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Investigating International Health Markets: Methodological Problems and Challenges

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Processes of privatisation and liberalisation around the world would lead us to expect a growth in the private provision of health and social care services, which in turn we would expect to lead to a growth in the international trading of such services. However, the available data are not adequate to allow us to develop a clear and comprehensive picture of the scope and nature of this emerging world market. What data do exist may take a variety of forms and be pitched at different levels of analysis. Such data may be focused at the level of firms providing such services, at the national level; at the level of regional organisations and agreements; or at the level of international organisations and agreements. This article discusses the methodological problems and challenges of attempting to integrate such diverse forms of data and levels of analysis. It is concluded that a comprehensive analysis must not only include all of these levels, but take account of the ways in which processes at different levels may interact to reinforce the tendency towards trade in healthcare services.

Introduction

Governments all over the world have engaged in processes of privatisation in the last two decades, and these processes have increasingly been matched by those involving the liberalisation of trade. We might therefore expect such processes to lead not only to an increase in the private provision of healthcare services, but also to an increase in the international trading of such services and therefore, potentially at least, to the development of an international market in healthcare services. However, the available data are not adequate to allow us to develop a clear and comprehensive picture of the scope and nature of this emerging market. Despite a growing literature on processes of privatisation and liberalisation as they relate to healthcare, it remains difficult to gain an overall view of how health markets are expanding, especially in terms of how such markets may be becoming integrated at an international level. As the Working Group on Health and the International Economy of the World Health Organisation's Commission on Macroeconomics and Health argued:

> There is a pressing need to improve data on the health sector, in particular on the nature and extent of trade and investment transactions in this sector. Much of the current analysis on the

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> effects of liberalisation in the health sector is qualitative in nature, based mainly on experiences of particular countries, and that too frequently is anecdotal rather than based on hard data. (Ahluwalia, 2002: 22)

What data do exist may take a variety of forms and be pitched at different levels of analysis. As Buse *et al*. argue (2002: 271), new approaches, methods or tools may be needed to analyse health policy at the global level.

This article identifies some of the key forms of data that do exist, and discusses the methodological problems and challenges of attempting to integrate such diverse forms of data and levels of analysis. The article is organised into sections covering the level of the firm itself, the national level, the regional level and the international level.

The firm level

One approach to the development of international health markets has been to focus on the extent of internationalisation among firms providing health services. Work recently completed compares the extent of internationalisation among large corporate providers of health goods and services (Holden, 2005). Companies with health-related activities included in *Fortune* magazine's G500 list of the world's largest companies (*Fortune*, 22 July 2002) were allocated to one of five categories: *providers of services* to the end consumer, such as hospital providers; *producers of goods* such as pharmaceuticals; *suppliers of services* to state providers or private providers, such as pharmaceutical wholesalers; *private health insurers*; and companies involved in *the provision or maintenance of premises*. The extent of internationalisation in each of these health-related sectors was measured according to three indicators: sales abroad as percentage of total sales; staff abroad as percentage of total staff; and total number of countries with operations.

This study found that rates of internationalisation varied greatly between these sectors. Rates of internationalisation were highest among producers of goods, which were mainly producers of pharmaceuticals and diagnostic equipment. Such firms were among the most internationalised in the world. By contrast, internationalisation among providers of services was very low. This was explained partly by the fact that the largest private providers of hospital and pharmacy services were US firms serving the huge domestic market. However, whilst this study indicated that direct providers of health services were not highly internationalised, these results should be considered with some caution. Using the G500 as the basis of the analysis may have led to an underestimation of the extent of internationalisation among health service providers, since the G500 lists the largest firms in the world. Whilst we would expect internationalised firms to be larger than average, internationalised service providers are likely to be smaller than goods producers, and thus may not feature in a list such as the G500.

An alternative approach, which more easily allows for analysis of the nature and behaviour of smaller, but potentially highly internationalised firms, is to utilise case studies of internationalising firms. Such an approach faces many of the problems of how to select appropriate cases that are discussed for country case studies in the next section. Nevertheless, it also allows for better study of the qualitative aspects of internationalisation, such as firm strategy (Holden, 2002).

The greater extent of internationalisation among producers of health-related goods when compared with that of providers of services largely reflects the fact that such goods

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have always been produced by the private sector in most countries. In contrast, health services, especially in the advanced capitalist world, have been directly provided by the state much more frequently. We thus need to understand processes of reform and privatisation at the national level if we are to map the emerging market in health and social care and this is addressed next.

The national level

National-level data are best situated within the context of comparative research. Comparative research has traditionally been concerned with issues of appropriateness and equivalence (May, 2001: 214). That is, the methods and concepts used must be appropriate to the cultures being studied, and the categories and the meanings attached to them must be equivalent between cultures if the research is to be valid. Issues of language and translation may be particularly relevant. As May points out (2001: 215), language problems, and the high costs of comparative survey and observational research, may lead to a reliance on official publications, with consequently partial and incomplete results. Kennett and Yeates (2001: 55) point out that the problems of the comparability of national statistics have increasingly been overcome by harmonised data compiled under the auspices of international organisations. The data collecting activities of these organisations are governed by adherence to international guidelines on methodological procedure and are aimed at promoting international comparability and consistency of data. However, Kennett and Yeates point to the arguments of Glover (1996) that the process of harmonising data 'tends to blur the distinction between each country and render invisible the details behind each national classification, and the differences between social institutions and social policies from one country to another' (Kennett and Yeates, 2001: 60).

The most influential comparative work in social policy of recent years has been that of Esping-Andersen (1990), which identified three key types of welfare 'regime'. That work, however, did not make explicit reference to the health sector, and was focused solely upon advanced capitalist countries, although important work has been done by Gough on adapting regime theory to developing countries (1999, and other papers available at www.bath.ac.uk/ifipa/GSP). There has been a great deal of comparative work on healthcare systems in recent years, but this has been poorly integrated with the wider comparative welfare state literature and has instead tended to focus solely on the key institutions and mechanisms of healthcare delivery, such as funding arrangements and associated reforms (see for example the Health Systems in Transition country profiles and studies in funding and regulation produced by the European Observatory on Health Care Systems, www.observatory.dk). Such work usually classifies health systems according to whether they are national health systems or social insurance systems, with the USA as a rare example of private insurance dominance. Whilst this is clearly relevant to the process of mapping markets in healthcare, it is only recently that specific attention has been given to changes in the public/private mix in provision, and the international aspects of this are usually neglected.

Holden (2003) has argued that the three basic components of welfare state intervention identified by Le Grand *et al*. (1992) – that is, direct provision, tax/subsidy, and regulation – can be used to provide an analytical framework within which the internationalisation of for-profit healthcare firms can be explained. It is thus processes

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of change that alter the balance between these three types of state intervention which provide the opportunities for, or barriers to, the expansion of for-profit firms. (The analysis of regulation is particularly important to the development of trade in healthcare, since in addition to the domestic regulatory structure, international trade in healthcare is governed by specific regulations which affect, for example, the migration of healthcare practitioners – see Chanda, 2001: 26). Such an analytical framework provides the consistency of categories necessary for comparative work, but is flexible enough to encompass the wide variations in the structures of different health systems. Such national-level reform processes are in turn shaped to varying degrees by the processes and prescriptions of the international organisations and agreements discussed below.

Private provision of health services does not necessarily indicate international trade in those services, although it does provide the prerequisite for the development of an international market. Furthermore, there are a wide variety of healthcare services, some of which may be easier to privatise than others. Chakraborty and Harding (2003: 79) argue that the rationale for the direct state provision or otherwise of these various services depends on their 'buyability'. Buyability of goods and services is determined by their intrinsic levels of contestability (whether firms can enter and exit the market easily); of information asymmetry (whether the quality of the service is easy to assess); and of measurability (whether it is easy to precisely measure inputs, processes, outputs and outcomes). They provide a useful table (2003: 80), which charts the varying levels of contestability and measurability of different goods and services (with measurability capturing much of the information asymmetry). This indicates that a range of health goods and services are regarded as relatively 'buyable', including (to varying degrees) pharmaceutical retailing, wholesaling and production; routine diagnostics; hospital support services; and ambulatory clinical care.

Hospital services, however, are regarded as less buyable. This provides a rationale for focusing on the hospital sector when attempting to ascertain the trend towards trade in healthcare, since hospitals are regarded as only moderately buyable. The extent of private participation in such services is thus extremely variable across countries, and where private expansion does take place it provides a focus for ascertaining the potential problems involved and the need for regulation. Furthermore, since hospitals are large organisations, with matching requirements for high levels of capital investment, where they are privately run they are much more likely to be owned and/or managed by large corporations. Hospital services thus provide us with the best possible link between processes of privatisation in health services and those of internationalisation, particularly foreign direct investment (FDI) or 'commercial presence'.

Chakraborty and Harding (2003) point out how little information there is on the private sector, particularly in developing countries, and provide a guide to undertaking a private health sector assessment in such countries. However, comparative work must involve selection of a relatively small number of countries, if the aim is to focus in depth on institutions and practices without skating over significant differences. The problem then arises as to which are the appropriate countries to focus on. Chanda (2001) deals with this problem by highlighting those countries where significant trade in healthcare has already clearly begun to take place. In this respect, he identifies Cuba, Jordan, China, India, Chile, Tunisia and Indonesia as significant examples of developing countries, and the UK and the USA as significant examples of developed countries. The problem with this is that the result is not strictly comparative, but rather a series of case studies of countries which

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may not be representative of the wider category (i.e. developed or developing countries). It is legitimate, of course, to use case studies to illustrate key issues in relation to any given topic. Whilst this approach does not allow us to gain a comprehensive overview of healthcare markets, it can serve to illustrate their nature. Cases should, however, be chosen according to a clear rationale. For example, they may be chosen on the basis of their apparent typicality, or conversely, on the basis that they are extreme examples of the phenomenon being studied. In Chanda's case the rationale would seem to be to choose extreme examples (in the sense of countries which have gone furthest down the road of international trade in health services), and this would seem to be a sensible approach if the goal is to understand the implications of an expansion in health services trade (Chanda, 2001).

An alternative approach is to attempt to ascertain broad trends in different types of countries. The problem with this approach is that it is in danger of glossing over the considerable differences between countries. There is a significant danger of over-generalisation, and various authors have alerted us to the problems of the convergence thesis (McPake, 2002; Marmor, 2001). Despite these problems, this is probably the best approach, where the goal is to gain an overview of the extent of healthcare privatisation and trade internationally. Such an analysis may then be supported by individual country examples where this serves to illustrate processes of change. Given the nature of the current global political economy, countries are most appropriately divided up initially on the basis of three broad types: the advanced capitalist countries; the transitional countries of Eastern Europe and the former Soviet Union; and the developing countries. Although broad, these categories reflect differing levels of economic development, which in turn play a substantial part in determining the level of development (and therefore nature) of health systems. However, developed countries in particular will need to be further sub-divided by type between national health systems, social insurance systems, and private insurance systems. Within these categories, processes of change in the forms of provision, finance and regulation can be analysed in order to map the development of health markets.

Nevertheless, even where this approach is taken, the types of data available are somewhat restricted. For example, the Organisation for Economic Co-operation and Development (OECD) provides the most complete data set available for the advanced capitalist countries, yet this primarily provides data on the balance between public and private *finance*, which may tell us little about the public–private mix in *provision*. The World Health Organisation (WHO) provides data on private beds as a percentage of total beds for many countries, but this makes no distinction between for-profit and not-for-profit providers. Nevertheless, work is proceeding on constructing a standardised system of internationally comparable National Health Accounts which cover providers of healthcare services and sources of funding, as well as healthcare by functions of care, and which is intended to include some data on international trade in health services (OECD, 2000).

Private firms may in fact have more data than official agencies. As Mabbett (1998: 361) points out, comparative data in Social Policy has often been confined to the activities of the welfare *state*, although those of other actors are increasingly recognised as relevant. Thus, 'privatisation of provision can mean that data are also privatised', in the sense that accountancy and consultancy firms may collect relevant data which are sold to multinational employers, but which are very expensive for most researchers (Mabbet,

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1998: 362). Furthermore, our analysis cannot be limited to the national level, since the actions of governments will be influenced by international agreements and supranational organisations. The rest of this article briefly addresses these aspects, by first discussing the regional level, and then the international level.

The regional level

Trade in health services may be influenced at the regional level primarily through the provisions of the European Union (EU), the North American Free Trade Agreement (NAFTA) and Mercosur. The EU facilitates the regional mobility of professionals through provisions for the convergence and coordination of qualifications and standards. It also facilitates cross-border consumption of health services through insurance portability and payments arrangements (Chanda, 2001: 73–74). EU competition and public procurement policies may further facilitate international trade by influencing contracting decisions. The European Court of Justice has also made several recent decisions which may affect trade in health services (Blomqvist, 2004: 153; Leibfried and Pierson, 2000).

The North American Free Trade Agreement (NAFTA) between the USA, Canada and Mexico, involves similar provisions to the General Agreement on Trade in Services (GATS, discussed below), and, like GATS, includes investment as a form of trade in services. Appleton (1999) argues that NAFTA prevents governments from expanding into new areas of provision and renders privatisation virtually irreversible. There is evidence that cross-border establishment of healthcare facilities has grown following the creation of NAFTA (Chanda, 2001: 72).

The Southern Cone Common Market (Mercosaur) was created in Latin America in 1991. One of the main initiatives in healthcare has been to establish exchanges among health insurance programmes to cover tourists and to develop pilot experiments to integrate health insurance systems at the regional level (Chanda, 2001: 67). There have also been initiatives to facilitate the exchange of services between health cooperatives through cross-border consumption and to facilitate the cross-border movement of professionals (ibid).

Regional trade agreements are therefore potentially an important factor in facilitating and reinforcing national-level processes of change that favour private providers, and the impact of their interactions with such national reform processes requires greater study. The impact of international organisations is likely to be as significant, and this is discussed next.

The international level

International organisations such as the International Monetary Fund (IMF) and the World Bank make policy at the international level and have significant influence over many national governments, particularly those of the developing and transitional countries. This role is very well documented (see for example, McPake 2002), and space does not permit us to discuss it fully here. However, IMF and World Bank policies usually promote the private sector in public services, and are therefore likely to facilitate and reinforce national-level reform processes favouring trade in health services in similar ways as the regional organisations and agreements discussed above. The prescriptions of such international institutions, and the way that they interact with national-level processes,

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must therefore be taken into account when undertaking cross-national studies of the type discussed above.

The World Trade Organisation (WTO) is also becoming particularly important to trade in services between countries, principally through the General Agreement on Trade in Services (GATS). GATS facilitates liberalisation through a process in which countries make commitments in specific sectors. GATS identifies four types of trade in services, all of which are found in health service provision: cross-border delivery (made possible particularly by information and communication technologies); consumption abroad (where the consumer travels to another country); commercial presence (foreign direct investment, for example through the establishment of a hospital); and movement of natural persons (where practitioners work outside their home country).

Adlung and Carzaniga (2002) have analysed the current pattern of GATS commitments on healthcare (see also Chanda, 2001: 77–86). As Adlung and Carzaniga point out, GATS is important not just because it may lead to greater liberalisation, but because commitments 'translate into legally binding obligations what has already been achieved autonomously, and thus advance or consolidate developments that have been going on for years in many countries' (ibid.: 14). However, as a comparison with other sectors, they indicate that, while over 90 per cent of WTO members undertook some form of commitment on tourism services and about 70 per cent included financial or telecommunications services in their Uruguay Round schedules, less than 40 per cent made commitments on education and health (2002: 14). Apart from education, no service sector has drawn fewer bindings than the health sector (ibid.: 20). However, although Article 1:3 of GATS exempts services provided in the exercise of governmental authority, once any services are privatised or commercialised, they automatically fall under the GATS Most Favoured Nation (MFN) principle, regardless of whether they have been scheduled or not. Thus, any and all foreign providers permitted to operate would have to be treated in a like and non-discriminatory manner (ibid: 16, 19).

Adlung and Carzaniga (2002: 20) suggest that requests for liberalisation of the health sector in the Uruguay Round may have been weak, and point out that, in the current Doha Round, health services are the only large services sector that had not generated any negotiating proposals during the early stages of the round. They argue that, in the absence of vocal export interests, many governments might have hesitated to request access commitments abroad and reciprocate by way of their own bindings on health services. They point out that there were apparently no pace setters comparable with the role played, owing to strong export interests, by the US, the EC and other OECD countries in areas such as telecommunications and financial services. However, US healthcare industry lobby groups have been pressing for further liberalisation abroad, and the stated intention of the WTO is to push for progressive liberalisation. Whilst the extent of current commitments under GATS are fairly minimal, therefore, the agreement is likely to attain greater significance as time goes on. Once again, the interaction of such trade negotiations with national-level reform processes must be considered. However, the role of corporations in political lobbying in favour of binding trade agreements which favour their interests are also clearly important, and the firm level of analysis must therefore also be considered.

Firms also interact directly with international organisations through Global Public–Private Partnerships (GPPPs). International organisations, particularly the World Health Organisation (WHO), have been involved in a series of GPPPs in recent years, which

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typically involve collaboration between the international organisation(s), developing country governments and multinational corporations, such as pharmaceuticals firms. These include the Global Alliance for Vaccination and Immunisation (GAVI), the Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Improved Nutrition (GAIN). Such initiatives mark a shift in the approach of organisations such as the WHO towards greater collaboration with the private sector. They have been criticised for including industry in policy making and agenda setting, without providing the mechanisms to deal with conflicts of interest, for lending the moral legitimacy of United Nations organisations to private business interests, and for putting 'the normative functions of the UN at risk' (Ollila, 2003). GPPPs have also been used as a way of attempting to pump-prime FDI and expand markets (Buse and Walt, 2002). As the president of the medical systems unit of Becton Dickinson & Co said of one GPPP: 'Of course we want to help eradicate neonatal tetanus, but we also want to stimulate the use of non-reusable injection devices, and to build relationships with ministries of health that might buy other products from us as their economies develop' (Deutsch, cited in Buse and Walt, 2002: 53).

Conclusions

Given current processes of privatisation and liberalisation affecting the health sector, there is a pressing need to identify sources of data that will allow us to map the scope and nature of the emerging international market in healthcare. This article has identified some of the key sources of data, and has discussed the methodological problems and challenges relating to these. The process of mapping the emerging international health market is made more difficult by the fact that the data exist at a number of levels of analysis. This is bound to be the case, since it reflects the reality of multi-level processes and mechanisms of governance in the current global economy. Varied data exist relating to the level of the firm, to the national level, to regional processes and institutions and to international organisations and agreements. It has been argued here that the mapping of private markets at the national level is best done on a broad comparative basis, comparing trends in advanced capitalist, transitional and developing countries. However, the nature and scope of markets at the national level are increasingly influenced by and interact with processes at the other levels of analysis identified. International trade agreements such as the GATS, for example, represent processes that are likely both to encourage national-level privatisation processes and to reinforce and institutionalise them where they have already taken place. A comprehensive analysis must therefore not only include all of the levels of analysis identified here, but also take account of the ways in which processes at different levels may interact to reinforce the tendency towards trade in healthcare services.

References

Adlung, R. and Carzaniga, A. (2002), 'Health services under the General Agreement on Trade in Services', in *Trade in Health Services: Global, Regional and Country Perspectives*, Washington DC: Pan American Health Organisation, Program on Public Policy and Health, Division of Health and Human Development.

Ahluwalia, I.J. (Chair) (2002), 'Health and the International Economy', The Report of Working Group Four of the Commission on Macroeconomics and Health, World Health Organization, Geneva.

https://doi.org/10.1017/S1474746405002617 Published online by Cambridge University Press

Appleton, B. (1999), 'International agreements and national health plans: NAFTA', in D. Drache, and T. Sullivan (Eds.), *Market Limits in Health Reform: Public Success, Private Failure*, London: Routledge.

Blomqvist, P. (2004), 'The choice revolution: privatization of Swedish welfare services in the 1990s', *Social Policy and Administration*, 38, 2, 139–155.

Buse, K., Drager, N., Fustukian, S., and Lee, K. (2002), 'Globalisation and health policy: trends and opportunities', in K. Lee, K. Buse and S. Fustukian (Eds.), *Health Policy in a Globalising World*, Cambridge: Cambridge University Press.

Buse, K. and Walt, G. (2002), 'Globalisation and multilateral public–private health partnerships: issues for health policy', in K. Lee, K. Buse and S. Fustukian (Eds.), *Health Policy in a Globalising World*, Cambridge: Cambridge University Press.

Chakraborty, S. and Harding, A. (2003), 'Conducting a private health sector assessment', in A. Harding and A. S. Preker (Eds.), *Private Participation in Health Services*, Washington, DC: World Bank.

Chanda, R. (2001), *Trade in Health Services: Working Paper WG 4:5 of the Commission on Macroeconomics and Health*, Geneva: World Health Organization.

Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press.

Glover, J. (1996), 'Epistemological and methodological considerations in secondary analysis', in L. Hantrais and S. Mangen (Eds.), *Cross-National Research Methods in the Social Sciences*, London: Pinter.

Gough, I. (1999), (revised 2000), 'Welfare regimes: on adapting the framework to developing countries', Social Policy in Development Contexts Working Paper 1, University of Bath.

Holden, C. (2002), 'The internationalisation of long term care provision: economics and strategy', *Global Social Policy*, 2, 1, 47–67.

Holden, C. (2003), 'Actors and motives in the internationalisation of health businesses', *Business and Politics*, 5, 3, 287–302.

Holden, C. (2005), 'The internationalisation of corporate healthcare: extent and emerging trends', *Competition and Change*, 9, 2, 185–203.

Kennett, P. and Yeates, N. (2001), 'Defining and constructing the research process', in P. Kennet, *Comparative Social Policy*, Buckingham: Open University Press.

Leibfried, S. and Pierson, P. (2000), 'Social policy: left to courts and markets?', in H. Wallace, and W. Wallace (Eds.), *Policy-Making in the European Union*, Oxford: Oxford University Press.

Le Grand, J., Propper, C., and Robinson, R. (1992), *The Economics of Social Problems*, Basingstoke: Macmillan.

McPake, B. (2002), 'The globalisation of health sector reform policies: is "lesson drawing" part of the process?', in K. Lee, K. Buse and S. Fustukian (Eds.), *Health Policy in a Globalising World*, Cambridge: Cambridge University Press.

Mabbett, D. (1998), 'European and international data sources', in P. Alcock, A. Erskine and M. May (Eds.), *The Student's Companion to Social Policy*, Oxford: Blackwell.

Marmor, T.R. (2001), 'Comparing global health systems: lessons and caveats', in W. W. Wieners (Ed.), *Global Health Care Markets: A Comprehensive Guide to Regions, Trends, and Opportunities Shaping the International Health Arena*, San Francisco: Jossey-Bas.

May, T. (2001), *Social Research: Issues, Methods and Process*, Buckingham: Open University Press.

OECD (2000), *A System of Health Accounts*, Paris: OECD.

Ollila, E. (2003), 'Global health-related public–private partnerships and the United Nations', GASPP Policy Brief No.2, Globalism and Social Policy Programme, Sheffield.

https://doi.org/10.1017/S1474746405002617 Published online by Cambridge University Press