective choices. Typically, the government is expected to select and supply public goods, and finance it through general taxation. But in smaller public settings, the community should cooperate and contribute to finance public goods provision. Then, the question is how the community could determine each others paying capacity and how to avoid free riders.

Many collective or environmental health issues can be considered public goods. Yet, most health goods and services are not of public nature. Medical or dental care services and medications (even the so-called basic or essential medications) are private goods. Its consumption is associated with the idea of "who needs that specific drug on that specific moment."

Are they tradable or not? The macroeconomic concept of a good's tradability is much broader than the microeconomic concept of marketability, where the analysis is restricted to examine only the issue of a given good's market demand and value under "specific local or regional" circumstances. Under a macroeconomic concept, tradable goods are the ones that compete at "the international level" on any market. The number of health goods meeting these characteristics is currently increasing: most medications, vaccinations (please differ from the vaccination process itself) or immunobiological products, some medical equipment and hospital inputs could fit into this category. With telemedicine and global

health markets, the strategies of information, software, and capacity building in health may be considered tradable services as well.

In addition to the economic discussion, it would be worth presenting a social debate with regard to the process of appropriation, access and distribution of health goods and services. *Should they be allocated by meritocratic or universal standards? Should there be focus or should it be an indiscriminate provision of these goods and services?*

Should it be meritocratic or Universal? With the exception of healthcare charitable institutions, the concept that prevailed in the past was that health goods and services were associated with the capacity of payment, or were attributed to those who were under the protection of social security institutions.⁷ This Bismarckian concept of social rights was gradually overlapped or replaced by a Beveridgian concept of citizenship after the Second World War. This later concept expanded rights and health goods and services access to universal standards. This concept has worked in developed countries, where socio-economic conditions allowed for granting universal rights to healthcare. But socio-economic conditions and unbalance levels in most of the developing countries do not allow for implementing universality as a provision guarantee to everybody. Thus, it generates three kinds of equity dilemma: a) *waiting lists for specific procedures* due to institutional and budget limits. Services are granted on a first come first served basis. This is not ideal once the state should be able to allocate services and goods according to necessity. Who needs it the most? Or who deserves it most? Or who really could not afford this service at any other private venue; b) *privileged information* (who knows where the service is available at the moment and how to reach it or consumes it?), and; c) *unavailability* (on poorer regions or places far away from urban centers, there is no possibility

⁷ In many European or Latin American countries, the associative or labor-base mutualism preceded the public social security institutions, as a way to guarantee collective medical care.

of consumption because services are either restricted or simply do not exist).

Should health goods and services provision be focused or indiscriminate? The universal provision of healthcare as a right does not necessarily lead to the idea that everyone has rights to all health goods and services through public provision free of charge. In uneven societies where public resources are scarce, one of the ways to reach universal access to health goods and services is to guarantee an organized access to a market for those who can afford to pay for it. The state should then subsidize or provide a focused free access for those who cannot pay for it. This could be made focusing supply. The downside would be to possibly create segmented markets. The other way to do this would be focusing demand. In this case, those who cannot pay for services are granted a monetary subsidy (direct or through an intermediary institution). The goal is to have them participating in the market under the same conditions as those who can actually afford those services and goods.⁸

2.2 The Complexity of Health Production

Health production is much more broad and sophisticated than what is simply provided by private health services.⁹ It includes a set of other industries, like medications, vaccines, medical equipment, information technology (as data warehouse), professional standards, applied managerial techniques and basic inputs for outpatient care and hospital services.

⁸ There could be some problems associated with information asymmetry concerning who used the service, who provided it and who paid for it. With privileged information, the supplying institution could get advantages charging higher prices for a service that has been delivered. If there is no communication channel between user and the paying institution, there is the possibility of frauds, known as the risks of third payer.

⁹ Gadelha (2002) provides an updated view on this topic in Brazil

It demands huge efforts in formal education, capacity building and training in health and other associated subjects, and is backed by a broad sector of basic and applied research. It involves the entire knowledge spectrum, from biological sciences, physics, chemistry, pharmacy, and engineering, to economic and social sciences, management and administration patterns as well.

It also comprises financial and insurance sectors, since most of private health markets in developed countries are based on insurance and health insurance plans. These require modern and complex management mechanisms and can improve when financial services and derivatives markets are well developed and easily available.

The private and philanthropic sectors are naturally involved on health production. But in addition to those, the state participates in the fields of regulation, surveillance and the specific provision of public health goods. As an example, the government is involved in the fight against transmissible diseases and to guarantee healthy physical and social environments.

Based on the range of productive activities and all economic chains entailed, one can conclude that it would be impossible to hold a simplistic view on the effects of potential global markets integration of the health sector. The increasing work division associated with this sector and its strong technological and product innovation potential lead to the existence of goods and services in the health productive complex. These goods and services hold lower or higher potential to be integrated to global markets.

2.3 Health as Pre-Requirement to Commercial Integration

There are new and old reasons that would justify health as a basic condition to integrate markets at global or regional level. The old reasons are related to the commercial integration process and the historical importance of public health measures in the last 150 years. The new reasons are linked to current unbalances on access to health services and goods. It is seen as a factor

influencing not only on commodities prices but also production decisions on a global scale.

Old Reasons: Global health improvements on the 20th Century were greatly fostered by preventive medicine and, to a lesser extent, by curative services. Even though families usually hold in high regard the later type of service, especially due to its visibility in improving a specific individual health condition, the former is very important as well. A not so visible work was developed to improve collective health conditions at global level. It was associated with the development and application of vaccinations against transmissible diseases, basic sanitation efforts, eradication of vectors that transmit such diseases and sanitary education for the poorest populations.

The investment associated with these collective health efforts played a crucial role in the development of commercial flows since late 19th Century until today. Harbor surveillance and the sanitation of big cities have ensured hastened growth of trade transactions. Besides, it avoided the contamination and transmission risk of a global epidemic.

Today such investments are almost completed in developed countries, although there are still expenses related to sanitary and epidemiological surveillance systems maintenance. Those are needed to avoid the emergence of new diseases focuses. Yet, those countries are not exempt from the emergence of epidemics. For instance, AIDS spread in wealthy nations starting in the 1980's. More recently, SARS temporarily affected and closed commercial transaction to important countries such as China and Canada. Today¹⁰, the world is struggling with the fear of an avian flu world epidemic. It already killed 112 people and have over 200 confirmed cases among humans. If there were no international cooperation efforts and efficient local systems of sanitary surveillance, it will be much harder to control these spreading diseases.

¹⁰ Accumulated cases from January 2003 until July 13th, 2006.

Public health and sanitary surveillance strategies have been, and still are, historical demands of globalization. They also help setting up new economic markets. It is common sense that vectors transmitting diseases do not respect national boundaries. Developed nations and international organizations have emphasized the need to vanish epidemiologic risk as a precondition to economic markets integration. On the other hand, sanitary surveillance actions, harbors' health and frontier control' rules are the first topics discussed on any economic integration strategy.

New Reasons: During the last few years, many developing countries have increased the competitiveness of their products on international markets. They usually provide low-cost manufactured products to developed countries, as well as their traditional products, generally commodities. This change was partially associated with a wider commercial openness in developed countries. In the United States, the average percentage of imports taxes dropped from 15% to 6% from 1951 to 1979.¹¹ Nevertheless, since then the drop has not been so sharp. USA import taxes are now around 3% on average. They are much higher to products where developing countries have been traditionally more competitive in the last decades. Hence, developed countries, which used to be the main free trade advocates, in opposition to developing countries that protected their markets through commercial barriers and imports replacement strategies, have recently started practicing again a defensive protectionism on their markets. This is most notably associated with commodities and low cost industrial products.

Labor related issues like low wages, social liabilities, and taxes are the main factors that have increased developing countries' competitiveness. In most developed nations, social charges include expensive health care

¹¹ According to Dobbs (2004) the North-American commercial deficit increased from US\$19 billion in 1980 to US\$ 0.5 trillion in 2004, benefiting countries like China, Japan, Germany, Canada, and Mexico.

insurance. In most developing countries workers do not have access to such luxuries or protection.¹² Developed countries claim that they would be willing to open commercial barriers if products imported from developing countries were produced based on salaries and acceptable¹³ social liabilities (Including medical assistance). With that proposal developed countries want to abolish competitiveness based on labor price differentials. Wealthy nations intend to restrict competition to bare physical productivity, where they have more comparative advantages. Therefore, the topic of worker social protection concerns health conditions. It includes occupational and environmental health. It has been gradually introduced onto the globalization and economic blocks discussion.

2.4 The role of the state in healthcare and the process of commercial integration

This section will first present the discussion about the decision-making process associated with public financing health goods and services. Then, it will present the public or private nature of goods financed by the state. This finance includes both production and provision of these goods, and it is discussed in a globalization

¹² For example, the average daily salary in China's transformation industry is US\$0,86 while in the United States it is US\$35, 00. That leads to a hastened process of internationalization of the North-American market where, for example, 75% of the toys sold are imported. It could also lead to an increase in the migration of capitals from developed countries to developing countries, as a way for reducing the production costs associated with factors and taxes. However, although this is a reality, the geographic and location-related factors are responsible for maintaining most of the developed countries' capitals involved in the production nearby their commercial centers (REDDING; VENABLES, 2000).

¹³ In the center of this discussion there are some sectors that actually take advantage of the opportunity to support the improvement of health conditions in developing countries, while others only use it to -- under a humanitarian argument -- keep on defending the niche of protection to national producers who are inefficient in the developed countries' markets.

context, with increasing international trade and the emergence of economic blocks.

Musgrove (1999) affirms that equity and economic efficiency issues could justify government action and public health expenditure. In order to guarantee equity, the public sector should prioritize the poor and try to avoid moral hazard¹⁴. It should only finance procedures where cost-effectiveness is the same for different people (horizontal equity). It should prioritize treatment to those with more serious health conditions who cannot afford to pay for it (vertical equity). It should apply the rule of rescue, according to which the State should support any high probability life-saving procedure. This support is made regardless of the state's chance of recovering the cost of treatment.

In the light of economic efficiency, public action would be worthy in order to correct market failures in the provision and consumption of health goods and services. One example would be the production of public goods, or health regulation and, eventually financing health. The state should finance goods that bring great positive externalities or that avoid negative externalities from other sectors. It should also finance goods that avoid catastrophic situations, where efforts towards mobilizing resources through the market would be difficult or not quick enough.

Drawing on these concepts, Musgrove proposes a tree of decisions associated with public resources allocation in health. Using the criteria

¹⁴ The concept of moral hazard in health is associated with situations where, under some supply circumstances, the marginal cost for an individual to consume an additional amount of a health good or service is higher than the marginal cost to the society, resulting in a sub-optimal allotment of resources available to the sector. Therefore, the permanence of such situation may lead to health infrastructure growth above the socially optimum needs. If that happens, for example, in a medical insurance, the insurer has to recalculate the insurance premiums and, therefore, increase the insurance price for all consumers, thus creating barriers to the adhesion of the less resourced individuals.

of effectiveness in relation to costs and equity, Musgrove concludes that public health expenditures would be justified in the following contexts: (a) public goods; (b) private goods associated with great externalities; (c) private goods with catastrophic costs that are not guaranteed for most people, and; (d) private goods that benefit the poor.

Here are examples of each of the four categories of health goods or services suggested on the Musgrove analysis. In the first case (public good), we could insert the sanitary surveillance services. In the second case (private goods associated with great externalities, where the demand is not met) we have mosquito nets impregnated with insecticide to fight malaria in regions with high prevalence of that disease. In the third case (private goods with catastrophic costs that are not insured for most of the population) we have high-tech procedures, like cardiac surgeries for poor population without medical insurance, for example. In the last case (private goods that benefit the poorest) there would be essential medications.

2.5 Factors Leading to Public Health Financing Regionalization

What would lead governments to finance healthcare out of its national borders? Which reasons lead governments to purchase health goods and services in other countries, or even make international investments in health? How does the issue of health affect relationships among countries that are part of an economic block? In order to understand the involvement of one or more neighboring countries in the production of health goods and services elsewhere, or which health conditions could provide mutual benefits to economic links and to the common welfare of those countries' population, one should study a few basic situations.

- a) If "A" and "B" are neighboring countries, it is mutual interest that the epidemics that emerge in A should not pass the frontier and affect the population of B. Therefore the regional control of vector-transmissible diseases is a necessary investment for both

nations, regardless of where the epidemic had its first outbreak.

- b) If besides being neighbors, A and B have commercial relations, the people involved on the transporting and trading business should not bear transmissible diseases. Thus it requires coordinated sanitary surveillance at both countries' terrestrial frontiers and ports, in order to avoid mutual contaminations.
- c) If A and B attract tourism and business visitors, these should receive care in the hosting country while traveling. Visitors can catch a disease, or suffer accidents, which can demand emergency medical care.
- d) If A and B countries integrate their labor markets, as happens in the European Union, they should promote regulation of their health insurance, occupational and environmental health system. They should also provide public services if there is no private structure for them. They must guarantee reciprocal rights of medical care and allow for a regular and functioning market of social protection for those workers.
- e) If A and B countries can be integrated and achieve more economic efficiency and comparative advantage in the complementary production of such goods than in their competitive production, their respective governments should then develop regulations and joint efforts to provide for technological transfer. They should also attempt to remove commercial barriers and maximize efficiency in the provision of and access to such goods and services. This will work to the benefit of these countries' population.

These situations clearly show that countries need to coordinate efforts in regulating or promoting public and private health goods and services production on a regional basis. The solution for cases a) and b) would be to implement joint actions in sanitary and epidemiological surveillance at border areas. These are the most characteristic cases of regional public goods. On the other hand, cases c), d) and e) solutions are not based necessarily on regional public goods. But they do require higher levels of integration in order to adopt joint measures on the issue. The issues of regional public goods and goods that although private, would be interesting to have countries on economic blocks finance, provide or regulate will be discussed on the next section.

2.6 Regional Public Goods concept and use on the Health Sector

Regional goods or services are those that make public goods go beyond national borders. Their production entails benefits to countries, populations, and generations. Its consumption brings positive externalities or minimizes negative externalities for all citizens of a given set of countries on that region. They are public because benefits are collectively appropriated. They are regional because benefits are extended beyond national limits. For example, peace and security of a group of countries in a region; the fight against drugs production and trafficking; environmental preservation associated with air and water resources conservation, epidemiological surveillance, fight against transmissible diseases, among others.

In 2003, the United Nations Development Program (UNDP) estimated the global cost of non-action and remedial actions to solve access problems associated with some global public goods, as can be depicted from the table below.

Table 1: Annual estimated costs of non-action and remedial actions to provide solutions to problems related to access to global public goods (in US\$ billion PPP)

Kind of cost	International financial stability	International trade regime	Excessive disease load	Climatic stability	Global peace and security
Non-action	50,0	260,0	1.138,0	780.0	358.0
Remedial action	0,3	20,0	93.0	125.0	71.0

Source: UNDP, 2003.

The successful regional integration of a block of countries is highly associated with the selection process and due management of regional public goods. These should be agreed on, regulated, and supplied at regional level. Efficiency in the production and consumption of regional public goods (RPG) requires several pre-conditions, among which:

- To identify the needs, the effective and potential level of production, and comparative advantages associated with such goods and services in each member country of the economic block or region considered. In this process, it is essential to seek for equity differentials concerning access to goods and services that may become RPG and discuss if they are subject to a cost-effective reduction along the integration process;
- To promote information and communication campaigns about the proper use and advantages associated with the consumption of those goods. Countries should also approximate public and private economic players interested in its regulation and production;
- To promote international dialogues among policy makers and decision-makers. These must take into consideration prior multi-lateral agreements on regulation, promotion, and trade. This must be made in order to seek the most responsive ways of producing and supplying such goods;
- To abolish or reduce imports and exports barriers to elements and components required for the consumption of such goods. It will enhance regional comparative advantages with lower transaction costs and

reduce limitations to supply in face of regional demand;

- To obtain adequate incentives and financing mechanisms to subsidize or facilitate credit to nations that cannot afford the required means to produce such goods; and,
- To assess and follow-up the positive results associated with extended access and use of such goods, in order to get acquainted with the factors that may increase production and future use on the regional block.

The identification of required production and equity of access to RPGs is a difficult process of coordination that may require the support of institutions coordinating economic blocks, or even technical cooperation efforts by international development financing organizations. The types of technical cooperation for producing regional public goods could be:

- a) *Externally oriented*, whenever the initiative is originated by external agents to produce a RPG relevant to a specific nation (For example: when an international institution prepares and promotes the use of AIDS preventive protocols specific to a given country);
- b) *Oriented to within*, whenever motivation comes from one or more countries in the region to adjust nationally the RPG production forms to international regulations (general quality standards in the production of vaccinations, for example);
- c) *Inter-governmental*, when several governments work together in an effort towards producing an RPG (international

efforts to produce vaccination against AIDS); and

- d) *Through a network*, when several countries articulate to promote consensual adjustments to the production of an RPG based on commercial agreements signed within the scope of an economic block, to meet a demand regionally differentiated (production of essential medications to the European community, for example.)

The equity aspect is troublesome when one advances in the regional integration process associated with RPGs in health. It is more likely to reach equity in health in the absence of major socio-economic differences among countries part of a given economic block. It also helps when the poorest countries' populations are not so small compared to that of other member countries. Here, the cost of increasing social equity can be assumed, in a planned way, by the economic block coordination. It must be set upon participating countries' mutual agreement. This happened to Portugal and Greece (and to some extent to Turkey) in the process to establish the EU.

If there are huge social inequalities and large contingents of poor individuals in the population of the countries part of the economic block, the establishment of RPGs in health could be endangered. The same is true concerning the coverage of basic health care between small and equitable countries and big and non-equitable countries belonging to the same economic block. For example, a country like Uruguay could not freely provide services of highly specialized medicine universal in the context of that country, to Paraguayan visitors. It would induce the unmet Paraguayan demand, which does not have access at home to that kind of service. Its population would go to Uruguay and thus could endanger the fiscal sustainability of that country's program.

Finally, the definition of health goods or services as RPG's sometimes is established through regulations, before it is verified as such. Only reality can prove if it is really an RPR, mixed goods or just private goods that generate positive externalities. Regardless of the

economic nature of the goods, it would be important to guarantee their effectiveness in relation to costs entailed to a set of countries that decides to foster the consumption of those goods through regulations or public subsidy. In that sense, strategies on vaccination or essential medications could behave as RPGs, provided they could count on adequate legislation. In practice, however, except for the sanitary surveillance actions at frontier zones, there are few cases of proven RPGs whether in national or international contexts.

2.7 The Issue of Reciprocity in Health Care among Countries

Health care reciprocity treaties depend on several circumstances. Reciprocity guarantees to foreign visitors, tourists and workers the same health rights as regular citizens or permanent residents. This increase visits in between citizens of countries holding reciprocity agreements. Generally speaking, the main reasons that lead to health care reciprocity between countries are as follows:

- a) *Tourism and businesses*: countries endowed with comprehensive and universal public system may expand their health services to foreigners, aiming at developing tourism or commercial links. Therefore, two or more countries may enter agreements so that visitors may be served by health public services whenever necessary. In general, the situation is more complex when countries with different systems are neighbors, since the reason for visiting the foreign country may become the use of the health system itself ¹⁵, thus expanding the risk of increasing the costs of national services of a given country, with no perspectives of reimbursement;

¹⁵ To generate additional revenues and avoid visiting foreigners' consumption of expensive health services, Cuba -- through its international commercial affairs corporation - Cubanacan -- started developing, in early 1990's, programs on Health Tourism, where agreements are signed directly with stakeholders or Health Plans in several countries, for the remunerated use of specialized health services.

- b) *Similarity of health protection systems:* Countries with similar health systems, whether concerning their organization or the content of services package supplied or services' quality, are more prone to develop health reciprocity agreements. For example, on May 4th 1998, Australia signed an agreement with New Zealand guaranteeing reciprocity to citizens from both countries with regard to the use of public health services. This agreement applies whether their citizens are temporarily or permanently staying on each other's territory. Both countries' public and universal services are ranked among the best in the world. Furthermore, Australia has public health care reciprocity agreements with several countries in the world, such as the United Kingdom, Malta, Sweden, Italy, Holland, Norway and Finland; and,
- c) *Labor immigration:* Neighboring countries face labor immigration issues, and that is one of the reasons for integration, and for most of health services reciprocity-related themes in European countries development prior to the efforts towards creating the European Union. In Latin America, for example, Chile and Peru hold health reciprocity agreements. The first one, through the Chilean public National Health Fund (FONASA), provides free services to the workers migrating population, notably in the Country's northern region¹⁶. Since the number of Chileans in Peru is much lower than that of Peruvians in Chile, the reciprocity -- favorable to Peru in terms of health expenses -- is counterbalanced by the use of Peruvian labor force -- cheaper than the Chilean -- in Chile's economic activities. As counterpart to said care, Peru supplies Chile with medications to fight some endemic diseases. A similar case is found in Costa Rica, to where Nicaraguans migrate

during the plantations harvest season. Despite Costa Rica's universal system's good quality of care, its access is restricted to its citizens only. Nicaraguans immigrants can count on health care for vaccination, emergencies, and occupational diseases, but are excluded from long-term treatments. Therefore, a cheaper labor source is guaranteed, while avoiding the risk of transmissible diseases and epidemics in the territory of Costa Rica. In fact, there is no reciprocity since the same treatment would not be available to Costa Ricans in Nicaragua.

On some contexts, despite favorable social and economic homogeneity, healthcare services reciprocity does not arise. Most of such cases are associated with different concepts of social policies organization. The two major economies in NAFTA -- United States and Canada -- do not hold reciprocity agreements concerning health services use. That is basically because the systems are organized in a completely different way. The Canadian system is based on a free public and universal health coverage. Americans, with the exception of those below poverty line (served by MEDICAID) or over 65 years old (served by MEDICARE), are protected by private health insurance schemes partially or wholly paid by the corporations and individuals. When Americans travel they are expected to contract additional coverage before leaving the country. Americans living in Canada are only covered by the national health system if they decide to adopt Canadian citizenship. Tourists and temporary visitors are not granted the right to universal health provided by the Canadian government. This system is financed with tax earnings. Similarly, the American public system does not reimburse expenses incurred by its publicly insured citizens abroad. Neither does ordinary private health insurance plans. The same is also true for Canadian citizens in the USA, as they don't earn reimbursement for expenses while traveling to their southern neighbor.

¹⁶ FONASA is a public care service to meet the population that does not earn enough to be a member of ISAPRE, the informal market, and indigent population. The ISAPRES are private health insurance companies that freely compete for the population's range of higher incomes, serving about 30% of the Chilean population.

2.8 - Other issues that require state presence on International Health Markets Regulation

In addition to the agreements related to RPG and reciprocity agreements, other factors could lead to relationships among national governments directed at promoting health actions and policies, such as:

- a) *Scientific research protocols: this has been one of the broadest fields* of countries' cooperation in health, within or outside of the scope of economic blocks. For example, in August 1996, France and Canada signed an administrative agreement in the field of research and development of new medications, sanitary surveillance, health promotion through means of campaigns against drugs and tobacco. Finally, they have also made efforts to include in the project studies in the field of medical care providers;
- b) *Capacity building and organization to develop similar economic activities:* Good and safety health environment is extremely relevant as an input to some kinds of activity, like tourism, for instance. Conscious that tourism is the major source of revenue for the Caribbean population and that visitors' health is a necessary driving force to keep up this success, in 1996 sixteen Caribbean countries constructed an

alliance for sanitary control of hotels in the region. The alliance aimed at enhancing control over prevalent diseases and visitors' health care. The goal is to turn the region into an even safer place for travel and cruising. The alliance is based on three levels of cooperation: a) the commitment of national health authorities and the hotel industry to sanitary surveillance, notification and communication of events that could affect public health among the Region's countries; b) specialized training in basic public health concepts for waiters, cooks, maids and all the staff who deal with food hygiene and accommodations in hotels, restaurants, maritime cruise companies, etc.;

- c) *mutual assistance agreements between countries to provide medical care through local public health services to eventual visitors who become sick; and,*
- c) *Bilateral aid:* Bilateral technical cooperation agreements are the usual ways of advancing cooperation actions on different themes, including health. There are several examples associated with this theme. For example, in July 2000, India and the United States signed a 5-year renewable agreement to study and develop topics on reproductive health, including research on new contraceptive methods and the control of sexually transmitted diseases.

3. Private Markets, Health and Regional Integration

Regional integration in private health markets has more to do with commercial aspects than issues related to social rights. Most of this discussion passes through topics like basic inputs, medications, and medical technology. In turn, the topics related to medical inputs and medications bring up aspects that are also very complex, like differential pricing, technology transfer, and patents. The discussion on medical equipment and technology – one of the fastest expanding industries in the world – involves important aspects related to regulation of the use of such technology, its cost-effectiveness ratio and its adjustment to the epidemiological profile and organization of health services on each country.

Another international market that is experiencing remarkable growth is information technology, where tele-medicine, remote capacity-building and training, and even distance service provision, like distance laboratory testing, are outstanding topics. Once again, the discussion on these themes involves common protocols and regulation among countries related to satellite-based communication standards, access to broadband technology and other issues.

Health capacity building through on-site courses, masters' degrees and doctorates, and others related to health professions are also a growing work field. Aspects such as licensing of activities and franchise agreements are crucial to the working of such markets. In the last few years, Latin America has experienced strong expansion of such courses, mainly those focused on management. Many of them are prerequisites for taking office posts in establishments and institutions that manage health systems and services in the Region.

Finally, a branch that is flourishing within private health markets integration is services provision itself. Those are made not through the displacement of health services, since these last

are not internationally tradable, as previously defined, but through health insurance institutions. New financial products associated with that market and portability features of insurance develop behind it in the need for several private self-regulating institutions. Those are defined through the process of licensing, certification and accreditation of institutions that guarantee minimum quality standards for medical care at international level.

Many other areas as Regional integration of inputs, medications, medical technology, information technology and capacity-building allow to open room for broad debates, which are beyond the scope of this paper. The present discussion limited the debate to relevant aspects of health services integration through institutions and insurance modalities, involving international self-regulation mechanisms, on one hand, and health insurance portability standards, on the other hand.

3.1 Regional Integration, Regulation and Self-regulation of Health Services

The development of international networks of health insurance, or of institutions that may be hired to render health services following international standards, is a pre-condition to developing private health services' markets. There is increasing concern among health insurance companies in central countries. The concern is directed at finding market niches for their financial and health insurance products in developing countries. Simultaneously, the diversification of such products in these markets leads to the idea of health insurances as an international protection for everywhere citizens. Thus, it leads to standardizing and guaranteeing quality of health services standards in developing countries.

Guaranteeing health services quality involves three kinds of activities: a) Establishing minimum operation requirements for facilities

and entities which are typically government-ruled; b) Guaranteeing quality supply according to parameters developed or accepted by an international private suppliers' network; and, c) guaranteeing quality of staff rendering services (mainly physicians and nurses). For the last two cases there is concrete evidence of self-regulation on the part of the participating spheres rather than of public regulation. However, when dealing with foment to international markets expansion, the State may be compelled to assume or foster, in the developing country, at least transitorily, processes that in developed countries are called self-regulation.

The guarantee of minimum working requirements goes through *licensing* processes. The government sets forth conditions for health facilities, a school to train professionals, a drugstore, a laboratory or any other health institution to be awarded its working license. However, since licensing is also a minimum set of requirements, sometimes the local standard does not consider the minimum quality standards required for an institution to meet international demand. This affects its participation in an integrated health insurance network, for example.

More sophisticated self-regulatory processes, following parameters established through international networks, are defined through *accreditation* processes. Those are instances where an international health network defines the requirements in terms of facilities, composition of professional teams, guarantees of services to be provided, comfort standards, outputs evaluation processes and else. Accreditation is a process that can be expanded to institutions belonging to the fostering apparatus; (medical schools) services provision institutions, (hospitals, out patient care units, specialized clinics, laboratories, etc.) or even to health insurance operators (where it checks managerial processes, financial adjustment mechanisms and actuarial risk, etc.)¹⁷ Although

¹⁷ In many developed countries, like the United States, the accreditation process is necessary because there is no governmental sphere of health

accreditation started in the USA on the early twentieth century, only now it is becoming an increasing trend in many other developed and developing countries.

It is necessary to guarantee not only the quality of health professionals' qualifications, but also the quality of their knowledge when they are hired. Knowledge update must be taken into consideration according to the latest advances incorporated to medical practice. These can be verified through *certification* processes (when the professional graduates) and *re-certification* (that verifies knowledge updating). The role-played by licensing, certification and accreditation activities as tools to integrate private health markets can be discerned from Table 2, below.

services quality control. In this sense, the Government assigns to external authorities the power of developing peer-to-peer review processes for public facilities. For private facilities, the process is voluntary and usually non-profitable. Associative institutions like the JCAHO (Joint Commission for Accreditation of Hospitals) account for 92% of the accreditation of North-American hospitals. That commission performs auditing in hospitals at every 3 years, and is composed by a council of 28 individuals (14 representatives of physicians in different categories, 7 of other health professionals and 7 representatives of the users' population).

Table 2: Distinctive Characteristics of Licensing, Certification, and Accreditation Processes in the Process of Integrating Private Health Markets

Characteristics	Licensing	Certification	Accreditation
Applied to	Health services and plans, or institutions of professional training;	Health professionals	Health services and plans, or institutions of professional training;
Regulatory authority	Government	Governments, peers of managers;	Governments, peers of managers;
Required for	Working	Hiring or contract renewal;	Hiring, contract renewal, or inclusion in the providers' list;
Purpose	Standardization	Adjustment of protocols and contents	Standardization and quality control
Duration	Permanent	Permanent or for extendable fixed-term	Extendable fixed-term
Standards	Minimum of quality	Professional competencies	Products, processes and outputs;
Quality Verification	Little	High	High
Performance Evaluation	No	Regular	Permanent
Management	Simple	Intermediary	Complex
Requirements for Renewal	Almost automatic	Test required	Complex re-evaluation

As it can be learned from Table 2, accreditation processes tend to be more complex than those of licensing, and certification processes are intermediary because they aim only at guaranteeing the professional training quality. Therefore, the commercial integration of health services stands for changes in licensing activities. These are based on public management. The certification of professionals and accreditation of activities involves not only the government as the ultimate guarantor, but also international institutions. Civil society is also important to maintain minimum quality

standards to those services. That leads health services to depart from State-tutored regulation to self-regulation, in an impartial way. Finally, it is done through properly qualified international and civil society institutions.

3.2 The issue of Health Insurance Portability

As previously mentioned, although health services are not internationally tradable since they are rendered to individuals at sites other than where there are physical facilities and the labor force to deliver them, we could say that

health plans are internationally tradable. What theoretically allows for that feature is the portability of health insurance instruments.

Individuals' rights to health insurance portability are basically to keep coverage standards. This is usually an issue when the insured severs voluntarily or involuntarily the bond with the employer or the insurer, and needs to change policies. Portability ensures the rights awarded to an individual if he is transferred to another health plan, another region, or country. The transfer (or portability) depends mainly on the degree of health insurance markets development in each region or country, as well as on the existing asymmetries in the coverage system.

The standardization of conditions and quality of services, partially guaranteed by international accreditation mechanisms for health institutions, allows health insurance plans on developed countries to provide international services, using existing facilities in other countries. It may even allow health insurance operators to be internationalized and, thus, replicate their structures in other countries, providing health plans with an international coverage.

This apparently simple reality involves great complexity and demands large standardization efforts. Even in national contexts, the portability issue is crucial to structure private health systems, since it increases the system's outreach, competitiveness and equity. However, its achievement also involves several management-related problems: administrative, financial and actuarial.

In the light of administrative management, there are several forms of health insurance organization, ranging from free selection at all levels, to plans that limit the services to a closed network of providers or to providers that institutionally belong to the same insurance institution.

In the aspect of financial management, the plans range from pre-payment to post-payment, passing through those that charge moderate rates, co-payment for services, and other modalities.

Concerning actuarial management, the information on risk varies from company to company. Some use risk evaluation forms to differentiate the policy price just by assuming some morbidity-mortality profiles based on demographic (sex and age) and socio-economic information. Others decide to assume the average risk of a given group of individuals, and do not charge different prices for policies.

In this sense, faced with the different service care, financing and risk structures, a beneficiary can hardly negotiate the portability of his health insurance with another insurer or services organization modality without implying a redefinition of prices, costs, grace periods, utilization protocols and free selection of providers. According to Biasoto (2003), *"portability is not an isolated issue; it should be understood within a system set that comprises characteristics such as the perception of contributory regimes and the sustainability of private health managing entities. The sustainability issue is very complex in any situation, both for risk management conditions among restricted populations, and for the perverse market practices in an environment with sharp risk and client selections. In cases like that of Brazil's, where the population income characteristics and the low adherence of employers make the market even more limited, the weaknesses intrinsic to the system are intensified"*.

The duty of health insurance regulation or self-regulation entities is, to a large extent, to guarantee minimum standards to ensure health insurance portability to individuals who want to change from the region or even change the plan, therefore improving the existing mechanisms of insurance and re-insurance. Nevertheless, that sometimes is not possible, even in the context of more developed countries.

In the United States, for example, the Health Insurance Portability and Accountability Act (HIPAA) introduced an article that, in 1996, amended the Employee Retirement Income Security Act (ERISA). That Act governs most of the nation's labor and social security relations, including discrimination at work and access to

health coverage by corporations. In relation to health, the act awards rights and protection to collective health plans' beneficiaries when they move from one State to another, even in the event of termination of labor links with the previous job. Furthermore, the relations of workers' health insurance coverage at intra-state level are ruled by each State's regulations.

HIPAA has restrictions for coverage in the event of pre-existing disease. If coverage is interrupted for more than 63 days, HIPAA's guarantee is then voided. Coverage thus becomes guaranteed by the US government and ceases to overload private insurers with that onus. Even for non-retired individuals, MEDICARE covers medical care for chronic diseases under given circumstances, and this is one of them.

There is no law guaranteeing health insurance portability within the scope of NAFTA. It means

that if an American worker, for work reasons, migrates to Mexico or Canada, he or she is no longer institutionally protected. Nevertheless, the North-American Free trade Agreement labor commission is analyzing some measures to guarantee existing agreements on health protections to workers who migrate to other countries.

There are some examples of health insurance international portability. Yet, those are restricted to expensive private plans supplied on a small scale. In general travel agencies and operators provide international health insurance to clients traveling in excursions. Therefore, despite huge and complex obstacles aforementioned, there are endless possibilities on this area. They appear both at national and international level, not only in developed countries, but also in developing countries.

4. The Cases of the European Union, NAFTA, and MERCOSUR

4.1 -The Case of the European Union

European social policies (and health is not an exception) were structured so as to build successive rings of social protection, in an evolutionary concept of public insurance that starts with Bismarck, in the end of the nineteenth century, and culminates with Beveridge, in the second half of the twentieth century. Because of that process, in most European countries health care coverage is universal, and there is not much room for the massive proliferation of private markets. Coverage pressures, horizontal and vertical equity have all led health expenditures to surge as a big share of the GDP. This happened in the last thirty years, and it was due not only to demographic and technological factors, but also to increasing consumption demands and standards of the overall European population.

On the other hand, the process of establishing the EU has already been going on for decades. But only recently has the EU adopted some absolute measures towards unifying health services. The measures comprise, in addition to public health, the integration of basic health care supply.

Public Health: In the field of Public Health, on April 15 1998, the European Community Council enacted a resolution on public health protection for member countries' population. The resolution aims at improving the quality of information on population health status in different countries, and providing guidance for collective responses to epidemics and transmissible diseases, joint efforts in policies of promotion, prevention and improvement of life quality, including specific guidance on vaccination and change of population habits, control on the production, advertisement and use of tobacco in public spaces, control on the use of drugs, alcohol and doping in Sport, joint

programs against AIDS, food and personal effects inspection, etc. The proposal is to gradually develop and agree on a unified European legislation on public health measures, integrated to other social and economic policies, including trade.

Primary Health Care Supply: For health services supply there are reciprocity-based agreements and resolutions on the use of health services among citizens of different countries of the European Community. However, the heavy traffic of information among countries aimed at achieving such rights has been an additional factor in bureaucratizing services, an obstacle to expanding the scope of such agreements.

The proposal to simplify bureaucracy and advance the expansion of health rights to citizens involved establishing the *European Health Insurance Card*. The Card is valid on all member countries and also in Switzerland, Norway, Iceland, Liechtenstein and the Caribbean Islands of Guadeloupe, (a French department). It will protect citizens and permanent residents, allowing ready access to the public health system of the country where they are staying, visiting or working. The right to require a card was extended to permanent residents since June 1st 2003¹⁸, through regulation 859/2003. It certainly helps to ensure the regular flow of work and protects access to basic health care needs of the continent's population. It is a huge advancement, but the debate on its creation and implementation dates back a long way.

The Council of the European Union member countries presented, on May 26 1986, the suggestion of creating that card. However, it was only 10 years later (1996) that the European Parliament enacted a resolution to start with the cards' implementation. The card dissemination

¹⁸ At the time it was still form E-111 on the UK.

and use should be simple. But legal, technical and political difficulties have prevented several European countries from entering on an agreement up to that point. This led to delays and impairing advances on this topic. Only after almost twenty years the card was approved on June 1st 2004, to substitute the E- 111 form (on the UK) and all other E forms as well.

The card facilitates unification and coverage through relatively standardized parameters for low-cost and highly-effective actions that should be integrated and agreed on within the scope of European countries; It includes primary care services and more specialized services, like fighting cancer and cardio-vascular diseases. The card will use e-smart technology, i.e., a chip with the required information for controlling the health of the population on all EU countries.¹⁹ Therefore, it is hoped to abolish several controls, forms and documents that were required to develop the existing health protection agreements oriented to European citizens, in force in different countries.

The launching of the smart card with chip does not have a fixed date so far. This is mostly due to EU member countries' different technological stages. According to the European Parliament, the health card should be a symbol of the Community, as important as the unified currency, Euro. It will facilitate mobility for the region workers, micro-entrepreneurs, and students pursuing better opportunities.

Over the last few years, the European Union has achieved major advances in the regulation of health rights reciprocity affairs. It may be considered the most developed economic block in this regard. Another important example of unification is the integration of labor markets for health professionals, with efforts towards

¹⁹ In fact, many European countries like Belgium, Denmark, Germany, Greece, Spain, France, Ireland, Italy, Luxemburg and Holland have already implemented national experiences of health e-smarts, for different purposes. Therefore, the experience of using that kind of card is not external to the European countries' context and, presumably, there would be no major practical problems or cultural resistance to its use.

integrating curricula and requirements for exercising professions. However, the heterogeneity in Europe in terms of economic development is apparently less than that of other continents. This eases the developments of reciprocity themes.

4.2 - The case of NAFTA

Since North America is much more heterogeneous than the core European countries, and since it harbors countries with extremely different concepts of society, economy, populations' basic rights and health policies, the NAFTA faces many more obstacles in the implementation of joint cooperation programs, integration and reciprocity in health issues than the EU. In face of the deep differences among the American, Canadian and Mexican health systems in terms of structure, financing and basic coverage of social groups, and the desirable levels of regulation in the private market, health integration is almost inexistent in there.

There are some initiatives in the field of labor security, occupational health and work accidents among NAFTA countries, aiming at implementing common occupational and environmental health parameters that allow for complying with international provisions. Many of those initiatives are still study projects that may come into being in the future. The NAALC – North-American Agreement on Labor Cooperation – has tried to advance on questions of occupational and environmental health and labor safety, as well as in other more complex issues, like portability of medical care rights to workers. However, in face of the lack of interest of the member countries in deepening these topics and the rising complexity of immigration issues, the regulatory production related to that agreement is scarce and irrelevant.

Therefore, the debates on integration of health rights and other related topics are far from even starting, because of the strong differences in administrative and coverage concepts in the health system of the three countries part of NAFTA. It is widely known that Canada can count on a public, universal, and good-quality

health system. Therefore, it reports better health indexes for its population, greater equity of access and lower *per capita* health expense than its closest neighbour. Public care in the USA is focused on the poorest population (MEDICAID) and adults over 65 years old (MEDICARE). The active population must rely on private insurance or voluntary coverage, whether paid by corporations or themselves.

Mexico, in turn, has a public health network focused on three aid systems: the first one, for the formal labor market (private sector) bound to the Mexican Social Security Institute (IMSS). The second one, for federal public servants (ISSSTE) and the third, under implementation, which is a popular health insurance financed with fiscal resources and operated in a decentralized way, to serve the indigent population and the informal labor market. This network will use the existing local and state level public health systems as a base to expand its operations. This project has been relatively successful, but it will take a long time to be implemented, and Mexico will continue to report great disparities in quality and level of health coverage.

One of the great social dilemmas of NAFTA, which does not affect Canada, is the labor migration at Mexico-USA border. The population of Latin American origin counts for 13.8% of the US population, and is the largest minority in the country, followed by the African-American population. More than 24 million individuals of Mexican origin live in the USA and, of them, at least one third was born in Mexico. The remittances from Mexican residents (permanent or temporary residents) correspond to the first source of external currency in the Mexican economy, amounted to US\$ 63 Billions in 2004. However, that population is less covered by health assistance than the average American citizen. According to the 2001 data, only 46% of the Mexican population residing in the USA was covered by health insurance, in comparison to an average of 86% of total population. Several measures have been adopted to solve these problems, with little progress so far.

The first one was the establishment of a voluntary insurance for individuals of Mexican origin residing in the USA to participate in the IMSS. Because of costs involved, until 2000 insurance had not reached more than 3 thousand titular beneficiaries and 10 thousand dependants. Therefore, a more definitive solution was created by the end of the 1990's, upon the establishment of the Mexico – USA Commission to improve health status at border areas. The American side reports much worse health indicators than the Mexican. The USA's only goal is to simultaneously establish mechanisms of control against bio-terrorism.

The first joint objective of the Commission is to make diagnosis of public health needs and support the monitoring of health issues at the frontier. Based on that diagnosis, the next stage would be to provide financial, technical, or administrative support to assist public and philanthropic institutions in their search for strategies to prevent the problems, taking into consideration the experience and knowledge of the causes and techniques that those organizations have accumulated in dealing with such situations.

Another objective is to support activities of health promotion and prevention at the border, since that is a region that lacks economic resources and where poverty prevails. Therefore, it demands basic educational and preventive campaigns typical of developing countries, which were deactivated long ago in the public strategies of sanitary surveillance by the North-American government.

The support for a coordinated general information system could assist in achieving both objectives, which is a basic condition to guarantee success in achieving sanitary goals specifically set by the Commission, as follows:

- a) *On the Mexican side:* reduce to 5% the population without access to medical care; reduce mortality from cervical cancer by 20%; reduce mortality from diabetes by 10%; reduce the share of houses not served by wells or drainage systems; keep the level of AIDS at the same as that for the year

2000; improve the rates for mother-child health, mental health, vaccination and the results of public health programs; and,

- b) *On the North-American side:* reduce in 25% the population without access to health services; reduce cervical cancer by 30%; reduce mortality from diabetes by 20%; universalize the access to sanitation and reduce AIDS prevalence by 50%.

When comparing the parameters of actions and priorities on both sides of the frontier, some issues seem to be relevant. First of all, the population on both sides of the frontier reports similar needs – hence, the joint agenda – but the inflexion point of each country is different. The United States places priority on the fight against AIDS. Mexico focuses more on universal care, leaving few citizens out of medical care. And it reports more modest index reduction goals than those proposed by the United States. Somehow, even when pursuing integration, the participant countries prefer keeping their national priorities, their management styles, and ways of financing health.

4.3 - MERCOSUR perspectives

MERCOSUR is a common market that is closely bound to expansion movements and financial crisis on its five member countries (Argentina, Brazil, Paraguay, Uruguay and Venezuela) and two observers (Chile and Bolivia). Solidarity among those countries, as well as their economic alliances, sometimes are weakened or strengthened according to the dimension of the crisis faced in the region. The integration of health activities in that market has not appeared on major communication vehicles announces. But, somehow, has been debated and gradually regulated in the administrative and technical spheres of its member countries. By 2003, there were 274 pieces of legislation dealing with health in the legislative framework of that market.

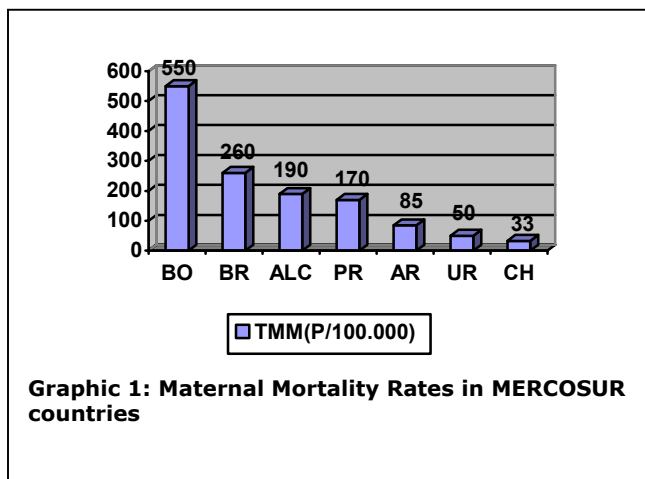
Most of the regulations deal with issues related to public healthy surveillance, control, and standardization of sanitary products more than with issues associated to the production and registration of medications, integration and

reciprocity of services to be mutually delivered to the member countries' citizens.

Table 3: Public Health Expenses as % of the GDP in Mercosur countries

Countries	1995	2000
AR	5.0	4.7
BO	2.9	4.9
BR	3.1	3.4
CH	2.4	3.1
PR	2.1	3.0
UR	4.6	5.1

The health system in the 6 countries concerned vary a lot in terms of organization and financing (Argentina, Uruguay and Bolivia are the countries that commit more public expenditure to health), report very discrepant coverage and equity levels (see maternal mortality rates disclosed in Graphic 1). Venezuela was not a member of MERCOSUR at that point.



Graphic 1: Maternal Mortality Rates in MERCOSUR countries

Despite the inexistence of any treaty explicitly stating the issue of reciprocity of public health protection systems and the health insurance portability among nations involved, the national or local public health services provide emergency care to foreigners without any previous agreement or financial compensation mechanisms. Such discrepancies in the levels of financing and supply of health services may lead to perverse incentives, in the lack of

international regulation, which could bring about uneven financing conditions.

That does not impair, in the unilateral view, the adoption of some measures to regulate and increase equity in access to services in regions reporting huge population's movement at the frontiers. Since the Brazilian government has the most aggressive health policy in the region now, in terms of coverage, it has adopted some measures such as free distribution of yellow-fever vaccines in Bolivia. As a counterpart, the Bolivian population must present the yellow-fever vaccination card when they come to Brazil. Similarly, the government of Brazil has endeavored to regulate medical care in the Triple Frontier Region (Argentina, Paraguay and Brazil) that is crossed everyday by countless migrants and, therefore, has more risk of transmission of diseases and of bio-terrorism.

Despite such partial efforts, the market integration of products, inputs, services and work in the health field is far from being a reality, demanding advances in several diagnoses that, up to now, are inexistent. Here, it would be necessary developing industrial policy studies to try to describe the working of the health productive complex, trying to characterize complementarities, overlapping and

comparative advantages for each country, in their different market branches.

This process should necessarily rest on the identification of comparative and political advantages ensued by the alignment of interests and markets, so that rights and guarantees of access to regional public health goods may be identified and respected.

Studies on industrial policy that evaluate the production of medications, inputs and medical equipment; specify the demands, production, regulation and use of human resources; identify needed researches and development of new products; allow the study of different modalities of public and private services organization and their articulations and contradictions to be settled, are core aspects that should be acknowledge during the process of adopting informed policies on the integration of those markets. It would also be worth identifying the needs for public and private investment, as well as the financial and credit policy for the sector, in addition to public and private insurance modalities, so as to identify future financing mechanisms for the sector, but now at the level of the economic block's needs rather than at each country's level.

5. Final Remarks

The benefits entailed by economic integration are more visible in the long run, but some of them can bring in short-term yields. For example, improvements in public health status as a result of common sanitary measures adopted, capable of increasing control over transmissible diseases and the prevention of chronic diseases can be quickly perceived. Regardless of the reciprocity among citizens, the sanitary campaigns jointly developed by the countries help eradicating diseases in regions that are not limited to geo-political frontiers.

Moreover, health equity is increased by the creation of a protection shield based on basic services and essential medications that may be enhanced in volumes of purchase, when the list is prepared by a set of countries aiming at fostering local production. The increased volume of purchase leads to greater economic efficiency in market integration and the establishment of comparative advantages in the production and selling of health goods and services. Therefore, the countries not only start producing local goods and services, but also start selling them to other international commercial blocks, in a coordinated way, generating positive effects on the economic growth rates for a given region or continent.

There are also risks, and they are not few. Creating pressures to increase investments in health through bilateral and multilateral aid, mainly in poorest countries, with no budgetary resources to sustain such investments, may lead to the waste of initiatives and the return to previous production standards.

There is the risk that the increasing health professionals' qualification without the corresponding fair remuneration in a competitive market between countries may lead to the

international migration of qualified labor force in health, put together with foreign assistance. The draining of minds may result in a reduction of the more educated class in less developed countries.

The risk entailed by increasing international trade and the capital flows associated to the sector, as well as the risk of concentrating markets in areas of higher profitability, may generate losses, increasing internal and cross-country unbalances. Health services are increasingly tradable and the better conditions provided in wealthy countries, with flexibility for quick capital transfers, without a due system of regulation and correction of asymmetries could generate impoverishment of institutions that are already installed in poorer countries.

Although the conditions for health market growth and internationalization and to their integration in economic blocks had been favorable in the 1990's, there are serious doubts about the continuity of the dynamics of that process at the beginning of the new millennium.

The international context, after the incidents of September 2001, has strong impacts on the shrinking of global investments and the continuity of commercial integration processes, particularly concerning the North-South relationship. That has deeper effects on health sectors, where risks associated to investments strongly depend on the expansion of income levels and its better distribution. In that light, the promises on health market integration in economic blocks may have to wait a little longer to come true. Even if one considers the long strides the EU and other countries have made in the last decade.

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