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# 13. THE CASE OF INDIA

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In the context of India, as for most developing countries, the focus of the discussion on trade in health services should begin with a discussion of national priorities in the health sector. Unlike commodity trade, trade in services in the social sectors, like education and health, can have a direct impact on these sectors of the economy by affecting the supply of, and demand for these services.

## I HEALTH SERVICES IN INDIA

Trade in health services must be seen in conjunction with national health priorities. The "Health for All" strategy was adopted by WHO and national governments as a goal that should guide all planning and policy-making in the health sector. Thus the first step is to assess whether India's current and future activities in trade in health services are consistent with its goal of health for all. However, to do so we need to review the state of the health and medical sector in India. The questions one has to ask are: How does India compare with other countries in the health status of the population? Are the current health infrastructure and services sufficient to meet the health needs of the population?

### Health status of the population

To assess whether India is reasonably close to the health-for-all objective, a quick look at the health status of the population would be useful. Since it is impossible to give a complete relative picture, we focus on three other countries in addition to India: a developed country like the United States, a relatively progressive country in the region like Sri Lanka and a neighbouring country in the same region which has performed poorly with respect to these socioeconomic and health indicators, Bangladesh. We choose a few selected health and related socioeconomic indicators to bring out the relative position of India (Table 1).

As can be seen from the table, the indicators of health status of the Indian population are generally worse than those of a developed country like the United States and also of a country in the region like Sri Lanka. Although India is definitely faring better compared to some of the other developing countries of the region like Bangladesh, it still has to go a long way towards achieving health for all. Infectious diseases are still the major cause of both morbidity and mortality in India, with non-infectious diseases also on the rise. There are newer diseases like AIDS spreading rapidly, and some others like tuberculosis, malaria, dengue re-emerging at an alarming pace. These facts, and the dual development with a large poor population and an increasing middle- and upper income class imply that India will have to invest in preventive and promotive health care as well as in curative care in the near future.

Table 1. **Selected health and socioeconomic indicators**

| | **United States** | **Sri Lanka** | **India** | **Bangladesh** |
|---|---|---|---|---|
| Life expectancy | 76 | 71.9 | 60.4 | 55.6 |
| Infant mortality rate, 1991 (°/$_{ooo}$) | 9 | 18 | 90 | 103 |
| Crude birth rate, 1991 (°/$_{ooo}$) | 16 | 21 | 30 | 34 |
| Crude death rate, 1991 (°/$_{ooo}$) | 9 | 6 | 10 | 13 |
| Median age at death, 1990 | 76 | 73 | 37 | 12 |
| GNP per capita (in US$), 1991 | 22 240 | 500 | 330 | 220 |
| Female literacy rate, 1995 (%) | 76[a] | 85 | 38 | 28 |

[a] 1991 figure
Source: *World Development Report 1993*

## Availability of health care

Any discussion on the availability of health care in a country begins with an overview of health care personnel and services available to the population at large. Though admittedly approximations, these statistics do help in relative comparisons and to get a sense of human and physical resource availability in the country. Table 2 gives the health personnel and infrastructure availability for the same four countries.

Table 2. **Selected indicators of health infrastructure and services**

| | United States | Sri Lanka | India | Bangladesh |
|---|---|---|---|---|
| Doctors/1,000 (1988-92) | 2.4 | 0.14 | 0.41 | 0.15 |
| Hospital beds/1,000 (1985-90) | 5.3 | 2.8 | 0.7 | 0.3 |
| Nurse to doctor ratio (1988-92) | 2.8 | 5.1 | 1.1 | 0.8 |
| Nurses/Nurse-midwives/1,000[a] | NA | 0.74 | 0.4 | 0.08 |

[a] For India, 1991 figure; for Sri Lanka and Bangladesh, 1994 figure.
Source: *World Development Report 1993,* and *Regional Health Report* 1996, WHO Regional Office for South-East Asia

The picture that emerges is that India is definitely lagging behind a country like the United States with regard to health infrastructure and services, but in terms of availability of physicians, it is doing significantly better than its neighbour Sri Lanka. On the hand, Sri Lanka has a large population of nurses and a very high nurse-to-doctor ratio. More recent evidence from the Ministry of Health indicates however that the availability of both doctors and nurses have been improving in India.

The figures indicate a relative shortage of hospitals, hospital beds and dispensaries. Evidence indicates that these services are much worse in the rural areas, with fewer doctors, nurses, hospitals and beds available for the population. Thus, it seems that as far as supply of services and infrastructure is concerned, India can hope to do much better. A slightly different issue is the quality, rather than the quantity of these services and infrastructure, a point to which we shall return below.

One important feature of the Indian medical system is the practice of alternative medicine. Table 3 gives the distribution of doctors for different types of medical systems. As the table indicates, allopathic doctors are only 43% of all doctors in India. There is a huge demand for alternative medicine from within India, and some evidence that there is a steady trickle of foreigners coming to India for treatment, especially in Ayurvedic medical care. For example, the Ayur

Vaidya Sala at Kottakkal in Kerala has gained popularity in Germany, the Gulf countries, Malaysia, the United Kingdom and the United States. Clearly India has a comparative advantage in these alternative systems, and this area is one potential growth area of in the context of trade in services.

Table 3. **Availability of doctors by type (1991)**

| **Type** | **Numbers (per cent)** |
|---|---|
| Allopathic | 3 94 068 (43%) |
| Ayurvedic | 3 37 966 (36%) |
| Homeopathic | 1 48 707 (16%) |
| Unani | 35 350 ( 4% |
| Others | 11 981 ( 5%) |
| Total | 9 28 072 (100%) |

Although data on other paramedics and technicians are unavailable, our discussions with hospitals and doctors indicated that this is an area where there is a lot of scope to improve availability. Though newer medical equipment is being imported into India, there seems to be a shortage of technicians trained to use it. Training and upgrading skills are important steps towards remedying this situation, and trade is definitely one route through which this can be done, in addition to domestic policies.

Until recently, much of the discussion on health care services had focused on the government or semi-government health facilities and organizations. It has been realized in the recent past that the private medical care sector has been growing at a tremendous pace, affecting the overall health care supply and the cost and quality of supply. Unfortunately, data on the private health care system have never been collected systematically, which is a problem one faces when discussing the Indian health sector as a whole. Table 4 indicates the distribution of hospital and hospital beds by private and public ownership, and Table 5 indicates the growth rate of hospital and hospital beds.

The tables indicate that India has a very large and expanding private medical sector, with more than 60% of the hospitals and dispensaries being in the private sector. Only about 10 per cent of all doctors (allopathic) work in the government sector, the rest are in the private sector. The growth rate in the private sector has also been very high, as indicated by Table 5. This has important implications regarding the extent to which rules, regulations and controls can be exercised over medical practitioners.

Table 4. **Distribution of health facilities and beds (1993)**

| Item | Total | Rural/urban (%) | | Public/private (%) | |
|---|---|---|---|---|---|
| Hospitals | 13 692 | 20.5 | 79.5 | 33.4 | 66.6 |
| Hospital beds | 596 203 | 15.8 | 84.2 | 64.6 | 35.4 |
| Dispensaries | 27 403 | 40.0 | 60.0 | 37.0 | 63.0 |
| Dispensary beds | 25 173 | 51.6 | 48.4 | 57.9 | 42.1 |

Source: *Health Information of India*, 1993.

Table 5. **Growth rate of hospitals and hospital beds**

| Years | Hospitals | | Hospital beds | |
|---|---|---|---|---|
| | Government | Private | Government | Private |
| 1974-78 | 6.4 | 43.7 | 11.3 | 20.1 |
| 1979-84 | 1.0 | 12.1 | 1.9 | 3.9 |
| 1984-88 | 2.6 | 17.2 | 3.3 | 6.8 |

Source: *Baru*, 1995.

Needless to say, private care is more extensive in the form of curative care, and is more urban-based. A number of studies have looked at demand for medical care in India and have found that individuals do spent large amounts in seeking health care from the private sector. A number of issues have been thrown open in these analyses, especially regarding the quality and cost of private health care.

A recent trend has been the rapidly expanding number of corporate hospitals like Apollo, Escorts and Batra. Health care is supposedly of higher quality and is available at a cost to those who can afford to pay for it. In many instances, the services provided are comparable to those in developed countries.

A point very relevant to the discussion on trade in health services is the number of doctors who train abroad and subsequently return to India. This is important in the context of temporary versus permanent outflow of health personnel. Table 6 gives an overall picture about doctors trained abroad.

As can be seen, the data suggest that the maximum number of doctors who go abroad for training prefer the United Kingdom, followed by the United States. Roughly about half of all doctors trained abroad return to the country. A lot has already been written on brain drain of trained personnel from India, and it is contended here that some of it may be truly a reflection of the state of higher studies and training in India. The lack of state-of-the-art equipment and

infrastructure in India may be one professional reason why doctors may want to remain in these countries. With more possibilities of competitive facilities and pay structure in India in the health sector, India may be able to retain more personnel.

A related issue is the temporary foreign assignment of Indian doctors. The only data we were able to locate on this indicated that as of 1992 there were only 33 bilateral agreements between India and six countries of the Middle East. Even though this number is surely a gross underestimate, it does indicate that for Indian doctors the Middle East is one important region for short-term assignments. One reason why this number is an underestimate could be because it only includes the government doctors who need to go through a formal process before they can leave the country; private arrangements between Indian doctors and these countries do not show up in the statistics. Even though these numbers may be underestimates, these statistics do indicate that there is scope to step up short-term exchange between countries. This will also help towards checking brain drain from the country, a point to which we shall return later.

Table 6. **Distribution of doctors trained abroad and returned**

| **Countries of destination** | **Total trained** | **% returned** | **Major specialties** [a] |
|---|---|---|---|
| United Kingdom | 3 653 | 48% | Surgery, obstetrics and gynaecology, general medicine |
| United States | 1 062 | 50% | General medicine, veterinary science, surgery |
| West Germany | 82 | 41% | General medicine, veterinary science |
| Other European countries | 279 | 52% | General medicine, surgery, veterinary science |
| Australia and New Zealand | 48 | 17% | Surgery |
| Other | 649 | 47% | Surgery, general medicine |

| | | | |
|---|---|---|---|
| **Total** | 5 949 | 48% | |

[a] In descending order of importance
Source: *Health Information of India*, 1993

## Does India have a shortage of health personnel and infrastructure?

It is important to ascertain whether the current supply of health personnel and infrastructure is adequate in the context of trade, especially if India is going to export more health personnel; this trade should not affect the availability of health services within the country. In the absence of data, it is not easy to assess this, but based on the discussion above and also on the evidence we collected in our many meetings, we give our conclusions below.

India is a long way from the goal of basic health care services for the entire population. That there is a large unmet need for health care services is clear from the way the private health care sector has grown, and is still growing in India. Another piece of evidence is the growing private practice by government doctors, which the government has been unable to prevent, though it is not permitted. With the growth of nursing homes, many government doctors are not only practising privately, but are consulting at (or even owning) these nursing homes.

There has also been a recent trend of government doctors resigning and joining the private sector. The remuneration and working conditions are definitely better in the private sector, and thus this is a perfectly rational response of doctors to market signals. However, to the extent that the government hospitals are supposed to be inexpensive care mostly for lower income groups, losing good doctors is bound to have an adverse impact on the availability of good health care for this segment of the population. If government doctors can relatively easily take up short term foreign assignments, they may have less reason to resign and join the private sector.

Two points emerge from the preceding discussion: that there is a large unmet need for doctors in the rural areas and among the poor, and that the growing private sector is unlikely to meet this need. This is because the private sector caters mostly to the richer sections of the population, and there seems to be a large unmet demand even among this population. Also, the private medical

sector is expanding only in curative care and mostly in the areas of hospitals and nursing homes. Thus, it is unlikely that in the near future the rural sector or the poorer sections of the society will receive an adequate supply of physicians and other health personnel, unless drastic policy changes are affected in the allocation of resources in the economy. Export of health services is going to take place initially from the pool of health resources that caters mainly to the better off, and is unlikely to affect the availability of health services to the larger, poorer population of India. In fact, with freer movements across boundaries, more competition and therefore a more uniform pay structure across organizations within the country, there may be improvements in both quality and quantity of health care available in India.

As for nurses, the nurse-to-population ratio as given in Table 2 indicates that India can probably improve the availability of nurses. But this is not due to fewer nurses overall. India currently has about 500 000 nurses, and there is a steady increase in the supply of nurses every year; for example between 1992 and 1993, the supply went up by 16%. Evidence indicates that a large number of nurses are migrating to the Middle-Eastern and other countries. The nursing profession is probably still not as lucrative as the profession of doctors in India. The other reason could be that the supply of nurses is still more than the demand, though with the fast growth in the private medical sector this may change soon. There probably needs to be an improvement in the quality of nursing, and this can only happen when international standards are easily observed within the country. Greater trade is bound to influence the quality of nurses available, and check the outflow to a certain extent.

Though we do not have data, our judgement is that India needs to have a well-trained and larger pool of technicians, and training and refresher courses for technicians is an area India should focus on. As will be discussed below, there is no visible trade in this area, but short-term training courses should be an area which is likely to yield huge benefits. The Indian health system is heavily dependent on doctors, often to the detriment of a system of quality health care which includes well-trained nurses and other health personnel.

While greater export of health services gives rise to the possibility of a larger exchange of nurses and technicians, the nature of these jobs is not conducive to short-term movements. This is because unlike doctors, quick

consulting is not easy for other health personnel; they need complementary personnel and infrastructure because of the general nature of their jobs. Thus the only exchange may be for short duration training, workshops or seminars, which again is unlikely to affect supply. Also, India is producing an increasing number of nurses every year, which may be sufficient to meet domestic demand.

As for technicians, the current skill levels are not competitive enough for there to be a large-scale demand for Indian technicians abroad. Greater trade possibilities can only enhance the skill levels, and it is hoped that in case of both nurses and technicians the Indian education system in these two areas would gear up suitably to increase both the quantity and quality of these two professions.

In sum, opening up the health services sector for trade is unlikely to affect in any significant way, the availability of health personnel in India, and may improve quality and availability.

## II TRADE IN HEALTH SERVICES: AREAS WITH POTENTIAL

In the context of India, telemedicine services are not very relevant as yet, though with the increasing use of the Internet, information regarding health and medicines is being increasingly exchanged. Also, telemedicine is an area which may take off after the other components of trade in health services have been developed, especially opening up the health sector to foreign investment. Thus, the most important modes of trade in the short run would be the category of service-providers working abroad, followed by foreign investment in the form of foreign health maintenance organizations (HMOs) setting up business in the country. Exchange of patients is also an area which has a lot of potential in terms of foreign exchange, and is already quite significant in India.

### Framework for discussion

Below we discuss both the current situation and the future possibilities of trade in health services in India, and identify instances that are not relevant to India at this juncture. Table 7 presents a possible framework to make the discussion more focused. We make an important distinction between the two

main types of trading partners: trade with developing countries and trade with developed countries, because the issues and possible areas of trade would differ between these two sets of countries. Inflows and outflows are discussed separately. Also, a distinction is made between the existing situation, and the possible short-run situation. Admittedly, in the long run, the trade and development situation will change both globally and in India, and other possibilities will open up. Domestic policy changes might affect health services as well as trade, but this is unlikely to happen in the near future. Thus to make the discussion more tractable, we focus only on the short run. In our analysis we make a distinction between what is **possible** and what is **desirable**. In Table 7, in the column marked "future", we indicate the possibilities, and will examine the desirable directions or the priorities in the next section.

Table 7. **Trade situation and future potential by type of trade and type of partner**

| Type of trade | A. To/from developing countries | | B. To/from developed countries | |
|---|---|---|---|---|
| | Current | Future | Current | Future |
| 1. Inflow of foreign doctors | No | No | Yes | Yes |
| 2. Outflow of Indian doctors | Yes | Yes | Yes | Yes |
| 3. Inflow of foreign nurses | No | No | No | No |
| 4. Outflow of Indian nurses | Yes | Yes | Yes | Yes |
| 5. Inflow of foreign other health personnel (e.g., technicians) | No | No | No | No |
| 6. Outflow of Indian health personnel (e.g., technicians) | No | No | Yes | Yes |

| | | | | |
|---|---|---|---|---|
| 7. Inflow of foreign patients | Yes | Yes | Yes | Yes |
| 8. Outflow of Indian patients | No | No | Yes | Yes |
| 9. Inflow of foreign capital | No | Yes | Yes | Yes |
| 10. Outflow of Indian capital | Yes | Yes | No | No |

The analysis focuses on trade in health services in the following five areas: doctors, nurses, other health personnel, patients and foreign investment. As explained above, we do not discuss telemedicine here.
This framework allows 20 separate headings to be discussed each for the current situation and future scenario. A "yes" or a "no" indicate the current situation and future possibility. Since not all the cases are relevant in the short run, we will discuss these first. It must be pointed out that direct data on any of these items are unavailable, so most of what we will say below is based on indirect evidence, discussions with experts and organizations, and our own understanding of the situation.

**Areas without trade possibilities in the short term**

*Inflow of foreign doctors from developing country into India (1A).* There is no evidence to indicate that doctors from developing countries are coming into India for short-term assignments. This is certainly because India has a pool of adequate and well-trained doctors compared with these countries. The situation may change in the medium- to long-term, but as of now, we do not consider this to be a significant possibility in the near future.

*Inflow of foreign nurses from developed and developing countries into India (3A, 3B).* Currently, the evidence does not indicate that there are any foreign nurses working for short-term assignments in India. In fact, unlike doctors, nursing as a profession is heavily dependent on the complementary availability of other critical inputs; a nurse would need directions from doctors and would also be dependent on the availability of facilities and even other

health personnel. Thus, it may not be attractive for nurses to come for short assignments. Further, compared with India, developing countries of the region do not have a comparative advantage either in terms of quantity or quality of nurses. As for nurses from developed countries, the remuneration would not encourage such movements. There are barriers to labour mobility of categories below managerial, executive and specialists. Thus it is unlikely that in the near future there would be short-term movements of nurses into India.

*Inflow of foreign technicians from developed and developing countries into India (5A,5B).* As in the case of nurses, currently there is no evidence to indicate that there are foreign technicians working in India. For the same reasons as mentioned in the case of nurses, it is unlikely that there will be large movements of technicians or other health personnel, from either of these groups of countries.

*Outflow of Indian technicians to developing countries (6A).* There is currently no evidence to indicate that technicians are going to developing countries for short-term assignments. This is again because the developing countries are not significantly different from India in terms of the quantity and quality of technicians. Thus, we do not expect much activity in the exchange of technicians and other paramedics between India and other developing countries in the near future.

*Outflow of Indian patients into developing countries (8A).* Though some countries like Sri Lanka have probably similar or better health care to offer, there is no evidence to indicate that Indian patients are going to developing countries for treatment. The quality of care has to be far superior to what is available within the country for an individual to go to the trouble of arranging a trip abroad.

*Outflow of Indian capital into developed countries (10B).* Evidence does not indicate that India is investing significantly in the health sector of developed countries. Clearly, India does not have a comparative advantage in terms of either financial resources or state-of-the-art technology in the health sector, and

unless standards improve substantially there is little likelihood of its investing in the near future.

We omit these six cases from the discussion below on current areas of trade in India.

**Areas of trade: current situation**

*Outflow of doctors and nurses to developing countries (2A, 4A).* As indicated above, there has recently been a steady stream of doctors and nurses going to other developing countries, especially to the Gulf and Middle-Eastern countries. Many assignments are really not short term, in the sense that there are many health professionals of Indian origin and also recent migrants in these countries. But there are also bilateral short-run assignments, especially for doctors.

*Outflow of doctors and other health personnel to developed countries (2B, 4B, 6B).* There are about 60,000 doctors and 35,000 doctors of Indian origin settled in the United States and the United Kingdom respectively, and there is still significant short-term movement from reputed institutes in India to these and other developed countries. These are mostly bilateral agreements, as in the previous case. The hospitals we surveyed said that many permanent doctors went abroad every year; one hospital reported as many as 184 doctors who went abroad in 1996.

There is not much evidence to indicate that nurses and other health personnel have been leaving from India on short-term assignments. Though a few hospitals did mention that nurses and technicians were sent abroad for training, this seems to be small percentage of the total. The important point to note is that temporary movements are mainly from public hospitals and institutions.

*Inflow of doctors from developed countries (1B).* There seems to be visiting faculty and scholars coming to Indian hospitals from Canada, the United Kingdom, the United States and other developed countries for short-term consulting and even training.

*Inflow of patients from developed and developing countries (7A, 7B).* Evidence indicates that there are people coming to India for treatment from the Gulf States, and also other neighbouring countries like Bangladesh, Mauritius, Nepal, Sri Lanka, etc. The quality of health care in India is better and also cheaper than in these countries. The proximity is also a key factor.

The hospitals we surveyed also revealed that some of the new and well-known hospitals receive foreign patients from developed countries like the United States. For example, the All India Institute of Medical Sciences received 342 foreign patients in 1995-1996, whereas Escorts received about 152. The total percentage of foreign patients could be as much as 5 per cent in these hospitals, with developing countries providing the bulk of these patients. One study indicates that the Apollo group of hospitals has been continuously receiving surgery cases from Chicago; these patients get treated at a quarter of the cost they would have incurred in their country.

All the hospitals surveyed said that there were no restrictions on admissions of foreign patients. However, one hospital mentioned that they were not equipped to deal with an influx of foreign patients.

*Outflow of Indian patients to developed countries (8B).* this trend has been diminishing; there many more individuals were going abroad a decade or so ago. However, there is still some movement, and this could be because some medical specialities or "super-specialties" are still not available on a large scale within India.

*Inflow of foreign capital from developed countries (9B).* There is evidence that a number of transnational corporations are investing huge sums of money in setting up new hospitals and state-of-the-art equipment. There is a trend towards super-specialty corporate hospitals in India, many of which are set up by transnationals or through collaboration between Indian and foreign companies.

One recent example of these ventures is the proposed Sir Edward Dunlop Hospital, a US$40 million cardiac centre at Faridabad being set up by a consortium of three sets of companies, one each from Australia, Canada and India. This hospital will be followed by a chain of polyclinics and diagnostic

centres across the country. There are many such similar joint ventures, which got a boost from the government's policy of allowing more private sector participation in the health sector.

*Inflow of foreign capital from developing countries (9A).* Evidence does not indicate any significant trade in this direction. This is a potential area of growth, which may happen in the future with a more liberal and free trade environment

*Outflow of Indian capital into developing countries (10A).* No data were available on this, but anecdotal evidence indicates that some Indian companies, together with foreign partners, may be investing in health facilities in the region. This trend is likely to increase in the future, as the corporate hospital chains expand their operation.

On the basis of the above, it seems that India is already engaged in substantial trade of health services, of doctors and patients, and more recently of foreign capital. We will discuss below the existing barriers to trade, if any, in each of these fields, and the priority areas for India if the goal is to dismantle these barriers to increase trade.

## III PRIORITIES IN TRADE FOR INDIA

Health care services are estimated to be worth about US$ three trillion globally, with a small but growing component of trade. Although India contributes as yet a very insignificant amount to this trade, enormous potential exists for it to expand.

There are mainly two reasons to engage in trade in health services: to earn foreign exchange and to improve health services available within the country. To us it seems that if the first objective can be achieved without adversely affecting the second objective, it should be what economists call a”Pareto optimal” where nobody is worse off but someone is better off. There is yet a third objective, which is the objective of free global trade, which must go beyond India's own domestic priorities. Since trade must involve more than one

partner, it is imperative to recognize the benefits of a more liberalized global trade. Thus we prioritize below the growth areas, keeping in mind both India's domestic objectives, as well as the wider objective of fewer barriers to world trade.

*Foreign patients coming to India*. Currently, as discussed above, there are many foreign patients who are coming to India for treatment, both from developing and developed countries. The cost advantages vis-à-vis developed countries, and the quality advantage vis-à-vis developing countries, are the primary reasons for this trade. For example, the cost of coronary bypass surgery could be as low as Rs. 70,000 to 100,000, whereas it would be about Rs. 1.5 million to 2 million in the Western countries. Similarly, the cost of a liver transplant is about Rs. 7 million in the United States, whereas it is one-tenth of this price in India. For patients coming from other developing countries, the comparative advantage is both in terms of quality and price. This is one area where there can be major expansion in the future. This inflow will be mostly in hospital-based curative care, and is unlikely to crowd out nationals for the reasons mentioned in the first part of the paper. In addition to the foreign exchange, this will also make our facilities more competitive and improve standards within India. One important growth area is in alternative medicines, which is already attracting some patients from abroad. The different systems of medicines should be given special attention so that India can offer these services in a competitive fashion.

*Foreign capital or foreign presence in India.* As mentioned above, in the recent past, several transnationals have linked up with Indian companies to set up super-specialty hospitals and polyclinics in India. This trend is a good one since it will fulfil all the three objectives mentioned above. First, it will earn India considerable foreign exchange. Secondly, since the investing countries are almost all from the developed world, the standard of health services will improve if we are able to attract the right kind of investment, and we will gain by the expertise and the state-of-the art technology that this kind of investment would bring. This kind of trade would also encourage the inflow of doctors and

possibly other health personnel, and help towards a more global market in health services.

However, the only care one has to take is that obsolete technology does not come in with foreign investment, and that we truly gain from such an exchange. India also has to be careful about not creating a supply glut, since there is evidence that some of the similar Indian private companies are not able to sustain themselves due to cost overruns and lack of demand. For example, the Tamil Nadu Hospital Limited is seeking cheaper funding options, including infusion of foreign equity, because of huge cost overruns. Indiscriminate setting up of these corporate hospitals is likely to prove counterproductive and also hurt the indigenous hospitals.

*Exchange of health personnel.* Though this exchange will not make much difference to the exchequer, it is important for constant skill renewal and information exchange. Since health services are an area where skills need to be constantly renewed, this should be an area of focus for policy makers.

## IV COMMITMENTS AND BARRIERS TO TRADE

We turn now to trade barriers. Is India able to trade efficiently or at all in these areas? What should be India's stand on each of these areas? But first, has India or any other country made any commitment under GATS?

### Commitments

Commitments made by Members regarding market access and related matters, constitute the most important element of GATS. Examination of the commitments reveals that of the various health-related services, the commitments mostly concern hospital services.

Commitments for hospitals services have been made by Austria, the European Union, Hungary, Japan, Poland, the United States, and 15 developing countries including India, Malaysia, Mexico and Pakistan. Much smaller numbers of countries have made commitments for other human health services or other categories of health-related services. However, a number of countries have opened up the medical and dental services sub-sector under professional services (13 countries), and are allowing service suppliers like nurses and midwives under professional services (eight countries). It is interesting to find that some of these countries have not made commitments in health services but have allowed dental and medical services, and services of nurses and midwives.

Turning to hospital services, which is the main category of health services for which commitments have been made, it would be useful to look at the nature of commitments for the four modes of trade. As regards cross-border supply (telemedicine), most countries have kept it unbound, mainly on ground of technical infeasibility (at present). By contrast, most countries have put no limits on the "Consumption abroad" mode of trade in health services. Interestingly, India has kept this mode unbound, i.e. no commitment has been made about market access or national treatment. In regard to the third mode of supply, namely commercial presence, most countries have made commitments. Some countries have placed no restrictions on this mode, while some others (e.g. the United States, the European Union) have imposed certain limits. The limits are mostly about the foreign equity share permissible. In addition, there are

requirements of authorization and licensing; but this is to be expected for a foreign firm setting up a hospital. India allows this mode of health service supply only through incorporation with a foreign equity ceiling of 51 per cent. There is no limit on national treatment, implying thereby that such a hospital would receive the same treatment as hospital set up by an Indian entrepreneur.

The fourth mode, namely presence of natural persons as providers of service, is quite important, and has attracted a large number of commitments. Although a few countries have imposed no restrictions on this mode of supply of medical service, several others have laid down conditions on entry of natural personnel as service providers. In most cases, however, this mode is unbound except for horizontal commitments (i.e. those that apply to all sectors). The commitments of the European Union, India, Malaysia, Mexico and the United States are, for example, of this nature. The horizontal commitments make it difficult for foreign nationals to enter these countries as natural persons providing service, except as intercorporate transferees, managers, executives or high-level specialists. Doctors are accepted as specialists. It is therefore possible for Indian doctors to go to foreign countries as natural persons, subject to certain other restrictions, for example local regulations governing medical practice which often involves passing country-specific examinations.

India's horizontal commitment regarding professionals (which would include doctors) is that the natural person should be engaged by a juridical person in India as part of a service contract for rendering professional services for which he or she possesses the necessary academic credentials and professional qualifications and three years' experience. Another condition is that entry and stay in this category shall be for a maximum period of one year.

Another point to be noted here is that many of the countries which have opened their health-related services have asked for exemptions from applying most-favoured nation treatment. These countries, which include the United States, may therefore offer an advantage to health service providers from friendly countries, for example, those belonging to a trading bloc or those with whom a bilateral investment treaty exists.

## Barriers to trade

The above discussion brought out that on the whole only a limited access has been provided by the Members to their markets for health-related services. It would be useful to look at the four different modes of supply of health services and spell out the barriers to trade that exist at present from the point of view of India's exports or imports of health services.

The first mode of supply, which includes telemedicine and other means of cross-border provision does not seem to be subject to any trade barrier at present. India has kept this mode unbound on the ground of technical infeasibility. Yet, it is quite possible that in the next 10 to 15 years such a network of cross-border supply will be set up in India. Thus, Indian doctors may provide diagnoses and advisory services (say, for magnetic-resonance imaging scan) to neighbouring developing countries, or foreign-owned hospitals in India established in the coming years may receive such services from doctors of the investing countries. Possibilities of such cross-border trade exist, and although India has made no commitments, there is at present no obvious barrier to such trade. It should be pointed out here that a number of countries, such as Malaysia, have imposed no limits on the cross-border supply of health services. India has made such commitment only in respect of telecommunication services. Even for computer and related services, India has made no commitment on cross-border supply.

For the second mode of supply, i.e. consumption abroad, India has made no commitments, though this is the predominant mode in which trade is taking place at present. Interestingly, most Member countries have put no limits on this mode of trade in health services. India's noncommittal attitude notwithstanding, inward and outward flow of patients to and from India seems to be virtually unrestricted, as discussed above. This does not imply, however, that there are no barriers to trade. One such barrier arises from the question of reimbursement of medical expenses. For example, for consumption of medical services by United States citizens, federal or state government reimbursement of medical expenses is limited to licensed, certified facilities in the United States or in a specific American state. This obviously comes in the way of consumption of health care facilities abroad and by the United States citizen. This restriction is not present

in the commitment of the European Union, although it is not clear if citizens of these countries can claim reimbursement from their governments/ insurance companies for expenses incurred in obtaining medical treatment abroad. In the case of India too, it would be difficult for a government employee to claim reimbursement for medical treatment received abroad (unless it were an emergency). Although the corporate sector is more liberal with its employees in the matter of health facilities, it is doubtful whether employees (barring possibly top executives) would be reimbursed cost of medical treatment received abroad.

Evidently, this is an area in which greater trade can be achieved through negotiations on reimbursement facilities. One particular action that can be taken is to ensure that if United States investors set up hospitals in India then reimbursement of medical expenses should be allowed for United States citizens treated in such a hospital.

With regard to the third mode, commercial presence, most countries have made commitments, as has India. Thus, in principal, it is possible for foreigners to set up hospitals in India, and Indians to set up hospitals abroad, both in developed and developing countries. Certain trade barriers, however, remain. One of them is the limit on permissible equity held by foreigners. In the case of India, the limit on foreign equity is 51 per cent (100 per cent for nonresident Indians). But there are countries in which the foreign equity ceiling has been set at a lower level (say 30 per cent). This is obviously a barrier to trade in health services, and calls for further negotiation with a view to relaxing the limit on foreign equity participation.

The importance of this mode of health service provision should be recognized. As discussed above, such investment from abroad may encourage more and more developed country patients to come to India for treatment. Again, such investment may be accompanied by foreign specialists coming to India and serving in such establishment for short periods.

Besides permissible foreign equity participation, there could be other restrictions on the "commercial presence" mode of health care exports. For example, the United States has maintained its right to impose a need-based quantitative limit on the establishment of hospitals and health care facilities. Another obstacle in this regard is that foreign enterprises and domestic enterprises may not receive the same treatment in the matter of acquisition of

land. An Indian entrepreneur trying to set up a hospital in the United States may face difficulties in acquiring land for this purpose.

As regards, the fourth mode of supply, natural persons, considerable barriers exist to trade because most countries want to regulate strictly the inflow of such persons. Consider the case of the United States. For entry and temporary stay of fashion models and specialty occupations, the United States commitment is up to 65,000 persons annually on a worldwide basis. The share of India in that figure would obviously be small, and that for doctors would be minuscule. There are, in addition, strict conditions for market access. The wages paid to the person should be the same as those paid to nationals in that profession (which eliminates the advantage of India as a cheap source of medical specialists). No labour management dispute should be in progress at the place of employment. No worker should have been laid off in the preceding six months and no American worker should be displaced in the 90-day period following the filing of an application or the 90-day period preceding and following the filing of any visa petition supported by an application. The employer should have taken and should take timely and significant steps to recruit and retain sufficient American workers in the specialty occupation.

Another difficulty that arises for the fourth mode of service provision is that in the matter of taxation foreigners are treated in the same way as United States citizens. Since natural persons as providers of service for a short period may be subject to taxation in their home country, being treated in the same way as a United States citizen implies that they might suffer double taxation.

A different category of problems regarding movement of natural persons arises from the fact that they would be subject to the regulations of professional bodies. They would be required to satisfy the requirements of professional qualification in order to be able to provide the service. For persons taking up short-term assignment, these regulations can be quite restrictive.

## V CONCLUSIONS AND POLICY RECOMMENDATIONS

After analysing GATS and the Indian situation, we conclude that the Agreement is a positive step towards a freer trade regime in health services, though it has achieved little in terms of immediate liberalization.

As for India's position, we believe that opening up the various areas of health services will be beneficial for the country as a whole. Trade in health services would affect curative care in India only in the short run. In the long run, the whole system of health care is likely to be influenced by the opening up of this sector. We contend that this opening up is unlikely to affect the availability of health care within the country, and may in fact improve the quality and even the quantity of curative care available. For achieving the overall objective of health for all, India needs to make drastic changes in domestic policy in the health sector, and trade in health services will not adversely affect this objective.

The priorities in this area identified in this paper are three: outflow of health personnel, inflow of patients and inflow of foreign capital. This does not mean that these are the only three areas of current trade. However, these are areas where India is currently engaged in trade in health services, and where it should hope to gain the most.

The barriers to trade existing in these areas currently prevent an expansion of trade. Below we recommend specific steps that can be taken to remove or relax the barriers in these three, and in other, areas where India is currently engaged in trade.

The first recommendation we make is in the areas of greater commitments. Unlike GATT, GATS is a much more loose set of agreements, which has resulted by and large in countries not making commitments. The commitments thus far basically amount to a binding of the status quo. But the basic purpose of the agreement in terms of reduction of discrimination and enhancement of market access has not occurred. Unless countries come forward and make commitments, the objectives of GATS will remain unrealized. In the spirit of GATS, developed countries should take initiatives in this regard to make greater market-access commitments, and show a willingness to collaborate with developing countries.

Secondly, overall restrictions on short-term movements of medical personnel should be reviewed and relaxed so as to facilitate the easy exchange of health personnel across countries. In this context, one key demand of

developing countries was commitments that would make it possible for independent professionals to work abroad, without the requirement of commercial presence. This demand has however been bypassed in the sets of commitments that have been made so far by the developed countries. There have been very few offers for contract professionals and none for semiskilled and unskilled workers. Further, several developed countries have imposed an economic needs test. thereby severely restricting the flow of cross-border professionals. For example, the United States offer of accepting 65,000 persons annually is too low and also comes with several other restrictive clauses.

As far as exchange of health personnel is concerned, there needs to be a standardization of rules regarding educational degrees and their recognition by Member countries. One of the major deterrents towards greater exchange of health personnel in India has been the fact that Indian medical degrees and diplomas are not recognized by many developed countries. A system of mutual recognition for qualification requirements and technical standards need to be worked out globally, so that no arbitrary rejection of deserving candidates takes place. However, while global agreement on standards is required, countries need to review their own medical education system to ensure that a minimum standard in medical education and training is maintained.

As for specific measures that India can take to promote a more conducive trade environment to take advantage of greater trade in health services, the following points may be of relevance.

India should have a more open mind towards foreign investment in the health sector. However, this should be accompanied by a system of regulations relating to the health sector as a whole, which would prevent unfair practices by both domestic and foreign establishments.

Further, India has a very strong and unique system of alternative medicines. This is an area which should be given more attention, especially in the context of foreign patients coming into India for treatment.

Lastly, India should recognize its competitive advantage in exports of health services between countries and the various trading blocs of the region. It should take the lead in making bi- and multilateral agreements and commitments which would promote a freer environment in trade in health services.